Health Care Amendments

2025 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: James A. Dunnigan

Senate Sponsor: Evan J. Vickers

LONG TITLE

General Description:

This bill amends provisions related to health care practices.

Highlighted Provisions:

This bill:

- amends provisions regarding the use of credit card payments to health care providers;
- amends provisions related to dental claims practices; and
- allows dentists to dispense medications under certain circumstances.

Money Appropriated in this Bill:

None

Other Special Clauses:

None

Utah Code Sections Affected:

AMENDS:

31A-26-301.6, as last amended by Laws of Utah 2024, Chapter 120

31A-26-301.7, as enacted by Laws of Utah 2021, Chapter 288

58-88-201, as last amended by Laws of Utah 2023, Chapter 329

58-88-202, as last amended by Laws of Utah 2024, Chapter 210

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

Section 1. Section **31A-26-301.6** is amended to read:

31A-26-301.6 . Health care claims practices.

(1) As used in this section:

(a) "Health care provider" means a person licensed to provide health care under:

(i) Title 26B, Chapter 2, Part 2, Health Care Facility Licensing and Inspection; or

(ii) Title 58, Occupations and Professions.

(b) "Insurer" means an admitted or authorized insurer, as defined in Section 31A-1-301, and includes:

(i) a health maintenance organization; and

(ii) a third party administrator that is subject to this title, provided that nothing in this section may be construed as requiring a third party administrator to use its own funds to pay claims that have not been funded by the entity for which the third party administrator is paying claims.

(c) "Provider" means a health care provider to whom an insurer is obligated to pay directly in connection with a claim by virtue of:

(i) an agreement between the insurer and the provider;

(ii) an accident and health insurance policy or contract of the insurer; or

(iii) state or federal law.

(2) An insurer shall timely pay every valid insurance claim submitted by a provider in accordance with this section.

(3)(a) Except as provided in Subsection (4), within 30 days of the day on which the insurer receives a written claim, an insurer shall:

(i) pay the claim; or

(ii) deny the claim and provide a written explanation for the denial.

(b)(i) Subject to Subsection (3)(b)(ii), the time period described in Subsection (3)(a) may be extended by 15 days if the insurer:

(A) determines that the extension is necessary due to matters beyond the control of the insurer; and

(B) before the end of the 30-day period described in Subsection (3)(a), notifies the provider and insured in writing of:

(I) the circumstances requiring the extension of time; and

(II) the date by which the insurer expects to pay the claim or deny the claim with a written explanation for the denial.

(ii) If an extension is necessary due to a failure of the provider or insured to submit the information necessary to decide the claim:

(A) the notice of extension required by this Subsection (3)(b) shall specifically describe the required information; and

(B) the insurer shall give the provider or insured at least 45 days from the day on which the provider or insured receives the notice before the insurer denies the claim for failure to provide the information requested in Subsection

(3)(b)(ii)(A).

(4)(a) In the case of a claim for income replacement benefits, within 45 days of the day on which the insurer receives a written claim, an insurer shall:

(i) pay the claim; or

(ii) deny the claim and provide a written explanation of the denial.

(b) Subject to Subsections (4)(d) and (e), the time period described in Subsection (4)(a) may be extended for 30 days if the insurer:

(i) determines that the extension is necessary due to matters beyond the control of the insurer; and

(ii) before the expiration of the 45-day period described in Subsection (4)(a), notifies the insured of:

(A) the circumstances requiring the extension of time; and

(B) the date by which the insurer expects to pay the claim or deny the claim with a written explanation for the denial.

(c) Subject to Subsections (4)(d) and (e), the time period for complying with Subsection (4)(a) may be extended for up to an additional 30 days from the day on which the 30-day extension period provided in Subsection (4)(b) ends if before the day on which the 30-day extension period ends, the insurer:

(i) determines that due to matters beyond the control of the insurer a decision cannot be rendered within the 30-day extension period; and

(ii) notifies the insured of:

(A) the circumstances requiring the extension; and

(B) the date as of which the insurer expects to pay the claim or deny the claim with a written explanation for the denial.

(d) A notice of extension under this Subsection (4) shall specifically explain:

(i) the standards on which entitlement to a benefit is based; and

(ii) the unresolved issues that prevent a decision on the claim.

(e) If an extension allowed by Subsection (4)(b) or (c) is necessary due to a failure of the insured to submit the information necessary to decide the claim:

(i) the notice of extension required by Subsection (4)(b) or (c) shall specifically describe the necessary information; and

(ii) the insurer shall give the insured at least 45 days from the day on which the insured receives the notice before the insurer denies the claim for failure to provide the information requested in Subsection (4)(b) or (c).

(5) If a period of time is extended as permitted under Subsection (3)(b), (4)(b), or (4)(c), due to an insured or provider failing to submit information necessary to decide a claim, the period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to the insured or provider until the date on which the insured or provider responds to the request for additional information.

(6) An insurer shall pay all sums to the provider or insured that the insurer is obligated to pay on the claim, and provide a written explanation of the insurer's decision regarding any part of the claim that is denied within 20 days of receiving the information requested under Subsection (3)(b), (4)(b), or (4)(c).

(7)(a) Whenever an insurer makes a payment to a provider on any part of a claim under this section, the insurer shall also send to the insured an explanation of benefits paid.

(b) Whenever an insurer denies any part of a claim under this section, the insurer shall also send to the insured:

(i) a written explanation of the part of the claim that was denied; and

(ii) notice of the adverse benefit determination review process established under Section 31A-22-629.

(c) This Subsection (7) does not apply to a person receiving benefits under the state Medicaid program as defined in Section 26B-3-101, unless required by the Department of Health and Human Services or federal law.

(8)(a) A late fee shall be imposed on:

(i) an insurer that fails to timely pay a claim in accordance with this section; and

(ii) a provider that fails to timely provide information on a claim in accordance with this section.

(b) The late fee described in Subsection (8)(a) shall be determined by multiplying together:

(i) the total amount of the claim the insurer is obliged to pay;

(ii) the total number of days the response or the payment is late; and

(iii) 0.033% daily interest rate.

(c) Any late fee paid or collected under this Subsection (8) shall be separately identified on the documentation used by the insurer to pay the claim.

(d) For purposes of this Subsection (8), "late fee" does not include an amount that is less than $1.

(9) Each insurer shall establish a review process to resolve claims-related disputes between the insurer and providers.

(10) An insurer or person representing an insurer may not engage in any unfair claim settlement practice with respect to a provider. Unfair claim settlement practices include:

(a) knowingly misrepresenting a material fact or the contents of an insurance policy in connection with a claim;

(b) failing to acknowledge and substantively respond within 15 days to any written communication from a provider relating to a pending claim;

(c) denying or threatening to deny the payment of a claim for any reason that is not clearly described in the insured's policy;

(d) failing to maintain a payment process sufficient to comply with this section;

(e) failing to maintain claims documentation sufficient to demonstrate compliance with this section;

(f) failing, upon request, to give to the provider written information regarding the specific rate and terms under which the provider will be paid for health care services;

(g) failing to timely pay a valid claim in accordance with this section as a means of influencing, intimidating, retaliating, or gaining an advantage over the provider with respect to an unrelated claim, an undisputed part of a pending claim, or some other aspect of the contractual relationship;

(h) failing to pay the sum when required and as required under Subsection (8) when a violation has occurred;

(i) threatening to retaliate or actual retaliation against a provider for the provider applying this section;

(j) any material violation of this section; and

(k) any other unfair claim settlement practice established in rule or law.

(11)(a) The provisions of this section shall apply to each contract between an insurer and a provider for the duration of the contract.

(b) Notwithstanding Subsection (11)(a), this section may not be the basis for a bad faith insurance claim.

(c) Nothing in Subsection (11)(a) may be construed as limiting the ability of an insurer and a provider from including provisions in their contract that are more stringent than the provisions of this section.

(12)(a) Pursuant to Chapter 2, Part 2, Duties and Powers of Commissioner, the commissioner may conduct examinations to determine an insurer's level of compliance with this section and impose sanctions for each violation.

(b) The commissioner may adopt rules only as necessary to implement this section.

(c) The commissioner may establish rules to facilitate the exchange of electronic confirmations when claims-related information has been received.

(d) Notwithstanding Subsection (12)(b), the commissioner may not adopt rules regarding the review process required by Subsection (9).

(13) Nothing in this section may be construed as limiting the collection rights of a provider under Section 31A-26-301.5.

(14) Nothing in this section may be construed as limiting the ability of an insurer to:

(a) recover any amount improperly paid to a provider or an insured:

(i) in accordance with Section 31A-31-103 or any other provision of state or federal law;

(ii) within 24 months of the amount improperly paid for a coordination of benefits error;

(iii) within 12 months of the amount improperly paid for any other reason not identified in Subsection (14)(a)(i) or (ii); or

(iv) within 36 months of the amount improperly paid when the improper payment was due to a recovery by Medicaid, Medicare, the Children's Health Insurance Program, or any other state or federal health care program;

(b) take any action against a provider that is permitted under the terms of the provider contract and not prohibited by this section;

(c) report the provider to a state or federal agency with regulatory authority over the provider for unprofessional, unlawful, or fraudulent conduct; or

(d) enter into a mutual agreement with a provider to resolve alleged violations of this section through mediation or binding arbitration.

(15) A provider may only seek recovery from the insurer for an amount improperly paid by the insurer within the same time frames as Subsections (14)(a) and (b).

(16)(a) An insurer may offer the remittance of payment through a credit card or other similar arrangement.

(b)(i) A provider may elect not to receive remittance through a credit card or other similar arrangement.

(ii) An insurer:

(A) shall permit a provider's election described in Subsection (16)(b)(i) to apply to the provider's entire practice;[~~and~~]

(B) may not require a provider's election described in Subsection (16)(b)(i) to be made on a patient-by-patient basis[~~.~~] ; and

(C) shall allow a provider to opt out of all credit card or other similar arrangements for every plan offered by the insurer through a single opt out process.

(iii) If a provider elects not to receive remittance through a credit card or other similar arrangement, that decision remains in effect until:

(A) the provider affirmatively elects to receive remittance through credit card or similar arrangement; or

(B) a new contract is issued.

(c) An insurer may not require a provider or insured to accept remittance through a credit card or other similar arrangement.

(d) An insurer shall allow a tangible check as a form of acceptable payment.

Section 2. Section **31A-26-301.7** is amended to read:

31A-26-301.7 . Dental claim transparency and practices.

(1) As used in this section:

(a) "Bundling" means the practice of combining distinct dental procedures into one procedure for billing purposes.

(b) "Dental plan" means the same as that term is defined in Section 31A-22-646.

(c) "Downcoding" means the adjustment of a claim submitted to a dental plan to a less complex or lower cost procedure code.

(d) "Covered services" means the same as that term is defined in Section 31A-22-646.

(e) "Material change" means a change to:

(i) a dental plan's rules, guidelines, policies, or procedures concerning payment for dental services;

(ii) the general policies of the dental plan that affect a reimbursement paid to providers; or

(iii) the manner by which a dental plan adjudicates and pays a claim for services.

(2) An insurer that contracts or renews a contract with a dental provider shall:

(a) make a copy of the insurer's current dental plan policies available online; and

(b) if requested by a provider, send a copy of the policies to the provider through mail or electronic mail.

(3) Dental policies described in Subsection (2) shall include:

(a) a summary of all material changes made to a dental plan since the policies were last updated;

(b) the downcoding and bundling policies that the insurer reasonably expects to be

applied to the dental provider or provider's services as a matter of policy; and

(c) a description of the dental plan's utilization review procedures, including:

(i) a procedure for an enrollee of the dental plan to obtain review of an adverse determination in accordance with Section 31A-22-629; and

(ii) a statement of a provider's rights and responsibilities regarding the procedures described in Subsection (3)(c)(i).

(4) An insurer may not maintain a dental plan that:

(a) based on the provider's contracted fee for covered services, uses downcoding in a manner that prevents a dental provider from collecting the contracted fee for the actual service performed from either the plan or the patient;[~~or~~]

(b) uses bundling in a manner where a procedure code is labeled as nonbillable to the patient unless, under generally accepted practice standards, the procedure code is for a procedure that may be provided in conjunction with another procedure[~~.~~] ;

(c) does not allow a dental provider to seek payment of the contracted fee for a covered service from the patient when the insurer denies payment for the service, unless under generally accepted practice standards, the service performed should not be billed; or

(d) beginning January 1, 2026, automatically recoups an overpayment unless:

(i) the recoupment occurs more than 60 days from the day the insurer sends a notice of the overpayment; or

(ii) the dental provider affirmatively elects to have recoupment occur earlier than 60 days from the day the insurer sends a notice of the overpayment.

(5)(a) An insurer shall ensure that an explanation of benefits for a dental plan includes the reason for any downcoding or bundling result.

(b) A dental provider who receives an overpayment from a dental plan shall return the amount of the overpayment through check or other means to the dental plan within 60 days from the day the insurer sends a notice of the overpayment.

(c) A dental provider shall make reasonable efforts to inform patients of services that may not be covered by the patient's dental plan if the dental provider will perform a service that may not be covered.

Section 3. Section **58-88-201** is amended to read:

58-88-201 . Definitions.

As used in this part:

(1)(a) "Dispense" means the delivery by a prescriber of a prescription drug or device to a

patient, including the packaging, labeling, and security necessary to prepare and safeguard the drug or device for supplying to a patient.

(b) "Dispense" does not include:

(i) prescribing or administering a drug or device; or

(ii) delivering to a patient a sample packaged for individual use by a licensed manufacturer or re-packager of a drug or device.

(2) "Dispensing practitioner" means an individual who:

(a) is currently licensed as:

(i) a physician and surgeon under Chapter 67, Utah Medical Practice Act;

(ii) an osteopathic physician and surgeon under Chapter 68, Utah Osteopathic Medical Practice Act;

(iii) an advanced practice registered nurse under Subsection 58-31b-301(2)(d);[~~or~~]

(iv) a physician assistant under Chapter 70a, Utah Physician Assistant Act; or

(v) a dentist under Chapter 69, Dentist and Dental Hygienist Practice Act;

(b) is authorized by state law to prescribe and administer drugs in the course of professional practice; and

(c) practices at a licensed dispensing practice.

(3) "Drug" means the same as that term is defined in Section 58-17b-102.

(4) "Health care practice" means:

(a) a health care facility as defined in Section 26B-2-201; or

(b) the offices of one or more private prescribers, whether for individual or group practice.

(5) "Licensed dispensing practice" means a health care practice that is licensed as a dispensing practice under Section 58-88-202.

Section 4. Section **58-88-202** is amended to read:

58-88-202 . Dispensing practice -- Drugs that may be dispensed -- Limitations and exceptions.

(1) Notwithstanding Section 58-17b-302, a dispensing practitioner may dispense a drug at a licensed dispensing practice if the drug is:

(a) packaged in a fixed quantity per package by:

(i) the drug manufacturer;

(ii) a pharmaceutical wholesaler or distributor; or

(iii) a pharmacy licensed under Chapter 17b, Pharmacy Practice Act;

(b) dispensed:

(i) at a licensed dispensing practice at which the dispensing practitioner regularly practices; and

(ii) under a prescription issued by the dispensing practitioner to the dispensing practitioner's patient;

(c) except as provided in Subsection (6), for a condition that is not expected to last longer than 30 days; and

(d) for a condition for which the patient has been evaluated by the dispensing practitioner on the same day on which the dispensing practitioner dispenses the drug.

(2) A dispensing practitioner may not dispense:

(a) a controlled substance as defined in Section 58-37-2;

(b) a drug or class of drugs that is designated by the division under Subsection 58-88-205 (2); or

[~~(c) gabapentin; or~~]

[~~(d)~~] (c) a supply of a drug under this part that exceeds a 30-day supply.

(3) A dispensing practitioner may not make a claim against workers' compensation or automobile insurance for a drug dispensed under this part for outpatient use unless the dispensing practitioner is contracted with a pharmacy network established by the claim payor.

(4) When a dispensing practitioner dispenses a drug to the patient under this part, a dispensing practitioner shall:

(a) disclose to the patient verbally and in writing that the patient is not required to fill the prescription through the licensed dispensing practice and that the patient has a right to fill the prescription through a pharmacy; and

(b) if the patient will be responsible to pay cash for the drug, disclose:

(i) that the patient will be responsible to pay cash for the drug; and

(ii) the amount that the patient will be charged by the licensed dispensing practice for the drug.

(5) This part does not:

(a) require a dispensing practitioner to dispense a drug under this part;

(b) limit a health care prescriber from dispensing under Chapter 17b, Part 8, Dispensing Medical Practitioner and Dispensing Medical Practitioner Clinic Pharmacy; or

(c) apply to a physician who dispenses:

(i) a drug sample, as defined in Section 58-17b-102, to a patient in accordance with Section 58-1-501.3 or Section 58-17b-610; or

(ii) a drug in an emergency situation as defined by the division in rule under Chapter 17b, Pharmacy Practice Act.

(6) A dispensing practitioner that is a dentist may dispense prescription fluoride medication regardless of whether the condition the fluoride is treating will last longer than 30 days.

Section 5. **Effective Date.**

This bill takes effect on May 7, 2025.