LEGISLATIVE GENERAL COUNSEL
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Representative Brian M. Greene proposes the following substitute bill:

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 exclusions of a licensed athletic trainer from certain provisions of the
11 insurance code.
12 **Highlighted Provisions:**
13 This bill:
14 ▸ repeals exclusions of a licensed athletic trainer from:
15 • the definition of "health care provider" in the Health Discount Program
16 Consumer Protection Act; and
17 • preferred provider nondiscrimination provisions for a managed care
18 organization; and
19 ▸ makes technical changes.
20 **Money Appropriated in this Bill:**
21 None
22 **Other Special Clauses:**
23 None
24 **Utah Code Sections Affected:**
25 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

32 *Be it enacted by the Legislature of the state of Utah:*
33 Section 1. Section **31A-8a-102** is amended to read:
34 **31A-8a-102. Definitions.**
35 For purposes of this chapter:
36 (1) "Fee" means any periodic charge for use of a discount program.
37 (2) "Health care provider" means a health care provider as defined in Section
38 78B-3-403[~~, with the exception of "licensed athletic trainer,"~~] who:
39 (a) is practicing within the scope of the provider's license; and
40 (b) has agreed either directly or indirectly, by contract or any other arrangement with a
41 health discount program operator, to provide a discount to enrollees of a health discount
42 program.
43 (3) (a) "Health discount program" means a business arrangement or contract in which a
44 person pays fees, dues, charges, or other consideration in exchange for a program that provides
45 access to health care providers who agree to provide a discount for health care services.
46 (b) "Health discount program" does not include a program that does not charge a
47 membership fee or require other consideration from the member to use the program's discounts
48 for health services.
49 (4) "Health discount program marketer" means a person, including a private label
50 entity, that markets, promotes, sells, or distributes a health discount program but does not
51 operate a health discount program.
52 (5) "Health discount program operator" means a person that provides a health discount
53 program by entering into a contract or agreement, directly or indirectly, with a person or
54 persons in this state who agree to provide discounts for health care services to enrollees of the
55 health discount program and determines the charge to members.
56 (6) "Value-added benefit" means a discount offering with no additional charge made by

57 a health insurer or health maintenance organization that is licensed under this title, in
58 connection with existing contracts with the health insurer or health maintenance organization.
59 Section 2. Section **31A-22-618.5** is amended to read:
60 **31A-22-618.5. Coverage of insurance mandates imposed after January 1, 2009.**
61 (1) The purpose of this section is to increase the range of health benefit plans available
62 in the small group, small employer group, large group, and individual insurance markets.
63 (2) A health maintenance organization that is subject to Chapter 8, Health Maintenance
64 Organizations and Limited Health Plans:
65 (a) shall offer to potential purchasers at least one health benefit plan that is subject to
66 the requirements of Chapter 8, Health Maintenance Organizations and Limited Health Plans;
67 and
68 (b) may offer to a potential purchaser one or more health benefit plans that:
69 (i) are not subject to one or more of the following:
70 (A) the limitations on insured indemnity benefits in Subsection 31A-8-105(4);
71 (B) except as provided in Subsection (2)(b)(ii), basic health care services as defined in
72 Section 31A-8-101; or
73 (C) coverage mandates enacted after January 1, 2009 that are not required by federal
74 law, provided that the insurer offers one plan under Subsection (2)(a) that covers the mandate
75 enacted after January 1, 2009; and
76 (ii) when offering a health plan under this section, provide coverage for an emergency
77 medical condition as required by Section 31A-22-627.
78 (3) An insurer that offers a health benefit plan that is not subject to Chapter 8, Health
79 Maintenance Organizations and Limited Health Plans:
80 (a) may offer a health benefit plan that is not subject to Section 31A-22-618 and
81 Subsection [~~31A-45-303(3)(b)(iii)~~] 31A-45-303(4);
82 (b) when offering a health plan under this Subsection (3), shall provide coverage of
83 emergency care services as required by Section 31A-22-627; and
84 (c) is not subject to coverage mandates enacted after January 1, 2009 that are not
85 required by federal law, provided that an insurer offers one plan that covers a mandate enacted
86 after January 1, 2009.
87 (4) Section 31A-8-106 does not prohibit the offer of a health benefit plan under

88 Subsection (2)(b).
89 (5) (a) Any difference in price between a health benefit plan offered under Subsections
90 (2)(a) and (b) shall be based on actuarially sound data.
91 (b) Any difference in price between a health benefit plan offered under Subsection
92 (3)(a) shall be based on actuarially sound data.
93 (6) Nothing in this section limits the number of health benefit plans that an insurer may
94 offer.
95 Section 3. Section **31A-27a-403** is amended to read:
96 **31A-27a-403. Continuance of coverage -- Health maintenance organizations.**
97 (1) As used in this section:
98 (a) "Basic health care services" [~~is as~~] means the same at that term is defined in Section
99 31A-8-101.
100 [~~(b) "Enrollee" is as defined in Section 31A-8-101.~~]
101 [~~(c)~~] (b) "Health care" [~~is as~~] means the same at that term is defined in Section
102 31A-1-301.
103 [~~(d)~~] (c) "Health maintenance organization" [~~is as~~] means the same at that term is
104 defined in Section 31A-8-101.
105 [~~(e)~~] (d) "Limited health plan" [~~is as~~] means the same at that term is defined in Section
106 31A-8-101.
107 [~~(f)~~] (e) (i) "Managed care organization" means an entity licensed by, or holding a
108 certificate of authority from, the department to furnish health care services or health insurance.
109 (ii) "Managed care organization" includes:
110 (A) a limited health plan;
111 (B) a health maintenance organization;
112 (C) a preferred provider organization;
113 (D) a fraternal benefit society; or
114 (E) an entity similar to an entity described in Subsections (1)[~~(f)~~](e)(ii)(A) through (D).
115 (iii) "Managed care organization" does not include:
116 (A) an insurer or other person that is eligible for membership in a guaranty association
117 under Chapter 28, Guaranty Associations;
118 (B) a mandatory state pooling plan;

119 (C) a mutual assessment company or an entity that operates on an assessment basis; or
120 (D) an entity similar to an entity described in Subsections (1)[(f)](e)(iii)(A) through
121 (C).
122 [(g)] (f) "Participating provider" means a provider who, under a contract with a
123 managed care organization authorized under Section 31A-8-407, agrees to provide health care
124 services to enrollees with an expectation of receiving payment:
125 (i) directly or indirectly, from the managed care organization; and
126 (ii) other than a copayment.
127 [(h)] (g) "Participating provider contract" means the agreement between a participating
128 provider and a managed care organization authorized under Section 31A-8-407.
129 [(i)] (h) "Preferred provider" means a provider who agrees to provide health care
130 services under an agreement authorized under [Subsection 31A-22-617(1)] Section
131 31A-45-303.
132 [(j)] (i) "Preferred provider contract" means the written agreement between a preferred
133 provider and a managed care organization authorized under [Subsection 31A-22-617(1)]
134 Section 31A-45-303.
135 [(k)] (j) (i) Except as provided in Subsection (1)[(k)](j)(ii), "preferred provider
136 organization" means a person that:
137 (A) furnishes at a minimum, through a preferred provider, basic health care services to
138 an enrollee in return for prepaid periodic payments in an amount agreed to before the time
139 during which the health care may be furnished;
140 (B) is obligated to the enrollee to arrange for the services described in Subsection
141 (1)[(k)](j)(i)(A); and
142 (C) permits the enrollee to obtain health care services from a provider who is not a
143 preferred provider.
144 (ii) "Preferred provider organization" does not include:
145 (A) an insurer licensed under Chapter 7, Nonprofit Health Service Insurance
146 Corporations; or
147 (B) an individual who contracts to render professional or personal services that the
148 individual performs.
149 [(l)] (k) "Provider" [is as defined in Section 31A-8-101.] means any person who:

150 (i) furnishes health care directly to the enrollee; and
151 (ii) is licensed or otherwise authorized to furnish the health care in this state.
152 [~~(m)~~] (l) "Uncovered expenditure" means a cost of health care services that is covered
153 by an organization for which an enrollee is liable in the event of the managed care
154 organization's insolvency.
155 (2) The rehabilitator or liquidator may take one or more of the actions described in
156 Subsections (2)(a) through (g) to assure continuation of health care coverage for enrollees of an
157 insolvent managed care organization.
158 (a) (i) Subject to Subsection (2)(a)(ii), a rehabilitator or liquidator may require a
159 participating provider or preferred provider to continue to provide the health care services the
160 provider is required to provide under the provider's participating provider contract or preferred
161 provider contract until the earlier of:
162 (A) 90 days after the day on which the following is filed:
163 (I) a petition for rehabilitation; or
164 (II) a petition for liquidation; or
165 (B) the day on which the term of the contract ends.
166 (ii) A requirement by the rehabilitator or liquidator under Subsection (2)(a)(i) that a
167 participating provider or preferred provider continue to provide health care services under the
168 provider's participating provider contract or preferred provider contract expires when health
169 care coverage for all enrollees of the insolvent managed care organization is obtained from
170 another managed care organization or insurer.
171 (b) (i) Subject to Subsection (2)(b)(ii), a rehabilitator or liquidator may reduce the fees
172 a participating provider or preferred provider is otherwise entitled to receive from the managed
173 care organization under the provider's participating provider contract or preferred provider
174 contract during the time period in Subsection (2)(a)(i).
175 (ii) Notwithstanding Subsection (2)(b)(i), a rehabilitator or liquidator may not reduce a
176 fee to less than 75% of the regular fee set forth in the provider's participating provider contract
177 or preferred provider contract.
178 (iii) An enrollee shall continue to pay the same copayments, deductibles, and other
179 payments for services received from a participating provider or preferred provider that the
180 enrollee is required to pay before the day on which the following is filed:

181 (A) the petition for rehabilitation; or
182 (B) the petition for liquidation.
183 (c) A participating provider or preferred provider shall:
184 (i) accept the amounts specified in Subsection (2)(b) as payment in full; and
185 (ii) relinquish the right to collect additional amounts from the insolvent managed care
186 organization's enrollee.
187 (d) Subsections (2)(b) and (c) apply to the fees paid to a provider who agrees to
188 provide health care services to an enrollee but is not a preferred or participating provider.
189 (e) If the managed care organization is a health maintenance organization, Subsections
190 (2)(e)(i) through (vi) apply.
191 (i) A solvent health maintenance organization licensed under Chapter 8, Health
192 Maintenance Organizations and Limited Health Plans, shall extend to the enrollees of an
193 insolvent health maintenance organization all rights, privileges, and obligations of being an
194 enrollee in the accepting health maintenance organization:
195 (A) subject to Subsections (2)(e)(ii), (iii), and (v);
196 (B) upon notification from and subject to the direction of the rehabilitator or liquidator
197 of an insolvent health maintenance organization licensed under Chapter 8, Health Maintenance
198 Organizations and Limited Health Plans; and
199 (C) if the solvent health maintenance organization operates within a portion of the
200 insolvent health maintenance organization's service area.
201 (ii) Notwithstanding Subsection (2)(e)(i), the accepting health maintenance
202 organization shall give credit to an enrollee for any waiting period already satisfied under the
203 enrollee's contract with the insolvent health maintenance organization.
204 (iii) A health maintenance organization accepting an enrollee of an insolvent health
205 maintenance organization under Subsection (2)(e)(i) shall charge the enrollee the premiums
206 applicable to the existing business of the accepting health maintenance organization.
207 (iv) A health maintenance organization's obligation to accept an enrollee under
208 Subsection (2)(e)(i) is limited in number to the accepting health maintenance organization's pro
209 rata share of all health maintenance organization enrollees in this state, as determined after
210 excluding the enrollees of the insolvent insurer.
211 (v) (A) The rehabilitator or liquidator of an insolvent health maintenance organization

212 shall take those measures that are possible to ensure that no health maintenance organization is
213 required to accept more than its pro rata share of the adverse risk represented by the enrollees
214 of the insolvent health maintenance organization.
215 (B) If the methodology used by the rehabilitator or liquidator to assign an enrollee is
216 one that can be expected to produce a reasonably equitable distribution of adverse risk, that
217 methodology and its results are acceptable under this Subsection (2)(e)(v).
218 (vi) (A) Notwithstanding Section 31A-27a-402, the rehabilitator or liquidator may
219 require all solvent health maintenance organizations to pay for the covered claims incurred by
220 the enrollees of the insolvent health maintenance organization.
221 (B) As determined by the rehabilitator or liquidator, payments required under this
222 Subsection (2)(e)(vi) may:
223 (I) begin as of the day on which the following is filed:
224 (Aa) the petition for rehabilitation; or
225 (Bb) the petition for liquidation; and
226 (II) continue for a maximum period through the time all enrollees are assigned pursuant
227 to this section.
228 (C) If the rehabilitator or liquidator makes an assessment under this Subsection
229 (2)(e)(vi), the rehabilitator or liquidator shall assess each solvent health maintenance
230 organization its pro rata share of the total assessment based upon its premiums from the
231 previous calendar year.
232 (D) (I) A solvent health maintenance organization required to pay for covered claims
233 under this Subsection (2)(e)(vi) may file a claim against the estate of the insolvent health
234 maintenance organization.
235 (II) Any claim described in Subsection (2)(e)(vi)(D)(I), if allowed by the rehabilitator
236 or liquidator, shall share in any distributions from the estate of the insolvent health
237 maintenance organization as a Class 3 claim.
238 (f) (i) A rehabilitator or liquidator may transfer, through sale or otherwise, the group
239 and individual health care obligations of the insolvent managed care organization to one or
240 more other managed care organizations or other insurers, if those other managed care
241 organizations and other insurers:
242 (A) are licensed to provide the same health care services in this state that are held by

243 the insolvent managed care organization; or
244 (B) have a certificate of authority to provide the same health care services in this state
245 that is held by the insolvent managed care organization.
246 (ii) The rehabilitator or liquidator may combine group and individual health care
247 obligations of the insolvent managed care organization in any manner the rehabilitator or
248 liquidator considers best to provide for continuous health care coverage for the maximum
249 number of enrollees of the insolvent managed care organization.
250 (iii) If the terms of a proposed transfer of the same combination of group and
251 individual policy obligations to more than one other managed care organization or insurer are
252 otherwise equal, the rehabilitator or liquidator shall give preference to the transfer of the group
253 and individual policy obligations of an insolvent managed care organization as follows:
254 (A) from one category of managed care organization to another managed care
255 organization of the same category, as follows:
256 (I) from a limited health plan to a limited health plan;
257 (II) from a health maintenance organization to a health maintenance organization;
258 (III) from a preferred provider organization to a preferred provider organization;
259 (IV) from a fraternal benefit society to a fraternal benefit society; and
260 (V) from an entity similar to an entity described in this Subsection (2)(f)(iii)(A) to a
261 category that is similar;
262 (B) from one category of managed care organization to another managed care
263 organization, regardless of the category of the transferee managed care organization; and
264 (C) from a managed care organization to a nonmanaged care provider of health care
265 coverage, including insurers.
266 (g) If an insolvent managed care organization has required surplus, a rehabilitator or
267 liquidator may use the insolvent managed care organization's required surplus to continue to
268 provide coverage for the insolvent managed care organization's enrollees, including paying
269 uncovered expenditures.
270 Section 4. Section **31A-45-303** is amended to read:
271 **31A-45-303. Network provider contract provisions.**
272 (1) Managed care organizations may provide for enrollees to receive services or
273 reimbursement under the health benefit plans in accordance with this section.

274 (2) (a) Subject to restrictions under this section, a managed care organization may enter
275 into contracts with health care providers under which the health care providers agree to be a
276 network provider and supply services, at prices specified in the contracts, to enrollees.
277 (b) A network provider contract shall require the network provider to accept the
278 specified payment in [~~this~~] Subsection (2)(a) as payment in full, relinquishing the right to
279 collect amounts other than copayments, coinsurance, and deductibles from the enrollee.
280 (c) The insurance contract may reward the enrollee for selection of network providers
281 by:
282 (i) reducing premium rates;
283 (ii) reducing deductibles;
284 (iii) coinsurance;
285 (iv) other copayments; or
286 (v) any other reasonable manner.
287 (3) [~~(a)~~] When reimbursing for services of health care providers that are not network
288 providers, the managed care organization may:
289 [~~(i)~~] (a) make direct payment to the enrollee; and
290 [~~(ii)~~] (b) impose a deductible on coverage of health care providers not under contract.
291 [~~(b) (i) Subsections (3)(b)(iii) and (c) apply to a managed care organization licensed~~
292 ~~under:~~]
293 [~~(A) Chapter 5, Domestic Stock and Mutual Insurance Corporations;~~]
294 [~~(B) Chapter 7, Nonprofit Health Service Insurance Corporations; or~~]
295 [~~(C) Chapter 14, Foreign Insurers; and~~]
296 [~~(ii) Subsections (3)(b)(iii) and (c) and Subsection (6)(b) do not apply to a managed~~
297 ~~care organization licensed under Chapter 8, Health Maintenance Organizations and Limited~~
298 ~~Health Plans.~~]
299 [~~(iii)~~] (4) (a) When selecting health care providers with whom to contract under
300 Subsection (2), a managed care organization [~~described in Subsection (3)(b)(i)~~] may not
301 unfairly discriminate between classes of health care providers, but may discriminate within a
302 class of health care providers, subject to [~~Subsection (6)~~] Subsections (7) and (8).
303 [~~(c)~~] (b) For purposes of this section, unfair discrimination between classes of health
304 care providers includes:

305 (i) refusal to contract with class members in reasonable proportion to the number of
306 insureds covered by the insurer and the expected demand for services from class members; and
307 (ii) refusal to cover procedures for one class of providers that are:
308 (A) commonly used by members of the class of health care providers for the treatment
309 of illnesses, injuries, or conditions;
310 (B) otherwise covered by the managed care organization; and
311 (C) within the scope of practice of the class of health care providers.
312 [~~(4)~~] (5) (a) Before the enrollee consents to the insurance contract, the managed care
313 organization shall fully disclose to the enrollee that the managed care organization has entered
314 into network provider contracts.
315 (b) The managed care organization shall provide sufficient detail on the network
316 provider contracts to permit the enrollee to agree to the terms of the insurance contract.
317 (c) The managed care organization shall provide at least the following information:
318 [~~(a)~~] (i) a list of the health care providers under contract, and if requested their business
319 locations and specialties;
320 [~~(b)~~] (ii) a description of the insured benefits, including deductibles, coinsurance, or
321 other copayments;
322 [~~(c)~~] (iii) a description of the quality assurance program required under Subsection (5);
323 and
324 [~~(d)~~] (iv) a description of the adverse benefit determination procedures required under
325 Section 31A-22-629.
326 [~~(5)~~] (6) (a) A managed care organization using network provider contracts shall
327 maintain a quality assurance program for [~~assuring~~] ensuring that the care provided by the
328 network providers meets prevailing standards in the state.
329 (b) (i) The commissioner in consultation with the executive director of the Department
330 of Health may designate qualified persons to perform an audit of the quality assurance
331 program.
332 (ii) The auditors shall have full access to all records of the managed care organization
333 and the managed care organization's health care providers, including medical records of
334 individual patients.
335 (c) (i) The information contained in the medical records of individual patients shall

336 remain confidential.
337 (ii) All information, interviews, reports, statements, memoranda, or other data
338 furnished for purposes of the audit and any findings or conclusions of the auditors are
339 privileged.
340 (iii) The information is not subject to discovery, use, or receipt in evidence in any legal
341 proceeding except hearings before the commissioner concerning alleged violations of this
342 section.
343 [~~(6) (a)~~] (7) A health care provider or managed care organization may not discriminate
344 against a network provider for agreeing to a contract under Subsection (2).
345 [~~(b) (i) Subsections (6)(b) and (c) apply to a managed care organization that is~~
346 ~~described in Subsection (3)(b)(i) and do not apply to a managed care organization described in~~
347 ~~Subsection (3)(b)(ii).~~]
348 [~~(ii)~~] (8) (a) A health care provider licensed to treat an illness or injury within the scope
349 of the health care provider's practice, that is willing and able to meet the terms and conditions
350 established by the managed care organization for designation as a network provider, shall be
351 able to apply for and receive the designation as a network provider.
352 (b) Contract terms and conditions may include reasonable [~~limitations~~] limits on the
353 number of designated network providers based upon substantial objective and economic
354 grounds, or expected use of particular services based upon prior provider-patient profiles.
355 (c) Upon the written request of a provider excluded from a network provider contract,
356 the commissioner may hold a hearing to determine if the managed care organization's exclusion
357 of the provider is based on the criteria [~~set forth in~~] described in this Subsection [~~(6)(b)~~] (8).
358 (9) Subsections (4) and (8):
359 (a) apply to a managed care organization licensed under:
360 (i) Chapter 5, Domestic Stock and Mutual Insurance Corporations;
361 (ii) Chapter 7, Nonprofit Health Service Insurance Corporations; or
362 (iii) Chapter 14, Foreign Insurers; and
363 (b) do not apply to a managed care organization licensed under Chapter 8, Health
364 Maintenance Organizations and Limited Health Plans.
365 [~~(7)~~] (10) Nothing in this section [~~is to~~] may be construed as [~~to require~~] requiring a
366 managed care organization to offer a certain benefit or service as part of a health benefit plan.

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