

UTAH

Unlike other state codes, the Utah Insurance Code specifies an amount that a plan must pay for services received by a non contract provider—at least 75 percent of the average amount paid by the insurer for comparable services of preferred health care providers. Additionally, the code states that the plan can make these payments to the insured rather than to the provider. And the insurer can impose a deductible for services provided by an out-of-network provider. Further, the code stipulates specific conditions under which the insurer is required to pay an independent facility or provider. These condition have to do with ensuring access to individuals living in rural areas.

It also states that a non-contracting provider cannot balance billed a patient, if the insurer has paid the provider according to 31A-8-501(4 a and b).

The relevant sections of this chapter are attached and include: Preferred Provider Contract Provisions and Access to Health Care Providers and Coverage of Emergency Medical Services.

31A-22-617 Preferred Provider Contract Provisions

(2) (a) Subject to Subsections (2)(b) through (2)(f), an insurer using preferred health care provider contracts shall pay for the services of health care providers not under the contract, unless the illnesses or injuries treated by the health care provider are not within the scope of the insurance contract. As used in this section, "class of health care providers" means all health care providers licensed or licensed and certified by the state within the same professional, trade, occupational, or facility licensure or licensure and certification category established pursuant to Titles 26, Utah Health Code and 58, Occupations and Professions.

(b) (i) Until July 1, 2012, when the insured receives services from a health care provider not under contract, the insurer shall reimburse the insured for at least 75% of the average amount paid by the insurer for comparable services of preferred health care providers who are members of the same class of health care providers.

(ii) Notwithstanding Subsection (2)(b)(i), an insurer may offer a health plan that complies with the provisions of Subsection **31A-22-618.5(3)**.

(iii) The commissioner may adopt a rule dealing with the determination of what constitutes 75% of the average amount paid by the insurer under Subsection (2)(b)(i) for comparable services of preferred health care providers who are members of the same class of health care providers.

(c) When reimbursing for services of health care providers not under contract, the insurer may make direct payment to the insured.

(d) Notwithstanding Subsection (2)(b), an insurer using preferred health care provider contracts may impose a deductible on coverage of health care providers not under contract.

(e) When selecting health care providers with whom to contract under Subsection (1), an insurer may not unfairly discriminate between classes of health care providers, but may discriminate within a class of health care providers, subject to Subsection (7).

(f) For purposes of this section, unfair discrimination between classes of health care providers shall include:

(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 utilized by members of the class of health care providers for the treatment of illnesses, injuries, or conditions;

(B) otherwise covered by the insurer; and

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

(3) Before the insured consents to the insurance contract, the insurer shall fully disclose to the insured that it has entered into preferred health care provider contracts. The insurer shall provide sufficient detail on the preferred health care provider contracts to permit the insured to agree to the terms of the insurance contract. The insurer 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 any deductibles, coinsurance, or other copayments;

(c) a description of the quality assurance program required under Subsection (4); and

(d) a description of the adverse benefit determination procedures required under Subsection (5).

(4) (a) An insurer using preferred health care provider contracts shall maintain a quality assurance program for assuring that the care provided by the health care providers under contract 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 organization and its 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.

(5) An insurer using preferred health care provider contracts shall provide a reasonable procedure for resolving complaints and adverse benefit determinations initiated by the insureds and health care providers.

(6) An insurer 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.

(7) (a) A health care provider or insurer may not discriminate against a preferred health care provider for agreeing to a contract under Subsection (1).

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

(8) Upon the written request of a provider excluded from a provider contract, the commissioner may hold a hearing to determine if the insurer's exclusion of the provider is based on the criteria set forth in Subsection (7)(b).

(9) Insurers are subject to the provisions of Sections **31A-22-613.5**, **31A-22-614.5**, and **31A-22-618**.

(10) Nothing in this section is to be construed as to require an insurer to offer a certain benefit or service as part of a health benefit plan.

(11) This section does not apply to catastrophic mental health coverage provided in accordance with Section **31A-22-625**.

31A-8-501 Access to Health Care Providers

(1) As used in this section:

(a) "Class of health care provider" means a health care provider or a health care facility regulated by the state within the same professional, trade, occupational, or certification category established under Title 58, Occupations and Professions, or within the same facility licensure category established under Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act.

(b) "Covered health care services" or "covered services" means health care services for which an enrollee is entitled to receive under the terms of a health maintenance organization contract.

(c) "Credentialed staff member" means a health care provider with active staff privileges at an independent hospital or federally qualified health center.

(d) "Federally qualified health center" means as defined in the Social Security Act, 42

U.S.C. Sec. 1395x.

(e) "Independent hospital" means a general acute hospital or a critical access hospital that:

(i) is either:

(A) located 20 miles or more from any other general acute hospital or critical access hospital; or

(B) licensed as of January 1, 2004;

(ii) is licensed pursuant to Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act; and

(iii) is controlled by a board of directors of which 51% or more reside in the county where the hospital is located and:

(A) the board of directors is ultimately responsible for the policy and financial decisions of the hospital; or

(B) the hospital is licensed for 60 or fewer beds and is not owned, in whole or in part, by an entity that owns or controls a health maintenance organization if the hospital is a contracting facility of the organization.

(f) "Noncontracting provider" means an independent hospital, federally qualified health center, or credentialed staff member who has not contracted with a health maintenance organization to provide health care services to enrollees of the organization.

(2) Except for a health maintenance organization which is under the common ownership or control of an entity with a hospital located within 10 paved road miles of an independent hospital, a health maintenance organization shall pay for covered health care services rendered to an enrollee by an independent hospital, a credentialed staff member at an independent hospital, or a credentialed staff member at his local practice location if:

(a) the enrollee:

(i) lives or resides within 30 paved road miles of the independent hospital; or

(ii) if Subsection (2)(a)(i) does not apply, lives or resides in closer proximity to the independent hospital than a contracting hospital;

(b) the independent hospital is located prior to December 31, 2000 in a county with a population density of less than 100 people per square mile, or the independent hospital is located in a county with a population density of less than 30 people per square mile; and

(c) the enrollee has complied with the prior authorization and utilization review requirements otherwise required by the health maintenance organization contract.

(3) A health maintenance organization shall pay for covered health care services rendered to an enrollee at a federally qualified health center if:

(a) the enrollee:

(i) lives or resides within 30 paved road miles of the federally qualified health center;

or

(ii) if Subsection (3)(a)(i) does not apply, lives or resides in closer proximity to the federally qualified health center than a contracting provider;

(b) the federally qualified health center is located in a county with a population density of less than 30 people per square mile; and

(c) the enrollee has complied with the prior authorization and utilization review requirements otherwise required by the health maintenance organization contract.

(4) (a) A health maintenance organization shall reimburse a noncontracting provider or the enrollee for covered services rendered pursuant to Subsection (2) a like dollar amount as it pays to contracting providers under a noncapitated arrangement for comparable services.

(b) A health maintenance organization shall reimburse a federally qualified health center or the enrollee for covered services rendered pursuant to Subsection (3) a like amount as paid by the health maintenance organization under a noncapitated arrangement for comparable services to a contracting provider in the same class of health care providers as the provider who rendered the service.

(5) (a) A noncontracting independent hospital may not balance bill a patient when the health maintenance organization reimburses a noncontracting independent hospital or an enrollee in accordance with Subsection (4)(a).

(b) A noncontracting federally qualified health center may not balance bill a patient when the federally qualified health center or the enrollee receives reimbursement in accordance with Subsection (4)(b).

(6) A noncontracting provider may only refer an enrollee to another noncontracting provider so as to obligate the enrollee's health maintenance organization to pay for the resulting services if:

(a) the noncontracting provider making the referral or the enrollee has received prior authorization from the organization for the referral; or

(b) the practice location of the noncontracting provider to whom the referral is made:

(i) is located in a county with a population density of less than 25 people per square mile; and

(ii) is within 30 paved road miles of:

(A) the place where the enrollee lives or resides; or

(B) the independent hospital or federally qualified health center at which the enrollee may receive covered services pursuant to Subsection (2) or (3).

(7) Notwithstanding this section, a health maintenance organization may contract directly with an independent hospital, federally qualified health center, or credentialed staff member.

(8) (a) A health maintenance organization that violates any provision of this section is subject to sanctions as determined by the commissioner in accordance with Section 31A-2-308.

(b) Violations of this section include:

(i) failing to provide the notice required by Subsection (8)(d) by placing the notice in any health maintenance organization's provider list that is supplied to enrollees, including any website maintained by the health maintenance organization;

(ii) failing to provide notice of an enrollee's rights under this section when:

(A) an enrollee makes personal contact with the health maintenance organization by telephone, electronic transaction, or in person; and

(B) the enrollee inquires about his rights to access an independent hospital or federally qualified health center; and

(iii) refusing to reprocess or reconsider a claim, initially denied by the health maintenance organization, when the provisions of this section apply to the claim.

(c) The commissioner shall, pursuant to Chapter 2, Part 2, Duties and Powers of Commissioner:

(i) adopt rules as necessary to implement this section;

(ii) identify in rule:

(A) the counties with a population density of less than 100 people per square mile;

(B) independent hospitals as defined in Subsection (1)(e); and

(C) federally qualified health centers as defined in Subsection (1)(d).

(d) (i) A health maintenance organization shall:

(A) use the information developed by the commissioner under Subsection (8)(c) to identify the rural counties, independent hospitals, and federally qualified health centers that are located in the health maintenance organization's service area; and

(B) include the providers identified under Subsection (8)(d)(i)(A) in the notice required in Subsection (8)(d)(ii).

(ii) The health maintenance organization shall provide the following notice, in bold type, to enrollees as specified under Subsection (8)(b)(i), and shall keep the notice current:

"You may be entitled to coverage for health care services from the following non-HMO contracted providers if you live or reside within 30 paved road miles of the listed providers, or if you live or reside in closer proximity to the listed providers than to your HMO contracted providers:

This list may change periodically, please check on our website or call for verification. Please be advised that if you choose a noncontracted provider you will be responsible for any charges not covered by your health insurance plan.

If you have questions concerning your rights to see a provider on this list you may contact your health maintenance organization at _____. If the HMO does not resolve your problem, you may contact the Office of Consumer Health Assistance in the Insurance Department, toll free."

(e) A person whose interests are affected by an alleged violation of this section may contact the Office of Consumer Health Assistance and request assistance, or file a complaint as provided in Section **31A-2-216**.

31A-22-627 Coverage of Emergency Medical Services

(1) A health insurance policy or health maintenance organization contract may not:

- (a) require any form of preauthorization for treatment of an emergency medical condition until after the insured's condition has been stabilized; or
- (b) deny a claim for any covered evaluation, covered diagnostic test, or other covered treatment considered medically necessary to stabilize the emergency medical condition of an insured.

(2) A health insurance policy or health maintenance organization contract may require authorization for the continued treatment of an emergency medical condition after the insured's condition has been stabilized. If such authorization is required, an insurer who does not accept or reject a request for authorization may not deny a claim for any evaluation, diagnostic testing, or other treatment considered medically necessary that occurred between the time the request was received and the time the insurer rejected

the request for authorization.

(3) For purposes of this section:

(a) "emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of medicine and health, would reasonably expect the absence of immediate medical attention at a hospital emergency department to result in:

(i) placing the insured's health, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;

(ii) serious impairment to bodily functions; or

(iii) serious dysfunction of any bodily organ or part; and

(b) "hospital emergency department" means that area of a hospital in which emergency services are provided on a 24-hour-a-day basis.

(4) Nothing in this section may be construed as:

(a) altering the level or type of benefits that are provided under the terms of a contract or policy; or

(b) restricting a policy or contract from providing enhanced benefits for certain emergency medical conditions that are identified in the policy or contract.