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MEDICAL BENEFITS RECOVERY AMENDMENTS

2008 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: Allen M. Christensen

House Sponsor: Bradley G. Last

LONG TITLE

Committee Note:

The Medicaid Interim Committee recommended this bill.

General Description:

This bill amends the Medical Benefits Recovery Act to provide that a lien, to recover medical assistance benefits provided by the state, may be imposed against the real property of a person who is an inpatient in a care facility, during the life of that person. The bill also amends provisions related to the recovery of medical assistance from an estate or trust and recodifies the Medical Benefits Recovery Act.

Highlighted Provisions:

This bill:

- defines terms;
- recodifies the Medical Benefits Recovery Act;
- modifies provisions related to recovery of medical assistance from a recipient's estate or a trust, so that recovery can be made as soon as an exception to recovery, relating to a surviving spouse or child, is no longer in effect;
- provides for the imposition of a lien, authorized by the federal Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), against the real property of a person who is an inpatient in a care facility, during the life of that person;
- establishes procedures, requirements, and exemptions, relating to imposing a

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TEFRA lien;

- establishes a rebuttable presumption that a person who is an inpatient in a care facility cannot reasonably be expected to be discharged from the care facility and return to the person's home, if the person has been an inpatient in a care facility for a period of at least 180 consecutive days;
- provides for review and appeal of a decision to impose a TEFRA lien;
- provides for the dissolution and removal of a TEFRA lien;
- provides that an agency that the department contracts with to recover funds paid for medical assistance under the Medical Benefits Recovery Act shall be the sole agency that imposes or removes a TEFRA lien; and
- makes technical changes.

Monies Appropriated in this Bill:

None

Other Special Clauses:

None

Utah Code Sections Affected:

AMENDS:

31A-4-107.5, as enacted by Laws of Utah 2007, Chapter 64

31A-22-610, as last amended by Laws of Utah 2007, Chapter 307

31A-22-610.5, as last amended by Laws of Utah 2004, Chapters 108 and 185

34A-2-417, as last amended by Laws of Utah 2007, Chapter 62

34A-2-422, as last amended by Laws of Utah 2007, Chapter 63

75-3-805, as last amended by Laws of Utah 1998, Chapter 145

75-7-508, as last amended by Laws of Utah 2007, Chapter 64

75-7-511, as renumbered and amended by Laws of Utah 2004, Chapter 89

ENACTS:

26-19-404, Utah Code Annotated 1953

26-19-501, Utah Code Annotated 1953

26-19-502, Utah Code Annotated 1953

26-19-503, Utah Code Annotated 1953

26-19-504, Utah Code Annotated 1953

26-19-505, Utah Code Annotated 1953
26-19-506, Utah Code Annotated 1953
26-19-507, Utah Code Annotated 1953
26-19-508, Utah Code Annotated 1953
26-19-509, Utah Code Annotated 1953
RENUMBERS AND AMENDS:
26-19-101, (Renumbered from 26-19-1, as enacted by Laws of Utah 1981, Chapter 126)
26-19-102, (Renumbered from 26-19-2, as last amended by Laws of Utah 2007, Chapter 64)
26-19-103, (Renumbered from 26-19-3, as last amended by Laws of Utah 1984, Chapter 34)
26-19-201, (Renumbered from 26-19-4.5, as last amended by Laws of Utah 1998, Chapter 145)
26-19-301, (Renumbered from 26-19-4.7, as enacted by Laws of Utah 2007, Chapter 64)
26-19-302, (Renumbered from 26-19-14, as last amended by Laws of Utah 1995, Chapter 102)
26-19-303, (Renumbered from 26-19-9.5, as enacted by Laws of Utah 2004, Chapter 72)
26-19-304, (Renumbered from 26-19-9, as enacted by Laws of Utah 1993, Chapter 145)
26-19-305, (Renumbered from 26-19-8, as last amended by Laws of Utah 2007, Chapter 64)
26-19-401, (Renumbered from 26-19-5, as last amended by Laws of Utah 2005, Chapter 103)
26-19-402, (Renumbered from 26-19-6, as last amended by Laws of Utah 2004, Chapter 72)
26-19-403, (Renumbered from 26-19-7, as last amended by Laws of Utah 2005, Chapter 103)
26-19-405, (Renumbered from 26-19-13.5, as last amended by Laws of Utah 2004, Chapter 72)
26-19-406, (Renumbered from 26-19-13.7, as enacted by Laws of Utah 1998, Chapter

145)

26-19-601, (Renumbered from 26-19-9.7, as enacted by Laws of Utah 2004, Chapter 72)

26-19-602, (Renumbered from 26-19-19, as enacted by Laws of Utah 1998, Chapter 145)

26-19-603, (Renumbered from 26-19-15, as last amended by Laws of Utah 1984, Chapter 34)

26-19-604, (Renumbered from 26-19-16, as enacted by Laws of Utah 1981, Chapter 126)

26-19-605, (Renumbered from 26-19-17, as last amended by Laws of Utah 1984, Chapter 34)

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

Section 1. Section **26-19-101**, which is renumbered from Section 26-19-1 is renumbered and amended to read:

CHAPTER 19. MEDICAL BENEFITS RECOVERY ACT

Part 1. General Provisions

[~~26-19-1~~]. 26-19-101. Title.

This chapter [~~shall be~~] is known [~~and may be cited~~] as the "Medical Benefits Recovery Act."

Section 2. Section **26-19-102**, which is renumbered from Section 26-19-2 is renumbered and amended to read:

[~~26-19-2~~]. 26-19-102. Definitions.

As used in this chapter:

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

(2) "Care facility" means:

(a) a nursing facility;

(b) an intermediate care facility for the mentally retarded; or

(c) any other medical institution.

[~~(2)~~] (3) "Claim" means:

(a) a request or demand for payment; or

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

[~~(3)~~] (4) "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)~~] (5) "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)~~] (6) "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.

(7) "Inpatient" means a person who is a patient and a resident of a care facility.

[~~(6)~~] (8) "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.

[~~(7)~~] (9) "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.

[~~(8)~~] (10) "Office of Recovery Services" means the Office of Recovery Services within the Department of Human Services.

[~~(9)~~] (11) "Provider" means a person or entity who provides services to a recipient.

[~~(10)~~] (12) "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 [~~(10)~~] (12)(a) if the person is a minor or an incapacitated person; or

(c) the estate and survivors of a person under Subsection [~~(10)~~] (12)(a) if the person is deceased.

[~~(11)~~] (13) "State plan" means the state Medicaid program as enacted in accordance with Title XIX, federal Social Security Act.

(14) "TEFRA lien" means a lien, authorized under the Tax Equity and Fiscal Responsibility Act of 1982, against the real property of an individual prior to the individual's death, as described in 42 U.S.C. 1396p.

[~~(12)~~] (15) "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.

[~~(13)~~] (16) "Trust" shall have the same meaning as provided in Section 75-1-201.

Section 3. Section **26-19-103**, which is renumbered from Section 26-19-3 is renumbered and amended to read:

[~~26-19-3~~]. 26-19-103. Program established by department -- Promulgation of rules.

(1) The department shall establish and maintain a program for the recoupment of medical assistance.

(2) The department may promulgate rules to implement the purposes of this chapter.

Section 4. Section **26-19-201**, which is renumbered from Section 26-19-4.5 is renumbered and amended to read:

Part 2. Assignment of Rights

[~~26-19-4.5~~]. 26-19-201. Assignment of rights to benefits.

(1) (a) To the extent that medical assistance is actually provided to a recipient, all benefits for medical services or payments from a third party otherwise payable to or on behalf of a recipient are assigned by operation of law to the department if the department provides, or becomes obligated to provide, medical assistance, regardless of who made application for the benefits on behalf of the recipient.

(b) The assignment:

(i) authorizes the department to submit its claim to the third party and authorizes payment of benefits directly to the department; and

(ii) is effective for all medical assistance.

(2) The department may recover the assigned benefits or payments in accordance with Section [~~26-19-5~~] 26-19-401 and as otherwise provided by law.

(3) The assignment of benefits includes medical support and third party payments ordered, decreed, or adjudged by any court of this state or any other state or territory of the United States. That assignment is not in lieu of, and does not supersede or alter any other court order, decree, or judgment.

(4) When an assignment takes effect, the recipient is entitled to receive medical assistance, and the benefits paid to the department are a reimbursement to the department.

Section 5. Section **26-19-301**, which is renumbered from Section 26-19-4.7 is renumbered and amended to read:

Part 3. Insurance Provisions

[~~26-19-4.7~~]. 26-19-301. 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 6. Section **26-19-302**, which is renumbered from Section 26-19-14 is renumbered and amended to read:

[~~26-19-14~~]. 26-19-302. Insurance policies not to deny or reduce benefits of persons eligible for state medical assistance -- Exemptions.

(1) A policy of accident or sickness insurance issued or renewed after May 12, 1981, may not contain any provision denying or reducing benefits because services are rendered to an

insured or dependent who is eligible for or receiving medical assistance from the state.

(2) After May 12, 1981, no association, corporation, or organization may deliver, issue for delivery, or renew any subscriber's contract which contains any provisions denying or reducing benefits because services are rendered to a subscriber or dependent who is eligible for or receiving medical assistance from the state.

(3) After May 12, 1981, no association, corporation, business, or organization authorized to do business in this state and which provides or pays for any health care benefits may deny or reduce benefits because services are rendered to a beneficiary who is eligible for or receiving medical assistance from the state.

(4) Notwithstanding Subsection (1), (2), or (3), the Utah State Public Employees Health Program, administered by the Utah State Retirement Board, is not required to reimburse any agency of state government for custodial care which the agency provides, through its staff or facilities, to members of the Utah State Public Employees Health Program.

(5) This section is subject to the provisions of Subsection 31A-22-610.5(3).

Section 7. Section **26-19-303**, which is renumbered from Section 26-19-9.5 is renumbered and amended to read:

[~~26-19-9.5~~]. 26-19-303. Availability of insurance policy.

If the third party does not pay the department's claim or lien within 30 days from the date the claim or lien is received, the third party shall:

(1) provide a written explanation if the claim is denied;

(2) specifically describe and request any additional information from the department that is necessary to process the claim; and

(3) provide the department or its agent a copy of any relevant or applicable insurance or benefit policy.

Section 8. Section **26-19-304**, which is renumbered from Section 26-19-9 is renumbered and amended to read:

[~~26-19-9~~]. 26-19-304. Employee benefit plans.

As allowed pursuant to 29 U.S.C. Section 1144, an employee benefit plan may not include any provision that has the effect of limiting or excluding coverage or payment for any health care for an individual who would otherwise be covered or entitled to benefits or services under the terms of the employee benefit plan based on the fact that the individual is eligible for

or is provided services under the state plan.

Section 9. Section **26-19-305**, which is renumbered from Section 26-19-8 is renumbered and amended to read:

[~~26-19-8~~]. 26-19-305. Statute of limitations -- Survival of right of action -- Insurance policy not to limit time allowed for recovery.

(1) (a) Subject to Subsection (6), action commenced by the department under this chapter against a health insurance entity must be commenced within:

(i) subject to Subsection (7), six years after the day on which the department 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~~] 26-19-405 or Part 5, TEFRA Liens.

(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 10. Section **26-19-401**, which is renumbered from Section 26-19-5 is renumbered and amended to read:

Part 4. General Recovery Provisions

[~~26-19-5~~]. 26-19-401. Recovery of medical assistance from third party -- Lien -- Notice -- Action -- Compromise or waiver -- Recipient's right to action protected.

(1) (a) When the department provides or becomes obligated to provide medical assistance to a recipient that a third party is obligated to pay for, the department may recover the medical assistance directly from that third party.

(b) Any claim arising under Subsection (1)(a) or Section [~~26-19-4.5~~] 26-19-201 to recover medical assistance provided to a recipient is a lien against any proceeds payable to or on behalf of the recipient by that third party. This lien has priority over all other claims to the proceeds, except claims for [~~attorney's~~] attorney fees and costs authorized under Subsection [~~26-19-7~~] 26-19-403(2)(c)(ii).

(2) (a) The department shall mail or deliver written notice of its claim or lien to the third party at its principal place of business or last-known address.

(b) The notice shall include:

(i) the recipient's name;

(ii) the approximate date of illness or injury;

(iii) a general description of the type of illness or injury; and

(iv) if applicable, the general location where the injury is alleged to have occurred.

(3) The department may commence an action on its claim or lien in its own name, but that claim or lien is not enforceable as to a third party unless:

(a) the third party receives written notice of the department's claim or lien before it settles with the recipient; or

(b) the department has evidence that the third party had knowledge that the department

provided or was obligated to provide medical assistance.

(4) The department may:

(a) waive a claim or lien against a third party in whole or in part; or

(b) compromise, settle, or release a claim or lien.

(5) An action commenced under this section does not bar an action by a recipient or a dependent of a recipient for loss or damage not included in the department's action.

(6) The department's claim or lien on proceeds under this section is not affected by the transfer of the proceeds to a trust, annuity, financial account, or other financial instrument.

Section 11. Section **26-19-402**, which is renumbered from Section 26-19-6 is renumbered and amended to read:

[~~26-19-6~~]. 26-19-402. Action by department -- Notice to recipient.

(1) (a) Within 30 days after commencing an action under Subsection [~~26-19-5~~] 26-19-401(3), the department shall give the recipient, [~~his~~] the recipient's guardian, personal representative, trustee, estate, or survivor, whichever is appropriate, written notice of the action by:

(i) personal service or certified mail to the last known address of the person receiving the notice; or

(ii) if no last-known address is available, by publishing a notice once a week for three successive weeks in a newspaper of general circulation in the county where the recipient resides.

(b) Proof of service shall be filed in the action.

(c) The recipient may intervene in the department's action at any time before trial.

(2) The notice required by Subsection (1) shall name the court in which the action is commenced and advise the recipient of:

(a) the right to intervene in the proceeding;

(b) the right to obtain a private attorney; and

(c) the department's right to recover medical assistance directly from the third party.

Section 12. Section **26-19-403**, which is renumbered from Section 26-19-7 is renumbered and amended to read:

[~~26-19-7~~]. 26-19-403. Notice of claim by recipient -- Department response -- Conditions for proceeding -- Collection agreements.

(1) (a) A recipient may not file a claim, commence an action, or settle, compromise, release, or waive a claim against a third party for recovery of medical costs for an injury, disease, or disability for which the department has provided or has become obligated to provide medical assistance, without the department's written consent as provided in Subsection (2)(b) or (4).

(b) For purposes of Subsection (1)(a), consent may be obtained if:

(i) a recipient who files a claim, or commences an action against a third party notifies the department in accordance with Subsection (1)(d) within ten days of making [~~his~~] the recipient's claim or commencing an action; or

(ii) an attorney, who has been retained by the recipient to file a claim, or commence an action against a third party, notifies the department in accordance with Subsection (1)(d) of the recipient's claim:

(A) within 30 days after being retained by the recipient for that purpose; or

(B) within 30 days from the date the attorney either knew or should have known that the recipient received medical assistance from the department.

(c) Service of the notice of claim to the department shall be made by certified mail, personal service, or by e-mail in accordance with Rule 5 of the Utah Rules of Civil Procedure, to the director of the Office of Recovery Services.

(d) The notice of claim shall include the following information:

(i) the name of the recipient;

(ii) the recipient's Social Security number;

(iii) the recipient's date of birth;

(iv) the name of the recipient's attorney if applicable;

(v) the name or names of individuals or entities against whom the recipient is making the claim, if known;

(vi) the name of the third party's insurance carrier, if known;

(vii) the date of the incident giving rise to the claim; and

(viii) a short statement identifying the nature of the recipient's claim.

(2) (a) Within 30 days of receipt of the notice of the claim required in Subsection (1), the department shall acknowledge receipt of the notice of the claim to the recipient or the recipient's attorney and shall notify the recipient or the recipient's attorney in writing of the

following:

(i) if the department has a claim or lien pursuant to Section [~~26-19-5~~] 26-19-401 or has become obligated to provide medical assistance; and

(ii) whether the department is denying or granting written consent in accordance with Subsection (1)(a).

(b) The department shall provide the recipient's attorney the opportunity to enter into a collection agreement with the department, with the recipient's consent, unless:

(i) the department, prior to the receipt of the notice of the recipient's claim pursuant to Subsection (1), filed a written claim with the third party, the third party agreed to make payment to the department before the date the department received notice of the recipient's claim, and the agreement is documented in the department's record; or

(ii) there has been a failure by the recipient's attorney to comply with any provision of this section by:

(A) failing to comply with the notice provisions of this section;

(B) failing or refusing to enter into a collection agreement;

(C) failing to comply with the terms of a collection agreement with the department; or

(D) failing to disburse funds owed to the state in accordance with this section.

(c) (i) The collection agreement shall be:

(A) consistent with this section and the attorney's obligation to represent the recipient and represent the state's claim; and

(B) state the terms under which the interests of the department may be represented in an action commenced by the recipient.

(ii) If the recipient's attorney enters into a written collection agreement with the department, or includes the department's claim in the recipient's claim or action pursuant to Subsection (4), the department shall pay [~~attorney's~~] attorney fees at the rate of 33.3% of the department's total recovery and shall pay a proportionate share of the litigation expenses directly related to the action.

(d) The department is not required to enter into a collection agreement with the recipient's attorney for collection of personal injury protection under Subsection 31A-22-302(2).

(3) (a) If the department receives notice pursuant to Subsection (1), and notifies the

recipient and the recipient's attorney that the department will not enter into a collection agreement with the recipient's attorney, the recipient may proceed with the recipient's claim or action against the third party if the recipient excludes from the claim:

(i) any medical expenses paid by the department; or

(ii) any medical costs for which the department is obligated to provide medical assistance.

(b) When a recipient proceeds with a claim under Subsection (3)(a), the recipient shall provide written notice to the third party of the exclusion of the department's claim for expenses under Subsection (3)(a)(i) or (ii).

(4) If the department receives notice pursuant to Subsection (1), and does not respond within 30 days to the recipient or the recipient's attorney, the recipient or the recipient's attorney:

(a) may proceed with the recipient's claim or action against the third party;

(b) may include the state's claim in the recipient's claim or action; and

(c) may not negotiate, compromise, settle, or waive the department's claim without the department's consent.

[~~(5) The department has an unconditional right to intervene in an action commenced by a recipient against a third party for the purpose of recovering medical costs for which the department has provided or has become obligated to provide medical assistance.~~]

[~~(6) (a) If the recipient proceeds without complying with the provisions of this section, the department is not bound by any decision, judgment, agreement, settlement, or compromise rendered or made on the claim or in the action.~~]

[~~(b) The department may recover in full from the recipient or any party to which the proceeds were made payable all medical assistance which it has provided and retains its right to commence an independent action against the third party, subject to Subsection 26-19-5(3).~~]

[~~(7) Any amounts assigned to and recoverable by the department pursuant to Sections 26-19-4.5 and 26-19-5 collected directly by the recipient shall be remitted to the Bureau of Medical Collections within the Office of Recovery Services no later than five business days after receipt.~~]

[~~(8) (a) Any amounts assigned to and recoverable by the department pursuant to Sections 26-19-4.5 and 26-19-5 collected directly by the recipient's attorney must be remitted~~

~~to the Bureau of Medical Collections within the Office of Recovery Services no later than 30 days after the funds are placed in the attorney's trust account.~~]

[~~(b) The date by which the funds must be remitted to the department may be modified based on agreement between the department and the recipient's attorney.~~]

[~~(c) The department's consent to another date for remittance may not be unreasonably withheld.~~]

[~~(d) If the funds are received by the recipient's attorney, no disbursements shall be made to the recipient or the recipient's attorney until the department's claim has been paid.~~]

[~~(9) A recipient or recipient's attorney who knowingly and intentionally fails to comply with this section is liable to the department for:~~]

[~~(a) the amount of the department's claim or lien pursuant to Subsection (5);~~]

[~~(b) a penalty equal to 10% of the amount of the department's claim; and~~]

[~~(c) attorney's fees and litigation expenses related to recovering the department's claim.~~]

Section 13. Section **26-19-404** is enacted to read:

26-19-404. Department's right to intervene -- Department's interests protected -- Remitting funds -- Disbursements -- Liability and penalty for noncompliance.

(1) The department has an unconditional right to intervene in an action commenced by a recipient against a third party for the purpose of recovering medical costs for which the department has provided or has become obligated to provide medical assistance.

(2) (a) If the recipient proceeds without complying with the provisions of Section 26-19-403 or this section, the department is not bound by any decision, judgment, agreement, settlement, or compromise rendered or made on the claim or in the action.

(b) The department:

(i) may recover in full from the recipient, or any party to which the proceeds were made payable, all medical assistance that the department has provided; and

(ii) retains the right to commence an independent action against the third party, subject to Subsection 26-19-401(3).

(3) Any amounts assigned to and recoverable by the department pursuant to Sections 26-19-201 and 26-19-401 collected directly by the recipient shall be remitted to the Bureau of Medical Collections within the Office of Recovery Services no later than five business days

after receipt.

(4) (a) Any amounts assigned to and recoverable by the department pursuant to Sections 26-19-201 and 26-19-401 collected directly by the recipient's attorney must be remitted to the Bureau of Medical Collections within the Office of Recovery Services no later than 30 days after the funds are placed in the attorney's trust account.

(b) The date by which the funds must be remitted to the department may be modified based on agreement between the department and the recipient's attorney.

(c) The department's consent to another date for remittance may not be unreasonably withheld.

(d) If the funds are received by the recipient's attorney, no disbursements shall be made to the recipient or the recipient's attorney until the department's claim has been paid.

(5) A recipient or recipient's attorney who knowingly and intentionally fails to comply with Section 26-19-403 or this section is liable to the department for:

(a) the amount of the department's claim or lien pursuant to Subsection (1);

(b) a penalty equal to 10% of the amount of the department's claim; and

(c) attorney fees and litigation expenses related to recovering the department's claim.

Section 14. Section **26-19-405**, which is renumbered from Section 26-19-13.5 is renumbered and amended to read:

[~~26-19-13.5~~]. 26-19-405. Estate and trust recovery.

(1) Upon a recipient's death, the department may recover from the recipient's estate and any trust, in which the recipient is the grantor and a beneficiary, medical assistance correctly provided for the benefit of the recipient when [~~he~~] the recipient was 55 years of age or older [~~if, at the time of death~~], so long as the recipient has no:

(a) surviving spouse; or

(b) child:

(i) younger than 21 years of age; or

(ii) who is blind or permanently and totally disabled.

(2) (a) The amount of medial assistance correctly provided for the benefit of a recipient and recoverable under this section is a lien against the estate of the deceased recipient or any trust when the recipient is the grantor and a beneficiary.

(b) The lien holds the same priority as reasonable and necessary medical expenses of

the last illness as provided in Section 75-3-805.

(3) (a) The department shall perfect the lien by filing a notice in the court of appropriate jurisdiction for the amount of the lien, in the same manner as a creditor's claim is filed, prior to final distribution.

(b) The department may file an amended lien prior to the entry of the final order closing the estate.

(4) Claims against a deceased recipient's inter vivos trust shall be presented in accordance with Sections 75-7-509 and 75-7-510.

(5) Any trust provision that denies recovery for medical assistance is void at the time of its making.

(6) Nothing in this section affects the right of the department to recover Medicaid assistance before a recipient's death under Section [~~26-19-4.5~~] 26-19-201 or [~~Section 26-19-13.7~~] 26-19-406.

Section 15. Section **26-19-406**, which is renumbered from Section 26-19-13.7 is renumbered and amended to read:

[~~26-19-13.7~~]. 26-19-406. Recovery from recipient of incorrectly provided medical assistance.

The department may:

(1) recover medical assistance incorrectly provided, whether due to administrative or factual error or fraud, from the recipient or [~~his~~] the recipient's estate; and

(2) pursuant to a judgment, impose a lien against real property of the recipient.

Section 16. Section **26-19-501** is enacted to read:

Part 5. TEFRA Liens

26-19-501. TEFRA liens authorized -- Grounds for TEFRA liens -- Exemptions.

(1) Except as provided in Subsections (2) and (3), the department may impose a TEFRA lien on the real property of a person for the amount of medical assistance provided for, or to, the person while the person is an inpatient in a care facility, if:

(a) the person is an inpatient in a care facility;

(b) the person is required, as a condition of receiving services under the state plan, to spend for costs of medical care all but a minimal amount of the person's income required for personal needs; and

(c) the department determines that the person cannot reasonably be expected to:

(i) be discharged from the care facility; and

(ii) return to the person's home.

(2) The department may not impose a lien on the home of a person described in Subsection (1), if any of the following people are lawfully residing in the home:

(a) the spouse of the person;

(b) a child of the person, if the child is:

(i) under 21 years of age; or

(ii) blind or permanently and totally disabled, as defined in Title 42 U.S.C. 1382c(a)(3)(F); or

(c) a sibling of the person, if the sibling:

(i) has an equity interest in the home; and

(ii) resided in the home for at least one year immediately preceding the day on which the person was admitted to the care facility.

(3) The department may not impose a TEFRA lien on the real property of a person, unless:

(a) the person has been an inpatient in a care facility for the 180-day period immediately preceding the day on which the lien is imposed;

(b) the department serves:

(i) a preliminary notice of intent to impose a TEFRA lien relating to the real property, in accordance with Section 26-19-503; and

(ii) a final notice of intent to impose a TEFRA lien relating to the real property, in accordance with Section 26-19-504; and

(c) the person:

(i) does not file a timely request for review of the department's decision under Title 63, Chapter 46b, Administrative Procedures Act; or

(ii) the department's decision is upheld upon final review or appeal under Title 63, Chapter 46b, Administrative Procedures Act.

Section 17. Section **26-19-502** is enacted to read:

26-19-502. Presumption of permanency.

There is a rebuttable presumption that a person who is an inpatient in a care facility

cannot reasonably be expected to be discharged from a care facility and return to the person's home, if the person has been an inpatient in a care facility for a period of at least 180 consecutive days.

Section 18. Section **26-19-503** is enacted to read:

26-19-503. Preliminary notice of intent to impose a TEFRA lien.

(1) Prior to imposing a TEFRA lien on real property, the department shall serve a preliminary notice of intent to impose a TEFRA lien, on the person described in Subsection 26-19-501(1), who owns the property.

(2) The preliminary notice of intent shall:

(a) be served in person, or by certified mail, on the person described in Subsection 26-19-501(1), and, if the department is aware that the person has a legally authorized representative, on the representative;

(b) include a statement indicating that, according to the department's records, the person:

(i) meets the criteria described in Subsections 26-19-501(1)(a) and (b);

(ii) has been an inpatient in a care facility for a period of at least 180 days immediately preceding the day on which the department provides the notice to the person; and

(iii) is legally presumed to be in a condition where it cannot reasonably be expected that the person will be discharged from the care facility and return to the person's home;

(c) indicate that the department intends to impose a TEFRA lien on real property belonging to the person;

(d) describe the real property that the TEFRA lien will apply to;

(e) describe the current amount of, and purpose of, the TEFRA lien;

(f) indicate that the amount of the lien may continue to increase as the person continues to receive medical assistance;

(g) indicate that the person may seek to prevent the TEFRA lien from being imposed on the real property by providing documentation to the department that:

(i) establishes that the person does not meet the criteria described in Subsection 26-19-501(1)(a) or (b);

(ii) establishes that the person has not been an inpatient in a care facility for a period of at least 180 days;

(iii) rebuts the presumption described in Section 26-19-502; or

(iv) establishes that the real property is exempt from imposition of a TEFRA lien under Subsection 26-19-501(2);

(h) indicate that if the owner fails to provide the documentation described in Subsection (2)(g) within 30 days after the day on which the preliminary notice of intent is served, the department will issue a final notice of intent to impose a TEFRA lien on the real property and will proceed to impose the lien;

(i) identify the type of documentation that the owner may provide to comply with Subsection (2)(g);

(j) describe the circumstances under which a TEFRA lien is required to be released; and

(k) describe the circumstances under which the department may seek to recover the lien.

Section 19. Section **26-19-504** is enacted to read:

26-19-504. Final notice of intent to impose a TEFRA lien.

(1) The department may issue a final notice of intent to impose a TEFRA lien on real property if:

(a) a preliminary notice of intent relating to the property is served in accordance with Subsection 26-19-503;

(b) it is at least 30 days after the day on which the preliminary notice of intent was served; and

(c) the department has not received documentation or other evidence that adequately establishes that a TEFRA lien may not be imposed on the real property.

(2) The final notice of intent to impose a TEFRA lien on real property shall:

(a) be served in person, or by certified mail, on the person described in Subsection 26-19-501(1), who owns the property, and, if the department is aware that the person has a legally authorized representative, on the representative;

(b) indicate that the department has complied with the requirements for filing the final notice of intent under Subsection (1);

(c) include a statement indicating that, according to the department's records, the person:

(i) meets the criteria described in Subsections 26-19-501(1)(a) and (b);

(ii) has been an inpatient in a care facility for a period of at least 180 days immediately preceding the day on which the department provides the notice to the person; and

(iii) is legally presumed to be in a condition where it cannot reasonably be expected that the person will be discharged from the care facility and return to the person's home;

(d) indicate that the department intends to impose a TEFRA lien on real property belonging to the person;

(e) describe the real property that the TEFRA lien will apply to;

(f) describe the current amount of, and purpose of, the TEFRA lien;

(g) indicate that the amount of the lien may continue to increase as the person continues to receive medical assistance;

(h) describe the circumstances under which a TEFRA lien is required to be released;

(i) describe the circumstances under which the department may seek to recover the lien;

(j) describe the right of the person to challenge the decision of the department in an adjudicative proceeding; and

(k) indicate that failure by the person to successfully challenge the decision of the department will result in the TEFRA lien being imposed.

Section 20. Section **26-19-505** is enacted to read:

26-19-505. Review of department decision.

A person who has been served with a final notice of intent to impose a TEFRA lien under Section 26-19-504, may seek agency or judicial review of that decision under Title 63, Chapter 46b, Administrative Procedures Act.

Section 21. Section **26-19-506** is enacted to read:

26-19-506. Dissolution and removal of TEFRA lien.

(1) A TEFRA lien shall dissolve and be removed by the department if the person described in Subsection 26-19-501(1):

(a) (i) is discharged from the care facility; and

(ii) returns to the person's home; or

(b) provides sufficient documentation to the department that:

(i) rebuts the presumption described in Section 26-19-502; or

(ii) any of the following people are lawfully residing in the person's home:

(A) the spouse of the person;

(B) a child of the person, if the child is:

(I) under 21 years of age; or

(II) blind or permanently and totally disabled, as defined in Title 42 U.S.C. 1382c(a)(3)(F); or

(C) a sibling of the person, if the sibling:

(I) has an equity interest in the home; and

(II) resided in the home for at least one year immediately preceding the day on which the person was admitted to the care facility.

(2) A person described in Subsection 26-19-501(1)(a) may, at any time after the department has imposed a lien under this part, file a request for the department to remove the lien.

(3) A request filed under Subsection (2) shall be considered and reviewed pursuant to Title 63, Chapter 46b, Administrative Procedures Act.

Section 22. Section **26-19-507** is enacted to read:

26-19-507. Expenditures included in lien -- Other proceedings.

(1) A TEFRA lien imposed on real property under this part includes all expenses relating to medical assistance provided or paid for under the state plan from the first day that the person is placed in a care facility, regardless of when the lien is imposed or filed on the property.

(2) Nothing in this part affects or prevents the department from bringing or pursuing any other legally authorized action to recover medical assistance or to set aside a fraudulent or improper conveyance.

Section 23. Section **26-19-508** is enacted to read:

26-19-508. Contract with another government agency.

If the department contracts with another government agency to recover funds paid for medical assistance under this chapter, that government agency shall be the sole agency that determines whether to impose or remove a TEFRA lien under this part.

Section 24. Section **26-19-509** is enacted to read:

26-19-509. Precedence of the Tax Equity and Fiscal Responsibility Act of 1982.

If any provision of this part conflicts with the requirements of the Tax Equity and Fiscal Responsibility Act of 1982 for imposing a lien against the property of an individual prior to the individual's death, under 42 U.S.C. 1396p, the provisions of the Tax Equity and Fiscal Responsibility Act of 1982 take precedence and shall be complied with by the department.

Section 25. Section **26-19-601**, which is renumbered from Section 26-19-9.7 is renumbered and amended to read:

Part 6. Miscellaneous Provisions

[~~26-19-9.7~~]. 26-19-601. Legal recognition of electronic claims records.

Pursuant to Title 46, Chapter 4, Uniform Electronic Transactions Act:

(1) a claim submitted to the department for payment may not be denied legal effect, enforceability, or admissibility as evidence in any court in any civil action because it is in electronic form; and

(2) a third party shall accept an electronic record of payments by the department for medical services on behalf of a recipient as evidence in support of the department's claim.

Section 26. Section **26-19-602**, which is renumbered from Section 26-19-19 is renumbered and amended to read:

[~~26-19-19~~]. 26-19-602. Direct payment to the department by third party.

(1) Any third party required to make payment to the department pursuant to this chapter shall make the payment directly to the department or its designee.

(2) The department may negotiate a payment or payment instrument it receives in connection with Subsection (1) without the cosignature or other participation of the recipient or any other party.

Section 27. Section **26-19-603**, which is renumbered from Section 26-19-15 is renumbered and amended to read:

[~~26-19-15~~]. 26-19-603. Attorney general or county attorney to represent department.

The attorney general or a county attorney shall represent the department in any action commenced under this chapter.

Section 28. Section **26-19-604**, which is renumbered from Section 26-19-16 is renumbered and amended to read:

[~~26-19-16~~]. 26-19-604. Department's right to attorney fees and costs.

In any action brought by the department under this chapter in which it prevails, the department shall recover along with the principal sum and interest, a reasonable [~~attorney's~~] attorney fee and costs incurred.

Section 29. Section **26-19-605**, which is renumbered from Section 26-19-17 is renumbered and amended to read:

[~~26-19-17~~]. 26-19-605. Application of provisions contrary to federal law prohibited.

In no event shall any provision contained in this chapter be applied contrary to existing federal law.

Section 30. Section **31A-4-107.5** is amended 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~~] 26-19-102, 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~~] 26-19-301:

(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 31. Section **31A-22-610** is amended to read:

31A-22-610. Dependent coverage from moment of birth or adoption.

(1) As used in this section:

(a) "Child" means, in connection with any adoption, or placement for adoption of the child, an individual who is younger than 18 years of age as of the date of the adoption or placement for adoption.

(b) "Placement for adoption" means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of the adoption of the child.

(2) (a) Except as provided in Subsection (5), if an accident and health insurance policy

provides coverage for any members of the policyholder's or certificate holder's family, the policy shall provide that any health insurance benefits applicable to dependents of the insured are applicable on the same basis to:

(i) a newly born child from the moment of birth; and

(ii) an adopted child:

(A) beginning from the moment of birth, if placement for adoption occurs within 30 days of the child's birth; or

(B) beginning from the date of placement, if placement for adoption occurs 30 days or more after the child's birth.

(b) The coverage described in this Subsection (2):

(i) is not subject to any preexisting conditions; and

(ii) includes any injury or sickness, including the necessary care and treatment of medically diagnosed:

(A) congenital defects;

(B) birth abnormalities; or

(C) prematurity.

(c) (i) Subject to Subsection (2)(c)(ii), a claim for services for a newly born child or an adopted child may be denied until the child is enrolled.

(ii) Notwithstanding Subsection (2)(c)(i), an otherwise eligible claim denied under Subsection (2)(c)(i) is eligible for payment and may be resubmitted or reprocessed once a child is enrolled pursuant to Subsection (2)(d) or (e).

(d) If the payment of a specific premium is required to provide coverage for a child of a policyholder or certificate holder, for there to be coverage for the child, the policyholder or certificate holder shall enroll:

(i) a newly born child within 30 days after the date of birth of the child; or

(ii) an adopted child within 30 days after the day of placement of adoption.

(e) If the payment of a specific premium is not required to provide coverage for a child of a policyholder or certificate holder, for the child to receive coverage the policyholder or certificate holder shall enroll a newly born child or an adopted child no later than 30 days after the first notification of denial of a claim for services for that child.

(3) (a) The coverage required by Subsection (2) as to children placed for the purpose of

adoption with a policyholder or certificate holder continues in the same manner as it would with respect to a child of the policyholder or certificate holder unless:

(i) the placement is disrupted prior to legal adoption; and

(ii) the child is removed from placement.

(b) The coverage required by Subsection (2) ends if the child is removed from placement prior to being legally adopted.

(4) The provisions of this section apply to employee welfare benefit plans as defined in Section [~~26-19-2~~] 26-19-102.

(5) If an accident and health insurance policy that is not subject to the special enrollment rights described in 45 C.F.R. Sec. 146.117(b) provides coverage for one individual, the insurer may choose to:

(a) provide coverage according to this section; or

(b) allow application, subject to the insurer's underwriting criteria for:

(i) a newborn;

(ii) an adopted child; or

(iii) a child placed for adoption.

Section 32. Section **31A-22-610.5** is amended to read:

31A-22-610.5. Dependent coverage.

(1) As used in this section, "child" has the same meaning as defined in Section 78-45-2.

(2) (a) Any individual or group accident and health insurance policy or health maintenance organization contract that provides coverage for a policyholder's or certificate holder's dependent shall not terminate coverage of an unmarried dependent by reason of the dependent's age before the dependent's 26th birthday and shall, upon application, provide coverage for all unmarried dependents up to age 26.

(b) The cost of coverage for unmarried dependents 19 to 26 years of age shall be included in the premium on the same basis as other dependent coverage.

(c) This section does not prohibit the employer from requiring the employee to pay all or part of the cost of coverage for unmarried dependents.

(3) An individual or group accident and health insurance policy or health maintenance organization contract shall reinstate dependent coverage, and for purposes of all exclusions and

limitations, shall treat the dependent as if the coverage had been in force since it was terminated; if:

(a) the dependent has not reached the age of 26 by July 1, 1995;

(b) the dependent had coverage prior to July 1, 1994;

(c) prior to July 1, 1994, the dependent's coverage was terminated solely due to the age of the dependent; and

(d) the policy has not been terminated since the dependent's coverage was terminated.

(4) (a) When a parent is required by a court or administrative order to provide health insurance coverage for a child, an accident and health insurer may not deny enrollment of a child under the accident and health insurance plan of the child's parent on the grounds the child:

(i) was born out of wedlock and is entitled to coverage under Subsection (5);

(ii) was born out of wedlock and the custodial parent seeks enrollment for the child under the custodial parent's policy;

(iii) is not claimed as a dependent on the parent's federal tax return; or

(iv) does not reside with the parent or in the insurer's service area.

(b) A child enrolled as required under Subsection (4)(a)(iv) is subject to the terms of the accident and health insurance plan contract pertaining to services received outside of an insurer's service area. A health maintenance organization must comply with Section 31A-8-502.

(5) When a child has accident and health coverage through an insurer of a noncustodial parent, and when requested by the noncustodial or custodial parent, the insurer shall:

(a) provide information to the custodial parent as necessary for the child to obtain benefits through that coverage, but the insurer or employer, or the agents or employees of either of them, are not civilly or criminally liable for providing information in compliance with this Subsection (5)(a), whether the information is provided pursuant to a verbal or written request;

(b) permit the custodial parent or the service provider, with the custodial parent's approval, to submit claims for covered services without the approval of the noncustodial parent; and

(c) make payments on claims submitted in accordance with Subsection (5)(b) directly to the custodial parent, the child who obtained benefits, the provider, or the state Medicaid

agency.

(6) When a parent is required by a court or administrative order to provide health coverage for a child, and the parent is eligible for family health coverage, the insurer shall:

(a) permit the parent to enroll, under the family coverage, a child who is otherwise eligible for the coverage without regard to an enrollment season restrictions;

(b) if the parent is enrolled but fails to make application to obtain coverage for the child, enroll the child under family coverage upon application of the child's other parent, the state agency administering the Medicaid program, or the state agency administering 42 U.S.C. 651 through 669, the child support enforcement program; and

(c) (i) when the child is covered by an individual policy, not disenroll or eliminate coverage of the child unless the insurer is provided satisfactory written evidence that:

(A) the court or administrative order is no longer in effect; or

(B) the child is or will be enrolled in comparable accident and health coverage through another insurer which will take effect not later than the effective date of disenrollment; or

(ii) when the child is covered by a group policy, not disenroll or eliminate coverage of the child unless the employer is provided with satisfactory written evidence, which evidence is also provided to the insurer, that Subsection (9)(c)(i), (ii) or (iii) has happened.

(7) An insurer may not impose requirements on a state agency that has been assigned the rights of an individual eligible for medical assistance under Medicaid and covered for accident and health benefits from the insurer that are different from requirements applicable to an agent or assignee of any other individual so covered.

(8) Insurers may not reduce their coverage of pediatric vaccines below the benefit level in effect on May 1, 1993.

(9) When a parent is required by a court or administrative order to provide health coverage, which is available through an employer doing business in this state, the employer shall:

(a) permit the parent to enroll under family coverage any child who is otherwise eligible for coverage without regard to any enrollment season restrictions;

(b) if the parent is enrolled but fails to make application to obtain coverage of the child, enroll the child under family coverage upon application by the child's other parent, by the state agency administering the Medicaid program, or the state agency administering 42 U.S.C. 651

through 669, the child support enforcement program;

(c) not disenroll or eliminate coverage of the child unless the employer is provided satisfactory written evidence that:

(i) the court order is no longer in effect;

(ii) the child is or will be enrolled in comparable coverage which will take effect no later than the effective date of disenrollment; or

(iii) the employer has eliminated family health coverage for all of its employees; and

(d) withhold from the employee's compensation the employee's share, if any, of premiums for health coverage and to pay this amount to the insurer.

(10) An order issued under Section 62A-11-326.1 may be considered a "qualified medical support order" for the purpose of enrolling a dependent child in a group accident and health insurance plan as defined in Section 609(a), Federal Employee Retirement Income Security Act of 1974.

(11) This section does not affect any insurer's ability to require as a precondition of any child being covered under any policy of insurance that:

(a) the parent continues to be eligible for coverage;

(b) the child shall be identified to the insurer with adequate information to comply with this section; and

(c) the premium shall be paid when due.

(12) The provisions of this section apply to employee welfare benefit plans as defined in Section [~~26-19-2~~] 26-19-102.

(13) The commissioner shall adopt rules interpreting and implementing this section with regard to out-of-area court ordered dependent coverage.

Section 33. Section **34A-2-417** is amended to read:

34A-2-417. Claims and benefits -- Time limits for filing -- Burden of proof.

(1) Except with respect to prosthetic devices or in a permanent total disability case, an employee is entitled to be compensated for a medical expense if:

(a) the medical expense is:

(i) reasonable in amount; and

(ii) necessary to treat the industrial accident; and

(b) the employee submits or makes a reasonable attempt to submit the medical

expense:

(i) to the employee's employer or insurance carrier for payment; and

(ii) within one year from the later of:

(A) the day on which the medical expense is incurred; or

(B) the day on which the employee knows or in the exercise of reasonable diligence should have known that the medical expense is related to the industrial accident.

(2) (a) A claim described in Subsection (2)(b) is barred, unless the employee:

(i) files an application for hearing with the Division of Adjudication no later than six years from the date of the accident; and

(ii) by no later than 12 years from the date of the accident, is able to meet the employee's burden of proving that the employee is due the compensation claimed under this chapter.

(b) Subsection (2)(a) applies to a claim for compensation for:

(i) temporary total disability benefits;

(ii) temporary partial disability benefits;

(iii) permanent partial disability benefits; or

(iv) permanent total disability benefits.

(c) The commission may enter an order awarding or denying an employee's claim for compensation under this chapter within a reasonable time period beyond 12 years from the date of the accident, if:

(i) the employee complies with Subsection (2)(a); and

(ii) 12 years from the date of the accident:

(A) (I) the employee is fully cooperating in a commission approved reemployment plan; and

(II) the results of that commission approved reemployment plan are not known; or

(B) the employee is actively adjudicating issues of compensability before the commission.

(3) A claim for death benefits is barred unless an application for hearing is filed within one year of the date of death of the employee.

(4) (a) (i) Subject to Subsections (2)(c) and (4)(b), after an employee files an application for hearing within six years from the date of the accident, the Division of

Adjudication may enter an order to show cause why the employee's claim should not be dismissed because the employee has failed to meet the employee's burden of proof to establish an entitlement to compensation claimed in the application for hearing.

(ii) The order described in Subsection (4)(a)(i) may be entered on the motion of the:

(A) Division of Adjudication;

(B) employee's employer; or

(C) employer's insurance carrier.

(b) Under Subsection (4)(a), the Division of Adjudication may dismiss a claim:

(i) without prejudice; or

(ii) with prejudice only if:

(A) the Division of Adjudication adjudicates the merits of the employee's entitlement to the compensation claimed in the application for hearing; or

(B) the employee fails to comply with Subsection (2)(a)(ii).

(c) If a claim is dismissed without prejudice under Subsection (4)(b), the employee is subject to the time limits under Subsection (2)(a) to claim compensation under this chapter.

(5) A claim for compensation under this chapter is subject to a claim or lien for recovery under Section [~~26-19-5~~] 26-19-401.

Section 34. Section **34A-2-422** is amended to read:

34A-2-422. Compensation exempt from execution -- Transfer of payment rights.

(1) For purposes of this section:

(a) "Payment rights under workers' compensation" means the right to receive compensation under this chapter or Chapter 3, Utah Occupational Disease Act, including the payment of a workers' compensation claim, award, benefit, or settlement.

(b) (i) Subject to Subsection (1)(b)(ii), "transfer" means:

(A) a sale;

(B) an assignment;

(C) a pledge;

(D) an hypothecation; or

(E) other form of encumbrance or alienation for consideration.

(ii) "Transfer" does not include the creation or perfection of a security interest in a right to receive a payment under a blanket security agreement entered into with an insured

depository institution, in the absence of any action to:

(A) redirect the payments to:

(I) the insured depository institution; or

(II) an agent or successor in interest to the insured depository institution; or

(B) otherwise enforce a blanket security interest against the payment rights.

(2) Compensation before payment:

(a) is exempt from:

(i) all claims of creditors; and

(ii) attachment or execution; and

(b) shall be paid only to employees or their dependents, except as provided in Sections [~~26-19-5~~] 26-19-401 and 34A-2-417.

(3) (a) Subject to Subsection (3)(b), beginning April 30, 2007, a person may not:

(i) transfer payment rights under workers' compensation; or

(ii) accept or take any action to provide for a transfer of payment rights under workers' compensation.

(b) A person may take an action prohibited under Subsection (3)(a) if the commission approves the transfer of payment rights under workers' compensation:

(i) before the transfer of payment rights under workers' compensation takes effect; and

(ii) upon a determination by the commission that:

(A) the person transferring the payment rights under workers' compensation received before executing an agreement to transfer those payment rights:

(I) adequate notice that the transaction involving the transfer of payment rights under workers' compensation involves the transfer of those payment rights; and

(II) an explanation of the financial consequences of and alternatives to the transfer of payment rights under workers' compensation in sufficient detail that the person transferring the payment rights under workers' compensation made an informed decision to transfer those payment rights; and

(B) the transfer of payment rights under workers' compensation is in the best interest of the person transferring the payment rights under workers' compensation taking into account the welfare and support of that person's dependents.

(c) The approval by the commission of the transfer of a person's payment rights under

workers' compensation is a full and final resolution of the person's payment rights under workers' compensation that are transferred:

(i) if the commission approves the transfer of the payment rights under workers' compensation in accordance with Subsection (3)(b); and

(ii) once the person no longer has a right to appeal the decision in accordance with this title.

Section 35. Section **75-3-805** is amended to read:

75-3-805. Classification of claims.

(1) If the applicable assets of the estate are insufficient to pay all claims in full, the personal representative shall make payment in the following order:

(a) reasonable funeral expenses;

(b) costs and expenses of administration;

(c) debts and taxes with preference under federal law;

(d) reasonable and necessary medical and hospital expenses of the last illness of the decedent, including compensation of persons attending [~~him~~] the decedent, and medical assistance if Section [~~26-19-13.5~~] 26-19-405 applies;

(e) debts and taxes with preference under other laws of this state; and

(f) all other claims.

(2) No preference shall be given in the payment of any claim over any other claim of the same class, and a claim due and payable shall not be entitled to a preference over claims not due.

Section 36. 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~~] the creditor's 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 Section [~~26-19-2~~] 26-19-102, 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~~] 26-19-405 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.

Section 37. Section **75-7-511** is amended to read:

75-7-511. Classification of claims.

(1) If the applicable assets of the deceased settlor's estate or trust estate are insufficient to pay all claims in full, the trustee shall make payment in the following order:

(a) reasonable funeral expenses;

(b) costs and expenses of administration;

(c) debts and taxes with preference under federal law;

(d) reasonable and necessary medical and hospital expenses of the last illness of the deceased settlor, including compensation of persons attending him, and medical assistance if Section [~~26-19-13.5~~] 26-19-405 applies;

(e) debts and taxes with preference under other laws of this state; and

(f) all other claims.

(2) No preference shall be given in the payment of any claim over any other claim of the same class, and a claim due and payable shall not be entitled to a preference over claims not

1082 due.

Legislative Review Note
as of 12-12-07 10:02 AM

Office of Legislative Research and General Counsel

S.B. 50 - Medical Benefits Recovery Amendments

Fiscal Note

2008 General Session

State of Utah

State Impact

Enactment of this legislation may result in increased collections for the State.

Individual, Business and/or Local Impact

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

1/8/2008, 11:30:54 AM, Lead Analyst: Frandsen, R.

Office of the Legislative Fiscal Analyst