1 **ACCESS TO QUALIFIED HEALTH CARE**
2 **PROVIDERS**
3 2008 GENERAL SESSION
4 STATE OF UTAH
5 **Chief Sponsor: D. Chris Buttars**
6 House Sponsor: ____________
7
8 **LONG TITLE**
9 **General Description:**
10 This bill amends provisions related to access to qualified health care providers in the
11 Health Maintenance Organization and Preferred Provider Organization Chapters of the
12 Insurance Code.
13 **Highlighted Provisions:**
14 This bill:
15 ▸ defines "qualified provider";
16 ▸ provides that a health maintenance organization and preferred provider organization
17 must reimburse an insured for services of a qualified provider who is not under
18 contract if those services are otherwise covered by the insurance plan;
19 ▸ establishes the reimbursement rate for noncontracted qualified providers which is
20 based on the amount that would be paid to a member of the same class of health
21 care provider;
22 ▸ allows the health maintenance organization or preferred provider organization to
23 impose copayments and deductibles for noncontracted qualified providers;
24 ▸ prohibits the insurer from imposing cost sharing measures greater than those
25 imposed with participating providers;
26 ▸ requires the insurer to make payment directly to the qualified provider for
27 out-patient services;

28 ▸ clarifies the payment responsibilities of the insured;
29 ▸ restricts the amount a nonparticipating qualified provider who accepts the
30 reimbursement rate may balance bill; and
31 ▸ requires that out-of-pocket payments by insureds to noncontracted qualified
32 providers shall apply to any plan deductible or out-of-pocket maximums.
33 **Monies Appropriated in this Bill:**
34 None
35 **Other Special Clauses:**
36 None
37 **Utah Code Sections Affected:**
38 AMENDS:
39 **31A-22-617**, as last amended by Laws of Utah 2007, Chapter 309
40 ENACTS:
41 **31A-8-503**, Utah Code Annotated 1953
42

43 *Be it enacted by the Legislature of the state of Utah:*
44 Section 1. Section **31A-8-503** is enacted to read:
45 **31A-8-503. Reimbursement of noncontracted providers.**
46 (1) As used in this section:
47 (a) "Class of health care providers" means all health care providers licensed, or
48 licensed and certified by the state, within the same professional, trade, occupational, or facility
49 licensure, or licensure and certification category established pursuant to Title 26, Utah Health
50 Code, and Title 58, Occupations and Professions.
51 (b) (i) "Qualified provider" means a health care provider:
52 (A) whose license is in good standing in the state;
53 (B) who can provide proof of medical liability coverage;
54 (C) who is certified in the provider's field of practice by a nationally recognized
55 certification organization; and
56 (D) who has been either:
57 (I) credentialed by a hospital licensed in the state; or
58 (II) included on a provider panel for any accident and health insurer in the state.

59 (ii) "Qualified provider" does not include a general acute hospital licensed under Title
60 26, Chapter 21, Health Care Facility Licensing and Inspection Act.
61 (2) (a) Subject to Subsections (2)(b) through (d), a health maintenance organization
62 shall pay for the services of a qualified provider who is not a participating provider with the
63 health maintenance organization, unless the illness or injury treated by the qualified provider is
64 not within the scope of the insured's health maintenance organization's health benefit plan.
65 (b) When the insured receives services from a qualified provider who is not a
66 participating provider for the insured's health maintenance organization benefit plan, the health
67 maintenance organization shall reimburse the insured, in accordance with Subsection (2)(c), in
68 an amount equal to at least 90% of the amount that would be paid by the health maintenance
69 organization to:
70 (i) a participating provider; and
71 (ii) a member of the same class of health care provider.
72 (c) When reimbursing for the services of an out-patient qualified provider who is not a
73 participating provider, the health maintenance organization shall make direct payment to the
74 qualified provider.
75 (d) Notwithstanding Subsection (2)(b), a health maintenance organization may:
76 (i) impose a deductible or copayment on coverage of a medical condition treated by a
77 nonparticipating qualified provider if the deductible or copayment is not greater than the
78 deductible or copayment imposed on the same medical condition treated by a participating
79 provider for the insured's health benefit plan; and
80 (ii) not impose cost-sharing measures, including copayments, deductibles, and
81 coinsurance, greater than those imposed on the same medical condition treated by a
82 participating provider for the insured's health benefit plan.
83 (3) (a) When an insured receives services from a nonparticipating qualified provider
84 who is reimbursed under the provisions of Subsection (2)(b), the insured is responsible for any
85 copayments and deductibles that are imposed by the insurer under Subsection (2)(d).
86 (b) A nonparticipating qualified provider who accepts the 90% reimbursement rate
87 designated in Subsection (2)(b) may balance bill the insured for up to 110% of the in-network
88 allowed amount for the medical condition treated.
89 (4) This section does not apply when an individual's health maintenance organization

90 benefit plan is a Medicaid program or the Children's Health Insurance Program under Title 26,
91 Chapter 18, Medical Assistance Act.
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. This Subsection (1)(a)(iii)
110 does not apply to the claim of a general acute hospital to the extent it is inconsistent with the
111 hospital's provider agreement.
112 (iv) An organization may not penalize a provider solely for pursuing a claims dispute
113 or otherwise demanding payment for a sum believed owing.
114 (v) If an insurer permits another entity with which it does not share common ownership
115 or control to use or otherwise lease one or more of the organization's networks of participating
116 providers, the organization shall ensure, at a minimum, that the entity pays participating
117 providers in accordance with the same fee schedule and general payment policies as the
118 organization would for that network.
119 (b) The insurance contract may reward the insured for selection of preferred health care
120 providers by:

121 (i) reducing premium rates;
122 (ii) reducing deductibles;
123 (iii) coinsurance;
124 (iv) other copayments; or
125 (v) any other reasonable manner.
126 (c) If the insurer is a managed care organization, as defined in Subsection
127 31A-27a-403(1)(f):
128 (i) the insurance contract and the health care provider contract shall provide that in the
129 event the managed care organization becomes insolvent, the rehabilitator or liquidator may:
130 (A) require the health care provider to continue to provide health care services under
131 the contract until the earlier of:
132 (I) 90 days after the date of the filing of a petition for rehabilitation or the petition for
133 liquidation; or
134 (II) the date the term of the contract ends; and
135 (B) subject to Subsection (1)(c)(v), reduce the fees the provider is otherwise entitled to
136 receive from the managed care organization during the time period described in Subsection
137 (1)(c)(i)(A);
138 (ii) the provider is required to:
139 (A) accept the reduced payment under Subsection (1)(c)(i)(B) as payment in full; and
140 (B) relinquish the right to collect additional amounts from the insolvent managed care
141 organization's enrollee, as defined in Subsection 31A-27a-403(1)(b);
142 (iii) if the contract between the health care provider and the managed care organization
143 has not been reduced to writing, or the contract fails to contain the language required by
144 Subsection (1)(c)(i), the provider may not collect or attempt to collect from the enrollee:
145 (A) sums owed by the insolvent managed care organization; or
146 (B) the amount of the regular fee reduction authorized under Subsection (1)(c)(i)(B);
147 (iv) the following may not bill or maintain any action at law against an enrollee to
148 collect sums owed by the insolvent managed care organization or the amount of the regular fee
149 reduction authorized under Subsection (1)(c)(i)(B):
150 (A) a provider;
151 (B) an agent;

152 (C) a trustee; or
153 (D) an assignee of a person described in Subsections (1)(c)(iv)(A) through (C); and
154 (v) notwithstanding Subsection (1)(c)(i):
155 (A) a rehabilitator or liquidator may not reduce a fee by less than 75% of the provider's
156 regular fee set forth in the contract; and
157 (B) the enrollee shall continue to pay the copayments, deductibles, and other payments
158 for services received from the provider that the enrollee was required to pay before the filing
159 of:
160 (I) a petition for rehabilitation; or
161 (II) a petition for liquidation.
162 (2) (a) Subject to Subsections (2)(b) through [~~(2)(f)~~] (g), an insurer, including a health
163 maintenance organization governed by Chapter 8, Health Maintenance Organizations and
164 Limited Health Plans, using preferred or participating health care provider contracts shall pay
165 for the services of health care providers not under the contract, unless the illnesses or injuries
166 treated by the health care provider are not within the scope of the insurance contract. As used
167 in this section, "class of health care providers" means all health care providers licensed or
168 licensed and certified by the state within the same professional, trade, occupational, or facility
169 licensure or licensure and certification category established pursuant to Titles 26, Utah Health
170 Code and 58, Occupations and Professions.
171 (b) When the insured receives services from a health care provider not under contract,
172 the insurer shall reimburse the insured for at least [~~75%~~] 90% of the average amount paid by
173 the insurer for comparable services of preferred health care providers who are members of the
174 same class of health care providers. The commissioner may adopt a rule dealing with the
175 determination of what constitutes [~~75%~~] 90% of the average amount paid by the insurer for
176 comparable services of preferred health care providers who are members of the same class of
177 health care providers.
178 (c) When reimbursing for services of out patient health care providers not under
179 contract, the insurer [~~may~~] shall make direct payment to the [~~insured~~] provider.
180 (d) (i) Notwithstanding Subsection (2)(b), an insurer using preferred or participating
181 health care provider contracts may impose a deductible and copayments on coverage of a
182 medical condition treated by a health care [~~providers~~] provider not under contract with the

183 insurer, if the deductible, copayment, or coinsurance is not greater than the deductible,
184 copayment, or coinsurance imposed on the same medical condition treated by a health care
185 provider who is under contract with the insurer.
186 (ii) When an insured receives services from a health care provider not under contract
187 who is reimbursed under the provisions of Subsection (2)(b), the insured is responsible for any
188 copayments or deductibles that are imposed by the insurer under Subsection (2)(d).
189 (e) When selecting health care providers with whom to contract under Subsection (1),
190 an insurer may not unfairly discriminate between classes of health care providers, but may
191 discriminate within a class of health care providers, subject to Subsection (7).
192 (f) For purposes of this section, unfair discrimination between classes of health care
193 providers shall include:
194 (i) refusal to contract with class members in reasonable proportion to the number of
195 insureds covered by the insurer and the expected demand for services from class members; and
196 (ii) refusal to cover procedures for one class of providers that are:
197 (A) commonly utilized by members of the class of health care providers for the
198 treatment of illnesses, injuries, or conditions;
199 (B) otherwise covered by the insurer; and
200 (C) within the scope of practice of the class of health care providers.
201 (g) (i) A health care provider not under contract with the insurer, who accepts the 90%
202 reimbursement rate from the insured's health plan may balance bill the insured for up to 110%
203 of the in-network allowed amount for the medical condition treated by the out of network
204 provider.
205 (ii) When an insured receives services from a health care provider not under contract
206 who is reimbursed under the provisions of Subsection (2)(b), the insured is responsible for any
207 copayments or deductibles that are imposed by the insurer under Subsection (2)(d).
208 (3) Before the insured consents to the insurance contract, the insurer shall fully disclose
209 to the insured that it has entered into preferred health care provider contracts. The insurer shall
210 provide sufficient detail on the preferred health care provider contracts to permit the insured to
211 agree to the terms of the insurance contract. The insurer shall provide at least the following
212 information:
213 (a) a list of the health care providers under contract and if requested their business

214 locations and specialties;
215 (b) a description of the insured benefits, including any deductibles, coinsurance, or
216 other copayments;
217 (c) a description of the quality assurance program required under Subsection (4); and
218 (d) a description of the adverse benefit determination procedures required under
219 Subsection (5).
220 (4) (a) An insurer using preferred health care provider contracts shall maintain a quality
221 assurance program for assuring that the care provided by the health care providers under
222 contract meets prevailing standards in the state.
223 (b) The commissioner in consultation with the executive director of the Department of
224 Health may designate qualified persons to perform an audit of the quality assurance program.
225 The auditors shall have full access to all records of the organization and its health care
226 providers, including medical records of individual patients.
227 (c) The information contained in the medical records of individual patients shall
228 remain confidential. All information, interviews, reports, statements, memoranda, or other data
229 furnished for purposes of the audit and any findings or conclusions of the auditors are
230 privileged. The information is not subject to discovery, use, or receipt in evidence in any legal
231 proceeding except hearings before the commissioner concerning alleged violations of this
232 section.
233 (5) An insurer using preferred health care provider contracts shall provide a reasonable
234 procedure for resolving complaints and adverse benefit determinations initiated by the insureds
235 and health care providers.
236 (6) An insurer may not contract with a health care provider for treatment of illness or
237 injury unless the health care provider is licensed to perform that treatment.
238 (7) (a) A health care provider or insurer may not discriminate against a preferred health
239 care provider for agreeing to a contract under Subsection (1).
240 (b) Any health care provider licensed to treat any illness or injury within the scope of
241 the health care provider's practice, who is willing and able to meet the terms and conditions
242 established by the insurer for designation as a preferred health care provider, shall be able to
243 apply for and receive the designation as a preferred health care provider. Contract terms and
244 conditions may include reasonable limitations on the number of designated preferred health

245 care providers based upon substantial objective and economic grounds, or expected use of
246 particular services based upon prior provider-patient profiles.
247 (8) Upon the written request of a provider excluded from a provider contract, the
248 commissioner may hold a hearing to determine if the insurer's exclusion of the provider is
249 based on the criteria set forth in Subsection (7)(b).
250 (9) Insurers are subject to the provisions of Sections 31A-22-613.5, 31A-22-614.5, and
251 31A-22-618.
252 (10) Nothing in this section is to be construed as to require an insurer to offer a certain
253 benefit or service as part of a health benefit plan.
254 (11) This section does not apply to catastrophic mental health coverage provided in
255 accordance with Section 31A-22-625.

Legislative Review Note
as of 1-8-08 1:58 PM

Office of Legislative Research and General Counsel

Fiscal Note

S.B. 121 - Access to Qualified Health Care Providers

2008 General Session

State of Utah

State Impact

Enactment of this bill will require additional appropriations of approximately $700,000 from various sources as shown in the table below. Over time, costs may decrease if enough subscribers utilize out-of-network providers whose reimbursement rates are 90% of allowable network charges under this bill, and because of potential competition between network providers and out-of-network providers.

	FY 2008 Approp.	FY 2009 Approp.	FY 2010 Approp.	FY 2008 Revenue	FY 2009 Revenue	FY 2010 Revenue
General Fund	$0	$386,400	$386,400	$0	$0	$0
Uniform School Fund	$0	$29,400	$29,400	$0	$0	$0
Transportation Fund	$0	$28,000	$28,000	$0	$0	$0
Federal Funds	$0	$112,000	$112,000	$0	$0	$0
Dedicated Credits	$0	$60,900	$60,900	$0	$0	$0
Restricted Funds	$0	$60,900	$60,900	$0	$0	$0
Transfers	$0	$22,400	$22,400	$0	$0	$0
Total	**$0**	**$700,000**	**$700,000**	**$0**	**$0**	**$0**

Individual, Business and/or Local Impact

Businesses and local governments may initially experience increased medical and administrative costs associated with additional insurance coverage requirements. Individuals may benefit from the ability to go to other health providers that are not covered by their current insurance. Individuals may also encounter additional costs from increased insurance premiums and balance billing. Over time, costs may decrease if enough subscribers utilize out-of-network providers whose reimbursement rates are 90% of allowable network charges under this bill, and because of potential competition between network providers and out-of-network providers.