

Representative R. Curt Webb proposes the following substitute bill:

HEALTH CARE DEBT COLLECTION AMENDMENTS

2017 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: R. Curt Webb

Senate Sponsor: Curtis S. Bramble

LONG TITLE

General Description:

This bill modifies and enacts provisions related to health care claims practices.

Highlighted Provisions:

This bill:

- ▶ defines terms;
- ▶ modifies the circumstances under which a health care provider may make a report to a credit bureau or use the services of a collection agency against an insured;

~~It → [→ provides a private right of action against a health care provider who fails to comply with the provisions of this bill;] ← It~~

- ▶ addresses administrative penalties for a health care provider who fails to comply with the provisions of this bill; and

- ▶ makes technical and conforming changes.

Money Appropriated in this Bill:

None

Other Special Clauses:

None

Utah Code Sections Affected:

AMENDS:



57 ~~[(2)(a)]~~ (3) ~~[Except as provided in Section 31A-22-610.1, a]~~ A health care provider
 58 may;

59 (a) except as provided in Section 31A-22-610.1, bill and collect for any deductible,
 60 copayment, or uncovered service[;]; and

61 ~~(b) [A health care provider may]~~ bill an insured for services covered by health
 62 insurance policies or ~~[may]~~ otherwise notify the insured of the expenses covered by the
 63 policies. ~~[However, a]~~

64 (4) (a) Subject to Subsection (4)(b), a health care provider may not make any report to
 65 a credit bureau[;] or use the services of a collection agency[; or use methods other than routine
 66 billing or notification] until;

67 (i) the later of:

68 [(i)] (A) [the expiration of] 60 days after the day on which the time afforded to an
 69 insurer under Section 31A-26-301.6 to determine its obligation to pay or deny the claim
 70 without penalty expires; or

71 [(ii)] (B) in the case of Medicare beneficiaries or retirees 65 years of age or older, 60
 72 days from the date Medicare determines its liability for the claim[;];

73 (ii) after the applicable date described in Subsection (4)(a)(i), the health care provider
 74 sends a notice to the insured by certified mail with return receipt requested that states:

75 (A) the amount that the insured owes;

76 (B) a date that is at least 30 days after the day on which the health care provider sends
 77 the notice by which the insured must pay the amount owed;

78 (C) that if the insured fails to timely pay the amount owed, the health care provider
 79 may make a report to a credit bureau or use the services of a collection agency; and

80 (D) that each action described in Subsection (4)(a)(ii)(C) may negatively impact the
 81 insured's credit score; and

82 (iii) after the date stated in the notice in accordance with Subsection (4)(a)(ii)(B).

83 (b) A health care provider satisfies the requirements described in Subsection (4)(a) if
 84 the health care provider complies with the provisions of 26 C.F.R. Sec. 1.501(r)-6.

85 ~~H→ [(5)(a) An insured may file an action in district court against a health care provider for~~
 86 ~~a violation of a provision of Subsection (4).~~

87 ~~—— (b) If the court finds that the health care provider violated a provision of Subsection —~~

88 ~~(4), the court shall award the insured:~~

89 ~~—— (i) actual damages;~~

90 ~~—— (ii) costs; and~~

91 ~~—— (iii) reasonable attorney fees.] ←H~~

92 [⊖] H→ [⊖] (5) ←H Beginning October 31, 1992, all insurers covering the insured shall
92a notify the

93 insured of payment and the amount of payment made to the health care provider.

94 [⊕] H→ [⊕] (6) ←H A health care provider shall return to an insured any amount the
94a insured

95 overpaid, including interest that begins accruing 90 days after the date of the overpayment, if:

96 [⊕] (a) the insured has multiple insurers with whom the health care provider has
97 contracts that cover the insured; and

98 [⊕] (b) the health care provider becomes aware that the health care provider has
99 received, for any reason, payment for a claim in an amount greater than the health care
100 provider's contracted rate allows.

101 [⊕] H→ [⊕] (7) ←H The commissioner shall make rules consistent with this chapter
101a governing

102 disclosure to the insured of customary charges by health care providers on the explanation of
103 benefits as part of the claims payment process. These rules shall be limited to the form and
104 content of the disclosures on the explanation of benefits, and shall include:

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

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

109 (i) a participating provider; and

110 (ii) prohibited from balance billing.

111 Section 3. Section **58-1-508** is enacted to read:

112 **58-1-508. Failure to follow certain health care claims practices -- Penalties.**

113 (1) As used in this section, "health care provider" means an individual who is licensed
114 to provide health care services under this title.

115 (2) The division may assess a fine of up to \$500 per violation against a health care
116 provider who violates Subsection 31A-36-301.5(4).

117 (3) The division shall waive the fine described in Subsection (2) if:

118 (a) the health care provider demonstrates to the division that the health care provider