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HEALTH CARE FACILITY BALANCE BILLING AMENDMENTS

2020 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: James A. Dunnigan

Senate Sponsor: _____

LONG TITLE

General Description:

This bill enacts provisions relating to balance billing for emergency services by a health care facility.

Highlighted Provisions:

This bill:

- defined terms; and
- enacts procedures that managed care organizations and a health care facility must follow if there is a dispute regarding payment for certain emergency services.

Money Appropriated in this Bill:

None

Other Special Clauses:

None

Utah Code Sections Affected:

ENACTS:

26-21-33, Utah Code Annotated 1953

31A-22-653, Utah Code Annotated 1953

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

Section 1. Section **26-21-33** is enacted to read:

H.B. 456

26-21-33. Balance billing for emergency services prohibited -- Violation of chapter.

(1) As used in this section:

(a) "Balance billing" means the same as that term is defined in Section 31A-22-653.

(b) "Emergency services" means the same as that term is defined in Section 31A-22-653.

(2) Beginning January 1, 2021, it is a violation of this chapter for a health care facility to balance bill a patient for emergency services in violation of Section 31A-22-653.

(3) A health care facility that violates Subsection (2) is subject to Section 26-21-11.

Section 2. Section **31A-22-653** is enacted to read:

31A-22-653. Managed care organization out-of-network services -- Health care facilities -- Emergency services -- Balance billing.

(1) As used in this section:

(a) (i) "Balance billing" means the practice of a health care facility billing a managed care organization enrollee for the difference between a health care facility charge and the managed care organization's allowed amount.

(ii) "Balance billing" does not include billing an enrollee for cost sharing required by the enrollee's health benefit plan, including copayments, coinsurance, and deductibles.

(b) "Covered benefit" means a health care service covered under the terms of a health benefit plan.

(c) "Emergency services" means the same as that term is defined in 42 C.F.R. Sec. 2590.715-2719A.

(d) "Health care facility" means the same as that term is defined in Section 26-21-2.

(e) "Managed care organization" means:

(i) a managed care organization as defined in Section 31A-27a-403; and

(ii) a third party administrator.

(2) Upon receiving a bill from a non-network health care facility with the benchmark rate described in Subsection (5)(b)(i), a managed care organization shall:

(a) reimburse a non-network health care facility for emergency services in accordance with this section;

(b) (i) pay a non-network health care facility directly for emergency services provided

to an enrollee; and

(ii) send a remittance to the non-network health care facility with the information required under Subsection (2)(e);

(c) pay a non-network health care facility for emergency services in accordance with Subsection (5);

(d) count toward any deductible or out-of-pocket maximum applied under the enrollee's plan any cost sharing payments made by the enrollee with respect to emergency services reimbursed under this section in the same manner as if such cost sharing payments were paid for services or care furnished by an in-network health care facility; and

(e) provide to the non-network health care facility a remittance that includes:

(i) the amount the non-network health care facility may attempt to collect from the enrollee for the enrollee's cost sharing, including unmet deductibles, copayments, and coinsurance; and

(ii) the managed care organization's allowed amount under Subsection (2)(c) for the emergency services.

(3) If a non-network health care facility sends a bill directly to an enrollee for emergency services, the bill shall notify the enrollee:

(a) that the emergency services were performed by a health care facility that is not a network health care facility for the enrollee's health benefit plan; and

(b) that the enrollee is responsible for paying the enrollee's applicable in-network cost sharing amount.

(4) A non-network health care facility that receives payment from the managed care organization under Subsection (2)(c):

(a) may rely on the remittance provided by the managed care organization to the enrollee and the non-network health care facility under Subsection (2)(b)(ii);

(b) shall accept the payment from the enrollee under Subsection (3)(b) as payment in full for the emergency services from the enrollee; and

(c) may not attempt to collect payment from an enrollee for emergency services in excess of the amount under Subsection (4)(b).

(5) (a) When a managed care organization receives a bill for emergency services from a non-network health care facility, the managed care organization shall:

(i) ensure that the enrollee is responsible for no more than the applicable in-network cost sharing amount; and

(ii) may elect to pay a non-network health care facility for emergency services:

(A) as submitted by the health care facility;

(B) the benchmark rate described in Subsection (5)(b)(i); or

(C) in an amount mutually agreed upon by the managed care organization and the health care facility.

(b) (i) The benchmark rate under this section is the median of the health care facility's contracted in-network rates with all managed care organizations in the state.

(ii) A managed care organization may submit a request to the department to verify the benchmark rate submitted by a health care facility under this section.

(c) This section does not preclude a managed care organization and a non-network health care facility from agreeing to a different payment arrangement if:

(i) the enrollee is responsible for no more than the applicable in-network cost sharing amount; and

(ii) the enrollee has no legal obligation to pay the balance for emergency services remaining after the payments under Subsection (4).