~~{deleted text}~~ shows text that was in SB0294 but was deleted in SB0294S01.

inserted text shows text that was not in SB0294 but was inserted into SB0294S01.

DISCLAIMER: This document is provided to assist you in your comparison of the two bills. Sometimes this automated comparison will not be completely accurate. Therefore, you need to read the actual bill. This automatically generated document could experience abnormalities caused by: limitations of the compare program; bad input data; the timing of the compare; and other potential causes.

Senator J. Stuart Adams proposes the following substitute bill:

PATIENT ACCESS REFORM

2011 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: J. Stuart Adams

House Sponsor: ____________

LONG TITLE

General Description:

This bill amends provisions related to access to health ~~{care providers in the Health Maintenance Organization and Preferred Provider Organization Chapters of}~~insurance in the Insurance Code.

Highlighted Provisions:

This bill:

- ~~{provides that a health maintenance organization and preferred provider organization must reimburse an insured for services of a health care provider who is not under contract if those services are otherwise covered by the insurance plan;~~
- ~~establishes the reimbursement rate for noncontracted providers, which is based on the amount that would be paid to a member of the same class of health care provider;~~

- ~~allows the health maintenance organization or preferred provider organization to impose copayments and deductibles for noncontracted providers;~~
- ~~prohibits the insurer from imposing cost-sharing measures greater than those imposed with participating providers;~~
- ~~requires the insurer to make payment directly to the health care provider for out-patient services;~~
- ~~clarifies the payment responsibilities of the insured;~~
- ~~prohibits a nonparticipating provider who accepts the 95% reimbursement rate from balance billing the insured for additional costs; and~~
- ~~requires that out-of-pocket payments by insureds to noncontracted providers shall apply to any plan deductible or out-of-pocket maximums}~~amends the case characteristics that a small employer carrier may use when establishing premium rates for a group;
- changes the ratio that may be used for the age bands to an overall ratio that may not exceed 6:1;
- changes the ratio that may be used for family tiers to a ratio that may not exceed 6:1;
- amends the family tier structure by allowing a carrier, at the carrier's option, to use five tiers rather than four tiers, with the new optional fifth tier separating employee plus one dependent from employee plus more than one dependent; and
- makes technical amendments.

Money Appropriated in this Bill:

None

Other Special Clauses:

None

Utah Code Sections Affected:

AMENDS:

~~{31A-22-617}~~31A-30-106.1, as ~~{last amended}~~enacted by Laws of Utah ~~{2009}~~2010, Chapter ~~{12}~~68

~~{ENACTS:~~

~~**31A-8-503**, Utah Code Annotated 1953~~

}

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

Section 1. Section {**31A-8-503** is enacted to read:

31A-8-503. Reimbursement of noncontracted providers.

(1) 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 Title 26, Utah Health Code, and Title 58, Occupations and Professions.

(2) (a) Subject to Subsections (2)(b) through (d), a health maintenance organization shall pay for the services of providers who are not participating providers with the health maintenance organization, unless the illnesses or injuries treated by the provider are not within the scope of the insured's health maintenance organization's}**31A-30-106.1** is amended to read:

31A-30-106.1. Small employer premiums -- Rating restrictions -- Disclosure.

(1) Premium rates for small employer health benefit {plan.

(b) When the insured receives services from a provider who is not a participating provider for the insured's health maintenance organization benefit plan, the health maintenance organization shall reimburse the insured}plans under this chapter are subject to the provisions of this section for a health benefit plan that is issued or renewed, on or after January 1, 2011.

(2) (a) The index rate for a rating period for any class of business may not exceed the index rate for any other class of business by more than 20%.

(b) For a class of business, the premium rates charged during a rating period to covered insureds with similar case characteristics for the same or similar coverage, or the rates that could be charged to an employer group under the rating system for that class of business, may not vary from the index rate by more than 30% of the index rate, except when catastrophic mental health coverage is selected as provided in Subsection 31A-22-625(2)(d).

(3) The percentage increase in the premium rate charged to a covered insured for a new rating period, adjusted pro rata for rating periods less than a year, may not exceed the sum of the following:

(a) the percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period;

(b) any adjustment, not to exceed 15% annually for rating periods of less than one year,

due to the claim experience, health status, or duration of coverage of the covered individuals as determined from the small employer carrier's rate manual for the class of business, except when catastrophic mental health coverage is selected as provided in Subsection 31A-22-625(2)(d); and

(c) any adjustment due to change in coverage or change in the case characteristics of the covered insured as determined for the class of business from the small employer carrier's rate manual.

(4) (a) Adjustments in rates for claims experience, health status, and duration from issue may not be charged to individual employees or dependents.

(b) Rating adjustments and factors, including case characteristics, shall be applied uniformly and consistently to the rates charged for all employees and dependents of the small employer.

(c) Rating factors shall produce premiums for identical groups that:

(i) differ only by the amounts attributable to plan design; and

(ii) do not reflect differences due to the nature of the groups assumed to select particular health benefit products.

(d) A small employer carrier shall treat all health benefit plans issued or renewed in the same calendar month as having the same rating period.

(5) A health benefit plan that uses a restricted network provision may not be considered similar coverage to a health benefit plan that does not use a restricted network provision, provided that use of the restricted network provision results in substantial difference in claims costs.

(6) The small employer carrier may [not use] only use the following case characteristics [other than the following]:

(a) age, in accordance with Subsection ({2)(c), in an amount equal to at least 95% of the amount that would be paid by the health maintenance organization to:

(i) a participating provider; and

(ii) a member of the same class of health care provider.

(c) When reimbursing for services of out-patient providers who are not participating providers, the health maintenance organization shall make direct payment to the provider.

(d) Notwithstanding Subsection (2)(b), a health maintenance organization may:

(i) impose a deductible or copayment on coverage of a medical condition treated by nonparticipating providers if the deductible or copayment is not greater than the deductible or copayment imposed on the same medical condition treated by participating providers for the insured's health benefit plan; and

(ii) not impose cost-sharing measures, including copayments, deductibles, and coinsurance greater than those imposed on the same medical condition treated by participating providers for the insured's health benefit plan.

(3) (a) When an insured receives services from a nonparticipating provider who is reimbursed under the provisions of Subsection (2)(b), the insured is responsible for any copayments and deductibles that are imposed by the insurer under Subsection (2)(d).

(b) A nonparticipating provider who accepts the 95% reimbursement rate designated in Subsection (2)(b) may not balance bill the insured for any costs above those designated in Subsection (3)(a).

(4) This section does not apply when an individual's health maintenance organization benefit plan is a Medicaid program or the Children's Health Insurance Program under Title 26, Chapter 18, Medical Assistance Act.

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

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

Health insurance policies may provide for insureds to receive services or reimbursement under the policies }7);

(b) geographic area; and

(c) family composition in accordance with {preferred health care provider contracts as follows:

(1) Subject to restrictions under this section, any insurer or third party administrator may enter into contracts with health care providers as defined in Section 78B-3-403 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 health care provider contract may 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.

(ii) 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) 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. This Subsection (1)(a)(iii) 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}Subsection (8).

[(a) age, as] (7) Age shall be determined at the beginning of the plan year, limited to:

[(i)] (a) the following age bands:

[(A)] (i) less than 20;

[(B)] (ii) 20-24;

[(C)] (iii) 25-29;

[(D)] (iv) 30-34;

[(E)] (v) 35-39;

[(F)] (vi) 40-44;

[(G)] (vii) 45-49;

[(H)] (viii) 50-54;

[(I)] (ix) 55-59;

[(J)] (x) 60-64; and

[(K)] (xi) 65 and above; and

[(ii)] (b) (i) a standard slope ratio range for each age band, applied to each family composition tier rating structure under Subsection [(6)(c)] (8):

(A) as developed by the department by administrative rule; and

(B) not to exceed an overall ratio of [5] 6:1; and

[(C)] (ii) the age slope ratios for each age band may not overlap[;].

[(b) geographic area; and]

[(c) family] (8) Family composition[;] is limited to:

[(i)] (a) an overall ratio of [5] 6:1 or less; and

[(ii)] (b) a [four] tier rating structure that includes:

(i) four tiers that include:

(A) employee only;

(B) employee plus spouse;

(C) employee plus a dependent or dependents; and

(D) a family, consisting of an employee plus spouse, and a dependent or dependents[-]; or

(ii) five tiers that include:

(A) employee only;

(B) employee plus spouse;

(C) employee plus a dependent; and

(D) employee plus more than one dependent, other than a spouse; and

(E) a family, consisting of an employee plus spouse, and a dependent or dependents.

[(7)] (9) If a health benefit plan is a health benefit plan into which the small employer carrier is no longer enrolling new covered insureds, the small employer carrier shall use the percentage change in the base premium rate, provided that the change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit product into which the small employer carrier is actively enrolling new covered insureds.

[(8)] (10) (a) A covered carrier may not transfer a covered insured involuntarily into or out of a class of business.

(b) A covered carrier may not offer to transfer a covered insured into or out of a class of business unless the offer is made to transfer all covered insureds in the class of business without regard to:

(i) case characteristics;

(ii) claim experience;

(iii) health status; or

(iv) duration of coverage since issue.

[~~(9)~~] (11) (a) Each small employer carrier shall maintain at the small employer carrier's principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate that the small employer carrier's rating methods and practices are:

(i) based upon commonly accepted actuarial assumptions; and

(ii) 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-27a-403(1)(f):~~

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

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

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

~~(B) subject to Subsection (1)(c)(v), 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);~~

~~(ii) the provider is required to:~~

~~(A) accept the reduced payment under Subsection (1)(c)(i)(B) 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-27a-403(1)(b);~~

~~(iii) 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}sound actuarial principles.

(b) (i) Each small employer carrier shall file with the commissioner on or before April 1 of each year, in a form and manner and containing information as prescribed by the commissioner, an actuarial certification certifying that:

(A) the small employer carrier is in compliance with this chapter; and

(B) the rating methods of the small employer carrier are actuarially sound.

(ii) A copy of the certification required by Subsection [(9)] ({1}11)({c}b)(i){, 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);

(iv) 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):

(A) a provider;

(B) an agent;

(C) a trustee; or

(D) an assignee of a person} shall be retained by the small employer carrier at the small employer carrier's principal place of business.

(c) A small employer carrier shall make the information and documentation described in {Subsections (1)(c)(iv)(A) through (C); and

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

(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)](g), an insurer, including a health maintenance organization governed by Chapter 8, Health Maintenance Organizations and

Limited Health Plans, using preferred or participating 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) (i) Until July 1, 2012, when the insured receives services from a health care provider not under contract, the insurer shall reimburse the insured for at least [75%] 95% 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.

(ii) Notwithstanding Subsection (2)(b)(i), an insurer may offer a health plan that complies with the provisions of Subsection 31A-22-618.5(3) if the insurer offers one health benefit plan that complies with Subsection (2)(b)(i).

(iii) The commissioner may adopt a rule dealing with the determination of what constitutes [75%] 95% of the average amount paid by the insurer under Subsection (2)(b)(i) 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 outpatient health care providers not under contract, the insurer [may] shall make direct payment to the [insured] provider.

(d) (i) Notwithstanding Subsection (2)(b), an insurer using preferred or participating health care provider contracts may impose a deductible and copayments on coverage of a medical condition treated by health care providers not under contract[.] with the insurer, if the deductible, copayment, or coinsurance is not greater that the deductible, copayment, or coinsurance imposed on the same medical condition treated by health care providers not under contract with the insurer.

(ii) Out-of-pocket payments by insureds to health care providers not under contract shall apply toward deductibles and out-of-pocket maximums in the same way and to the same extent as payments to preferred or participating providers.

(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.

(g) (i) A health care provider not under contract with the insurer who accepts the 95% reimbursement from the insured's health plan may not balance bill the insured for costs above the reimbursement rate.

(ii) When an insured receives services from a health care provider not under contract that are reimbursed under the provisions of Subsection (2)(b), the insured is responsible for any copayments or deductibles that are imposed by the insurer under Subsection (2)(d).

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

~~(10) 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) This section does not apply to catastrophic mental health coverage provided in accordance with Section 31A-22-625.~~

~~**Legislative Review Note**~~

~~**as of 2-18-11 9:15 AM**~~

~~**Office of Legislative Research and General Counsel**~~}this Subsection [~~(9)~~] (11) available to the commissioner upon request.

[~~(10)~~] (12) (a) The commissioner shall, by July 1, 2010, establish rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to:

(i) implement this chapter; and

(ii) assure that rating practices used by small employer carriers under this section and carriers for individual plans under Section 31A-30-106, as effective on January 1, 2011, are consistent with the purposes of this chapter.

(b) The rules may:

(i) assure that differences in rates charged for health benefit plans by carriers are reasonable and reflect objective differences in plan design, not including differences due to the nature of the groups or individuals assumed to select particular health benefit plans; and

(ii) prescribe the manner in which case characteristics may be used by small employer and individual carriers.

[~~(11)~~] (13) Records submitted to the commissioner under this section shall be maintained by the commissioner as protected records under Title 63G, Chapter 2, Government Records Access and Management Act.