

1 **PATIENT ACCESS TO PROVIDERS AND**
2 **CONTRACTING AMENDMENTS**

3 2005 GENERAL SESSION

4 STATE OF UTAH

5 **Sponsor: Rebecca D. Lockhart**

7 **LONG TITLE**

8 **General Description:**

9 This bill amends the Insurance Code to modify the conditions under which a health care
10 provider may bring an action against a health maintenance organization or preferred
11 provider organization for payment, and requires objective provider contracting
12 provisions.

13 **Highlighted Provisions:**

14 This bill:

- 15 ▶ specifies when a participating provider in a health maintenance organization may
16 bring an action for enforcement of payment;
- 17 ▶ specifies when a participating provider in a preferred provider organization may
18 bring an action for enforcement of payment;
- 19 ▶ requires comparable payment of network providers when the network's panel of
20 providers are leased to another unaffiliated entity;
- 21 ▶ requires the use of objective criteria for adding or terminating a provider from an
22 HMO or PPO panel; and
- 23 ▶ prohibits an insurer from taking adverse action against a contracted provider when
24 an insured decides to access health care outside the provider network.

25 **Monies Appropriated in this Bill:**

26 None

27 **Other Special Clauses:**



28 This bill takes effect on January 1, 2006.

29 **Utah Code Sections Affected:**

30 AMENDS:

31 **31A-8-407**, as last amended by Chapter 252, Laws of Utah 2003

32 **31A-22-617**, as last amended by Chapter 131, Laws of Utah 2003

33 ENACTS:

34 **31A-22-617.1**, Utah Code Annotated 1953



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

37 Section 1. Section **31A-8-407** is amended to read:

38 **31A-8-407. Written contracts -- Limited liability of enrollee.**

39 (1) (a) Every contract between an organization and a participating provider of health
40 care services shall be in writing and shall set forth that if the organization:

41 (i) fails to pay for health care services as set forth in the contract, the enrollee may not
42 be liable to the provider for any sums owed by the organization; and

43 (ii) becomes insolvent, the rehabilitator or liquidator may require the participating
44 provider of health care services to:

45 (A) continue to provide health care services under the contract between the
46 participating provider and the organization until the earlier of:

47 (I) 90 days after the date of the filing of a petition for rehabilitation or the petition for
48 liquidation; or

49 (II) the date the term of the contract ends; and

50 (B) subject to Subsection (1)(c), reduce the fees the participating provider is otherwise
51 entitled to receive from the organization under the contract between the participating provider
52 and the organization during the time period described in Subsection (1)(a)(ii)(A).

53 (b) If the conditions of Subsection (1)(c) are met, the participating provider shall:

54 (i) accept the reduced payment as payment in full; and

55 (ii) relinquish the right to collect additional amounts from the insolvent organization's
56 enrollee.

57 (c) Notwithstanding Subsection (1)(a)(ii)(B):

58 (i) the rehabilitator or liquidator may not reduce a fee to less than 75% of the regular

59 fee set forth in the participating provider contract; and

60 (ii) the enrollee shall continue to pay the same copayments, deductibles, and other
61 payments for services received from the participating provider that the enrollee was required to
62 pay before the filing of:

63 (A) the petition for rehabilitation; or

64 (B) the petition for liquidation.

65 (2) A participating provider may not collect or attempt to collect from the enrollee
66 sums owed by the organization or the amount of the regular fee reduction authorized under
67 Subsection (1)(a)(ii) if the participating provider contract:

68 (a) is not in writing as required in Subsection (1); or

69 (b) fails to contain the language required by Subsection (1).

70 (3) (a) A person listed in Subsection (3)(b) may not bill or maintain any action at law
71 against an enrollee to collect:

72 (i) sums owed by the organization; or

73 (ii) the amount of the regular fee reduction authorized under Subsection (1)(a)(ii).

74 (b) Subsection (3)(a) applies to:

75 (i) a participating provider;

76 (ii) an agent;

77 (iii) a trustee; or

78 (iv) an assignee of a person described in Subsections (3)(b)(i) through (iii).

79 (c) In any dispute involving a provider's claim for reimbursement, the same shall be
80 determined in accordance with applicable law, the provider contract, the subscriber contract,
81 and the organization's written payment policies in effect at the time services were rendered.

82 (d) If the parties are unable to resolve their dispute, the matter shall be subject to
83 binding arbitration by a jointly selected arbitrator. Each party is to bear its own expense except
84 the cost of the jointly selected arbitrator shall be equally shared. ~~H~~→ **This Subsection (d) does not**
84a **apply to the claim of a general acute hospital to the extent it is inconsistent with the hospital's**
84b **provider agreement.** ←~~H~~

85 (e) An organization may not penalize a provider solely for pursuing a claims dispute or
86 otherwise demanding payment for a sum believed owing.

87 (4) If an organization permits another private entity with which it does not share
88 common ownership or control to use or otherwise lease one or more of the organization's
89 networks that include participating providers, the organization shall ensure, at a minimum, that

90 the entity pays participating providers in accordance with the same fee schedule and general
 91 payment policies as the organization would for that network ~~H→~~ **unless payment for services is**
 91a **governed by a public program's fee schedule** ~~←H~~ .

92 Section 2. Section 31A-22-617 is amended to read:

93 **31A-22-617. Preferred provider contract provisions.**

94 Health insurance policies may provide for insureds to receive services or
 95 reimbursement under the policies in accordance with preferred health care provider contracts as
 96 follows:

97 (1) Subject to restrictions under this section, any insurer or third party administrator
 98 may enter into contracts with health care providers as defined in Section 78-14-3 under which
 99 the health care providers agree to supply services, at prices specified in the contracts, to
 100 persons insured by an insurer.

101 (a) (i) A health care provider contract may require the health care provider to accept the
 102 specified payment as payment in full, relinquishing the right to collect additional amounts from
 103 the insured person.

104 (ii) In any dispute involving a provider's claim for reimbursement, the same shall be
 105 determined in accordance with applicable law, the provider contract, the subscriber contract,
 106 and the insurer's written payment policies in effect at the time services were rendered.

107 (iii) If the parties are unable to resolve their dispute, the matter shall be subject to
 108 binding arbitration by a jointly selected arbitrator. Each party is to bear its own expense except
 109 the cost of the jointly selected arbitrator shall be equally shared. ~~H→~~ **This Subsection (iii) does not**
 109a **apply to the claim of a general acute hospital to the extent it is inconsistent with the hospital's**
 109b **provider agreement.** ~~←H~~

110 (iv) An organization may not penalize a provider solely for pursuing a claims dispute
 111 or otherwise demanding payment for a sum believed owing.

112 (v) If an insurer permits another entity with which it does not share common ownership
 113 or control to use or otherwise lease one or more of the organization's networks of participating
 114 providers, the organization shall ensure, at a minimum, that the entity pays participating
 115 providers in accordance with the same fee schedule and general payment policies as the
 116 organization would for that network.

117 (b) The insurance contract may reward the insured for selection of preferred health care
 118 providers by:

119 (i) reducing premium rates;

120 (ii) reducing deductibles;

121 (iii) coinsurance;

122 (iv) other copayments; or

123 (v) any other reasonable manner.

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

125 31A-27-311.5(1)(f):

126 (i) the insurance contract and the health care provider contract shall provide that in the

127 event the managed care organization becomes insolvent, the rehabilitator or liquidator may:

128 (A) require the health care provider to continue to provide health care services under

129 the contract until the earlier of:

130 (I) 90 days after the date of the filing of a petition for rehabilitation or the petition for

131 liquidation; or

132 (II) the date the term of the contract ends; and

133 (B) subject to Subsection (1)(c)(v), reduce the fees the provider is otherwise entitled to

134 receive from the managed care organization during the time period described in Subsection

135 (1)(c)(i)(A);

136 (ii) the provider is required to:

137 (A) accept the reduced payment under Subsection (1)(c)(i)(B) as payment in full; and

138 (B) relinquish the right to collect additional amounts from the insolvent managed care

139 organization's enrollee, as defined in Subsection 31A-27-311.5(1)(b);

140 (iii) if the contract between the health care provider and the managed care organization

141 has not been reduced to writing, or the contract fails to contain the language required by

142 Subsection (1)(c)(i), the provider may not collect or attempt to collect from the enrollee:

143 (A) sums owed by the insolvent managed care organization; or

144 (B) the amount of the regular fee reduction authorized under Subsection (1)(c)(i)(B);

145 (iv) the following may not bill or maintain any action at law against an enrollee to

146 collect sums owed by the insolvent managed care organization or the amount of the regular fee

147 reduction authorized under Subsection (1)(c)(i)(B):

148 (A) a provider;

149 (B) an agent;

150 (C) a trustee; or

151 (D) an assignee of a person described in Subsections (1)(c)(iv)(A) through (C); and

152 (v) notwithstanding Subsection (1)(c)(i):

153 (A) a rehabilitator or liquidator may not reduce a fee by less than 75% of the provider's
154 regular fee set forth in the contract; and

155 (B) the enrollee shall continue to pay the copayments, deductibles, and other payments
156 for services received from the provider that the enrollee was required to pay before the filing
157 of:

158 (I) a petition for rehabilitation; or

159 (II) a petition for liquidation.

160 (2) (a) Subject to Subsections (2)(b) through (2)(f), an insurer using preferred health
161 care provider contracts shall pay for the services of health care providers not under the contract,
162 unless the illnesses or injuries treated by the health care provider are not within the scope of the
163 insurance contract. As used in this section, "class of health care providers" means all health
164 care providers licensed or licensed and certified by the state within the same professional,
165 trade, occupational, or facility licensure or licensure and certification category established
166 pursuant to Titles 26, Utah Health Code and 58, Occupations and Professions.

167 (b) When the insured receives services from a health care provider not under contract,
168 the insurer shall reimburse the insured for at least 75% of the average amount paid by the
169 insurer for comparable services of preferred health care providers who are members of the
170 same class of health care providers. The commissioner may adopt a rule dealing with the
171 determination of what constitutes 75% of the average amount paid by the insurer for
172 comparable services of preferred health care providers who are members of the same class of
173 health care providers.

174 (c) When reimbursing for services of health care providers not under contract, the
175 insurer may make direct payment to the insured.

176 (d) Notwithstanding Subsection (2)(b), an insurer using preferred health care provider
177 contracts may impose a deductible on coverage of health care providers not under contract.

178 (e) When selecting health care providers with whom to contract under Subsection (1),
179 an insurer may not unfairly discriminate between classes of health care providers, but may
180 discriminate within a class of health care providers, subject to Subsection (7).

181 (f) For purposes of this section, unfair discrimination between classes of health care
182 providers shall include:

183 (i) refusal to contract with class members in reasonable proportion to the number of
184 insureds covered by the insurer and the expected demand for services from class members; and

185 (ii) refusal to cover procedures for one class of providers that are:

186 (A) commonly utilized by members of the class of health care providers for the
187 treatment of illnesses, injuries, or conditions;

188 (B) otherwise covered by the insurer; and

189 (C) within the scope of practice of the class of health care providers.

190 (3) Before the insured consents to the insurance contract, the insurer shall fully disclose
191 to the insured that it has entered into preferred health care provider contracts. The insurer shall
192 provide sufficient detail on the preferred health care provider contracts to permit the insured to
193 agree to the terms of the insurance contract. The insurer shall provide at least the following
194 information:

195 (a) a list of the health care providers under contract and if requested their business
196 locations and specialties;

197 (b) a description of the insured benefits, including any deductibles, coinsurance, or
198 other copayments;

199 (c) a description of the quality assurance program required under Subsection (4); and

200 (d) a description of the adverse benefit determination procedures required under
201 Subsection (5).

202 (4) (a) An insurer using preferred health care provider contracts shall maintain a quality
203 assurance program for assuring that the care provided by the health care providers under
204 contract meets prevailing standards in the state.

205 (b) The commissioner in consultation with the executive director of the Department of
206 Health may designate qualified persons to perform an audit of the quality assurance program.
207 The auditors shall have full access to all records of the organization and its health care
208 providers, including medical records of individual patients.

209 (c) The information contained in the medical records of individual patients shall
210 remain confidential. All information, interviews, reports, statements, memoranda, or other data
211 furnished for purposes of the audit and any findings or conclusions of the auditors are
212 privileged. The information is not subject to discovery, use, or receipt in evidence in any legal
213 proceeding except hearings before the commissioner concerning alleged violations of this

214 section.

215 (5) An insurer using preferred health care provider contracts shall provide a reasonable
216 procedure for resolving complaints and adverse benefit determinations initiated by the insureds
217 and health care providers.

218 (6) An insurer may not contract with a health care provider for treatment of illness or
219 injury unless the health care provider is licensed to perform that treatment.

220 (7) (a) A health care provider or insurer may not discriminate against a preferred health
221 care provider for agreeing to a contract under Subsection (1).

222 (b) Any health care provider licensed to treat any illness or injury within the scope of
223 the health care provider's practice, who is willing and able to meet the terms and conditions
224 established by the insurer for designation as a preferred health care provider, shall be able to
225 apply for and receive the designation as a preferred health care provider. Contract terms and
226 conditions may include reasonable limitations on the number of designated preferred health
227 care providers based upon substantial objective and economic grounds, or expected use of
228 particular services based upon prior provider-patient profiles.

229 (8) Upon the written request of a provider excluded from a provider contract, the
230 commissioner may hold a hearing to determine if the insurer's exclusion of the provider is
231 based on the criteria set forth in Subsection (7)(b).

232 (9) Insurers are subject to the provisions of Sections 31A-22-613.5, 31A-22-614.5, and
233 31A-22-618.

234 (10) Nothing in this section is to be construed as to require an insurer to offer a certain
235 benefit or service as part of a health benefit plan.

236 (11) This section does not apply to catastrophic mental health coverage provided in
237 accordance with Section 31A-22-625.

238 Section 3. Section **31A-22-617.1** is enacted to read:

239 **31A-22-617.1. Objective criteria for adding or terminating participating**
240 **providers.**

241 (1) (a) Every insurer, including a health maintenance organization governed by Chapter
242 8, Health Maintenance Organization and Limited Health Plans, shall establish criteria for
243 adding health care providers to a new or existing provider panel.

244 (b) Criteria under Subsection (1)(a) may include, but are not limited to:

245 (i) training, certification, and hospital privileges;
246 (ii) number of physicians needed to adequately serve the insurer's population; and
247 (iii) any other factor that is reasonably related to promote or protect good patient care,
248 address costs, take into account on-call and cross-coverage relationships between providers, or
249 serve the lawful interests of the insurer.

250 (c) An insurer shall make such criteria available to any provider upon request and shall
251 file the same with the department.

252 (d) Upon receipt of a provider application and upon receiving all necessary
253 information, an insurer shall make a decision on a provider's application for participation
254 within 120 days.

255 (e) If the provider applicant is rejected, the insurer shall inform the provider of the
256 reason for the rejection relative to the criteria established in accordance with Subsection (1)(b).

257 (f) An insurer may not reject a provider applicant based solely on:

258 (i) the provider's staff privileges at a general acute care hospital not under contract with
259 the insurer; or

260 (ii) the provider's referral patterns for patients who are not covered by the insurer.

261 (g) Criteria set out in Subsection (1)(b) may be modified or changed from time to time
262 to meet the business needs of the market in which the insurer operates and, if modified, will be
263 filed with the department as provided in Subsection (1)(c).

264 (h) With the exception of Subsection (1)(f), this section does not create any new or
265 additional private right of action for redress.

266 (2) (a) For the first two years, an insurer may terminate its contract with a provider
267 with or without cause upon giving the requisite amount of notice provided in the agreement,
268 but in no case shall it be less than 60 days.

269 (b) An agreement may be terminated for cause as provided in the contract established
270 between the insurer and the provider. Such contract shall contain sufficiently certain criteria so
271 that the provider can be reasonably informed of the grounds for termination for cause.

272 (c) Prior to termination for cause, the insurer shall:

273 (i) inform the provider of the intent to terminate and the grounds for doing so;

274 (ii) at the request of the provider, meet with the provider to discuss the reasons for
275 termination;

276 (iii) if the insurer has a reasonable basis to believe that the provider may correct the
277 conduct giving rise to the notice of termination, the insurer may, at its discretion, place the
278 provider on probation with corrective action requirements, restrictions, or both, as necessary to
279 protect patient care; and

280 (iv) if the insurer has a reasonable basis to believe that the provider has engaged in
281 fraudulent conduct or poses a significant risk to patient care or safety, the insurer may
282 immediately suspend the provider from further performance under the contract, provided that
283 the remaining provisions of this Subsection (2) are followed in a timely manner before
284 termination may become final.

285 (d) Each insurer shall establish an internal appeal process for actions that may result in
286 terminated participation with cause and make known to the provider the procedure for
287 appealing such termination.

288 (i) Providers dissatisfied with the results of the appeal process may, if both parties
289 agree, submit the matters in dispute to mediation.

290 (ii) If the matters in dispute are not mediated, or should mediation be unsuccessful, the
291 dispute shall be subject to binding arbitration, by an arbitrator jointly selected by the parties the
292 cost of which shall be jointly shared. Each party shall bear its own additional expenses.

293 (e) A termination under Subsection (2)(a) or (b) may not be based on:

294 (i) the provider's staff privileges at a general acute care hospital not under contract with
295 the insurer; or

296 (ii) the provider's referral patterns for patients who are not covered by the insurer.

297 (3) Notwithstanding any other section of this title, an insurer may not take adverse
298 action against or reduce reimbursement to a contracted provider ~~H~~→ **who is not under a capitated**
298a **reimbursement arrangement** ←~~H~~ because of the decision of an
299 insured to access health care services from a noncontracted provider in a manner permitted by
300 the insured's health insurance plan, regardless of how the plan is designated.

301 Section 4. **Effective date.**

302 This bill takes effect on January 1, 2006.

Legislative Review Note

as of 2-8-05 9:23 AM

Based on a limited legal review, this legislation has not been determined to have a high probability of being held unconstitutional.

Office of Legislative Research and General Counsel

Fiscal Note
Bill Number HB0272

Patient Access to Providers and Contracting Amendments

17-Feb-05

11:11 AM

State Impact

No fiscal impact.

Individual and Business Impact

Enforcement is by private right of action. Any fiscal impact to insurers, HMO's, and providers will be dependent on actions taken under the provisions of this bill.

Office of the Legislative Fiscal Analyst