LEGISLATIVE GENERAL COUNSEL
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MEDICAID RECOVERY AMENDMENTS

2007 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: Allen M. Christensen

House Sponsor: Merlynn T. Newbold

LONG TITLE

General Description:

This bill amends the Medicaid Benefits Recovery Act and the Insurance Code to comply with the federal Deficit Reduction Act.

Highlighted Provisions:

This bill:

- defines terms;
- establishes, as a condition of doing business in the state, requirements for health insurance entities relating to providing information to the state, accepting the right of the state to recover Medicaid expenses, and approving valid claims by the state;
- permits a claim for Medicaid recovery to be submitted up to three years after the day on which the health care item or service upon which the claim is based was provided;
- extends the statute of limitations for an action to recover Medicaid expenses, unless the action was time-barred on or before April 30, 2007;
- prohibits insurance policies from imposing a Medicaid insurance recovery deadline that is earlier than the deadline provided for in this bill;
- provides for enforcement of the provisions of this bill and for penalties against health insurance entities that are regulated by the Department of Insurance; and
- makes technical changes.

Monies Appropriated in this Bill:

S.B. 117

None

Other Special Clauses:

None

Utah Code Sections Affected:

AMENDS:

26-19-2, as last amended by Chapter 103, Laws of Utah 2005

26-19-8, as last amended by Chapter 72, Laws of Utah 2004

75-7-508, as last amended by Chapter 103, Laws of Utah 2005

ENACTS:

26-19-4.7, Utah Code Annotated 1953

31A-4-107.5, Utah Code Annotated 1953

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

Section 1. Section **26-19-2** is amended to read:

26-19-2. Definitions.

As used in this chapter:

(1) "Annuity" shall have the same meaning as provided in Section 31A-1-301.

(2) "Claim" means:

(a) a request or demand for payment; or

(b) a cause of action for money or damages arising under any law.

(3) "Employee welfare benefit plan" means a medical insurance plan developed by an employer under 29 U.S.C. Section 1001, et seq., the Employee Retirement Income Security Act of 1974 as amended.

(4) "Estate" means, regarding a deceased recipient:

(a) all real and personal property or other assets included within a decedent's estate as defined in Section 75-1-201;

(b) the decedent's augmented estate as defined in Section 75-2-203; and

(c) that part of other real or personal property in which the decedent had a legal interest at the time of death including assets conveyed to a survivor, heir, or assign of the decedent through joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangement.

(5) "Health insurance entity" means:

(a) an insurer;

(b) a person who administers, manages, provides, offers, sells, carries, or underwrites health insurance, as defined in Section 31A-1-301;

(c) a self-insured plan;

(d) a group health plan, as defined in Subsection 607(1) of the federal Employee Retirement Income Security Act of 1974;

(e) a service benefit plan;

(f) a managed care organization;

(g) a pharmacy benefit manager;

(h) an employee welfare benefit plan; or

(i) a person who is, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service.

[~~(5)~~] (6) "Insurer" includes:

(a) a group health plan as defined in Subsection 607(1) of the federal Employee Retirement Income Security Act of 1974;

(b) a health maintenance organization; and

(c) any entity offering a health service benefit plan.

[~~(6)~~] (7) "Medical assistance" means:

(a) all funds expended for the benefit of a recipient under Title 26, Chapter 18, Medical Assistance Act, or under Titles XVIII and XIX, federal Social Security Act; and

(b) any other services provided for the benefit of a recipient by a prepaid health care delivery system under contract with the department.

[~~(7)~~] (8) "Office of Recovery Services" means the Office of Recovery Services within the Department of Human Services.

[~~(8)~~] (9) "Provider" means a person or entity who provides services to a recipient.

[~~(9)~~] (10) "Recipient" means:

(a) a person who has applied for or received medical assistance from the state;

(b) the guardian, conservator, or other personal representative of a person under Subsection [~~(9)~~] (10)(a) if the person is a minor or an incapacitated person; or

(c) the estate and survivors of a person under Subsection [~~(9)~~] (10)(a) if the person is

deceased.

[~~(10)~~] (11) "State plan" means the state Medicaid program as enacted in accordance with Title XIX, federal Social Security Act.

[~~(11)~~] (12) "Third party" includes:

(a) an individual, institution, corporation, public or private agency, trust, estate, insurance carrier, employee welfare benefit plan, health maintenance organization, health service organization, preferred provider organization, governmental program such as Medicare, CHAMPUS, and workers' compensation, which may be obligated to pay all or part of the medical costs of injury, disease, or disability of a recipient, unless any of these are excluded by department rule; and

(b) a spouse or a parent who:

(i) may be obligated to pay all or part of the medical costs of a recipient under law or by court or administrative order; or

(ii) has been ordered to maintain health, dental, or accident and health insurance to cover medical expenses of a spouse or dependent child by court or administrative order.

[~~(12)~~] (13) "Trust" shall have the same meaning as provided in Section 75-1-201.

Section 2. Section **26-19-4.7** is enacted to read:

26-19-4.7. Health insurance entity -- Duties related to state claims for Medicaid payment or recovery.

As a condition of doing business in the state, a health insurance entity shall:

(1) with respect to a person who is eligible for, or is provided, medical assistance under the state plan, upon the request of the Department of Health, provide information to determine:

(a) during what period the person, or the spouse or dependent of the person, may be or may have been, covered by the health insurance entity; and

(b) the nature of the coverage that is or was provided by the health insurance entity described in Subsection (1)(a), including the name, address, and identifying number of the plan;

(2) accept the state's right of recovery and the assignment to the state of any right of a person to payment from a party for an item or service for which payment has been made under the state plan;

(3) respond to any inquiry by the Department of Health regarding a claim for payment

for any health care item or service that is submitted no later than three years after the day on which the health care item or service is provided; and

(4) not deny a claim submitted by the Department of Health solely on the basis of the date of submission of the claim, the type or format of the claim form, or failure to present proper documentation at the point-of-sale that is the basis for the claim, if:

(a) the claim is submitted no later than three years after the day on which the item or service is furnished; and

(b) any action by the Department of Health to enforce the rights of the state with respect to the claim is commenced no later than six years after the day on which the claim is submitted.

Section 3. Section **26-19-8** is amended to read:

26-19-8. Statute of limitations -- Survival of right of action -- Insurance policy not to limit time allowed for recovery.

(1) (a) [~~An~~] Subject to Subsection (6), action commenced by the department, or the Office of Recovery Services on behalf of the department, under this chapter against a health insurance [~~carrier or employee welfare benefit plan~~] entity must be commenced within:

[~~(i) two years after the date of the injury or onset of the illness; or~~]

(i) subject to Subsection (7), six years after the day on which the department or the Office of Recovery Services submits the claim for recovery or payment for the health care item or service upon which the action is based; or

(ii) six months after the date of the last payment for medical assistance, whichever is later.

(b) An action against any other third party, the recipient, or anyone to whom the proceeds are payable must be commenced within:

(i) four years after the date of the injury or onset of the illness; or

(ii) six months after the date of the last payment for medical assistance, whichever is later.

(2) The death of the recipient does not abate any right of action established by this chapter.

(3) (a) No insurance policy issued or renewed after June 1, 1981, may contain any provision that limits the time in which the department may submit its claim to recover medical

assistance benefits to a period of less than 24 months from the date the provider furnishes services or goods to the recipient.

(b) No insurance policy issued or renewed after April 30, 2007, may contain any provision that limits the time in which the department may submit its claim to recover medical assistance benefits to a period of less than that described in Subsection (1)(a).

(4) The provisions of this section do not apply to Section 26-19-13.5.

(5) The provisions of this section supercede any other sections regarding the time limit in which an action must be commenced, including Section 75-7-509.

(6) (a) Subsection (1)(a) extends the statute of limitations on a cause of action described in Subsection (1)(a) that was not time-barred on or before April 30, 2007.

(b) Subsection (1)(a) does not revive a cause of action that was time-barred on or before April 30, 2007.

(7) An action described in Subsection (1)(a) may not be commenced if the claim for recovery or payment described in Subsection (1)(a)(i) is submitted later than three years after the day on which the health care item or service upon which the claim is based was provided.

Section 4. Section **31A-4-107.5** is enacted to read:

31A-4-107.5. Penalty for failure of a regulated health insurance entity to fulfill duties related to state claims for Medicaid payment or recovery.

(1) For purposes of this section, "regulated health insurance entity" means a health insurance entity, as defined in Section 26-19-2, that is subject to regulation by the department.

(2) If a regulated health insurance entity fails to comply with the provisions of Section 26-19-4.7:

(a) the commissioner may revoke or suspend, in whole or in part, a license, certificate of authority, registration, or other authority that is granted by the commissioner to the regulated health insurance entity; and

(b) the regulated health insurance entity is subject to the penalties and procedures provided for in Section 31A-2-308.

Section 5. Section **75-7-508** is amended to read:

75-7-508. Notice to creditors.

(1) A trustee for an inter vivos revocable trust, upon the death of the settlor, may publish a notice to creditors once a week for three successive weeks in a newspaper of general

circulation in the county where the settlor resided at the time of death. The notice required by this Subsection (1) must:

(a) provide the trustee's name and address; and

(b) notify creditors:

(i) of the deceased settlor; and

(ii) to present their claims within three months after the date of the first publication of the notice or be forever barred from presenting the claim.

(2) A trustee shall give written notice by mail or other delivery to any known creditor of the deceased settlor, notifying the creditor to present his claim within 90 days from the published notice if given as provided in Subsection (1) or within 60 days from the mailing or other delivery of the notice, whichever is later, or be forever barred. Written notice shall be the notice described in Subsection (1) or a similar notice.

(3) (a) If the deceased settlor received medical assistance, as defined in [~~Subsection 26-19-2(6)~~] Section 26-19-2, at any time after the age of 55, the trustee for an inter vivos revocable trust, upon the death of the settlor, shall mail or deliver written notice to the Director of the Office of Recovery Services, on behalf of the Department of Health, to present any claim under Section 26-19-13.5 within 60 days from the mailing or other delivery of notice, whichever is later, or be forever barred.

(b) If the trustee does not mail notice to the director of the Office of Recovery Services on behalf of the department in accordance with Subsection (3)(a), the department shall have one year from the death of the settlor to present its claim.

(4) The trustee shall not be liable to any creditor or to any successor of the deceased settlor for giving or failing to give notice under this section.

Legislative Review Note
as of 1-9-07 8:52 AM

Office of Legislative Research and General Counsel

S.B. 117 - Medicaid Recovery Amendments

Fiscal Note

2007 General Session

State of Utah

State Impact

Enactment of this bill will not require additional appropriations. The result could be increased collections to be used to offset escalating Medicaid expenses. The amount can not be estimated.

Individual, Business and/or Local Impact

Enactment of this bill likely will not result in direct, measurable costs and/or benefits for individuals, businesses, or local governments.

1/18/2007, 11:11:52 AM, Lead Analyst: Greer, W.

Office of the Legislative Fiscal Analyst