LEGISLATIVE GENERAL COUNSEL
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H.B. 457

HEALTH INSURANCE AMENDMENTS

2020 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: James A. Dunnigan

Senate Sponsor: _____

LONG TITLE

General Description:

This bill enacts requirements related to billing and provider networks for certain health insurance plans.

Highlighted Provisions:

This bill:

- defines terms;
- requires a managed care organization to provide adequate coverage of certain health care services in the managed care organization's network;
- requires a managed care organization to publish and maintain a provider directory of health care providers that are in the managed care organization's network; and
- enacts procedures that a managed care organization and a non-network health care professional must follow if there is a dispute regarding payment for certain emergency services.

Money Appropriated in this Bill:

None

Other Special Clauses:

None

Utah Code Sections Affected:

ENACTS:

31A-22-653, Utah Code Annotated 1953

H.B. 457

31A-22-654, Utah Code Annotated 1953

31A-22-655, Utah Code Annotated 1953

58-1-510, Utah Code Annotated 1953

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

Section 1. Section **31A-22-653** is enacted to read:

31A-22-653. Access to managed care organization health care providers.

(1) As used in this section:

(a) (i) "Balance billing" means the practice of a licensed provider billing a managed care organization enrollee for the difference between a licensed provider's charge and the managed care organization's allowed amount.

(ii) "Balance billing" does not include billing an enrollee for cost sharing required by the enrollee's health benefit plan, including copayments, coinsurance, and deductibles.

(b) "Covered benefit" means a health care service covered under the terms of a health benefit plan.

(c) "Emergency services" means the same as that term is defined in 42 C.F.R. Sec. 2590.715-2719A.

(d) "Licensed provider" means an individual who is licensed under Title 58, Occupations and Professions, to provide health care.

(e) "Managed care organization" means:

(i) a managed care organization as defined in Section 31A-27a-403; and

(ii) a third party administrator.

(f) (i) "Post stabilization care" means services related to emergency services that:

(A) are provided by the physician who performed the emergency services;

(B) are provided after an enrollee's condition is no longer considered an emergency medical condition as defined in Section 31A-22-627;

(C) stabilize as defined in 42 U.S.C. Sec. 1395dd(e)(3) or improve or resolve the enrollee's condition; and

(D) are provided within 90 days after the day on which the enrollee's condition is no longer considered an emergency medical condition as defined in Section 31A-22-627.

(ii) "Post stabilization care" does not include health care facility charges or laboratory

charges.

(2) A managed care organization that offers or administers a network plan shall maintain a network that is sufficient in number and appropriate types of licensed providers, including those that serve predominantly low-income, medically underserved individuals, to ensure that all services to enrollees, including children and adults, will be accessible without unreasonable travel or delay.

(3) An enrollee under a managed care organization's network plan shall have access to emergency services 24 hours per day, seven days per week.

(4) (a) A managed care organization that provides a network plan shall provide adequate access to current and potential enrollees through a contracted network of health care providers, including health care facilities, for each county within the managed care organization's filed service area.

(b) Adequate access under Subsection (4)(a) is demonstrated if the managed care organization:

(i) has a network of health care providers that meets the maximum travel time and distance standards in, and has sufficient numbers of, health care providers to meet the minimum number of requirements set forth by:

(A) the Centers for Medicare and Medicaid Services for Medicare Advantage plans; and

(B) modifications to and extensions of the standards in Subsection (4)(b)(i)(A) adopted by the commissioner by administrative rule based on nationally recognized standards and as necessary to reflect the age and demographics of the enrollees in the network plan and the availability of rural health care providers; and

(ii) meets adequacy and sufficiency standards established by the commissioner by administrative rule made in accordance with this Subsection (4) and Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

(c) The commissioner shall adopt administrative rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to establish reasonable standards under Subsection (4)(b)(ii).

Section 2. Section **31A-22-654** is enacted to read:

31A-22-654. Managed care organization provider directories.

(1) As used in this section:

(a) "Licensed provider" means the same as that term is defined in Section 31A-22-653.

(b) "Managed care organization" means the same as that term is defined in Section 31A-22-653.

(2) (a) A managed care organization shall post electronically a current and accurate directory of licensed providers for each of the organization's network plans.

(b) In making the directory available electronically, the managed care organization shall ensure the general public is able to view all of the current licensed providers for a plan through a clearly identifiable link or tab and without creating or accessing an account or entering a policy or contract number.

(c) The managed care organization shall update each network plan provider directory at least monthly.

(d) A managed care organization does not violate the requirement of Subsection (2)(c) if the managed care organization fails to update the directory because a licensed provider has failed to notify the managed care organization of a change to the licensed provider's information.

(3) A managed care organization shall make available through a searchable electronic directory, for each network plan, the following information about each licensed provider in the managed care organization's network plan, as submitted to the managed care organization by the licensed provider:

(a) the licensed provider's name;

(b) the licensed provider's gender;

(c) participating office locations;

(d) specialty;

(e) medical group affiliations, if applicable;

(f) participating facility affiliations, if applicable;

(g) languages spoken other than English, if applicable;

(h) whether the licensed provider is accepting new patients; and

(i) contact information.

(4) The provider directory under this section shall accommodate the communication needs of individuals with disabilities and include a link to or information regarding available

assistance for individuals with limited English proficiency.

Section 3. Section **31A-22-655** is enacted to read:

31A-22-655. Managed care organization out-of-network services -- Emergency services -- Post stabilization care -- Balance billing.

(1) As used in this section:

(a) "Balance billing" means the same as that term is defined in Section 31A-22-653.

(b) "Covered benefit" means the same as that term is defined in Section 31A-22-653.

(c) "Emergency services" means the same as that term is defined in Section 31A-22-653.

(d) "Licensed provider" means the same as that term is defined in Section 31A-22-653.

(e) "Managed care organization" means the same as that term is defined in Section 31A-22-653.

(f) "Post stabilization care" means the same as that term is defined in Section 31A-22-653.

(2) Upon receiving a bill from a non-network licensed provider with the applicable benchmark rate described in Subsection (5)(b)(i), a managed care organization shall:

(a) reimburse a non-network licensed provider for emergency services and post stabilization care in accordance with this section;

(b) (i) pay a non-network licensed provider directly for emergency services and post stabilization care provided to an enrollee; and

(ii) send an explanation of benefits to the non-network licensed provider with the information required under Subsection (2)(f);

(c) pay a non-network licensed provider for emergency services in accordance with Subsection (5);

(d) pay a non-network licensed provider for post stabilization care at the in-network allowed amount for the patient's managed care organization plan if:

(i) the patient and the licensed provider agree to the post stabilization care;

(ii) the non-network licensed provider agrees to abide by the managed care organization's terms and conditions of care that would apply to a network licensed provider; and

(iii) the licensed provider submits a single claim for all post stabilization care with a

written request for payment under this Subsection (2)(d);

(e) ensure that the enrollee is responsible for no more than the applicable in-network cost sharing amount; and

(f) provide an explanation of benefits to the enrollee and a remittance to the non-network licensed provider that includes:

(i) the amount the non-network licensed provider may attempt to collect from the enrollee for the enrollee's cost sharing, including unmet deductibles, copayments, and coinsurance; and

(ii) the managed care organization's allowed amount under Subsection (2)(c) for the emergency services or Subsection (2)(d) for post stabilization care.

(3) If a non-network licensed provider sends a bill directly to an enrollee for emergency services or post stabilization care, the bill shall notify the enrollee:

(a) that the emergency services or post stabilization care were performed by a licensed provider who is not a network licensed provider for the enrollee's health benefit plan; and

(b) that the enrollee is responsible for paying the enrollee's applicable in-network cost sharing amount.

(4) A non-network licensed provider who receives payment from the managed care organization under Subsection (2)(c) or (d):

(a) may rely on the remittance provided by the managed care organization to the non-network licensed provider under Subsection (2)(f);

(b) shall accept the payment from the enrollee under Subsection (3)(b) as payment in full for the emergency services and post stabilization care from the enrollee; and

(c) may not attempt to collect payment from an enrollee for emergency services or post stabilization care in excess of the amount under Subsection (3)(b).

(5) (a) When a managed care organization receives a bill for emergency services from a non-network licensed provider, the managed care organization shall:

(i) ensure that the enrollee is responsible for no more than the applicable in-network cost sharing amount; and

(ii) may elect to pay a non-network licensed provider for emergency services:

(A) as submitted by the licensed provider;

(B) the applicable benchmark rate described in Subsection (5)(b); or

(C) in an amount mutually agreed upon by the managed care organization and the licensed provider.

(b) (i) The benchmark rate under this section is:

(A) for an emergency room physician, the median of the emergency room physician's contracted in-network rates with all managed care organizations in the state; and

(B) for a licensed provider who is not an emergency room physician, the 80th percentile of all total amounts paid for the particular health care service performed by a licensed provider in the state in the same or similar specialty as reported in the all payer claims database maintained by the Department of Health.

(ii) A managed care organization may submit a request to the department to verify the benchmark rate submitted by a licensed provider under this section.

(iii) A licensed provider may request the information described in Subsection (5)(b)(i)(B) from the department for the purpose of providing a bill under Subsection (2).

(c) This section does not preclude a managed care organization and a non-network licensed provider from agreeing to a different payment arrangement if:

(i) the enrollee is responsible for no more than the applicable in-network cost sharing amount; and

(ii) the enrollee has no legal obligation to pay the balance for emergency services remaining after the payments under Subsection (4).

Section 4. Section **58-1-510** is enacted to read:

58-1-510. Health care provider -- Unprofessional conduct to balance bill for emergency services.

(1) As used in this section:

(a) "Balance billing" means the same as that term is defined in Section 31A-22-653.

(b) "Emergency services" means the same as that term is defined in Section 31A-22-653.

(c) "Licensed provider" means the same as that term is defined in Section 31A-22-653.

(2) It is unprofessional conduct for a licensed provider to engage in balance billing for emergency services in violation of Section 31A-22-655.