

Representative R. Curt Webb proposes the following substitute bill:

HEALTH CARE DEBT COLLECTION AMENDMENTS

2017 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: R. Curt Webb

Senate Sponsor: Curtis S. Bramble

LONG TITLE

General Description:

This bill modifies and enacts provisions related to health care claims practices.

Highlighted Provisions:

This bill:

- ▶ defines terms;
- ▶ modifies the circumstances under which a health care provider may make a report to a credit bureau or use the services of a collection agency against an insured;
- ▶ addresses administrative penalties for a health care provider who fails to comply with the provisions of this bill; and
- ▶ makes technical and conforming changes.

Money Appropriated in this Bill:

None

Other Special Clauses:

None

Utah Code Sections Affected:

AMENDS:

31A-26-301.5, as last amended by Laws of Utah 2016, Chapter 124

62A-2-112, as last amended by Laws of Utah 2016, Chapter 211



26 ENACTS:

27 **26-21-11.1**, Utah Code Annotated 1953

28 **58-1-508**, Utah Code Annotated 1953

29

30 *Be it enacted by the Legislature of the state of Utah:*

31 Section 1. Section **26-21-11.1** is enacted to read:

32 **26-21-11.1. Failure to follow certain health care claims practices -- Penalties.**

33 (1) The department may assess a fine of up to \$500 per violation against a health care

34 facility that violates Subsection ~~§~~ **31A-36-301.5(4)** **31A-26-301.5(4)** ~~§~~ .

35 (2) The department shall waive the fine described in Subsection (1) if:

36 (a) the health care facility demonstrates to the department that the health care facility
37 mitigated and reversed any damage to the insured caused by the health care facility's violation;

38 or

39 (b) the insured does not pay the full amount due on the bill that is the subject of the

40 violation, including any interest, fees, costs, and expenses, within 120 days after the day on

41 which the health care facility makes a report to a credit bureau or uses the services of a

42 collection agency in violation of Subsection **31A-26-301.5(4)**.

43 Section 2. Section **31A-26-301.5** is amended to read:

44 **31A-26-301.5. Health care claims practices.**

45 (1) As used in this section ~~§~~ **["health"]** :

46a (a) **"Health** ~~§~~ **care provider"** means:

47 ~~§~~ **[(a)] (i)** ~~§~~ **a health care facility as defined in Section **26-21-2**; or**

48 ~~§~~ **[(b)] (ii)** ~~§~~ **a person licensed to provide health care services under:**

49 ~~§~~ **[(c)] (A)** ~~§~~ **Title 58, Occupations and Professions; or**

50 ~~§~~ **[(d)] (B)** ~~§~~ **Title 62A, Chapter 2, Licensure of Programs and Facilities.**

49a ~~§~~ **(b) "Text message" means a real time or near real time message that consists of text and**
49b **is transmitted to a device identified by a telephone number.** ~~§~~

50 ~~[(1)] (2)~~ Except as provided in Section **31A-8-407**, an insured retains ultimate
51 responsibility for paying for health care services the insured receives. If a service is covered by
52 one or more individual or group health insurance policies, all insurers covering the insured
53 have the responsibility to pay valid health care claims in a timely manner according to the
54 terms and limits specified in the policies.

55 ~~[(2)(a)] (3)~~ ~~[Except as provided in Section **31A-22-610.1, a**]~~ **A** health care provider

56 may:

57 (a) except as provided in Section 31A-22-610.1, bill and collect for any deductible,
 58 copayment, or uncovered service[-]; and

59 (b) [A health care provider may] bill an insured for services covered by health
 60 insurance policies or [may] otherwise notify the insured of the expenses covered by the
 61 policies. [However, a]

62 (4) (a) Except as provided in Subsection (4)(c), a health care provider may not make
 63 any report to a credit bureau[-] or use the services of a collection agency[-, or use methods other
 64 than routine billing or notification until the later of] unless the health care provider:

65 (i) (A) after the expiration of the time afforded to an insurer under Section
 66 31A-26-301.6 to determine [its] the insurer's obligation to pay or deny the claim without
 67 penalty[-; or], sends a notice described in Subsection (4)(b) to the insured by certified mail with
 68 return receipt requested ~~Ŝ→~~ , **priority mail, or text message** ←Ŝ ; and

69 (B) makes the report to a credit bureau or uses the services of a collection agency after
 70 the date stated in the notice in accordance with Subsection (4)(b)(ii)(A); or

71 (ii) (A) in the case of a Medicare [beneficiaries or retirees] beneficiary or retiree 65
 72 years of age or older, [~~60 days from~~] after the date Medicare determines [its] Medicare's
 73 liability for the claim[-], sends a notice described in Subsection (4)(b) to the insured by
 74 certified mail with return receipt requested ~~Ŝ→~~ , **priority mail, or text message** ←Ŝ ; and

75 (B) makes the report to a credit bureau or uses the services of a collection agency after
 76 the date stated in the notice in accordance with Subsection (4)(b)(ii)(B).

77 (b) A notice described in Subsection (4)(a) shall state:

78 (i) the amount that the insured owes;

79 (ii) the date by which the insured must pay the amount owed that is:

80 (A) at least 45 days after the day on which the health care provider sends the notice; or

81 (B) if the insured is a Medicare beneficiary or retiree 65 years of age or older, at least
 82 60 days after the day on which the health care provider sends the notice;

83 (iii) that if the insured fails to timely pay the amount owed, the health care provider
 84 may make a report to a credit bureau or use the services of a collection agency; and

85 (iv) that each action described in Subsection (4)(b)(iii) may negatively impact the
 86 insured's credit score.

87 (c) A health care provider satisfies the requirements described in Subsections (4)(a)

88 and (b) if the health care provider complies with the provisions of 26 C.F.R. Sec. 1.501(r)-6.

89 ~~[(e)]~~ (5) Beginning October 31, 1992, all insurers covering the insured shall notify the
90 insured of payment and the amount of payment made to the health care provider.

91 ~~[(f)]~~ (6) A health care provider shall return to an insured any amount the insured
92 overpaid, including interest that begins accruing 90 days after the date of the overpayment, if:

93 ~~[(f)]~~ (a) the insured has multiple insurers with whom the health care provider has
94 contracts that cover the insured; and

95 ~~[(f)]~~ (b) the health care provider becomes aware that the health care provider has
96 received, for any reason, payment for a claim in an amount greater than the health care
97 provider's contracted rate allows.

98 ~~[(g)]~~ (7) The commissioner shall make rules consistent with this chapter governing
99 disclosure to the insured of customary charges by health care providers on the explanation of
100 benefits as part of the claims payment process. These rules shall be limited to the form and
101 content of the disclosures on the explanation of benefits, and shall include:

102 (a) a requirement that the method of determination of any specifically referenced
103 customary charges and the range of the customary charges be disclosed; and

104 (b) a prohibition against an implication that the health care provider is charging
105 excessively if the health care provider is:

106 (i) a participating provider; and

107 (ii) prohibited from balance billing.

108 Section 3. Section **58-1-508** is enacted to read:

109 **58-1-508. Failure to follow certain health care claims practices -- Penalties.**

110 (1) As used in this section, "health care provider" means an individual who is licensed
111 to provide health care services under this title.

112 (2) The division may assess a fine of up to \$500 per violation against a health care
113 provider who violates Subsection ~~5~~ → ~~31A-36-301.5(4)~~ 31A-26-301.5(4) ← ~~5~~ .

114 (3) The division shall waive the fine described in Subsection (2) if:

115 (a) the health care provider demonstrates to the division that the health care provider
116 mitigated and reversed any damage to the insured caused by the health care provider's
117 violation; or

118 (b) the insured does not pay the full amount due on the bill that is the subject of the

119 violation, including any interest, fees, costs, and expenses, within 120 days after the day on
 120 which the health care provider makes a report to a credit bureau or uses the services of a
 121 collection agency in violation of Subsection 31A-26-301.5(4).

122 Section 4. Section 62A-2-112 is amended to read:

123 **62A-2-112. Violations -- Penalties.**

124 (1) A used in this section, "health care provider" means a person licensed to provide
 125 health care services under this chapter.

126 ~~[(+)]~~ (2) The office may deny, place conditions on, suspend, or revoke a human
 127 services license, if it finds, related to the human services program:

128 (a) that there has been a failure to comply with the rules established under this chapter;

129 (b) evidence of aiding, abetting, or permitting the commission of any illegal act; or

130 (c) evidence of conduct adverse to the standards required to provide services and
 131 promote public trust, including aiding, abetting, or permitting the commission of abuse,
 132 neglect, exploitation, harm, mistreatment, or fraud.

133 ~~[(2)]~~ (3) The office may restrict or prohibit new admissions to a human services
 134 program, if it finds:

135 (a) that there has been a failure to comply with rules established under this chapter;

136 (b) evidence of aiding, abetting, or permitting the commission of any illegal act; or

137 (c) evidence of conduct adverse to the standards required to provide services and
 138 promote public trust, including aiding, abetting, or permitting the commission of abuse,
 139 neglect, exploitation, harm, mistreatment, or fraud.

140 (4) (a) The office may assess a fine of up to \$500 per violation against a health care
 141 provider who violates Subsection ~~Ŝ~~ → ~~[31A-36-301.5(4)]~~ 31A-26-301.5(4) ← ~~Ŝ~~.

142 (b) The office shall waive the fine described in Subsection (4)(a) if:

143 (i) the health care provider demonstrates to the office that the health care provider
 144 mitigated and reversed any damage to the insured caused by the health care provider's
 145 violation; or

146 (ii) the insured does not pay the full amount due on the bill that is the subject of the
 147 violation, including any interest, fees, costs, and expenses, within 120 days after the day on
 148 which the health care provider makes a report to a credit bureau or uses the services of a
 149 collection agency in violation of Subsection 31A-26-301.5(4).