

Part 4 Operations

31A-8-401 Enrollee participation.

Every organization shall provide a reasonable procedure, consistent with Section 31A-4-116, for allowing enrollees to participate in matters of policy of the organization and for resolving complaints and adverse benefit determinations initiated by enrollees or providers.

Amended by Chapter 308, 2002 General Session

31A-8-402.3 Discontinuance, nonrenewal, or changes to group health benefit plans.

- (1) Except as otherwise provided in this section, a group health benefit plan for a plan sponsor is renewable and continues in force:
 - (a) with respect to all eligible employees and dependents; and
 - (b) at the option of the plan sponsor.
- (2) A health benefit plan for a plan sponsor may be discontinued or nonrenewed for a network plan, if:
 - (a) there is no longer any enrollee under the group health plan who lives, resides, or works in:
 - (i) the service area of the insurer; or
 - (ii) the area for which the insurer is authorized to do business; or
 - (b) for coverage made available in the small or large employer market only through an association, if:
 - (i) the employer's membership in the association ceases; and
 - (ii) the coverage is terminated uniformly without regard to any health status-related factor relating to any covered individual.
- (3) A health benefit plan for a plan sponsor may be discontinued if:
 - (a) a condition described in Subsection (2) exists;
 - (b) the plan sponsor fails to pay premiums or contributions in accordance with the terms of the contract;
 - (c) the plan sponsor:
 - (i) performs an act or practice that constitutes fraud; or
 - (ii) makes an intentional misrepresentation of material fact under the terms of the coverage;
 - (d) the insurer:
 - (i) elects to discontinue offering a particular health benefit product delivered or issued for delivery in this state; and
 - (ii)
 - (A) provides notice of the discontinuation in writing:
 - (I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee; and
 - (II) at least 90 days before the date the coverage will be discontinued;
 - (B) provides notice of the discontinuation in writing:
 - (I) to the commissioner; and
 - (II) at least three working days prior to the date the notice is sent to the affected plan sponsors, employees, and dependents of the plan sponsors or employees;
 - (C) offers to each plan sponsor, on a guaranteed issue basis, the option to purchase:
 - (I) all other health benefit products currently being offered by the insurer in the market; or
 - (II) in the case of a large employer, any other health benefit product currently being offered in that market; and

- (D) in exercising the option to discontinue that product and in offering the option of coverage in this section, acts uniformly without regard to:
 - (I) the claims experience of a plan sponsor;
 - (II) any health status-related factor relating to any covered participant or beneficiary; or
 - (III) any health status-related factor relating to any new participant or beneficiary who may become eligible for the coverage; or
- (e) the insurer:
 - (i) elects to discontinue all of the insurer's health benefit plans in:
 - (A) the small employer market;
 - (B) the large employer market; or
 - (C) both the small employer and large employer markets; and
 - (ii)
 - (A) provides notice of the discontinuation in writing:
 - (I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee; and
 - (II) at least 180 days before the date the coverage will be discontinued;
 - (B) provides notice of the discontinuation in writing:
 - (I) to the commissioner in each state in which an affected insured individual is known to reside; and
 - (II) at least 30 working days prior to the date the notice is sent to the affected plan sponsors, employees, and the dependents of the plan sponsors or employees;
 - (C) discontinues and nonrenews all plans issued or delivered for issuance in the market; and
 - (D) provides a plan of orderly withdrawal as required by Section 31A-4-115.
- (4) A large employer health benefit plan may be discontinued or nonrenewed:
 - (a) if a condition described in Subsection (2) exists; or
 - (b) for noncompliance with the insurer's:
 - (i) minimum participation requirements; or
 - (ii) employer contribution requirements.
- (5) A small employer health benefit plan may be discontinued or nonrenewed:
 - (a) if a condition described in Subsection (2) exists; or
 - (b) for noncompliance with the insurer's employer contribution requirements.
- (6) A small employer health benefit plan may be nonrenewed:
 - (a) if a condition described in Subsection (2) exists; or
 - (b) for noncompliance with the insurer's minimum participation requirements.
- (7)
 - (a) Except as provided in Subsection (7)(d), an eligible employee may be discontinued if after issuance of coverage the eligible employee:
 - (i) engages in an act or practice in connection with the coverage that constitutes fraud; or
 - (ii) makes an intentional misrepresentation of material fact in connection with the coverage.
 - (b) An eligible employee that is discontinued under Subsection (7)(a) may reenroll:
 - (i) 12 months after the date of discontinuance; and
 - (ii) if the plan sponsor's coverage is in effect at the time the eligible employee applies to reenroll.
 - (c) At the time the eligible employee's coverage is discontinued under Subsection (7)(a), the insurer shall notify the eligible employee of the right to reenroll when coverage is discontinued.
 - (d) An eligible employee may not be discontinued under this Subsection (7) because of a fraud or misrepresentation that relates to health status.

- (8) For purposes of this section, a reference to "plan sponsor" includes a reference to the employer:
 - (a) with respect to coverage provided to an employer member of the association; and
 - (b) if the health benefit plan is made available by an insurer in the employer market only through:
 - (i) an association;
 - (ii) a trust; or
 - (iii) a discretionary group.
- (9) An insurer may modify a health benefit plan for a plan sponsor only:
 - (a) at the time of coverage renewal; and
 - (b) if the modification is effective uniformly among all plans with that product.

Amended by Chapter 290, 2014 General Session

Amended by Chapter 300, 2014 General Session

Amended by Chapter 425, 2014 General Session

31A-8-402.5 Individual discontinuance and nonrenewal.

- (1)
 - (a) Except as otherwise provided in this section, a health benefit plan offered on an individual basis is renewable and continues in force:
 - (i) with respect to all individuals or dependents; and
 - (ii) at the option of the individual.
 - (b) Subsection (1)(a) applies regardless of:
 - (i) whether the contract is issued through:
 - (A) a trust;
 - (B) an association;
 - (C) a discretionary group; or
 - (D) other similar grouping; or
 - (ii) the situs of delivery of the policy or contract.
- (2) A health benefit plan may be discontinued or nonrenewed:
 - (a) for a network plan, if:
 - (i) the individual no longer lives, resides, or works in:
 - (A) the service area of the insurer; or
 - (B) the area for which the insurer is authorized to do business; and
 - (ii) coverage is terminated uniformly without regard to any health status-related factor relating to any covered individual; or
 - (b) for coverage made available through an association, if:
 - (i) the individual's membership in the association ceases; and
 - (ii) the coverage is terminated uniformly without regard to any health status-related factor relating to any covered individual.
- (3) A health benefit plan may be discontinued if:
 - (a) a condition described in Subsection (2) exists;
 - (b) the individual fails to pay premiums or contributions in accordance with the terms of the health benefit plan, including any timeliness requirements;
 - (c) the individual:
 - (i) performs an act or practice in connection with the coverage that constitutes fraud; or
 - (ii) makes an intentional misrepresentation of material fact under the terms of the coverage;
 - (d) the insurer:

- (i) elects to discontinue offering a particular health benefit product delivered or issued for delivery in this state; and
- (ii)
 - (A) provides notice of the discontinuation in writing:
 - (I) to each individual provided coverage; and
 - (II) at least 90 days before the date the coverage will be discontinued;
 - (B) provides notice of the discontinuation in writing:
 - (I) to the commissioner; and
 - (II) at least three working days prior to the date the notice is sent to the affected individuals;
 - (C) offers to each covered individual on a guaranteed issue basis, the option to purchase all other individual health benefit products currently being offered by the insurer for individuals in that market; and
 - (D) acts uniformly without regard to any health status-related factor of covered individuals or dependents of covered individuals who may become eligible for coverage; or
- (e) the insurer:
 - (i) elects to discontinue all of the insurer's health benefit plans in the individual market; and
 - (ii)
 - (A) provides notice of the discontinuation in writing:
 - (I) to each individual provided coverage; and
 - (II) at least 180 days before the date the coverage will be discontinued;
 - (B) provides notice of the discontinuation in writing:
 - (I) to the commissioner in each state in which an affected insured individual is known to reside; and
 - (II) at least 30 working days prior to the date the notice is sent to the affected individuals;
 - (C) discontinues and nonrenews all health benefit plans the insurer issues or delivers for issuance in the individual market; and
 - (D) acts uniformly without regard to any health status-related factor of covered individuals or dependents of covered individuals who may become eligible for coverage.

Amended by Chapter 252, 2003 General Session

31A-8-402.7 Discontinuance and nonrenewal limitations.

- (1) Subject to Section 31A-4-115, an insurer that elects to discontinue offering a health benefit plan under Subsections 31A-8-402.3(3)(e) and 31A-8-402.5(3)(e) is prohibited from writing new business:
 - (a) in the market in this state for which the insurer discontinues or does not renew; and
 - (b) for a period of five years beginning on the date of discontinuation of the last coverage that is discontinued.
- (2) If an insurer is doing business in one established geographic service area of the state, Sections 31A-8-402.3 and 31A-8-402.5 apply only to the insurer's operations in that service area.
- (3) The commissioner may, by rule or order, define the scope of service area.

Amended by Chapter 78, 2005 General Session

31A-8-403 Examination of organization and providers.

Examinations of a health maintenance organization and its providers shall be conducted according to the provisions of Chapter 2, Administration of the Insurance Laws. Except during

an audit of the internal quality control system, medical records of individual patients kept by the organization or its providers are not subject to examination.

Enacted by Chapter 204, 1986 General Session

31A-8-404 Annual audit of internal quality control.

Each organization shall prepare an annual report of the effectiveness of the organization's internal quality control. The report shall be in a form prescribed by the commissioner after consultation with the director of the Department of Health, and shall be certified and signed by two officers of the organization. The commissioner may at any time require an audit of an organization's quality control system. The audit shall be performed by qualified persons designated by the commissioner. Auditors shall have full access to all records of the organization and its providers, including medical records of individual patients. The information contained in the medical records of individual patients shall remain confidential, and information derived from those records may not be used in a manner that could directly or indirectly identify an individual. All information, interviews, reports, statements, memoranda, or other data furnished by reason of the audit and any findings or conclusions of the auditors are privileged and are not subject to discovery, use, or receipt in evidence in any legal proceeding except hearings before the commissioner or the director of the Department of Health concerning alleged violations of the provisions of this chapter.

Amended by Chapter 314, 1994 General Session

31A-8-405 Confidentiality of medical records and audits.

Unless a court orders otherwise, the department shall treat the following records and information as confidential and prevent their disclosure to the public:

- (1) the medical records of enrollees of an organization; and
- (2) the annual audits performed under Section 31A-8-404.

Enacted by Chapter 204, 1986 General Session

31A-8-406 Distribution by nonprofit organizations.

A nonprofit organization may pay compensation in a reasonable amount to its members, trustees, or officers for services rendered, may make reasonable incentive payments to its providers, may confer benefits upon its members in conformity with its purposes, may pay interest on certificates of indebtedness issued by it evidencing capital contributions, and upon dissolution or final liquidation may make distributions to its members as permitted by Title 16, Chapter 6a, Utah Revised Nonprofit Corporation Act, and no such payment, benefit, or distribution shall be considered to be a dividend or distribution of income. Notwithstanding Section 31A-8-105, and in addition to the powers granted in that section, a nonprofit organization has all powers conferred upon it by Section 16-6a-302.

Amended by Chapter 300, 2000 General Session

31A-8-407 Written contracts -- Limited liability of enrollee -- Provider claim disputes -- Leased networks.

- (1)

- (a) Every contract between an organization and a participating provider of health care services shall be in writing and shall set forth that if the organization:
 - (i) fails to pay for health care services as set forth in the contract, the enrollee may not be liable to the provider for any sums owed by the organization; and
 - (ii) becomes insolvent, the rehabilitator or liquidator may require the participating provider of health care services to:
 - (A) continue to provide health care services under the contract between the participating provider and the organization until the earlier of:
 - (I) 90 days after the date of the filing of a petition for rehabilitation or the petition for liquidation; or
 - (II) the date the term of the contract ends; and
 - (B) subject to Subsection (1)(c), reduce the fees the participating provider is otherwise entitled to receive from the organization under the contract between the participating provider and the organization during the time period described in Subsection (1)(a)(ii)(A).
 - (b) If the conditions of Subsection (1)(c) are met, the participating provider shall:
 - (i) accept the reduced payment as payment in full; and
 - (ii) relinquish the right to collect additional amounts from the insolvent organization's enrollee.
 - (c) Notwithstanding Subsection (1)(a)(ii)(B):
 - (i) the rehabilitator or liquidator may not reduce a fee to less than 75% of the regular fee set forth in the participating provider contract; and
 - (ii) the enrollee shall continue to pay the same copayments, deductibles, and other payments for services received from the participating provider that the enrollee was required to pay before the filing of:
 - (A) the petition for rehabilitation; or
 - (B) the petition for liquidation.
- (2) A participating provider may not collect or attempt to collect from the enrollee sums owed by the organization or the amount of the regular fee reduction authorized under Subsection (1)(a)(ii) if the participating provider contract:
- (a) is not in writing as required in Subsection (1); or
 - (b) fails to contain the language required by Subsection (1).
- (3)
- (a) A person listed in Subsection (3)(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)(a)(ii).
 - (b) Subsection (3)(a) applies to:
 - (i) a participating provider;
 - (ii) an agent;
 - (iii) a trustee; or
 - (iv) an assignee of a person described in Subsections (3)(b)(i) through (iii).
 - (c) In any dispute involving a provider's claim for reimbursement, the same shall be determined in accordance with applicable law, the provider contract, the subscriber contract, and the 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 is to bear its own expense except the cost of the jointly selected arbitrator shall be equally shared. This Subsection (3)(d) does not apply to the claim of a general acute hospital to the extent it is inconsistent with the hospital's provider agreement.

- (e) An organization may not penalize a provider solely for pursuing a claims dispute or otherwise demanding payment for a sum believed owing.
- (4) If an organization permits another private entity with which it does not share common ownership or control to use or otherwise lease one or more of the organization's networks that include participating providers, the organization shall ensure, at a minimum, that the entity pays participating providers in accordance with the same fee schedule and general payment policies as the organization would for that network unless payment for services is governed by a public program's fee schedule.

Amended by Chapter 3, 2005 Special Session 1

Amended by Chapter 3, 2005 Special Session 1

31A-8-408 Organizations offering point of service or point of sale products.

Effective July 1, 1991, a health maintenance organization offering products that permit members the option of obtaining covered services from a noncontracted provider, which is a point of service or point of sale product, shall comply with the requirements of Subsections (1) through (7).

- (1) The cost of an encounter with a noncontracted provider is considered an uncovered expenditure as defined in Section 31A-8-101.
- (2)
 - (a) An organization shall report to the commissioner on a monthly basis the number of encounters with contracted and noncontracted providers if the organization offers to sell a:
 - (i) point of service product; or
 - (ii) point of sale product.
 - (b) The commissioner shall:
 - (i) define the form, content, and due date of the report required by this Subsection (2); and
 - (ii) require audited reports of the information on a yearly basis.
- (3) An organization may not offer a point of service product or a point of sale product unless the organization has secured contracts with participating providers located within the organization's service area for each covered service other than those unusual or infrequently used health services that are not available from the organization's health care providers.
- (4) An organization may not enroll a member who does not work or reside in the service area as defined by rule, except this Subsection (4) does not apply to a dependent of an enrollee.
- (5) Any organization that exceeds the 10% limit of unusual or infrequently used health services as defined in Section 31A-8-101 is subject to a forfeiture of up to \$50 per encounter.
- (6) An organization shall disclose to employees and members the existence of the 10% limit:
 - (a) at enrollment; or
 - (b) prior to enrollment.
- (7) The commissioner shall hold hearings and adopt rules providing any additional limitations or requirements necessary to secure the public interest in conformity with this section.

Amended by Chapter 308, 2002 General Session