Heard in the Health and Human Services Interim Committee on 11/19/2025

Health Plan Provider Directory Amendments

2026 GENERAL SESSION

STATE OF UTAH

Chief Sponsor:

Sponsor:

LONG TITLE

General Description:

This bill addresses provider directories and timely access to behavioral health services.

Highlighted Provisions:

This bill:

- ▸ requires covered insurers to:
  - assist enrollees in accessing behavioral health services in a timely manner;
  - facilitate an insured obtaining behavioral health services from an out-of-network provider if an in-network provider is not available in a timely manner;
  - publish health care provider directories;
  - regularly update health care provider directories; and
  - take certain steps to ensure the accuracy of provider directories;
- ▸ authorizes Utah's insurance commissioner to:
  - make rules to implement the provisions of this bill; and
  - impose penalties for failure to comply with provisions of this bill;
- ▸ requires providers to respond to an insurer's request for verification of provider directory information within a certain period of time and provides that a failure to comply constitutes unprofessional conduct;
- ▸ requires the Department of Health and Human Services to establish requirements for the state Medicaid program that are substantially similar to the requirements for private insurers related to timely access to behavioral health services and health care provider directories; and
- ▸ defines terms.

Money Appropriated in this Bill:

None

Other Special Clauses:

None

Utah Code Sections Affected:

AMENDS:

58-1-501, as last amended by Laws of Utah 2025, Chapter 138

58-1-502, as last amended by Laws of Utah 2020, Chapter 339

ENACTS:

26B-3-143, Utah Code Annotated 1953

31A-22-663, Utah Code Annotated 1953

31A-22-664, Utah Code Annotated 1953

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

Section 1. Section **26B-3-143** is enacted to read:

26B-3-143 . Timely access to behavioral health services -- Health care provider directories.

(1) The department shall establish requirements for the Medicaid program that are substantially similar to the requirements under:

(a) Section 31A-22-663, regarding timely access to behavioral health services; and

(b) Section 31A-22-664, regarding health care provider directories.

(2) The department may amend the Medicaid program and apply for waivers for the Medicaid program, if necessary, to implement Subsection (1).

Section 2. Section **31A-22-663** is enacted to read:

31A-22-663 . Timely access to behavioral health services -- Single case agreement.

(1) As used in this section:

(a) "Covered insurer" means an insurer that offers health insurance that includes coverage for behavioral health services.

(b)(i) "Behavioral health services" means:

(A) mental health treatment or services; or

(B) substance use treatment or services.

(ii) "Behavioral health services" includes telehealth services and telemedicine services.

(c) "Insurer" means the same as that term is defined in Section 31A-22-634.

(d) "Mental health provider" means the same as that term is defined in Section 31A-22-658.

(e) "Telehealth services" means the same as that term is defined in Section 26B-4-704.

(f) "Telemedicine services" means the same as that term is defined in Section 26B-4-704.

(g) "Timely manner" means:

(i) no more than seven days after the day on which an insured first attempts to access behavioral health services; and

(ii) no more than 24 hours after the date and time that an insured first seeks to access urgent, emergency, or crisis behavioral health services.

(2) Beginning July 1, 2026, a covered insurer shall:

(a) establish a procedure to assist an enrollee to access behavioral health services from an out-of-network mental health provider when no in-network mental health provider is available in a timely manner; and

(b) if an enrollee in a covered insurer's health benefit plan is unable to obtain covered behavioral health services from an in-network mental health provider in a timely manner, enter into a single case agreement that allows the enrollee to receive covered behavioral health services from an out-of-network mental health provider.

(3)(a) A covered insurer shall include in a single case agreement described in Subsection (2)(b):

(i) a requirement that the covered insurer reimburse the out-of-network mental health provider for the covered behavioral health services at a rate negotiated by the provider and insurer, subject to the member cost-sharing requirements imposed by the health benefit plan;

(ii) a requirement that the covered insurer apply the same coinsurance, copayments, and deductibles that would apply for the behavioral health services if the behavioral health services were provided by a mental health provider that is an in-network mental health provider;

(iii) any terms that a network provider is subject to under the health benefit plan; and

(iv) the length and scope of the single case agreement.

(b) Notwithstanding Subsection (3)(a)(ii):

(i) a covered insurer's payment under a single case agreement described in Subsection (2)(b) constitutes payment in full to the provider for the behavioral health services the enrollee receives; and

(ii) the provider may not seek additional payment from the enrollee except for applicable cost sharing.

(4) A covered insurer shall ensure that a single case agreement described in Subsection (2)(b) only permits an insured to receive behavioral health services:

(a) that are:

(i) within the out-of-network mental health provider's scope of practice; and

(ii) behavioral health services that are otherwise covered under the enrollee's health benefit plan; and

(b) that are not experimental, unless the insurer covers experimental treatments for physical health conditions in compliance with the Mental Health Parity and Addiction Equity Act, Pub. L. No. 110-343.

(5) A covered insurer shall:

(a) document all payments the covered insurer makes under a health benefit plan to a mental health provider under this section; and

(b) provide the documentation described in Subsection (5)(a) to the department upon request.

(6) Subsections (2)(b), (3), and (4) do not apply if behavioral health services are available in a timely manner.

(7) The commissioner may:

(a) make rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to implement this section; and

(b) bring an action in accordance with Section 31A-2-308 and Title 63G, Chapter 4, Administrative Procedures Act, for a violation of this section.

Section 3. Section **31A-22-664** is enacted to read:

31A-22-664 . Health care provider directories.

(1) As used in this section:

(a) "Exempt health care professional" means a person exempt from licensure under a title listed in Subsection 58-13-3(2)(c).

(b) "Exempt mental health provider" means an individual exempt from licensure under Section 58-60-107.

(c) "Health care facility" means the same as that term is defined in Section 26B-2-201.

(d) "Health care professional" means the same as that term is defined in Section 58-13-3.

(e) "Hospital" means a facility licensed under Title 26B, Chapter 2, Part 2, Health Care Facility Licensing and Inspection, as a general acute hospital or specialty hospital.

(f) "Insurer" means the same as that term is defined in Section 31A-22-634.

(g) "Mental health provider" means the same as that term is defined in Section 31A-22-658.

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

(i) "Provider" means:

(i) a health care professional;

(ii) an exempt health care professional;

(iii) a mental health provider;

(iv) an exempt mental health provider; or

(v) a pharmacy.

(j) "Provider directory" means a list of in-network providers for each of an insurer's health benefit plans.

(k) "Telehealth services" means the same as that term is defined in Section 26B-4-704.

(l) "Telemedicine services" means the same as that term is defined in Section 26B-4-704.

(2) Beginning July 1, 2026, an insurer shall:

(a) publish a provider directory for each of the insurer's health benefit plans; and

(b) update the provider directory no less frequently than every 60 days.

(3) An insurer shall ensure that, except as provided in Subsection (6):

(a) a provider directory:

(i) is easily and publicly accessible:

(A) through a conspicuous link on the home page of the insurer's website; and

(B) without requiring an individual to create an account or submit a policy or contract number; and

(ii) is in a format that is searchable and downloadable; and

(b) a provider may update the provider's information, including contact information and whether the provider is accepting new patients, in the provider directory:

(i) electronically;

(ii) on the covered insurer's website; and

(iii) through a conspicuous link on the home page of the insurer's website.

(4) A provider directory shall include:

(a) in plain language:

(i) a description of the criteria the insurer used to build the health benefit plan's provider network; and

(ii) if applicable:

(A) a description of the criteria the insurer used to tier health care providers;

(B) how the health benefit plan designates health care provider tiers or levels; and

(C) a notice that authorization or referral may be required to access some health care providers; and

(b) contact information an insured or member of the public may use to report to the health benefit plan inaccurate information in a provider directory, which may include:

(i) a phone number;

(ii) an email address; or

(iii) a link to a website or online reporting form.

(5) In addition to the information required under Subsection (4):

(a) a provider directory of health care professionals and exempt health care professionals shall include:

(i) each health care professional's and exempt health care professional's:

(A) name;

(B) contact information, including:

(I) internet address;

(II) physical address; and

(III) phone number; and

(C) specialty, if applicable;

(ii) whether the health care professional or exempt health care professional is accepting new patients;

(iii) if an exempt health care professional treats patients under the supervision of a health care professional, whether the exempt health care professional is accepting new patients; and

(iv) whether the health care professional or exempt health care professional offers telehealth services or telemedicine services;

(b) a provider directory of health care facilities that are hospitals shall include each hospital's:

(i) name;

(ii) if the hospital is a specialty hospital, the specialty type;

(iii) location or locations;

(iv) accreditation status;

(v) customer service phone number; and

(vi) internet address;

(c) a provider directory of health care facilities other than hospitals shall include each health care facility's:

(i) name;

(ii) type;

(iii) services provided;

(iv) location or locations;

(v) customer service phone number; and

(vi) internet address;

(d) a provider directory of pharmacies shall include each pharmacy's:

(i) name;

(ii) type;

(iii) services provided, including whether the pharmacy offers mail-order or specialty pharmacy services;

(iv) location or locations;

(v) customer service phone number; and

(vi) internet address; and

(e) a provider directory of mental health providers and exempt mental health providers shall include:

(i) each mental health provider's:

(A) name;

(B) contact information, including:

(I) internet address;

(II) physical address; and

(III) phone number; and

(C) specialty, if applicable;

(ii) whether the mental health provider or exempt mental health provider is accepting new patients;

(iii) if an exempt mental health provider treats patients under the supervision of a mental health provider, whether the exempt mental health provider is accepting new patients; and

(iv) whether the mental health provider or exempt mental health provider offers telehealth services or telemedicine services.

(6)(a) An insurer may provide, in addition to an electronic provider directory, a provider directory in print format.

(b) An insurer shall provide a provider directory in print format to an insured upon request of the insured.

(c) In addition to the requirements described in Subsections (4) and (5), a provider directory in print format shall include:

(i) the internet address of the insurer's website where the insurer's electronic provider directory is published;

(ii) the health benefit plan's customer service phone number;

(iii) a disclosure that the information in the provider directory is accurate as of the date of printing; and

(iv) a notice that an insured or prospective insured should consult the health benefit plan's electronic provider directory or call the health benefit plan's customer service phone number to obtain current provider directory information.

(7) When an insurer receives a report of inaccurate information in a provider directory, the insurer shall:

(a) promptly investigate the report; and

(b) no later than the end of the second business day after the day on which the insurer receives the report:

(i) verify the accuracy of the information in the provider directory; or

(ii) for an electronic provider directory, update the inaccurate information with accurate information.

(8)(a) An insurer shall take steps to ensure the accuracy of the information in a provider directory, including contacting providers to verify that provider information is up to date.

(b) When an insurer contacts a provider to verify the accuracy of a provider's information in a provider directory, the provider shall respond to the insurer's request for verification no later than 10 business days after the day on which the insurer contacts the provider.

(9)(a) An insurer shall, at least annually, audit each provider directory for accuracy.

(b) An audit of a provider directory shall:

(i)(A) include the two mental health specialties and four physical health specialties most utilized by insureds; and

(B) include at least one specialty related to mental health; or

(ii) audit a reasonable sample size of providers, if the sample size includes behavioral health providers.

(c) An insurer shall:

(i) retain documentation of each audit performed under this Subsection (9);

(ii) submit the audit to the commissioner annually, on or before December 31, and upon the commissioner's request; and

(iii) based on the results of the audit:

(A) verify and attest to the accuracy of the information in a provider directory; and

(B) update inaccurate information in a provider directory with accurate information.

(10) An insurer shall annually report to the commissioner on:

(a) the number of reports of inaccuracies in provider directories the insurer received;

(b) the timeliness of the insurer's response to a report of inaccuracies in a provider directory;

(c) any corrective action the insurer took in response to a report of inaccuracies in a provider directory;

(d) all audits the insurer conducted in accordance with this section; and

(e) any other information related to provider directory accuracy the commissioner considers relevant.

(11) An insurer, a health care facility, a hospital, or a provider that is subject to this section shall comply with all applicable requirements of the No Surprises Act, 42 U.S.C. Secs. 300gg-111 through 300gg-139, and federal regulations adopted in accordance with that act.

(12) The commissioner shall make rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to implement the provisions of this section.

(13) In addition to the penalties authorized under Section 31A-2-308, if the commissioner determines that an insured reasonably relied on inaccurate information in a provider directory when the insured received services covered under the insured's health benefit plan, the commissioner may:

(a) if the commissioner determines that the insurer knew or reasonably should have known the information was inaccurate:

(i) require the insurer to provide coverage for all covered health care services the insured received; and

(ii) reimburse the insured for the amount the insured paid for the health care services that exceeds what the insured would have paid if the services were delivered by an in-network provider; and

(b) if the commissioner determines that the provider provided inaccurate information or failed to update the information, require the insurer to reimburse the provider at the in-network rate.

(14) The Division of Professional Licensing may impose administrative penalties in accordance with Section 58-1-502 and the provider's respective licensing chapter, for a provider's violation of Subsection (8).

Section 4. Section **58-1-501** is amended to read:

58-1-501 . Unlawful and unprofessional conduct.

(1) "Unlawful conduct" means conduct, by any person, that is defined as unlawful under this title and includes:

(a) practicing or engaging in, representing oneself to be practicing or engaging in, or attempting to practice or engage in any profession requiring licensure under this title, except the behavioral health technician under Chapter 60, Part 6, Behavioral Health Coach and Technician Licensing Act, if the person is:

(i) not licensed to do so or not exempted from licensure under this title; or

(ii) restricted from doing so by a suspended, revoked, restricted, temporary, probationary, or inactive license;

(b)(i) impersonating another licensee or practicing a profession under a false or assumed name, except as permitted by law; or

(ii) for a licensee who has had a license under this title reinstated following disciplinary action, practicing the same profession using a different name than the name used before the disciplinary action, except as permitted by law and after notice to, and approval by, the division;

(c) knowingly employing any other person to practice or engage in or attempt to practice or engage in any profession licensed under this title if the employee is not licensed to do so under this title;

(d) knowingly permitting the person's authority to practice or engage in any profession licensed under this title to be used by another, except as permitted by law;

(e) obtaining a passing score on a licensure examination, applying for or obtaining a license, or otherwise dealing with the division or a licensing board through the use of fraud, forgery, or intentional deception, misrepresentation, misstatement, or omission;

(f)(i) issuing, or aiding and abetting in the issuance of, an order or prescription for a drug or device to a person located in this state:

(A) without prescriptive authority conferred by a license issued under this title, or by an exemption to licensure under this title; or

(B) with prescriptive authority conferred by an exception issued under this title or a multistate practice privilege recognized under this title, if the prescription was issued without first obtaining information, in the usual course of professional practice, that is sufficient to establish a diagnosis, to identify underlying conditions, and to identify contraindications to the proposed

treatment; and

(ii) Subsection (1)(f)(i) does not apply to treatment rendered in an emergency, on-call or cross coverage situation, provided that the person who issues the prescription has prescriptive authority conferred by a license under this title, or is exempt from licensure under this title; or

(g) aiding or abetting any other person to violate any statute, rule, or order regulating a profession under this title.

(2)(a) "Unprofessional conduct" means conduct, by a licensee or applicant, that is defined as unprofessional conduct under this title or under any rule adopted under this title and includes:

(i) violating any statute, rule, or order regulating an a profession under this title;

(ii) violating, or aiding or abetting any other person to violate, any generally accepted professional or ethical standard applicable to an occupation or profession regulated under this title;

(iii) subject to the provisions of Subsection (4), engaging in conduct that results in conviction, a plea of nolo contendere, or a plea of guilty or nolo contendere that is held in abeyance pending the successful completion of probation with respect to a crime that, when considered with the functions and duties of the profession for which the license was issued or is to be issued, bears a substantial relationship to the licensee's or applicant's ability to safely or competently practice the profession;

(iv) engaging in conduct that results in disciplinary action, including reprimand, censure, diversion, probation, suspension, or revocation, by any other licensing or regulatory authority having jurisdiction over the licensee or applicant in the same profession if the conduct would, in this state, constitute grounds for denial of licensure or disciplinary proceedings under Section 58-1-401;

(v) engaging in conduct, including the use of intoxicants, drugs, narcotics, or similar chemicals, to the extent that the conduct does, or might reasonably be considered to, impair the ability of the licensee or applicant to safely engage in the profession;

(vi) practicing or attempting to practice a profession regulated under this title despite being physically or mentally unfit to do so;

(vii) practicing or attempting to practice a or profession regulated under this title through gross incompetence, gross negligence, or a pattern of incompetency or negligence;

(viii) practicing or attempting to practice a profession requiring licensure under this

title by any form of action or communication which is false, misleading, deceptive, or fraudulent;

(ix) practicing or attempting to practice a profession regulated under this title beyond the scope of the licensee's competency, abilities, or education;

(x) practicing or attempting to practice a profession regulated under this title beyond the scope of the licensee's license;

(xi) verbally, physically, mentally, or sexually abusing or exploiting any person through conduct connected with the licensee's practice under this title or otherwise facilitated by the licensee's license;

(xii) acting as a supervisor without meeting the qualification requirements for that position that are defined by statute or rule;

(xiii) issuing, or aiding and abetting in the issuance of, an order or prescription for a drug or device:

(A) without first obtaining information in the usual course of professional practice, that is sufficient to establish a diagnosis, to identify conditions, and to identify contraindications to the proposed treatment; or

(B) with prescriptive authority conferred by an exception issued under this title, or a multi-state practice privilege recognized under this title, if the prescription was issued without first obtaining information, in the usual course of professional practice, that is sufficient to establish a diagnosis, to identify underlying conditions, and to identify contraindications to the proposed treatment;

(xiv) violating a provision of Section 58-1-501.5;

(xv) violating the terms of an order governing a license; [~~or~~]

(xvi) violating Section 58-1-511[~~.~~] ; or

(xvii) violating Subsection 31A-22-664(8).

(b) "Unprofessional conduct" does not include:

(i) a health care provider, as defined in Section 78B-3-403 and who is licensed under this title, deviating from medical norms or established practices if the conditions described in Subsection (5) are met; and

(ii) notwithstanding Section 58-1-501.6, a health care provider advertising that the health care provider deviates from medical norms or established practices, including the maladies the health care provider treats, if the health care provider:

(A) does not guarantee any results regarding any health care service;

(B) fully discloses on the health care provider's website that the health care provider deviates from medical norms or established practices with a conspicuous statement; and

(C) includes the health care provider's contact information on the website.

(3) Unless otherwise specified by statute or administrative rule, in a civil or administrative proceeding commenced by the division under this title, a person subject to any of the unlawful and unprofessional conduct provisions of this title is strictly liable for each violation.

(4) The following are not evidence of engaging in unprofessional conduct under Subsection (2)(a)(iii):

(a) an arrest not followed by a conviction; or

(b) a conviction for which an individual's incarceration has ended more than five years before the date of the division's consideration, unless:

(i) after the incarceration the individual has engaged in additional conduct that results in another conviction, a plea of nolo contendere, or a plea of guilty or nolo contendere that is held in abeyance pending the successful completion of probation; or

(ii) the conviction was for:

(A) a violent felony as defined in Section 76-3-203.5;

(B) a felony related to a criminal sexual act under Title 76, Chapter 5, Part 4, Sexual Offenses, or Title 76, Chapter 5b, Sexual Exploitation Act;

(C) a felony related to criminal fraud or embezzlement, including a felony under Title 76, Chapter 6, Part 5, Fraud, or Title 76, Chapter 6, Part 4, Theft; or

(D) a crime or a pattern of crimes that demonstrates a substantial potential to harm Utah patients or consumers, as may be determined by the director in a process defined by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

(5) In accordance with Subsection (2)(b)(i), a health care provider may deviate from medical norms or established practices if:

(a) the health care provider does not deviate outside of the health care provider's scope of practice and possesses the education, training, and experience to competently and safely administer the alternative health care service;

(b) the health care provider does not provide an alternative health care service that is otherwise contrary to any state or federal law;

(c) the alternative health care service has reasonable potential to be of benefit to the patient to whom the alternative health care service is to be given;

(d) the potential benefit of the alternative health care service outweighs the known harms or side effects of the alternative health care service;

(e) the alternative health care service is reasonably justified under the totality of the circumstances;

(f) after diagnosis but before providing the alternative health care service:

(i) the health care provider educates the patient on the health care services that are within the medical norms and established practices;

(ii) the health care provider discloses to the patient that the health care provider is recommending an alternative health care service that deviates from medical norms and established practices;

(iii) the health care provider discusses the rationale for deviating from medical norms and established practices with the patient;

(iv) the health care provider discloses any potential risks associated with deviation from medical norms and established practices; and

(v) the patient signs and acknowledges a notice of deviation; and

(g) before providing an alternative health care service, the health care provider discloses to the patient that the patient may enter into an agreement describing what would constitute the health care provider's negligence related to deviation.

(6) As used in this section, "notice of deviation" means a written notice provided by a health care provider to a patient that:

(a) is specific to the patient;

(b) indicates that the health care provider is deviating from medical norms or established practices in the health care provider's recommendation for the patient's treatment;

(c) describes how the alternative health care service deviates from medical norms or established practices;

(d) describes the potential risks and benefits associated with the alternative health care service;

(e) describes the health care provider's reasonably justified rationale regarding the reason for the deviation; and

(f) provides clear and unequivocal notice to the patient that the patient is agreeing to receive the alternative health care service which is outside medical norms and established practices.

Section 5. Section **58-1-502** is amended to read:

58-1-502 . Unlawful and unprofessional conduct -- Penalties.

(1)(a) Unless otherwise specified in this title, a person who violates the unlawful conduct provisions defined in this title is guilty of a class A misdemeanor.

(b) Unless a specific fine amount is specified elsewhere in this title, the director or the director's designee may assess an administrative fine of up to $1,000 for each instance of unprofessional or unlawful conduct defined in this title.

(2)(a) In addition to any other statutory penalty for a violation related to a specific occupation or profession regulated by this title, if upon inspection or investigation, the division concludes that a person has violated Subsection 58-1-501(1)(a), (1)(c), (1)(g), [~~or~~] (2)(a)(xv), or (2)(a)(xvii), or a rule or order issued with respect to those subsections, and that disciplinary action is appropriate, the director or the director's designee from within the division shall promptly:

(i) issue a citation to the person according to this section and any pertinent rules;

(ii) attempt to negotiate a stipulated settlement; or

(iii) notify the person to appear before an adjudicative proceeding conducted under Title 63G, Chapter 4, Administrative Procedures Act.

(b)(i) The division may assess a fine under this Subsection (2) against a person who violates Subsection 58-1-501(1)(a), (1)(c), (1)(g), [~~or~~] (2)(a)(xv), or (2)(a)(xvii), or a rule or order issued with respect to those subsections, as evidenced by:

(A) an uncontested citation;

(B) a stipulated settlement; or

(C) a finding of a violation in an adjudicative proceeding.

(ii) The division may, in addition to or in lieu of a fine under Subsection (2)(b)(i), order the person to cease and desist from violating Subsection 58-1-501(1)(a), (1)(c), (1)(g), [~~or~~] (2)(a)(xv), or (2)(a)(xvii), or a rule or order issued with respect to those subsections.

(c) Except for a cease and desist order, the division may not assess the licensure sanctions cited in Section 58-1-401 through a citation.

(d) A citation shall:

(i) be in writing;

(ii) describe with particularity the nature of the violation, including a reference to the provision of the chapter, rule, or order alleged to have been violated;

(iii) clearly state that the recipient must notify the division in writing within 20

calendar days of service of the citation if the recipient wishes to contest the citation at a hearing conducted under Title 63G, Chapter 4, Administrative Procedures Act; and

(iv) clearly explain the consequences of failure to timely contest the citation or to make payment of a fine assessed by the citation within the time specified in the citation.

(e) The division may issue a notice in lieu of a citation.

(f)(i) If within 20 calendar days from the service of the citation, the person to whom the citation was issued fails to request a hearing to contest the citation, the citation becomes the final order of the division and is not subject to further agency review.

(ii) The period to contest a citation may be extended by the division for cause.

(g) The division may refuse to issue or renew, suspend, revoke, or place on probation the license of a licensee who fails to comply with a citation after it becomes final.

(h) The failure of an applicant for licensure to comply with a citation after it becomes final is a ground for denial of license.

(i) Subject to the time limitations described in Subsection 58-1-401(6), the division may not issue a citation under this section after the expiration of one year following the date on which the violation that is the subject of the citation is reported to the division.

(j) The director or the director's designee shall assess fines according to the following:

(i) for the first offense handled pursuant to Subsection (2)(a), a fine of up to $1,000;

(ii) for a second offense handled pursuant to Subsection (2)(a), a fine of up to $2,000; and

(iii) for each subsequent offense handled pursuant to Subsection (2)(a), a fine of up to $2,000 for each day of continued offense.

(3)(a) An action for a first or second offense that has not yet resulted in a final order of the division may not preclude initiation of a subsequent action for a second or subsequent offense during the pendency of a preceding action.

(b) The final order on a subsequent action is considered a second or subsequent offense, respectively, provided the preceding action resulted in a first or second offense, respectively.

(4)(a) The director may collect a penalty that is not paid by:

(i) referring the matter to a collection agency; or

(ii) bringing an action in the district court of the county where the person against

whom the penalty is imposed resides or in the county where the office of the director is located.

(b) A county attorney or the attorney general of the state shall provide legal assistance and advice to the director in an action to collect a penalty.

(c) A court may award reasonable attorney fees and costs to the prevailing party in an action brought by the division to collect a penalty.

Section 6. **Effective Date.**

This bill takes effect on May 6, 2026.