LEGISLATIVE GENERAL COUNSEL
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S.B. 254

MATERNITY INSURANCE COVERAGE FOR ADOPTIVE PARENTS

2000 GENERAL SESSION

STATE OF UTAH

Sponsor: Ed P. Mayne

AN ACT RELATING TO INSURANCE; REQUIRING A PARTICIPATING HEALTH CARE PROVIDER TO CHARGE AN INSURED WHO QUALIFIES FOR THE ADOPTION INDEMNITY BENEFIT THE SAME NEGOTIATED FEE THAT IT WOULD HAVE CHARGED THE INSURER.

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

AMENDS:

31A-22-610.1, as last amended by Chapter 178, Laws of Utah 1999

31A-26-301.5, as last amended by Chapter 181, Laws of Utah 1996

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

Section 1. Section **31A-22-610.1** is amended to read:

31A-22-610.1. Adoption indemnity benefit.

(1) (a) If an insured has coverage for maternity benefits on the date of an adoptive placement, the insured's policy shall provide an adoption indemnity benefit payable to the insured, if a child is placed for adoption with the insured within 90 days of the child's birth.

(b) An insurer that has paid the adoption indemnity benefit under Subsection (1)(a) may seek reimbursement of the benefit if:

(i) the postplacement evaluation disapproves the adoption placement; and

(ii) a court rules the adoption may not be finalized because of an act or omission of an adoptive parent or parents that affects the child's health or safety.

(c) The commissioner shall:

(i) establish, by rule, the amount of the adoption indemnity benefit provided under Subsection (1) at a minimum of $2,500; and

(ii) review the amount of the adoption indemnity benefit every two years to make any necessary and reasonable adjustments, taking into account the average insurance cost of an uncomplicated birth.

(d) Each insurer shall pay its pro rata share of the adoption indemnity benefit if each adoptive parent:

(i) has coverage for maternity benefits with a different insurer; and

(ii) makes a claim for the adoption indemnity benefit provided in Subsection (1)(a).

(2) If a policy offers optional maternity benefits, it shall also offer coverage for adoption indemnity benefits if:

(a) a child is placed for adoption with the insured within 90 days of the child's birth; and

(b) the adoption is finalized within one year of the child's birth.

(3) If a health care provider is under contract with an insurer to provide maternity benefits under any form of fee schedule or discount, the health care provider may only bill and collect from an insured who qualifies for the adoption indemnity benefit an amount that is equal to:

(a) the amount the health care provider would have billed the insurer for the services under the fee schedule or discount; and

(b) any cost-sharing factors, such as deductibles and copayments, that the insured would have otherwise been obligated to pay for the services under the terms of the policy.

Section 2. 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) [~~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) 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 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.

Legislative Review Note
as of 2-7-00 7:06 PM

A limited legal review of this legislation raises no obvious constitutional or statutory concerns.

Office of Legislative Research and General Counsel