

Superseded 5/13/2014

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)(e), an insurer using preferred health care provider contracts is subject to the reimbursement requirements in Section 31A-8-501 on or after January 1, 2014.
 - (b) When reimbursing for services of health care providers not under contract, the insurer may make direct payment to the insured.
 - (c) An insurer using preferred health care provider contracts may impose a deductible on coverage of health care providers not under contract.
 - (d) 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).
 - (e) For purposes of this section, unfair discrimination between classes of health care providers includes:
 - (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 used 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) Except as provided in Subsection 31A-22-618.5(3)(a), insurers are subject to 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), Subsection (7)(b), and Section 31A-22-618, 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.