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HEALTH CARE PROVIDER AMENDMENTS

2013 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: Francis D. Gibson

Senate Sponsor: _____

LONG TITLE

General Description:

This bill amends the definition of "health care provider" in the Utah Health Care Malpractice Act.

Highlighted Provisions:

This bill:

- expands the definition of "health care provider" to include licensed athletic trainers;
- exempts the term "licensed athletic trainer" from the definition of "health care provider" in provisions of the insurance code; and
- makes technical changes.

Money Appropriated in this Bill:

None

Other Special Clauses:

None

Utah Code Sections Affected:

AMENDS:

31A-8a-102, as last amended by Laws of Utah 2008, Chapter 3

31A-22-617, as last amended by Laws of Utah 2009, Chapter 12

31A-29-103, as last amended by Laws of Utah 2011, Chapters 284 and 400

78B-3-403, as last amended by Laws of Utah 2009, Chapter 220

H.B. 146

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

Section 1. Section **31A-8a-102** is amended to read:

31A-8a-102. Definitions.

For purposes of this chapter:

(1) "Fee" means any periodic charge for use of a discount program.

(2) "Health care provider" means a health care provider as defined in Section 78B-3-403, with the exception of "licensed athletic trainer," who:

(a) is practicing within the scope of the provider's license; and

(b) has agreed either directly or indirectly, by contract or any other arrangement with a health discount program operator, to provide a discount to enrollees of a health discount program.

(3) "Health discount program" means a business arrangement or contract in which a person pays fees, dues, charges, or other consideration in exchange for a program that provides access to health care providers who agree to provide a discount for health care services.

(4) "Operates a health discount program" or "health discount program operator" means to:

(a) enter into a contract or agreement either directly or indirectly with a health care provider in this state which the health care provider agrees to provide discounts to enrollees of the health discount program;

(b) enter into a contract or agreement either directly or indirectly with a person in this state to provide access to more than one health care provider who has agreed to provide discounts for medical services to enrollees of the health discount program;

(c) sell or distribute a health discount program in this state; or

(d) place your name on and market or promote a health discount program in this state.

(5) "Value-added benefit" means a discount offering with no additional charge made by a health insurer or health maintenance organization that is licensed under this title, in connection with existing contracts with the health insurer or health maintenance organization.

Section 2. Section **31A-22-617** is amended to read:

31A-22-617. Preferred provider contract provisions.

Health insurance policies may provide for insureds to receive services or reimbursement under the policies in accordance with preferred health care provider contracts as

follows:

(1) Subject to restrictions under this section, any insurer or third party administrator may enter into contracts with health care providers as defined in Section 78B-3-403 under which the health care providers agree to supply services, at prices specified in the contracts, to persons insured by an insurer.

(a) (i) A health care provider contract may require the health care provider to accept the specified payment as payment in full, relinquishing the right to collect additional amounts from the insured person.

(ii) In any dispute involving a provider's claim for reimbursement, the same shall be determined in accordance with applicable law, the provider contract, the subscriber contract, and the insurer's written payment policies in effect at the time services were rendered.

(iii) If the parties are unable to resolve their dispute, the matter shall be subject to binding arbitration by a jointly selected arbitrator. Each party is to bear its own expense except the cost of the jointly selected arbitrator shall be equally shared. This Subsection (1)(a)(iii) does not apply to the claim of a general acute hospital to the extent it is inconsistent with the hospital's provider agreement.

(iv) An organization may not penalize a provider solely for pursuing a claims dispute or otherwise demanding payment for a sum believed owing.

(v) If an insurer permits another entity with which it does not share common ownership or control to use or otherwise lease one or more of the organization's networks of participating providers, the organization shall ensure, at a minimum, that the entity pays participating providers in accordance with the same fee schedule and general payment policies as the organization would for that network.

(b) The insurance contract may reward the insured for selection of preferred health care providers by:

(i) reducing premium rates;

(ii) reducing deductibles;

(iii) coinsurance;

(iv) other copayments; or

(v) any other reasonable manner.

(c) If the insurer is a managed care organization, as defined in Subsection

31A-27a-403(1)(f):

(i) the insurance contract and the health care provider contract shall provide that in the event the managed care organization becomes insolvent, the rehabilitator or liquidator may:

(A) require the health care provider to continue to provide health care services under the contract until the earlier of:

(I) 90 days after the date of the filing of a petition for rehabilitation or the petition for liquidation; or

(II) the date the term of the contract ends; and

(B) subject to Subsection (1)(c)(v), reduce the fees the provider is otherwise entitled to receive from the managed care organization during the time period described in Subsection (1)(c)(i)(A);

(ii) the provider is required to:

(A) accept the reduced payment under Subsection (1)(c)(i)(B) as payment in full; and

(B) relinquish the right to collect additional amounts from the insolvent managed care organization's enrollee, as defined in Subsection 31A-27a-403(1)(b);

(iii) if the contract between the health care provider and the managed care organization has not been reduced to writing, or the contract fails to contain the language required by Subsection (1)(c)(i), the provider may not collect or attempt to collect from the enrollee:

(A) sums owed by the insolvent managed care organization; or

(B) the amount of the regular fee reduction authorized under Subsection (1)(c)(i)(B);

(iv) the following may not bill or maintain any action at law against an enrollee to collect sums owed by the insolvent managed care organization or the amount of the regular fee reduction authorized under Subsection (1)(c)(i)(B):

(A) a provider;

(B) an agent;

(C) a trustee; or

(D) an assignee of a person described in Subsections (1)(c)(iv)(A) through (C); and

(v) notwithstanding Subsection (1)(c)(i):

(A) a rehabilitator or liquidator may not reduce a fee by less than 75% of the provider's regular fee set forth in the contract; and

(B) the enrollee shall continue to pay the copayments, deductibles, and other payments

for services received from the provider that the enrollee was required to pay before the filing of:

(I) a petition for rehabilitation; or

(II) a petition for liquidation.

(2) (a) Subject to Subsections (2)(b) through (2)(f), an insurer using preferred health care provider contracts shall pay for the services of health care providers not under the contract, unless the illnesses or injuries treated by the health care provider are not within the scope of the insurance contract. As used in this section, "class of health care providers" means all health care providers licensed or licensed and certified by the state within the same professional, trade, occupational, or facility licensure or licensure and certification category established pursuant to Titles 26, Utah Health Code and 58, Occupations and Professions.

(b) (i) Until July 1, 2012, when the insured receives services from a health care provider not under contract, the insurer shall reimburse the insured for at least 75% of the average amount paid by the insurer for comparable services of preferred health care providers who are members of the same class of health care providers.

(ii) Notwithstanding Subsection (2)(b)(i), an insurer may offer a health plan that complies with the provisions of Subsection 31A-22-618.5(3).

(iii) The commissioner may adopt a rule dealing with the determination of what constitutes 75% of the average amount paid by the insurer under Subsection (2)(b)(i) for comparable services of preferred health care providers who are members of the same class of health care providers.

(c) When reimbursing for services of health care providers not under contract, the insurer may make direct payment to the insured.

(d) Notwithstanding Subsection (2)(b), an insurer using preferred health care provider contracts may impose a deductible on coverage of health care providers not under contract.

(e) When selecting health care providers with whom to contract under Subsection (1), an insurer may not unfairly discriminate between classes of health care providers, but may discriminate within a class of health care providers, subject to Subsection (7).

(f) For purposes of this section, unfair discrimination between classes of health care providers shall include:

(i) refusal to contract with class members in reasonable proportion to the number of

insureds covered by the insurer and the expected demand for services from class members; and

(ii) refusal to cover procedures for one class of providers that are:

(A) commonly utilized by members of the class of health care providers for the treatment of illnesses, injuries, or conditions;

(B) otherwise covered by the insurer; and

(C) within the scope of practice of the class of health care providers.

(3) Before the insured consents to the insurance contract, the insurer shall fully disclose to the insured that it has entered into preferred health care provider contracts. The insurer shall provide sufficient detail on the preferred health care provider contracts to permit the insured to agree to the terms of the insurance contract. The insurer shall provide at least the following information:

(a) a list of the health care providers under contract and if requested their business locations and specialties;

(b) a description of the insured benefits, including any deductibles, coinsurance, or other copayments;

(c) a description of the quality assurance program required under Subsection (4); and

(d) a description of the adverse benefit determination procedures required under Subsection (5).

(4) (a) An insurer using preferred health care provider contracts shall maintain a quality assurance program for assuring that the care provided by the health care providers under contract meets prevailing standards in the state.

(b) The commissioner in consultation with the executive director of the Department of Health may designate qualified persons to perform an audit of the quality assurance program. The auditors shall have full access to all records of the organization and its health care providers, including medical records of individual patients.

(c) The information contained in the medical records of individual patients shall remain confidential. All information, interviews, reports, statements, memoranda, or other data furnished for purposes of the audit and any findings or conclusions of the auditors are privileged. The information is not subject to discovery, use, or receipt in evidence in any legal proceeding except hearings before the commissioner concerning alleged violations of this section.

(5) An insurer using preferred health care provider contracts shall provide a reasonable procedure for resolving complaints and adverse benefit determinations initiated by the insureds and health care providers.

(6) An insurer may not contract with a health care provider for treatment of illness or injury unless the health care provider is licensed to perform that treatment.

(7) (a) A health care provider or insurer may not discriminate against a preferred health care provider for agreeing to a contract under Subsection (1).

(b) Any health care provider licensed to treat any illness or injury within the scope of the health care provider's practice, who is willing and able to meet the terms and conditions established by the insurer for designation as a preferred health care provider, shall be able to apply for and receive the designation as a preferred health care provider. Contract terms and conditions may include reasonable limitations on the number of designated preferred health care providers based upon substantial objective and economic grounds, or expected use of particular services based upon prior provider-patient profiles.

(8) Upon the written request of a provider excluded from a provider contract, the commissioner may hold a hearing to determine if the insurer's exclusion of the provider is based on the criteria set forth in Subsection (7)(b).

(9) Insurers are subject to the provisions of Sections 31A-22-613.5, 31A-22-614.5, and 31A-22-618.

(10) Nothing in this section is to be construed as to require an insurer to offer a certain benefit or service as part of a health benefit plan.

(11) This section does not apply to catastrophic mental health coverage provided in accordance with Section 31A-22-625.

(12) Notwithstanding the provisions of Subsection (1), an insurer or third party administrator is not required to, but may, enter into contracts with licensed athletic trainers, licensed under Title 58, Chapter 40a, Athletic Trainer Licensing Act.

Section 3. Section **31A-29-103** is amended to read:

31A-29-103. Definitions.

As used in this chapter:

(1) "Board" means the board of directors of the pool created in Section 31A-29-104.

(2) (a) "Creditable coverage" has the same meaning as provided in Section 31A-1-301.

(b) "Creditable coverage" does not include a period of time in which there is a significant break in coverage, as defined in Section 31A-1-301.

(3) "Domicile" means the place where an individual has a fixed and permanent home and principal establishment:

(a) to which the individual, if absent, intends to return; and

(b) in which the individual, and the individual's family voluntarily reside, not for a special or temporary purpose, but with the intention of making a permanent home.

(4) "Enrollee" means an individual who has met the eligibility requirements of the pool and is covered by a pool policy under this chapter.

(5) "Health benefit plan":

(a) is defined in Section 31A-1-301; and

(b) does not include a plan that:

(i) (A) has a maximum actuarial value less than 100% of a health benefit plan described in Subsection (5)(c); or

(B) has a maximum annual limit of $100,000 or less; and

(ii) meets other criteria established by the board.

(c) For purposes of Subsection (5)(b)(i)(A) the health benefit plan shall:

(i) be a federally qualified high deductible health plan;

(ii) have a deductible that has the lowest deductible that qualifies as a federally qualified high deductible health plan as adjusted by federal law; and

(iii) not exceed an annual out-of-pocket maximum equal to three times the amount of the deductible.

(6) "Health care facility" means any entity providing health care services which is licensed under Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act.

(7) "Health care insurance" is defined in Section 31A-1-301.

(8) "Health care provider" has the same meaning as provided in Section 78B-3-403[-]. with the exception of "licensed athletic trainer."

(9) "Health care services" means:

(a) any service or product:

(i) used in furnishing to any individual medical care or hospitalization; or

(ii) incidental to furnishing medical care or hospitalization; and

(b) any other service or product furnished for the purpose of preventing, alleviating, curing, or healing human illness or injury.

(10) "Health maintenance organization" has the same meaning as provided in Section 31A-8-101.

(11) "Health plan" means any arrangement by which an individual, including a dependent or spouse, covered or making application to be covered under the pool has:

(a) access to hospital and medical benefits or reimbursement including group or individual insurance or subscriber contract;

(b) coverage through:

(i) a health maintenance organization;

(ii) a preferred provider prepayment;

(iii) group practice;

(iv) individual practice plan; or

(v) health care insurance;

(c) coverage under an uninsured arrangement of group or group-type contracts including employer self-insured, cost-plus, or other benefits methodologies not involving insurance;

(d) coverage under a group type contract which is not available to the general public and can be obtained only because of connection with a particular organization or group; and

(e) coverage by Medicare or other governmental benefit.

(12) "HIPAA" means the Health Insurance Portability and Accountability Act.

(13) "HIPAA eligible" means an individual who is eligible under the provisions of the Health Insurance Portability and Accountability Act.

(14) "Insurer" means:

(a) an insurance company authorized to transact accident and health insurance business in this state;

(b) a health maintenance organization; or

(c) a self-insurer not subject to federal preemption.

(15) "Medicaid" means coverage under Title XIX of the Social Security Act, 42 U.S.C. Sec. 1396 et seq., as amended.

(16) "Medicare" means coverage under both Part A and B of Title XVIII of the Social

Security Act, 42 U.S.C. Sec. 1395 et seq., as amended.

(17) "Plan of operation" means the plan developed by the board in accordance with Section 31A-29-105 and includes the articles, bylaws, and operating rules adopted by the board under Section 31A-29-106.

(18) "Pool" means the Utah Comprehensive Health Insurance Pool created in Section 31A-29-104.

(19) "Pool fund" means the Comprehensive Health Insurance Pool Enterprise Fund created in Section 31A-29-120.

(20) "Pool policy" means a health benefit plan policy issued under this chapter.

(21) "Preexisting condition" has the same meaning as defined in Section 31A-1-301.

(22) (a) "Resident" or "residency" means a person who is domiciled in this state.

(b) A resident retains residency if that resident leaves this state:

(i) to serve in the armed forces of the United States; or

(ii) for religious or educational purposes.

(23) "Third party administrator" has the same meaning as provided in Section 31A-1-301.

Section 4. Section **78B-3-403** is amended to read:

78B-3-403. Definitions.

As used in this part:

(1) "Audiologist" means a person licensed to practice audiology under Title 58, Chapter 41, Speech-language Pathology and Audiology Licensing Act.

(2) "Certified social worker" means a person licensed to practice as a certified social worker under Section 58-60-205.

(3) "Chiropractic physician" means a person licensed to practice chiropractic under Title 58, Chapter 73, Chiropractic Physician Practice Act.

(4) "Clinical social worker" means a person licensed to practice as a clinical social worker under Section 58-60-205.

(5) "Commissioner" means the commissioner of insurance as provided in Section 31A-2-102.

(6) "Dental hygienist" means a person licensed to engage in the practice of dental hygiene as defined in Section 58-69-102.

(7) "Dentist" means a person licensed to engage in the practice of dentistry as defined in Section 58-69-102.

(8) "Division" means the Division of Occupational and Professional Licensing created in Section 58-1-103.

(9) "Future damages" includes a judgment creditor's damages for future medical treatment, care or custody, loss of future earnings, loss of bodily function, or future pain and suffering.

(10) "Health care" means any act or treatment performed or furnished, or which should have been performed or furnished, by any health care provider for, to, or on behalf of a patient during the patient's medical care, treatment, or confinement.

(11) "Health care facility" means general acute hospitals, specialty hospitals, home health agencies, hospices, nursing care facilities, assisted living facilities, birthing centers, ambulatory surgical facilities, small health care facilities, health care facilities owned or operated by health maintenance organizations, and end stage renal disease facilities.

(12) "Health care provider" includes any person, partnership, association, corporation, or other facility or institution who causes to be rendered or who renders health care or professional services as a hospital, health care facility, physician, registered nurse, licensed practical nurse, nurse-midwife, licensed Direct-entry midwife, dentist, dental hygienist, optometrist, clinical laboratory technologist, pharmacist, physical therapist, physical therapist assistant, podiatric physician, psychologist, chiropractic physician, naturopathic physician, osteopathic physician, osteopathic physician and surgeon, audiologist, speech-language pathologist, clinical social worker, certified social worker, social service worker, marriage and family counselor, practitioner of obstetrics, licensed athletic trainer, or others rendering similar care and services relating to or arising out of the health needs of persons or groups of persons and officers, employees, or agents of any of the above acting in the course and scope of their employment.

(13) "Hospital" means a public or private institution licensed under Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act.

(14) "Licensed athletic trainer" means a person licensed under Title 58, Chapter 40a, Athletic Trainer Licensing Act.

[~~(14)~~] (15) "Licensed Direct-entry midwife" means a person licensed under the

Direct-entry Midwife Act to engage in the practice of direct-entry midwifery as defined in Section 58-77-102.

[~~(15)~~] (16) "Licensed practical nurse" means a person licensed to practice as a licensed practical nurse as provided in Section 58-31b-301.

[~~(16)~~] (17) "Malpractice action against a health care provider" means any action against a health care provider, whether in contract, tort, breach of warranty, wrongful death, or otherwise, based upon alleged personal injuries relating to or arising out of health care rendered or which should have been rendered by the health care provider.

[~~(17)~~] (18) "Marriage and family therapist" means a person licensed to practice as a marriage therapist or family therapist under Sections 58-60-305 and 58-60-405.

[~~(18)~~] (19) "Naturopathic physician" means a person licensed to engage in the practice of naturopathic medicine as defined in Section 58-71-102.

[~~(19)~~] (20) "Nurse-midwife" means a person licensed to engage in practice as a nurse midwife under Section 58-44a-301.

[~~(20)~~] (21) "Optometrist" means a person licensed to practice optometry under Title 58, Chapter 16a, Utah Optometry Practice Act.

[~~(21)~~] (22) "Osteopathic physician" means a person licensed to practice osteopathy under Title 58, Chapter 68, Utah Osteopathic Medical Practice Act.

[~~(22)~~] (23) "Patient" means a person who is under the care of a health care provider, under a contract, express or implied.

[~~(23)~~] (24) "Periodic payments" means the payment of money or delivery of other property to a judgment creditor at intervals ordered by the court.

[~~(24)~~] (25) "Pharmacist" means a person licensed to practice pharmacy as provided in Section 58-17b-301.

[~~(25)~~] (26) "Physical therapist" means a person licensed to practice physical therapy under Title 58, Chapter 24b, Physical Therapy Practice Act.

[~~(26)~~] (27) "Physical therapist assistant" means a person licensed to practice physical therapy, within the scope of a physical therapist assistant license, under Title 58, Chapter 24b, Physical Therapy Practice Act.

[~~(27)~~] (28) "Physician" means a person licensed to practice medicine and surgery under Title 58, Chapter 67, Utah Medical Practice Act.

[~~(28)~~] (29) "Podiatric physician" means a person licensed to practice podiatry under Title 58, Chapter 5a, Podiatric Physician Licensing Act.

[~~(29)~~] (30) "Practitioner of obstetrics" means a person licensed to practice as a physician in this state under Title 58, Chapter 67, Utah Medical Practice Act, or under Title 58, Chapter 68, Utah Osteopathic Medical Practice Act.

[~~(30)~~] (31) "Psychologist" means a person licensed under Title 58, Chapter 61, Psychologist Licensing Act, to engage in the practice of psychology as defined in Section 58-61-102.

[~~(31)~~] (32) "Registered nurse" means a person licensed to practice professional nursing as provided in Section 58-31b-301.

[~~(32)~~] (33) "Relative" means a patient's spouse, parent, grandparent, stepfather, stepmother, child, grandchild, brother, sister, half brother, half sister, or spouse's parents. The term includes relationships that are created as a result of adoption.

[~~(33)~~] (34) "Representative" means the spouse, parent, guardian, trustee, attorney-in-fact, person designated to make decisions on behalf of a patient under a medical power of attorney, or other legal agent of the patient.

[~~(34)~~] (35) "Social service worker" means a person licensed to practice as a social service worker under Section 58-60-205.

[~~(35)~~] (36) "Speech-language pathologist" means a person licensed to practice speech-language pathology under Title 58, Chapter 41, Speech-language Pathology and Audiology Licensing Act.

[~~(36)~~] (37) "Tort" means any legal wrong, breach of duty, or negligent or unlawful act or omission proximately causing injury or damage to another.

[~~(37)~~] (38) "Unanticipated outcome" means the outcome of a medical treatment or procedure that differs from an expected result.

Legislative Review Note
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