

Representative Brian M. Greene proposes the following substitute bill:

**HEALTH INSURANCE ATHLETIC TRAINER
SERVICES AMENDMENTS**

2018 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: Brian M. Greene

Senate Sponsor: _____

LONG TITLE

General Description:

This bill repeals exclusions of a licensed athletic trainer from certain provisions of the insurance code.

Highlighted Provisions:

This bill:

▶ repeals exclusions of a licensed athletic trainer from:

- the definition of "health care provider" in the Health Discount Program Consumer Protection Act; and
- preferred provider nondiscrimination provisions for a managed care organization; and

▶ makes technical changes.

Money Appropriated in this Bill:

None

Other Special Clauses:

None

Utah Code Sections Affected:

AMENDS:



26 [31A-8a-102](#), as last amended by Laws of Utah 2013, Chapters 104 and 135
 27 [31A-22-618.5](#), as last amended by Laws of Utah 2017, Chapter 292
 28 [31A-27a-403](#), as enacted by Laws of Utah 2007, Chapter 309
 29 [31A-45-303](#), as last amended by Laws of Utah 2017, Chapter 168 and renumbered and

30 amended by Laws of Utah 2017, Chapter 292

31 ENACTS:

32 [58-40a-306](#), Utah Code Annotated 1953



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

35 Section 1. Section [31A-8a-102](#) is amended to read:

36 **[31A-8a-102](#). Definitions.**

37 For purposes of this chapter:

38 (1) "Fee" means any periodic charge for use of a discount program.

39 (2) "Health care provider" means a health care provider as defined in Section

40 [78B-3-403](#)~~[, with the exception of "licensed athletic trainer,"]~~ who:

41 (a) is practicing within the scope of the provider's license; and

42 (b) has agreed either directly or indirectly, by contract or any other arrangement with a
43 health discount program operator, to provide a discount to enrollees of a health discount
44 program.

45 (3) (a) "Health discount program" means a business arrangement or contract in which a
46 person pays fees, dues, charges, or other consideration in exchange for a program that provides
47 access to health care providers who agree to provide a discount for health care services.

48 (b) "Health discount program" does not include a program that does not charge a
49 membership fee or require other consideration from the member to use the program's discounts
50 for health services.

51 (4) "Health discount program marketer" means a person, including a private label
52 entity, that markets, promotes, sells, or distributes a health discount program but does not
53 operate a health discount program.

54 (5) "Health discount program operator" means a person that provides a health discount
55 program by entering into a contract or agreement, directly or indirectly, with a person or
56 persons in this state who agree to provide discounts for health care services to enrollees of the

57 health discount program and determines the charge to members.

58 (6) "Value-added benefit" means a discount offering with no additional charge made by
59 a health insurer or health maintenance organization that is licensed under this title, in
60 connection with existing contracts with the health insurer or health maintenance organization.

61 Section 2. Section **31A-22-618.5** is amended to read:

62 **31A-22-618.5. Coverage of insurance mandates imposed after January 1, 2009.**

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

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

67 (a) shall offer to potential purchasers at least one health benefit plan that is subject to
68 the requirements of Chapter 8, Health Maintenance Organizations and Limited Health Plans;
69 and

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

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

72 (A) the limitations on insured indemnity benefits in Subsection [31A-8-105\(4\)](#);

73 (B) except as provided in Subsection (2)(b)(ii), basic health care services as defined in
74 Section [31A-8-101](#); or

75 (C) coverage mandates enacted after January 1, 2009 that are not required by federal
76 law, provided that the insurer offers one plan under Subsection (2)(a) that covers the mandate
77 enacted after January 1, 2009; and

78 (ii) when offering a health plan under this section, provide coverage for an emergency
79 medical condition as required by Section [31A-22-627](#).

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

82 (a) may offer a health benefit plan that is not subject to Section [31A-22-618](#) and
83 Subsection [~~[31A-45-303\(3\)\(b\)\(iii\)](#)~~ [31A-45-303\(4\)](#)];

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

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

88 after January 1, 2009.

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

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

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

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

97 Section 3. Section 31A-27a-403 is amended to read:

98 **31A-27a-403. Continuance of coverage -- Health maintenance organizations.**

99 (1) As used in this section:

100 (a) "Basic health care services" [~~is as~~] means the same at that term is defined in Section
101 31A-8-101.

102 [~~(b)~~] "~~Enrollee~~" ~~is as defined in Section 31A-8-101.~~

103 [~~(c)~~] (b) "Health care" [~~is as~~] means the same at that term is defined in Section
104 31A-1-301.

105 [~~(d)~~] (c) "Health maintenance organization" [~~is as~~] means the same at that term is
106 defined in Section 31A-8-101.

107 [~~(e)~~] (d) "Limited health plan" [~~is as~~] means the same at that term is defined in Section
108 31A-8-101.

109 [~~(f)~~] (e) (i) "Managed care organization" means an entity licensed by, or holding a
110 certificate of authority from, the department to furnish health care services or health insurance.

111 (ii) "Managed care organization" includes:

112 (A) a limited health plan;

113 (B) a health maintenance organization;

114 (C) a preferred provider organization;

115 (D) a fraternal benefit society; or

116 (E) an entity similar to an entity described in Subsections (1)[~~(f)~~](e)(ii)(A) through (D).

117 (iii) "Managed care organization" does not include:

118 (A) an insurer or other person that is eligible for membership in a guaranty association

119 under Chapter 28, Guaranty Associations;

120 (B) a mandatory state pooling plan;

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

122 (D) an entity similar to an entity described in Subsections (1)~~(f)~~(e)(iii)(A) through

123 (C).

124 ~~(g)~~ (f) "Participating provider" means a provider who, under a contract with a
125 managed care organization authorized under Section 31A-8-407, agrees to provide health care
126 services to enrollees with an expectation of receiving payment:

127 (i) directly or indirectly, from the managed care organization; and

128 (ii) other than a copayment.

129 ~~(h)~~ (g) "Participating provider contract" means the agreement between a participating
130 provider and a managed care organization authorized under Section 31A-8-407.

131 ~~(i)~~ (h) "Preferred provider" means a provider who agrees to provide health care
132 services under an agreement authorized under ~~[Subsection 31A-22-617(1)]~~ Section
133 31A-45-303.

134 ~~(j)~~ (i) "Preferred provider contract" means the written agreement between a preferred
135 provider and a managed care organization authorized under ~~[Subsection 31A-22-617(1)]~~
136 Section 31A-45-303.

137 ~~(k)~~ (j) (i) Except as provided in Subsection (1)~~(k)~~(j)(ii), "preferred provider
138 organization" means a person that:

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

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

144 (C) permits the enrollee to obtain health care services from a provider who is not a
145 preferred provider.

146 (ii) "Preferred provider organization" does not include:

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

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

150 individual performs.

151 ~~[(h)]~~ (k) "Provider" ~~[is as defined in Section 31A-8-101.]~~ means any person who:

152 (i) furnishes health care directly to the enrollee; and

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

154 ~~[(m)]~~ (l) "Uncovered expenditure" means a cost of health care services that is covered
155 by an organization for which an enrollee is liable in the event of the managed care
156 organization's insolvency.

157 (2) The rehabilitator or liquidator may take one or more of the actions described in
158 Subsections (2)(a) through (g) to assure continuation of health care coverage for enrollees of an
159 insolvent managed care organization.

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

164 (A) 90 days after the day on which the following is filed:

165 (I) a petition for rehabilitation; or

166 (II) a petition for liquidation; or

167 (B) the day on which the term of the contract ends.

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

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

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

180 (iii) An enrollee shall continue to pay the same copayments, deductibles, and other

181 payments for services received from a participating provider or preferred provider that the
182 enrollee is required to pay before the day on which the following is filed:

183 (A) the petition for rehabilitation; or

184 (B) the petition for liquidation.

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

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

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

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

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

193 (i) A solvent health maintenance organization licensed under Chapter 8, Health
194 Maintenance Organizations and Limited Health Plans, shall extend to the enrollees of an
195 insolvent health maintenance organization all rights, privileges, and obligations of being an
196 enrollee in the accepting health maintenance organization:

197 (A) subject to Subsections (2)(e)(ii), (iii), and (v);

198 (B) upon notification from and subject to the direction of the rehabilitator or liquidator
199 of an insolvent health maintenance organization licensed under Chapter 8, Health Maintenance
200 Organizations and Limited Health Plans; and

201 (C) if the solvent health maintenance organization operates within a portion of the
202 insolvent health maintenance organization's service area.

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

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

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

212 excluding the enrollees of the insolvent insurer.

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

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

220 (vi) (A) Notwithstanding Section 31A-27a-402, the rehabilitator or liquidator may
221 require all solvent health maintenance organizations to pay for the covered claims incurred by
222 the enrollees of the insolvent health maintenance organization.

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

225 (I) begin as of the day on which the following is filed:

226 (Aa) the petition for rehabilitation; or

227 (Bb) the petition for liquidation; and

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

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

234 (D) (I) A solvent health maintenance organization required to pay for covered claims
235 under this Subsection (2)(e)(vi) may file a claim against the estate of the insolvent health
236 maintenance organization.

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

240 (f) (i) A rehabilitator or liquidator may transfer, through sale or otherwise, the group
241 and individual health care obligations of the insolvent managed care organization to one or
242 more other managed care organizations or other insurers, if those other managed care

243 organizations and other insurers:

244 (A) are licensed to provide the same health care services in this state that are held by
245 the insolvent managed care organization; or

246 (B) have a certificate of authority to provide the same health care services in this state
247 that is held by the insolvent managed care organization.

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

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

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

258 (I) from a limited health plan to a limited health plan;

259 (II) from a health maintenance organization to a health maintenance organization;

260 (III) from a preferred provider organization to a preferred provider organization;

261 (IV) from a fraternal benefit society to a fraternal benefit society; and

262 (V) from an entity similar to an entity described in this Subsection (2)(f)(iii)(A) to a
263 category that is similar;

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

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

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

272 Section 4. Section **31A-45-303** is amended to read:

273 **31A-45-303. Network provider contract provisions.**

274 (1) Managed care organizations may provide for enrollees to receive services or
275 reimbursement under the health benefit plans in accordance with this section.

276 (2) (a) Subject to restrictions under this section, a managed care organization may enter
277 into contracts with health care providers under which the health care providers agree to be a
278 network provider and supply services, at prices specified in the contracts, to enrollees.

279 (b) A network provider contract shall require the network provider to accept the
280 specified payment in [this] Subsection (2)(a) as payment in full, relinquishing the right to
281 collect amounts other than copayments, coinsurance, and deductibles from the enrollee.

282 (c) The insurance contract may reward the enrollee for selection of network providers
283 by:

- 284 (i) reducing premium rates;
- 285 (ii) reducing deductibles;
- 286 (iii) coinsurance;
- 287 (iv) other copayments; or
- 288 (v) any other reasonable manner.

289 (3) ~~[(a)]~~ When reimbursing for services of health care providers that are not network
290 providers, the managed care organization may:

- 291 ~~[(i)]~~ (a) make direct payment to the enrollee; and
- 292 ~~[(ii)]~~ (b) impose a deductible on coverage of health care providers not under contract.
- 293 ~~[(b) (i) Subsections (3)(b)(iii) and (c) apply to a managed care organization licensed~~
- 294 ~~under:]~~

295 ~~[(A) Chapter 5, Domestic Stock and Mutual Insurance Corporations;]~~

296 ~~[(B) Chapter 7, Nonprofit Health Service Insurance Corporations; or]~~

297 ~~[(C) Chapter 14, Foreign Insurers; and]~~

298 ~~[(ii) Subsections (3)(b)(iii) and (c) and Subsection (6)(b) do not apply to a managed~~
299 ~~care organization licensed under Chapter 8, Health Maintenance Organizations and Limited~~
300 ~~Health Plans.]~~

301 ~~[(iii)]~~ (4) (a) When selecting health care providers with whom to contract under
302 Subsection (2), a managed care organization ~~[described in Subsection (3)(b)(i)]~~ may not
303 unfairly discriminate between classes of health care providers, but may discriminate within a
304 class of health care providers, subject to ~~[Subsection (6)]~~ Subsections (7) and (8).

305 ~~[(e)]~~ (b) For purposes of this section, unfair discrimination between classes of health
306 care providers includes:

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

309 (ii) refusal to cover procedures for one class of providers that are:

310 (A) commonly used by members of the class of health care providers for the treatment
311 of illnesses, injuries, or conditions;

312 (B) otherwise covered by the managed care organization; and

313 (C) within the scope of practice of the class of health care providers.

314 ~~[(4)]~~ (5) (a) Before the enrollee consents to the insurance contract, the managed care
315 organization shall fully disclose to the enrollee that the managed care organization has entered
316 into network provider contracts.

317 (b) The managed care organization shall provide sufficient detail on the network
318 provider contracts to permit the enrollee to agree to the terms of the insurance contract.

319 (c) The managed care organization shall provide at least the following information:

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

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

324 ~~[(c)]~~ (iii) a description of the quality assurance program required under Subsection (5);
325 and

326 ~~[(d)]~~ (iv) a description of the adverse benefit determination procedures required under
327 Section [31A-22-629](#).

328 ~~[(5)]~~ (6) (a) A managed care organization using network provider contracts shall
329 maintain a quality assurance program for ~~[assuring]~~ ensuring that the care provided by the
330 network providers meets prevailing standards in the state.

331 (b) (i) The commissioner in consultation with the executive director of the Department
332 of Health may designate qualified persons to perform an audit of the quality assurance
333 program.

334 (ii) The auditors shall have full access to all records of the managed care organization
335 and the managed care organization's health care providers, including medical records of

336 individual patients.

337 (c) (i) The information contained in the medical records of individual patients shall
338 remain confidential.

339 (ii) All information, interviews, reports, statements, memoranda, or other data
340 furnished for purposes of the audit and any findings or conclusions of the auditors are
341 privileged.

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

345 ~~[(6)(a)]~~ (7) A health care provider or managed care organization may not discriminate
346 against a network provider for agreeing to a contract under Subsection (2).

347 ~~[(b) (i) Subsections (6)(b) and (c) apply to a managed care organization that is
348 described in Subsection (3)(b)(i) and do not apply to a managed care organization described in
349 Subsection (3)(b)(ii).]~~

350 ~~[(ii) A]~~ (8) (a) Except as provided in Subsection (8)(b), ~~H~~→ a ←~~H~~ health care provider
350a licensed to
351 treat an illness or injury within the scope of the health care provider's practice, that is willing
352 and able to meet the terms and conditions established by the managed care organization for
353 designation as a network provider, shall be able to apply for and receive the designation as a
354 network provider.

355 (b) Contract terms and conditions may include reasonable ~~[limitations]~~ limits on the
356 number of designated network providers based upon substantial objective and economic
357 grounds, or expected use of particular services based upon prior provider-patient profiles.

358 (c) Upon the written request of a provider excluded from a network provider contract,
359 the commissioner may hold a hearing to determine if the managed care organization's exclusion
360 of the provider is based on the criteria ~~[set forth in]~~ described in this Subsection ~~[(6)(b)]~~ (8).

361 (9) Subsections (4) and (8):

362 (a) apply to a managed care organization licensed under:

363 (i) Chapter 5, Domestic Stock and Mutual Insurance Corporations;

364 (ii) Chapter 7, Nonprofit Health Service Insurance Corporations; or

365 (iii) Chapter 14, Foreign Insurers; and

366 (b) do not apply to a managed care organization licensed under Chapter 8, Health

367 Maintenance Organizations and Limited Health Plans.

368 ~~[(7)]~~ (10) Nothing in this section ~~[is to]~~ may be construed as ~~[to require]~~ requiring a
369 managed care organization to offer a certain benefit or service as part of a health benefit plan.

370 ~~[(8) Notwithstanding Subsection (2) or Subsection (6)(b), a managed care organization~~
371 ~~described in Subsection (3)(b)(i) or third party administrator is not required to, but may, enter~~
372 ~~into a contract with a licensed athletic trainer, licensed under Title 58, Chapter 40a, Athletic~~
373 ~~Trainer Licensing Act.]~~

374 Section 5. Section **58-40a-306** is enacted to read:

375 **58-40a-306. Insurance coverage not mandated.**

376 This chapter does not mandate health insurance coverage, or reimbursement by an
377 insurer, for athletic trainer services.