Bill Spotlight: Utah MCO Transparency

Promoting Medicaid Transparency and Accountability

Status: Effective May 6, 2026

On March 18, 2026, Utah's House Bill 566 passed into law, enacting key reporting and oversight reforms for managed care. Little is publicly known about how managed care organizations (MCOs) spend taxpayer funds, the scale of erroneous payments, or enrollee claims and utilization patterns. HB 566 directly addresses these gaps by requiring robust public reporting, independent audits, improper-payment recovery, and an accessible online dashboard.

Utah's reforms were a good first step, serving as a model for other states. Utah residents would further benefit with two additional provisions in law. First, actuaries charged with setting capitation rates must be truly independent from the MCO, its parent company, or related parties. Second, steps should be taken to reduce fraud or remove erroneous payments from the underlying capitation payment calculations — preventing the cost of fraud from compounding over time.

Key Provisions of the Legislation

- Requires the Division of Integrated Healthcare to establish and maintain a public online dashboard displaying plan-specific data on spending (medical claims, non-benefit services, prescription drugs, ER visits) and utilization (enrollees receiving care in emergency rooms or filing no claims). The dashboard must be operational by the end of 2026.
- Mandates that MCOs submit copies of all CMS reports and data to the division within 30 days for public release (with protected health information redacted).
- Requires MCOs and subcontractors to quarterly identify and document improper payments, perform root-cause analyses, repay overpayments, and submit corrective action plans — with reports published online.
- Requires independent audits of MCOs and other participants; the Department of Medicaid must publish these audits and improper-payment summaries.
- Directs the division to publish an annual report on MCO financial performance and service utilization for legislative review.
- Strengthens enforcement by embedding compliance requirements in MCO contracts, authorizing sanctions (including a 5-year ban on new contracts for serious violations unless corrective actions are demonstrated).

Expected Results

- This bill brings much-needed sunlight to Utah's dominant Medicaid payment model.
- The new dashboard, mandatory quarterly improper-payment reporting, independent audits, and meaningful sanctions will enable better oversight, reduce waste, and improve program integrity.
- By making data transparent and enforcing compliance, HB 566 empowers policymakers to hold MCOs accountable — better aligning incentives to benefit Utah's Medicaid enrollees and taxpayers.

Policy Rationale

More than half of states, including Utah, now cover at least four in five Medicaid enrollees through managed care organizations (MCOs). In Utah, approximately 83 percent of enrollees receive coverage through MCOs across roughly two dozen contracts. Yet oversight, accountability, and financial transparency remain weak.

In a capitated system, MCOs receive fixed monthly payments per enrollee. Federal rules require an 85 percent medical loss ratio, which incentivizes insurers to maximize spending to avoid paying rebates. But this spending is often obscured through related entities owned by the insurer or a parent company—like pharmacy benefit managers or hospitals.[1] Encounter data measures spending and utilization but often lacks detail. State-directed payments (large payments that states direct the MCO to make to providers) are buried in rates. Payment-error reviews focus only on capitation accuracy, missing downstream provider payments or quality. Actuarial reviews can also face financial conflicts when the same firms serve both the state and MCOs during rate setting.

These shortcomings limit legislators' and the public's ability to ensure MCOs are efficiently serving enrollees while protecting taxpayer dollars. HB 566 enacts two of the three core reforms.

[1] The Medical Loss Ratio (MLR) is a federal requirement that governs the ratio of administrative expenditures and spending on patient care for an MCO. The federal minimum MLR is 85 percent, meaning that an MCO must direct at least 85 percent of its expenditures toward patient care. In practice, the MLR incentivizes higher premiums, consolidation, and sophisticated gaming. The objective is more often to inflate the apparent patient spend while ultimately returning these funds to the insurer as profit.