

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;
- 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:



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

27 **62A-2-112**, as last amended by Laws of Utah 2016, Chapter 211

28 ENACTS:

29 **26-21-11.1**, Utah Code Annotated 1953

30 **58-1-508**, Utah Code Annotated 1953

31

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

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

33 **26-21-11.1. Failure to follow certain health care claims practices -- Penalties.**

34 (1) The department may assess a fine of up to \$500 per violation against a health care
35 facility that violates Subsection **31A-36-301.5**(4).

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

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

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

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

45 **31A-26-301.5. Health care claims practices.**

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

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

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

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

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

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

57 ~~[(2)(a)]~~ (3) ~~[Except as provided in Section 31A-22-610.1, a]~~ A health care provider
58 may;

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

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

64 (4) (a) Subject to Subsection (4)(b), a health care provider may not make any report to
65 a credit bureau[-] or use the services of a collection agency[-, or use methods other than routine
66 billing or notification] until:

67 (i) the later of:

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

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

73 (ii) after the applicable date described in Subsection (4)(a)(i), the health care provider
74 sends a notice to the insured by certified mail with return receipt requested that states:

75 (A) the amount that the insured owes;

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

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

80 (D) that each action described in Subsection (4)(a)(ii)(C) may negatively impact the
81 insured's credit score; and

82 (iii) after the date stated in the notice in accordance with Subsection (4)(a)(ii)(B).

83 (b) A health care provider satisfies the requirements described in Subsection (4)(a) if
84 the health care provider complies with the provisions of 26 C.F.R. Sec. 1.501(r)-6.

85 (5) (a) An insured may file an action in district court against a health care provider for
86 a violation of a provision of Subsection (4).

87 (b) If the court finds that the health care provider violated a provision of Subsection

88 (4), the court shall award the insured:

89 (i) actual damages;

90 (ii) costs; and

91 (iii) reasonable attorney fees.

92 ~~[(e)]~~ (6) Beginning October 31, 1992, all insurers covering the insured shall notify the
93 insured of payment and the amount of payment made to the health care provider.

94 ~~[(d)]~~ (7) A health care provider shall return to an insured any amount the insured
95 overpaid, including interest that begins accruing 90 days after the date of the overpayment, if:

96 ~~[(i)]~~ (a) the insured has multiple insurers with whom the health care provider has
97 contracts that cover the insured; and

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

101 ~~[(3)]~~ (8) The commissioner shall make rules consistent with this chapter governing
102 disclosure to the insured of customary charges by health care providers on the explanation of
103 benefits as part of the claims payment process. These rules shall be limited to the form and
104 content of the disclosures on the explanation of benefits, and shall include:

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

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

109 (i) a participating provider; and

110 (ii) prohibited from balance billing.

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

112 **58-1-508. Failure to follow certain health care claims practices -- Penalties.**

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

115 (2) The division may assess a fine of up to \$500 per violation against a health care
116 provider who violates Subsection [31A-36-301.5](#)(4).

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

118 (a) 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; or

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

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

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

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

~~[(+)]~~ (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;

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

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

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

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

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

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

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

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

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

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

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