LEGISLATIVE GENERAL COUNSEL
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H.B. 140
1st Sub. (Buff)

Representative Chad E. Bennion proposes to substitute the following bill:

HEALTH CLAIMS PROCESSING AND HEALTH CLAIMS AUDITING ACT

2001 GENERAL SESSION

STATE OF UTAH

Sponsor: Chad E. Bennion

This act modifies the Insurance Code. This act amends health care claims practices by adding a limitation to the circumstances in which a health care provider may initiate collection efforts against an insured individual. This act provides an effective date.

This act affects sections of Utah Code Annotated 1953 as follows:

AMENDS:

31A-26-301.5, as last amended by Chapter 198, Laws of Utah 2000

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

Section 1. Section **31A-26-301.5** is amended to read:

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

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

(2) (a) Except as provided in Section 31A-22-610.1, a health care provider may bill and collect for any deductible, copayment, or uncovered service.

(b) A health care provider may bill an insured for services covered by health insurance policies or may otherwise notify the insured of the expenses covered by the policies. However, a provider may not make any report to a credit bureau, use the services of a collection agency, or use methods other than routine billing or notification until the later of:

(i) 15 days after the date all insurance companies covering the insured have paid their portion of the claim covered by the policies;

(ii) 60 days from the date all insurers covering the insured are billed for the covered service; [~~or~~]

(iii) 20 days after the provider has submitted to an insurer notice that the provider has submitted all information requested by the insurer that is in the provider's possession related to the claim; or

[~~(iii)~~] (iv) in the case of medicare beneficiaries or retirees 65 years of age or older, 60 days from the date medicare determines its liability for the claim.

(c) [~~Beginning October 31, 1992, all~~] All insurers covering the insured shall notify the insured of payment and the amount of payment made to the provider.

(3) 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 provider is charging excessively if the provider is:

(i) a participating provider; and

(ii) prohibited from balance billing.

Section 2. **Effective date.**

This act takes effect on July 1, 2001.