LEGISLATIVE GENERAL COUNSEL
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1 **HEALTH INSURANCE ATHLETIC TRAINER SERVICES**
2 **AMENDMENTS**
3 2018 GENERAL SESSION
4 STATE OF UTAH
5 **Chief Sponsor: Brian M. Greene**
6 Senate Sponsor: ____________
7
8 **LONG TITLE**
9 **General Description:**
10 This bill repeals an exclusion from preferred provider nondiscrimination provisions for
11 athletic trainer services.
12 **Highlighted Provisions:**
13 This bill:
14 ▸ makes technical changes; and
15 ▸ repeals an exclusion from preferred provider nondiscrimination provisions for
16 athletic trainer services.
17 **Money Appropriated in this Bill:**
18 None
19 **Other Special Clauses:**
20 None
21 **Utah Code Sections Affected:**
22 AMENDS:
23 **31A-22-618.5**, as last amended by Laws of Utah 2017, Chapter 292
24 **31A-27a-403**, as enacted by Laws of Utah 2007, Chapter 309
25 **31A-45-303**, as last amended by Laws of Utah 2017, Chapter 168 and renumbered and
26 amended by Laws of Utah 2017, Chapter 292
27

28 *Be it enacted by the Legislature of the state of Utah:*
29 Section 1. Section **31A-22-618.5** is amended to read:
30 **31A-22-618.5. Coverage of insurance mandates imposed after January 1, 2009.**
31 (1) The purpose of this section is to increase the range of health benefit plans available
32 in the small group, small employer group, large group, and individual insurance markets.
33 (2) A health maintenance organization that is subject to Chapter 8, Health Maintenance
34 Organizations and Limited Health Plans:
35 (a) shall offer to potential purchasers at least one health benefit plan that is subject to
36 the requirements of Chapter 8, Health Maintenance Organizations and Limited Health Plans;
37 and
38 (b) may offer to a potential purchaser one or more health benefit plans that:
39 (i) are not subject to one or more of the following:
40 (A) the limitations on insured indemnity benefits in Subsection 31A-8-105(4);
41 (B) except as provided in Subsection (2)(b)(ii), basic health care services as defined in
42 Section 31A-8-101; or
43 (C) coverage mandates enacted after January 1, 2009 that are not required by federal
44 law, provided that the insurer offers one plan under Subsection (2)(a) that covers the mandate
45 enacted after January 1, 2009; and
46 (ii) when offering a health plan under this section, provide coverage for an emergency
47 medical condition as required by Section 31A-22-627.
48 (3) An insurer that offers a health benefit plan that is not subject to Chapter 8, Health
49 Maintenance Organizations and Limited Health Plans:
50 (a) may offer a health benefit plan that is not subject to Section 31A-22-618 and
51 Subsection [~~31A-45-303(3)(b)(iii)~~] 31A-45-303(4);
52 (b) when offering a health plan under this Subsection (3), shall provide coverage of
53 emergency care services as required by Section 31A-22-627; and
54 (c) is not subject to coverage mandates enacted after January 1, 2009 that are not
55 required by federal law, provided that an insurer offers one plan that covers a mandate enacted
56 after January 1, 2009.
57 (4) Section 31A-8-106 does not prohibit the offer of a health benefit plan under
58 Subsection (2)(b).

59 (5) (a) Any difference in price between a health benefit plan offered under Subsections
60 (2)(a) and (b) shall be based on actuarially sound data.
61 (b) Any difference in price between a health benefit plan offered under Subsection
62 (3)(a) shall be based on actuarially sound data.
63 (6) Nothing in this section limits the number of health benefit plans that an insurer may
64 offer.
65 Section 2. Section **31A-27a-403** is amended to read:
66 **31A-27a-403. Continuance of coverage -- Health maintenance organizations.**
67 (1) As used in this section:
68 (a) "Basic health care services" [is as] means the same at that term is defined in Section
69 31A-8-101.
70 [(b) "Enrollee" is as defined in Section 31A-8-101.]
71 [(c)] (b) "Health care" [is as] means the same at that term is defined in Section
72 31A-1-301.
73 [(d)] (c) "Health maintenance organization" [is as] means the same at that term is
74 defined in Section 31A-8-101.
75 [(e)] (d) "Limited health plan" [is as] means the same at that term is defined in Section
76 31A-8-101.
77 [(f)] (e) (i) "Managed care organization" means an entity licensed by, or holding a
78 certificate of authority from, the department to furnish health care services or health insurance.
79 (ii) "Managed care organization" includes:
80 (A) a limited health plan;
81 (B) a health maintenance organization;
82 (C) a preferred provider organization;
83 (D) a fraternal benefit society; or
84 (E) an entity similar to an entity described in Subsections (1)[(f)](e)(ii)(A) through (D).
85 (iii) "Managed care organization" does not include:
86 (A) an insurer or other person that is eligible for membership in a guaranty association
87 under Chapter 28, Guaranty Associations;
88 (B) a mandatory state pooling plan;
89 (C) a mutual assessment company or an entity that operates on an assessment basis; or

90 (D) an entity similar to an entity described in Subsections (1)[(f)](e)(iii)(A) through
91 (C).
92 [(g)] (f) "Participating provider" means a provider who, under a contract with a
93 managed care organization authorized under Section 31A-8-407, agrees to provide health care
94 services to enrollees with an expectation of receiving payment:
95 (i) directly or indirectly, from the managed care organization; and
96 (ii) other than a copayment.
97 [(h)] (g) "Participating provider contract" means the agreement between a participating
98 provider and a managed care organization authorized under Section 31A-8-407.
99 [(i)] (h) "Preferred provider" means a provider who agrees to provide health care
100 services under an agreement authorized under [Subsection 31A-22-617(1)] Section
101 31A-45-303.
102 [(j)] (i) "Preferred provider contract" means the written agreement between a preferred
103 provider and a managed care organization authorized under [Subsection 31A-22-617(1)]
104 Section 31A-45-303.
105 [(k)] (j) (i) Except as provided in Subsection (1)[(k)](j)(ii), "preferred provider
106 organization" means a person that:
107 (A) furnishes at a minimum, through a preferred provider, basic health care services to
108 an enrollee in return for prepaid periodic payments in an amount agreed to before the time
109 during which the health care may be furnished;
110 (B) is obligated to the enrollee to arrange for the services described in Subsection
111 (1)[(k)](j)(i)(A); and
112 (C) permits the enrollee to obtain health care services from a provider who is not a
113 preferred provider.
114 (ii) "Preferred provider organization" does not include:
115 (A) an insurer licensed under Chapter 7, Nonprofit Health Service Insurance
116 Corporations; or
117 (B) an individual who contracts to render professional or personal services that the
118 individual performs.
119 [(l)] (k) "Provider" [is as defined in Section 31A-8-101.] means any person who:
120 (i) furnishes health care directly to the enrollee; and

121 (ii) is licensed or otherwise authorized to furnish the health care in this state.
122 [(m)] (l) "Uncovered expenditure" means a cost of health care services that is covered
123 by an organization for which an enrollee is liable in the event of the managed care
124 organization's insolvency.
125 (2) The rehabilitator or liquidator may take one or more of the actions described in
126 Subsections (2)(a) through (g) to assure continuation of health care coverage for enrollees of an
127 insolvent managed care organization.
128 (a) (i) Subject to Subsection (2)(a)(ii), a rehabilitator or liquidator may require a
129 participating provider or preferred provider to continue to provide the health care services the
130 provider is required to provide under the provider's participating provider contract or preferred
131 provider contract until the earlier of:
132 (A) 90 days after the day on which the following is filed:
133 (I) a petition for rehabilitation; or
134 (II) a petition for liquidation; or
135 (B) the day on which the term of the contract ends.
136 (ii) A requirement by the rehabilitator or liquidator under Subsection (2)(a)(i) that a
137 participating provider or preferred provider continue to provide health care services under the
138 provider's participating provider contract or preferred provider contract expires when health
139 care coverage for all enrollees of the insolvent managed care organization is obtained from
140 another managed care organization or insurer.
141 (b) (i) Subject to Subsection (2)(b)(ii), a rehabilitator or liquidator may reduce the fees
142 a participating provider or preferred provider is otherwise entitled to receive from the managed
143 care organization under the provider's participating provider contract or preferred provider
144 contract during the time period in Subsection (2)(a)(i).
145 (ii) Notwithstanding Subsection (2)(b)(i), a rehabilitator or liquidator may not reduce a
146 fee to less than 75% of the regular fee set forth in the provider's participating provider contract
147 or preferred provider contract.
148 (iii) An enrollee shall continue to pay the same copayments, deductibles, and other
149 payments for services received from a participating provider or preferred provider that the
150 enrollee is required to pay before the day on which the following is filed:
151 (A) the petition for rehabilitation; or

152 (B) the petition for liquidation.
153 (c) A participating provider or preferred provider shall:
154 (i) accept the amounts specified in Subsection (2)(b) as payment in full; and
155 (ii) relinquish the right to collect additional amounts from the insolvent managed care
156 organization's enrollee.
157 (d) Subsections (2)(b) and (c) apply to the fees paid to a provider who agrees to
158 provide health care services to an enrollee but is not a preferred or participating provider.
159 (e) If the managed care organization is a health maintenance organization, Subsections
160 (2)(e)(i) through (vi) apply.
161 (i) A solvent health maintenance organization licensed under Chapter 8, Health
162 Maintenance Organizations and Limited Health Plans, shall extend to the enrollees of an
163 insolvent health maintenance organization all rights, privileges, and obligations of being an
164 enrollee in the accepting health maintenance organization:
165 (A) subject to Subsections (2)(e)(ii), (iii), and (v);
166 (B) upon notification from and subject to the direction of the rehabilitator or liquidator
167 of an insolvent health maintenance organization licensed under Chapter 8, Health Maintenance
168 Organizations and Limited Health Plans; and
169 (C) if the solvent health maintenance organization operates within a portion of the
170 insolvent health maintenance organization's service area.
171 (ii) Notwithstanding Subsection (2)(e)(i), the accepting health maintenance
172 organization shall give credit to an enrollee for any waiting period already satisfied under the
173 enrollee's contract with the insolvent health maintenance organization.
174 (iii) A health maintenance organization accepting an enrollee of an insolvent health
175 maintenance organization under Subsection (2)(e)(i) shall charge the enrollee the premiums
176 applicable to the existing business of the accepting health maintenance organization.
177 (iv) A health maintenance organization's obligation to accept an enrollee under
178 Subsection (2)(e)(i) is limited in number to the accepting health maintenance organization's pro
179 rata share of all health maintenance organization enrollees in this state, as determined after
180 excluding the enrollees of the insolvent insurer.
181 (v) (A) The rehabilitator or liquidator of an insolvent health maintenance organization
182 shall take those measures that are possible to ensure that no health maintenance organization is

183 required to accept more than its pro rata share of the adverse risk represented by the enrollees
184 of the insolvent health maintenance organization.
185 (B) If the methodology used by the rehabilitator or liquidator to assign an enrollee is
186 one that can be expected to produce a reasonably equitable distribution of adverse risk, that
187 methodology and its results are acceptable under this Subsection (2)(e)(v).
188 (vi) (A) Notwithstanding Section 31A-27a-402, the rehabilitator or liquidator may
189 require all solvent health maintenance organizations to pay for the covered claims incurred by
190 the enrollees of the insolvent health maintenance organization.
191 (B) As determined by the rehabilitator or liquidator, payments required under this
192 Subsection (2)(e)(vi) may:
193 (I) begin as of the day on which the following is filed:
194 (Aa) the petition for rehabilitation; or
195 (Bb) the petition for liquidation; and
196 (II) continue for a maximum period through the time all enrollees are assigned pursuant
197 to this section.
198 (C) If the rehabilitator or liquidator makes an assessment under this Subsection
199 (2)(e)(vi), the rehabilitator or liquidator shall assess each solvent health maintenance
200 organization its pro rata share of the total assessment based upon its premiums from the
201 previous calendar year.
202 (D) (I) A solvent health maintenance organization required to pay for covered claims
203 under this Subsection (2)(e)(vi) may file a claim against the estate of the insolvent health
204 maintenance organization.
205 (II) Any claim described in Subsection (2)(e)(vi)(D)(I), if allowed by the rehabilitator
206 or liquidator, shall share in any distributions from the estate of the insolvent health
207 maintenance organization as a Class 3 claim.
208 (f) (i) A rehabilitator or liquidator may transfer, through sale or otherwise, the group
209 and individual health care obligations of the insolvent managed care organization to one or
210 more other managed care organizations or other insurers, if those other managed care
211 organizations and other insurers:
212 (A) are licensed to provide the same health care services in this state that are held by
213 the insolvent managed care organization; or

214 (B) have a certificate of authority to provide the same health care services in this state
215 that is held by the insolvent managed care organization.
216 (ii) The rehabilitator or liquidator may combine group and individual health care
217 obligations of the insolvent managed care organization in any manner the rehabilitator or
218 liquidator considers best to provide for continuous health care coverage for the maximum
219 number of enrollees of the insolvent managed care organization.
220 (iii) If the terms of a proposed transfer of the same combination of group and
221 individual policy obligations to more than one other managed care organization or insurer are
222 otherwise equal, the rehabilitator or liquidator shall give preference to the transfer of the group
223 and individual policy obligations of an insolvent managed care organization as follows:
224 (A) from one category of managed care organization to another managed care
225 organization of the same category, as follows:
226 (I) from a limited health plan to a limited health plan;
227 (II) from a health maintenance organization to a health maintenance organization;
228 (III) from a preferred provider organization to a preferred provider organization;
229 (IV) from a fraternal benefit society to a fraternal benefit society; and
230 (V) from an entity similar to an entity described in this Subsection (2)(f)(iii)(A) to a
231 category that is similar;
232 (B) from one category of managed care organization to another managed care
233 organization, regardless of the category of the transferee managed care organization; and
234 (C) from a managed care organization to a nonmanaged care provider of health care
235 coverage, including insurers.
236 (g) If an insolvent managed care organization has required surplus, a rehabilitator or
237 liquidator may use the insolvent managed care organization's required surplus to continue to
238 provide coverage for the insolvent managed care organization's enrollees, including paying
239 uncovered expenditures.
240 Section 3. Section **31A-45-303** is amended to read:
241 **31A-45-303. Network provider contract provisions.**
242 (1) Managed care organizations may provide for enrollees to receive services or
243 reimbursement under the health benefit plans in accordance with this section.
244 (2) (a) Subject to restrictions under this section, a managed care organization may enter

245 into contracts with health care providers under which the health care providers agree to be a
246 network provider and supply services, at prices specified in the contracts, to enrollees.
247 (b) A network provider contract shall require the network provider to accept the
248 specified payment in [this] Subsection (2)(a) as payment in full, relinquishing the right to
249 collect amounts other than copayments, coinsurance, and deductibles from the enrollee.
250 (c) The insurance contract may reward the enrollee for selection of network providers
251 by:
252 (i) reducing premium rates;
253 (ii) reducing deductibles;
254 (iii) coinsurance;
255 (iv) other copayments; or
256 (v) any other reasonable manner.
257 (3) [(a)] When reimbursing for services of health care providers that are not network
258 providers, the managed care organization may:
259 [(i)] (a) make direct payment to the enrollee; and
260 [(ii)] (b) impose a deductible on coverage of health care providers not under contract.
261 [(b) (i) Subsections (3)(b)(iii) and (c) apply to a managed care organization licensed
262 under:]
263 [(A) Chapter 5, Domestic Stock and Mutual Insurance Corporations;]
264 [(B) Chapter 7, Nonprofit Health Service Insurance Corporations; or]
265 [(C) Chapter 14, Foreign Insurers; and]
266 [(ii) Subsections (3)(b)(iii) and (c) and Subsection (6)(b) do not apply to a managed
267 care organization licensed under Chapter 8, Health Maintenance Organizations and Limited
268 Health Plans.]
269 [(iii)] (4) (a) When selecting health care providers with whom to contract under
270 Subsection (2), a managed care organization [described in Subsection (3)(b)(i)] may not
271 unfairly discriminate between classes of health care providers, but may discriminate within a
272 class of health care providers, subject to [Subsection (6)] Subsections (7) and (8).
273 [(c)] (b) For purposes of this section, unfair discrimination between classes of health
274 care providers includes:
275 (i) refusal to contract with class members in reasonable proportion to the number of

276 insureds covered by the insurer and the expected demand for services from class members; and
277 (ii) refusal to cover procedures for one class of providers that are:
278 (A) commonly used by members of the class of health care providers for the treatment
279 of illnesses, injuries, or conditions;
280 (B) otherwise covered by the managed care organization; and
281 (C) within the scope of practice of the class of health care providers.
282 [(4)] (5) (a) Before the enrollee consents to the insurance contract, the managed care
283 organization shall fully disclose to the enrollee that the managed care organization has entered
284 into network provider contracts.
285 (b) The managed care organization shall provide sufficient detail on the network
286 provider contracts to permit the enrollee to agree to the terms of the insurance contract.
287 (c) The managed care organization shall provide at least the following information:
288 [(a)] (i) a list of the health care providers under contract, and if requested their business
289 locations and specialties;
290 [(b)] (ii) a description of the insured benefits, including deductibles, coinsurance, or
291 other copayments;
292 [(c)] (iii) a description of the quality assurance program required under Subsection (5);
293 and
294 [(d)] (iv) a description of the adverse benefit determination procedures required under
295 Section 31A-22-629.
296 [(5)] (6) (a) A managed care organization using network provider contracts shall
297 maintain a quality assurance program for [assuring] ensuring that the care provided by the
298 network providers meets prevailing standards in the state.
299 (b) (i) The commissioner in consultation with the executive director of the Department
300 of Health may designate qualified persons to perform an audit of the quality assurance
301 program.
302 (ii) The auditors shall have full access to all records of the managed care organization
303 and the managed care organization's health care providers, including medical records of
304 individual patients.
305 (c) (i) The information contained in the medical records of individual patients shall
306 remain confidential.

307 (ii) All information, interviews, reports, statements, memoranda, or other data
308 furnished for purposes of the audit and any findings or conclusions of the auditors are
309 privileged.
310 (iii) The information is not subject to discovery, use, or receipt in evidence in any legal
311 proceeding except hearings before the commissioner concerning alleged violations of this
312 section.
313 [(6) (a)] (7) A health care provider or managed care organization may not discriminate
314 against a network provider for agreeing to a contract under Subsection (2).
315 [(b) (i) Subsections (6)(b) and (c) apply to a managed care organization that is
316 described in Subsection (3)(b)(i) and do not apply to a managed care organization described in
317 Subsection (3)(b)(ii).]
318 [(ii)] (8) (a) A health care provider licensed to treat an illness or injury within the scope
319 of the health care provider's practice, that is willing and able to meet the terms and conditions
320 established by the managed care organization for designation as a network provider, shall be
321 able to apply for and receive the designation as a network provider.
322 (b) Contract terms and conditions may include reasonable [limitations] limits on the
323 number of designated network providers based upon substantial objective and economic
324 grounds, or expected use of particular services based upon prior provider-patient profiles.
325 (c) Upon the written request of a provider excluded from a network provider contract,
326 the commissioner may hold a hearing to determine if the managed care organization's exclusion
327 of the provider is based on the criteria [set forth in] described in this Subsection [(6)(b)] (8).
328 (9) Subsections (4) and (8):
329 (a) apply to a managed care organization licensed under:
330 (i) Chapter 5, Domestic Stock and Mutual Insurance Corporations;
331 (ii) Chapter 7, Nonprofit Health Service Insurance Corporations; or
332 (iii) Chapter 14, Foreign Insurers; and
333 (b) do not apply to a managed care organization licensed under Chapter 8, Health
334 Maintenance Organizations and Limited Health Plans.
335 [(7)] (10) Nothing in this section [is to] may be construed as [to require] requiring a
336 managed care organization to offer a certain benefit or service as part of a health benefit plan.
337 [(8) Notwithstanding Subsection (2) or Subsection (6)(b), a managed care organization

338 ~~described in Subsection (3)(b)(i) or third party administrator is not required to, but may, enter~~
339 ~~into a contract with a licensed athletic trainer, licensed under Title 58, Chapter 40a, Athletic~~
340 ~~Trainer Licensing Act.~~]

Legislative Review Note
Office of Legislative Research and General Counsel