# HEALTH CARE DEBT COLLECTION AMENDMENTS

2017 GENERAL SESSION

STATE OF UTAH

**Chief Sponsor: R. Curt Webb**

Senate Sponsor: Curtis S. Bramble

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**LONG TITLE**

**General Description:**

This bill modifies and enacts provisions related to health care claims practices.

**Highlighted Provisions:**

This bill:

- defines terms;
- modifies the circumstances under which a health care provider may make a report to a credit bureau or use the services of a collection agency against an insured;
- addresses administrative penalties for a health care provider who fails to comply with the provisions of this bill; and
- makes technical and conforming changes.

**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 2016, Chapter 124

**62A-2-112**, as last amended by Laws of Utah 2016, Chapter 211

ENACTS:

**26-21-11.1**, Utah Code Annotated 1953

**58-1-508**, Utah Code Annotated 1953

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

Section 1. Section **26-21-11.1** is enacted to read:

**26-21-11.1. Failure to follow certain health care claims practices -- Penalties.**

(1) The department may assess a fine of up to $500 per violation against a health care facility that violates Subsection 31A-26-301.5(4).

(2) The department shall waive the fine described in Subsection (1) if:

(a) the health care facility demonstrates to the department that the health care facility mitigated and reversed any damage to the insured caused by the health care facility's violation; or

(b) the insured does not pay the full amount due on the bill that is the subject of the violation, including any interest, fees, costs, and expenses, within 120 days after the day on which the health care facility makes a report to a credit bureau or uses the services of a collection agency in violation of Subsection 31A-26-301.5(4).

Section 2. 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.

(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.

[~~(1)~~] (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.

[~~(2) (a)~~] (3) [~~Except as provided in Section 31A-22-610.1, a~~] 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) [~~A health care provider may~~] bill an insured for services covered by health insurance policies or [~~may~~] otherwise notify the insured of the expenses covered by the policies. [~~However, a~~]

(4) (a) Except as provided in Subsection (4)(c), a health care provider may not make any report to a credit bureau[~~,~~] or use the services of a collection agency[~~, or use methods other than routine billing or notification until the later of~~] unless the health care provider:

(i) (A) after the expiration of the time afforded to an insurer under Section 31A-26-301.6 to determine [~~its~~] the insurer's obligation to pay or deny the claim without penalty[~~; or~~], 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 after the date stated in the notice in accordance with Subsection (4)(b)(ii)(A); or

(ii) (A) in the case of a Medicare [~~beneficiaries or retirees~~] beneficiary or retiree 65 years of age or older, [~~60 days from~~] after the date Medicare determines [~~its~~] 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 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 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 sends the notice;

(iii) that if the insured fails to timely pay the amount owed, the health care provider may make a report to a credit bureau or use the services of a collection agency; and

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

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

[~~(c)~~] (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.

[~~(d)~~] (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:

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

[~~(ii)~~] (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.

[~~(3)~~] (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.

Section 3. Section **58-1-508** is enacted to read:

**58-1-508. Failure to follow certain health care claims practices -- Penalties.**

(1) As used in this section, "health care provider" means an individual who is licensed to

provide health care services under this title.

(2) The division may assess a fine of up to $500 per violation against a health care provider who violates Subsection 31A-26-301.5(4).

(3) The division shall waive the fine described in Subsection (2) if:

(a) the health care provider demonstrates to the division that the health care provider mitigated and reversed any damage to the insured caused by the health care provider's violation; or

(b) the insured does not pay the full amount due on the bill that is the subject of the violation, including any interest, fees, costs, and expenses, within 120 days after the day on which the health care provider makes a report to a credit bureau or uses the services of a collection agency in violation of Subsection 31A-26-301.5(4).

Section 4. Section **62A-2-112** is amended to read:

**62A-2-112. Violations -- Penalties.**

(1) As used in this section, "health care provider" means a person licensed to provide health care services under this chapter.

[~~(1)~~] (2) The office may deny, place conditions on, suspend, or revoke a human services license, if it finds, related to the human services program:

(a) that there has been a failure to comply with the rules established under this chapter;

(b) evidence of aiding, abetting, or permitting the commission of any illegal act; or

(c) evidence of conduct adverse to the standards required to provide services and promote public trust, including aiding, abetting, or permitting the commission of abuse, neglect, exploitation, harm, mistreatment, or fraud.

[~~(2)~~] (3) The office may restrict or prohibit new admissions to a human services program, if it finds:

(a) that there has been a failure to comply with rules established under this chapter;

(b) evidence of aiding, abetting, or permitting the commission of any illegal act; or

(c) evidence of conduct adverse to the standards required to provide services and promote public trust, including aiding, abetting, or permitting the commission of abuse, neglect, exploitation, harm, mistreatment, or fraud.

(4) (a) The office may assess a fine of up to $500 per violation against a health care provider who violates Subsection 31A-26-301.5(4).

(b) The office shall waive the fine described in Subsection (4)(a) if:

(i) the health care provider demonstrates to the office that the health care provider mitigated and reversed any damage to the insured caused by the health care provider's violation; or

(ii) the insured does not pay the full amount due on the bill that is the subject of the violation, including any interest, fees, costs, and expenses, within 120 days after the day on which the health care provider makes a report to a credit bureau or uses the services of a collection agency in violation of Subsection 31A-26-301.5(4).