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₵ 02-20-20 5:11 PM ₵

H.B. 380

HEALTH CARE CONSUMER PROTECTION AMENDMENTS

2020 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: Norman K. Thurston

Senate Sponsor: _____

LONG TITLE

General Description:

This bill amends the Insurance Code.

Highlighted Provisions:

This bill:

- creates a definition;
- prohibits a health care provider from misrepresenting that the provider is a contracted provider under a health benefit plan when that is not the case; and
- specifies that a violation is a violation of the Utah Consumer Sales Practices Act.

Money Appropriated in this Bill:

None

Other Special Clauses:

None

Utah Code Sections Affected:

AMENDS:

31A-45-301, as enacted by Laws of Utah 2017, Chapter 292

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

Section 1. Section **31A-45-301** is amended to read:

31A-45-301. Written contracts -- Limited liability of enrollee -- Provider claim disputes -- Leased networks.

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(1) As used in this section, "health care provider" means a person licensed to provide health care under:

(a) Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act; or

(b) Title 58, Occupations and Professions.

[~~(1)~~] (2) A managed care organization may not contract with a health care provider for treatment of illness or injury unless the health care provider is licensed to perform that treatment. Every contract between a managed care organization and a network provider shall be in writing and shall set forth that if the managed care organization:

(a) fails to pay for health care services as set forth in the contract, the enrollee is not liable to the health care provider for any sums owed by the managed care organization; and

(b) becomes insolvent, the rehabilitator or liquidator may require the network provider to:

(i) continue to provide health care services under the contract between the network provider and the managed care organization until the earlier of:

(A) 90 days after the date of the filing of a petition for rehabilitation or a petition for liquidation; or

(B) the date the term of the contract ends; and

(ii) subject to Subsection [~~(3)~~] (4), reduce the fees the network provider is otherwise entitled to receive from the managed care organization under the contract between the network provider and the managed care organization during the time period described in Subsection [~~(1)~~] (2)(b)(i).

[~~(2)~~] (3) If the conditions of Subsection [~~(3)~~] (4) are met, the network provider:

(a) shall accept the reduced payment as payment in full; and

(b) as provided in Subsection [~~(1)~~] (2)(a), may not collect additional amounts from the insolvent managed care organization's enrollee, except as may be owed under Subsection [~~(3)~~] (4)(b).

[~~(3)~~] (4) Notwithstanding Subsection [~~(1)~~] (2)(b)(ii):

(a) the rehabilitator or liquidator may not reduce a fee to less than 75% of the regular fee set forth in the network provider contract; and

(b) the enrollee shall continue to pay the same copayments, deductibles, and other payments for services received from the network provider that the enrollee was required to pay

before the filing of:

(i) the petition for rehabilitation; or

(ii) the petition for liquidation.

[~~(4)~~] (5) A network provider may not collect or attempt to collect from the enrollee sums owed by the managed care organization or the amount of the regular fee reduction authorized under Subsection [~~(1)~~] (2)(b)(ii) if the network provider contract:

(a) is not in writing as required in Subsection [~~(1)~~] (2); or

(b) fails to contain the language required by Subsection [~~(1)~~] (2).

[~~(5)~~] (6) (a) A person listed in Subsection [~~(5)~~] (6)(b) may not bill or maintain any action at law against an enrollee to collect:

(i) sums owed by the organization; or

(ii) the amount of the regular fee reduction authorized under Subsection [~~(1)~~] (2)(b)(ii).

(b) Subsection [~~(5)~~] (6)(a) applies to:

(i) a network provider;

(ii) an agent;

(iii) a trustee; or

(iv) an assignee of a person described in Subsections [~~(5)~~] (6)(b)(i) through (iii).

(c) In any dispute involving a network provider's claim for reimbursement, the network provider's claim shall be determined in accordance with applicable law, the network provider contract, the enrollee contract, and the managed care organization's written payment policies in effect at the time services were rendered.

(d) If the parties are unable to resolve their dispute, the matter shall be subject to binding arbitration by a jointly selected arbitrator. Each party shall bear its own expense except that the cost of the jointly selected arbitrator shall be equally shared. This Subsection [~~(5)~~] (6)(d) does not apply to the claim of a general acute hospital to the extent the claim is inconsistent with the hospital's provider agreement.

(e) A managed care organization may not penalize a network provider solely for pursuing a claims dispute or otherwise demanding payment for a sum believed owing.

[~~(6)~~] (7) If a managed care organization permits another private entity with which the managed care organization does not share common ownership or control to use or otherwise lease one or more of the organization's networks that include network providers, the managed

care organization shall ensure, at a minimum, that the entity pays the network providers included in the managed care organization's network in accordance with the same fee schedule and general payment policies as the managed care organization would pay for those network providers, unless payment for services is governed by a public program's fee schedule.

(8) (a) Neither a health care provider, nor a health care provider's representative, may represent to an enrollee that the health care provider is a contracted provider under the enrollee's health benefit plan if the health care provider is not a contracted provider under the enrollee's health benefit plan.

(b) A violation of Subsection (8)(a) is a deceptive act or practice under Section 13-11-4.