**Steve Eliason** proposes the following substitute bill:

# Health Provider Directory and Access Amendments

2026 GENERAL SESSION

STATE OF UTAH

**Chief Sponsor: Steve Eliason**

Senate Sponsor: Kirk A. Cullimore

**LONG TITLE**

**General Description:**

This bill addresses provider directories and timely access to behavioral health services.

**Highlighted Provisions:**

This bill:

- requires covered insurers to:
  - assist enrollees in accessing behavioral health services in a timely manner;
  - facilitate an insured obtaining behavioral health services from an out-of-network provider if an in-network provider is not available in a timely manner;
  - publish health care provider directories;
  - regularly update health care provider directories; and
  - take certain steps to ensure the accuracy of provider directories;
- permits the Public Employees' Benefit and Insurance Program (program) to adjust the program's business practice to mitigate financial impacts of certain provisions;
- authorizes Utah's insurance commissioner (commissioner) to make rules to implement certain provisions of this bill;
- requires providers to respond to an insurer's request for verification of provider directory information within a certain period of time;
- requires the commissioner to issue an educational letter to a provider that demonstrates a pattern of violations of certain provisions;
- requires the division to convene a working group to study the feasibility and cost of creating and maintaining a statewide behavioral health provider directory (working group) and report to the Health and Human Services Interim Committee;
- provides a repeal date for the working group; and
- defines terms.

**Money Appropriated in this Bill:**

None

**Other Special Clauses:**

None

**Utah Code Sections Affected:**

AMENDS:

**63I-2-258**, as last amended by Laws of Utah 2025, Chapter 277

ENACTS:

**31A-22-663**, Utah Code Annotated 1953

**31A-22-664**, Utah Code Annotated 1953

**58-1-113**, Utah Code Annotated 1953

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

Section 1. Section **31A-22-663** is enacted to read:

**31A-22-663 . Timely access to behavioral health services -- Single case agreement.**

(1) As used in this section:

(a) "Covered insurer" means an insurer that offers health insurance that includes coverage for behavioral health services.

(b)(i) "Behavioral health services" means:

(A) mental health treatment or services; or

(B) substance use treatment or services.

(ii) "Behavioral health services" includes telehealth services and telemedicine services.

(c) "Insurer" means the same as that term is defined in Section 31A-22-634.

(d) "Mental health provider" means the same as that term is defined in Section 31A-22-658.

(e) "Telehealth services" means the same as that term is defined in Section 26B-4-704.

(f) "Telemedicine services" means the same as that term is defined in Section 26B-4-704.

(g) "Timely manner" means:

(i) no more than 15 days after the day on which an insured first attempts to access behavioral health services; and

(ii) no more than 24 hours after the date and time that an insured first seeks to access urgent, emergency, or crisis behavioral health services.

(2) Beginning January 1, 2027, a covered insurer shall:

(a) establish a procedure to assist an enrollee to access behavioral health services from

an out-of-network mental health provider when no in-network mental health provider is available in a timely manner; and

(b) if an enrollee in a covered insurer's health benefit plan is unable to obtain covered behavioral health services from an in-network mental health provider in a timely manner, enter into a single case agreement that allows the enrollee to receive covered behavioral health services from an out-of-network mental health provider.

(3)(a) A covered insurer shall include in a negotiated single case agreement described in Subsection (2)(b):

(i) a requirement that the covered insurer reimburse the out-of-network mental health provider for the covered behavioral health services at a rate negotiated by the provider and insurer, subject to the member cost-sharing requirements imposed by the health benefit plan;

(ii) a requirement that the covered insurer apply the same coinsurance, copayments, and deductibles that would apply for the behavioral health services if the behavioral health services were provided by a mental health provider that is an in-network mental health provider;

(iii) any terms that a network provider is subject to under the health benefit plan; and

(iv) the length and scope of the single case agreement.

(b) Notwithstanding Subsection (3)(a)(ii):

(i) a covered insurer's payment under a single case agreement described in Subsection (2)(b) constitutes payment in full to the provider for the behavioral health services the enrollee receives; and

(ii) the provider may not seek additional payment from the enrollee except for applicable cost sharing.

(4) A covered insurer shall ensure that a single case agreement described in Subsection (2)(b) only permits an insured to receive behavioral health services:

(a) that are:

(i) within the out-of-network mental health provider's scope of practice; and

(ii) behavioral health services that are otherwise covered under the enrollee's health benefit plan; and

(b) that are not experimental, unless the insurer covers experimental treatments for physical health conditions in compliance with the Mental Health Parity and Addiction Equity Act, Pub. L. No. 110-343.

(5) A covered insurer shall:

(a) document all payments the covered insurer makes under a health benefit plan to a mental health provider under this section; and

(b) provide the documentation described in Subsection (5)(a) to the department upon request.

(6) Subsections (2)(b), (3), and (4) do not apply if behavioral health services are available in a timely manner.

(7) The commissioner may:

(a) make rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to implement this section; and

(b) bring an action in accordance with Section 31A-2-308 and Title 63G, Chapter 4, Administrative Procedures Act, for a violation of this section.

Section 2. Section **31A-22-664** is enacted to read:

**31A-22-664 . Health care provider directories.**

(1) As used in this section:

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

(b) "Exempt health care professional" means a person exempt from licensure under a title listed in Subsection 58-13-3(2)(c).

(c) "Exempt mental health provider" means an individual exempt from licensure under Section 58-60-107.

(d) "Health care facility" means the same as that term is defined in Section 26B-2-201.

(e) "Health care professional" means the same as that term is defined in Section 58-13-3.

(f) "Hospital" means a facility licensed under Title 26B, Chapter 2, Part 2, Health Care Facility Licensing and Inspection, as a general acute hospital or specialty hospital.

(g) "Insurer" means the same as that term is defined in Section 31A-22-634.

(h) "Mental health provider" means the same as that term is defined in Section 31A-22-658.

(i) "PEHP" means the Public Employees' Benefit and Insurance Program created in Section 49-20-103.

(j) "Pharmacy" means the same as that term is defined in Section 58-17b-102.

(k) "Provider" means:

(i) a health care professional;

(ii) an exempt health care professional;

(iii) a mental health provider;

(iv) an exempt mental health provider; or

(v) a pharmacy.

(l) "Provider directory" means a list of in-network providers for each of an insurer's health benefit plans.

(m) "Telehealth services" means the same as that term is defined in Section 26B-4-704.

(n) "Telemedicine services" means the same as that term is defined in Section 26B-4-704.

(2) Beginning January 1, 2027, an insurer shall:

(a) publish a provider directory for each of the insurer's health benefit plans; and

(b) update the provider directory no less frequently than every 60 days.

(3) An insurer shall ensure that, except as provided in Subsection (6):

(a) a provider directory:

(i) is easily and publicly accessible:

(A) through a conspicuous link on the home page of the insurer's website; and

(B) without requiring an individual to create an account or submit a policy or contract number; and

(ii) is in a format that is searchable and downloadable; and

(b) a provider may update the provider's information, including contact information and whether the provider is accepting new patients, in the provider directory:

(i) electronically;

(ii) on the insurer's website; and

(iii) through a conspicuous link on the home page of the insurer's website.

(4) A provider directory shall include:

(a) in plain language:

(i) a description of the criteria the insurer used to build the health benefit plan's provider network; and

(ii) if applicable:

(A) a description of the criteria the insurer used to tier health care providers;

(B) how the health benefit plan designates health care provider tiers or levels; and

(C) a notice that authorization or referral may be required to access some health care providers; and

(b) contact information an insured or member of the public may use to report to the health benefit plan inaccurate information in a provider directory, which may include:

(i) a phone number;

(ii) an email address; or

(iii) a link to a website or online reporting form.

(5) In addition to the information required under Subsection (4):

(a) a provider directory of health care professionals and exempt health care professionals shall include:

(i) each health care professional's and exempt health care professional's:

(A) name;

(B) contact information, including:

(I) internet address, if applicable;

(II) physical address; and

(III) phone number; and

(C) specialty, if applicable;

(ii) whether the health care professional or exempt health care professional is accepting new patients;

(iii) if an exempt health care professional treats patients under the supervision of a health care professional, whether the exempt health care professional is accepting new patients; and

(iv) whether the health care professional or exempt health care professional offers telehealth services or telemedicine services;

(b) a provider directory of health care facilities that are hospitals shall include each hospital's:

(i) name;

(ii) if the hospital is a specialty hospital, the specialty type;

(iii) location or locations;

(iv) accreditation status;

(v) phone number; and

(vi) internet address, if applicable;

(c) a provider directory of health care facilities other than hospitals shall include each health care facility's:

(i) name;

(ii) type;

(iii) services provided;

(iv) location or locations;

(v) phone number; and

(vi) internet address, if applicable;

(d) a provider directory of pharmacies shall include each pharmacy's:

(i) name;

(ii) type;

(iii) services provided, including whether the pharmacy offers mail-order or specialty pharmacy services;

(iv) location or locations;

(v) phone number; and

(vi) internet address, if applicable; and

(e) a provider directory of mental health providers and exempt mental health providers shall include:

(i) each mental health provider's:

(A) name;

(B) contact information, including:

(I) internet address, if applicable;

(II) physical address; and

(III) phone number; and

(C) specialty, if applicable;

(ii) whether the mental health provider or exempt mental health provider is accepting new patients;

(iii) if an exempt mental health provider treats patients under the supervision of a mental health provider, whether the exempt mental health provider is accepting new patients; and

(iv) whether the mental health provider or exempt mental health provider offers telehealth services or telemedicine services.

(6)(a) An insurer may provide, in addition to an electronic provider directory, a provider directory in print format.

(b) An insurer shall provide a provider directory in print format to an insured upon request of the insured.

(c) In addition to the requirements described in Subsections (4) and (5), a provider directory in print format shall include:

(i) the internet address of the insurer's website where the insurer's electronic provider directory is published;

(ii) the health benefit plan's customer service phone number;

(iii) a disclosure that the information in the provider directory is accurate, to the best of the insurer's knowledge, based on the information the provider provided, as of

the date of printing; and

(iv) a notice that an insured or prospective insured should consult the health benefit plan's electronic provider directory or call the health benefit plan's customer service phone number to obtain current provider directory information.

(7) When an insurer receives a report of inaccurate information in a provider directory, the insurer shall:

(a) promptly investigate the report; and

(b) no later than the end of the 20th business day after the day on which the insurer receives the report:

(i) verify the accuracy of the information in the provider directory; or

(ii) for an electronic provider directory, update the inaccurate information with accurate information.

(8)(a) An insurer shall take steps to ensure the accuracy of the information in a provider directory, including contacting providers to verify that provider information is up to date.

(b) When an insurer contacts a provider to verify the accuracy of a provider's information in a provider directory, the provider shall respond to the insurer's request for verification no later than 15 business days after the day on which the insurer contacts the provider.

(9)(a) An insurer shall, at least annually, audit each provider directory for accuracy.

(b) An audit of a provider directory shall:

(i)(A) include the two mental health specialties and four physical health specialties most utilized by insureds; and

(B) include at least one specialty related to mental health; or

(ii) audit a reasonable sample size of providers, if the sample size includes mental health providers.

(c) An insurer shall:

(i) retain documentation of each audit performed under this Subsection (9);

(ii) submit the audit to the commissioner annually, on or before December 31, and upon the commissioner's request; and

(iii) based on the results of the audit:

(A) verify and attest to the accuracy of the information in a provider directory; and

(B) update inaccurate information in a provider directory with accurate information.

(10)(a) An insurer shall annually report to the commissioner on:

(i) the number of reports of inaccuracies in provider directories the insurer received;

(ii) the timeliness of the insurer's response to a report of inaccuracies in a provider directory;

(iii) any corrective action the insurer took in response to a report of inaccuracies in a provider directory;

(iv) the identity of providers that failed to timely respond to the insurer's request for verification as required under Subsection (8);

(v) all audits the insurer conducted in accordance with this section; and

(vi) any other information related to provider directory accuracy the commissioner considers relevant.

(b) If the commissioner finds that a provider demonstrates a repeated pattern of violations of Subsection (8), the commissioner shall issue an educational letter to the provider

(11) An insurer, a health care facility, a hospital, or a provider that is subject to this section shall comply with all applicable requirements of the No Surprises Act, 42 U.S.C. Secs. 300gg-111 through 300gg-139, and federal regulations adopted in accordance with that act.

(12) The commissioner shall make rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to implement the provisions of this section.

(13) In addition to the penalties authorized under Section 31A-2-308, if the commissioner determines that, when an insured received services under the insured's health benefit plan, the insured reasonably relied on inaccurate information in a provider directory, the commissioner may:

(a) if the commissioner determines that the insurer knew or reasonably should have known the information was inaccurate:

(i) require the insurer to provide coverage for all covered health care services the insured received; and

(ii) reimburse the insured for the amount the insured paid for the health care services that exceeds what the insured would have paid if the services were delivered by an in-network provider; and

(b) if the commissioner determines that the provider provided inaccurate information or failed to update the information, require the insurer to reimburse the provider at the in-network rate.

(14) The commissioner shall provide to the division the reports described in Subsection (10)(a).

(15) PEHP may adjust the PEHP's business practices to mitigate any financial impacts of compliance with this section.

Section 3. Section **58-1-113** is enacted to read:

**58-1-113 . Statewide behavioral health provider database study.**

(1) As used in this section:

(a) "Accountable care organization" means a managed care organization, as defined in 42 C.F.R. Sec. 438, that contracts with the Department of Health and Human Services under the provisions of Section 26B-3-202.

(b) "Behavioral health provider" means a mental health provider that provides behavioral health services.

(c) "Behavioral health services" means:

(i) mental health treatment or services; or

(ii) substance use treatment or services.

(d) "Commissioner" means Utah's insurance commissioner.

(e) "Database" means the statewide behavioral health provider database described in Subsection (2).

(f) "Department of Health and Human Services" means the Department of Health and Human Services created in Section 26B-1-201.

(g) "Division of Integrated Healthcare" means the Division of Integrated Healthcare created in Section 26B-1-204.

(h) "Insurer" means:

(i) an insurer as that term is defined in Section 31A-22-634;

(ii) an accountable care organization;

(iii) a behavioral health plan as that term is defined in 26B-3-203; or

(iv) for an adult who is covered through the traditional fee for service Medicaid model in counties without Medicaid accountable care organizations or the state's Medicaid accountable care organization delivery system, the Division of Integrated Healthcare.

(i) "Mental health provider" means the same as that term is defined in Section 31A-22-658.

(j) "PEHP" means the Public Employees' Benefit and Insurance Program created in Section 49-20-103.

(k) "Provider directory" means a provider directory created in accordance with Section 31A-22-664.

(l) "Telehealth services" means the same as that term is defined in Section 26B-4-704.

(m) "Telemedicine services" means the same as that term is defined in Section 26B-4-704.

(2) On or before June 30, 2026, the division shall convene a working group to study and develop recommendations regarding the feasibility and cost of creating and maintaining a database of behavioral health providers in the state, including:

(a) an analysis of the requirements for a statewide behavioral health provider database that:

(i) is accessible to the public;

(ii) allows a person accessing the database to search behavioral health providers by:

(A) license status;

(B) areas of specialty the behavioral health provider provides, including treatment of specific mental health diagnoses and disorders;

(C) insurers with which the behavioral health provider is under contract; and

(D) whether the behavioral health provider offers any or all of the following:

(I) in-person services;

(II) telehealth services; or

(III) telemedicine services;

(iii) indicates what methods of payment a behavioral health provider accepts, including whether the behavioral health provider accepts cash only;

(iv) indicates a behavioral health provider's availability for scheduling an appointment;

(v) for each insurer, codes by color or other method whether each behavioral health provider in the insurer's network:

(A) is accepting new patients;

(B) requires a prospective new patient to call for availability; or

(C) is not accepting new patients;

(vi) allows an insurer to access the database and update information about behavioral health providers in the insurer's network;

(vii) allows a behavioral health provider to access the database and update and verify the behavioral health provider's information;

(viii) allows the division to communicate with a behavioral health provider in the

database to prompt the behavioral health provider to review and verify information in the database;

(ix) allows the division to import information from an insurer's provider directory into the database; and

(x) allows an insurer to import information about behavioral health providers in the insurer's network into the insurer's provider directory; and

(b) a determination of whether existing software or technology that PEHP owns or controls meets, or could be modified to meet, the requirements for the features described in Subsection (2)(a).

(3) The division shall coordinate with the Department of Health and Human Services, PEHP, the Insurance Department, and accountable care organizations to determine the membership of the working group described in Subsection (2).

(4) The division shall present to the Health and Human Services Interim Committee, on or before the date of the committee's November 2026 meeting, on:

(a) the recommendations described in Subsection (2); and

(b) reports the division has received from the commissioner under Subsection 31A-22-664(14) before the date of the division's presentation, if any.

Section 4. Section **63I-2-258** is amended to read:

**63I-2-258 . Repeal dates: Title 58.**

[~~Reserved.~~] Section 58-1-113, Statewide behavioral health provider database study, is repealed July 1, 2027.

Section 5. **Effective Date.**

This bill takes effect on May 6, 2026.