LEGISLATIVE GENERAL COUNSEL
₡ Approved for Filing: C.J. Dupont ₡
₡ 01-21-05 10:40 AM ₡

S.B. 34
1st Sub. (Green)

Senator Parley G. Hellewell proposes the following substitute bill:

1 # PATIENT ACCESS REFORM

2 2005 GENERAL SESSION

3 STATE OF UTAH

4 **Sponsor: Parley G. Hellewell**

5

6 **LONG TITLE**

7 **General Description:**

8 This bill amends provisions related to access to health care providers in the Health
9 Maintenance Organization and Preferred Provider Organization Chapters of the
10 Insurance Code.

11 **Highlighted Provisions:**

12 This bill:

13 ▸ provides that a health maintenance organization and preferred provider organization
14 must reimburse an insured for services of a health care provider who is not under
15 contract if those services are otherwise covered by the insurance plan;

16 ▸ establishes the reimbursement rate for noncontracted providers which is based on
17 the amount that would be paid to a member of the same class of health care
18 provider;

19 ▸ allows the health maintenance organization or preferred provider organization to
20 impose copayments and deductibles for noncontracted providers;

21 ▸ prohibits the insurer from imposing cost sharing measures greater than those
22 imposed with participating providers;

23 ▸ requires the insurer to make payment directly to the health care provider for
24 out-patient services;

25 ▸ clarifies the payment responsibilities of the insured;

26 ▸ prohibits a nonparticipating provider who accepts the 95% reimbursement rate from
27 balance billing the insured for additional costs; and
28 ▸ requires that out-of-pocket payments by insureds to noncontracted providers shall
29 apply to any plan deductible or out-of-pocket maximums.
30 **Monies Appropriated in this Bill:**
31 None
32 **Other Special Clauses:**
33 None
34 **Utah Code Sections Affected:**
35 AMENDS:
36 **31A-22-617**, as last amended by Chapter 131, Laws of Utah 2003
37 ENACTS:
38 **31A-8-503**, Utah Code Annotated 1953
39

40 *Be it enacted by the Legislature of the state of Utah:*
41 Section 1. Section **31A-8-503** is enacted to read:
42 **31A-8-503. Reimbursement of noncontracted providers.**
43 (1) As used in this section, "class of health care providers" means all health care
44 providers licensed, or licensed and certified by the state, within the same professional, trade,
45 occupational, or facility licensure, or licensure and certification category established pursuant
46 to Title 26, Utah Health Code, and Title 58, Occupations and Professions.
47 (2) (a) Subject to Subsections (2)(b) through (2)(d), a health maintenance organization
48 shall pay for the services of providers who are not participating providers with the health
49 maintenance organization, unless the illnesses or injuries treated by the provider are not within
50 the scope of the insured's health maintenance organization's health benefit plan.
51 (b) When the insured receives services from a provider who is not a participating
52 provider for the insured's health maintenance organization benefit plan, the health maintenance
53 organization shall reimburse the insured, in accordance with Subsection (2)(c), in an amount
54 equal to at least 95% of the amount that would be paid by the health maintenance organization
55 to:
56 (i) a participating provider; and

57 (ii) a member of the same class of health care provider.
58 (c) When reimbursing for services of out-patient providers who are not participating
59 providers, the health maintenance organization shall make direct payment to the provider.
60 (d) Notwithstanding Subsection (2)(b), a health maintenance organization may:
61 (i) impose a deductible or copayment on coverage of a medical condition treated by
62 nonparticipating providers if the deductible or copayment is not greater than the deductible or
63 copayment imposed on the same medical condition treated by participating providers for the
64 insured's health benefit plan; and
65 (ii) not impose cost-sharing measures, including copayments, deductibles, and
66 coinsurance, greater than those imposed on the same medical condition treated by participating
67 providers for the insured's health benefit plan.
68 (3) (a) When an insured receives services from a nonparticipating provider who is
69 reimbursed under the provisions of Subsection (2)(b), the insured is responsible for any
70 copayments and deductibles that are imposed by the insurer under Subsection (2)(d).
71 (b) A nonparticipating provider who accepts the 95% reimbursement rate designated in
72 Subsection (2)(b) may not balance bill the insured for any costs above those designated in
73 Subsection (3)(a).
74 Section 2. Section **31A-22-617** is amended to read:
75 **31A-22-617. Preferred provider contract provisions.**
76 Health insurance policies may provide for insureds to receive services or
77 reimbursement under the policies in accordance with preferred health care provider contracts as
78 follows:
79 (1) Subject to restrictions under this section, any insurer or third party administrator
80 may enter into contracts with health care providers as defined in Section 78-14-3 under which
81 the health care providers agree to supply services, at prices specified in the contracts, to
82 persons insured by an insurer.
83 (a) A health care provider contract may require the health care provider to accept the
84 specified payment as payment in full, relinquishing the right to collect additional amounts from
85 the insured person.
86 (b) The insurance contract may reward the insured for selection of preferred health care
87 providers by:

88 (i) reducing premium rates;
89 (ii) reducing deductibles;
90 (iii) coinsurance;
91 (iv) other copayments; or
92 (v) any other reasonable manner.
93 (c) If the insurer is a managed care organization, as defined in Subsection
94 31A-27-311.5(1)(f):
95 (i) the insurance contract and the health care provider contract shall provide that in the
96 event the managed care organization becomes insolvent, the rehabilitator or liquidator may:
97 (A) require the health care provider to continue to provide health care services under
98 the contract until the earlier of:
99 (I) 90 days after the date of the filing of a petition for rehabilitation or the petition for
100 liquidation; or
101 (II) the date the term of the contract ends; and
102 (B) subject to Subsection (1)(c)(v), reduce the fees the provider is otherwise entitled to
103 receive from the managed care organization during the time period described in Subsection
104 (1)(c)(i)(A);
105 (ii) the provider is required to:
106 (A) accept the reduced payment under Subsection (1)(c)(i)(B) as payment in full; and
107 (B) relinquish the right to collect additional amounts from the insolvent managed care
108 organization's enrollee, as defined in Subsection 31A-27-311.5(1)(b);
109 (iii) if the contract between the health care provider and the managed care organization
110 has not been reduced to writing, or the contract fails to contain the language required by
111 Subsection (1)(c)(i), the provider may not collect or attempt to collect from the enrollee:
112 (A) sums owed by the insolvent managed care organization; or
113 (B) the amount of the regular fee reduction authorized under Subsection (1)(c)(i)(B);
114 (iv) the following may not bill or maintain any action at law against an enrollee to
115 collect sums owed by the insolvent managed care organization or the amount of the regular fee
116 reduction authorized under Subsection (1)(c)(i)(B):
117 (A) a provider;
118 (B) an agent;

119 (C) a trustee; or
120 (D) an assignee of a person described in Subsections (1)(c)(iv)(A) through (C); and
121 (v) notwithstanding Subsection (1)(c)(i):
122 (A) a rehabilitator or liquidator may not reduce a fee by less than 75% of the provider's
123 regular fee set forth in the contract; and
124 (B) the enrollee shall continue to pay the copayments, deductibles, and other payments
125 for services received from the provider that the enrollee was required to pay before the filing
126 of:
127 (I) a petition for rehabilitation; or
128 (II) a petition for liquidation.
129 (2) (a) Subject to Subsections (2)(b) through (2)[~~(f)~~](g), an insurer, including a health
130 maintenance organization governed by Chapter 8, Health Maintenance Organizations and
131 Limited Health Plans, using preferred or participating health care provider contracts shall pay
132 for the services of health care providers not under the contract, unless the illnesses or injuries
133 treated by the health care provider are not within the scope of the insurance contract. As used
134 in this section, "class of health care providers" means all health care providers licensed or
135 licensed and certified by the state within the same professional, trade, occupational, or facility
136 licensure or licensure and certification category established pursuant to Titles 26, Utah Health
137 Code and 58, Occupations and Professions.
138 (b) When the insured receives services from a health care provider not under contract,
139 the insurer shall reimburse the insured for at least [~~75%~~] 95% of the average amount paid by
140 the insurer for comparable services of preferred health care providers who are members of the
141 same class of health care providers. The commissioner may adopt a rule dealing with the
142 determination of what constitutes [~~75%~~] 95% of the average amount paid by the insurer for
143 comparable services of preferred health care providers who are members of the same class of
144 health care providers.
145 (c) When reimbursing for services of outpatient health care providers not under
146 contract, the insurer [~~may~~] shall make direct payment to the [~~insured~~] provider.
147 (d) (i) Notwithstanding Subsection (2)(b), an insurer using preferred or participating
148 health care provider contracts may impose a deductible and copayments on coverage of a
149 medical condition treated by health care providers not under contract with the insurer, if the

150 deductible, copayment, or coinsurance is not greater than the deductible, copayment, or
151 coinsurance imposed on the same medical condition treated by health care providers who are
152 under contract with the insurer.
153 (ii) Out-of-pocket payments by insureds to health care providers not under contract
154 shall apply toward deductibles and out-of-pocket maximums in the same way and to the same
155 extent as payments to preferred or participating providers.
156 (e) When selecting health care providers with whom to contract under Subsection (1),
157 an insurer may not unfairly discriminate between classes of health care providers, but may
158 discriminate within a class of health care providers, subject to Subsection (7).
159 (f) For purposes of this section, unfair discrimination between classes of health care
160 providers shall include:
161 (i) refusal to contract with class members in reasonable proportion to the number of
162 insureds covered by the insurer and the expected demand for services from class members; and
163 (ii) refusal to cover procedures for one class of providers that are:
164 (A) commonly utilized by members of the class of health care providers for the
165 treatment of illnesses, injuries, or conditions;
166 (B) otherwise covered by the insurer; and
167 (C) within the scope of practice of the class of health care providers.
168 (g) (i) A health care provider not under contract with the insurer, who accepts the 95%
169 reimbursement rate from the insured's health plan may not balance bill the insured for costs
170 above the reimbursement rate.
171 (ii) When an insured receives services from a health care provider not under contract
172 who is reimbursed under the provisions of Subsection (2)(b), the insured is responsible for any
173 copayments or deductibles that are imposed by the insurer under Subsection (2)(d).
174 . (3) Before the insured consents to the insurance contract, the insurer shall fully disclose
175 to the insured that it has entered into preferred health care provider contracts. The insurer shall
176 provide sufficient detail on the preferred health care provider contracts to permit the insured to
177 agree to the terms of the insurance contract. The insurer shall provide at least the following
178 information:
179 (a) a list of the health care providers under contract and if requested their business
180 locations and specialties;

181 (b) a description of the insured benefits, including any deductibles, coinsurance, or
182 other copayments;
183 (c) a description of the quality assurance program required under Subsection (4); and
184 (d) a description of the adverse benefit determination procedures required under
185 Subsection (5).
186 (4) (a) An insurer using preferred health care provider contracts shall maintain a quality
187 assurance program for assuring that the care provided by the health care providers under
188 contract meets prevailing standards in the state.
189 (b) The commissioner in consultation with the executive director of the Department of
190 Health may designate qualified persons to perform an audit of the quality assurance program.
191 The auditors shall have full access to all records of the organization and its health care
192 providers, including medical records of individual patients.
193 (c) The information contained in the medical records of individual patients shall
194 remain confidential. All information, interviews, reports, statements, memoranda, or other data
195 furnished for purposes of the audit and any findings or conclusions of the auditors are
196 privileged. The information is not subject to discovery, use, or receipt in evidence in any legal
197 proceeding except hearings before the commissioner concerning alleged violations of this
198 section.
199 (5) An insurer using preferred health care provider contracts shall provide a reasonable
200 procedure for resolving complaints and adverse benefit determinations initiated by the insureds
201 and health care providers.
202 (6) An insurer may not contract with a health care provider for treatment of illness or
203 injury unless the health care provider is licensed to perform that treatment.
204 (7) (a) A health care provider or insurer may not discriminate against a preferred health
205 care provider for agreeing to a contract under Subsection (1).
206 (b) Any health care provider licensed to treat any illness or injury within the scope of
207 the health care provider's practice, who is willing and able to meet the terms and conditions
208 established by the insurer for designation as a preferred health care provider, shall be able to
209 apply for and receive the designation as a preferred health care provider. Contract terms and
210 conditions may include reasonable limitations on the number of designated preferred health
211 care providers based upon substantial objective and economic grounds, or expected use of

212 particular services based upon prior provider-patient profiles.
213 (8) Upon the written request of a provider excluded from a provider contract, the
214 commissioner may hold a hearing to determine if the insurer's exclusion of the provider is
215 based on the criteria set forth in Subsection (7)(b).
216 (9) Insurers are subject to the provisions of Sections 31A-22-613.5, 31A-22-614.5, and
217 31A-22-618.
218 (10) Nothing in this section is to be construed as to require an insurer to offer a certain
219 benefit or service as part of a health benefit plan.
220 (11) This section does not apply to catastrophic mental health coverage provided in
221 accordance with Section 31A-22-625.