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**H.B. 163**
**3rd Sub. (Cherry)**

**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.

H.B. 163

**Monies Appropriated in this Bill:**

None

**Other Special Clauses:**

This bill takes effect on January 1, 2008.

**Utah Code Sections Affected:**

AMENDS:

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

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

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

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

REPEALS:

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

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

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

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

Organizations may:

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

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

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

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

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

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

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

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

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

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

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

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

(a) $100,000; and

(b) 50% of the greater of:

(i) $900,000;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) reducing premium rates;

(ii) reducing deductibles;

(iii) reducing coinsurance;

(iv) reducing other copayments; or

(v) any other reasonable manner.

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

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

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

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

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

(ii) [~~This~~] Subsection [~~(1)(a)(iii)~~] (7)(b)(i) does not apply to the claim of a general acute hospital to the extent it is inconsistent with the hospital's provider agreement.

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

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

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

[~~(i) reducing premium rates;~~]

[~~(ii) reducing deductibles;~~]

[~~(iii) coinsurance;~~]

[~~(iv) other copayments; or~~]

[~~(v) any other reasonable manner.~~]

[~~(c) If the insurer is a managed care organization, as defined in Subsection 31A-27-311.5(1)(f):~~]

[~~(i) the~~] (8) (a) An insurance contract and the health care provider contract shall provide that in the event the managed care organization becomes insolvent, the rehabilitator or liquidator may:

[~~(A)~~] (i) require the health care provider to continue to provide health care services under the contract until the earlier of:

[~~(I)~~] (A) 90 days after the date of the filing of a petition for rehabilitation or the petition for liquidation; or

[~~(II)~~] (B) the date the term of the contract ends; and

[~~(B)~~] (ii) subject to Subsection [~~(1)(c)(v)~~] (8)(c)(ii), reduce the fees the provider is otherwise entitled to receive from the managed care organization during the time period described in Subsection [~~(1)(c)(i)(A);~~] (8)(a)(i).

[~~(ii)~~] (b) In the event the managed care organization becomes insolvent, the provider:

(i) is required to:

(A) accept the reduced payment under Subsection [~~(1)(c)(i)(B)~~] (8)(a)(ii) as payment in full; and

(B) relinquish the right to collect additional amounts from the insolvent managed care organization's enrollee, as defined in Subsection 31A-27-311.5(1)(b); and

[~~(iii)~~] (ii) may not, if the contract between the health care provider and the managed care organization has not been reduced to writing, or the contract fails to contain the language required by Subsection [~~(1)(c)(i)~~] (8)(a), the provider may not collect or attempt to collect from the enrollee:

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

(B) the amount of the regular fee reduction authorized under Subsection [~~(1)(c)(i)(B);~~] (8)(a)(ii).

[~~(iv)~~] (c) (i) In the event the managed care organization becomes insolvent, the following may not bill or maintain any action at law against an enrollee to collect sums owed

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

(A) a provider;

(B) an agent;

(C) a trustee; or

(D) an assignee of a person described in Subsections [~~(1)(c)(iv)(A) through (C);~~] (8)(c)(i)(A) through (D); and

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

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

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

(I) a petition for rehabilitation; or

(II) a petition for liquidation.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(A) make payments directly to the insured; and

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

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

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

(i) will reimburse the insured in an amount or percentage specified in the contract, however, that percentage may not be less than 50% of the average amount paid by the insurer for comparable services of preferred health care providers who are members of the same class of health care providers unless the illness or injury treated by the health care provider are not within the scope of the insurance contract;

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

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

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

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

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

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

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

(a) Section 31A-22-613.5[~~,~~];

(b) Section 31A-22-614.5[~~,~~]; and

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

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

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

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

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

(1) As used in this section:

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

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

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

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

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

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

(ii) "managed care organization" includes:

(A) a limited health plan;

(B) a health maintenance organization;

(C) a preferred provider organization;

(D) a fraternal benefit society; or

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

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

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

(B) a mandatory state pooling plan;

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

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

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

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

(i) "preferred provider" means a provider who agrees to provide health care services under an agreement authorized under Subsection 31A-22-617[~~(1)~~](3);

(j) "preferred provider contract" means the written agreement between a preferred provider and a managed care organization authorized under Subsection 31A-22-617[~~(1)~~](3);

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

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

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

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

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

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

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

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

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

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

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

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

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

(I) a petition for rehabilitation; or

(II) a petition for liquidation; or

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

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

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

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

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

(A) the petition for rehabilitation; or

(B) the petition for liquidation.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(I) [~~from~~] a limited health plan to a limited health plan;

(II) [~~from~~] a health maintenance organization to a health maintenance organization;

(III) [~~from~~] a preferred provider organization to a preferred provider organization;

(IV) [~~from~~] a fraternal benefit society to a fraternal benefit society; and

(V) [~~from~~] any entity similar to any of the above to a category that is similar;

(B) from one category of managed care organization to another managed care organization, regardless of the category of the transferee managed care organization; and

(C) from a managed care organization to a nonmanaged care provider of health care coverage, including insurers.

(f) If an insolvent managed care organization has required surplus, a rehabilitator or liquidator may use the insolvent managed care organization's required surplus to continue to provide coverage for the insolvent managed care organization's enrollees, including paying uncovered expenditures.

Section 5. **Repealer.**

This bill repeals:

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

Section 6. **Effective date.**

This bill takes effect on January 1, 2008.

# Fiscal Note

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

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.

*2/16/2007, 3:15:42 PM, Lead Analyst: Eckersley, S.*

**Office of the Legislative Fiscal Analyst**