LEGISLATIVE GENERAL COUNSEL
₵ Approved for Filing: C.J. Dupont ₵
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H.B. 247

HEALTH CARE BILLING AMENDMENTS

2017 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: Dixon M. Pitcher

Senate Sponsor: _____

LONG TITLE

General Description:

This bill regulates the reimbursement and billing for certain emergency services.

Highlighted Provisions:

This bill:

- applies to health benefit plans entered into or renewed on or after January 1, 2018;
- requires a health insurer to pay non-network health care providers for emergency services provided to an enrollee;
- establishes a benchmark for payment for emergency services provided by a non-network health care provider;
- prohibits a non-network health care provider who receives payment from the health insurer for emergency services from balance billing the enrollee;
- requires a health care provider to give an enrollee notice of assistance the enrollee may receive from the insurance commissioner if the enrollee receives a bill from a non-network heath care provider for emergency services;
- makes balanced billing for emergency services unprofessional conduct under health care provider licensing laws; and
- requires a sunset review of the benchmark for payment of emergency services by July 1, 2022.

Money Appropriated in this Bill:

None

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Other Special Clauses:

None

Utah Code Sections Affected:

AMENDS:

31A-22-627, as last amended by Laws of Utah 2016, Chapter 295

63I-2-231, as last amended by Laws of Utah 2016, Chapter 138

ENACTS:

26-21-30, Utah Code Annotated 1953

31A-22-627.5, Utah Code Annotated 1953

58-1-509, Utah Code Annotated 1953

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

Section 1. Section **26-21-30** is enacted to read:

26-21-30. Emergency medical services -- Balance billing -- Violation of chapter.

(1) For purposes of this section:

(a) "Balance billing" means the same as that term is defined in Section 31A-22-627.5.

(b) "Emergency services" means the same as that term is defined in Section 31A-22-627.5.

(2) Beginning January 1, 2018, 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-22-627.5.

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

Section 2. Section **31A-22-627** is amended to read:

31A-22-627. Coverage of emergency medical services.

(1) A health insurance policy or health maintenance organization contract:

(a) shall provide, at a minimum, coverage of emergency services:

(i) as required in 29 C.F.R. Sec. 2590.715-2719A; and

(ii) for plans entered into or renewed on or after January 1, 2018, as required in Subsection (1)(a)(i) and in Section 31A-22-627.5; and

(b) may not:

(i) require any form of preauthorization for treatment of an emergency medical condition until after the insured's condition has been stabilized; or

(ii) deny a claim for any covered evaluation, covered diagnostic test, or other covered treatment considered medically necessary to stabilize the emergency medical condition of an insured.

(2) A health insurance policy or health maintenance organization contract may require authorization for the continued treatment of an emergency medical condition after the insured's condition has been stabilized. If such authorization is required, an insurer who does not accept or reject a request for authorization may not deny a claim for any evaluation, diagnostic testing, or other treatment considered medically necessary that occurred between the time the request was received and the time the insurer rejected the request for authorization.

(3) For purposes of this section:

(a) "emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of medicine and health, would reasonably expect the absence of immediate medical attention at a hospital emergency department to result in:

(i) placing the insured's health, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;

(ii) serious impairment to bodily functions; or

(iii) serious dysfunction of any bodily organ or part; and

(b) "hospital emergency department" means that area of a hospital in which emergency services are provided on a 24-hour-a-day basis.

(4) Nothing in this section may be construed as:

(a) altering the level or type of benefits that are provided under the terms of a contract or policy; or

(b) restricting a policy or contract from providing enhanced benefits for certain emergency medical conditions that are identified in the policy or contract.

(5) Notwithstanding Section 31A-2-308, if the commissioner finds an insurer has violated this section, the commissioner may:

(a) work with the insurer to improve the insurer's compliance with this section; or

(b) impose the following fines:

(i) not more than $5,000; or

(ii) twice the amount of any profit gained from violations of this section.

Section 3. Section **31A-22-627.5** is enacted to read:

31A-22-627.5. Emergency services -- Non-network providers -- Balance billing.

(1) For purposes of this section:

(a) (i) "Balance billing" means the practice of a health care provider billing an enrollee for the difference between the health care provider's charge and the amount of reimbursement by the managed care organization under Subsection (2)(c).

(ii) "Balance billing" does not include billing an enrollee for copayments, coinsurance, or deductibles.

(b) "Emergency medical condition" means the same as that term is defined in Section 31A-22-627.

(c) "Emergency services" means, with respect to an emergency medical condition:

(i) a medical or mental health screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate the emergency medical condition; and

(ii) any further medical or mental health examination and treatment, to the extent the treatment or examination is within the capabilities of the emergency department and the staff, to stabilize the patient.

(d) "Managed care organization" means a third-party administrator as that term is defined in Section 31A-1-103, or a person:

(i) licensed:

(A) under Chapter 5, Domestic Stock and Mutual Insurance Corporations;

(B) under Chapter 7, Nonprofit Health Service Insurance Corporation;

(C) as a health maintenance organization under Chapter 8, Health Maintenance Organizations and Limited Health Plans; or

(D) under Chapter 14, Foreign Insurers; and

(ii) that requires an enrollee to use, or offers incentives, including financial incentives, for an enrollee to use, network providers.

(e) "Network provider" means a health care provider who has an agreement with a managed care organization to provide health care services to an enrollee with an expectation of receiving payment, other than coinsurance, copayments, or deductibles, directly from the managed care organization.

(2) (a) For plans entered into or renewed on or after January 1, 2018, a managed care organization shall reimburse a non-network provider for emergency services in accordance with this section.

(b) A managed care organization shall accept assignment of benefits from an enrollee for emergency services provided by a non-network provider.

(c) Except as provided in Subsection (2)(f), payment to a non-network provider for emergency services shall be the greater of:

(i) the median amount negotiated by the managed care organization with the network providers for the emergency services furnished, without regard to copayments or coinsurance obligations of the enrollee;

(ii) the amount for the emergency services calculated using the same method generally used by managed care organizations to determine payments for non-network services, without regard to copayments or coinsurance obligations of the enrollee; or

(iii) the eightieth percentile of the charges for a particular emergency service performed by a health care provider in the same or similar specialty in Utah, as reported in a benchmarking database maintained by an organization selected by the commissioner under Subsection (2)(d).

(d) The commissioner shall designate, by administrative rule, a national database of charges under Subsection (2)(c), which database shall be established and maintained by a national independent not-for-profit corporation that collects private medical and dental claims, contributed by payers nationwide, developed with the support of independent academic experts, and not affiliated with an insurer.

(e) A managed care organization shall pay a non-network provider for emergency services:

(i) as submitted by the provider; or

(ii) in accordance with the benchmark established in Subsection (2)(c).

(f) This section does not preclude a managed care organization and a non-network provider from agreeing to a different payment arrangement.

(3) When a non-network provider sends a bill directly to an enrollee for emergency services, the non-network provider shall include a statement on the bill informing the enrollee:

(a) that the emergency services were performed by a provider who is not a network

provider for the enrollee's health benefit plan;

(b) that the enrollee:

(i) is responsible for paying the enrollee's applicable in-network cost-sharing amount;

(ii) has no legal obligation to pay the remaining balance for the emergency services;

(iii) shall either:

(A) accept and pay the remaining balance for the emergency services provided by the non-network provider; or

(B) forward the bill for the remaining balance to the enrollee's managed care organization; and

(iv) may contact the state insurance commissioner's office for assistance; and

(c) of the online address and telephone number for the insurance department's consumer assistance office.

(4) A non-network provider who receives payment from the managed care organization under Subsection (2)(c):

(a) shall accept the payment under Subsection (2)(c) and the cost-sharing payment from the enrollee as payment in full for the emergency services; and

(b) may not attempt to collect payment from an enrollee for emergency services, excluding appropriate cost-sharing payment from the enrollee.

(5) The rights and remedies provided under this section to an enrollee shall be in addition to, and may not preempt, any other rights and remedies available to an enrollee under state or federal law.

(6) (a) On or before November 30, 2021, the commissioner shall report to the Business and Labor Interim Committee regarding the benchmark established under Subsections (2)(c) and (d) and whether the payment benchmarks should be modified.

(b) This section is repealed in accordance with Section 63I-2-231.

Section 4. Section **58-1-509** is enacted to read:

58-1-509. Health care provider -- Emergency services -- Balance billing-Unprofessional conduct.

(1) For purposes of this section:

(a) "Balance billing" means the same as that term is defined in Section 31A-22-627.5.

(b) "Emergency services" means the same as that term is defined in Section

31A-22-627.5.

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

(i) defined as a health care provider under Section 78B-3-403; and

(ii) licensed under this title.

(2) Beginning January 1, 2018, it is unprofessional conduct for a health care provider to balance bill a patient for emergency services in violation of Section 31A-22-627.5.

(3) A health care provider who violates this section is subject to Section 58-1-502.

Section 5. Section **63I-2-231** is amended to read:

63I-2-231. Repeal dates, Title 31A.

(1) Section 31A-22-315.5 is repealed July 1, 2019.

(2) Title 31A, Chapter 42, Defined Contribution Risk Adjuster Act, is repealed December 31, 2018.

(3) Section 31A-22-627.5 is repealed July 1, 2022.

Legislative Review Note
Office of Legislative Research and General Counsel