HB0443S01 compared with HB0443

~~{deleted text}~~ shows text that was in HB0443 but was deleted in HB0443S01.

Inserted text shows text that was not in HB0443 but was inserted into HB0443S01.

DISCLAIMER: This document is provided to assist you in your comparison of the two bills. Sometimes this automated comparison will NOT be completely accurate. Therefore, you need to read the actual bills. This automatically generated document could contain inaccuracies caused by: limitations of the compare program; bad input data; or other causes.

Representative Mike Winder proposes the following substitute bill:

HEALTH CARE COST TRANSPARENCY

2019 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: Mike Winder

Senate Sponsor: ~~{_____}~~Jacob L. Anderegg

LONG TITLE

General Description:

This bill requires the publication of certain prices and information related to health care services.

Highlighted Provisions:

This bill:

- requires a hospital to provide a complete list of itemized charges to a patient within a specified time period;
- requires a health care facility to publish information related to standard charges;
- requires certain health care providers to publish prices and related information for the health care provider's most commonly performed procedures; and
- makes technical changes.

Money Appropriated in this Bill:

None

Other Special Clauses:

~~{ None }~~ This bill provides a coordination clause.

Utah Code Sections Affected:

AMENDS:

26-21-20, as last amended by Laws of Utah 2009, Chapter 11

26-21-27, as enacted by Laws of Utah 2010, Chapter 68

ENACTS:

58-1-509, Utah Code Annotated 1953

Utah Code Sections Affected by Coordination Clause:

26-21-20, as last amended by Laws of Utah 2009, Chapter 11

26-21-27, as enacted by Laws of Utah 2010, Chapter 68

58-1-509, Utah Code Annotated 1953

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

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

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

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

(a) an ambulatory surgical facility;

(b) a general acute hospital; and

(c) a specialty hospital.

(2) (a) A hospital shall provide a complete statement of itemized charges to any patient receiving medical care or other services from that hospital[~~.~~] within 120 days after the later of:

(i) the day on which the patient is discharged from the hospital; and

(ii) the date of the medical care or other services.

(b) (i) A hospital may not charge more than the amount listed in the complete statement of itemized charges described in Subsection (2)(a).

(ii) If a hospital fails to provide a complete statement of itemized charges in accordance with Subsection (2)(a), the hospital may not charge the patient for the medical care or other services.

(3) (a) The statement shall be provided to the patient or the patient's personal representative or agent at the hospital's expense, personally, by mail, or by verifiable electronic delivery after the hospital receives an explanation of benefits from a third party payer which indicates the patient's remaining responsibility for the hospital charges.

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

(4) The statement required by this section:

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

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

(ii) shall include other appropriate language if the statement is sent to the patient under Subsection (3)(b); and

(c) may not include charges of physicians who bill separately.

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

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

Section 2. Section **26-21-27** is amended to read:

26-21-27. Disclosure and publication of health care facility charges.

(1) As used in this section, "standard charges" means the machine readable list of standard charges that a health care facility is required to publish on the internet under 42 U.S.C. Sec. 300gg-18.

(2) Beginning January 1, 2011, a health care facility licensed under this chapter shall, when requested by a consumer:

[~~(1)~~] (a) make a list of prices charged by the facility available for the consumer that includes the facility's:

[~~(a)~~] (i) in-patient procedures;

[~~(b)~~] (ii) out-patient procedures;

[~~(c)~~] (iii) the 50 most commonly prescribed drugs in the facility;

[~~(d)~~] (iv) imaging services; and

[~~(e)~~] (v) implants; and

[~~(2)~~] (b) provide the consumer with information regarding any discounts the facility provides for:

[~~(a)~~] (i) charges for services not covered by insurance; or

[~~(b)~~] (ii) prompt payment of billed charges.

(3) Beginning January 1, 2020, a health care facility licensed under this chapter shall publish the following information with the health care facility's standard charges:

(a) a plain-English description of each procedure in the standard charges; and

(b) the following statement: "Although the charges shown are based on recent data, the amount you are charged could differ. If you have health insurance, please contact your insurer to confirm the portion of the charge that you may be responsible for. If you do not have health insurance, please contact our billing staff to discuss payment options prior to receiving the procedure."

Section 3. Section **58-1-509** is enacted to read:

58-1-509. Publication of health care provider prices.

(1) As used in this section:

(a) "Allowed price" means the median of the amount allowed as a claim under the health benefit plans with which a health care provider has a contractual relationship, unweighted by the number of patients participating in each plan.

(b) (i) "Charged price" means:

(A) the amount most frequently charged during the previous 12 months;

(B) the median amount charged during the previous 12 months; or

(C) the range of amounts charged during the previous 12 months that begins at the 25th percentile of all amounts charged during the previous 12 months and ends at the 75th percentile of all amounts charged during the previous 12 months.

(ii) "Charged price" does not include any reduction based on source of payment or patient circumstance.

(c) "Claim" means the same as that term is defined in Section 31A-1-301.

(d) "CPT code" means a code within the American Medical Association's Current

Procedural Terminology.

(e) "Health benefit plan" means the same as that term is defined in Section 31A-1-301.

(f) "Health care provider" means an individual who is:

(i) described in Section 78B-3-403; and

(ii) licensed under this title.

(2) Beginning January 1, 2020, in accordance with Subsection (3), a health care provider shall publish at least once each year the charged price and the allowed price for:

(a) the 25 procedures most commonly performed by the health care provider; or

(b) all procedures performed by the health care provider.

(3) The information described in Subsection (2) shall be:

(a) (i) published to the health care provider's website in a manner that permits unrestricted access by the public;

(ii) published to another website that is readily identifiable by a person trying to find the information; or

(iii) if the procedures are performed at a clinic with three or fewer other health care providers of the same type, made available without request in the clinic's patient waiting area;

(b) published in a single document;

(c) identified by CPT code;

(d) accompanied by a plain-English description of each procedure; and

(e) accompanied by the following statement: "Although the prices shown are based on recent data, your price could differ. If you have health insurance, please contact your insurer to confirm the portion of the price for which you are responsible. If you do not have health insurance, please contact our billing staff to discuss payment options prior to receiving the procedure."

Section 4. **Coordinating H.B. 433 with H.B. 178 -- Omitting substantive changes.**

If this H.B. 443 and H.B. 178, Health Care Charges, both pass and become law, it is the intent of the Legislature that the Office of Legislative Research and General Counsel, in preparing the Utah Code database for publication, not make the changes in H.B. 443.