1 **Health Care Amendments**

2025 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: James A. Dunnigan

Senate Sponsor:

2

3 **LONG TITLE**

4 **General Description:**

5 This bill amends provisions related to health care practices.

6 **Highlighted Provisions:**

7 This bill:

8 ▸ amends provisions regarding the use of credit card payments to health care providers;

9 ▸ amends provisions related to dental claims practices; and

10 ▸ allows dentists to dispense medications under certain circumstances.

11 **Money Appropriated in this Bill:**

12 None

13 **Other Special Clauses:**

14 None

15 **Utah Code Sections Affected:**

16 AMENDS:

17 **31A-26-301.6**, as last amended by Laws of Utah 2024, Chapter 120

18 **31A-26-301.7**, as enacted by Laws of Utah 2021, Chapter 288

19 **58-88-201**, as last amended by Laws of Utah 2023, Chapter 329

20 **58-88-202**, as last amended by Laws of Utah 2024, Chapter 210

21

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

23 Section 1. Section **31A-26-301.6** is amended to read:

24 **31A-26-301.6 . Health care claims practices.**

25 (1) As used in this section:

26 (a) "Health care provider" means a person licensed to provide health care under:

27 (i) Title 26B, Chapter 2, Part 2, Health Care Facility Licensing and Inspection; or

28 (ii) Title 58, Occupations and Professions.

29 (b) "Insurer" means an admitted or authorized insurer, as defined in Section 31A-1-301,

30 and includes:

31 (i) a health maintenance organization; and
32 (ii) a third party administrator that is subject to this title, provided that nothing in this
33 section may be construed as requiring a third party administrator to use its own
34 funds to pay claims that have not been funded by the entity for which the third
35 party administrator is paying claims.
36 (c) "Provider" means a health care provider to whom an insurer is obligated to pay
37 directly in connection with a claim by virtue of:
38 (i) an agreement between the insurer and the provider;
39 (ii) an accident and health insurance policy or contract of the insurer; or
40 (iii) state or federal law.
41 (2) An insurer shall timely pay every valid insurance claim submitted by a provider in
42 accordance with this section.
43 (3)(a) Except as provided in Subsection (4), within 30 days of the day on which the
44 insurer receives a written claim, an insurer shall:
45 (i) pay the claim; or
46 (ii) deny the claim and provide a written explanation for the denial.
47 (b)(i) Subject to Subsection (3)(b)(ii), the time period described in Subsection (3)(a)
48 may be extended by 15 days if the insurer:
49 (A) determines that the extension is necessary due to matters beyond the control
50 of the insurer; and
51 (B) before the end of the 30-day period described in Subsection (3)(a), notifies the
52 provider and insured in writing of:
53 (I) the circumstances requiring the extension of time; and
54 (II) the date by which the insurer expects to pay the claim or deny the claim
55 with a written explanation for the denial.
56 (ii) If an extension is necessary due to a failure of the provider or insured to submit
57 the information necessary to decide the claim:
58 (A) the notice of extension required by this Subsection (3)(b) shall specifically
59 describe the required information; and
60 (B) the insurer shall give the provider or insured at least 45 days from the day on
61 which the provider or insured receives the notice before the insurer denies the
62 claim for failure to provide the information requested in Subsection
63 (3)(b)(ii)(A).
64 (4)(a) In the case of a claim for income replacement benefits, within 45 days of the day

65 on which the insurer receives a written claim, an insurer shall:
66 (i) pay the claim; or
67 (ii) deny the claim and provide a written explanation of the denial.
68 (b) Subject to Subsections (4)(d) and (e), the time period described in Subsection (4)(a)
69 may be extended for 30 days if the insurer:
70 (i) determines that the extension is necessary due to matters beyond the control of the
71 insurer; and
72 (ii) before the expiration of the 45-day period described in Subsection (4)(a), notifies
73 the insured of:
74 (A) the circumstances requiring the extension of time; and
75 (B) the date by which the insurer expects to pay the claim or deny the claim with a
76 written explanation for the denial.
77 (c) Subject to Subsections (4)(d) and (e), the time period for complying with Subsection
78 (4)(a) may be extended for up to an additional 30 days from the day on which the
79 30-day extension period provided in Subsection (4)(b) ends if before the day on
80 which the 30-day extension period ends, the insurer:
81 (i) determines that due to matters beyond the control of the insurer a decision cannot
82 be rendered within the 30-day extension period; and
83 (ii) notifies the insured of:
84 (A) the circumstances requiring the extension; and
85 (B) the date as of which the insurer expects to pay the claim or deny the claim
86 with a written explanation for the denial.
87 (d) A notice of extension under this Subsection (4) shall specifically explain:
88 (i) the standards on which entitlement to a benefit is based; and
89 (ii) the unresolved issues that prevent a decision on the claim.
90 (e) If an extension allowed by Subsection (4)(b) or (c) is necessary due to a failure of the
91 insured to submit the information necessary to decide the claim:
92 (i) the notice of extension required by Subsection (4)(b) or (c) shall specifically
93 describe the necessary information; and
94 (ii) the insurer shall give the insured at least 45 days from the day on which the
95 insured receives the notice before the insurer denies the claim for failure to
96 provide the information requested in Subsection (4)(b) or (c).
97 (5) If a period of time is extended as permitted under Subsection (3)(b), (4)(b), or (4)(c),
98 due to an insured or provider failing to submit information necessary to decide a claim,

99 the period for making the benefit determination shall be tolled from the date on which
100 the notification of the extension is sent to the insured or provider until the date on which
101 the insured or provider responds to the request for additional information.
102 (6) An insurer shall pay all sums to the provider or insured that the insurer is obligated to
103 pay on the claim, and provide a written explanation of the insurer's decision regarding
104 any part of the claim that is denied within 20 days of receiving the information requested
105 under Subsection (3)(b), (4)(b), or (4)(c).
106 (7)(a) Whenever an insurer makes a payment to a provider on any part of a claim under
107 this section, the insurer shall also send to the insured an explanation of benefits paid.
108 (b) Whenever an insurer denies any part of a claim under this section, the insurer shall
109 also send to the insured:
110 (i) a written explanation of the part of the claim that was denied; and
111 (ii) notice of the adverse benefit determination review process established under
112 Section 31A-22-629.
113 (c) This Subsection (7) does not apply to a person receiving benefits under the state
114 Medicaid program as defined in Section 26B-3-101, unless required by the
115 Department of Health and Human Services or federal law.
116 (8)(a) A late fee shall be imposed on:
117 (i) an insurer that fails to timely pay a claim in accordance with this section; and
118 (ii) a provider that fails to timely provide information on a claim in accordance with
119 this section.
120 (b) The late fee described in Subsection (8)(a) shall be determined by multiplying
121 together:
122 (i) the total amount of the claim the insurer is obliged to pay;
123 (ii) the total number of days the response or the payment is late; and
124 (iii) 0.033% daily interest rate.
125 (c) Any late fee paid or collected under this Subsection (8) shall be separately identified
126 on the documentation used by the insurer to pay the claim.
127 (d) For purposes of this Subsection (8), "late fee" does not include an amount that is less
128 than $1.
129 (9) Each insurer shall establish a review process to resolve claims-related disputes between
130 the insurer and providers.
131 (10) An insurer or person representing an insurer may not engage in any unfair claim
132 settlement practice with respect to a provider. Unfair claim settlement practices include:

133 (a) knowingly misrepresenting a material fact or the contents of an insurance policy in
134 connection with a claim;
135 (b) failing to acknowledge and substantively respond within 15 days to any written
136 communication from a provider relating to a pending claim;
137 (c) denying or threatening to deny the payment of a claim for any reason that is not
138 clearly described in the insured's policy;
139 (d) failing to maintain a payment process sufficient to comply with this section;
140 (e) failing to maintain claims documentation sufficient to demonstrate compliance with
141 this section;
142 (f) failing, upon request, to give to the provider written information regarding the
143 specific rate and terms under which the provider will be paid for health care services;
144 (g) failing to timely pay a valid claim in accordance with this section as a means of
145 influencing, intimidating, retaliating, or gaining an advantage over the provider with
146 respect to an unrelated claim, an undisputed part of a pending claim, or some other
147 aspect of the contractual relationship;
148 (h) failing to pay the sum when required and as required under Subsection (8) when a
149 violation has occurred;
150 (i) threatening to retaliate or actual retaliation against a provider for the provider
151 applying this section;
152 (j) any material violation of this section; and
153 (k) any other unfair claim settlement practice established in rule or law.
154 (11)(a) The provisions of this section shall apply to each contract between an insurer and
155 a provider for the duration of the contract.
156 (b) Notwithstanding Subsection (11)(a), this section may not be the basis for a bad faith
157 insurance claim.
158 (c) Nothing in Subsection (11)(a) may be construed as limiting the ability of an insurer
159 and a provider from including provisions in their contract that are more stringent than
160 the provisions of this section.
161 (12)(a) Pursuant to Chapter 2, Part 2, Duties and Powers of Commissioner, the
162 commissioner may conduct examinations to determine an insurer's level of
163 compliance with this section and impose sanctions for each violation.
164 (b) The commissioner may adopt rules only as necessary to implement this section.
165 (c) The commissioner may establish rules to facilitate the exchange of electronic
166 confirmations when claims-related information has been received.

167 (d) Notwithstanding Subsection (12)(b), the commissioner may not adopt rules
168 regarding the review process required by Subsection (9).
169 (13) Nothing in this section may be construed as limiting the collection rights of a provider
170 under Section 31A-26-301.5.
171 (14) Nothing in this section may be construed as limiting the ability of an insurer to:
172 (a) recover any amount improperly paid to a provider or an insured:
173 (i) in accordance with Section 31A-31-103 or any other provision of state or federal
174 law;
175 (ii) within 24 months of the amount improperly paid for a coordination of benefits
176 error;
177 (iii) within 12 months of the amount improperly paid for any other reason not
178 identified in Subsection (14)(a)(i) or (ii); or
179 (iv) within 36 months of the amount improperly paid when the improper payment
180 was due to a recovery by Medicaid, Medicare, the Children's Health Insurance
181 Program, or any other state or federal health care program;
182 (b) take any action against a provider that is permitted under the terms of the provider
183 contract and not prohibited by this section;
184 (c) report the provider to a state or federal agency with regulatory authority over the
185 provider for unprofessional, unlawful, or fraudulent conduct; or
186 (d) enter into a mutual agreement with a provider to resolve alleged violations of this
187 section through mediation or binding arbitration.
188 (15) A provider may only seek recovery from the insurer for an amount improperly paid by
189 the insurer within the same time frames as Subsections (14)(a) and (b).
190 (16)(a) An insurer may offer the remittance of payment through a credit card or other
191 similar arrangement.
192 (b)(i) A provider may elect not to receive remittance through a credit card or other
193 similar arrangement.
194 (ii) An insurer:
195 (A) shall permit a provider's election described in Subsection (16)(b)(i) to apply to
196 the provider's entire practice; [~~and~~]
197 (B) may not require a provider's election described in Subsection (16)(b)(i) to be
198 made on a patient-by-patient basis[~~.~~] ; and
199 (C) shall allow a provider to opt out of all credit card or other similar
200 arrangements for every plan offered by the insurer through a single opt out

201 process.
202 (iii) If a provider elects not to receive remittance through a credit card or other
203 similar arrangement, that decision remains in effect until:
204 (A) the provider affirmatively elects to receive remittance through credit card or
205 similar arrangement; or
206 (B) a new contract is issued.
207 (c) An insurer may not require a provider or insured to accept remittance through a
208 credit card or other similar arrangement.
209 (d) An insurer shall accept a tangible check as a form of acceptable payment.
210 Section 2. Section **31A-26-301.7** is amended to read:
211 **31A-26-301.7 . Dental claim transparency and practices.**
212 (1) As used in this section:
213 (a) "Bundling" means the practice of combining distinct dental procedures into one
214 procedure for billing purposes.
215 (b) "Dental plan" means the same as that term is defined in Section 31A-22-646.
216 (c) "Downcoding" means the adjustment of a claim submitted to a dental plan to a less
217 complex or lower cost procedure code.
218 (d) "Covered services" means the same as that term is defined in Section 31A-22-646.
219 (e) "Material change" means a change to:
220 (i) a dental plan's rules, guidelines, policies, or procedures concerning payment for
221 dental services;
222 (ii) the general policies of the dental plan that affect a reimbursement paid to
223 providers; or
224 (iii) the manner by which a dental plan adjudicates and pays a claim for services.
225 (2) An insurer that contracts or renews a contract with a dental provider shall:
226 (a) make a copy of the insurer's current dental plan policies available online; and
227 (b) if requested by a provider, send a copy of the policies to the provider through mail or
228 electronic mail.
229 (3) Dental policies described in Subsection (2) shall include:
230 (a) a summary of all material changes made to a dental plan since the policies were last
231 updated;
232 (b) the downcoding and bundling policies that the insurer reasonably expects to be
233 applied to the dental provider or provider's services as a matter of policy; and
234 (c) a description of the dental plan's utilization review procedures, including:

235 (i) a procedure for an enrollee of the dental plan to obtain review of an adverse
236 determination in accordance with Section 31A-22-629; and
237 (ii) a statement of a provider's rights and responsibilities regarding the procedures
238 described in Subsection (3)(c)(i).
239 (4) An insurer may not maintain a dental plan that:
240 (a) based on the provider's contracted fee for covered services, uses downcoding in a
241 manner that prevents a dental provider from collecting the fee for the actual service
242 performed from either the plan or the patient; [~~or~~]
243 (b) uses bundling in a manner where a procedure code is labeled as nonbillable to the
244 patient unless, under generally accepted practice standards, the procedure code is for
245 a procedure that may be provided in conjunction with another procedure[~~.~~] ;
246 (c) does not allow a dental provider to bill the patient for a service when the insurer
247 denies the claim for the service, unless under generally accepted practice standards,
248 the service performed should not be billed; or
249 (d) automatically recoups an overpayment unless:
250 (i) the recoupment occurs more than 60 days from the day the insurer sends a notice
251 of the overpayment; or
252 (ii) the dental provider affirmatively elects to have recoupment occur earlier than 60
253 days from the day the insurer sends a notice of the overpayment.
254 (5)(a) An insurer shall ensure that an explanation of benefits for a dental plan includes
255 the reason for any downcoding or bundling result.
256 (b) A dental provider who receives an overpayment from a dental plan shall return the
257 amount of the overpayment through check or other means to the dental plan within
258 60 days from the day the insurer sends a notice of the overpayment.
259 (c) A dental provider shall make reasonable efforts to inform patients of services that
260 may not be covered by the patient's dental plan if the dental provider will perform a
261 service that may not be covered.
262 Section 3. Section **58-88-201** is amended to read:
263 **58-88-201 . Definitions.**
264 As used in this part:
265 (1)(a) "Dispense" means the delivery by a prescriber of a prescription drug or device to a
266 patient, including the packaging, labeling, and security necessary to prepare and
267 safeguard the drug or device for supplying to a patient.
268 (b) "Dispense" does not include:

269 (i) prescribing or administering a drug or device; or
270 (ii) delivering to a patient a sample packaged for individual use by a licensed
271 manufacturer or re-packager of a drug or device.
272 (2) "Dispensing practitioner" means an individual who:
273 (a) is currently licensed as:
274 (i) a physician and surgeon under Chapter 67, Utah Medical Practice Act;
275 (ii) an osteopathic physician and surgeon under Chapter 68, Utah Osteopathic
276 Medical Practice Act;
277 (iii) an advanced practice registered nurse under Subsection 58-31b-301(2)(d); [~~or~~]
278 (iv) a physician assistant under Chapter 70a, Utah Physician Assistant Act<u>; or</u>
279 <u>(v) a dentist under Chapter 69, Dentist and Dental Hygienist Practice Act;</u>
280 (b) is authorized by state law to prescribe and administer drugs in the course of
281 professional practice; and
282 (c) practices at a licensed dispensing practice.
283 (3) "Drug" means the same as that term is defined in Section 58-17b-102.
284 (4) "Health care practice" means:
285 (a) a health care facility as defined in Section 26B-2-201; or
286 (b) the offices of one or more private prescribers, whether for individual or group
287 practice.
288 (5) "Licensed dispensing practice" means a health care practice that is licensed as a
289 dispensing practice under Section 58-88-202.
290 Section 4. Section **58-88-202** is amended to read:
291 **58-88-202 . Dispensing practice -- Drugs that may be dispensed -- Limitations**
292 **and exceptions.**
293 (1) Notwithstanding Section 58-17b-302, a dispensing practitioner may dispense a drug at a
294 licensed dispensing practice if the drug is:
295 (a) packaged in a fixed quantity per package by:
296 (i) the drug manufacturer;
297 (ii) a pharmaceutical wholesaler or distributor; or
298 (iii) a pharmacy licensed under Chapter 17b, Pharmacy Practice Act;
299 (b) dispensed:
300 (i) at a licensed dispensing practice at which the dispensing practitioner regularly
301 practices; and
302 (ii) under a prescription issued by the dispensing practitioner to the dispensing

303 practitioner's patient;
304 (c) except as provided in Subsection (6), for a condition that is not expected to last
305 longer than 30 days; and
306 (d) for a condition for which the patient has been evaluated by the dispensing
307 practitioner on the same day on which the dispensing practitioner dispenses the drug.
308 (2) A dispensing practitioner may not dispense:
309 (a) a controlled substance as defined in Section 58-37-2;
310 (b) a drug or class of drugs that is designated by the division under Subsection 58-88-205
311 (2); or
312 [(c) gabapentin; or]
313 [(d)] (c) a supply of a drug under this part that exceeds a 30-day supply.
314 (3) A dispensing practitioner may not make a claim against workers' compensation or
315 automobile insurance for a drug dispensed under this part for outpatient use unless the
316 dispensing practitioner is contracted with a pharmacy network established by the claim
317 payor.
318 (4) When a dispensing practitioner dispenses a drug to the patient under this part, a
319 dispensing practitioner shall:
320 (a) disclose to the patient verbally and in writing that the patient is not required to fill the
321 prescription through the licensed dispensing practice and that the patient has a right
322 to fill the prescription through a pharmacy; and
323 (b) if the patient will be responsible to pay cash for the drug, disclose:
324 (i) that the patient will be responsible to pay cash for the drug; and
325 (ii) the amount that the patient will be charged by the licensed dispensing practice for
326 the drug.
327 (5) This part does not:
328 (a) require a dispensing practitioner to dispense a drug under this part;
329 (b) limit a health care prescriber from dispensing under Chapter 17b, Part 8, Dispensing
330 Medical Practitioner and Dispensing Medical Practitioner Clinic Pharmacy; or
331 (c) apply to a physician who dispenses:
332 (i) a drug sample, as defined in Section 58-17b-102, to a patient in accordance with
333 Section 58-1-501.3 or Section 58-17b-610; or
334 (ii) a drug in an emergency situation as defined by the division in rule under Chapter
335 17b, Pharmacy Practice Act.
336 (6) A dispensing practitioner that is a dentist may dispense prescription fluoride medication

337 regardless of whether the condition the fluoride is treating will last longer than 30 days.

338 Section 5. **Effective Date.**

339 This bill takes effect on May 7, 2025.