

Representative James A. Dunnigan proposes the following substitute bill:

OPTIONS FOR HEALTH CARE

2007 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: James A. Dunnigan

Senate Sponsor: Curtis S. Bramble

LONG TITLE

General Description:

This bill amends provisions of the Accident and Health Insurance and Health Maintenance Organizations and Limited Health Plans part of the Insurance Code.

Highlighted Provisions:

This bill:

- ▶ reorganizes the provisions of the preferred provider statute;
- ▶ allows an insurer to offer different policies of coverage for nonparticipating providers including:
 - a policy that reimburses nonparticipating providers at 75% of the fee schedule for covered services; and
 - other policies that establish other reimbursement and cost sharing as specified in the insurance contract;
- ▶ permits discrimination between and among classes of health care providers if certain conditions are met;
- ▶ repeals certain restrictions on Health Maintenance Organizations that offer a point of service plan;
- ▶ amends definition in the Health Maintenance Organization chapter; and
- ▶ makes conforming amendments.



26 **Monies Appropriated in this Bill:**

27 None

28 **Other Special Clauses:**

29 This bill takes effect on January 1, 2008.

30 **Utah Code Sections Affected:**

31 AMENDS:

32 **31A-8-105**, as last amended by Chapter 329, Laws of Utah 1998

33 **31A-8-211**, as last amended by Chapter 308, Laws of Utah 2002

34 **31A-22-617**, as last amended by Chapter 3, Laws of Utah 2005, First Special Session

35 **31A-27-311.5**, as last amended by Chapter 252, Laws of Utah 2003

36 REPEALS:

37 **31A-8-408**, as last amended by Chapter 308, Laws of Utah 2002



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

40 Section 1. Section **31A-8-105** is amended to read:

41 **31A-8-105. General powers of organizations.**

42 Organizations may:

43 (1) buy, sell, lease, encumber, construct, renovate, operate, or maintain hospitals,
44 health care clinics, other health care facilities, and other real and personal property incidental to
45 and reasonably necessary for the transaction of the business and for the accomplishment of the
46 purposes of the organization;

47 (2) furnish health care through providers which are under contract with the
48 organization;

49 (3) contract with insurance companies licensed in this state or with health service
50 corporations authorized to do business in this state for insurance, indemnity, or reimbursement
51 for the cost of health care furnished by the organization;

52 (4) offer to its enrollees, in addition to health care, insured indemnity benefits~~[, but~~
53 ~~only for emergency care, out-of-area coverage, unusual or infrequently used health services as~~
54 ~~defined in Section 31A-8-101, and adoption benefits as provided in Section 31A-22-610.1];~~

55 (5) receive from governmental or private agencies payments covering all or part of the
56 cost of the health care furnished by the organization;

57 (6) lend money to a medical group under contract with it or with a corporation under its
58 control to acquire or construct health care facilities or for other uses to further its program of
59 providing health care services to its enrollees;

60 (7) be owned jointly by health care professionals and persons not professionally
61 licensed without violating Utah law; [~~and~~]

62 (8) offer to its enrolles a product that permits members the option of obtaining services
63 from a noncontracted provider, which is a point of service or point of sale product; and

64 [~~(8)~~] (9) do all other things necessary for the accomplishment of the purposes of the
65 organization.

66 Section 2. Section **31A-8-211** is amended to read:

67 **31A-8-211. Deposit.**

68 (1) Except as provided in Subsection (2), each health maintenance organization
69 authorized in this state shall maintain a deposit with the commissioner under Section
70 31A-2-206 in an amount equal to the sum of:

71 (a) \$100,000; and

72 (b) 50% of the greater of:

73 (i) \$900,000;

74 (ii) 2% of the annual premium revenues as reported on the most recent annual financial
75 statement filed with the commissioner; or

76 (iii) an amount equal to the sum of three months uncovered health care expenditures as
77 defined in Section 31A-8-101, and as reported on the most recent financial statement filed with
78 the commissioner.

79 (2) (a) After a hearing the commissioner may exempt a health maintenance
80 organization from the deposit requirement of Subsection (1) if:

81 (i) the commissioner determines that the enrollees' interests are adequately protected;

82 (ii) the health maintenance organization has been continuously authorized to do
83 business in this state for at least five years; and

84 (iii) the health maintenance organization has \$5,000,000 surplus in excess of the health
85 maintenance organization's company action level RBC as defined in Subsection
86 31A-17-601(8)(b).

87 (b) The commissioner may rescind an exemption given under Subsection (2)(a).

88 (3) (a) Each limited health plan authorized in this state shall maintain a deposit with
89 the commissioner under Section 31A-2-206 in an amount equal to the minimum capital or
90 permanent surplus plus 50% of the greater of:

91 (i) .5 times minimum required capital or minimum permanent surplus; or

92 (ii) (A) during the first year of operation, 10% of the limited health plan's projected
93 uncovered expenditures for the first year of operation;

94 (B) during the second year of operation, 12% of the limited health plan's projected
95 uncovered expenditures for the second year of operation;

96 (C) during the third year of operation, 14% of the limited health plan's projected
97 uncovered expenditures for the third year of operation;

98 (D) during the fourth year of operation, 18% of the limited health plan's projected
99 uncovered expenditures during the fourth year of operation; or

100 (E) during the fifth year of operation, and during all subsequent years, 20% of the
101 limited health plan's projected uncovered expenditures for the previous 12 months.

102 (b) Projections of future uncovered expenditures shall be established in a manner that
103 is approved by the commissioner.

104 (4) A deposit required by this section may be counted toward the minimum capital or
105 minimum permanent surplus required under Section 31A-8-209.

106 Section 3. Section 31A-22-617 is amended to read:

107 **31A-22-617. Preferred provider contract provisions.**

108 (1) For purposes of this section, "class of health care provider" means all health care
109 providers licensed and certified by the state within the same professional, trade, occupational,
110 or facility licensure and certification category established pursuant to Titles 26, Utah Health
111 Code and 58, Occupations and Professions.

112 (2) Health insurance policies may provide for insureds to receive services or
113 reimbursement under the policies in accordance with preferred health care provider contracts
114 [as follows:] subject to the provisions of this section.

115 ~~[(1) Subject to restrictions under this section, any]~~

116 (3) An insurer or third party administrator may enter into contracts with health care
117 providers as defined in Section 78-14-3 under which the health care providers agree to supply
118 services, at prices specified in the contracts, to persons insured by an insurer.

119 [(a)(i)-A] (4) An insurer using a health care provider contract [may] permitted by this
120 section shall:

121 (a) in accordance with Subsection (10), pay for the services of health care providers not
122 under contract with the insurer, unless the illnesses or injuries treated by the health care
123 provider are not within the scope of the insurance contract;

124 (b) before the insured consents to the insurance contract, fully disclose to the insured
125 that the insurer has entered into preferred health care provider contracts, and provide sufficient
126 detail on the preferred health care provider contracts to permit the insured to agree to the terms
127 of the insurance contract;

128 (c) provide the insured with at least the following information:

129 (i) a list of the health care providers under contract and if requested, their business
130 locations and specialties;

131 (ii) a description of the insured benefits, including any deductibles, coinsurance, or
132 other copayments;

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

135 (iv) a description of the adverse benefit determination procedures required under
136 Subsection (4)(e);

137 (d) maintain a quality assurance program for assuring that the care provided by the
138 health care providers under contract meets prevailing standards in the state;

139 (e) in accordance with Subsection (7), provide a reasonable procedure for resolving
140 complaints and adverse benefit determinations; and

141 (f) if an insurer permits another entity with which it does not share common ownership
142 or control to use or otherwise lease one or more of the organization's networks of participating
143 providers, ensure, at a minimum, that the entity pays participating providers in accordance with
144 the same fee schedule and general payment policies as the organization would for that network.

145 (5) An insurer using a health care provider contract permitted by this section may:

146 (a) require the health care provider to accept the specified payment as payment in full,
147 relinquishing the right to collect additional amounts from the insured person[-];

148 (b) make direct payment to an insured when reimbursing for services of health care
149 providers not under contract;

150 (c) impose a deductible on coverage of health care providers not under contract; and

151 (d) reward the insured for selection of preferred health care providers by:

152 (i) reducing premium rates;

153 (ii) reducing deductibles;

154 (iii) reducing coinsurance;

155 (iv) reducing other copayments; or

156 (v) any other reasonable manner.

157 (6) An insurer using a health care provider contract permitted by this section may not:

158 (a) penalize a provider solely for pursuing a claims dispute under the provisions of this
159 section, or otherwise demanding payment for sums believed owing; and

160 (b) contract with a health care provider for treatment of illness or injury unless the
161 health care provider is licensed to perform that treatment.

162 [(ii)] (7) (a) In any dispute involving a provider's claim for reimbursement, the same
163 shall be determined in accordance with applicable law, the provider contract, the subscriber
164 contract, and the insurer's written payment policies in effect at the time services were rendered.

165 [(iii)] (b) (i) If the parties are unable to resolve their dispute, the matter shall be subject
166 to binding arbitration by a jointly selected arbitrator. Each party is to bear its own expense
167 except the cost of the jointly selected arbitrator shall be equally shared.

168 (ii) [This] Subsection [(+)(a)(iii)] (7)(b)(i) does not apply to the claim of a general
169 acute hospital to the extent it is inconsistent with the hospital's provider agreement.

170 [(iv) An organization may not penalize a provider solely for pursuing a claims dispute
171 or otherwise demanding payment for a sum believed owing.]

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

177 [(b) The insurance contract may reward the insured for selection of preferred health
178 care providers by:]

179 [(i) reducing premium rates;]

180 [(ii) reducing deductibles;]

181 ~~[(iii) coinsurance;]~~
 182 ~~[(iv) other copayments; or]~~
 183 ~~[(v) any other reasonable manner.]~~
 184 ~~[(c) If the insurer is a managed care organization, as defined in Subsection~~
 185 ~~31A-27-311.5(1)(f):]~~
 186 ~~[(i) the]~~ (8) (a) An insurance contract and the health care provider contract shall
 187 provide that in the event the managed care organization becomes insolvent, the rehabilitator or
 188 liquidator may:
 189 ~~[(A)]~~ (i) require the health care provider to continue to provide health care services
 190 under the contract until the earlier of:
 191 ~~[(F)]~~ (A) 90 days after the date of the filing of a petition for rehabilitation or the petition
 192 for liquidation; or
 193 ~~[(H)]~~ (B) the date the term of the contract ends; and
 194 ~~[(B)]~~ (ii) subject to Subsection ~~[(1)(c)(v)]~~ (8)(c)(ii), reduce the fees the provider is
 195 otherwise entitled to receive from the managed care organization during the time period
 196 described in Subsection ~~[(1)(c)(i)(A);]~~ (8)(a)(i).
 197 ~~[(ii)]~~ (b) In the event the managed care organization becomes insolvent, the provider:
 198 (i) is required to:
 199 (A) accept the reduced payment under Subsection ~~[(1)(c)(i)(B)]~~ (8)(a)(ii) as payment in
 200 full; and
 201 (B) relinquish the right to collect additional amounts from the insolvent managed care
 202 organization's enrollee, as defined in Subsection 31A-27-311.5(1)(b); and
 203 ~~[(iii)]~~ (ii) may not, if the contract between the health care provider and the managed
 204 care organization has not been reduced to writing, or the contract fails to contain the language
 205 required by Subsection ~~[(1)(c)(i)]~~ (8)(a), the provider may not collect or attempt to collect from
 206 the enrollee:
 207 (A) sums owed by the insolvent managed care organization; or
 208 (B) the amount of the regular fee reduction authorized under Subsection ~~[(1)(c)(i)(B);]~~
 209 (8)(a)(ii).
 210 ~~[(iv)]~~ (c) (i) In the event the managed care organization becomes insolvent, the
 211 following may not bill or maintain any action at law against an enrollee to collect sums owed

212 by the insolvent managed care organization or the amount of the regular fee reduction
213 authorized under Subsection ~~[(1)(c)(i)(B)]~~ (8)(a)(ii):

- 214 (A) a provider;
- 215 (B) an agent;
- 216 (C) a trustee; or
- 217 (D) an assignee of a person described in Subsections ~~[(1)(c)(iv)(A) through (C)]~~
218 (8)(c)(i)(A) through (D); and

219 ~~[(v)]~~ (ii) notwithstanding Subsection ~~[(1)(c)(i)]~~ (8)(a):

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

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

- 225 (I) a petition for rehabilitation; or
- 226 (II) a petition for liquidation.

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

234 ~~[(b) When the insured receives services from a health care provider not under contract,
235 the insurer shall reimburse the insured for at least 75% of the average amount paid by the
236 insurer for comparable services of preferred health care providers who are members of the
237 same class of health care providers. The commissioner may adopt a rule dealing with the
238 determination of what constitutes 75% of the average amount paid by the insurer for
239 comparable services of preferred health care providers who are members of the same class of
240 health care providers.]~~

241 ~~[(c) When reimbursing for services of health care providers not under contract, the
242 insurer may make direct payment to the insured.]~~

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

245 ~~[(e) When selecting health care providers with whom to contract under Subsection (1),~~
246 ~~an insurer may not unfairly discriminate between classes of health care providers, but may~~
247 ~~discriminate within a class of health care providers, subject to Subsection (7).]~~

248 ~~[(f) For purposes of this section, unfair discrimination between classes of health care~~
249 ~~providers shall include:]~~

250 ~~[(i) refusal to contract with class members in reasonable proportion to the number of~~
251 ~~insureds covered by the insurer and the expected demand for services from class members;~~
252 ~~and]~~

253 ~~[(ii) refusal to cover procedures for one class of providers that are:]~~

254 ~~[(A) commonly utilized by members of the class of health care providers for the~~
255 ~~treatment of illnesses, injuries, or conditions;]~~

256 ~~[(B) otherwise covered by the insurer; and]~~

257 ~~[(C) within the scope of practice of the class of health care providers.]~~

258 ~~[(3) Before the insured consents to the insurance contract, the insurer shall fully~~
259 ~~disclose to the insured that it has entered into preferred health care provider contracts. The~~
260 ~~insurer shall provide sufficient detail on the preferred health care provider contracts to permit~~
261 ~~the insured to agree to the terms of the insurance contract. The insurer shall provide at least the~~
262 ~~following information:]~~

263 ~~[(a) a list of the health care providers under contract and if requested their business~~
264 ~~locations and specialties;]~~

265 ~~[(b) a description of the insured benefits, including any deductibles, coinsurance, or~~
266 ~~other copayments;]~~

267 ~~[(c) a description of the quality assurance program required under Subsection (4); and]~~

268 ~~[(d) a description of the adverse benefit determination procedures required under~~
269 ~~Subsection (5).]~~

270 ~~[(4) (a) An insurer using preferred health care provider contracts shall maintain a~~
271 ~~quality assurance program for assuring that the care provided by the health care providers under~~
272 ~~contract meets prevailing standards in the state.]~~

273 ~~[(b) The commissioner in consultation with the executive director of the Department of~~

274 Health may designate qualified persons to perform an audit of the quality assurance program.
275 The auditors shall have full access to all records of the organization and its health care
276 providers, including medical records of individual patients.]

277 [~~(c)~~ The information contained in the medical records of individual patients shall
278 remain confidential. All information, interviews, reports, statements, memoranda, or other data
279 furnished for purposes of the audit and any findings or conclusions of the auditors are
280 privileged. The information is not subject to discovery, use, or receipt in evidence in any legal
281 proceeding except hearings before the commissioner concerning alleged violations of this
282 section.]

283 [~~(5)~~ An insurer using preferred health care provider contracts shall provide a
284 reasonable procedure for resolving complaints and adverse benefit determinations initiated by
285 the insureds and health care providers.]

286 [~~(6)~~ An insurer may not contract with a health care provider for treatment of illness or
287 injury unless the health care provider is licensed to perform that treatment.]

288 [~~(7)~~ (a) A health care provider or insurer may not discriminate against a preferred
289 health care provider for agreeing to a contract under Subsection (1).]

290 [~~(b)~~ (9)(a) Any health care provider licensed to treat any illness or injury within the
291 scope of the health care provider's practice, who is willing and able to meet the terms and
292 conditions established by the insurer under Section 31A-22-617.1 for designation as a preferred
293 health care provider, shall be able to apply for and receive the designation as a preferred health
294 care provider. [~~Contract terms and conditions may include reasonable limitations on the~~
295 ~~number of designated preferred health care providers based upon substantial objective and~~
296 ~~economic grounds, or expected use of particular services based upon prior provider-patient~~
297 ~~profiles.]~~

298 [~~(8)~~ (b) Upon the written request of a provider excluded from a provider contract, the
299 commissioner may hold a hearing to determine if the insurer's exclusion of the provider is
300 based on the criteria set forth in Subsection [~~(7)(b)~~] (9)(a).

301 (10)(a) An insurer using preferred health care provider contracts shall offer the
302 coverage for services of health care providers not under contract that is required by this section.

303 (b) An insurer shall offer at least one policy that provides:

304 (i) when the insured receives services from a health care provider not under contract,

305 the insurer shall reimburse the insured for at least 75% of the average amount paid by the
 306 insurer for comparable services of preferred health care providers who are members of the
 307 same class of health care providers unless the illness or injury treated by the health care
 308 provider are not within the scope of the insurance contract;

309 (ii) when reimbursing for the services of a health care provider not under contract with
 310 the insurer, the insurer may:

311 (A) make payments directly to the insured; and

312 (B) impose a deductible on coverage of health care providers not under contract; and

313 (iii) notwithstanding the provisions of Section 31A-22-618, when selecting health care
 314 providers with whom to contract with, an insurer may discriminate within and between a class
 315 of health care providers subject to Subsection (9).

316 (c) An insurer may offer policies that provide that when an insured receives services
 317 from a health care provider not under contract, the insurer:

318 (i) will reimburse the insured in an amount or percentage specified in the contract,

319 however, that percentage may not be less than ~~5~~ :

319a (A) ~~50~~ % of the average amount paid by the insurer

320 for comparable services of preferred health care providers who are members of the same class
 321 of health care providers unless the illness or injury treated by the health care provider are not
 322 within the scope of the insurance contract; ~~5~~ and

322a (B) **75% of the average amount paid by the insurer for the treatment of an emergency**

322b **medical condition as required under Section 31A-22-627; ~~5~~**

323 (ii) may impose deductibles, copayments, coinsurance, or other out-of-pocket expenses
 324 as specified in the contract;

325 (iii) when reimbursing for services, will make payment to the insured or the health care
 326 provider as specified in the contract; and

327 (iv) may select providers in accordance with Subsection (10)(b)(iii).

328 (11) (a) The commissioner in consultation with the executive director of the
 329 Department of Health may designate qualified persons to perform an audit of the quality
 330 assurance program of an insurer under this part. The auditors shall have full access to all
 331 records of the organization and its health care providers, including medical records of
 332 individual patients.

333 (b) The information contained in the medical records of individual patients shall
 334 remain confidential. All information, interviews, reports, statements, memoranda, or other data
 335 furnished for purposes of the audit and any findings or conclusions of the auditors are

336 privileged. The information is not subject to discovery, use, or receipt in any legal
337 proceeding except hearings before the commissioner concerning alleged violations of this
338 section.

339 [~~9~~] (12) Insurers are subject to the provisions of [Sections]:

340 (a) Section 31A-22-613.5[:];

341 (b) Section 31A-22-614.5[:]; and

342 (c) except as provided in Subsection (10), Section 31A-22-618.

343 [~~10~~] (13) Nothing in this section is to be construed as to require an insurer to offer a
344 certain benefit or service as part of a health benefit plan.

345 [~~11~~] (14) This section does not apply to catastrophic mental health coverage provided
346 in accordance with Section 31A-22-625.

347 Section 4. Section **31A-27-311.5** is amended to read:

348 **31A-27-311.5. Continuance of coverage -- Health maintenance organizations.**

349 (1) As used in this section:

350 (a) "basic health care services" is as defined in Section 31A-8-101;

351 (b) "enrollee" is as defined in Section 31A-8-101;

352 (c) "health care" is as defined in Section 31A-1-301;

353 (d) "health maintenance organization" is as defined in Section 31A-8-101;

354 (e) "limited health plan" is as defined in Section 31A-8-101;

355 (f) (i) "managed care organization" means any entity licensed by, or holding a
356 certificate of authority from, the department to furnish health care services or health insurance;

357 (ii) "managed care organization" includes:

358 (A) a limited health plan;

359 (B) a health maintenance organization;

360 (C) a preferred provider organization;

361 (D) a fraternal benefit society; or

362 (E) any entity similar to an entity described in Subsections (1)(f)(ii)(A) through (D);

363 (iii) "managed care organization" does not include:

364 (A) an insurer or other person that is eligible for membership in a guaranty association
365 under Chapter 28, Guaranty Associations;

366 (B) a mandatory state pooling plan;

367 (C) a mutual assessment company or any entity that operates on an assessment basis; or

368 (D) any entity similar to an entity described in Subsections (1)(f)(iii)(A) through (C);

369 (g) "participating provider" means a provider who, under a contract with a managed
370 care organization authorized under Section 31A-8-407, agrees to provide health care services to
371 enrollees with an expectation of receiving payment, directly or indirectly, from the managed
372 care organization, other than copayment;

373 (h) "participating provider contract" means the agreement between a participating
374 provider and a managed care organization authorized under Section 31A-8-407;

375 (i) "preferred provider" means a provider who agrees to provide health care services
376 under an agreement authorized under Subsection 31A-22-617[~~(+)~~](3);

377 (j) "preferred provider contract" means the written agreement between a preferred
378 provider and a managed care organization authorized under Subsection 31A-22-617[~~(+)~~](3);

379 (k) (i) except as provided in Subsection (1)(k)(ii), "preferred provider organization"
380 means any person that:

381 (A) furnishes at a minimum, through preferred providers, basic health care services to
382 an enrollee in return for prepaid periodic payments in an amount agreed to prior to the time
383 during which the health care may be furnished;

384 (B) is obligated to the enrollee to arrange for the services described in Subsection
385 (1)(k)(i)(A); and

386 (C) permits the enrollee to obtain health care services from providers who are not
387 preferred providers; and

388 (ii) "preferred provider organization" does not include:

389 (A) an insurer licensed under Chapter 7, Nonprofit Health Service Insurance
390 Corporations; or

391 (B) an individual who contracts to render professional or personal services that the
392 individual performs;

393 (l) "provider" is as defined in Section 31A-8-101; and

394 (m) "uncovered expenditure" means the costs of health care services that are covered
395 by an organization for which an enrollee is liable in the event of the managed care
396 organization's insolvency.

397 (2) The rehabilitator or liquidator may take one or more of the actions described in

398 Subsections (2)(a) through (f) to assure continuation of health care coverage for enrollees of an
399 insolvent managed care organization.

400 (a) (i) Subject to Subsection (2)(a)(ii), a rehabilitator or liquidator may require a
401 participating provider and preferred provider of health care services to continue to provide the
402 health care services the provider is required to provide under the provider's participating
403 provider contract or preferred provider contract until the earlier of:

404 (A) 90 days after the date of the filing of:

405 (I) a petition for rehabilitation; or

406 (II) a petition for liquidation; or

407 (B) the date the term of the contract ends.

408 (ii) A requirement by the rehabilitator or liquidator under Subsection (2)(a)(i) that a
409 participating provider or preferred provider continue to provide health care services under a
410 provider's participating provider contract or preferred providers contract expires when health
411 care coverage for all enrollees of the insolvent managed care organization is obtained from
412 another managed care organization or insurer.

413 (b) (i) Subject to Subsection (2)(b)(ii), a rehabilitator or liquidator may reduce the fees
414 a participating provider or preferred provider is otherwise entitled to receive from the managed
415 care organization under its participating provider contract or preferred provider contract during
416 the time period in Subsection (2)(a)(i).

417 (ii) Notwithstanding Subsection (2)(b)(i) a rehabilitator or liquidator may not reduce a
418 fee to less than 75% of the regular fee set forth in the respective participating provider contract
419 or preferred provider contract.

420 (iii) An enrollee shall continue to pay the same copayments, deductibles, and other
421 payments for services received from the participating provider or preferred provider that the
422 enrollee was required to pay before the date of filing of:

423 (A) the petition for rehabilitation; or

424 (B) the petition for liquidation.

425 (c) (i) A participating provider or preferred provider shall:

426 (A) accept the amounts specified in Subsection (2)(b) as payment in full; and

427 (B) relinquish the right to collect additional amounts from the insolvent managed care
428 organization's enrollee.

429 (ii) Subsections (2)(b) and (2)(c)(i) shall apply to the fees paid to a provider who agrees
430 to provide health care services to an enrollee but is not a preferred or participating provider.

431 (d) If the managed care organization is a health maintenance organization, Subsections
432 (2)(d)(i) through (vi) apply.

433 (i) Subject to Subsections (2)(d)(ii), (iii), and (v), upon notification from and subject to
434 the direction of the rehabilitator or liquidator of a health maintenance organization licensed
435 under Chapter 8, Health Maintenance Organizations and Limited Health Plans, a solvent health
436 maintenance organization licensed under Chapter 8, Health Maintenance Organizations and
437 Limited Health Plans, and operating within a portion of the insolvent health maintenance
438 organization's service area shall extend to the enrollees all rights, privileges, and obligations of
439 being an enrollee in the accepting health maintenance organization.

440 (ii) Notwithstanding Subsection (2)(d)(i), the accepting health maintenance
441 organization shall give credit to an enrollee for any waiting period already satisfied under the
442 provisions of the enrollee's contract with the insolvent health maintenance organization.

443 (iii) A health maintenance organization accepting an enrollee of an insolvent health
444 maintenance organization under Subsection (2)(d)(i) shall charge the enrollee the premiums
445 applicable to the existing business of the accepting health maintenance organization.

446 (iv) A health maintenance organization's obligation to accept an enrollee under
447 Subsection (2)(d)(i) is limited in number to the accepting health maintenance organization's pro
448 rata share of all health maintenance organization enrollees in this state, as determined after
449 excluding the enrollees of the insolvent insurer.

450 (v) (A) The rehabilitator or liquidator of an insolvent health maintenance organization
451 shall take those measures that are possible to ensure that no health maintenance organization is
452 required to accept more than its pro rata share of the adverse risk represented by the enrollees
453 of the insolvent health maintenance organization.

454 (B) If the methodology used by the rehabilitator or liquidator to assign an enrollee is
455 one that can be expected to produce a reasonably equitable distribution of adverse risk, that
456 methodology and its results are acceptable under this Subsection (2)(d)(v).

457 (vi) (A) Notwithstanding Section 31A-27-311, the rehabilitator or liquidator may
458 require all solvent health maintenance organizations to pay for the covered claims incurred by
459 the enrollees of the insolvent health maintenance organization.

460 (B) As determined by the rehabilitator or liquidator, payments required under this
461 Subsection (2)(d)(vi) may:

462 (I) begin as of the filing of the petition for rehabilitation or the petition for liquidation;
463 and

464 (II) continue for a maximum period through the time all enrollees are assigned pursuant
465 to this section.

466 (C) If the rehabilitator or liquidator makes an assessment under this Subsection
467 (2)(d)(vi), the rehabilitator or liquidator shall assess each solvent health maintenance
468 organization its pro rata share of the total assessment based upon its premiums from the
469 previous calendar year.

470 (D) (I) A solvent health maintenance organization required to pay for covered claims
471 under this Subsection (2)(d)(vi) shall be entitled to file a claim against the estate of the
472 insolvent health maintenance organization.

473 (II) Any claim described in Subsection (2)(d)(vi)(D)(I), if allowed by the rehabilitator
474 or liquidator, shall share in any distributions from the estate of the insolvent health
475 maintenance organization as a Class 3 claim.

476 (e) (i) A rehabilitator or liquidator may transfer, through sale, or otherwise, the group
477 and individual health care obligations of the insolvent managed care organization to other
478 managed care organizations or other insurers, if those other managed care organizations and
479 other insurers are licensed or have a certificate of authority to provide the same health care
480 services in this state that is held by the insolvent managed care organization.

481 (ii) The rehabilitator or liquidator may combine group and individual health care
482 obligations of the insolvent managed care organization in any manner the rehabilitator or
483 liquidator considers best to provide for continuous health care coverage for the maximum
484 number of enrollees of the insolvent managed care organization.

485 (iii) If the terms of a proposed transfer of the same combination of group and
486 individual policy obligations to more than one other managed care organization or insurer are
487 otherwise equal, the rehabilitator or liquidator shall give preference to the transfer of the group
488 and individual policy obligations of an insolvent managed care organization as follows:

489 (A) from one category of managed care organization to another managed care
490 organization of the same category, as follows:

- 491 (I) [~~from~~] a limited health plan to a limited health plan;
492 (II) [~~from~~] a health maintenance organization to a health maintenance organization;
493 (III) [~~from~~] a preferred provider organization to a preferred provider organization;
494 (IV) [~~from~~] a fraternal benefit society to a fraternal benefit society; and
495 (V) [~~from~~] any entity similar to any of the above to a category that is similar;
496 (B) from one category of managed care organization to another managed care
497 organization, regardless of the category of the transferee managed care organization; and
498 (C) from a managed care organization to a nonmanaged care provider of health care
499 coverage, including insurers.
500 (f) If an insolvent managed care organization has required surplus, a rehabilitator or
501 liquidator may use the insolvent managed care organization's required surplus to continue to
502 provide coverage for the insolvent managed care organization's enrollees, including paying
503 uncovered expenditures.

504 **Section 5. Repealer.**

505 This bill repeals:

506 **Section 31A-8-408, Organizations offering point of service or point of sales**
507 **products.**

508 **Section 6. Effective date.**

509 This bill takes effect on January 1, 2008.

H.B. 163 3rd Sub. (Cherry) - Options for Health Care

Fiscal Note

2007 General Session

State of Utah

State Impact

Enactment of this bill will not require additional appropriations.

Individual, Business and/or Local Impact

Enactment of this bill likely will not result in direct, measurable costs and/or benefits for individuals, businesses, or local governments.
