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COORDINATION OF HEALTH INSURANCE BENEFIT AMENDMENTS

2016 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: Norman K Thurston

Senate Sponsor: Deidre M. Henderson

LONG TITLE

General Description:

This bill addresses payments to health care providers through coordination of benefits.

Highlighted Provisions:

This bill:

- prevents a health care provider from collecting a payment in an amount greater than the patient's lowest contracted rate; and
- requires a health care provider to return overpayments to patients and insurers.

Money Appropriated in this Bill:

None

Other Special Clauses:

None

Utah Code Sections Affected:

AMENDS:

31A-26-301.5, as last amended by Laws of Utah 2001, Chapter 240

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

Section 1. Section **31A-26-301.5** is amended to read:

31A-26-301.5. Health care claims practices.

(1) Except as provided in Section 31A-8-407, an insured retains ultimate responsibility

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for paying for health care services the insured receives. If a service is covered by one or more individual or group health insurance policies, all insurers covering the insured have the responsibility to pay valid health care claims in a timely manner according to the terms and limits specified in the policies.

(2) (a) Except as provided in Section 31A-22-610.1, a health care provider may bill and collect for any deductible, copayment, or uncovered service.

(b) A health care provider may bill an insured for services covered by health insurance policies or may otherwise notify the insured of the expenses covered by the policies. However, a provider may not make any report to a credit bureau, use the services of a collection agency, or use methods other than routine billing or notification until the later of:

(i) the expiration of the time afforded to an insurer under Section 31A-26-301.6 to determine its obligation to pay or deny the claim without penalty; or

(ii) in the case of medicare beneficiaries or retirees 65 years of age or older, 60 days from the date medicare determines its liability for the claim.

(c) Beginning October 31, 1992, all insurers covering the insured shall notify the insured of payment and the amount of payment made to the provider.

(d) If an insured has multiple insurers:

(i) a health care provider may not collect payment for a claim in an amount greater than the lowest contracted rate between the insured and one of the insured's insurers; and

(ii) if a health care provider becomes aware, including when an insured presents the provider with an explanation of benefits from an insurer, that the provider has received, for any reason, payment for a claim in an amount greater than the provider's contracted rate allows, the provider shall return, including interest accruing from the date of the overpayment:

(A) to the insured, the amount the insured overpaid; and

(B) to each insurer, the amount each insurer overpaid.

(3) The commissioner shall make rules consistent with this chapter governing disclosure to the insured of customary charges by health care providers on the explanation of benefits as part of the claims payment process. These rules shall be limited to the form and content of the disclosures on the explanation of benefits, and shall include:

(a) a requirement that the method of determination of any specifically referenced customary charges and the range of the customary charges be disclosed; and

(b) a prohibition against an implication that the provider is charging excessively if the provider is:

(i) a participating provider; and

(ii) prohibited from balance billing.

Legislative Review Note
Office of Legislative Research and General Counsel