

Representative Merlynn T. Newbold proposes the following substitute bill:

HEALTH REFORM - ADMINISTRATIVE

SIMPLIFICATION

2009 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: Merlynn T. Newbold

Senate Sponsor: Gregory S. Bell

LONG TITLE

General Description:

This bill modifies the Health Code and the Insurance Code to provide standards for the exchange of information between health care providers, health care insurers, and patients regarding payment for services.

Highlighted Provisions:

This bill:

- ▶ amends the timing of the requirement that a hospital sends an itemized bill to a patient;
- ▶ creates a systemwide, broad based demonstration project between health care payers and health care providers for innovating the payment and delivery of health care in the state;
- ▶ establishes a coordination of benefits process;
- ▶ requires health benefit plans to issue to enrollees a printed card containing health plan information;
- ▶ requires an insurer to provide access to information sufficient for a health care provider to determine the compensation or payment terms for health care services;
- ▶ requires the Insurance Department to convene a group of providers and payers to



26 establish standards for the electronic exchange of health plan information using card swipe
27 technology which is compatible with national electronic standards;

28 ▶ prohibits an insurer from requiring less than one business day's notice of an
29 emergency in-patient hospital admission; and

30 ▶ amends the period of time in which an insurer can recover an amount paid to a
31 health care provider when the insurer determines the payment was incorrect.

32 **Monies Appropriated in this Bill:**

33 None

34 **Other Special Clauses:**

35 None

36 **Utah Code Sections Affected:**

37 AMENDS:

38 **26-21-20**, as last amended by Laws of Utah 2000, Chapter 86

39 **31A-26-301.6**, as last amended by Laws of Utah 2007, Chapter 307

40 ENACTS:

41 **31A-22-614.6**, Utah Code Annotated 1953

42 **31A-22-636**, Utah Code Annotated 1953

43 **31A-22-637**, Utah Code Annotated 1953

44 REPEALS AND REENACTS:

45 **31A-22-619**, as last amended by Laws of Utah 2001, Chapter 116



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

48 Section 1. Section **26-21-20** is amended to read:

49 **26-21-20. Requirement for hospitals to provide statements of itemized charges to**
50 **patients.**

51 (1) For purposes of this section, "hospital" includes:

52 (a) an ambulatory surgical facility;

53 (b) a general acute hospital; and

54 (c) a specialty hospital.

55 ~~[(1) Each hospital, as defined in Section 26-21-2,]~~

56 (2) A hospital shall provide a statement of itemized charges to any patient receiving

57 medical care or other services from that hospital.

58 ~~[(2)]~~ (3) (a) The statement shall be provided to the patient or ~~[his]~~ the patient's personal
59 representative or agent at the hospital's expense, personally, by mail, or by verifiable electronic
60 delivery [at the time any statement is provided to any person or entity for billing purposes:]
61 after the hospital receives an explanation of benefits from a third party payer which indicates
62 the patient's remaining responsibility for the hospital charges.

63 (b) If the statement is not provided to a third party, it shall be provided to the patient as
64 soon as possible and practicable.

65 ~~[(3)]~~ (4) The statement required by this section:

66 (a) shall itemize each of the charges actually provided by the hospital to the patient[-];

67 (b) (i) shall include the words in bold "THIS IS THE BALANCE DUE AFTER
68 PAYMENT FROM YOUR HEALTH INSURER"; or

69 (ii) shall include other appropriate language if the statement is sent to the patient under
70 Subsection (2)(b); and

71 ~~[(4) The statement]~~ (c) may not include charges of physicians who bill separately.

72 (5) The requirements of this section do not apply to patients who receive services from
73 a hospital under Title XIX of the Social Security Act.

74 ~~[(6) A statement of charges to be paid by a third party and related information provided~~
75 ~~to a patient pursuant to this section]~~

76 (6) Nothing in this section prohibits a hospital from sending an itemized billing
77 statement to a patient before the hospital has received an explanation of benefits from an
78 insurer. If a hospital provides a statement of itemized charges to a patient prior to receiving the
79 explanation of benefits from an insurer, the itemized statement shall be marked in bold:
80 "DUPLICATE: DO NOT PAY" or other appropriate language.

81 Section 2. Section **31A-22-614.6** is enacted to read:

82 **31A-22-614.6. Health care delivery and payment reform demonstration projects.**

83 (1) The Legislature finds that:

84 (a) current health care delivery and payment systems do not provide systemwide
85 aligned incentives for the appropriate delivery of health care;

86 (b) some health care providers and health care payers have developed ideas for health
87 care delivery and payment system reform, but lack the critical number of patient lives and

88 payer involvement to accomplish systemwide reform; and

89 (c) there is a compelling state interest to encourage as many health care providers and
90 health care payers to join together and coordinate efforts at systemwide health care delivery and
91 payment reform.

92 (2) (a) The Office of Consumer Health Services within the Governor's Office of
93 Economic Development shall convene meetings of health care providers and health care payers
94 through a neutral, non-biased entity that can demonstrate it has the support of a broad base of
95 the participants in this process for the purpose of coordinating broad based demonstration
96 projects for health care delivery and payment reform.

97 (b) (i) The speaker of the House of Representatives may appoint a person who is a
98 member of the House of Representatives, or from the Office of Legislative Research and
99 General Counsel, to attend the meetings convened under Subsection (2)(a).

100 (ii) The president of the Senate may appoint a person who is a senator, or from the
101 Office of Legislative Research and General Counsel to attend the meetings convened under
102 Subsection (2)(a).

103 (c) Participation in the coordination efforts by health care providers and health care
104 payers is voluntary, but is encouraged.

105 (3) The commissioner and the Office of Consumer Health Services shall facilitate
106 coordinated broad based demonstration projects for health care delivery and payment reform
107 between various health care providers and health care payers who elect to participate in the
108 demonstration projects by:

109 (a) consulting with health care providers and health care payers who elect to join
110 together in a broad based reform demonstration project; and

111 (b) adopting administrative rules in accordance with Title 63G, Chapter 3, Utah
112 Administrative Rulemaking Act, as necessary to implement the demonstration project.

113 (4) The Office of Consumer Health Services and the commissioner shall report to the
114 Health Reform Task Force by October 2009, and to the Legislature's Business and Labor
115 Interim Committee every October thereafter regarding the progress towards coordination of
116 broad based health care system payment and delivery reform.

117 Section 3. Section **31A-22-619** is repealed and reenacted to read:

118 **31A-22-619. Coordination of benefits.**

119 (1) When a carrier is coordinating benefits for an insured between two or more
120 accident and health insurance policies, a carrier shall determine the order of payment of
121 benefits in the following order of priority:

122 (a) the benefits of the plan of the subscriber whose birthday month and day is earlier in
123 the calendar year are determined before those of a subscriber whose birthday falls later in the
124 year;

125 (b) if both subscribers have the same birthday month and day under Subsection (1)(a),
126 the benefits of the subscriber whose first name on the policy appears first in alphabetical order
127 shall be determined first; and

128 (c) if the priority of determining payment cannot be made under Subsections (1)(a) or
129 (b), each carrier shall pay its pro-rata share of a claim.

130 (2) (a) Except as permitted in Subsection (2)(b), a carrier shall not consider the
131 following for underwriting or risk adjusting purposes:

132 (i) an applicant's birth month or day; or

133 (ii) the applicant's name.

134 (b) Subsection (2)(a) does not prohibit underwriting or risk adjustment based on the
135 age of the applicant.

136 (3) Notwithstanding the provisions of Subsections (1) and (2), an accident and health
137 insurance policy's cost sharing requirements are the subscriber's responsibility.

138 Section 4. Section **31A-22-636** is enacted to read:

139 **31A-22-636. Standardized health benefit plan cards.**

140 (1) As used in this section, "insurer" means:

141 (a) an insurer governed by this part as described in Section 31A-22-600;

142 (b) a health maintenance organization governed by Chapter 8, Health Maintenance
143 Organizations and Limited Health Benefit Plans;

144 (c) a third party administrator; and

145 (d) notwithstanding Subsection 31A-1-103(3)(f) and Section 31A-22-600, a health,
146 medical, or conversion policy offered under Title 49, Chapter 20, Public Employees' Benefit
147 and Insurance Program Act.

148 (2) In accordance with Subsection (3), an insurer must use and issue a health benefit
149 plan information card for the insurer's enrollees upon the purchase or renewal of, or enrollment

150 in a health benefit plan on or after July 1, 2010.

151 (3) The health benefit plan card shall include:

152 (a) the covered person's name;

153 (b) the name of the carrier and the carrier network name;

154 (c) the contact information for the carrier or health benefit plan administrator;

155 (d) general information regarding copayments and deductibles; and

156 (e) an indication of whether the health benefit plan is regulated by the state.

157 (4) (a) The commissioner shall work with the Department of Health, the Health Data

158 Authority, health care providers groups, and with state and national organizations that are

159 developing uniform standards for the electronic exchange of health insurance claims or

160 uniform standards for the electronic exchange of clinical health records.

161 (b) When the commissioner determines that the groups described in Subsection (4)(a)

162 have reached a consensus regarding the electronic technology and standards necessary to

163 electronically exchange insurance enrollment and coverage information, the commissioner

164 shall begin the rulemaking process under Title 63G, Chapter 3, Utah Administrative

165 Rulemaking Act, to adopt standardized electronic interchange technology.

166 (C) After rules are adopted under Subsection (4)(a), health care providers and their

167 licensing boards under Title 58, Occupations and Professions, and health facilities licensed

168 under Title 26, Chapter 21, Health Care Facilities Licensing, shall work together to implement

169 the adoption of card swipe technology.

170 Section 5. Section **31A-22-637** is enacted to read:

171 **31A-22-637. Health care provider payment information -- Notice of admissions.**

172 (1) For purposes of this section, "insurer" is as defined in Section 31A-22-636.

173 (2) (a) An insurer shall provide its health care providers who are under contract with

174 the insurer access to current information necessary for the health care provider to determine:

175 (i) the effect of procedure codes on payment or compensation before a claim is

176 submitted for a procedure;

177 (ii) the plans and carrier networks that the health care provider is subject to as part of

178 the contract with the carrier; and

179 (iii) in accordance with Subsection 31A-26-301.6(10)(f), the specific rate and terms

180 under which the provider will be paid for health care services.

181 (b) The information required by Subsection (2)(a) may be provided through a website,
182 and if requested by the health care provider, notice of updated website shall be provided by the
183 carrier.

184 (3) (a) An insurer shall not require a health care provider by contract, reimbursement
185 procedure, or otherwise to notify the insurer of a hospital in-patient emergency admission
186 within a period of time that is less than one business day of the hospital inpatient admission, if
187 compliance with the notification requirement would result in notification by the health care
188 provider on a weekend or federal holiday.

189 (b) Subsection (3)(a) does not prohibit the applicability or administration of other
190 contract provisions between an insurer and a health care provider that require pre-authorization
191 for scheduled in-patient admissions.

192 Section 6. Section **31A-26-301.6** is amended to read:

193 **31A-26-301.6. Health care claims practices.**

194 (1) As used in this section:

195 (a) "Articulate reason" may include a determination regarding:

196 (i) eligibility for coverage;

197 (ii) preexisting conditions;

198 (iii) applicability of other public or private insurance;

199 (iv) medical necessity; and

200 (v) any other reason that would justify an extension of the time to investigate a claim.

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

202 (i) Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act; or

203 (ii) Title 58, Occupations and Professions.

204 (c) "Insurer" means an admitted or authorized insurer, as defined in Section

205 31A-1-301, and includes:

206 (i) a health maintenance organization; and

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

211 (d) "Provider" means a health care provider to whom an insurer is obligated to pay

212 directly in connection with a claim by virtue of:

- 213 (i) an agreement between the insurer and the provider;
- 214 (ii) a health insurance policy or contract of the insurer; or
- 215 (iii) state or federal law.

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

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

- 220 (i) pay the claim; or
- 221 (ii) deny the claim and provide a written explanation for the denial.

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

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

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

- 228 (I) the circumstances requiring the extension of time; and
- 229 (II) the date by which the insurer expects to pay the claim or deny the claim with a
230 written explanation for the denial.

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

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

235 (B) the insurer shall give the provider or insured at least 45 days from the day on which
236 the provider or insured receives the notice before the insurer denies the claim for failure to
237 provide the information requested in Subsection (3)(b)(ii)(A).

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

- 240 (i) pay the claim; or
- 241 (ii) deny the claim and provide a written explanation of the denial.

242 (b) Subject to Subsections (4)(d) and (e), the time period described in Subsection (4)(a)

243 may be extended for 30 days if the insurer:

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

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

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

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

251 (c) Subject to Subsections (4)(d) and (e), the time period for complying with
252 Subsection (4)(a) may be extended for up to an additional 30 days from the day on which the
253 30-day extension period provided in Subsection (4)(b) ends if before the day on which the
254 30-day extension period ends, the insurer:

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

257 (ii) notifies the insured of:

258 (A) the circumstances requiring the extension; and

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

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

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

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

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

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

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

271 (5) If a period of time is extended as permitted under Subsection (3)(b), (4)(b), or
272 (4)(c), due to an insured or provider failing to submit information necessary to decide a claim,
273 the period for making the benefit determination shall be tolled from the date on which the

274 notification of the extension is sent to the insured or provider until the date on which the
275 insured or provider responds to the request for additional information.

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

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

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

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

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

287 (c) This Subsection (7) does not apply to a person receiving benefits under the state
288 Medicaid program as defined in Section 26-18-2, unless required by the Department of Health
289 or federal law.

290 (8) (a) Beginning with health care claims submitted on or after January 1, 2002, a late
291 fee shall be imposed on:

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

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

295 (b) For the first 90 days that a claim payment or a provider response to a request for
296 information is late, the late fee shall be determined by multiplying together:

297 (i) the total amount of the claim;

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

299 (iii) .1%.

300 (c) For a claim payment or a provider response to a request for information that is 91 or
301 more days late, the late fee shall be determined by adding together:

302 (i) the late fee for a 90-day period under Subsection (8)(b); and

303 (ii) the following multiplied together:

304 (A) the total amount of the claim;

305 (B) the total number of days the response or payment was late beyond the initial 90-day
306 period; and

307 (C) the rate of interest set in accordance with Section 15-1-1.

308 (d) Any late fee paid or collected under this section shall be separately identified on the
309 documentation used by the insurer to pay the claim.

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

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

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

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

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

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

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

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

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

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

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

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

335 (j) any material violation of this section; and

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

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

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

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

344 (12) (a) Pursuant to Chapter 2, Part 2, Duties and Powers of Commissioner, and
345 beginning January 1, 2002, the commissioner may conduct examinations to determine an
346 insurer's level of compliance with this section and impose sanctions for each violation.

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

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

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

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

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

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

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

358 (ii) within ~~[36]~~ 24 months of the amount improperly paid for a coordination of benefits
359 error; ~~[or]~~

360 (iii) within ~~[18]~~ 12 months of the amount improperly paid for any other reason not
361 identified in Subsection (14)(a)(i) or (ii); or

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

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

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

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

371 (15) A health care provider or an insured individual may only seek recovery from the
372 insurer for an amount improperly paid by the insurer within the same time frames as
373 Subsections (14)(a) and (b).

H.B. 165 1st Sub. (Buff) - Health Reform - Administrative Simplification

Fiscal Note

2009 General Session

State of Utah

State Impact

Enactment of this bill will not require additional appropriations.

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.
