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HEALTH INSURANCE ATHLETIC TRAINER SERVICES AMENDMENTS

2019 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: Paul Ray

Senate Sponsor: _____

LONG TITLE

General Description:

This bill repeals exclusions of a licensed athletic trainer from certain provisions of the insurance code.

Highlighted Provisions:

This bill:

- repeals exclusions of a licensed athletic trainer from:
  - the definition of "health care provider" in the Health Discount Program Consumer Protection Act; and
  - preferred provider nondiscrimination provisions for a managed care organization; and
- makes technical changes.

Money Appropriated in this Bill:

None

Other Special Clauses:

None

Utah Code Sections Affected:

AMENDS:

31A-8a-102, as last amended by Laws of Utah 2018, Chapter 319

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

H.B. 368

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

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

ENACTS:

58-40a-306, Utah Code Annotated 1953

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

Section 1. Section **31A-8a-102** is amended to read:

31A-8a-102. Definitions.

As used in this chapter:

(1) "Fee" means any periodic charge for use of a discount program.

(2) "Health care provider" means a health care provider as defined in Section 78B-3-403[~~, with the exception of "licensed athletic trainer,"~~] who:

(a) is practicing within the scope of the provider's license; and

(b) has agreed either directly or indirectly, by contract or any other arrangement with a health discount program operator, to provide a discount to enrollees of a health discount program.

(3) (a) "Health discount program" means a business arrangement or contract in which a person pays fees, dues, charges, or other consideration in exchange for a program that provides access to health care providers who agree to provide a discount for health care services.

(b) "Health discount program" does not include a program that does not charge a membership fee or require other consideration from the member to use the program's discounts for health services.

(4) "Health discount program marketer" means a person, including a private label entity, that markets, promotes, sells, or distributes a health discount program but does not operate a health discount program.

(5) "Health discount program operator" means a person that provides a health discount program by entering into a contract or agreement, directly or indirectly, with a person or persons in this state who agree to provide discounts for health care services to enrollees of the health discount program and determines the charge to members.

(6) "Marketing" means making or causing to be made any communication that contains

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

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

Section 2. Section **31A-22-618.5** is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

after January 1, 2009.

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

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

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

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

Section 3. Section **31A-27a-403** is amended to read:

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

(1) As used in this section:

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

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

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

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

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

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

(ii) "Managed care organization" includes:

(A) a limited health plan;

(B) a health maintenance organization;

(C) a preferred provider organization;

(D) a fraternal benefit society; or

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

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

(A) an insurer or other person that is eligible for membership in a guaranty association

under Chapter 28, Guaranty Associations;

(B) a mandatory state pooling plan;

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

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

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

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

(ii) other than a copayment.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(I) a petition for rehabilitation; or

(II) a petition for liquidation; or

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

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

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

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

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

(A) the petition for rehabilitation; or

(B) the petition for liquidation.

(c) A participating provider or preferred provider shall:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(Aa) the petition for rehabilitation; or

(Bb) the petition for liquidation; and

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

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

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

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

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

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

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

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

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

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

(I) from a limited health plan to a limited health plan;

(II) from a health maintenance organization to a health maintenance organization;

(III) from a preferred provider organization to a preferred provider organization;

(IV) from a fraternal benefit society to a fraternal benefit society; and

(V) from an entity similar to an entity described in this Subsection (2)(f)(iii)(A) to a category that is similar;

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

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

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

Section 4. 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)(a) as payment in full, relinquishing the right to collect amounts other than copayments, coinsurance, and deductibles from the enrollee.

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

[~~(ii)~~] (b) 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)~~] (4) (a) 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)~~] Subsections (7) and (8).

[~~(c)~~] (b) 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)~~] (5) (a) 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.

(b) 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.

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

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

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

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

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

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

(b) (i) 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.

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

(ii) 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.

(iii) 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)~~] (7) 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~~] (8) (a) Except as provided in Subsection (8)(b), 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.

(b) Contract terms and conditions may include reasonable [~~limitations~~] limits 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~~] described in this Subsection [~~(6)(b)~~] (8).

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

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

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

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

(iii) Chapter 14, Foreign Insurers; and

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

[~~(7)~~] (10) Nothing in this section [~~is to~~] may be construed as [~~to require~~] requiring 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.~~]

Section 5. Section **58-40a-306** is enacted to read:

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

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