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₵ 02-17-17 9:59 AM ₵

H.B. 395

1 # HEALTH INSURANCE AMENDMENTS

2 2017 GENERAL SESSION

3 STATE OF UTAH

4 **Chief Sponsor: James A. Dunnigan**

5 Senate Sponsor: ____________

6

7 **LONG TITLE**

8 **General Description:**

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

12 **Highlighted Provisions:**

13 This bill:

14 ▸ effective January 1, 2018:

15 • establishes provider network adequacy standards for managed care
16 organizations;

17 • establishes standards for provider directories;

18 • requires reimbursement of health care providers who provide out of network
19 emergency services to an enrollee;

20 • establishes a reimbursement benchmark for out of network emergency services;

21 • prohibits a health care provider who is reimbursed by a managed care
22 organization, based on the benchmark, from balance billing an enrollee in an
23 amount that exceeds a certain cap;

24 • requires a health care provider to give an enrollee notice of certain rights if the
25 health care provider sends an enrollee a bill for emergency services; and

26 • makes it a violation of licensing laws for a health care provider to balance bill
27 an enrollee under certain circumstances;

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28 ▸ amends the penalties under the prompt pay requirements for health insurers; and
29 ▸ makes technical amendments and conforming amendments.
30 **Money Appropriated in this Bill:**
31 None
32 **Other Special Clauses:**
33 This bill provides a special effective date.
34 **Utah Code Sections Affected:**
35 AMENDS:
36 **31A-8-101**, as last amended by Laws of Utah 2002, Chapter 308
37 **31A-8-105**, as last amended by Laws of Utah 1998, Chapter 329
38 **31A-8-213**, as last amended by Laws of Utah 2007, Chapter 309
39 **31A-22-618.5**, as last amended by Laws of Utah 2014, Chapters 290 and 300
40 **31A-26-301.6**, as last amended by Laws of Utah 2009, Chapter 11
41 ENACTS:
42 **26-21-30**, Utah Code Annotated 1953
43 **31A-22-645**, Utah Code Annotated 1953
44 **31A-22-646**, Utah Code Annotated 1953
45 **31A-22-647**, Utah Code Annotated 1953
46 **58-1-509**, Utah Code Annotated 1953
47 REPEALS:
48 **31A-8-104**, as last amended by Laws of Utah 1997, Chapter 185
49 **31A-8-408**, as last amended by Laws of Utah 2002, Chapter 308
50

51 *Be it enacted by the Legislature of the state of Utah:*
52 Section 1. Section **26-21-30** is enacted to read:
53 **26-21-30. Violation of chapter.**
54 (1) For purposes of this section:
55 (a) "Balanced billing" means the same as that term is defined in Section 31A-22-645.
56 (b) "Emergency services" means the same as that term is defined in Section
57 31A-22-645.
58 (2) Beginning January 1, 2018, it is a violation of this chapter for a health care facility

59 to balance bill a patient for emergency services in violation of Section 31A-22-647.

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

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

62 **31A-8-101. Definitions.**

63 For purposes of this chapter:

64 (1) "Basic health care services" means:

65 (a) emergency care;

66 (b) inpatient hospital and physician care;

67 (c) outpatient medical services; and

68 (d) out-of-area coverage.

69 (2) "Director of health" means:

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

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

72 (3) "Enrollee" means an individual:

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

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

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

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

77 (a) other than:

78 (i) an insurer licensed under Chapter 7, Nonprofit Health Service Insurance

79 Corporations; or

80 (ii) an individual who contracts to render professional or personal services that the

81 individual directly performs; and

82 (b) that:

83 (i) furnishes at a minimum, either directly or through arrangements with others, basic

84 health care services to an enrollee in return for prepaid periodic payments agreed to in amount

85 prior to the time during which the health care may be furnished; and

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

87 accessible health care.

88 (6) (a) "Limited health plan" means, except as limited under Subsection (6)(b), any

89 person who furnishes, either directly or through arrangements with others, services:

90 (i) of:
91 (A) dentists;
92 (B) optometrists;
93 (C) physical therapists;
94 (D) podiatrists;
95 (E) psychologists;
96 (F) physicians;
97 (G) chiropractic physicians;
98 (H) naturopathic physicians;
99 (I) osteopathic physicians;
100 (J) social workers;
101 (K) family counselors;
102 (L) other health care providers; or
103 (M) reasonable combinations of the services described in this Subsection (6)(a)(i);
104 (ii) to an enrollee;
105 (iii) in return for prepaid periodic payments agreed to in amount prior to the time
106 during which the services may be furnished; and
107 (iv) for which the person is obligated to the enrollee to arrange for or directly provide
108 the available and accessible services described in this Subsection (6)(a).
109 (b) "Limited health plan" does not include:
110 (i) a health maintenance organization;
111 (ii) an insurer licensed under Chapter 7, Nonprofit Health Service Insurance
112 Corporations; or
113 (iii) an individual who contracts to render professional or personal services that the
114 individual performs.
115 (7) (a) "Nonprofit organization" or "nonprofit corporation" means an organization no
116 part of the income of which is distributable to its members, trustees, or officers, or a nonprofit
117 cooperative association, except in a manner allowed under Section 31A-8-406.
118 (b) "Nonprofit health maintenance organization" and "nonprofit limited health plan"
119 are used when referring specifically to one of the types of organizations with "nonprofit" status.
120 (8) "Organization" means a health maintenance organization and limited health plan,

121 unless used in the context of:
122 (a) "organization permit," which is described in Sections 31A-8-204 and 31A-8-206; or
123 (b) "organization expenses," which is described in Section 31A-8-208.
124 (9) "Participating provider" means a provider as defined in Subsection (10) who, under
125 a contract with the health maintenance organization, agrees to provide health care services to
126 enrollees with an expectation of receiving payment, directly or indirectly, from the health
127 maintenance organization, other than copayment.
128 (10) "Provider" means any person who:
129 (a) furnishes health care directly to the enrollee; and
130 (b) is licensed or otherwise authorized to furnish the health care in this state.
131 (11) "Uncovered expenditures" means the costs of health care services that are covered
132 by an organization for which an enrollee is liable in the event of the organization's insolvency.
133 [~~(12) "Unusual or infrequently used health services" means those health services that~~
134 ~~are projected to involve fewer than 10% of the organization's enrollees' encounters with~~
135 ~~providers, measured on an annual basis over the organization's entire enrollment.~~]
136 Section 3. Section **31A-8-105** is amended to read:
137 **31A-8-105. General powers of organizations.**
138 Organizations may:
139 (1) buy, sell, lease, encumber, construct, renovate, operate, or maintain hospitals,
140 health care clinics, other health care facilities, and other real and personal property incidental to
141 and reasonably necessary for the transaction of the business and for the accomplishment of the
142 purposes of the organization;
143 (2) furnish health care through providers which are under contract with the
144 organization;
145 (3) contract with insurance companies licensed in this state or with health service
146 corporations authorized to do business in this state for insurance, indemnity, or reimbursement
147 for the cost of health care furnished by the organization;
148 (4) offer to its enrollees, in addition to health care, insured indemnity benefits, but only
149 for emergency care, out-of-area coverage, [~~unusual or infrequently used health services as~~
150 ~~defined in Section 31A-8-101,~~] and adoption benefits as provided in Section 31A-22-610.1;
151 (5) receive from governmental or private agencies payments covering all or part of the

152 cost of the health care furnished by the organization;
153 (6) lend money to a medical group under contract with it or with a corporation under its
154 control to acquire or construct health care facilities or for other uses to further its program of
155 providing health care services to its enrollees;
156 (7) be owned jointly by health care professionals and persons not professionally
157 licensed without violating Utah law; and
158 (8) do all other things necessary for the accomplishment of the purposes of the
159 organization.
160 Section 4. Section **31A-8-213** is amended to read:
161 **31A-8-213. Certificate of authority.**
162 (1) An organization may apply for a certificate of authority at any time prior to the
163 expiration of its organization permit. The application shall include:
164 (a) a detailed statement by a principal officer about any material changes that have
165 taken place or are likely to take place in the facts on which the issuance of the organization
166 permit was based; and
167 (b) if any material changes are proposed in the business plan, the information about the
168 changes that would be required if an organization permit were then being applied for.
169 (2) The commissioner shall issue a certificate of authority, if the commissioner finds
170 that:
171 (a) the organization's capital and surplus complies with the requirements of Section
172 31A-8-209 as to the operations proposed under the new certificate of authority;
173 (b) there is no basis for revoking the organization permit under Section 31A-8-207;
174 (c) the deposit required by Section 31A-8-211 has been made; and
175 [~~(d) the organization satisfies the requirements of Section 31A-8-104; and~~]
176 [~~(e)~~] (d) all other applicable requirements of the law have been met.
177 (3) The certificate of authority shall specify any limits imposed by the commissioner
178 upon the organization's business or methods of operation, including the general types of health
179 care services the organization is authorized to provide.
180 (4) Upon the issuance of the certificate of authority:
181 (a) the board shall authorize and direct the issuance of certificates for shares, bonds, or
182 notes subscribed to under the organization permit, and of insurance policies upon qualifying

183 applications obtained under the organization permit; and
184 (b) the commissioner shall authorize the release to the organization of all funds held in
185 escrow under Section 31A-5-208, as adopted by Section 31A-8-206.
186 (5) (a) An organization may at any time apply to the commissioner for a new or
187 amended certificate of authority altering the limits on its business or methods of operation.
188 The application shall contain or be accompanied by that information reasonably required by the
189 commissioner under Subsections 31A-5-204(2) and 31A-8-205(2). The commissioner shall
190 issue the new certificate as requested if the commissioner finds that the organization continues
191 to satisfy the requirements specified under Subsection (2).
192 (b) If the commissioner issues an order under Chapter 27, Part 5, Administrative
193 Actions, against an organization, the commissioner may also revoke the organization's
194 certificate and issue a new one with any limitation the commissioner considers necessary.
195 Section 5. Section **31A-22-618.5** is amended to read:
196 **31A-22-618.5. Health benefit plan offerings.**
197 (1) The purpose of this section is to increase the range of health benefit plans available
198 in the small group, small employer group, large group, and individual insurance markets.
199 (2) A health maintenance organization that is subject to Chapter 8, Health Maintenance
200 Organizations and Limited Health Plans:
201 (a) shall offer to potential purchasers at least one health benefit plan that is subject to
202 the requirements of Chapter 8, Health Maintenance Organizations and Limited Health Plans;
203 and
204 (b) may offer to a potential purchaser one or more health benefit plans that:
205 (i) are not subject to one or more of the following:
206 (A) the limitations on insured indemnity benefits in Subsection 31A-8-105(4);
207 [~~(B) the limitation on point of service products in Subsections 31A-8-408(3) through~~
208 ~~(6);~~]
209 [~~(C)~~] (B) except as provided in Subsection (2)(b)(ii), basic health care services as
210 defined in Section 31A-8-101; or
211 [~~(D)~~] (C) coverage mandates enacted after January 1, 2009 that are not required by
212 federal law, provided that the insurer offers one plan under Subsection (2)(a) that covers the
213 mandate enacted after January 1, 2009; and

214 (ii) when offering a health plan under this section, provide coverage for an emergency
215 medical condition as required by Section 31A-22-627 as follows:
216 (A) within the organization's service area, covered services shall include health care
217 services from nonaffiliated providers when medically necessary to stabilize an emergency
218 medical condition; and
219 (B) outside the organization's service area, covered services shall include medically
220 necessary health care services for the treatment of an emergency medical condition that are
221 immediately required while the enrollee is outside the geographic limits of the organization's
222 service area.
223 (3) An insurer that offers a health benefit plan that is not subject to Chapter 8, Health
224 Maintenance Organizations and Limited Health Plans:
225 (a) may offer a health benefit plan that is not subject to Section 31A-22-618;
226 (b) when offering a health plan under this Subsection (3), shall provide coverage of
227 emergency care services as required by Section 31A-22-627; and
228 (c) is not subject to coverage mandates enacted after January 1, 2009 that are not
229 required by federal law, provided that an insurer offers one plan that covers a mandate enacted
230 after January 1, 2009.
231 (4) Section 31A-8-106 does not prohibit the offer of a health benefit plan under
232 Subsection (2)(b).
233 (5) (a) Any difference in price between a health benefit plan offered under Subsections
234 (2)(a) and (b) shall be based on actuarially sound data.
235 (b) Any difference in price between a health benefit plan offered under Subsection
236 (3)(a) shall be based on actuarially sound data.
237 (6) Nothing in this section limits the number of health benefit plans that an insurer may
238 offer.
239 Section 6. Section **31A-22-645** is enacted to read:
240 **31A-22-645. Access to managed care organization health care providers.**
241 (1) As used in this section and Sections 31A-22-646 and 31A-22-647:
242 (a) (i) "Balance billing" means the practice of a health care provider billing an enrollee:
243 (A) for the difference between the health care provider's charge and the managed care
244 organization's allowed amount; or

245 (B) more than the balance bill cap under Subsection 31A-22-647(2)(c).
246 (ii) "Balance billing" does not include billing an enrollee for:
247 (A) cost sharing required by the enrollee's plan, such as copayments, coinsurance, and
248 deductibles; and
249 (B) an amount that is less than the balance bill cap under Subsection 31A-22-647(2)(c).
250 (b) "Covered benefit" or "benefit" means the health care services to which a covered
251 person is entitled under the terms of a health benefit plan.
252 (c) "Emergency medical condition" means the same as that term is defined in Section
253 31A-22-627.
254 (d) "Emergency services" means, with respect to an emergency condition:
255 (i) a medical or mental health screening examination that is within the capability of the
256 emergency department of a hospital, including ancillary services routinely available to the
257 emergency department to evaluate the emergency medical condition; and
258 (ii) any further medical or mental health examination and treatment, to the extent the
259 treatment or examination is within the capabilities of the emergency department and the staff,
260 to stabilize the patient.
261 (e) "Managed care organization" means:
262 (i) a managed care organization as that term is defined in Section 31A-1-103; and
263 (ii) a third-party administrator as that term is defined in Section 31A-1-103.
264 (f) "Stabilize" means the same as that term is defined in 42 U.S.C. Sec. 1395dd(e)(3).
265 (2) A managed care organization offering or administering a network plan shall
266 maintain a network that is sufficient in numbers and appropriate types of providers, including
267 those that serve predominantly low-income, medically underserved individuals, to ensure that
268 all services to enrollees, including children and adults, will be accessible without unreasonable
269 travel or delay.
270 (3) An enrollee under a managed care organization's network plan shall have access to
271 emergency services 24 hours per day, seven days per week.
272 (4) (a) Upon the request of the commissioner, a managed care organization providing a
273 network plan shall demonstrate to the commissioner, in accordance with Subsection (4)(b), that
274 the managed care organization is able to provide adequate access to current and potential
275 enrollees through a contracted network of providers and facilities for all counties within the

276 managed care organization's filed service area.
277 (b) Adequate access is demonstrated if the managed care organization demonstrates
278 compliance with Subsection (4)(c) or (d).
279 (c) A managed care organization demonstrates network adequacy if the managed care
280 network meets the maximum travel time and distance standards in, and has sufficient numbers
281 of, health care professionals, providers, and facilities to meet the minimum number of
282 requirements set forth by:
283 (i) the Centers for Medicare and Medicaid Services for Medicare Advantage Plans; and
284 (ii) modifications to the standards in Subsection (4)(c)(i), adopted by the commissioner
285 by administrative rule, as necessary to reflect the age demographics of the enrollees in the
286 plans, and based on nationally recognized standards.
287 (d) A managed care organization demonstrates network adequacy if the managed care
288 organization meets adequacy and sufficiency standards established by the commissioner by
289 administrative rule made in accordance with Title 63G, Chapter 3, Utah Administrative
290 Rulemaking Act, and this Subsection (4)(d).
291 (e) The commissioner shall adopt administrative rules in compliance with Title 63G,
292 Chapter 3, Utah Administrative Rulemaking Act, to establish reasonable standards under
293 Subsection (4)(d) for:
294 (i) provider-covered person ratios by specialty;
295 (ii) primary care professional-covered person ratios;
296 (iii) geographic accessibility of providers;
297 (iv) geographic variation and population dispersion;
298 (v) waiting times for an appointment with participating providers;
299 (vi) hours of operation;
300 (vii) the ability of the network to meet the needs of covered persons, which may
301 include low-income persons, children and adults with serious, chronic, or complex health
302 conditions or physical or mental disabilities, or persons with limited English proficiency;
303 (viii) other health care service delivery system options, such as telemedicine or
304 telehealth, mobile clinics, centers of excellence, and other ways of delivering health care;
305 (ix) the volume of technological and specialty care services available to serve the needs
306 of covered persons requiring technologically advanced or specialty care services;

307 (x) the extent to which participating providers are accepting new patients;
308 (xi) the regionalization of specialty care, which may require some children and adults
309 to cross state lines for care;
310 (xii) a number of providers within a specified area, including rural or urban areas, that
311 takes into consideration an insured's travel time and distance to providers; and
312 (xiii) the manner in which a managed care organization demonstrates compliance with
313 the criteria established under this Subsection (4).
314 (5) A managed care organization shall provide notice in writing to enrollees that for a
315 covered benefit to be provided at a facility in the enrollee's health benefit plan network, there is
316 the possibility that the enrollee could be treated by a health care provider that is not in the same
317 network, which could result in higher cost-sharing and balance billing.
318 Section 7. Section **31A-22-646** is enacted to read:
319 **31A-22-646. Managed care organization provider directories.**
320 (1) (a) A managed care organization shall post electronically a current and accurate
321 provider directory for each of the organization's network plans.
322 (b) In making the directory available electronically, the managed care organization
323 shall ensure the general public is able to view all of the current providers for a plan through a
324 clearly identifiable link or tab and without creating or accessing an account or entering a policy
325 or contract number.
326 (c) The managed care organization shall update each network plan provider directory at
327 least monthly. A managed care organization does not violate the requirements of this
328 Subsection (1)(c) if a provider fails to notify the managed care organization of a change to the
329 provider's information.
330 (2) A managed care organization shall make available through an electronic provider
331 directory, for each network plan, the information under this subsection in a searchable format:
332 (a) for a health care provider who is licensed under Title 58, Occupations and
333 Professions:
334 (i) the health care provider's name;
335 (ii) the health care provider's gender;
336 (iii) participating office locations;
337 (iv) specialty and board certifications;

338 (v) medical group affiliations, if applicable;
339 (vi) participating facility affiliations, if applicable;
340 (vii) languages spoken, other than English, if applicable;
341 (viii) whether accepting new patients; and
342 (ix) contact information; and
343 (b) for facilities licensed under Title 26, Chapter 21, Health Facility Licensing and
344 Inspection Act, or Title 62A, Chapter 2, Licensure of Programs and Facilities:
345 (i) the facility name;
346 (ii) the type of facility;
347 (iii) participating facility locations;
348 (iv) facility accreditation status; and
349 (v) for facilities other than hospitals, type of services performed.
350 (3) A managed care organization shall provide a print copy of a current provider
351 directory upon request of an enrollee or a prospective enrollee.
352 (4) A provider directory, whether in electronic or print format, shall accommodate the
353 communication needs of individuals with disabilities, and include a link to or information
354 regarding available assistance for persons with limited English proficiency.
355 Section 8. Section **31A-22-647** is enacted to read:
356 **31A-22-647. Managed care organization out-of-network services -- Emergency**
357 **services -- Balance billing.**
358 (1) (a) A managed care organization shall have a process to ensure that an enrollee
359 obtains covered services at a network level of benefits, including a network level of cost
360 sharing, from a non-network provider, or shall make other arrangements acceptable to the
361 commissioner:
362 (i) in accordance with Section 31A-22-645; and
363 (ii) (A) when an enrollee is diagnosed with a condition or disease that requires
364 specialized health care services; and
365 (B) the managed care organization does not have a network provider of the required
366 specialty with the professional training and expertise to treat or provide the health care services
367 for the condition or disease, or cannot provide reasonable access to a network provider with the
368 required training or expertise to treat or provide health care services for the condition or

369 disease.
370 (b) A managed care organization shall:
371 (i) inform an enrollee of the process the enrollee may use to request access to obtain a
372 covered benefit from a non-network provider in accordance with Subsection (1)(a);
373 (ii) have a system in place that documents all requests to obtain covered benefits from
374 a non-network provider under Subsection (1)(a); and
375 (iii) ensure that requests to obtain a covered benefit from a non-network provider under
376 Subsection (1)(a) are addressed in a timely fashion appropriate to the covered person's
377 condition.
378 (2) (a) A managed care organization shall reimburse a non-network provider for
379 emergency services in accordance with this section.
380 (b) A managed care organization shall:
381 (i) accept assignment of benefits from an enrollee for emergency services provided by a
382 non-network provider; and
383 (ii) send an explanation of benefits to the non-network provider with the information
384 required under Subsection (5)(a).
385 (c) Payment to a non-network provider for emergency services shall be the greater of:
386 (i) the amount negotiated with in-network providers for the emergency services
387 furnished, excluding any in-network copayment or coinsurance imposed with respect to the
388 enrollee, as provided in Subsection (2)(d)(i); or
389 (ii) the amount for the emergency services calculated using the same method the
390 managed care organization generally uses to determine payments for out-of-network services,
391 such as the usual, customary, and reasonable amount, excluding any in-network copayment or
392 coinsurance imposed with respect to an enrollee, as provided in Subsection (2)(d)(ii).
393 (d) (i) If there is more than one amount negotiated with in-network providers for the
394 emergency service under Subsection (2)(c)(i), the amount is the median of these amounts,
395 excluding any in-network copayment or coinsurance imposed with respect to the enrollee. In
396 determining the median under this Subsection (2)(d)(i), the amount negotiated with each
397 in-network provider is treated as a separate amount, even if the same amount is paid to more
398 than one provider.
399 (ii) The amount under Subsection (2)(c)(ii) is determined without reduction for

400 out-of-network cost sharing that generally applies under the plan with respect to out-of-network
401 services. For example, if a plan generally pays 70% of the usual, customary, and reasonable
402 amount for out-of-network services, the amount under this Subsection (2)(d)(ii) for an
403 emergency service is 100% of the usual, customary, and reasonable amount for the service, not
404 reduced by the 30% coinsurance that would generally apply to out-of-network services, but
405 reduced by the in-network copayment or coinsurance that the enrollee would be responsible for
406 if the emergency service had been provided in-network.
407 (3) (a) A non-network provider who is reimbursed under Subsection (2)(c) may not
408 balance bill an enrollee in excess of the amount under Subsection (3)(b).
409 (b) A non-network provider may balance bill an enrollee in an amount that is the lesser
410 of:
411 (i) 5% above the in-network allowed amount for the emergency services; or
412 (ii) $5,000.
413 (4) (a) A managed care organization may elect to pay a non-network provider for
414 emergency services:
415 (i) as submitted by the provider;
416 (ii) in accordance with the benchmark established in Subsection (2)(c); or
417 (iii) in an amount mutually agreed upon by the managed care organization and the
418 provider.
419 (b) This section does not preclude a managed care organization and a non-network
420 provider from agreeing to a different payment arrangement if:
421 (i) the enrollee is responsible for no more than:
422 (A) the applicable in-network cost sharing amount; and
423 (B) the balance bill amount allowed under Subsection (2)(c); and
424 (ii) the enrollee has no legal obligation to pay the balance for emergency services
425 remaining after the payments under Subsection (4)(b)(i).
426 (c) If a non-network provider sends a bill directly to an enrollee for emergency
427 services, the bill shall notify the enrollee:
428 (i) that the emergency services were performed by a provider who is not a network
429 provider for the enrollee's health benefit plan;
430 (ii) that the enrollee is responsible for paying the enrollee's applicable in-network

431 cost-sharing amount and the additional balance bill allowed under Subsection (2)(c);
432 (iii) the enrollee has no legal obligation to pay the remaining balance for the emergency
433 services; and
434 (iv) the enrollee may contact the state insurance commissioner's office for assistance.
435 (5) A non-network provider who receives payment from the managed care organization
436 under Subsection (2)(c):
437 (a) may rely on the explanation of benefits provided by the managed care organization
438 to the enrollee and the non-network provider, informing the non-network provider of:
439 (i) the amount the non-network provider may attempt to collect from the enrollee for
440 the enrollee's cost sharing, including unmet deductibles, copayments, and coinsurance; and
441 (ii) the managed care organization's in-network allowed amount for the emergency
442 services;
443 (b) shall accept the following payment from the enrollee as payment in full for the
444 emergency services:
445 (i) payment of cost sharing from the enrollee; and
446 (ii) payment of the additional balance bill allowed under Subsection (2)(c); and
447 (c) may not attempt to collect payment from an enrollee for emergency services in
448 excess of the amount under Subsection (5)(b).
449 (6) The rights and remedies provided under this section to an enrollee shall be in
450 addition to, and may not preempt, any other rights and remedies available to an enrollee under
451 state or federal law.
452 (7) On or before November 30, 2021, the commissioner shall report to the Business
453 and Labor Interim Committee regarding the benchmark established in Subsections (2)(c) and
454 (d) and whether the payment benchmarks should be modified.
455 Section 9. Section **31A-26-301.6** is amended to read:
456 **31A-26-301.6. Health care claims practices.**
457 (1) As used in this section:
458 (a) "Articulable reason" may include a determination regarding:
459 (i) eligibility for coverage;
460 (ii) preexisting conditions;
461 (iii) applicability of other public or private insurance;

462 (iv) medical necessity; and
463 (v) any other reason that would justify an extension of the time to investigate a claim.
464 (b) "Health care provider" means a person licensed to provide health care under:
465 (i) Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act; or
466 (ii) Title 58, Occupations and Professions.
467 (c) "Insurer" means an admitted or authorized insurer, as defined in Section
468 31A-1-301, and includes:
469 (i) a health maintenance organization; and
470 (ii) a third party administrator that is subject to this title, provided that nothing in this
471 section may be construed as requiring a third party administrator to use its own funds to pay
472 claims that have not been funded by the entity for which the third party administrator is paying
473 claims.
474 (d) "Provider" means a health care provider to whom an insurer is obligated to pay
475 directly in connection with a claim by virtue of:
476 (i) an agreement between the insurer and the provider;
477 (ii) a health insurance policy or contract of the insurer; or
478 (iii) state or federal law.
479 (2) An insurer shall timely pay every valid insurance claim submitted by a provider in
480 accordance with this section.
481 (3) (a) Except as provided in Subsection (4), within 30 days of the day on which the
482 insurer receives a written claim, an insurer shall:
483 (i) pay the claim; or
484 (ii) deny the claim and provide a written explanation for the denial.
485 (b) (i) Subject to Subsection (3)(b)(ii), the time period described in Subsection (3)(a)
486 may be extended by 15 days if the insurer:
487 (A) determines that the extension is necessary due to matters beyond the control of the
488 insurer; and
489 (B) before the end of the 30-day period described in Subsection (3)(a), notifies the
490 provider and insured in writing of:
491 (I) the circumstances requiring the extension of time; and
492 (II) the date by which the insurer expects to pay the claim or deny the claim with a

493 written explanation for the denial.

494 (ii) If an extension is necessary due to a failure of the provider or insured to submit the
495 information necessary to decide the claim:

496 (A) the notice of extension required by this Subsection (3)(b) shall specifically describe
497 the required information; and

498 (B) the insurer shall give the provider or insured at least 45 days from the day on which
499 the provider or insured receives the notice before the insurer denies the claim for failure to
500 provide the information requested in Subsection (3)(b)(ii)(A).

501 (4) (a) In the case of a claim for income replacement benefits, within 45 days of the day
502 on which the insurer receives a written claim, an insurer shall:

503 (i) pay the claim; or

504 (ii) deny the claim and provide a written explanation of the denial.

505 (b) Subject to Subsections (4)(d) and (e), the time period described in Subsection (4)(a)
506 may be extended for 30 days if the insurer:

507 (i) determines that the extension is necessary due to matters beyond the control of the
508 insurer; and

509 (ii) before the expiration of the 45-day period described in Subsection (4)(a), notifies
510 the insured of:

511 (A) the circumstances requiring the extension of time; and

512 (B) the date by which the insurer expects to pay the claim or deny the claim with a
513 written explanation for the denial.

514 (c) Subject to Subsections (4)(d) and (e), the time period for complying with
515 Subsection (4)(a) may be extended for up to an additional 30 days from the day on which the
516 30-day extension period provided in Subsection (4)(b) ends if before the day on which the
517 30-day extension period ends, the insurer:

518 (i) determines that due to matters beyond the control of the insurer a decision cannot be
519 rendered within the 30-day extension period; and

520 (ii) notifies the insured of:

521 (A) the circumstances requiring the extension; and

522 (B) the date as of which the insurer expects to pay the claim or deny the claim with a
523 written explanation for the denial.

524 (d) A notice of extension under this Subsection (4) shall specifically explain:
525 (i) the standards on which entitlement to a benefit is based; and
526 (ii) the unresolved issues that prevent a decision on the claim.
527 (e) If an extension allowed by Subsection (4)(b) or (c) is necessary due to a failure of
528 the insured to submit the information necessary to decide the claim:
529 (i) the notice of extension required by Subsection (4)(b) or (c) shall specifically
530 describe the necessary information; and
531 (ii) the insurer shall give the insured at least 45 days from the day on which the insured
532 receives the notice before the insurer denies the claim for failure to provide the information
533 requested in Subsection (4)(b) or (c).
534 (5) If a period of time is extended as permitted under Subsection (3)(b), (4)(b), or
535 (4)(c), due to an insured or provider failing to submit information necessary to decide a claim,
536 the period for making the benefit determination shall be tolled from the date on which the
537 notification of the extension is sent to the insured or provider until the date on which the
538 insured or provider responds to the request for additional information.
539 (6) An insurer shall pay all sums to the provider or insured that the insurer is obligated
540 to pay on the claim, and provide a written explanation of the insurer's decision regarding any
541 part of the claim that is denied within 20 days of receiving the information requested under
542 Subsection (3)(b), (4)(b), or (4)(c).
543 (7) (a) Whenever an insurer makes a payment to a provider on any part of a claim
544 under this section, the insurer shall also send to the insured an explanation of benefits paid.
545 (b) Whenever an insurer denies any part of a claim under this section, the insurer shall
546 also send to the insured:
547 (i) a written explanation of the part of the claim that was denied; and
548 (ii) notice of the adverse benefit determination review process established under
549 Section 31A-22-629.
550 (c) This Subsection (7) does not apply to a person receiving benefits under the state
551 Medicaid program as defined in Section 26-18-2, unless required by the Department of Health
552 or federal law.
553 (8) (a) Beginning with health care claims submitted on or after January 1, 2002, a late
554 fee shall be imposed on:

555 (i) an insurer that fails to timely pay a claim in accordance with this section; and
556 (ii) a provider that fails to timely provide information on a claim in accordance with
557 this section.
558 [(b) For the first 90 days that a claim payment or a provider response to a request for
559 information is late, the late fee shall be determined by multiplying together:]
560 [(i) the total amount of the claim;]
561 [(ii) the total number of days the response or the payment is late; and]
562 [(iii) .1%.]
563 [(c) For a claim payment or a provider response to a request for information that is 91
564 or more days late, the late fee shall be determined by adding together:]
565 [(i) the late fee for a 90-day period under Subsection (8)(b); and]
566 [(ii) the following multiplied together:]
567 [(A) the total amount of the claim;]
568 [(B) the total number of days the response or payment was late beyond the initial
569 90-day period; and]
570 [(C) the rate of interest set in accordance with Section 15-1-1.]
571 (b) The late fee shall be the greater of:
572 (i) the contract statutory rate under Section 15-1-1; or
573 (ii) 12% per annum.
574 [(d)] (c) Any late fee paid or collected under this section shall be separately identified
575 on the documentation used by the insurer to pay the claim.
576 [(e)] (d) For purposes of this Subsection (8), "late fee" does not include an amount that
577 is less than $1.
578 (9) Each insurer shall establish a review process to resolve claims-related disputes
579 between the insurer and providers.
580 (10) An insurer or person representing an insurer may not engage in any unfair claim
581 settlement practice with respect to a provider. Unfair claim settlement practices include:
582 (a) knowingly misrepresenting a material fact or the contents of an insurance policy in
583 connection with a claim;
584 (b) failing to acknowledge and substantively respond within 15 days to any written
585 communication from a provider relating to a pending claim;

586 (c) denying or threatening to deny the payment of a claim for any reason that is not
587 clearly described in the insured's policy;
588 (d) failing to maintain a payment process sufficient to comply with this section;
589 (e) failing to maintain claims documentation sufficient to demonstrate compliance with
590 this section;
591 (f) failing, upon request, to give to the provider written information regarding the
592 specific rate and terms under which the provider will be paid for health care services;
593 (g) failing to timely pay a valid claim in accordance with this section as a means of
594 influencing, intimidating, retaliating, or gaining an advantage over the provider with respect to
595 an unrelated claim, an undisputed part of a pending claim, or some other aspect of the
596 contractual relationship;
597 (h) failing to pay the sum when required and as required under Subsection (8) when a
598 violation has occurred;
599 (i) threatening to retaliate or actual retaliation against a provider for the provider
600 applying this section;
601 (j) any material violation of this section; and
602 (k) any other unfair claim settlement practice established in rule or law.
603 (11) (a) The provisions of this section shall apply to each contract between an insurer
604 and a provider for the duration of the contract.
605 (b) Notwithstanding Subsection (11)(a), this section may not be the basis for a bad
606 faith insurance claim.
607 (c) Nothing in Subsection (11)(a) may be construed as limiting the ability of an insurer
608 and a provider from including provisions in their contract that are more stringent than the
609 provisions of this section.
610 (12) (a) Pursuant to Chapter 2, Part 2, Duties and Powers of Commissioner, and
611 beginning January 1, 2002, the commissioner may conduct examinations to determine an
612 insurer's level of compliance with this section and impose sanctions for each violation.
613 (b) The commissioner may adopt rules only as necessary to implement this section.
614 (c) The commissioner may establish rules to facilitate the exchange of electronic
615 confirmations when claims-related information has been received.
616 (d) Notwithstanding Subsection (12)(b), the commissioner may not adopt rules

617 regarding the review process required by Subsection (9).
618 (13) Nothing in this section may be construed as limiting the collection rights of a
619 provider under Section 31A-26-301.5.
620 (14) Nothing in this section may be construed as limiting the ability of an insurer to:
621 (a) recover any amount improperly paid to a provider or an insured:
622 (i) in accordance with Section 31A-31-103 or any other provision of state or federal
623 law;
624 (ii) within 24 months of the amount improperly paid for a coordination of benefits
625 error;
626 (iii) within 12 months of the amount improperly paid for any other reason not
627 identified in Subsection (14)(a)(i) or (ii); or
628 (iv) within 36 months of the amount improperly paid when the improper payment was
629 due to a recovery by Medicaid, Medicare, the Children's Health Insurance Program, or any
630 other state or federal health care program;
631 (b) take any action against a provider that is permitted under the terms of the provider
632 contract and not prohibited by this section;
633 (c) report the provider to a state or federal agency with regulatory authority over the
634 provider for unprofessional, unlawful, or fraudulent conduct; or
635 (d) enter into a mutual agreement with a provider to resolve alleged violations of this
636 section through mediation or binding arbitration.
637 (15) A health care provider may only seek recovery from the insurer for an amount
638 improperly paid by the insurer within the same time frames as Subsections (14)(a) and (b).
639 Section 10. Section **58-1-509** is enacted to read:
640 **58-1-509. Health care provider -- Emergency services -- Balanced billing --**
641 **Unprofessional conduct.**
642 (1) For purposes of this section:
643 (a) "Balanced billing" means the same as that term is defined in Section 31A-22-645.
644 (b) "Emergency services" means the same as that term is defined in Section
645 31A-22-645.
646 (c) "Health care provider" means an individual who is:
647 (i) defined as a health care provider under Section 78B-3-403; and

648 (ii) licensed under this title.
649 (2) Beginning January 1, 2018, it is unprofessional conduct for a health care provider
650 to balance bill a patient for emergency services in violation of Section 31A-22-647.
651 (3) A health care provider who violates this section is subject to Section 58-1-502.
652 Section 11. **Repealer.**
653 This bill repeals:
654 Section **31A-8-104, Determination of ability to provide services.**
655 Section **31A-8-408, Organizations offering point of service or point of sales**
656 **products.**
657 Section 12. **Effective date.**
658 This bill takes effect on January 1, 2018.

Legislative Review Note
Office of Legislative Research and General Counsel