

Representative James A. Dunnigan proposes the following substitute bill:

HEALTH INSURANCE AMENDMENTS

2017 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: James A. Dunnigan

Senate Sponsor: Brian E. Shiozawa

LONG TITLE

General Description:

This bill amends the Insurance Code and health care provider licensing laws related to health care provider network adequacy and payment for out of network emergency department services.

Highlighted Provisions:

This bill:

- ▶ effective January 1, 2018:
 - establishes provider network adequacy standards for managed care organizations;
 - establishes standards for provider directories;
 - establishes standards for state regulated insurers to reimburse health care providers who provide out of network emergency services or post stabilization care to an enrollee;
 - prohibits a health care provider who provides out-of-network emergency services to an enrollee of a state regulated plan, an ERISA plan, or a self funded plan, and who receives payment directly from the payor, from balance billing in excess of a cap;
 - requires a health care provider to give an enrollee notice of certain rights if the



- 26 health care provider sends an enrollee a bill for emergency services; and
- 27 • makes it a violation of licensing laws for a health care provider to balance bill
- 28 an enrollee under certain circumstances;
- 29 ▶ exempts a non-network provider who does not balance bill as of January 1, 2017,
- 30 from the reimbursement and balance billing requirements;
- 31 ▶ exempts a health care provider from balance billing restrictions if the health care
- 32 provider is licensed under Title 58, Division of Occupational and Professional
- 33 Licensing, and if the provider's practice is substantially emergency services
- 34 provided in a hospital emergency department;
- 35 ▶ requires the insurance commissioner to report to the Legislature's Business and
- 36 Labor Interim Committee by November 2019 regarding emergency service
- 37 reimbursement and balance billing;
- 38 ▶ sunsets the non-network emergency services provisions on January 1, 2021; and
- 39 ▶ makes technical amendments and conforming amendments.

40 **Money Appropriated in this Bill:**

41 None

42 **Other Special Clauses:**

43 This bill provides a special effective date.

44 **Utah Code Sections Affected:**

45 AMENDS:

46 **31A-8-101**, as last amended by Laws of Utah 2002, Chapter 308

47 **31A-8-105**, as last amended by Laws of Utah 1998, Chapter 329

48 **31A-8-213**, as last amended by Laws of Utah 2007, Chapter 309

49 **31A-22-618.5**, as last amended by Laws of Utah 2014, Chapters 290 and 300

50 **63I-2-231**, as last amended by Laws of Utah 2016, Chapter 138

51 ENACTS:

52 **26-21-30**, Utah Code Annotated 1953

53 **31A-22-645**, Utah Code Annotated 1953

54 **31A-22-646**, Utah Code Annotated 1953

55 **31A-22-647**, Utah Code Annotated 1953

56 **58-1-509**, Utah Code Annotated 1953

57 REPEALS:

58 [31A-8-104](#), as last amended by Laws of Utah 1997, Chapter 185

59 [31A-8-408](#), as last amended by Laws of Utah 2002, Chapter 308



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

62 Section 1. Section **26-21-30** is enacted to read:

63 **26-21-30. Violation of chapter.**

64 (1) For purposes of this section:

65 (a) "Balanced billing" means the same as that term is defined in Section [31A-22-645](#).

66 (b) "Emergency services" means the same as that term is defined in Section

67 [31A-22-645](#).

68 (2) Beginning January 1, 2018, it is a violation of this chapter for a health care facility
69 to balance bill a patient for emergency services in violation of Section [31A-22-647](#).

70 (3) A health care facility that violates this section is subject to Section [26-21-11](#).

71 Section 2. Section **31A-8-101** is amended to read:

72 **31A-8-101. Definitions.**

73 For purposes of this chapter:

74 (1) "Basic health care services" means:

75 (a) emergency care;

76 (b) inpatient hospital and physician care;

77 (c) outpatient medical services; and

78 (d) out-of-area coverage.

79 (2) "Director of health" means:

80 (a) the executive director of the Department of Health; or

81 (b) the authorized representative of the executive director of the Department of Health.

82 (3) "Enrollee" means an individual:

83 (a) who has entered into a contract with an organization for health care; or

84 (b) in whose behalf an arrangement for health care has been made.

85 (4) "Health care" is as defined in Section [31A-1-301](#).

86 (5) "Health maintenance organization" means any person:

87 (a) other than:

88 (i) an insurer licensed under Chapter 7, Nonprofit Health Service Insurance
89 Corporations; or
90 (ii) an individual who contracts to render professional or personal services that the
91 individual directly performs; and
92 (b) that:
93 (i) furnishes at a minimum, either directly or through arrangements with others, basic
94 health care services to an enrollee in return for prepaid periodic payments agreed to in amount
95 prior to the time during which the health care may be furnished; and
96 (ii) is obligated to the enrollee to arrange for or to directly provide available and
97 accessible health care.
98 (6) (a) "Limited health plan" means, except as limited under Subsection (6)(b), any
99 person who furnishes, either directly or through arrangements with others, services:
100 (i) of:
101 (A) dentists;
102 (B) optometrists;
103 (C) physical therapists;
104 (D) podiatrists;
105 (E) psychologists;
106 (F) physicians;
107 (G) chiropractic physicians;
108 (H) naturopathic physicians;
109 (I) osteopathic physicians;
110 (J) social workers;
111 (K) family counselors;
112 (L) other health care providers; or
113 (M) reasonable combinations of the services described in this Subsection (6)(a)(i);
114 (ii) to an enrollee;
115 (iii) in return for prepaid periodic payments agreed to in amount prior to the time
116 during which the services may be furnished; and
117 (iv) for which the person is obligated to the enrollee to arrange for or directly provide
118 the available and accessible services described in this Subsection (6)(a).

119 (b) "Limited health plan" does not include:
120 (i) a health maintenance organization;
121 (ii) an insurer licensed under Chapter 7, Nonprofit Health Service Insurance
122 Corporations; or
123 (iii) an individual who contracts to render professional or personal services that the
124 individual performs.

125 (7) (a) "Nonprofit organization" or "nonprofit corporation" means an organization no
126 part of the income of which is distributable to its members, trustees, or officers, or a nonprofit
127 cooperative association, except in a manner allowed under Section 31A-8-406.

128 (b) "Nonprofit health maintenance organization" and "nonprofit limited health plan"
129 are used when referring specifically to one of the types of organizations with "nonprofit" status.

130 (8) "Organization" means a health maintenance organization and limited health plan,
131 unless used in the context of:

132 (a) "organization permit," which is described in Sections 31A-8-204 and 31A-8-206; or

133 (b) "organization expenses," which is described in Section 31A-8-208.

134 (9) "Participating provider" means a provider as defined in Subsection (10) who, under
135 a contract with the health maintenance organization, agrees to provide health care services to
136 enrollees with an expectation of receiving payment, directly or indirectly, from the health
137 maintenance organization, other than copayment.

138 (10) "Provider" means any person who:

139 (a) furnishes health care directly to the enrollee; and

140 (b) is licensed or otherwise authorized to furnish the health care in this state.

141 (11) "Uncovered expenditures" means the costs of health care services that are covered
142 by an organization for which an enrollee is liable in the event of the organization's insolvency.

143 ~~[(12) "Unusual or infrequently used health services" means those health services that
144 are projected to involve fewer than 10% of the organization's enrollees' encounters with
145 providers, measured on an annual basis over the organization's entire enrollment.]~~

146 Section 3. Section 31A-8-105 is amended to read:

147 **31A-8-105. General powers of organizations.**

148 Organizations may:

149 (1) buy, sell, lease, encumber, construct, renovate, operate, or maintain hospitals,

150 health care clinics, other health care facilities, and other real and personal property incidental to
151 and reasonably necessary for the transaction of the business and for the accomplishment of the
152 purposes of the organization;

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

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

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

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

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

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

168 (8) do all other things necessary for the accomplishment of the purposes of the
169 organization.

170 Section 4. Section 31A-8-213 is amended to read:

171 **31A-8-213. Certificate of authority.**

172 (1) An organization may apply for a certificate of authority at any time prior to the
173 expiration of its organization permit. The application shall include:

174 (a) a detailed statement by a principal officer about any material changes that have
175 taken place or are likely to take place in the facts on which the issuance of the organization
176 permit was based; and

177 (b) if any material changes are proposed in the business plan, the information about the
178 changes that would be required if an organization permit were then being applied for.

179 (2) The commissioner shall issue a certificate of authority, if the commissioner finds
180 that:

181 (a) the organization's capital and surplus complies with the requirements of Section
182 31A-8-209 as to the operations proposed under the new certificate of authority;

183 (b) there is no basis for revoking the organization permit under Section 31A-8-207;

184 (c) the deposit required by Section 31A-8-211 has been made; and

185 [~~(d) the organization satisfies the requirements of Section 31A-8-104, and]~~

186 [(~~e~~)] (d) all other applicable requirements of the law have been met.

187 (3) The certificate of authority shall specify any limits imposed by the commissioner
188 upon the organization's business or methods of operation, including the general types of health
189 care services the organization is authorized to provide.

190 (4) Upon the issuance of the certificate of authority:

191 (a) the board shall authorize and direct the issuance of certificates for shares, bonds, or
192 notes subscribed to under the organization permit, and of insurance policies upon qualifying
193 applications obtained under the organization permit; and

194 (b) the commissioner shall authorize the release to the organization of all funds held in
195 escrow under Section 31A-5-208, as adopted by Section 31A-8-206.

196 (5) (a) An organization may at any time apply to the commissioner for a new or
197 amended certificate of authority altering the limits on its business or methods of operation.
198 The application shall contain or be accompanied by that information reasonably required by the
199 commissioner under Subsections 31A-5-204(2) and 31A-8-205(2). The commissioner shall
200 issue the new certificate as requested if the commissioner finds that the organization continues
201 to satisfy the requirements specified under Subsection (2).

202 (b) If the commissioner issues an order under Chapter 27, Part 5, Administrative
203 Actions, against an organization, the commissioner may also revoke the organization's
204 certificate and issue a new one with any limitation the commissioner considers necessary.

205 Section 5. Section 31A-22-618.5 is amended to read:

206 **31A-22-618.5. Health benefit plan offerings.**

207 (1) The purpose of this section is to increase the range of health benefit plans available
208 in the small group, small employer group, large group, and individual insurance markets.

209 (2) A health maintenance organization that is subject to Chapter 8, Health Maintenance
210 Organizations and Limited Health Plans:

211 (a) shall offer to potential purchasers at least one health benefit plan that is subject to

212 the requirements of Chapter 8, Health Maintenance Organizations and Limited Health Plans;
213 and

214 (b) may offer to a potential purchaser one or more health benefit plans that:

215 (i) are not subject to one or more of the following:

216 (A) the limitations on insured indemnity benefits in Subsection 31A-8-105(4);

217 [~~(B) the limitation on point of service products in Subsections 31A-8-408(3) through~~
218 ~~(6);]~~

219 [~~(C)~~] (B) except as provided in Subsection (2)(b)(ii), basic health care services as
220 defined in Section 31A-8-101; or

221 [~~(D)~~] (C) coverage mandates enacted after January 1, 2009 that are not required by
222 federal law, provided that the insurer offers one plan under Subsection (2)(a) that covers the
223 mandate enacted after January 1, 2009; and

224 (ii) when offering a health plan under this section, provide coverage for an emergency
225 medical condition as required by Section 31A-22-627 as follows:

226 (A) within the organization's service area, covered services shall include health care
227 services from nonaffiliated providers when medically necessary to stabilize an emergency
228 medical condition; and

229 (B) outside the organization's service area, covered services shall include medically
230 necessary health care services for the treatment of an emergency medical condition that are
231 immediately required while the enrollee is outside the geographic limits of the organization's
232 service area.

233 (3) An insurer that offers a health benefit plan that is not subject to Chapter 8, Health
234 Maintenance Organizations and Limited Health Plans:

235 (a) may offer a health benefit plan that is not subject to Section 31A-22-618;

236 (b) when offering a health plan under this Subsection (3), shall provide coverage of
237 emergency care services as required by Section 31A-22-627; and

238 (c) is not subject to coverage mandates enacted after January 1, 2009 that are not
239 required by federal law, provided that an insurer offers one plan that covers a mandate enacted
240 after January 1, 2009.

241 (4) Section 31A-8-106 does not prohibit the offer of a health benefit plan under
242 Subsection (2)(b).

243 (5) (a) Any difference in price between a health benefit plan offered under Subsections
244 (2)(a) and (b) shall be based on actuarially sound data.

245 (b) Any difference in price between a health benefit plan offered under Subsection
246 (3)(a) shall be based on actuarially sound data.

247 (6) Nothing in this section limits the number of health benefit plans that an insurer may
248 offer.

249 Section 6. Section **31A-22-645** is enacted to read:

250 **31A-22-645. Access to managed care organization health care providers.**

251 (1) As used in this section and Sections [31A-22-646](#) and [31A-22-647](#):

252 (a) (i) "Balance billing" means the practice of a health care provider billing an enrollee
253 for the difference between the health care provider's charge and the managed care
254 organization's allowed amount.

255 (ii) "Balance billing" does not include billing an enrollee for cost sharing required by
256 the enrollee's plan, such as copayments, coinsurance, and deductibles.

257 (b) "Covered benefit" or "benefit" means the health care services to which a covered
258 person is entitled under the terms of a health benefit plan.

259 (c) "Emergency medical condition" means the same as that term is defined in Section
260 [31A-22-627](#).

261 (d) "Emergency services" means, with respect to an emergency condition:

262 (i) a medical or mental health screening examination that is within the capability of the
263 emergency department of a hospital, including ancillary services routinely available to the
264 emergency department to evaluate the emergency medical condition; and

265 (ii) any further medical or mental health examination and treatment, to the extent the
266 treatment or examination is within the capabilities of the emergency department and the staff,
267 to stabilize the patient.

268 (e) "Managed care organization" means:

269 (i) a managed care organization as that term is defined in Section [31A-1-103](#); and

270 (ii) a third-party administrator as that term is defined in Section [31A-1-103](#).

271 (f) (i) "Post stabilization care" includes services related to emergency services that:

272 (A) are provided by a health care provider other than providers listed in Subsection

273 (1)(f)(ii), and are provided after an enrollee's condition is no longer considered an emergency

274 medical condition;

275 (B) maintain a stabilized condition or improve or resolve the enrollee's condition; and

276 (C) are provided within 90 consecutive days after the day the enrollee experienced the
277 emergency medical condition.

278 (ii) "Post stabilization care" does not include health care facility charges or laboratory
279 charges.

280 (g) "Stabilize" means the same as that term is defined in 42 U.S.C. Sec. 1395dd(e)(3).

281 (2) A managed care organization offering or administering a network plan shall
282 maintain a network that is sufficient in numbers and appropriate types of providers, including
283 those that serve predominantly low-income, medically underserved individuals, to ensure that
284 all services to enrollees, including children and adults, will be accessible without unreasonable
285 travel or delay.

286 (3) An enrollee under a managed care organization's network plan shall have access to
287 emergency services 24 hours per day, seven days per week.

288 (4) (a) Upon the request of the commissioner, a managed care organization providing a
289 network plan shall demonstrate to the commissioner, in accordance with Subsection (4)(b), that
290 the managed care organization is able to provide adequate access to current and potential
291 enrollees through a contracted network of providers and facilities for all counties within the
292 managed care organization's filed service area.

293 (b) Adequate access is demonstrated if the managed care organization demonstrates
294 compliance with Subsection (4)(c) or (d).

295 (c) A managed care organization demonstrates network adequacy if the managed care
296 network meets the maximum travel time and distance standards in, and has sufficient numbers
297 of, health care professionals, providers, and facilities to meet the minimum number of
298 requirements set forth by:

299 (i) the Centers for Medicare and Medicaid Services for Medicare Advantage Plans; and

300 (ii) modifications to the standards in Subsection (4)(c)(i), adopted by the commissioner
301 by administrative rule, as necessary to reflect the age demographics of the enrollees in the plans
302 and availability of rural health care providers, and based on nationally recognized standards.

303 (d) A managed care organization demonstrates network adequacy if the managed care
304 organization meets adequacy and sufficiency standards established by the commissioner by

305 administrative rule made in accordance with Title 63G, Chapter 3, Utah Administrative
306 Rulemaking Act, and this Subsection (4)(d).

307 (e) The commissioner shall adopt administrative rules in compliance with Title 63G,
308 Chapter 3, Utah Administrative Rulemaking Act, to establish reasonable standards under
309 Subsection (4)(d) for:

310 (i) provider-covered person ratios by specialty;

311 (ii) primary care professional-covered person ratios;

312 (iii) geographic accessibility of providers;

313 (iv) geographic variation and population dispersion;

314 (v) waiting times for an appointment with participating providers;

315 (vi) hours of operation;

316 (vii) the ability of the network to meet the needs of covered persons, which may
317 include low-income persons, children and adults with serious, chronic, or complex health
318 conditions or physical or mental disabilities, or persons with limited English proficiency;

319 (viii) other health care service delivery system options, such as telemedicine or
320 telehealth, mobile clinics, centers of excellence, and other ways of delivering health care;

321 (ix) the volume of technological and specialty care services available to serve the needs
322 of covered persons requiring technologically advanced or specialty care services;

323 (x) the extent to which participating providers are accepting new patients;

324 (xi) the regionalization of specialty care, which may require some children and adults
325 to cross state lines for care;

326 (xii) a number of providers within a specified area, including rural or urban areas, that
327 takes into consideration an insured's travel time and distance to providers; and

328 (xiii) the manner in which a managed care organization demonstrates compliance with
329 the criteria established under this Subsection (4).

330 (5) A managed care organization shall provide notice in writing to enrollees that for a
331 covered benefit to be provided at a facility in the enrollee's health benefit plan network, there is
332 the possibility that the enrollee could be treated by a health care provider that is not in the same
333 network, which could result in higher cost-sharing and balance billing.

334 Section 7. Section **31A-22-646** is enacted to read:

335 **31A-22-646. Managed care organization provider directories.**

336 (1) (a) A managed care organization shall post electronically a current and accurate
337 provider directory for each of the organization's network plans.

338 (b) In making the directory available electronically, the managed care organization
339 shall ensure the general public is able to view all of the current providers for a plan through a
340 clearly identifiable link or tab and without creating or accessing an account or entering a policy
341 or contract number.

342 (c) The managed care organization shall update each network plan provider directory at
343 least monthly. A managed care organization does not violate the requirements of this
344 Subsection (1)(c) if a provider fails to notify the managed care organization of a change to the
345 provider's information.

346 (2) A managed care organization shall make available through an electronic provider
347 directory, for each network plan, the information under this Subsection (2) in a searchable
348 format:

349 (a) for a health care provider who is licensed under Title 58, Occupations and
350 Professions:

- 351 (i) the health care provider's name;
- 352 (ii) the health care provider's gender;
- 353 (iii) participating office locations;
- 354 (iv) specialty and board certifications;
- 355 (v) medical group affiliations, if applicable;
- 356 (vi) participating facility affiliations, if applicable;
- 357 (vii) languages spoken, other than English, if applicable;
- 358 (viii) whether accepting new patients; and
- 359 (ix) contact information; and

360 (b) for facilities licensed under Title 26, Chapter 21, Health Care Facility Licensing
361 and Inspection Act, or Title 62A, Chapter 2, Licensure of Programs and Facilities:

- 362 (i) the facility name;
- 363 (ii) the type of facility;
- 364 (iii) participating facility locations;
- 365 (iv) facility accreditation status; and
- 366 (v) type of services performed for facilities other than hospitals.

367 (3) A managed care organization shall make a print copy of a current provider directory
368 available upon request of an enrollee or a prospective enrollee at least annually.

369 (4) A provider directory, whether in electronic or print format, shall accommodate the
370 communication needs of individuals with disabilities, and include a link to or information
371 regarding available assistance for persons with limited English proficiency.

372 Section 8. Section **31A-22-647** is enacted to read:

373 **31A-22-647. Managed care organization out-of-network services -- Emergency**
374 **services -- Post stabilization care -- Balance billing.**

375 (1) (a) A managed care organization shall have a process to ensure that an enrollee
376 obtains covered services at a network level of benefits, including a network level of cost
377 sharing, from a non-network provider, or shall make other arrangements acceptable to the
378 commissioner:

379 (i) in accordance with Section [31A-22-645](#); and

380 (ii) (A) when an enrollee is diagnosed with a condition or disease that requires
381 specialized health care services; and

382 (B) when the managed care organization does not have a network provider of the
383 required specialty with the professional training and expertise to treat or provide the health care
384 services for the condition or disease, or cannot provide reasonable access to a network provider
385 with the required training or expertise to treat or provide health care services for the condition
386 or disease.

387 (b) A managed care organization shall:

388 (i) inform an enrollee of the process the enrollee may use to request access to obtain a
389 covered benefit from a non-network provider in accordance with Subsection (1)(a);

390 (ii) have a system in place that documents all requests to obtain covered benefits from
391 a non-network provider under Subsection (1)(a); and

392 (iii) ensure that requests to obtain a covered benefit from a non-network provider under
393 Subsection (1)(a) are addressed in a timely fashion appropriate to the covered person's
394 condition.

395 (2) (a) Except for a health care provider who is exempt under Subsection (8), a
396 managed care organization shall reimburse a non-network provider for emergency services and
397 post stabilization care in accordance with this section.

398 (b) A managed care organization shall:

399 (i) accept assignment of benefits from an enrollee for emergency services and post
400 stabilization care provided by a non-network provider; and

401 (ii) send an explanation of benefits to the non-network provider with the information
402 required under Subsection (5)(a).

403 (c) A managed care organization shall pay a non-network provider for emergency
404 services the greater of the amount required in 45 C.F.R. Sec. 147.138, plus 5% of that amount.

405 (d) Payment to a non-network provider for post stabilization care shall be the greater
406 of:

407 (i) the payment required under the applicable provisions of 45 C.F.R. Sec. 147.138; or

408 (ii) 100% of the in-network allowed amount for the patient's managed care
409 organization plan.

410 (3) (a) Except as provided in Subsection (8), a non-network provider who receives
411 payment directly from a payor may not balance bill that payor's enrollee in excess of the
412 amount under this Subsection (3).

413 (b) A non-network provider may balance bill an enrollee for emergency services in an
414 amount that is the lesser of:

415 (i) 10% above the amount allowed under Subsection (2)(c) for the emergency services;

416 or

417 (ii) \$5,000.

418 (c) A non-network provider may not balance bill an enrollee for post stabilization care.

419 (4) (a) A managed care organization may elect to pay a non-network provider for
420 emergency services or post stabilization care:

421 (i) as submitted by the provider;

422 (ii) in accordance with the benchmark established in Subsection (2)(c) or (2)(d); or

423 (iii) in an amount mutually agreed upon by the managed care organization and the
424 provider.

425 (b) This section does not preclude a managed care organization and a non-network
426 provider from agreeing to a different payment arrangement if:

427 (i) except as provided in Subsection (8), the enrollee is responsible for no more than:

428 (A) the applicable in-network cost-sharing amount; and

429 (B) the balance bill amount allowed under Subsection (3); and
430 (ii) except as provided in Subsection (8), the enrollee has no legal obligation to pay the
431 balance for emergency services or post stabilization care remaining after the payments under
432 Subsection (4)(b)(i).

433 (c) If a non-network provider sends a bill directly to an enrollee for emergency services
434 or post stabilization care, the bill shall notify the enrollee:

435 (i) that the emergency services or post stabilization care were performed by a provider
436 who is not a network provider for the enrollee's health benefit plan;

437 (ii) that the enrollee is responsible for paying the enrollee's applicable in-network cost
438 sharing amount and the additional balance bill allowed under Subsection (3);

439 (iii) whether the enrollee has an obligation to pay the remaining balance for the
440 emergency services;

441 (iv) whether the non-network provider claims an exemption under Subsection (8); and

442 (v) that the enrollee may contact the state insurance commissioner's office for
443 assistance, which notice shall include contact information for the insurance department.

444 (5) A non-network provider who receives payment from the managed care organization
445 under Subsection (2)(c) or (2)(d):

446 (a) may rely on the explanation of benefits provided by the managed care organization
447 to the enrollee and the non-network provider, informing the non-network provider of:

448 (i) the amount the non-network provider may attempt to collect from the enrollee for
449 the enrollee's cost sharing, including unmet deductibles, copayments, and coinsurance; and

450 (ii) the managed care organization's allowed amount under Subsection (2)(c) for the
451 emergency services or Subsection (2)(d) for post stabilization care;

452 (b) except as provided in Subsection (8), shall accept the following payment from the
453 enrollee as payment in full for the emergency services and post stabilization care:

454 (i) payment of cost sharing from the enrollee; and

455 (ii) payment of the additional balance bill allowed under Subsection (3); and

456 (c) may not attempt to collect payment from an enrollee for emergency services or post
457 stabilization care in excess of the amount under Subsection (5)(b).

458 (6) The rights and remedies provided under this section to an enrollee shall be in
459 addition to, and may not preempt, any other rights and remedies available to an enrollee under

460 state or federal law.

461 (7) On or before November 30, 2019, the commissioner shall report to the Business
462 and Labor Interim Committee regarding:

463 (a) the benchmarks established in Subsection (2);

464 (b) the balance billing allowed under Subsection (3);

465 (c) whether the payment benchmarks and allowed balance billing should be modified;

466 (d) how many health care providers claimed an exemption under Subsection (8)(a), the
467 number of requests for assistance under Subsection (8)(b), and information about

468 determinations under Subsection (8)(c); and

469 (e) market conduct of managed care organizations regarding contracts with health care
470 providers for non-network emergency services and post stabilization care.

471 (8) A non-network provider is not subject to Subsections (2), (3), (4)(b), and (5)(b) of
472 this section if:

473 (a) (i) as of January 1, 2017, for the past calendar year, the non-network provider, by
474 practice or as a result of a contract, has not balance billed more than 10% of the provider's
475 insured patients who received out-of-network emergency services or post stabilization care;
476 and

477 (ii) the non-network provider, before January 1, 2018, submits a statement to the
478 commissioner:

479 (A) indicating that the provider is in compliance with Subsection (8)(a) and is not
480 subject to Subsections (2), (3), (4)(b), and (5)(b); or

481 (B) providing information required by the commissioner to verify that the health care
482 provider is in compliance with this Subsection (8)(a) and is not subject to Subsections (2), (3),
483 (4)(b), and (5)(b); or

484 (b) (i) the health care provider is licensed under Title 58, Division of Occupational and
485 Professional Licensing Act;

486 (ii) 95% or more of the health care provider's practice is the delivery of emergency
487 services in a hospital emergency department, as that term is defined in Section [31A-22-627](#);
488 and

489 (iii) the health care provider provides information required by the commissioner to
490 verify the health care provider is in compliance with this Subsection (8)(b).

491 (9) (a) The commissioner shall make administrative rules under Title 63G, Chapter 3,
492 Utah Administrative Rulemaking Act, to establish the information a health care provider shall
493 submit under Subsections (8)(a) and (b) to verify compliance with this Subsection (8).

494 (b) After a health care provider submits the information to verify the exemption under
495 Subsections (8)(a) and (b), the commissioner shall notify the health care provider whether the
496 health care provider is exempt under Subsection (8)(a) or (b).

497 (10) An enrollee who receives a bill from a non-network provider for emergency
498 services or post stabilization care, and who believes that the provisions of this section apply to
499 the emergency services or post stabilization care, may request the assistance of the
500 commissioner to determine if the health care provider met the requirements of Subsection
501 (8)(a) or (b).

502 (11) The commissioner may ask a health care provider who submitted a statement
503 under Subsection (8)(a)(ii)(A) to demonstrate compliance with Subsection (8)(a) if an enrollee
504 who receives a balance bill requests assistance from the commissioner. The commissioner may
505 not ask a health care provider who verified compliance under Subsection (8)(a)(ii)(B) or (8)(b)
506 to reverify compliance under this Subsection (9)(d).

507 (12) If the commissioner determines that the health care provider who submitted a
508 statement under Subsection (8)(a)(ii)(A) did not meet the requirements of Subsection (8)(a),
509 the managed care organization shall reimburse the non-network provider in accordance with
510 this section and the non-network provider is subject to the balance billing restrictions of this
511 section.

512 Section 9. Section **58-1-509** is enacted to read:

513 **58-1-509. Health care provider -- Emergency services -- Balance billing --**
514 **Unprofessional conduct.**

515 (1) For purposes of this section:

516 (a) "Balance billing" means the same as that term is defined in Section [31A-22-645](#).

517 (b) "Emergency services" means the same as that term is defined in Section
518 [31A-22-645](#).

519 (c) "Health care provider" means an individual who is:

520 (i) defined as a health care provider under Section [78B-3-403](#); and

521 (ii) licensed under this title.

522 (2) Beginning January 1, 2018, it is unprofessional conduct for a health care provider
523 to balance bill a patient for emergency services in violation of Section [31A-22-647](#).

524 (3) A health care provider who violates this section is subject to Section [58-1-502](#).

525 Section 10. Section **63I-2-231** is amended to read:

526 **63I-2-231. Repeal dates, Title 31A.**

527 (1) Section [31A-22-315.5](#) is repealed July 1, 2019.

528 (2) Section [31A-22-647](#) is repealed January 1, 2021.

529 [~~(2)~~] (3) Title 31A, Chapter 42, Defined Contribution Risk Adjuster Act, is repealed
530 December 31, 2018.

531 Section 11. **Repealer.**

532 This bill repeals:

533 Section [31A-8-104](#), **Determination of ability to provide services.**

534 Section [31A-8-408](#), **Organizations offering point of service or point of sales**
535 **products.**

536 Section 12. **Effective date.**

537 This bill takes effect on January 1, 2018.