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₵ 03-02-17 1:34 PM ₵

H.B. 395
3rd Sub. (Cherry)

Representative James A. Dunnigan proposes the following substitute bill:

HEALTH INSURANCE AMENDMENTS

2017 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: James A. Dunnigan

Senate Sponsor: _____

LONG TITLE

General Description:

This bill establishes standards a health insurance managed care organization must follow for health care provider network adequacy and payment for out of network emergency department services.

Highlighted Provisions:

This bill:

- ▸ effective January 1, 2018:
  - establishes provider network adequacy standards for managed care organizations;
  - establishes standards for provider directories;
  - requires reimbursement of health care providers who provide out of network emergency services or post stabilization care to an enrollee;
  - establishes a reimbursement benchmark for out of network emergency services and post stabilization care;
  - prohibits a health care provider who is reimbursed by a managed care organization, based on the benchmark, from balance billing an enrollee in an amount that exceeds a certain cap;
  - requires a health care provider to give an enrollee notice of certain rights if the

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health care provider sends an enrollee a bill for emergency services; and

- makes it a violation of licensing laws for a health care provider to balance bill an enrollee under certain circumstances;
  - exempts certain non-network providers from the reimbursement and balance billing requirements; and
  - makes technical amendments and conforming amendments.

Money Appropriated in this Bill:

None

Other Special Clauses:

This bill provides a special effective date.

Utah Code Sections Affected:

AMENDS:

31A-8-101, as last amended by Laws of Utah 2002, Chapter 308

31A-8-105, as last amended by Laws of Utah 1998, Chapter 329

31A-8-213, as last amended by Laws of Utah 2007, Chapter 309

31A-22-618.5, as last amended by Laws of Utah 2014, Chapters 290 and 300

ENACTS:

26-21-30, Utah Code Annotated 1953

31A-22-645, Utah Code Annotated 1953

31A-22-646, Utah Code Annotated 1953

31A-22-647, Utah Code Annotated 1953

58-1-509, Utah Code Annotated 1953

REPEALS:

31A-8-104, as last amended by Laws of Utah 1997, Chapter 185

31A-8-408, as last amended by Laws of Utah 2002, Chapter 308

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

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

26-21-30. Violation of chapter.

(1) For purposes of this section:

(a) "Balanced billing" means the same as that term is defined in Section 31A-22-645.

(b) "Emergency services" means the same as that term is defined in Section 31A-22-645.

(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-22-647.

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

Section 2. Section **31A-8-101** is amended to read:

31A-8-101. Definitions.

For purposes of this chapter:

(1) "Basic health care services" means:

(a) emergency care;

(b) inpatient hospital and physician care;

(c) outpatient medical services; and

(d) out-of-area coverage.

(2) "Director of health" means:

(a) the executive director of the Department of Health; or

(b) the authorized representative of the executive director of the Department of Health.

(3) "Enrollee" means an individual:

(a) who has entered into a contract with an organization for health care; or

(b) in whose behalf an arrangement for health care has been made.

(4) "Health care" is as defined in Section 31A-1-301.

(5) "Health maintenance organization" means any person:

(a) other than:

(i) an insurer licensed under Chapter 7, Nonprofit Health Service Insurance Corporations; or

(ii) an individual who contracts to render professional or personal services that the individual directly performs; and

(b) that:

(i) furnishes at a minimum, either directly or through arrangements with others, basic health care services to an enrollee in return for prepaid periodic payments agreed to in amount prior to the time during which the health care may be furnished; and

(ii) is obligated to the enrollee to arrange for or to directly provide available and

accessible health care.

(6) (a) "Limited health plan" means, except as limited under Subsection (6)(b), any person who furnishes, either directly or through arrangements with others, services:

(i) of:

(A) dentists;

(B) optometrists;

(C) physical therapists;

(D) podiatrists;

(E) psychologists;

(F) physicians;

(G) chiropractic physicians;

(H) naturopathic physicians;

(I) osteopathic physicians;

(J) social workers;

(K) family counselors;

(L) other health care providers; or

(M) reasonable combinations of the services described in this Subsection (6)(a)(i);

(ii) to an enrollee;

(iii) in return for prepaid periodic payments agreed to in amount prior to the time during which the services may be furnished; and

(iv) for which the person is obligated to the enrollee to arrange for or directly provide the available and accessible services described in this Subsection (6)(a).

(b) "Limited health plan" does not include:

(i) a health maintenance organization;

(ii) an insurer licensed under Chapter 7, Nonprofit Health Service Insurance Corporations; or

(iii) an individual who contracts to render professional or personal services that the individual performs.

(7) (a) "Nonprofit organization" or "nonprofit corporation" means an organization no part of the income of which is distributable to its members, trustees, or officers, or a nonprofit cooperative association, except in a manner allowed under Section 31A-8-406.

(b) "Nonprofit health maintenance organization" and "nonprofit limited health plan" are used when referring specifically to one of the types of organizations with "nonprofit" status.

(8) "Organization" means a health maintenance organization and limited health plan, unless used in the context of:

(a) "organization permit," which is described in Sections 31A-8-204 and 31A-8-206; or

(b) "organization expenses," which is described in Section 31A-8-208.

(9) "Participating provider" means a provider as defined in Subsection (10) who, under a contract with the health maintenance organization, agrees to provide health care services to enrollees with an expectation of receiving payment, directly or indirectly, from the health maintenance organization, other than copayment.

(10) "Provider" means any person who:

(a) furnishes health care directly to the enrollee; and

(b) is licensed or otherwise authorized to furnish the health care in this state.

(11) "Uncovered expenditures" means the costs of health care services that are covered by an organization for which an enrollee is liable in the event of the organization's insolvency.

[~~(12) "Unusual or infrequently used health services" means those health services that are projected to involve fewer than 10% of the organization's enrollees' encounters with providers, measured on an annual basis over the organization's entire enrollment.~~]

Section 3. Section **31A-8-105** is amended to read:

31A-8-105. General powers of organizations.

Organizations may:

(1) buy, sell, lease, encumber, construct, renovate, operate, or maintain hospitals, health care clinics, other health care facilities, and other real and personal property incidental to and reasonably necessary for the transaction of the business and for the accomplishment of the purposes of the organization;

(2) furnish health care through providers which are under contract with the organization;

(3) contract with insurance companies licensed in this state or with health service corporations authorized to do business in this state for insurance, indemnity, or reimbursement for the cost of health care furnished by the organization;

(4) offer to its enrollees, in addition to health care, insured indemnity benefits, but only

for emergency care, out-of-area coverage, [~~unusual or infrequently used health services as defined in Section 31A-8-101;~~] and adoption benefits as provided in Section 31A-22-610.1;

(5) receive from governmental or private agencies payments covering all or part of the cost of the health care furnished by the organization;

(6) lend money to a medical group under contract with it or with a corporation under its control to acquire or construct health care facilities or for other uses to further its program of providing health care services to its enrollees;

(7) be owned jointly by health care professionals and persons not professionally licensed without violating Utah law; and

(8) do all other things necessary for the accomplishment of the purposes of the organization.

Section 4. Section **31A-8-213** is amended to read:

31A-8-213. Certificate of authority.

(1) An organization may apply for a certificate of authority at any time prior to the expiration of its organization permit. The application shall include:

(a) a detailed statement by a principal officer about any material changes that have taken place or are likely to take place in the facts on which the issuance of the organization permit was based; and

(b) if any material changes are proposed in the business plan, the information about the changes that would be required if an organization permit were then being applied for.

(2) The commissioner shall issue a certificate of authority, if the commissioner finds that:

(a) the organization's capital and surplus complies with the requirements of Section 31A-8-209 as to the operations proposed under the new certificate of authority;

(b) there is no basis for revoking the organization permit under Section 31A-8-207;

(c) the deposit required by Section 31A-8-211 has been made; and

[~~(d) the organization satisfies the requirements of Section 31A-8-104; and~~]

[~~(c)~~] (d) all other applicable requirements of the law have been met.

(3) The certificate of authority shall specify any limits imposed by the commissioner upon the organization's business or methods of operation, including the general types of health care services the organization is authorized to provide.

(4) Upon the issuance of the certificate of authority:

(a) the board shall authorize and direct the issuance of certificates for shares, bonds, or notes subscribed to under the organization permit, and of insurance policies upon qualifying applications obtained under the organization permit; and

(b) the commissioner shall authorize the release to the organization of all funds held in escrow under Section 31A-5-208, as adopted by Section 31A-8-206.

(5) (a) An organization may at any time apply to the commissioner for a new or amended certificate of authority altering the limits on its business or methods of operation. The application shall contain or be accompanied by that information reasonably required by the commissioner under Subsections 31A-5-204(2) and 31A-8-205(2). The commissioner shall issue the new certificate as requested if the commissioner finds that the organization continues to satisfy the requirements specified under Subsection (2).

(b) If the commissioner issues an order under Chapter 27, Part 5, Administrative Actions, against an organization, the commissioner may also revoke the organization's certificate and issue a new one with any limitation the commissioner considers necessary.

Section 5. Section **31A-22-618.5** is amended to read:

31A-22-618.5. Health benefit plan offerings.

(1) The purpose of this section is to increase the range of health benefit plans available in the small group, small employer group, large group, and individual insurance markets.

(2) A health maintenance organization that is subject to Chapter 8, Health Maintenance Organizations and Limited Health Plans:

(a) shall offer to potential purchasers at least one health benefit plan that is subject to the requirements of Chapter 8, Health Maintenance Organizations and Limited Health Plans; and

(b) may offer to a potential purchaser one or more health benefit plans that:

(i) are not subject to one or more of the following:

(A) the limitations on insured indemnity benefits in Subsection 31A-8-105(4);

[~~(B) the limitation on point of service products in Subsections 31A-8-408(3) through (6);~~]

[~~(C)~~] (B) except as provided in Subsection (2)(b)(ii), basic health care services as defined in Section 31A-8-101; or

[~~(D)~~] (C) coverage mandates enacted after January 1, 2009 that are not required by federal law, provided that the insurer offers one plan under Subsection (2)(a) that covers the mandate enacted after January 1, 2009; and

(ii) when offering a health plan under this section, provide coverage for an emergency medical condition as required by Section 31A-22-627 as follows:

(A) within the organization's service area, covered services shall include health care services from nonaffiliated providers when medically necessary to stabilize an emergency medical condition; and

(B) outside the organization's service area, covered services shall include medically necessary health care services for the treatment of an emergency medical condition that are immediately required while the enrollee is outside the geographic limits of the organization's service area.

(3) An insurer that offers a health benefit plan that is not subject to Chapter 8, Health Maintenance Organizations and Limited Health Plans:

(a) may offer a health benefit plan that is not subject to Section 31A-22-618;

(b) when offering a health plan under this Subsection (3), shall provide coverage of emergency care services as required by Section 31A-22-627; and

(c) is not subject to coverage mandates enacted after January 1, 2009 that are not required by federal law, provided that an insurer offers one plan that covers a mandate enacted after January 1, 2009.

(4) Section 31A-8-106 does not prohibit the offer of a health benefit plan under Subsection (2)(b).

(5) (a) Any difference in price between a health benefit plan offered under Subsections (2)(a) and (b) shall be based on actuarially sound data.

(b) Any difference in price between a health benefit plan offered under Subsection (3)(a) shall be based on actuarially sound data.

(6) Nothing in this section limits the number of health benefit plans that an insurer may offer.

Section 6. Section **31A-22-645** is enacted to read:

31A-22-645. Access to managed care organization health care providers.

(1) As used in this section and Sections 31A-22-646 and 31A-22-647:

(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 managed care organization's allowed amount.

(ii) "Balance billing" does not include billing an enrollee for cost sharing required by the enrollee's plan, such as copayments, coinsurance, and deductibles.

(b) "Covered benefit" or "benefit" means the health care services to which a covered person is entitled under the terms of a health benefit plan.

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

(d) "Emergency services" means, with respect to an emergency 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.

(e) "Managed care organization" means:

(i) a managed care organization as that term is defined in Section 31A-1-103; and

(ii) a third-party administrator as that term is defined in Section 31A-1-103.

(f) (i) "Post stabilization care" includes services related to emergency services that:

(A) are provided by a health care provider other than providers listed in Subsection (1)(f)(ii), and are provided after an enrollee's condition is no longer considered an emergency medical condition;

(B) maintain a stabilized condition or improve or resolve the enrollee's condition; and

(C) are provided within 90 consecutive days after the day the enrollee experienced the emergency medical condition.

(ii) "Post stabilization care" does not include health care facility charges or laboratory charges.

(g) "Stabilize" means the same as that term is defined in 42 U.S.C. Sec. 1395dd(e)(3).

(2) A managed care organization offering or administering a network plan shall maintain a network that is sufficient in numbers and appropriate types of providers, including

those that serve predominantly low-income, medically underserved individuals, to ensure that all services to enrollees, including children and adults, will be accessible without unreasonable travel or delay.

(3) An enrollee under a managed care organization's network plan shall have access to emergency services 24 hours per day, seven days per week.

(4) (a) Upon the request of the commissioner, a managed care organization providing a network plan shall demonstrate to the commissioner, in accordance with Subsection (4)(b), that the managed care organization is able to provide adequate access to current and potential enrollees through a contracted network of providers and facilities for all counties within the managed care organization's filed service area.

(b) Adequate access is demonstrated if the managed care organization demonstrates compliance with Subsection (4)(c) or (d).

(c) A managed care organization demonstrates network adequacy if the managed care network meets the maximum travel time and distance standards in, and has sufficient numbers of, health care professionals, providers, and facilities to meet the minimum number of requirements set forth by:

(i) the Centers for Medicare and Medicaid Services for Medicare Advantage Plans; and

(ii) modifications to the standards in Subsection (4)(c)(i), adopted by the commissioner by administrative rule, as necessary to reflect the age demographics of the enrollees in the plans and availability of rural health care providers, and based on nationally recognized standards.

(d) A managed care organization demonstrates network adequacy if the managed care organization meets adequacy and sufficiency standards established by the commissioner by administrative rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, and this Subsection (4)(d).

(e) The commissioner shall adopt administrative rules in compliance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to establish reasonable standards under Subsection (4)(d) for:

(i) provider-covered person ratios by specialty;

(ii) primary care professional-covered person ratios;

(iii) geographic accessibility of providers;

(iv) geographic variation and population dispersion;

(v) waiting times for an appointment with participating providers;

(vi) hours of operation;

(vii) the ability of the network to meet the needs of covered persons, which may include low-income persons, children and adults with serious, chronic, or complex health conditions or physical or mental disabilities, or persons with limited English proficiency;

(viii) other health care service delivery system options, such as telemedicine or telehealth, mobile clinics, centers of excellence, and other ways of delivering health care;

(ix) the volume of technological and specialty care services available to serve the needs of covered persons requiring technologically advanced or specialty care services;

(x) the extent to which participating providers are accepting new patients;

(xi) the regionalization of specialty care, which may require some children and adults to cross state lines for care;

(xii) a number of providers within a specified area, including rural or urban areas, that takes into consideration an insured's travel time and distance to providers; and

(xiii) the manner in which a managed care organization demonstrates compliance with the criteria established under this Subsection (4).

(5) A managed care organization shall provide notice in writing to enrollees that for a covered benefit to be provided at a facility in the enrollee's health benefit plan network, there is the possibility that the enrollee could be treated by a health care provider that is not in the same network, which could result in higher cost-sharing and balance billing.

Section 7. Section **31A-22-646** is enacted to read:

31A-22-646. Managed care organization provider directories.

(1) (a) A managed care organization shall post electronically a current and accurate provider directory for each of the organization's network plans.

(b) In making the directory available electronically, the managed care organization shall ensure the general public is able to view all of the current providers for a plan through a clearly identifiable link or tab and without creating or accessing an account or entering a policy or contract number.

(c) The managed care organization shall update each network plan provider directory at least monthly. A managed care organization does not violate the requirements of this Subsection (1)(c) if a provider fails to notify the managed care organization of a change to the

provider's information.

(2) A managed care organization shall make available through an electronic provider directory, for each network plan, the information under this Subsection (2) in a searchable format:

(a) for a health care provider who is licensed under Title 58, Occupations and Professions:

(i) the health care provider's name;

(ii) the health care provider's gender;

(iii) participating office locations;

(iv) specialty and board certifications;

(v) medical group affiliations, if applicable;

(vi) participating facility affiliations, if applicable;

(vii) languages spoken, other than English, if applicable;

(viii) whether accepting new patients; and

(ix) contact information; and

(b) for facilities licensed under Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act, or Title 62A, Chapter 2, Licensure of Programs and Facilities:

(i) the facility name;

(ii) the type of facility;

(iii) participating facility locations;

(iv) facility accreditation status; and

(v) type of services performed for facilities other than hospitals.

(3) A managed care organization shall make a print copy of a current provider directory available upon request of an enrollee or a prospective enrollee at least annually.

(4) A provider directory, whether in electronic or print format, shall accommodate the communication needs of individuals with disabilities, and include a link to or information regarding available assistance for persons with limited English proficiency.

Section 8. Section **31A-22-647** is enacted to read:

31A-22-647. Managed care organization out-of-network services -- Emergency services -- Post stabilization care -- Balance billing.

(1) (a) A managed care organization shall have a process to ensure that an enrollee

obtains covered services at a network level of benefits, including a network level of cost sharing, from a non-network provider, or shall make other arrangements acceptable to the commissioner:

(i) in accordance with Section 31A-22-645; and

(ii) (A) when an enrollee is diagnosed with a condition or disease that requires specialized health care services; and

(B) when the managed care organization does not have a network provider of the required specialty with the professional training and expertise to treat or provide the health care services for the condition or disease, or cannot provide reasonable access to a network provider with the required training or expertise to treat or provide health care services for the condition or disease.

(b) A managed care organization shall:

(i) inform an enrollee of the process the enrollee may use to request access to obtain a covered benefit from a non-network provider in accordance with Subsection (1)(a);

(ii) have a system in place that documents all requests to obtain covered benefits from a non-network provider under Subsection (1)(a); and

(iii) ensure that requests to obtain a covered benefit from a non-network provider under Subsection (1)(a) are addressed in a timely fashion appropriate to the covered person's condition.

(2) (a) Except as provided in Subsection (8), a managed care organization shall reimburse a non-network provider for emergency services and post stabilization care in accordance with this section.

(b) A managed care organization shall:

(i) accept assignment of benefits from an enrollee for emergency services and post stabilization care provided by a non-network provider; and

(ii) send an explanation of benefits to the non-network provider with the information required under Subsection (5)(a).

(c) (i) Payment to a non-network provider for emergency services shall be the greater of the amount calculated under Subsection (2)(c)(ii) plus 5% of that amount.

(ii) The amount paid under Subsection (2)(c)(i) shall be the greater of:

(A) the amount negotiated with in-network providers for the emergency services

furnished, excluding any in-network copayment or coinsurance imposed with respect to the enrollee, as provided in Subsection (2)(d)(i); or

(B) the amount for the emergency services calculated using the same method the managed care organization generally uses to determine payments for out-of-network services, such as the usual, customary, and reasonable amount, excluding any in-network copayment or coinsurance imposed with respect to an enrollee, as provided in Subsection (2)(d)(ii).

(d) (i) If there is more than one amount negotiated with in-network providers for the emergency service under Subsection (2)(c)(i)(A), the amount is the median of these amounts, excluding any in-network copayment or coinsurance imposed with respect to the enrollee. In determining the median under this Subsection (2)(d)(i), the amount negotiated with each in-network provider is treated as a separate amount, even if the same amount is paid to more than one provider.

(ii) The amount under Subsection (2)(c)(ii)(B) is determined without reduction for out-of-network cost sharing that generally applies under the plan with respect to out-of-network services. For example, if a plan generally pays 70% of the usual, customary, and reasonable amount for out-of-network services, the amount under this Subsection (2)(d)(ii) for an emergency service is 100% of the usual, customary, and reasonable amount for the service, not reduced by the 30% coinsurance that would generally apply to out-of-network services, but reduced by the in-network copayment or coinsurance that the enrollee would be responsible for if the emergency service had been provided in-network.

(e) Payment to a non-network provider for post stabilization care shall be the greater of:

(i) the payment required under the applicable provisions of 45 C.F.R. Sec. 147.138; or

(ii) 100% of the in-network allowed amount for the patient's insurance plan.

(3) (a) Except as provided in Subsection (8), a non-network provider who is reimbursed under Subsection (2)(c) or (2)(e) may not balance bill an enrollee in excess of the amount under this Subsection (3).

(b) A non-network provider may balance bill an enrollee for emergency services in an amount that is the lesser of:

(i) 10% above the amount allowed under Subsection (2)(c) for the emergency services; or

(ii) $5,000.

(c) A non-network provider may not balance bill an enrollee for post stabilization care.

(4) (a) A managed care organization may elect to pay a non-network provider for emergency services or post stabilization care:

(i) as submitted by the provider;

(ii) in accordance with the benchmark established in Subsection (2)(c) or (2)(e); or

(iii) in an amount mutually agreed upon by the managed care organization and the provider.

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

(i) except as provided in Subsection (8), the enrollee is responsible for no more than:

(A) the applicable in-network cost-sharing amount; and

(B) the balance bill amount allowed under Subsection (3); and

(ii) except as provided in Subsection (8), the enrollee has no legal obligation to pay the balance for emergency services or post stabilization care remaining after the payments under Subsection (4)(b)(i).

(c) If a non-network provider sends a bill directly to an enrollee for emergency services or post stabilization care, the bill shall notify the enrollee:

(i) that the emergency services or post stabilization care were performed by a provider who is not a network provider for the enrollee's health benefit plan;

(ii) that the enrollee is responsible for paying the enrollee's applicable in-network cost sharing amount and the additional balance bill allowed under Subsection (3);

(iii) whether the enrollee has an obligation to pay the remaining balance for the emergency services;

(iv) whether the non-network provider claims an exemption under Subsection (8); and

(v) that the enrollee may contact the state insurance commissioner's office for assistance, which notice shall include contact information for the insurance department.

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

(a) may rely on the explanation of benefits provided by the managed care organization to the enrollee and the non-network provider, informing the non-network provider of:

(i) the amount the non-network provider may attempt to collect from the enrollee for the enrollee's cost sharing, including unmet deductibles, copayments, and coinsurance; and

(ii) the managed care organization's allowed amount under Subsection (2)(c) for the emergency services or Subsection (2)(e) for post stabilization care;

(b) except as provided in Subsection (8), shall accept the following payment from the enrollee as payment in full for the emergency services and post stabilization care:

(i) payment of cost sharing from the enrollee; and

(ii) payment of the additional balance bill allowed under Subsection (3); and

(c) may not attempt to collect payment from an enrollee for emergency services or post stabilization care in excess of the amount under Subsection (5)(b).

(6) 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.

(7) On or before November 30, 2019, the commissioner shall report to the Business and Labor Interim Committee regarding:

(a) the benchmarks established in Subsection (2);

(b) the balance billing allowed under Subsection (3);

(c) whether the payment benchmarks and allowed balance billing should be modified;

(d) how many health care providers claimed an exemption under Subsection (8)(a), the number of requests for assistance under Subsection (8)(b), and information about determinations under Subsection (8)(c);

(e) market conduct of managed care organizations regarding contracts with health care providers for non-network emergency services and post stabilization care; and

(f) recommendations as to whether the exemptions under Subsection (8) should continue.

(8) (a) A non-network provider is not subject to Subsections (2), (3), (4)(b), and (5)(b) of this section if:

(i) as of January 1, 2017, the non-network provider, by practice or as a result of a contract, has not balance billed more than 10% of the provider's insured patients who received out-of-network emergency services or post stabilization care; and

(ii) before January 1, 2018, the health care provider submits a statement to the

commissioner indicating that the provider is in compliance with Subsection (8)(a)(i) and is not subject to Subsections (2), (3), (4)(b), and (5)(b).

(b) An enrollee who receives a bill from a non-network provider for emergency services or post stabilization care, and who believes that the provisions of this section apply to the emergency services or post stabilization care, may request the assistance of the commissioner to determine if:

(i) the managed care organization should reimburse the provider under this section; and

(ii) the non-network provider should be subject to Subsections (2), (3), (4)(b), and (5)(b).

(c) (i) The commissioner may ask a health care provider to demonstrate compliance with Subsection (8)(a) if an enrollee who receives a balance bill requests assistance from the commissioner under Subsection (8)(b).

(ii) If the commissioner determines that the provisions of this section apply to the emergency services or the post stabilization care, the managed care organization shall reimburse the non-network provider in accordance with this section and the non-network provider is subject to the balance billing restrictions of this section.

Section 9. 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-22-645.

(b) "Emergency services" means the same as that term is defined in Section 31A-22-645.

(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-22-647.

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

Section 10. **Repealer.**

This bill repeals:

Section **31A-8-104, Determination of ability to provide services.**

Section **31A-8-408, Organizations offering point of service or point of sales products.**

Section 11. **Effective date.**

This bill takes effect on January 1, 2018.