

1 **HEALTH INSURANCE ATHLETIC TRAINER SERVICES**

2 **MODIFICATIONS**

3 2020 GENERAL SESSION

4 STATE OF UTAH

5 **Chief Sponsor: Bradley G. Last**

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 2018, Chapter 319

27 **31A-22-618**, as last amended by Laws of Utah 2019, Chapter 136



28 31A-22-618.5, as last amended by Laws of Utah 2017, Chapter 292

29 31A-27a-403, as last amended by Laws of Utah 2018, Chapters 281 and 391

30 31A-45-303, as last amended by Laws of Utah 2019, Chapter 193

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 As used in 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) "Marketing" means making or causing to be made any communication that contains

59 information that relates to a product or contract regulated under this chapter.

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

63 Section 2. Section 31A-22-618 is amended to read:

64 **31A-22-618. Nondiscrimination among health care professionals.**

65 (1) (a) Except as provided [~~under Section 31A-45-303 and~~] in Subsection (2), and
66 except as to insurers licensed under Chapter 8, Health Maintenance Organizations and Limited
67 Health Plans, no insurer may unfairly discriminate against any licensed class of health care
68 providers by structuring contract exclusions which exclude payment of benefits for the
69 treatment of any illness, injury, or condition by any licensed class of health care providers
70 when the treatment is within the scope of the licensee's practice and the illness, injury, or
71 condition falls within the coverage of the contract.

72 (b) Upon the written request of an insured alleging an insurer has violated this section,
73 the commissioner shall hold a hearing to determine if the violation exists.

74 (c) The commissioner may consolidate two or more related alleged violations into a
75 single hearing.

76 (2) (a) Coverage for licensed providers for behavioral analysis may be limited by an
77 insurer in accordance with Section 58-61-714.

78 (b) Nothing in this section prohibits an insurer from electing to provide coverage for
79 other licensed professionals whose scope of practice includes behavior analysis.

80 Section 3. Section 31A-22-618.5 is amended to read:

81 **31A-22-618.5. Coverage of insurance mandates imposed after January 1, 2009.**

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

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

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

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

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

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

92 (B) except as provided in Subsection (2)(b)(ii), basic health care services as defined in
93 Section 31A-8-101; or

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

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

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

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

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

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

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

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

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

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

116 Section 4. Section 31A-27a-403 is amended to read:

117 **31A-27a-403. Continuance of coverage -- Health maintenance organizations.**

118 (1) As used in this section:

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

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

122 ~~[(e)]~~ (b) "Health care" ~~[is as]~~ means the same as that term is defined in Section
123 [31A-1-301](#).

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

126 ~~[(e)]~~ (d) "Limited health plan" ~~[is as]~~ means the same as that term is defined in Section
127 [31A-8-101](#).

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

130 (ii) "Managed care organization" includes:

131 (A) a limited health plan;

132 (B) a health maintenance organization;

133 (C) a preferred provider organization;

134 (D) a fraternal benefit society; or

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

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

137 (A) an insurer or other person that is eligible for membership in a guaranty association
138 under Chapter 28, Guaranty Associations;

139 (B) a mandatory state pooling plan;

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

141 (D) an entity similar to an entity described in Subsections (1)~~[(f)]~~(e)(iii)(A) through
142 (C).

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

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

147 (ii) other than a copayment.

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

150 ~~[(i)]~~ (h) "Preferred provider" means a provider who agrees to provide health care
151 services under an agreement authorized under Subsection [31A-45-303\(2\)](#).

152 [fj] (i) "Preferred provider contract" means the written agreement between a preferred
153 provider and a managed care organization authorized under Subsection 31A-45-303(2).

154 [k] (j) (i) Except as provided in Subsection (1)[k](j)(ii), "preferred provider
155 organization" means a person that:

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

159 (B) is obligated to the enrollee to arrange for the services described in Subsection
160 (1)[k](j)(i)(A); and

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

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

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

166 (B) an individual who contracts to render professional or personal services that the
167 individual performs.

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

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

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

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

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

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

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

182 (I) a petition for rehabilitation; or

183 (II) a petition for liquidation; or

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

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

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

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

197 (iii) An enrollee shall continue to pay the same copayments, deductibles, and other
198 payments for services received from a participating provider or preferred provider that the
199 enrollee is required to pay before the day on which the following is filed:

200 (A) the petition for rehabilitation; or

201 (B) the petition for liquidation.

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

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

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

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

208 (e) This Subsection (2)(e) applies to a managed care organization that is a health
209 maintenance organization for a delinquency proceeding under this chapter that is initiated
210 before May 8, 2018.

211 (i) A solvent health maintenance organization licensed under Chapter 8, Health
212 Maintenance Organizations and Limited Health Plans, shall extend to the enrollees of an
213 insolvent health maintenance organization all rights, privileges, and obligations of being an

214 enrollee in the accepting health maintenance organization:

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

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

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

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

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

227 (iv) A health maintenance organization's obligation to accept an enrollee under
228 Subsection (2)(e)(i) is limited in number to the accepting health maintenance organization's pro
229 rata share of all health maintenance organization enrollees in this state, as determined after
230 excluding the enrollees of the insolvent insurer.

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

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

238 (vi) (A) Notwithstanding Section [31A-27a-402](#), the rehabilitator or liquidator may
239 require all solvent health maintenance organizations to pay for the covered claims incurred by
240 the enrollees of the insolvent health maintenance organization.

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

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

244 (Aa) the petition for rehabilitation; or

245 (Bb) the petition for liquidation; and

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

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

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

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

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

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

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

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

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

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

276 (I) from a limited health plan to a limited health plan;
277 (II) from a health maintenance organization to a health maintenance organization;
278 (III) from a preferred provider organization to a preferred provider organization;
279 (IV) from a fraternal benefit society to a fraternal benefit society; and
280 (V) from an entity similar to an entity described in this Subsection (2)(f)(iii)(A) to a
281 category that is similar;

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

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

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

290 Section 5. Section **31A-45-303** is amended to read:

291 **31A-45-303. Network provider contract provisions.**

292 (1) Managed care organizations may provide for enrollees to receive services or
293 reimbursement in accordance with this section.

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

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

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

302 (i) reducing premium rates;

303 (ii) reducing deductibles;

304 (iii) coinsurance;

305 (iv) other copayments; or

306 (v) any other reasonable manner.

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

309 ~~(i)~~ (a) make direct payment to the enrollee; and

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

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

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

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

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

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

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

323 ~~(e)~~ (b) For purposes of this section, unfair discrimination between classes of health
 324 care providers includes:

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

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

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

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

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

332 ~~(4)~~ (5) (a) Before the enrollee consents to the insurance contract, the managed care
 333 organization shall fully disclose to the enrollee that the managed care organization has entered
 334 into network provider contracts.

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

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

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

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

342 ~~[(c)]~~ (iii) a description of the quality assurance program required under Subsection
343 ~~[(5)]~~ (6); and

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

346 ~~[(5)]~~ (6) (a) A managed care organization using network provider contracts shall
347 maintain a quality assurance program for ~~[assuring]~~ ensuring that the care provided by the
348 network providers meets prevailing standards in the state.

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

352 (ii) The auditors shall have full access to all records of the managed care organization
353 and the managed care organization's health care providers, including medical records of
354 individual patients.

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

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

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

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

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

368 ~~[(ii) A]~~ (8) (a) Except as provided in Subsection (8)(b), a health care provider licensed

369 to treat an illness or injury within the scope of the health care provider's practice, that is willing
 370 and able to meet the terms and conditions established by the managed care organization for
 371 designation as a network provider, shall be able to apply for and receive the designation as a
 372 network provider.

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

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

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

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

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

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

383 (iii) Chapter 14, Foreign Insurers; and

384 (b) do not apply to a managed care organization licensed under Chapter 8, Health
 385 Maintenance Organizations and Limited Health Plans.

386 [(7)] (10) Nothing in this section [is to] may be construed as [to require] requiring a
 387 managed care organization to offer a certain benefit or service as part of a health benefit plan.

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

392 Section 6. Section **58-40a-306** is enacted to read:

393 **58-40a-306. Insurance coverage not mandated.**

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