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H.B. 174

1 # HEALTH INSURANCE -- ATHLETIC TRAINER SERVICES

2 2016 GENERAL SESSION

3 STATE OF UTAH

4 **Chief Sponsor: Dean Sanpei**

5 Senate Sponsor: ____________

6

7 **LONG TITLE**

8 **General Description:**

9 This bill amends the Insurance Code.

10 **Highlighted Provisions:**

11 This bill:

12 ▸ repeals an exclusion from preferred provider nondiscrimination provisions for

13 athletic trainer services; and

14 ▸ makes technical changes.

15 **Money Appropriated in this Bill:**

16 None

17 **Other Special Clauses:**

18 None

19 **Utah Code Sections Affected:**

20 AMENDS:

21 31A-22-617, as last amended by Laws of Utah 2014, Chapters 290 and 300

22

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

24 Section 1. Section **31A-22-617** is amended to read:

25 **31A-22-617. Preferred provider contract provisions.**

26 Health insurance policies may provide for insureds to receive services or

27 reimbursement under the policies in accordance with preferred health care provider contracts as

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28 follows:

29 (1) Subject to restrictions under this section, an insurer or third party administrator may

30 enter into contracts with health care providers as defined in Section 78B-3-403 under which the

31 health care providers agree to supply services, at prices specified in the contracts, to persons

32 insured by an insurer.

33 (a) (i) A health care provider contract may require the health care provider to accept the

34 specified payment in this Subsection (1) as payment in full, relinquishing the right to collect

35 additional amounts from the insured person.

36 (ii) In a dispute involving a provider's claim for reimbursement, the same shall be

37 determined in accordance with applicable law, the provider contract, the subscriber contract,

38 and the insurer's written payment policies in effect at the time services were rendered.

39 (iii) If the parties are unable to resolve their dispute, the matter shall be subject to

40 binding arbitration by a jointly selected arbitrator. Each party [~~is to~~] shall bear its own

41 expense, except that the cost of the jointly selected arbitrator shall be equally shared. This

42 Subsection (1)(a)(iii) does not apply to the claim of a general acute hospital to the extent it is

43 inconsistent with the hospital's provider agreement.

44 (iv) An organization may not penalize a provider solely for pursuing a claims dispute

45 or otherwise demanding payment for a sum believed owing.

46 (v) If an insurer permits another entity with which it does not share common ownership

47 or control to use or otherwise lease one or more of the organization's networks of participating

48 providers, the organization shall ensure, at a minimum, that the entity pays participating

49 providers in accordance with the same fee schedule and general payment policies as the

50 organization would for that network.

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

52 providers by:

53 (i) reducing premium rates;

54 (ii) reducing deductibles;

55 (iii) coinsurance;

56 (iv) other copayments; or

57 (v) any other reasonable manner.

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

59 31A-27a-403(1)(f):
60 (i) the insurance contract and the health care provider contract shall provide that in the
61 event the managed care organization becomes insolvent, the rehabilitator or liquidator may:
62 (A) require the health care provider to continue to provide health care services under
63 the contract until the earlier of:
64 (I) 90 days after the date of the filing of a petition for rehabilitation or [~~the~~] a petition
65 for liquidation; or
66 (II) the date the term of the contract ends; and
67 (B) subject to Subsection (1)(c)(v), reduce the fees the provider is otherwise entitled to
68 receive from the managed care organization during the time period described in Subsection
69 (1)(c)(i)(A);
70 (ii) the provider is required to:
71 (A) accept the reduced payment under Subsection (1)(c)(i)(B) as payment in full; and
72 (B) relinquish the right to collect additional amounts from the insolvent managed care
73 organization's enrollee, as defined in Subsection 31A-27a-403(1)(b);
74 (iii) if the contract between the health care provider and the managed care organization
75 has not been reduced to writing, or the contract fails to contain the requirements described in
76 Subsection (1)(c)(i), the provider may not collect or attempt to collect from the enrollee:
77 (A) sums owed by the insolvent managed care organization; or
78 (B) the amount of the regular fee reduction authorized under Subsection (1)(c)(i)(B);
79 (iv) the following may not bill or maintain an action at law against an enrollee to
80 collect sums owed by the insolvent managed care organization or the amount of the regular fee
81 reduction authorized under Subsection (1)(c)(i)(B):
82 (A) a provider;
83 (B) an agent;
84 (C) a trustee; or
85 (D) an assignee of a person described in Subsections (1)(c)(iv)(A) through (C); and
86 (v) notwithstanding Subsection (1)(c)(i):
87 (A) a rehabilitator or liquidator may not reduce a fee by less than 75% of the provider's
88 regular fee set forth in the contract; and
89 (B) the enrollee shall continue to pay the copayments, deductibles, and other payments

90 for services received from the provider that the enrollee was required to pay before the filing
91 of:
92 (I) a petition for rehabilitation; or
93 (II) a petition for liquidation.
94 (2) (a) Subject to Subsections (2)(b) through (2)(e), an insurer using preferred health
95 care provider contracts is subject to the reimbursement requirements in Section 31A-8-501 on
96 or after January 1, 2014.
97 (b) When reimbursing for services of health care providers not under contract, the
98 insurer may make direct payment to the insured.
99 (c) An insurer using preferred health care provider contracts may impose a deductible
100 on coverage of health care providers not under contract.
101 (d) When selecting health care providers with whom to contract under Subsection (1),
102 an insurer may not unfairly discriminate between classes of health care providers, but may
103 discriminate within a class of health care providers, subject to Subsection (7).
104 (e) For purposes of this section, unfair discrimination between classes of health care
105 providers includes:
106 (i) refusal to contract with class members in reasonable proportion to the number of
107 insureds covered by the insurer and the expected demand for services from class members; and
108 (ii) refusal to cover procedures for one class of providers that are:
109 (A) commonly used by members of the class of health care providers for the treatment
110 of illnesses, injuries, or conditions;
111 (B) otherwise covered by the insurer; and
112 (C) within the scope of practice of the class of health care providers.
113 (3) Before the insured consents to the insurance contract, the insurer shall fully disclose
114 to the insured that it has entered into preferred health care provider contracts. The insurer shall
115 provide sufficient detail on the preferred health care provider contracts to permit the insured to
116 agree to the terms of the insurance contract. The insurer shall provide at least the following
117 information:
118 (a) a list of the health care providers under contract, and if requested their business
119 locations and specialties;
120 (b) a description of the insured benefits, including deductibles, coinsurance, or other

121 copayments;
122 (c) a description of the quality assurance program required under Subsection (4); and
123 (d) a description of the adverse benefit determination procedures required under
124 Subsection (5).
125 (4) (a) An insurer using preferred health care provider contracts shall maintain a quality
126 assurance program for [~~assuring~~] ensuring that the care provided by the health care providers
127 under contract meets prevailing standards in the state.
128 (b) The commissioner, in consultation with the executive director of the Department of
129 Health, may designate qualified persons to perform an audit of the quality assurance program.
130 The auditors shall have full access to all records of the organization and its health care
131 providers, including medical records of individual patients.
132 (c) The information contained in the medical records of individual patients shall
133 remain confidential. All information, interviews, reports, statements, memoranda, or other data
134 furnished for purposes of the audit and any findings or conclusions of the auditors are
135 privileged. The information is not subject to discovery, use, or receipt in evidence in any legal
136 proceeding except hearings before the commissioner concerning alleged violations of this
137 section.
138 (5) An insurer using preferred health care provider contracts shall provide a reasonable
139 procedure for resolving complaints and adverse benefit determinations initiated by the insureds
140 and health care providers.
141 (6) An insurer may not contract with a health care provider for treatment of illness or
142 injury unless the health care provider is licensed to perform that treatment.
143 (7) (a) A health care provider or insurer may not discriminate against a preferred health
144 care provider for agreeing to a contract under Subsection (1).
145 (b) A health care provider licensed to treat an illness or injury within the scope of the
146 health care provider's practice, who is willing and able to meet the terms and conditions
147 established by the insurer for designation as a preferred health care provider, shall be able to
148 apply for and receive the designation as a preferred health care provider. Contract terms and
149 conditions may include reasonable [~~limitations~~] limits on the number of designated preferred
150 health care providers based upon substantial objective and economic grounds, or expected use
151 of particular services based upon prior provider-patient profiles.

152 (8) Upon the written request of a provider excluded from a provider contract, the
153 commissioner may hold a hearing to determine if the insurer's exclusion of the provider is
154 based on the criteria set forth in Subsection (7)(b).
155 (9) Nothing in this section [~~is to~~] may be construed as to require an insurer to offer a
156 certain benefit or service as part of a health benefit plan.
157 (10) This section does not apply to catastrophic mental health coverage provided in
158 accordance with Section 31A-22-625.
159 [~~(11) Notwithstanding Subsection (1), Subsection (7)(b), and Section 31A-22-618, an~~
160 ~~insurer or third party administrator is not required to, but may, enter into a contract with a~~
161 ~~licensed athletic trainer, licensed under Title 58, Chapter 40a, Athletic Trainer Licensing Act.~~]

Legislative Review Note
Office of Legislative Research and General Counsel