LEGISLATIVE GENERAL COUNSEL
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H.B. 204
1st Sub. (Buff)

Representative R. Curt Webb proposes the following substitute bill:

HEALTH CARE DEBT COLLECTION

2018 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: R. Curt Webb

Senate Sponsor: _____

LONG TITLE

General Description:

This bill amends provisions regarding health claims practices.

Highlighted Provisions:

This bill:

- amends provisions regarding health claims practices.

Money Appropriated in this Bill:

None

Other Special Clauses:

None

Utah Code Sections Affected:

AMENDS:

31A-26-301.5, as last amended by Laws of Utah 2017, Chapter 321

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

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

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

(1) As used in this section:

[~~(a) "Health care provider" means:~~]

[~~(i) a health care facility as defined in Section 26-21-2; or~~]

[~~(ii) a person licensed to provide health care services under:~~]

[~~(A) Title 58, Occupations and Professions; or~~]

[~~(B) Title 62A, Chapter 2, Licensure of Programs and Facilities.~~]

(a) (i) "Collection activity" means any action taken to recover funds that are past due or accounts that are in default:

(A) for health care services; and

(B) that may result in an adverse report to a credit agency.

(ii) "Collection activity" includes using the services of a collection agency to engage in collection services.

(iii) "Collection activity" does not include:

(A) billing or invoicing for funds that are not past due or accounts that are not in default; or

(B) providing the notice required in Subsection (4).

(b) "Text message" means a real time or near real time message that consists of text and is transmitted to a device identified by a telephone number.

(2) Except as provided in Section 31A-8-407, an insured retains ultimate responsibility for paying for health care services the insured receives. If a service is covered by one or more individual or group health insurance policies, all insurers covering the insured have the responsibility to pay valid health care claims in a timely manner according to the terms and limits specified in the policies.

(3) A health care provider may:

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

(b) bill an insured for services covered by health insurance policies or otherwise notify the insured of the expenses covered by the policies.

(4) (a) Except as provided in Subsection (4)(c), a health care provider or a third party may not make any report to a credit bureau or [~~use the services of a collection agency~~] engage in collection activity unless the health care provider or the third party:

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

sends a notice described in Subsection (4)(b) to the insured by certified mail with return receipt requested, priority mail, or text message; and

(B) makes the report to a credit bureau or [~~uses the services of a collection agency~~] engages in collection activity after the date stated in the notice in accordance with Subsection (4)(b)(ii)(A); or

(ii) (A) in the case of a Medicare beneficiary or retiree 65 years of age or older, after the date Medicare determines Medicare's liability for the claim, sends a notice described in Subsection (4)(b) to the insured by certified mail with return receipt requested, priority mail, or text message; and

(B) makes the report to a credit bureau or [~~uses the services of a collection agency~~] engages in collection activity after the date stated in the notice in accordance with Subsection (4)(b)(ii)(B).

(b) A notice described in Subsection (4)(a) shall state:

(i) the amount that the insured owes;

(ii) the date by which the insured must pay the amount owed that is:

(A) at least 45 days after the day on which the health care provider or the third party sends the notice; or

(B) if the insured is a Medicare beneficiary or retiree 65 years of age or older, at least 60 days after the day on which the health care provider or the third party sends the notice;

(iii) that if the insured fails to timely pay the amount owed, the health care provider or the third party may make a report to a credit bureau or [~~use the services of a collection agency;~~] engage in collection activity; and

(iv) that each action described in Subsection (4)(b)(iii) may negatively impact the insured's credit score.

(c) A health care provider or a third party satisfies the requirements described in Subsections (4)(a) and (b) if the health care provider or the third party complies with the provisions of 26 C.F.R. Sec. 1.501(r)-6.

(d) For a health care service rendered by a health care provider, the health care provider:

(i) retains ultimate responsibility for ensuring that the notice requirements described in this Subsection (4) are satisfied; and

(ii) is subject to the penalty described in Section 26-21-11.1, 58-1-508, or 62A-2-112 if the notice requirement described in this Subsection (4) is not satisfied.

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

(6) A health care provider shall return to an insured any amount the insured overpaid, including interest that begins accruing 90 days after the date of the overpayment, if:

(a) the insured has multiple insurers with whom the health care provider has contracts that cover the insured; and

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

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

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

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

(i) a participating provider; and

(ii) prohibited from balance billing.