

HEALTH CARE DEBT COLLECTION AMENDMENTS

2017 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: R. Curt Webb

Senate Sponsor: _____

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, use the services of a collection agency, or use a nonroutine billing or notification method against an insured;
- provides a private right of action against a health care provider who fails to comply with the provisions of this bill;
- 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



28 **62A-2-112**, as last amended by Laws of Utah 2016, Chapter 211

29 ENACTS:

30 **26-21-11.1**, Utah Code Annotated 1953

31 **58-1-508**, Utah Code Annotated 1953

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

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

35 **26-21-11.1. Failure to follow certain health care claims practices -- Penalties.**

36 (1) The department may assess a fine of up to \$500 per violation against a health care
37 facility that violates Subsection **31A-36-301.5**(3)(b).

38 (2) The department shall waive the fine described in Subsection (1) if the health care
39 facility demonstrates to the department that the health care facility mitigated and reversed any
40 damage to the insured caused by the health care facility's violation.

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

42 **31A-26-301.5. Health care claims practices.**

43 (1) As used in this section, "health care provider" means:

44 (a) a health care facility as defined in Section **26-21-2**; or

45 (b) a person licensed to provide health care services under:

46 (i) Title 58, Occupations and Professions; or

47 (ii) Title 62A, Chapter 2, Licensure of Programs and Facilities.

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

53 ~~[(2)]~~ (3) (a) ~~[Except as provided in Section **31A-22-610.1**, a]~~ A health care provider
54 may:

55 (i) except as provided in Section **31A-22-610.1**, bill and collect for any deductible,
56 copayment, or uncovered service[-]; and

57 ~~[(b)]~~ (ii) [A health care provider may] bill an insured for services covered by health
58 insurance policies or [may] otherwise notify the insured of the expenses covered by the

59 policies. [~~However, a~~]

60 (b) A health care provider may not make any report to a credit bureau, use the services
61 of a collection agency, or use [~~methods~~] any method other than routine billing or notification
62 until:

63 (i) the later of:

64 [(i)] (A) [~~the expiration of~~] 60 days after the day on which the time afforded to an
65 insurer under Section 31A-26-301.6 to determine its obligation to pay or deny the claim
66 without penalty expires; or

67 [(ii)] (B) in the case of Medicare beneficiaries or retirees 65 years of age or older, 60
68 days from the date Medicare determines its liability for the claim[-]; and

69 (ii) after the applicable date described in Subsection (3)(b)(i), the health care provider
70 sends a notice to the insured by certified mail with return receipt requested that states:

71 (A) the amount that the insured owes;

72 (B) a date that is at least 30 days after the day on which the health care provider sends
73 the notice by which the insured must pay the amount owed;

74 (C) that if the insured fails to timely pay the amount owed, the health care provider
75 may make a report to a credit bureau, use the services of a collection agency, or use another
76 nonroutine billing or notification method; and

77 (D) that each action described in Subsection (3)(b)(ii)(C) may negatively impact the
78 insured's credit score.

79 (c) (i) An insured may file an action in district court against a health care provider for a
80 violation of a provision of Subsection (3)(b).

81 (ii) If the court finds that the health care provider violated a provision of Subsection
82 (3)(b), the court shall award the insured:

83 (A) actual damages;

84 (B) costs; and

85 (C) reasonable attorney fees.

86 [(e)] (3) Beginning October 31, 1992, all insurers covering the insured shall notify the
87 insured of payment and the amount of payment made to the health care provider.

88 [(d)] (4) A health care provider shall return to an insured any amount the insured
89 overpaid, including interest that begins accruing 90 days after the date of the overpayment, if:

(i) the insured has multiple insurers with whom the health care provider has contracts that cover the insured; and

(ii) the health care provider becomes aware that the health care provider has received, for any reason, payment for a claim in an amount greater than the health care provider's contracted rate allows.

~~[(3)]~~ (5) The commissioner shall make rules consistent with this chapter governing disclosure to the insured of customary charges by health care providers on the explanation of benefits as part of the claims payment process. These rules shall be limited to the form and content of the disclosures on the explanation of benefits, and shall include:

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

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

(i) a participating provider; and

(ii) prohibited from balance billing.

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

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

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

(2) The division may assess a fine of up to \$500 per violation against a health care provider who violates Subsection [31A-36-301.5\(3\)\(b\)](#).

(3) The division shall waive the fine described in Subsection (2) if the health care provider demonstrates to the division that the health care provider mitigated and reversed any damage to the insured caused by the health care provider's violation.

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

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

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

~~[(1)]~~ (2) The office may deny, place conditions on, suspend, or revoke a human services license, if it finds, related to the human services program:

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

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

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

125 [~~(2)~~] (3) The office may restrict or prohibit new admissions to a human services
126 program, if it finds:

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

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

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

132 (4) (a) The office may assess a fine of up to \$500 per violation against a health care
133 provider who violates Subsection 31A-36-301.5(3)(b).

134 (b) The office shall waive the fine described in Subsection (4)(a) if the health care
135 provider demonstrates to the office that the health care provider mitigated and reversed any
136 damage to the insured caused by the health care provider's violation.

Legislative Review Note
Office of Legislative Research and General Counsel