LEGISLATIVE GENERAL COUNSEL
₡ Approved for Filing: C.R. Gilbert ₡
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Representative Raymond P. Ward proposes the following substitute bill:

1 # HEALTH CARE DEBT COLLECTION AMENDMENTS

2 2017 GENERAL SESSION

3 STATE OF UTAH

4 **Chief Sponsor: R. Curt Webb**

5 Senate Sponsor: ____________

6

7 **LONG TITLE**

8 **General Description:**

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

10 **Highlighted Provisions:**

11 This bill:

12 ▸ defines terms;

13 ▸ modifies the circumstances under which a health care provider may make a report to

14 a credit bureau or use the services of a collection agency against an insured;

15 ▸ addresses administrative penalties for a health care provider who fails to comply

16 with the provisions of this bill; and

17 ▸ makes technical and conforming changes.

18 **Money Appropriated in this Bill:**

19 None

20 **Other Special Clauses:**

21 None

22 **Utah Code Sections Affected:**

23 AMENDS:

24 **31A-26-301.5**, as last amended by Laws of Utah 2016, Chapter 124

25 **62A-2-112**, as last amended by Laws of Utah 2016, Chapter 211

26 ENACTS:
27 **26-21-11.1**, Utah Code Annotated 1953
28 **58-1-508**, Utah Code Annotated 1953
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30 *Be it enacted by the Legislature of the state of Utah:*
31 Section 1. Section **26-21-11.1** is enacted to read:
32 **26-21-11.1. Failure to follow certain health care claims practices -- Penalties.**
33 (1) The department may assess a fine of up to $500 per violation against a health care
34 facility that violates Subsection 31A-36-301.5(4).
35 (2) The department shall waive the fine described in Subsection (1) if:
36 (a) the health care facility demonstrates to the department that the health care facility
37 mitigated and reversed any damage to the insured caused by the health care facility's violation;
38 or
39 (b) the insured does not pay the full amount due on the bill that is the subject of the
40 violation, including any interest, fees, costs, and expenses, within 120 days after the day on
41 which the health care facility makes a report to a credit bureau or uses the services of a
42 collection agency in violation of Subsection 31A-26-301.5(4).
43 Section 2. Section **31A-26-301.5** is amended to read:
44 **31A-26-301.5. Health care claims practices.**
45 (1) As used in this section, "health care provider" means:
46 (a) a health care facility as defined in Section 26-21-2; or
47 (b) a person licensed to provide health care services under:
48 (i) Title 58, Occupations and Professions; or
49 (ii) Title 62A, Chapter 2, Licensure of Programs and Facilities.
50 [~~(1)~~] (2) Except as provided in Section 31A-8-407, an insured retains ultimate
51 responsibility for paying for health care services the insured receives. If a service is covered by
52 one or more individual or group health insurance policies, all insurers covering the insured
53 have the responsibility to pay valid health care claims in a timely manner according to the
54 terms and limits specified in the policies.
55 [~~(2) (a)~~] (3) [~~Except as provided in Section 31A-22-610.1, a~~] A health care provider
56 may:

57 (a) except as provided in Section 31A-22-610.1, bill and collect for any deductible,
58 copayment, or uncovered service[~~.~~]; and
59 (b) [~~A health care provider may~~] bill an insured for services covered by health
60 insurance policies or [~~may~~] otherwise notify the insured of the expenses covered by the
61 policies. [~~However, a~~]
62 (4) (a) Subject to Subsection (4)(b), a health care provider may not make any report to
63 a credit bureau[~~,~~] or use the services of a collection agency[~~, or use methods other than routine~~
64 ~~billing or notification~~] until:
65 (i) the later of:
66 [~~(i)~~] (A) [~~the expiration of~~] 60 days after the day on which the time afforded to an
67 insurer under Section 31A-26-301.6 to determine its obligation to pay or deny the claim
68 without penalty expires; or
69 [~~(ii)~~] (B) in the case of Medicare beneficiaries or retirees 65 years of age or older, 60
70 days from the date Medicare determines its liability for the claim[~~.~~];
71 (ii) after the applicable date described in Subsection (4)(a)(i), the health care provider
72 sends a notice to the insured by certified mail with return receipt requested that states:
73 (A) the amount that the insured owes;
74 (B) a date that is at least 30 days after the day on which the health care provider sends
75 the notice by which the insured must pay the amount owed;
76 (C) that if the insured fails to timely pay the amount owed, the health care provider
77 may make a report to a credit bureau or use the services of a collection agency; and
78 (D) that each action described in Subsection (4)(a)(ii)(C) may negatively impact the
79 insured's credit score; and
80 (iii) after the date stated in the notice in accordance with Subsection (4)(a)(ii)(B).
81 (b) A health care provider satisfies the requirements described in Subsection (4)(a) if
82 the health care provider complies with the provisions of 26 C.F.R. Sec. 1.501(r)-6.
83 [~~(c)~~] (5) Beginning October 31, 1992, all insurers covering the insured shall notify the
84 insured of payment and the amount of payment made to the health care provider.
85 [~~(d)~~] (6) A health care provider shall return to an insured any amount the insured
86 overpaid, including interest that begins accruing 90 days after the date of the overpayment, if:
87 [~~(i)~~] (a) the insured has multiple insurers with whom the health care provider has

88 contracts that cover the insured; and

89 [(ii)] (b) the health care provider becomes aware that the health care provider has

90 received, for any reason, payment for a claim in an amount greater than the health care

91 provider's contracted rate allows.

92 [(3)] (7) The commissioner shall make rules consistent with this chapter governing

93 disclosure to the insured of customary charges by health care providers on the explanation of

94 benefits as part of the claims payment process. These rules shall be limited to the form and

95 content of the disclosures on the explanation of benefits, and shall include:

96 (a) a requirement that the method of determination of any specifically referenced

97 customary charges and the range of the customary charges be disclosed; and

98 (b) a prohibition against an implication that the health care provider is charging

99 excessively if the health care provider is:

100 (i) a participating provider; and

101 (ii) prohibited from balance billing.

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

103 **58-1-508. Failure to follow certain health care claims practices -- Penalties.**

104 (1) As used in this section, "health care provider" means an individual who is licensed

105 to provide health care services under this title.

106 (2) The division may assess a fine of up to $500 per violation against a health care

107 provider who violates Subsection 31A-36-301.5(4).

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

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

110 mitigated and reversed any damage to the insured caused by the health care provider's

111 violation; or

112 (b) the insured does not pay the full amount due on the bill that is the subject of the

113 violation, including any interest, fees, costs, and expenses, within 120 days after the day on

114 which the health care provider makes a report to a credit bureau or uses the services of a

115 collection agency in violation of Subsection 31A-26-301.5(4).

116 Section 4. Section **62A-2-112** is amended to read:

117 **62A-2-112. Violations -- Penalties.**

118 (1) A used in this section, "health care provider" means a person licensed to provide

119 health care services under this chapter.
120 [(1)] (2) The office may deny, place conditions on, suspend, or revoke a human
121 services license, if it finds, related to the human services program:
122 (a) that there has been a failure to comply with the rules established under this chapter;
123 (b) evidence of aiding, abetting, or permitting the commission of any illegal act; or
124 (c) evidence of conduct adverse to the standards required to provide services and
125 promote public trust, including aiding, abetting, or permitting the commission of abuse,
126 neglect, exploitation, harm, mistreatment, or fraud.
127 [(2)] (3) The office may restrict or prohibit new admissions to a human services
128 program, if it finds:
129 (a) that there has been a failure to comply with rules established under this chapter;
130 (b) evidence of aiding, abetting, or permitting the commission of any illegal act; or
131 (c) evidence of conduct adverse to the standards required to provide services and
132 promote public trust, including aiding, abetting, or permitting the commission of abuse,
133 neglect, exploitation, harm, mistreatment, or fraud.
134 (4) (a) The office may assess a fine of up to $500 per violation against a health care
135 provider who violates Subsection 31A-36-301.5(4).
136 (b) The office shall waive the fine described in Subsection (4)(a) if:
137 (i) the health care provider demonstrates to the office that the health care provider
138 mitigated and reversed any damage to the insured caused by the health care provider's
139 violation; or
140 (ii) the insured does not pay the full amount due on the bill that is the subject of the
141 violation, including any interest, fees, costs, and expenses, within 120 days after the day on
142 which the health care provider makes a report to a credit bureau or uses the services of a
143 collection agency in violation of Subsection 31A-26-301.5(4).