

MEDICAL BENEFITS RECOVERY AMENDMENTS

2018 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: Daniel Hemmert

House Sponsor: Michael S. Kennedy

LONG TITLE

General Description:

This bill amends and enacts provisions related to state recovery of medical assistance benefits.

Highlighted Provisions:

This bill:

- ▶ defines terms;
- ▶ amends and enacts provisions related to recovery of medical assistance from a recipient's estate or trust;
- ▶ 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 an individual who is an inpatient in a care facility, during the life of that individual;
- ▶ establishes procedures, requirements, and exemptions, relating to imposing a TEFRA lien; and
- ▶ makes technical changes.

Money Appropriated in this Bill:

None

Other Special Clauses:

None

Utah Code Sections Affected:

AMENDS:



- 28 **31A-4-107.5**, as enacted by Laws of Utah 2007, Chapter 64
- 29 **31A-22-610**, as last amended by Laws of Utah 2007, Chapter 307
- 30 **31A-22-610.5**, as last amended by Laws of Utah 2017, Chapters 168 and 292
- 31 **34A-2-417**, as last amended by Laws of Utah 2010, Chapter 174
- 32 **34A-2-422**, as last amended by Laws of Utah 2007, Chapter 63
- 33 **75-3-803**, as last amended by Laws of Utah 2010, Chapter 223
- 34 **75-3-805**, as last amended by Laws of Utah 1998, Chapter 145
- 35 **75-7-508**, as last amended by Laws of Utah 2014, Chapter 142
- 36 **75-7-511**, as renumbered and amended by Laws of Utah 2004, Chapter 89

37 ENACTS:

- 38 **26-19-404**, Utah Code Annotated 1953
- 39 **26-19-501**, Utah Code Annotated 1953
- 40 **26-19-502**, Utah Code Annotated 1953
- 41 **26-19-503**, Utah Code Annotated 1953
- 42 **26-19-504**, Utah Code Annotated 1953
- 43 **26-19-505**, Utah Code Annotated 1953
- 44 **26-19-506**, Utah Code Annotated 1953
- 45 **26-19-507**, Utah Code Annotated 1953
- 46 **26-19-508**, Utah Code Annotated 1953
- 47 **26-19-509**, Utah Code Annotated 1953
- 48 **75-3-104.5**, Utah Code Annotated 1953

49 RENUMBERS AND AMENDS:

- 50 **26-19-101**, (Renumbered from 26-19-1, as enacted by Laws of Utah 1981, Chapter 126)
- 51 **26-19-102**, (Renumbered from 26-19-2, as last amended by Laws of Utah 2007,
- 52 Chapter 64)
- 53 **26-19-103**, (Renumbered from 26-19-3, as last amended by Laws of Utah 1984,
- 54 Chapter 34)
- 55 **26-19-201**, (Renumbered from 26-19-4.5, as last amended by Laws of Utah 1998,
- 56 Chapter 145)
- 57 **26-19-301**, (Renumbered from 26-19-4.7, as enacted by Laws of Utah 2007, Chapter
- 58 64)

- 59 **26-19-302**, (Renumbered from 26-19-14, as last amended by Laws of Utah 2017,
- 60 Chapter 292)
- 61 **26-19-303**, (Renumbered from 26-19-9.5, as enacted by Laws of Utah 2004, Chapter
- 62 72)
- 63 **26-19-304**, (Renumbered from 26-19-9, as enacted by Laws of Utah 1993, Chapter 145)
- 64 **26-19-305**, (Renumbered from 26-19-8, as last amended by Laws of Utah 2011,
- 65 Chapter 297)
- 66 **26-19-401**, (Renumbered from 26-19-5, as last amended by Laws of Utah 2005,
- 67 Chapter 103)
- 68 **26-19-402**, (Renumbered from 26-19-6, as last amended by Laws of Utah 2009,
- 69 Chapter 388)
- 70 **26-19-403**, (Renumbered from 26-19-7, as last amended by Laws of Utah 2011,
- 71 Chapter 297)
- 72 **26-19-405**, (Renumbered from 26-19-13.5, as last amended by Laws of Utah 2011,
- 73 Chapter 366)
- 74 **26-19-406**, (Renumbered from 26-19-13.7, as enacted by Laws of Utah 1998, Chapter
- 75 145)
- 76 **26-19-601**, (Renumbered from 26-19-9.7, as enacted by Laws of Utah 2004, Chapter
- 77 72)
- 78 **26-19-602**, (Renumbered from 26-19-19, as enacted by Laws of Utah 1998, Chapter
- 79 145)
- 80 **26-19-603**, (Renumbered from 26-19-15, as last amended by Laws of Utah 1984,
- 81 Chapter 34)
- 82 **26-19-604**, (Renumbered from 26-19-16, as enacted by Laws of Utah 1981, Chapter
- 83 126)
- 84 **26-19-605**, (Renumbered from 26-19-17, as last amended by Laws of Utah 1984,
- 85 Chapter 34)



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

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

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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 an individual with an intellectual disability; 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.

(5) "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

121 of a claim for a health care item or service.

122 (6) "Inpatient" means an individual who is a patient and a resident of a care facility.

123 [~~(6)~~] (7) "Insurer" includes:

124 (a) a group health plan as defined in Subsection 607(1) of the federal Employee

125 Retirement Income Security Act of 1974;

126 (b) a health maintenance organization; and

127 (c) any entity offering a health service benefit plan.

128 [~~(7)~~] (8) "Medical assistance" means:

129 (a) all funds expended for the benefit of a recipient under Title 26, Chapter 18, Medical
130 Assistance Act, or under Titles XVIII and XIX, federal Social Security Act; and

131 (b) any other services provided for the benefit of a recipient by a prepaid health care
132 delivery system under contract with the department.

133 [~~(8)~~] (9) "Office of Recovery Services" means the Office of Recovery Services within
134 the Department of Human Services.

135 [~~(9)~~] (10) "Provider" means a person or entity who provides services to a recipient.

136 [~~(10)~~] (11) "Recipient" means:

137 (a) [~~a person~~] an individual who has applied for or received medical assistance from
138 the state;

139 (b) the guardian, conservator, or other personal representative of [~~a person~~] an
140 individual under Subsection [~~(10)~~] (11)(a) if the [~~person~~] individual is a minor or an
141 incapacitated person; or

142 (c) the estate and survivors of [~~a person~~] an individual under Subsection [~~(10)~~] (11)(a),
143 if the [~~person~~] individual is deceased.

144 [~~(4)~~] (12) [~~"Estate"~~] "Recovery estate" means, regarding a deceased recipient:

145 (a) all real and personal property or other assets included within a decedent's estate as
146 defined in Section [75-1-201](#);

147 (b) the decedent's augmented estate as defined in Section [75-2-203](#); and

148 (c) that part of other real or personal property in which the decedent had a legal interest
149 at the time of death including assets conveyed to a survivor, heir, or assign of the decedent
150 through joint tenancy, tenancy in common, survivorship, life estate, living trust, or other
151 arrangement.

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

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

157 [(H)] (15) "Third party" includes:

158 (a) an individual, institution, corporation, public or private agency, trust, estate,
159 insurance carrier, employee welfare benefit plan, health maintenance organization, health
160 service organization, preferred provider organization, governmental program such as Medicare,
161 CHAMPUS, and workers' compensation, which may be obligated to pay all or part of the
162 medical costs of injury, disease, or disability of a recipient, unless any of these are excluded by
163 department rule; and

164 (b) a spouse or a parent who:

165 (i) may be obligated to pay all or part of the medical costs of a recipient under law or
166 by court or administrative order; or

167 (ii) has been ordered to maintain health, dental, or accident and health insurance to
168 cover medical expenses of a spouse or dependent child by court or administrative order.

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

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

172 ~~[26-19-3]~~. **26-19-103. Program established by department -- Promulgation of**
173 **rules.**

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

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

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

179 **Part 2. Assignment of Rights**

180 ~~[26-19-4.5]~~. **26-19-201. Assignment of rights to benefits.**

181 (1) (a) To the extent that medical assistance is actually provided to a recipient, all
182 benefits for medical services or payments from a third party otherwise payable to or on behalf

183 of a recipient are assigned by operation of law to the department if the department provides, or
 184 becomes obligated to provide, medical assistance, regardless of who made application for the
 185 benefits on behalf of the recipient.

186 (b) The assignment:

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

189 (ii) is effective for all medical assistance.

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

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

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

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

200 **Part 3. Insurance Provisions**

201 [~~26-19-4.7~~]. **26-19-301. Health insurance entity -- Duties related to state claims**
 202 **for Medicaid payment or recovery.**

203 As a condition of doing business in the state, a health insurance entity shall:

204 (1) with respect to [~~a person~~] an individual who is eligible for, or is provided, medical
 205 assistance under the state plan, upon the request of the Department of Health, provide
 206 information to determine:

207 (a) during what period the [~~person~~] individual, or the spouse or dependent of the
 208 [~~person~~] individual, may be or may have been, covered by the health insurance entity; and

209 (b) the nature of the coverage that is or was provided by the health insurance entity
 210 described in Subsection (1)(a), including the name, address, and identifying number of the
 211 plan;

212 (2) accept the state's right of recovery and the assignment to the state of any right of [~~a~~
 213 ~~person~~] an individual to payment from a party for an item or service for which payment has

214 been made under the state plan;

215 (3) respond to any inquiry by the Department of Health regarding a claim for payment
216 for any health care item or service that is submitted no later than three years after the day on
217 which the health care item or service is provided; and

218 (4) not deny a claim submitted by the Department of Health solely on the basis of the
219 date of submission of the claim, the type or format of the claim form, or failure to present
220 proper documentation at the point-of-sale that is the basis for the claim, if:

221 (a) the claim is submitted no later than three years after the day on which the item or
222 service is furnished; and

223 (b) any action by the Department of Health to enforce the rights of the state with
224 respect to the claim is commenced no later than six years after the day on which the claim is
225 submitted.

226 Section 6. Section **26-19-302**, which is renumbered from Section 26-19-14 is
227 renumbered and amended to read:

228 ~~[26-19-14]~~. **26-19-302**. **Insurance policies not to deny or reduce benefits of**
229 **individuals eligible for state medical assistance -- Exemptions.**

230 (1) A policy of accident or sickness insurance may not contain any provision denying
231 or reducing benefits because services are rendered to an insured or dependent who is eligible
232 for or receiving medical assistance from the state.

233 (2) An association, corporation, or organization may not deliver, issue for delivery, or
234 renew any subscriber's contract which contains any provisions denying or reducing benefits
235 because services are rendered to a subscriber or dependent who is eligible for or receiving
236 medical assistance from the state.

237 (3) An association, corporation, business, or organization authorized to do business in
238 this state and which provides or pays for any health care benefits may not deny or reduce
239 benefits because services are rendered to a beneficiary who is eligible for or receiving medical
240 assistance from the state.

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

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

247 **[26-19-9.5]. 26-19-303. Availability of insurance policy.**

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

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

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

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

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

257 **[26-19-9]. 26-19-304. Employee benefit plans.**

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

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

265 **[26-19-8]. 26-19-305. Statute of limitations -- Survival of right of action --**
266 **Insurance policy not to limit time allowed for recovery.**

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

269 (i) subject to Subsection (7), six years after the day on which the department submits
270 the claim for recovery or payment for the health care item or service upon which the action is
271 based; or

272 (ii) six months after the date of the last payment for medical assistance, whichever is
273 later.

274 (b) An action against any other third party, the recipient, or anyone to whom the
275 proceeds are payable shall be commenced within:

276 (i) four years after the date of the injury or onset of the illness; or
277 (ii) six months after the date of the last payment for medical assistance, whichever is
278 later.

279 (2) The death of the recipient does not abate any right of action established by this
280 chapter.

281 (3) (a) No insurance policy issued or renewed after June 1, 1981, may contain any
282 provision that limits the time in which the department may submit its claim to recover medical
283 assistance benefits to a period of less than 24 months from the date the provider furnishes
284 services or goods to the recipient.

285 (b) No insurance policy issued or renewed after April 30, 2007, may contain any
286 provision that limits the time in which the department may submit its claim to recover medical
287 assistance benefits to a period of less than that described in Subsection (1)(a).

288 (4) The provisions of this section do not apply to Section [~~26-19-13.5~~] 26-19-405 or
289 Part 5, TEFRA Liens.

290 (5) The provisions of this section supercede any other sections regarding the time limit
291 in which an action shall be commenced, including Section ~~75-7-509~~.

292 (6) (a) Subsection (1)(a) extends the statute of limitations on a cause of action
293 described in Subsection (1)(a) that was not time-barred on or before April 30, 2007.

294 (b) Subsection (1)(a) does not revive a cause of action that was time-barred on or
295 before April 30, 2007.

296 (7) An action described in Subsection (1)(a) may not be commenced if the claim for
297 recovery or payment described in Subsection (1)(a)(i) is submitted later than three years after
298 the day on which the health care item or service upon which the claim is based was provided.

299 Section 10. Section ~~26-19-401~~, which is renumbered from Section 26-19-5 is
300 renumbered and amended to read:

301 **Part 4. General Recovery Provisions**

302 ~~[26-19-5]~~. **26-19-401. Recovery of medical assistance from third party -- Lien**
303 **-- Notice -- Action -- Compromise or waiver -- Recipient's right to action protected.**

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

307 (b) Any claim arising under Subsection (1)(a) or Section ~~[26-19-4.5]~~ 26-19-201 to
308 recover medical assistance provided to a recipient is a lien against any proceeds payable to or
309 on behalf of the recipient by that third party. This lien has priority over all other claims to the
310 proceeds, except claims for ~~[attorney's]~~ attorney fees and costs authorized under Subsection
311 ~~[26-19-7]~~ 26-19-403(2)(c)(ii).

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

314 (b) The notice shall include:

315 (i) the recipient's name;

316 (ii) the approximate date of illness or injury;

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

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

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

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

323 (b) the department has evidence that the third party had knowledge that the department
324 provided or was obligated to provide medical assistance.

325 (4) The department may:

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

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

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

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

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

334 ~~[26-19-6]~~. **26-19-402. Action by department -- Notice to recipient.**

335 (1) (a) Within 30 days after commencing an action under Subsection ~~[26-19-5]~~

336 26-19-401(3), the department shall give the recipient, ~~[his]~~ the recipient's guardian, personal

337 representative, trustee, estate, or survivor, whichever is appropriate, written notice of the action

338 by:

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

341 (ii) if no last-known address is available, by publishing a notice:

342 (A) once a week for three successive weeks in a newspaper of general circulation in the
343 county where the recipient resides; and

344 (B) in accordance with Section 45-1-101 for three weeks.

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

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

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

349 (a) the right to intervene in the proceeding;

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

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

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

354 ~~[26-19-7]~~. **26-19-403. Notice of claim by recipient -- Department response --**
355 **Conditions for proceeding -- Collection agreements.**

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

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

362 (i) a recipient who files a claim, or commences an action against a third party notifies
363 the department in accordance with Subsection (1)(d) within 10 days of the recipient making the
364 claim or commencing an action; or

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

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

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

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

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

375 (i) the name of the recipient;

376 (ii) the recipient's Social Security number;

377 (iii) the recipient's date of birth;

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

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

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

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

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

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

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

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

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

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

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

- 400 (A) failing to comply with the notice provisions of this section;
- 401 (B) failing or refusing to enter into a collection agreement;
- 402 (C) failing to comply with the terms of a collection agreement with the department; or
- 403 (D) failing to disburse funds owed to the state in accordance with this section.

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

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

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

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

414 (d) The department is not required to enter into a collection agreement with the
415 recipient's attorney for collection of personal injury protection under Subsection
416 [31A-22-302\(2\)](#).

417 (3) (a) If the department receives notice pursuant to Subsection (1), and notifies the
418 recipient and the recipient's attorney that the department will not enter into a collection
419 agreement with the recipient's attorney, the recipient may proceed with the recipient's claim or
420 action against the third party if the recipient excludes from the claim:

- 421 (i) any medical expenses paid by the department; or
- 422 (ii) any medical costs for which the department is obligated to provide medical
423 assistance.

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

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

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

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

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

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

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

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

443 ~~[(7) Any amounts assigned to and recoverable by the department pursuant to Sections
444 26-19-4.5 and 26-19-5 collected directly by the recipient shall be remitted to the Bureau of
445 Medical Collections within the Office of Recovery Services no later than five business days
446 after receipt.]~~

447 ~~[(8) (a) Any amounts assigned to and recoverable by the department pursuant to
448 Sections 26-19-4.5 and 26-19-5 collected directly by the recipient's attorney shall be remitted to
449 the Bureau of Medical Collections within the Office of Recovery Services no later than 30 days
450 after the funds are placed in the attorney's trust account.]~~

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

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

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

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

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

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

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

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

463 **26-19-404. Department's right to intervene -- Department's interests protected --**
464 **Remitting funds -- Disbursements -- Liability and penalty for noncompliance.**

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

468 (2) (a) If the recipient proceeds without complying with the provisions of Section
469 26-19-403, the department is not bound by any decision, judgment, agreement, settlement, or
470 compromise rendered or made on the claim or in the action.

471 (b) The department:

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

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

476 (3) Any amounts assigned to and recoverable by the department pursuant to Sections
477 26-19-201 and 26-19-401 collected directly by the recipient shall be remitted to the Bureau of
478 Medical Collections within the Office of Recovery Services no later than five business days
479 after receipt.

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

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

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

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

490 (5) A recipient or recipient's attorney who knowingly and intentionally fails to comply
491 with this section is liable to the department for:

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

493 (b) a penalty equal to 10% of the amount of the department's claim; and
 494 (c) attorney fees and litigation expenses related to recovering the department's claim.

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

497 ~~[26-19-13.5].~~ **26-19-405. Estate and trust recovery.**

498 (1) ~~[Upon]~~ (a) Except as provided in Subsection (1)(b), upon a recipient's death, the
 499 department may recover from the recipient's recovery estate and any trust, in which the
 500 recipient is the grantor and a beneficiary, medical assistance correctly provided for the benefit
 501 of the recipient when the recipient was 55 years of age or older ~~[if, at the time of death, the~~
 502 ~~recipient has no:]~~.

503 ~~[(a) surviving spouse; or]~~

504 ~~[(b) child:]~~

505 ~~[(i) younger than 21 years of age; or]~~

506 ~~[(ii) who is blind or has a permanent and total disability.]~~

507 (b) The department may not make an adjustment or a recovery under Subsection (1)(a):

508 (i) while the deceased recipient's spouse is still living; or

509 (ii) if the deceased recipient has a surviving child who is:

510 (A) under age 21; or

511 (B) blind or disabled, as defined in the state plan.

512 (2) (a) The amount of ~~[medial]~~ medical assistance correctly provided for the benefit of
 513 a recipient and recoverable under this section is a lien against the deceased recipient's recovery
 514 ~~estate [of the deceased recipient]~~ or any trust when the recipient is the grantor and a
 515 beneficiary.

516 (b) The lien holds the same priority as reasonable and necessary medical expenses of
 517 the last illness as provided in Section [75-3-805](#).

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

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

523 (3) (a) For a lien described in Subsection (2), the department shall provide notice in

524 accordance with Section 38-12-102.

525 (b) Before final distribution, the department shall perfect the lien as follows:

526 (i) for an estate, by presenting the lien to the estate's personal representative in
527 accordance with Section 75-3-804; and

528 (ii) for a trust, by presenting the lien to the trustee in accordance with Section
529 75-7-510.

530 (c) The department may file an amended lien before the entry of the final order to close
531 the estate or trust.

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

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

536 (6) Nothing in this section affects the right of the department to recover Medicaid
537 assistance before a recipient's death under Section [26-19-4.5] 26-19-201 or Section
538 [26-19-13.7] 26-19-406.

539 (7) A lien imposed under this section is of indefinite duration.

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

542 **[26-19-13.7]. 26-19-406. Recovery from recipient of incorrectly provided**
543 **medical assistance.**

544 The department may:

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

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

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

549 **Part 5. TEFRA Liens**

550 **26-19-501. TEFRA liens authorized -- Grounds for TEFRA liens -- Exemptions.**

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

554 (a) the individual is an inpatient in a care facility;

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

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

559 (i) be discharged from the care facility; and

560 (ii) return to the individual's home.

561 (2) The department may not impose a lien on the home of an individual described in

562 Subsection (1), if any of the following individuals are lawfully residing in the home:

563 (a) the spouse of the individual;

564 (b) a child of the individual, if the child is:

565 (i) under 21 years of age; or

566 (ii) blind or permanently and totally disabled, as defined in Title 42 U.S.C. Sec.

567 1382c(a)(3)(F); or

568 (c) a sibling of the individual, if the sibling:

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

570 (ii) resided in the home for at least one year immediately preceding the day on which

571 the individual was admitted to the care facility.

572 (3) The department may not impose a TEFRA lien on the real property of an

573 individual, unless:

574 (a) the individual has been an inpatient in a care facility for the 180-day period

575 immediately preceding the day on which the lien is imposed;

576 (b) the department serves:

577 (i) a preliminary notice of intent to impose a TEFRA lien relating to the real property,

578 in accordance with Section [26-19-503](#); and

579 (ii) a final notice of intent to impose a TEFRA lien relating to the real property, in

580 accordance with Section [26-19-504](#); and

581 (c) (i) the individual does not file a timely request for review of the department's

582 decision under Title 63G, Chapter 4, Administrative Procedures Act; or

583 (ii) the department's decision is upheld upon final review or appeal under Title 63G,

584 Chapter 4, Administrative Procedures Act.

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

586 **26-19-502. Presumption of permanency.**

587 There is a rebuttable presumption that an individual who is an inpatient in a care facility
588 cannot reasonably be expected to be discharged from a care facility and return to the
589 individual's home, if the individual has been an inpatient in a care facility for a period of at
590 least 180 consecutive days.

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

592 **26-19-503. Preliminary notice of intent to impose a TEFRA lien.**

593 (1) Prior to imposing a TEFRA lien on real property, the department shall serve a
594 preliminary notice of intent to impose a TEFRA lien, on the individual described in Subsection
595 26-19-501(1), who owns the property.

596 (2) The preliminary notice of intent shall:

597 (a) be served in person, or by certified mail, on the individual described in Subsection
598 26-19-501(1), and, if the department is aware that the individual has a legally authorized
599 representative, on the representative;

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

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

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

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

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

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

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

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

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

615 (i) establishes that the individual does not meet the criteria described in Subsection
616 26-19-501(1)(a) or (b);

- 617 (ii) establishes that the individual has not been an inpatient in a care facility for a
618 period of at least 180 days;
- 619 (iii) rebuts the presumption described in Section [26-19-502](#); or
620 (iv) establishes that the real property is exempt from imposition of a TEFRA lien under
621 Subsection [26-19-501](#)(2);
- 622 (h) indicate that if the owner fails to provide the documentation described in
623 Subsection (2)(g) within 30 days after the day on which the preliminary notice of intent is
624 served, the department will issue a final notice of intent to impose a TEFRA lien on the real
625 property and will proceed to impose the lien;
- 626 (i) identify the type of documentation that the owner may provide to comply with
627 Subsection (2)(g);
- 628 (j) describe the circumstances under which a TEFRA lien is required to be released;
629 and
- 630 (k) describe the circumstances under which the department may seek to recover the
631 lien.

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

633 **26-19-504. Final notice of intent to impose a TEFRA lien.**

- 634 (1) The department may issue a final notice of intent to impose a TEFRA lien on real
635 property if:
- 636 (a) a preliminary notice of intent relating to the property is served in accordance with
637 Section [26-19-503](#);
- 638 (b) it is at least 30 days after the day on which the preliminary notice of intent was
639 served; and
- 640 (c) the department has not received documentation or other evidence that adequately
641 establishes that a TEFRA lien may not be imposed on the real property.
- 642 (2) The final notice of intent to impose a TEFRA lien on real property shall:
- 643 (a) be served in person, or by certified mail, on the individual described in Subsection
644 [26-19-501](#)(1), who owns the property, and, if the department is aware that the individual has a
645 legally authorized representative, on the representative;
- 646 (b) indicate that the department has complied with the requirements for filing the final
647 notice of intent under Subsection (1);

- 648 (c) include a statement indicating that, according to the department's records, the
649 individual:
- 650 (i) meets the criteria described in Subsections 26-19-501(1)(a) and (b);
651 (ii) has been an inpatient in a care facility for a period of at least 180 days immediately
652 preceding the day on which the department provides the notice to the individual; and
653 (iii) is legally presumed to be in a condition where it cannot reasonably be expected
654 that the individual will be discharged from the care facility and return to the individual's home;
655 (d) indicate that the department intends to impose a TEFRA lien on real property
656 belonging to the individual;
657 (e) describe the real property that the TEFRA lien will apply to;
658 (f) describe the current amount of, and purpose of, the TEFRA lien;
659 (g) indicate that the amount of the lien may continue to increase as the individual
660 continues to receive medical assistance;
661 (h) describe the circumstances under which a TEFRA lien is required to be released;
662 (i) describe the circumstances under which the department may seek to recover the
663 lien;
664 (j) describe the right of the individual to challenge the decision of the department in an
665 adjudicative proceeding; and
666 (k) indicate that failure by the individual to successfully challenge the decision of the
667 department will result in the TEFRA lien being imposed.

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

669 **26-19-505. Review of department decision.**

670 An individual who has been served with a final notice of intent to impose a TEFRA lien
671 under Section 26-19-504 may seek agency or judicial review of that decision under Title 63G,
672 Chapter 4, Administrative Procedures Act.

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

674 **26-19-506. Dissolution and removal of TEFRA lien.**

- 675 (1) A TEFRA lien shall dissolve and be removed by the department if the individual
676 described in Subsection 26-19-501(1):
- 677 (a) (i) is discharged from the care facility; and
678 (ii) returns to the individual's home; or

679 (b) provides sufficient documentation to the department that:
680 (i) rebuts the presumption described in Section 26-19-502; or
681 (ii) any of the following individuals are lawfully residing in the individual's home:
682 (A) the spouse of the individual;
683 (B) a child of the individual, if the child is under 21 years of age or blind or
684 permanently and totally disabled, as defined in Title 42 U.S.C. Sec. 1382c(a)(3)(F); or
685 (C) a sibling of the individual, if the sibling has an equity interest in the home and
686 resided in the home for at least one year immediately preceding the day on which the individual
687 was admitted to the care facility.

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

691 (3) A request filed under Subsection (2) shall be considered and reviewed pursuant to
692 Title 63G, Chapter 4, Administrative Procedures Act.

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

694 **26-19-507. Expenditures included in lien -- Other proceedings.**

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

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

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

703 **26-19-508. Contract with another government agency.**

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

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

708 **26-19-509. Precedence of the Tax Equity and Fiscal Responsibility Act of 1982.**

709 If any provision of this part conflicts with the requirements of the Tax Equity and Fiscal

710 Responsibility Act of 1982 for imposing a lien against the property of an individual prior to the
711 individual's death, under 42 U.S.C. Sec. 1396p, the provisions of the Tax Equity and Fiscal
712 Responsibility Act of 1982 take precedence and shall be complied with by the department.

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

715 **Part 6. Miscellaneous Provisions**

716 **~~[26-19-9.7].~~ 26-19-601. Legal recognition of electronic claims records.**

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

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

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

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

725 **~~[26-19-19].~~ 26-19-602. Direct payment to the department by third party.**

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

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

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

733 **~~[26-19-15].~~ 26-19-603. Attorney general or county attorney to represent**
734 **department.**

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

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

739 **~~[26-19-16].~~ 26-19-604. Department's right to attorney fees and costs.**

740 In any action brought by the department under this chapter in which it prevails, the

741 department shall recover along with the principal sum and interest, a reasonable [attorney's]
742 attorney fee and costs incurred.

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

745 ~~[26-19-17]~~. **26-19-605. Application of provisions contrary to federal law**
746 **prohibited.**

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

749 Section 30. Section **31A-4-107.5** is amended to read:

750 **31A-4-107.5. Penalty for failure of a regulated health insurance entity to fulfill**
751 **duties related to state claims for Medicaid payment or recovery.**

752 (1) For purposes of this section, "regulated health insurance entity" means a health
753 insurance entity, as defined in Section ~~[26-19-2]~~ 26-19-102, that is subject to regulation by the
754 department.

755 (2) If a regulated health insurance entity fails to comply with the provisions of Section
756 ~~[26-19-4.7]~~ 26-19-301:

757 (a) the commissioner may revoke or suspend, in whole or in part, a license, certificate
758 of authority, registration, or other authority that is granted by the commissioner to the regulated
759 health insurance entity; and

760 (b) the regulated health insurance entity is subject to the penalties and procedures
761 provided for in Section 31A-2-308.

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

763 **31A-22-610. Dependent coverage from moment of birth or adoption.**

764 (1) As used in this section:

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

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

770 (2) (a) Except as provided in Subsection (5), if an accident and health insurance policy
771 provides coverage for any members of the policyholder's or certificate holder's family, the

772 policy shall provide that any health insurance benefits applicable to dependents of the insured
773 are applicable on the same basis to:

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

775 (ii) an adopted child:

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

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

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

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

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

784 (A) congenital defects;

785 (B) birth abnormalities; or

786 (C) prematurity.

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

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

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

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

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

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

801 (3) (a) The coverage required by Subsection (2) as to children placed for the purpose of
802 adoption with a policyholder or certificate holder continues in the same manner as it would

803 with respect to a child of the policyholder or certificate holder unless:

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

805 (ii) the child is removed from placement.

806 (b) The coverage required by Subsection (2) ends if the child is removed from

807 placement prior to being legally adopted.

808 (4) The provisions of this section apply to employee welfare benefit plans as defined in

809 Section ~~[26-19-2]~~ [26-19-102](#).

810 (5) If an accident and health insurance policy that is not subject to the special

811 enrollment rights described in 45 C.F.R. Sec. 146.117(b) provides coverage for one individual,

812 the insurer may choose to:

813 (a) provide coverage according to this section; or

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

815 (i) a newborn;

816 (ii) an adopted child; or

817 (iii) a child placed for adoption.

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

819 **31A-22-610.5. Dependent coverage.**

820 (1) As used in this section, "child" has the same meaning as defined in Section

821 [78B-12-102](#).

822 (2) (a) Any individual or group accident and health insurance policy or managed care

823 organization contract that provides coverage for a policyholder's or certificate holder's

824 dependent may not terminate coverage of an unmarried dependent by reason of the dependent's

825 age before the dependent's 26th birthday and shall, upon application, provide coverage for all

826 unmarried dependents up to age 26.

827 (b) The cost of coverage for unmarried dependents 19 to 26 years of age shall be

828 included in the premium on the same basis as other dependent coverage.

829 (c) This section does not prohibit the employer from requiring the employee to pay all

830 or part of the cost of coverage for unmarried dependents.

831 (d) An individual or group health insurance policy or managed care organization shall

832 continue in force coverage for a dependent through the last day of the month in which the

833 dependent ceases to be a dependent:

834 (i) if premiums are paid; and
835 (ii) notwithstanding Sections [31A-22-618.6](#) and [31A-22-618.7](#).
836 (3) (a) When a parent is required by a court or administrative order to provide health
837 insurance coverage for a child, an accident and health insurer may not deny enrollment of a
838 child under the accident and health insurance plan of the child's parent on the grounds the
839 child:

- 840 (i) was born out of wedlock and is entitled to coverage under Subsection (4);
- 841 (ii) was born out of wedlock and the custodial parent seeks enrollment for the child
842 under the custodial parent's policy;
- 843 (iii) is not claimed as a dependent on the parent's federal tax return; or
- 844 (iv) does not reside with the parent or in the insurer's service area.

845 (b) A child enrolled as required under Subsection (3)(a)(iv) is subject to the terms of
846 the accident and health insurance plan contract pertaining to services received outside of an
847 insurer's service area.

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

850 (a) provide information to the custodial parent as necessary for the child to obtain
851 benefits through that coverage, but the insurer or employer, or the agents or employees of either
852 of them, are not civilly or criminally liable for providing information in compliance with this
853 Subsection (4)(a), whether the information is provided pursuant to a verbal or written request;

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

857 (c) make payments on claims submitted in accordance with Subsection (4)(b) directly
858 to the custodial parent, the child who obtained benefits, the provider, or the state Medicaid
859 agency.

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

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

864 (b) if the parent is enrolled but fails to make application to obtain coverage for the

865 child, enroll the child under family coverage upon application of the child's other parent, the
866 state agency administering the Medicaid program, or the state agency administering 42 U.S.C.
867 Sec. 651 through 669, the child support enforcement program; and

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

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

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

873 (ii) when the child is covered by a group policy, not disenroll or eliminate coverage of
874 the child unless the employer is provided with satisfactory written evidence, which evidence is
875 also provided to the insurer, that Subsection (8)(c)(i), (ii), or (iii) has happened.

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

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

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

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

887 (b) if the parent is enrolled but fails to make application to obtain coverage of the child,
888 enroll the child under family coverage upon application by the child's other parent, by the state
889 agency administering the Medicaid program, or the state agency administering 42 U.S.C. Sec.
890 651 through 669, the child support enforcement program;

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

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

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

896 (iii) the employer has eliminated family health coverage for all of its employees; and
897 (d) withhold from the employee's compensation the employee's share, if any, of
898 premiums for health coverage and to pay this amount to the insurer.

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

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

- 905 (a) the parent continues to be eligible for coverage;
- 906 (b) the child shall be identified to the insurer with adequate information to comply with
907 this section; and
- 908 (c) the premium shall be paid when due.

909 (11) This section applies to employee welfare benefit plans as defined in Section
910 ~~[26-19-2]~~ [26-19-102](#).

911 (12) (a) A policy that provides coverage to a child of a group member may not deny
912 eligibility for coverage to a child solely because:

- 913 (i) the child does not reside with the insured; or
- 914 (ii) the child is solely dependent on a former spouse of the insured rather than on the
915 insured.

916 (b) A child who does not reside with the insured may be excluded on the same basis as
917 a child who resides with the insured.

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

919 **34A-2-417. Claims and benefits -- Time limits for filing -- Burden of proof.**

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

- 922 (i) the medical expense is:
 - 923 (A) reasonable in amount; and
 - 924 (B) necessary to treat the industrial accident; and
- 925 (ii) the employee submits or makes a reasonable attempt to submit the medical
926 expense:

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

928 (B) within one year from the later of:

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

930 (II) the day on which the employee knows or in the exercise of reasonable diligence

931 should have known that the medical expense is related to the industrial accident.

932 (b) For an industrial accident that occurs on or after July 1, 1988, and is the basis of a
933 claim for a medical expense, an employee is entitled to be compensated for the medical
934 expense if the employee meets the requirements of Subsection (1)(a).

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

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

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

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

942 (i) temporary total disability benefits;

943 (ii) temporary partial disability benefits;

944 (iii) permanent partial disability benefits; or

945 (iv) permanent total disability benefits.

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

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

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

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

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

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

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

958 (4) (a) (i) Subject to Subsections (2)(c) and (4)(b), after an employee files an
959 application for hearing within six years from the date of the accident, the Division of
960 Adjudication may enter an order to show cause why the employee's claim should not be
961 dismissed because the employee has failed to meet the employee's burden of proof to establish
962 an entitlement to compensation claimed in the application for hearing.

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

964 (A) Division of Adjudication;

965 (B) employee's employer; or

966 (C) employer's insurance carrier.

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

968 (i) without prejudice; or

969 (ii) with prejudice only if:

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

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

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

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

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

978 **34A-2-422. Compensation exempt from execution -- Transfer of payment rights.**

979 (1) For purposes of this section:

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

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

984 (A) a sale;

985 (B) an assignment;

986 (C) a pledge;

987 (D) an hypothecation; or

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

989 (ii) "Transfer" does not include the creation or perfection of a security interest in a right
990 to receive a payment under a blanket security agreement entered into with an insured
991 depository institution, in the absence of any action to:

992 (A) redirect the payments to:

993 (I) the insured depository institution; or

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

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

996 (2) Compensation before payment:

997 (a) is exempt from:

998 (i) all claims of creditors; and

999 (ii) attachment or execution; and

1000 (b) shall be paid only to employees or their dependents, except as provided in Sections

1001 ~~[26-19-5]~~ [26-19-401](#) and [34A-2-417](#).

1002 (3) (a) Subject to Subsection (3)(b), beginning April 30, 2007, a person may not:

1003 (i) transfer payment rights under workers' compensation; or

1004 (ii) accept or take any action to provide for a transfer of payment rights under workers'
1005 compensation.

1006 (b) A person may take an action prohibited under Subsection (3)(a) if the commission
1007 approves the transfer of payment rights under workers' compensation:

1008 (i) before the transfer of payment rights under workers' compensation takes effect; and

1009 (ii) upon a determination by the commission that:

1010 (A) the person transferring the payment rights under workers' compensation received
1011 before executing an agreement to transfer those payment rights:

1012 (I) adequate notice that the transaction involving the transfer of payment rights under
1013 workers' compensation involves the transfer of those payment rights; and

1014 (II) an explanation of the financial consequences of and alternatives to the transfer of
1015 payment rights under workers' compensation in sufficient detail that the person transferring the
1016 payment rights under workers' compensation made an informed decision to transfer those
1017 payment rights; and

1018 (B) the transfer of payment rights under workers' compensation is in the best interest of
1019 the person transferring the payment rights under workers' compensation taking into account the

1020 welfare and support of that person's dependents.

1021 (c) The approval by the commission of the transfer of a person's payment rights under
1022 workers' compensation is a full and final resolution of the person's payment rights under
1023 workers' compensation that are transferred:

1024 (i) if the commission approves the transfer of the payment rights under workers'
1025 compensation in accordance with Subsection (3)(b); and

1026 (ii) once the person no longer has a right to appeal the decision in accordance with this
1027 title.

1028 Section 35. Section **75-3-104.5** is enacted to read:

1029 **75-3-104.5. Notice to the state.**

1030 (1) Within 30 days after the day on which a petitioner or personal representative files
1031 an action under this chapter for a decedent who was at least 55 years old, the petitioner or
1032 personal representative shall send a copy of the pleadings, by certified mail, to the Office of
1033 Recovery Services created in Section [62A-1-105](#).

1034 (2) Failure to provide notice as described in Subsection (1) tolls all limitations
1035 concerning the state's presentation or enforcement of a lien or claim under Section [26-19-405](#).

1036 Section 36. Section **75-3-803** is amended to read:

1037 **75-3-803. Limitations on presentation of claims.**

1038 (1) All claims against a decedent's estate which arose before the death of the decedent,
1039 including claims of the state and any subdivision of it, whether due or to become due, absolute
1040 or contingent, liquidated or unliquidated, founded on contract, tort, or other legal basis, if not
1041 barred earlier by other statute of limitations, are barred against the estate, the personal
1042 representative, and the heirs and devisees of the decedent, unless presented within the earlier of
1043 the following dates:

1044 (a) one year after the decedent's death; or

1045 (b) within the time provided by Subsection [75-3-801](#)(2) for creditors who are given
1046 actual notice, and where notice is published, within the time provided in Subsection
1047 [75-3-801](#)(1) for all claims barred by publication.

1048 (2) In all events, claims barred by the nonclaim statute at the decedent's domicile are
1049 also barred in this state.

1050 (3) All claims against a decedent's estate which arise at or after the death of the

1051 decedent, including claims of the state and any of its subdivisions, whether due or to become
1052 due, absolute or contingent, liquidated or unliquidated, founded on contract, tort, or other legal
1053 basis are barred against the estate, the personal representative, and the heirs and devisees of the
1054 decedent, unless presented as follows:

1055 (a) a claim based on a contract with the personal representative within three months
1056 after performance by the personal representative is due; or

1057 (b) any other claim within the later of three months after it arises, or the time specified
1058 in Subsection (1)(a).

1059 (4) Nothing in this section affects or prevents:

1060 (a) any proceeding to enforce any mortgage, pledge, or other lien upon property of the
1061 estate;

1062 (b) to the limits of the insurance protection only, any proceeding to establish liability of
1063 the decedent or the personal representative for which ~~he~~ the decedent or the personal
1064 representative is protected by liability insurance; ~~or~~

1065 (c) collection of compensation for services rendered and reimbursement for expenses
1066 advanced by the personal representative or by the attorney or accountant for the personal
1067 representative of the estate~~;~~; or

1068 (d) medical assistance recovery under Title 26, Chapter 19, Medical Benefits Recovery
1069 Act.

1070 (5) If a personal representative has not been timely appointed in accordance with this
1071 chapter, one may be appointed for the limited purposes of Subsection (4)(b) for any claim
1072 timely brought against the decedent.

1073 Section 37. Section **75-3-805** is amended to read:

1074 **75-3-805. Classification of claims.**

1075 (1) If the applicable assets of the estate are insufficient to pay all claims in full, the
1076 personal representative shall make payment in the following order:

1077 (a) reasonable funeral expenses;

1078 (b) costs and expenses of administration;

1079 (c) debts and taxes with preference under federal law;

1080 (d) reasonable and necessary medical and hospital expenses of the last illness of the
1081 decedent, including compensation of persons attending ~~him~~ the decedent, and medical

1082 assistance if Section [~~26-19-13.5~~] 26-19-405 applies;

1083 (e) debts and taxes with preference under other laws of this state; and

1084 (f) all other claims.

1085 (2) No preference shall be given in the payment of any claim over any other claim of
1086 the same class, and a claim due and payable shall not be entitled to a preference over claims not
1087 due.

1088 Section 38. Section ~~75-7-508~~ is amended to read:

1089 **75-7-508. Notice to creditors.**

1090 (1) (a) A trustee for an inter vivos revocable trust, upon the death of the settlor, may
1091 publish a notice to creditors:

1092 (i) once a week for three successive weeks in a newspaper of general circulation in the
1093 county where the settlor resided at the time of death; and

1094 (ii) in accordance with Section 45-1-101 for three weeks.

1095 (b) The notice required by Subsection (1)(a) shall:

1096 (i) provide the trustee's name and address; and

1097 (ii) notify creditors:

1098 (A) of the deceased settlor; and

1099 (B) to present their claims within three months after the date of the first publication of
1100 the notice or be forever barred from presenting the claim.

1101 (2) A trustee shall give written notice by mail or other delivery to any known creditor
1102 of the deceased settlor, notifying the creditor to present [~~his~~] the creditor's claim within 90 days
1103 from the published notice if given as provided in Subsection (1) or within 60 days from the
1104 mailing or other delivery of the notice, whichever is later, or be forever barred. Written notice
1105 shall be the notice described in Subsection (1) or a similar notice.

1106 (3) (a) If the deceased settlor received medical assistance, as defined in Section
1107 [~~26-19-2~~] 26-19-102, at any time after the age of 55, the trustee for an inter vivos revocable
1108 trust, upon the death of the settlor, shall mail or deliver written notice to the Director of the
1109 Office of Recovery Services, on behalf of the Department of Health, to present any claim under
1110 Section [~~26-19-13.5~~] 26-19-405 within 60 days from the mailing or other delivery of notice,
1111 whichever is later, or be forever barred.

1112 (b) If the trustee does not mail notice to the director of the Office of Recovery Services

1113 on behalf of the department in accordance with Subsection (3)(a), the department shall have
1114 one year from the death of the settlor to present its claim.

1115 (4) The trustee is not liable to any creditor or to any successor of the deceased settlor
1116 for giving or failing to give notice under this section.

1117 (5) The notice to creditors shall be valid against any creditor of the trust and also
1118 against any creditor of the estate of the deceased settlor.

1119 Section 39. Section **75-7-511** is amended to read:

1120 **75-7-511. Classification of claims.**

1121 (1) If the applicable assets of the deceased settlor's estate or trust estate are insufficient
1122 to pay all claims in full, the trustee shall make payment in the following order:

1123 (a) reasonable funeral expenses;

1124 (b) costs and expenses of administration;

1125 (c) debts and taxes with preference under federal law;

1126 (d) reasonable and necessary medical and hospital expenses of the last illness of the
1127 deceased settlor, including compensation of persons attending ~~him~~ the deceased settlor, and
1128 medical assistance if Section ~~[26-19-13.5]~~ 26-19-405 applies;

1129 (e) debts and taxes with preference under other laws of this state; and

1130 (f) all other claims.

1131 (2) No preference shall be given in the payment of any claim over any other claim of
1132 the same class, and a claim due and payable shall not be entitled to a preference over claims not
1133 due.