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H.B. 433

MEDICAL RETAINER AGREEMENT AMENDMENTS

2018 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: Ken Ivory

Senate Sponsor: _____

LONG TITLE

General Description:

This bill amends provisions of the Insurance Code relating to medical retainer agreements.

Highlighted Provisions:

This bill:

- allows a health care provider to bill an insurer for the services provided under a medical retainer agreement; and
- authorizes a managed care organization's network provider to collect fees from an enrollee due under a medical retainer agreement.

Money Appropriated in this Bill:

None

Other Special Clauses:

None

Utah Code Sections Affected:

AMENDS:

31A-4-106.5, as enacted by Laws of Utah 2012, Chapter 50

31A-45-303, as last amended by Laws of Utah 2017, Chapter 168 and renumbered and amended by Laws of Utah 2017, Chapter 292

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

H.B. 433

Section 1. Section **31A-4-106.5** is amended to read:

31A-4-106.5. Medical retainer agreements.

(1) For purposes of this section:

(a) "Medical retainer agreement" means a written contract:

(i) between:

(A) except as provided in Subsection (1)(b)(iii)(B), a natural person or a professional corporation, alone or with others professionally associated with the natural person or professional corporation; and

(B) an individual patient or a patient's representative; and

(ii) in which:

(A) the person described in Subsection (1)(a)(i)(A) agrees to provide routine health care services to the individual patient for an agreed upon fee and period of time; and

(B) either party to the contract may terminate the agreement upon written notice to the other party.

(b) "Routine health care services" include:

(i) screening, assessment, diagnosis, and treatment for the purpose of promotion of health, and detection and management of disease or injury;

(ii) supplies and prescription drugs that are dispensed in a health care provider's office; and

(iii) laboratory work, such as routine blood screening or routine pathology screening performed by a laboratory that:

(A) is associated with the health care provider entering into the medical retainer agreement; or

(B) if not associated with the health care provider, has entered into an agreement with the health care provider to provide the laboratory work without charging a fee to the patient for the laboratory work.

(2) A medical retainer agreement exempt from the provisions of Subsection 31A-4-106(2) [~~shall~~]:

(a) shall describe the specific routine health care services that are included in the contract;

(b) shall prominently state in writing that the retainer agreement is not health

insurance; and

(c) may not prohibit the health care provider[~~, but not~~] or the patient[~~,~~] from billing an insurer for the services provided under the medical retainer agreement.

Section 2. Section **31A-45-303** is amended to read:

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

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

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

(b) A network provider contract shall require the network provider to accept the specified payment in this Subsection (2) as payment in full, relinquishing the right to collect from the enrollee amounts other than:

(i) copayments, coinsurance, and deductibles [~~from the enrollee.~~]; and

(ii) any fee due under a medical retainer agreement entered into under Section 31A-4-106.5.

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

(i) reducing premium rates;

(ii) reducing deductibles;

(iii) coinsurance;

(iv) other copayments; or

(v) any other reasonable manner.

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

(i) make direct payment to the enrollee; and

(ii) impose a deductible on coverage of health care providers not under contract.

(b) (i) Subsections (3)(b)(iii) and (c) apply to a managed care organization licensed under:

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

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

(C) Chapter 14, Foreign Insurers; and

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

(iii) When selecting health care providers with whom to contract under Subsection (2), a managed care organization described in Subsection (3)(b)(i) may not unfairly discriminate between classes of health care providers, but may discriminate within a class of health care providers, subject to Subsection (6).

(c) For purposes of this section, unfair discrimination between classes of health care providers includes:

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

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

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

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

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

(4) Before the enrollee consents to the insurance contract, the managed care organization shall fully disclose to the enrollee that the managed care organization has entered into network provider contracts. The managed care organization shall provide sufficient detail on the network provider contracts to permit the enrollee to agree to the terms of the insurance contract. The managed care organization shall provide at least the following information:

(a) a list of the health care providers under contract, and if requested their business locations and specialties;

(b) a description of the insured benefits, including deductibles, coinsurance, or other copayments;

(c) a description of the quality assurance program required under Subsection (5); and

(d) a description of the adverse benefit determination procedures required under Section 31A-22-629.

(5) (a) A managed care organization using network provider contracts shall maintain a quality assurance program for assuring that the care provided by the network providers meets

prevailing standards in the state.

(b) The commissioner in consultation with the executive director of the Department of Health may designate qualified persons to perform an audit of the quality assurance program. The auditors shall have full access to all records of the managed care organization and the managed care organization's health care providers, including medical records of individual patients.

(c) The information contained in the medical records of individual patients shall remain confidential. All information, interviews, reports, statements, memoranda, or other data furnished for purposes of the audit and any findings or conclusions of the auditors are privileged. The information is not subject to discovery, use, or receipt in evidence in any legal proceeding except hearings before the commissioner concerning alleged violations of this section.

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

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

(ii) A health care provider licensed to treat an illness or injury within the scope of the health care provider's practice, that is willing and able to meet the terms and conditions established by the managed care organization for designation as a network provider, shall be able to apply for and receive the designation as a network provider. Contract terms and conditions may include reasonable limitations on the number of designated network providers based upon substantial objective and economic grounds, or expected use of particular services based upon prior provider-patient profiles.

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

(7) Nothing in this section is to be construed as to require a managed care organization to offer a certain benefit or service as part of a health benefit plan.

(8) Notwithstanding Subsection (2) or Subsection (6)(b), a managed care organization described in Subsection (3)(b)(i) or third party administrator is not required to, but may, enter

into a contract with a licensed athletic trainer, licensed under Title 58, Chapter 40a, Athletic Trainer Licensing Act.

Legislative Review Note
Office of Legislative Research and General Counsel