

## **Part 6**

### **Accident and Health Insurance**

#### **31A-22-600 Scope of Part 6.**

- (1) Except where a provision's application is otherwise specifically limited, this part applies to all:
  - (a) accident and health insurance contracts, including credit accident and health;
  - (b) franchise;
  - (c) group contracts; and
  - (d) a life insurance and annuity policy, but only if:
    - (i) it includes supplemental benefits and riders including accelerated benefits; and
    - (ii) receipt of benefits is contingent on morbidity requirements.
- (2) Nothing in this part applies to or affects:
  - (a) workers' compensation insurance;
  - (b) reinsurance; or
  - (c) accident and health insurance when it is part of or supplemental to liability, steam boiler, elevator, automobile, or other insurance covering loss of or damage to property, provided the loss, damage, or expense arises out of a hazard directly related to the other insurance.
- (3) Except as provided in Subsection (1), this part does not apply to or affect a life insurance or annuity policy including a life insurance policy:
  - (a) with a rider or supplemental benefit that accelerates the death benefit contingent upon a mortality risk specifically for one or more of the qualifying events of:
    - (i) terminal illness;
    - (ii) medical conditions requiring extraordinary medical intervention; or
    - (iii) permanent institutional confinement; and
  - (b) that provides the option of a lump-sum payment for those benefits.

Amended by Chapter 116, 2001 General Session

#### **31A-22-601 Applicability of life insurance provisions.**

Sections 31A-22-412 through 31A-22-417 apply to death benefits in accident and health insurance policies.

Amended by Chapter 116, 2001 General Session

#### **31A-22-602 Premium rates.**

- (1) This section does not apply to group accident and health insurance.
- (2) The benefits in an accident and health insurance policy shall be reasonable in relation to the premiums charged.
- (3) The commissioner shall prohibit the use of an accident and health insurance policy form or rates if the form or rates do not satisfy Subsection (2).

Amended by Chapter 308, 2002 General Session

#### **31A-22-603 Persons insured under an individual accident and health policy.**

A policy of individual accident and health insurance may insure only one person, except that originally or by subsequent amendment, upon the application of an adult policyholder, a policy may

insure any two or more eligible members of the policyholder's family, including spouse, dependent children, and any other person dependent upon the policyholder.

Amended by Chapter 138, 2016 General Session

**31A-22-604 Reimbursement by insurers of Medicaid benefits.**

- (1) As used in this section, "Medicaid" means the program under Title XIX of the federal Social Security Act.
- (2) Any accident and health insurer, including a group accident and health insurance plan, as defined in Section 607(1), Federal Employee Retirement Income Security Act of 1974, or health maintenance organization as defined in Section 31A-8-101, is prohibited from considering the availability or eligibility for medical assistance in this or any other state under Medicaid, when considering eligibility for coverage or making payments under its plan for eligible enrollees, subscribers, policyholders, or certificate holders.
- (3) To the extent that payment for covered expenses has been made under the state Medicaid program for health care items or services furnished to an individual in any case when a third party has a legal liability to make payments, the state is considered to have acquired the rights of the individual to payment by any other party for those health care items or services.
- (4) Title 26, Chapter 19, Medical Benefits Recovery Act, applies to reimbursement of insurers of Medicaid benefits.

Amended by Chapter 116, 2001 General Session

**31A-22-605 Accident and health insurance standards.**

- (1) The purposes of this section include:
  - (a) reasonable standardization and simplification of terms and coverages of individual and franchise accident and health insurance policies, including accident and health insurance contracts of insurers licensed under Chapter 7, Nonprofit Health Service Insurance Corporations, and Chapter 8, Health Maintenance Organizations and Limited Health Plans, to facilitate public understanding and comparison in purchasing;
  - (b) elimination of provisions contained in individual and franchise accident and health insurance contracts that may be misleading or confusing in connection with either the purchase of those types of coverages or the settlement of claims; and
  - (c) full disclosure in the sale of individual and franchise accident and health insurance contracts.
- (2) As used in this section:
  - (a) "Direct response insurance policy" means an individual insurance policy solicited and sold without the policyholder having direct contact with a natural person intermediary.
  - (b) "Medicare" is defined in Subsection 31A-22-620(1)(e).
  - (c) "Medicare supplement policy" is defined in Subsection 31A-22-620(1)(f).
- (3) This section applies to all individual and franchise accident and health policies.
- (4) The commissioner shall adopt rules relating to the following matters:
  - (a) standards for the manner and content of policy provisions, and disclosures to be made in connection with the sale of policies covered by this section, dealing with at least the following matters:
    - (i) terms of renewability;
    - (ii) initial and subsequent conditions of eligibility;
    - (iii) nonduplication of coverage provisions;
    - (iv) coverage of dependents;

- (v) preexisting conditions;
  - (vi) termination of insurance;
  - (vii) probationary periods;
  - (viii) limitations;
  - (ix) exceptions;
  - (x) reductions;
  - (xi) elimination periods;
  - (xii) requirements for replacement;
  - (xiii) recurrent conditions;
  - (xiv) coverage of persons eligible for Medicare; and
  - (xv) definition of terms;
- (b) minimum standards for benefits under each of the following categories of coverage in policies covered in this section:
- (i) basic hospital expense coverage;
  - (ii) basic medical-surgical expense coverage;
  - (iii) hospital confinement indemnity coverage;
  - (iv) major medical expense coverage;
  - (v) income replacement coverage;
  - (vi) accident only coverage;
  - (vii) specified disease or specified accident coverage;
  - (viii) limited benefit health coverage; and
  - (ix) nursing home and long-term care coverage;
- (c) the content and format of the outline of coverage, in addition to that required under Subsection (6);
- (d) the method of identification of policies and contracts based upon coverages provided; and
- (e) rating practices.
- (5) Nothing in Subsection (4)(b) precludes the issuance of policies that combine categories of coverage in that subsection provided that any combination of categories meets the standards of a component category of coverage.
- (6) The commissioner may adopt rules relating to the following matters:
- (a) establishing disclosure requirements for insurance policies covered in this section, designed to adequately inform the prospective insured of the need for and extent of the coverage offered, and requiring that this disclosure be furnished to the prospective insured with the application form, unless it is a direct response insurance policy;
  - (b)
    - (i) prescribing caption or notice requirements designed to inform prospective insureds that particular insurance coverages are not Medicare Supplement coverages;
    - (ii) the requirements of Subsection (6)(b)(i) apply to all insurance policies and certificates sold to persons eligible for Medicare; and
  - (c) requiring the disclosures or information brochures to be furnished to the prospective insured on direct response insurance policies, upon his request or, in any event, no later than the time of the policy delivery.
- (7) A policy covered by this section may be issued only if it meets the minimum standards established by the commissioner under Subsection (4), an outline of coverage accompanies the policy or is delivered to the applicant at the time of the application, and, except with respect to direct response insurance policies, an acknowledged receipt is provided to the insurer. The outline of coverage shall include:

- (a) a statement identifying the applicable categories of coverage provided by the policy as prescribed under Subsection (4);
  - (b) a description of the principal benefits and coverage;
  - (c) a statement of the exceptions, reductions, and limitations contained in the policy;
  - (d) a statement of the renewal provisions, including any reservation by the insurer of a right to change premiums;
  - (e) a statement that the outline is a summary of the policy issued or applied for and that the policy should be consulted to determine governing contractual provisions; and
  - (f) any other contents the commissioner prescribes.
- (8) If a policy is issued on a basis other than that applied for, the outline of coverage shall accompany the policy when it is delivered and it shall clearly state that it is not the policy for which application was made.
- (9) Notwithstanding Subsection 31A-22-606(1), limited accident and health policies or certificates issued to persons eligible for Medicare shall contain a notice prominently printed on or attached to the cover or front page which states that the policyholder or certificate holder has the right to return the policy for any reason within 30 days after its delivery and to have the premium refunded.

Amended by Chapter 78, 2005 General Session

**31A-22-605.1 Preexisting condition limitations.**

- (1) Any provision dealing with preexisting conditions shall be consistent with this section, Section 31A-22-609, and rules adopted by the commissioner.
- (2) Except as provided in this section, an insurer that elects to use an application form without questions concerning the insured's health or medical treatment history shall provide coverage under the policy for any loss which occurs more than 12 months after the effective date of coverage due to a preexisting condition which is not specifically excluded from coverage.
- (3)
- (a) An insurer that issues a specified disease policy may not deny a claim for loss due to a preexisting condition that occurs more than six months after the effective date of coverage.
  - (b) A specified disease policy may impose a preexisting condition exclusion only if the exclusion relates to a preexisting condition which first manifested itself within six months prior to the effective date of coverage or which was diagnosed by a physician at any time prior to the effective date of coverage.
- (4)
- (a) Except as provided in this Subsection (4), a health benefit plan may impose a preexisting condition exclusion only if:
    - (i) the exclusion relates to a preexisting condition for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period ending on the enrollment date from an individual licensed or similarly authorized to provide those services under state law and operating within the scope of practice authorized by state law;
    - (ii) the exclusion period ends no later than 12 months after the enrollment date, or in the case of a late enrollee, 18 months after the enrollment date; and
    - (iii) the exclusion period is reduced by the number of days of creditable coverage the enrollee has as of the enrollment date, in accordance with Subsection (4)(b).
  - (b)
    - (i) The amount of creditable coverage allowed under Subsection (4)(a)(iii) is determined by counting all the days on which the individual has one or more types of creditable coverage.

- (ii) Days of creditable coverage that occur before a significant break in coverage are not required to be counted.
  - (A) Days in a waiting period or affiliation period are not taken into account in determining whether a significant break in coverage has occurred.
  - (B) For an individual who elects federal COBRA continuation coverage during the second election period provided under the federal Trade Act of 2002, the days between the date the individual lost group health plan coverage and the first day of the second COBRA election period are not taken into account in determining whether a significant break in coverage has occurred.
- (c) A group health benefit plan may not impose a preexisting condition exclusion relating to pregnancy.
- (d)
  - (i) An insurer imposing a preexisting condition exclusion shall provide a written general notice of preexisting condition exclusion as part of any written application materials.
  - (ii) The general notice shall include:
    - (A) a description of the existence and terms of any preexisting condition exclusion under the plan, including the six-month period ending on the enrollment date, the maximum preexisting condition exclusion period, and how the insurer will reduce the maximum preexisting condition exclusion period by creditable coverage;
    - (B) a description of the rights of individuals:
      - (I) to demonstrate creditable coverage, including any applicable waiting periods, through a certificate of creditable coverage or through other means; and
      - (II) to request a certificate of creditable coverage from a prior plan;
    - (C) a statement that the current plan will assist in obtaining a certificate of creditable coverage from any prior plan or issuer if necessary; and
    - (D) a person to contact, and an address and telephone number for the person, for obtaining additional information or assistance regarding the preexisting condition exclusion.
- (e) An insurer may not impose any limit on the amount of time that an individual has to present a certificate or other evidence of creditable coverage.
- (f) This Subsection (4) does not preclude application of any waiting period applicable to all new enrollees under the plan.

Enacted by Chapter 78, 2005 General Session

**31A-22-605.5 Application.**

- (1) For purposes of this section "insurance mandate":
  - (a) means a mandatory obligation with respect to coverage, benefits, or the number or types of providers imposed on policies of accident and health insurance; and
  - (b) does not mean:
    - (i) an administrative rule imposing a mandatory obligation with respect to coverage, benefits, or providers unless that mandatory obligation was specifically imposed on policies of accident and health insurance by statute; or
    - (ii) an insurance mandate in an essential health benefits package imposed pursuant to the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, and the Health Care Education Reconciliation Act of 2010, Pub. L. No. 111-152, and federal rules related to their implementation.
- (2)

- (a) Notwithstanding the provisions of Subsection 31A-1-103(3)(f), the following shall apply to health coverage offered to the state employees' risk pool under Subsection 49-20-202(1)(a):
    - (i) any law enacted under this title that becomes effective after January 1, 2002, which provides for an insurance mandate for policies of accident and health insurance; and
    - (ii) in accordance with Section 31A-22-613.5, disclosure requirements for coverage limitations.
  - (b) Notwithstanding the provisions of Subsection 31A-1-103(3)(f), a health insurance mandate enacted under this title after January 1, 2012, shall apply to:
    - (i) health coverage offered to the state employees' risk pool under Subsection 49-20-202(1)(a); and
    - (ii) health coverage offered to public school districts, charter schools, and institutions of higher education under Subsection 49-20-201(1)(b).
  - (c) If health coverage offered to the state employees' risk pool under Subsections 49-20-201(1)(b) and 49-20-202(1)(a) offers coverage in the same manner and to the same extent as the coverage required by an insurance mandate enacted under this title or coverage that is greater than the insurance mandate enacted under this title, the coverage offered to state employees under Subsections 49-20-201(1)(b) and 49-20-202(1)(a) will be considered in compliance with the insurance mandate.
  - (d) The programs regulated under Subsections 49-20-201(1)(b) and 49-20-202(1)(a) shall report to the Retirement and Independent Entities Committee created under Section 63E-1-201 by November 30 of each year in which a mandate is enacted under the provisions of this section. The report shall include the costs and benefits of the particular mandatory obligation.
- (3)
- (a) An insurance mandate for policies of accident and health insurance enacted under this title after January 1, 2012, shall apply to a health plan offered by a public school district, a charter school, or a state funded institution of higher education that is not insured through the Public Employees' Benefit and Insurance Program.
  - (b) If an insurance mandate for policies of accident and health insurance is enacted under this title after January 1, 2012, the state shall determine whether each entity described in Subsections (2) and (3)(a) offers coverage in the same manner and to the same extent, or greater than the insurance coverage required in the mandate enacted after January 1, 2012.
  - (c) Before enacting an insurance mandate, the state shall, for each entity that does not offer coverage in accordance with Subsection (3)(b):
    - (i) determine the cost to the entity of implementing the insurance mandate; and
    - (ii) appropriate money necessary to fund the full cost to the entity of implementing the insurance mandate.

Amended by Chapter 127, 2012 General Session

**31A-22-606 Policy examination period.**

- (1)
  - (a) Except as provided in Subsection (2), all accident and health policies shall contain a notice prominently printed on or attached to the cover or front page stating that the policyholder has the right to return the policy for any reason within 10 days after its delivery.
  - (b) "Return" means delivery to the insurer or its agent or mailing of the policy to either, properly addressed and stamped for first class handling, with a written statement on the policy or an accompanying communication that it is being returned for termination of coverage. A policy returned under this Subsection (1) is void from the beginning and a policyholder returning his policy is entitled to a refund of any premium paid.

(2) This section does not apply to:

- (a) group policies;
- (b) policies issued to persons entitled to a 30-day examination period under Subsection 31A-22-605(9);
- (c) single premium nonrenewable policies issued for terms not longer than 60 days;
- (d) policies covering accidents only or accidental bodily injury only; and
- (e) other classes of policies which the commissioner by rule specifies after a finding that a right to return those policies would be impracticable or unnecessary to protect the policyholder's interests.

Amended by Chapter 78, 2005 General Session

**31A-22-607 Grace period.**

- (1)
  - (a) An individual or franchise accident and health insurance policy shall contain one or more clauses providing for a grace period for premium payment only of:
    - (i) at least 15 days for a weekly or monthly premium policy; and
    - (ii) 30 days for a policy that is not a weekly or monthly premium policy, for each premium after the first premium payment.
  - (b) An insurer may elect to include a grace period that is longer than 15 days for a weekly or monthly policy.
  - (c) An individual or franchise accident and health insurance policy is not in force during a grace period.
  - (d) If an insurer receives payment before a grace period expires, the individual or franchise accident and health insurance policy continues in force with no gap in coverage.
  - (e) If an insurer does not receive payment before a grace period expires, the individual or franchise accident and health insurance policy is terminated as of the last date for which the premium is paid in full.
  - (f) A grace period is not required if the policyholder has requested that the individual or franchise accident and health insurance policy be discontinued.
- (2)
  - (a) A group or blanket accident and health insurance policy shall provide for a grace period of at least 30 days, unless the policyholder gives written notice of discontinuance before the date of discontinuance, in accordance with the policy terms.
  - (b) A group or blanket accident and health insurance policy is in force during a grace period.
  - (c) If an insurer does not receive payment before a grace period expires, the group or blanket accident and health insurance policy is terminated as of the last day of the grace period.
  - (d) A group or blanket accident and health insurance policy may provide for payment of a pro rata premium for the period the group or blanket accident and health insurance policy is in effect during a grace period under this Subsection (2).
- (3) If an insurer has not guaranteed the insured a right to renew an accident and health insurance policy, a grace period beyond the expiration or anniversary date may, if provided in the accident and health insurance policy, be cut off by compliance with the notice provision under Subsection 31A-21-303(4)(b).

Amended by Chapter 284, 2011 General Session

**31A-22-608 Reinstatement of individual or franchise accident and health insurance policies.**

- (1) Every individual or franchise accident and health insurance policy shall contain a provision which reads as follows:

"REINSTATEMENT: If any renewal premium is not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by any agent duly authorized by the insurer to accept the premium, without also requiring an application for reinstatement, shall reinstate the policy. However, if the insurer or agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy shall be reinstated upon approval of this application from the insurer or, lacking this approval, upon the 45th day following the date of the conditional receipt, unless the insurer has previously notified the insured in writing of its disapproval of the application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than 10 days after that date. In all other respects the insured and insurer have the same rights under the reinstated policy as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed on or attached to this policy in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement."

- (2) The last sentence of the provision set forth in Subsection (1) may be omitted from any policy that the insured has the right to continue in force subject to its terms by the timely payment of premiums until at least age 50, or in the case of a policy issued after age 44, for at least five years from its date of issue.

Amended by Chapter 116, 2001 General Session

### **31A-22-609 Incontestability for accident and health insurance.**

- (1)
  - (a) A statement made by an applicant relating to the person's insurability, except fraudulent misrepresentation, may not be a basis for avoidance of a policy, coverage, or denial of a claim for loss incurred or disability commencing after the coverage has been in effect for two years.
  - (b) The insurer has the burden of proving fraud by clear and convincing evidence.
- (2) Except as provided under Section 31A-22-605.1, a claim for loss incurred or disability commencing after two years from the date of issue of the policy may not be reduced or denied on the ground that a disease or physical condition existed prior to the effective date of coverage, unless the condition was excluded from coverage by name or specific description in a provision that was in effect on the date of loss.
- (3) Except as provided in Subsection (1)(a), a specified disease policy may not include wording that provides a defense based upon a disease or physical condition that existed prior to the effective date of coverage except as allowed under Subsection 31A-22-605.1(2).

Amended by Chapter 78, 2005 General Session

### **31A-22-610 Dependent coverage from moment of birth or adoption.**

- (1) As used in this section:
  - (a) "Child" means, in connection with any adoption, or placement for adoption of the child, an individual who is younger than 18 years of age as of the date of the adoption or placement for adoption.

- (b) "Placement for adoption" means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of the adoption of the child.
- (2)
  - (a) Except as provided in Subsection (5), if an accident and health insurance policy provides coverage for any members of the policyholder's or certificate holder's family, the policy shall provide that any health insurance benefits applicable to dependents of the insured are applicable on the same basis to:
    - (i) a newly born child from the moment of birth; and
    - (ii) an adopted child:
      - (A) beginning from the moment of birth, if placement for adoption occurs within 30 days of the child's birth; or
      - (B) beginning from the date of placement, if placement for adoption occurs 30 days or more after the child's birth.
  - (b) The coverage described in this Subsection (2):
    - (i) is not subject to any preexisting conditions; and
    - (ii) includes any injury or sickness, including the necessary care and treatment of medically diagnosed:
      - (A) congenital defects;
      - (B) birth abnormalities; or
      - (C) prematurity.
  - (c)
    - (i) Subject to Subsection (2)(c)(ii), a claim for services for a newly born child or an adopted child may be denied until the child is enrolled.
    - (ii) Notwithstanding Subsection (2)(c)(i), an otherwise eligible claim denied under Subsection (2)(c)(i) is eligible for payment and may be resubmitted or reprocessed once a child is enrolled pursuant to Subsection (2)(d) or (e).
  - (d) If the payment of a specific premium is required to provide coverage for a child of a policyholder or certificate holder, for there to be coverage for the child, the policyholder or certificate holder shall enroll:
    - (i) a newly born child within 30 days after the date of birth of the child; or
    - (ii) an adopted child within 30 days after the day of placement of adoption.
  - (e) If the payment of a specific premium is not required to provide coverage for a child of a policyholder or certificate holder, for the child to receive coverage the policyholder or certificate holder shall enroll a newly born child or an adopted child no later than 30 days after the first notification of denial of a claim for services for that child.
- (3)
  - (a) The coverage required by Subsection (2) as to children placed for the purpose of adoption with a policyholder or certificate holder continues in the same manner as it would with respect to a child of the policyholder or certificate holder unless:
    - (i) the placement is disrupted prior to legal adoption; and
    - (ii) the child is removed from placement.
  - (b) The coverage required by Subsection (2) ends if the child is removed from placement prior to being legally adopted.
- (4) The provisions of this section apply to employee welfare benefit plans as defined in Section 26-19-2.
- (5) If an accident and health insurance policy that is not subject to the special enrollment rights described in 45 C.F.R. Sec. 146.117(b) provides coverage for one individual, the insurer may choose to:

- (a) provide coverage according to this section; or
- (b) allow application, subject to the insurer's underwriting criteria for:
  - (i) a newborn;
  - (ii) an adopted child; or
  - (iii) a child placed for adoption.

Amended by Chapter 307, 2007 General Session

**31A-22-610.1 Indemnity benefit for adoption or infertility treatments.**

- (1)
  - (a)
    - (i) If an insured has coverage for maternity benefits on the date of an adoptive placement, the insured's policy shall provide an adoption indemnity benefit payable to the insured, if a child is placed for adoption with the insured within 90 days of the child's birth. If more than one child from the same birth is placed for adoption with the insured, only one adoption indemnity benefit is required.
    - (ii) This section does not prevent an accident and health insurer from:
      - (A) adjusting the benefit payable under this section for cost sharing measures imposed under the policy or contract for maternity benefit coverage; or
      - (B) providing additional adoption indemnity benefits including:
        - (I) extending the period of time after birth in which a child must be placed with an insured; or
        - (II) providing a benefit in excess of the amount specified in Subsection (1)(c).
  - (b) An insurer that has paid the adoption indemnity benefit under Subsection (1)(a) may seek reimbursement of the benefit if:
    - (i) the postplacement evaluation disapproves the adoption placement; and
    - (ii) a court rules the adoption may not be finalized because of an act or omission of an adoptive parent or parents that affects the child's health or safety.
  - (c)
    - (i) The amount of the adoption indemnity benefit provided under Subsection (1) is \$4,000 subject to the adjustments permitted by Subsection (1)(a)(ii).
    - (ii) An insurer may comply with the provisions of this section by providing the \$4,000 adoption indemnity benefit to an enrollee to be used for the purpose of the enrollee obtaining infertility treatments rather than seeking reimbursement for an adoption in accordance with terms designated by the insurer.
  - (d) Each insurer shall pay its pro rata share of the adoption indemnity benefit if each adoptive parent:
    - (i) has coverage for maternity benefits with a different insurer; and
    - (ii) makes a claim for the adoption indemnity benefit provided in Subsection (1)(a).
- (2) If a policy offers optional maternity benefits, it shall also offer coverage for adoption indemnity benefits if:
  - (a) a child is placed for adoption with the insured within 90 days of the child's birth; and
  - (b) the adoption is finalized within one year of the child's birth.
- (3) If an insured qualifies for the adoption indemnity benefit under this section and receives services from a health care provider under contract with his insurer, the contracting health care provider may only collect from the insured the amount that the contracting health care provider is entitled to receive for such services under the contract, including any applicable copayment.
- (4) For purposes of this section, "contracting health care provider" means:
  - (a) a "participating provider" as defined in Section 31A-8-101; or

(b) a "preferred health care provider" as described in Section 31A-22-617.

Amended by Chapter 353, 2014 General Session

**31A-22-610.2 Maternity stay minimum limits.**

- (1)
  - (a) If an insured has coverage for maternity benefits, the policy may not be limited to a less than a 48-hour benefit for both mother and newborn with a normal vaginal delivery.
  - (b) If an insured has coverage for maternity benefits, the policy may not be limited to a less than 96-hour benefit for both mother and newborn with a caesarean section delivery.
- (2) Subsection (1) applies to an accident and health insurer who offers maternity coverage.

Amended by Chapter 116, 2001 General Session

**31A-22-610.5 Dependent coverage.**

- (1) As used in this section, "child" has the same meaning as defined in Section 78B-12-102.
- (2)
  - (a) Any individual or group accident and health insurance policy or health maintenance organization contract that provides coverage for a policyholder's or certificate holder's dependent may not terminate coverage of an unmarried dependent by reason of the dependent's age before the dependent's 26th birthday and shall, upon application, provide coverage for all unmarried dependents up to age 26.
  - (b) The cost of coverage for unmarried dependents 19 to 26 years of age shall be included in the premium on the same basis as other dependent coverage.
  - (c) This section does not prohibit the employer from requiring the employee to pay all or part of the cost of coverage for unmarried dependents.
  - (d) An individual health insurance policy, group health insurance policy, or health maintenance organization shall continue in force coverage for a dependent through the last day of the month in which the dependent ceases to be a dependent:
    - (i) if premiums are paid; and
    - (ii) notwithstanding Section 31A-8-402.3, 31A-8-402.5, 31A-22-721, 31A-30-107.1, or 31A-30-107.3.
- (3) An individual or group accident and health insurance policy or health maintenance organization contract shall reinstate dependent coverage, and for purposes of all exclusions and limitations, shall treat the dependent as if the coverage had been in force since it was terminated; if:
  - (a) the dependent has not reached the age of 26 by July 1, 1995;
  - (b) the dependent had coverage prior to July 1, 1994;
  - (c) prior to July 1, 1994, the dependent's coverage was terminated solely due to the age of the dependent; and
  - (d) the policy has not been terminated since the dependent's coverage was terminated.
- (4)
  - (a) When a parent is required by a court or administrative order to provide health insurance coverage for a child, an accident and health insurer may not deny enrollment of a child under the accident and health insurance plan of the child's parent on the grounds the child:
    - (i) was born out of wedlock and is entitled to coverage under Subsection (5);
    - (ii) was born out of wedlock and the custodial parent seeks enrollment for the child under the custodial parent's policy;
    - (iii) is not claimed as a dependent on the parent's federal tax return; or

- (iv) does not reside with the parent or in the insurer's service area.
- (b) A child enrolled as required under Subsection (4)(a)(iv) is subject to the terms of the accident and health insurance plan contract pertaining to services received outside of an insurer's service area. A health maintenance organization shall comply with Section 31A-8-502.
- (5) When a child has accident and health coverage through an insurer of a noncustodial parent, and when requested by the noncustodial or custodial parent, the insurer shall:
  - (a) provide information to the custodial parent as necessary for the child to obtain benefits through that coverage, but the insurer or employer, or the agents or employees of either of them, are not civilly or criminally liable for providing information in compliance with this Subsection (5)(a), whether the information is provided pursuant to a verbal or written request;
  - (b) permit the custodial parent or the service provider, with the custodial parent's approval, to submit claims for covered services without the approval of the noncustodial parent; and
  - (c) make payments on claims submitted in accordance with Subsection (5)(b) directly to the custodial parent, the child who obtained benefits, the provider, or the state Medicaid agency.
- (6) When a parent is required by a court or administrative order to provide health coverage for a child, and the parent is eligible for family health coverage, the insurer shall:
  - (a) permit the parent to enroll, under the family coverage, a child who is otherwise eligible for the coverage without regard to an enrollment season restrictions;
  - (b) if the parent is enrolled but fails to make application to obtain coverage for the child, enroll the child under family coverage upon application of the child's other parent, the state agency administering the Medicaid program, or the state agency administering 42 U.S.C. Sec. 651 through 669, the child support enforcement program; and
  - (c)
    - (i) when the child is covered by an individual policy, not disenroll or eliminate coverage of the child unless the insurer is provided satisfactory written evidence that:
      - (A) the court or administrative order is no longer in effect; or
      - (B) the child is or will be enrolled in comparable accident and health coverage through another insurer which will take effect not later than the effective date of disenrollment; or
    - (ii) when the child is covered by a group policy, not disenroll or eliminate coverage of the child unless the employer is provided with satisfactory written evidence, which evidence is also provided to the insurer, that Subsection (9)(c)(i), (ii) or (iii) has happened.
- (7) An insurer may not impose requirements on a state agency that has been assigned the rights of an individual eligible for medical assistance under Medicaid and covered for accident and health benefits from the insurer that are different from requirements applicable to an agent or assignee of any other individual so covered.
- (8) Insurers may not reduce their coverage of pediatric vaccines below the benefit level in effect on May 1, 1993.
- (9) When a parent is required by a court or administrative order to provide health coverage, which is available through an employer doing business in this state, the employer shall:
  - (a) permit the parent to enroll under family coverage any child who is otherwise eligible for coverage without regard to any enrollment season restrictions;
  - (b) if the parent is enrolled but fails to make application to obtain coverage of the child, enroll the child under family coverage upon application by the child's other parent, by the state agency administering the Medicaid program, or the state agency administering 42 U.S.C. Sec. 651 through 669, the child support enforcement program;
  - (c) not disenroll or eliminate coverage of the child unless the employer is provided satisfactory written evidence that:
    - (i) the court order is no longer in effect;

- (ii) the child is or will be enrolled in comparable coverage which will take effect no later than the effective date of disenrollment; or
  - (iii) the employer has eliminated family health coverage for all of its employees; and
  - (d) withhold from the employee's compensation the employee's share, if any, of premiums for health coverage and to pay this amount to the insurer.
- (10) An order issued under Section 62A-11-326.1 may be considered a "qualified medical support order" for the purpose of enrolling a dependent child in a group accident and health insurance plan as defined in Section 609(a), Federal Employee Retirement Income Security Act of 1974.
- (11) This section does not affect any insurer's ability to require as a precondition of any child being covered under any policy of insurance that:
- (a) the parent continues to be eligible for coverage;
  - (b) the child shall be identified to the insurer with adequate information to comply with this section; and
  - (c) the premium shall be paid when due.
- (12) The provisions of this section apply to employee welfare benefit plans as defined in Section 26-19-2.
- (13) The commissioner shall adopt rules interpreting and implementing this section with regard to out-of-area court ordered dependent coverage.

Amended by Chapter 297, 2011 General Session

**31A-22-610.6 Special enrollment for individuals receiving premium assistance.**

- (1) As used in this section:
- (a) "Premium assistance" means assistance under Title 26, Chapter 18, Medical Assistance Act, in the payment of premium.
  - (b) "Qualified beneficiary" means an individual who is approved to receive premium assistance.
- (2) Subject to the other provisions in this section, an individual may enroll under this section at a time outside of an employer health benefit plan open enrollment period, regardless of previously waiving coverage, if the individual is:
- (a) a qualified beneficiary who is eligible for coverage as an employee under the employer health benefit plan; or
  - (b) a dependent of the qualified beneficiary who is eligible for coverage under the employer health benefit plan.
- (3) To be eligible to enroll outside of an open enrollment period, an individual described in Subsection (2) shall enroll in the employer health benefit plan by no later than 30 days from the day on which the qualified beneficiary receives initial written notification, after July 1, 2008, that the qualified beneficiary is eligible to receive premium assistance.
- (4) An individual described in Subsection (2) may enroll under this section only in an employer health benefit plan that is available at the time of enrollment to similarly situated eligible employees or dependents of eligible employees.
- (5) Coverage under an employer health benefit plan for an individual described in Subsection (2) may begin as soon as the first day of the month immediately following enrollment of the individual in accordance with this section.
- (6) This section does not modify any requirement related to premiums that applies under an employer health benefit plan to a similarly situated eligible employee or dependent of an eligible employee under the employer health benefit plan.
- (7) An employer health benefit plan may require an individual described in Subsection (2) to satisfy a preexisting condition waiting period that:

- (a) is allowed under the Health Insurance Portability and Accountability Act; and
- (b) is not longer than 12 months.

Amended by Chapter 284, 2011 General Session

**31A-22-611 Coverage for children with a disability.**

(1) For the purposes of this section:

(a) "Dependent with a disability" means a child who is and continues to be both:

- (i) unable to engage in substantial gainful employment to the degree that the child can achieve economic independence due to a medically determinable physical or mental impairment which can be expected to result in death, or which has lasted or can be expected to last for a continuous period of not less than 12 months; and
- (ii) chiefly dependent upon an insured for support and maintenance since the child reached the age specified in Subsection 31A-22-610.5(2).

(b) "Mental impairment" means a mental or psychological disorder such as:

- (i) an intellectual disability;
- (ii) organic brain syndrome;
- (iii) emotional or mental illness; or
- (iv) specific learning disabilities as determined by the insurer.

(c) "Physical impairment" means a physiological disorder, condition, or disfigurement, or anatomical loss affecting one or more of the following body systems:

- (i) neurological;
- (ii) musculoskeletal;
- (iii) special sense organs;
- (iv) respiratory organs;
- (v) speech organs;
- (vi) cardiovascular;
- (vii) reproductive;
- (viii) digestive;
- (ix) genito-urinary;
- (x) hemic and lymphatic;
- (xi) skin; or
- (xii) endocrine.

(2) The insurer may require proof of the incapacity and dependency be furnished by the person insured under the policy within 30 days of the effective date or the date the child attains the age specified in Subsection 31A-22-610.5(2), and at any time thereafter, except that the insurer may not require proof more often than annually after the two-year period immediately following attainment of the limiting age by the dependent with a disability.

(3) Any individual or group accident and health insurance policy or health maintenance organization contract that provides coverage for a policyholder's or certificate holder's dependent shall, upon application, provide coverage for all unmarried dependents with a disability who have been continuously covered, with no break of more than 63 days, under any accident and health insurance since the age specified in Subsection 31A-22-610.5(2).

(4) Every accident and health insurance policy or contract that provides coverage of a dependent with a disability may not terminate the policy due to an age limitation.

Amended by Chapter 297, 2011 General Session

Amended by Chapter 366, 2011 General Session

**31A-22-612 Conversion privileges for insured former spouse.**

- (1) An accident and health insurance policy, which in addition to covering the insured also provides coverage to the spouse of the insured, may not contain a provision for termination of coverage of a spouse covered under the policy, except by entry of a valid decree of divorce or annulment between the parties.
- (2) Every policy which contains this type of provision shall provide that upon the entry of the divorce decree the spouse is entitled to have issued an individual policy of accident and health insurance without evidence of insurability, upon application to the company and payment of the appropriate premium. The policy shall provide the coverage being issued which is most nearly similar to the terminated coverage. Probationary or waiting periods in the policy are considered satisfied to the extent the coverage was in force under the prior policy.
- (3) When the insurer receives actual notice that the coverage of a spouse is to be terminated because of a divorce or annulment, the insurer shall promptly provide the spouse written notification of the right to obtain individual coverage as provided in Subsection (2), the premium amounts required, and the manner, place, and time in which premiums may be paid. The premium is determined in accordance with the insurer's table of premium rates applicable to the age and class of risk of the persons to be covered and to the type and amount of coverage provided. If the spouse applies and tenders the first monthly premium to the insurer within 30 days after receiving the notice provided by this Subsection (3), the spouse shall receive individual coverage that commences immediately upon termination of coverage under the insured's policy.
- (4) This section does not apply to accident and health insurance policies offered on a group blanket basis or a health benefit plan.

Amended by Chapter 244, 2015 General Session

**31A-22-613 Permitted provisions for accident and health insurance policies.**

The following provisions may be contained in an accident and health insurance policy, but if they are in that policy, they shall conform to at least the minimum requirements for the policyholder in this section.

- (1) Any provision respecting change of occupation may provide only for a lower maximum benefit payment and for reduction of loss payments proportionate to the change in appropriate premium rates, if the change is to a higher rated occupation, and this provision shall provide for retroactive reduction of premium rates from the date of change of occupation or the last policy anniversary date, whichever is the more recent, if the change is to a lower rated occupation.
- (2) Section 31A-22-405 applies to misstatement of age in accident and health policies, with the appropriate modifications of terminology.
- (3) Any policy which contains a provision establishing, as an age limit or otherwise, a date after which the coverage provided by the policy is not effective, and if that date falls within a period for which a premium is accepted by the insurer or if the insurer accepts a premium after that date, the coverage provided by the policy continues in force, subject to any right of cancellation, until the end of the period for which the premium was accepted. This Subsection (3) does not apply if the acceptance of premium would not have occurred but for a misstatement of age by the insured.
- (4)
  - (a) If an insured is otherwise eligible for maternity benefits, a policy may not contain language which requires an insured to obtain any additional preauthorization or preapproval for

customary and reasonable maternity care expenses or for the delivery of the child after an initial preauthorization or preapproval has been obtained from the insurer for prenatal care. A requirement for notice of admission for delivery is not a requirement for preauthorization or preapproval, however, the maternity benefit may not be denied or diminished for failure to provide admission notice. The policy may not require the provision of admission notice by only the insured patient.

- (b) This Subsection (4) does not prohibit an insurer from:
  - (i) requiring a referral before maternity care can be obtained;
  - (ii) specifying a group of providers or a particular location from which an insured is required to obtain maternity care; or
  - (iii) limiting reimbursement for maternity expenses and benefits in accordance with the terms and conditions of the insurance contract so long as such terms do not conflict with Subsection (4)(a).
- (5)
  - (a) An insurer may only represent that a policy offers a vision benefit if the policy provides reimbursement for materials or services provided under the policy.
  - (b) An insurer may only represent that a policy covers laser vision correction, whether photorefractive keratectomy, laser assisted in-situ keratomeluzis, or related procedure, if the procedure is at least a partially covered benefit.
- (6) If a policy excludes coverage for the diagnosis and treatment of autism spectrum disorders, the insurer may not deny a claim for a procedure or service that is otherwise covered in the accident and health insurance policy unless the autism spectrum disorder is the primary diagnosis or reason for the service or procedure in the particular claim.

Amended by Chapter 279, 2012 General Session

### **31A-22-613.5 Price and value comparisons of health insurance.**

- (1)
  - (a) This section applies to all health benefit plans.
  - (b) Subsection (2) applies to:
    - (i) all health benefit plans; and
    - (ii) coverage offered to state employees under Subsection 49-20-202(1)(a).
- (2)
  - (a) The commissioner shall promote informed consumer behavior and responsible health benefit plans by requiring an insurer issuing a health benefit plan to:
    - (i) provide to all enrollees, prior to enrollment in the health benefit plan written disclosure of:
      - (A) restrictions or limitations on prescription drugs and biologics including:
        - (I) the use of a formulary;
        - (II) co-payments and deductibles for prescription drugs; and
        - (III) requirements for generic substitution;
      - (B) coverage limits under the plan;
      - (C) any limitation or exclusion of coverage including:
        - (I) a limitation or exclusion for a secondary medical condition related to a limitation or exclusion from coverage; and
        - (II) easily understood examples of a limitation or exclusion of coverage for a secondary medical condition; and

- (D) whether the insurer permits an exchange of the adoption indemnity benefit in Section 31A-22-610.1 for infertility treatments, in accordance with Subsection 31A-22-610.1(1)(c)(ii) and the terms associated with the exchange of benefits; and
- (ii) provide the commissioner with:
  - (A) the information described in Subsections 31A-22-635(5) through (7) in the standardized electronic format required by Subsection 63N-11-107(1); and
  - (B) information regarding insurer transparency in accordance with Subsection (4).
- (b) An insurer shall provide the disclosure required by Subsection (2)(a)(i) in writing to the commissioner:
  - (i) upon commencement of operations in the state; and
  - (ii) anytime the insurer amends any of the following described in Subsection (2)(a)(i):
    - (A) treatment policies;
    - (B) practice standards;
    - (C) restrictions;
    - (D) coverage limits of the insurer's health benefit plan or health insurance policy; or
    - (E) limitations or exclusions of coverage including a limitation or exclusion for a secondary medical condition related to a limitation or exclusion of the insurer's health insurance plan.
- (c) An insurer shall provide the enrollee with notice of an increase in costs for prescription drug coverage due to a change in benefit design under Subsection (2)(a)(i)(A):
  - (i) either:
    - (A) in writing; or
    - (B) on the insurer's website; and
  - (ii) at least 30 days prior to the date of the implementation of the increase in cost, or as soon as reasonably possible.
- (d) If under Subsection (2)(a)(i)(A) a formulary is used, the insurer shall make available to prospective enrollees and maintain evidence of the fact of the disclosure of:
  - (i) the drugs included;
  - (ii) the patented drugs not included;
  - (iii) any conditions that exist as a precedent to coverage; and
  - (iv) any exclusion from coverage for secondary medical conditions that may result from the use of an excluded drug.
- (e)
  - (i) The commissioner shall develop examples of limitations or exclusions of a secondary medical condition that an insurer may use under Subsection (2)(a)(i)(C).
  - (ii) Examples of a limitation or exclusion of coverage provided under Subsection (2)(a)(i)(C) or otherwise are for illustrative purposes only, and the failure of a particular fact situation to fall within the description of an example does not, by itself, support a finding of coverage.
- (3) The commissioner:
  - (a) shall forward the information submitted by an insurer under Subsection (2)(a)(ii) to the Health Insurance Exchange created under Section 63N-11-104; and
  - (b) may request information from an insurer to verify the information submitted by the insurer under this section.
- (4) The commissioner shall:
  - (a) convene a group of insurers, a member representing the Public Employees' Benefit and Insurance Program, consumers, and an organization that provides multipayer and multiprovider quality assurance and data collection, to develop information for consumers to compare health insurers and health benefit plans on the Health Insurance Exchange, which shall include consideration of:

- (i) the number and cost of an insurer's denied health claims;
- (ii) the cost of denied claims that is transferred to providers;
- (iii) the average out-of-pocket expenses incurred by participants in each health benefit plan that is offered by an insurer in the Health Insurance Exchange;
- (iv) the relative efficiency and quality of claims administration and other administrative processes for each insurer offering plans in the Health Insurance Exchange; and
- (v) consumer assessment of each insurer or health benefit plan;
- (b) adopt an administrative rule that establishes:
  - (i) definition of terms;
  - (ii) the methodology for determining and comparing the insurer transparency information;
  - (iii) the data, and format of the data, that an insurer shall submit to the commissioner in order to facilitate the consumer comparison on the Health Insurance Exchange in accordance with Section 63N-11-107; and
  - (iv) the dates on which the insurer shall submit the data to the commissioner in order for the commissioner to transmit the data to the Health Insurance Exchange in accordance with Section 63N-11-107; and
- (c) implement the rules adopted under Subsection (4)(b) in a manner that protects the business confidentiality of the insurer.

Amended by Chapter 257, 2015 General Session

Amended by Chapter 283, 2015 General Session

**31A-22-614 Claims under accident and health policies.**

- (1) Section 31A-21-312 applies generally to claims under accident and health policies.
- (2)
  - (a) Subject to Subsection (1), an accident and health insurance policy may not contain a claim notice requirement less favorable to the insured than one which requires written notice of the claim within 20 days after the occurrence or commencement of any loss covered by the policy. The policy shall specify to whom claim notices may be given.
  - (b) If a loss of time benefit under a policy may be paid for a period of at least two years, an insurer may require periodic notices that the insured continues to have a disability, unless the insured is legally incapacitated. The insured's delay in giving that notice does not impair the insured's or beneficiary's right to any indemnity which would otherwise have accrued during the six months preceding the date on which that notice is actually given.
- (3) An accident and health insurance policy may not contain a time limit on proof of loss which is more restrictive to the insured than a provision requiring written proof of loss, delivered to the insurer, within the following time:
  - (a) for a claim where periodic payments are contingent upon continuing loss, within 90 days after the termination of the period for which the insurer is liable; or
  - (b) for any other claim, within 90 days after the date of the loss.
- (4)
  - (a)
    - (i) Section 31A-26-301 applies generally to the payment of claims.
    - (ii) Indemnity for loss of life is paid in accordance with the beneficiary designation effective at the time of payment. If no valid beneficiary designation exists, the indemnity is paid to the insured's estate. Any other accrued indemnities unpaid at the insured's death are paid to the insured's estate.

- (b) Reasonable facility of payment clauses, specified by the commissioner by rule or in approving the policy form, are permitted. Payment made in good faith and in accordance with those clauses discharges the insurer's obligation to pay those claims.
- (c) All or a portion of any indemnities provided under an accident and health policy on account of hospital, nursing, medical, or surgical services may, at the insurer's option, be paid directly to the hospital or person rendering the services.

Amended by Chapter 366, 2011 General Session

**31A-22-614.5 Uniform claims processing -- Electronic exchange of health information.**

- (1)
  - (a) Except as provided in Subsection (1)(c), all insurers offering health insurance shall use a uniform claim form and uniform billing and claim codes.
  - (b) Beginning January 1, 2011, all health benefit plans, and dental and vision plans, shall provide for the electronic exchange of uniform:
    - (i) eligibility and coverage information; and
    - (ii) coordination of benefits information.
  - (c) For purposes of Subsection (1)(a), "health insurance" does not include a policy or certificate that provides benefits solely for:
    - (i) income replacement; or
    - (ii) long-term care.
- (2)
  - (a) The uniform electronic standards and information required in Subsection (1) shall be adopted and approved by the commissioner in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.
  - (b) When adopting rules under this section the commissioner:
    - (i) shall:
      - (A) consult with national and state organizations involved with the standardized exchange of health data, and the electronic exchange of health data, to develop the standards for the use and electronic exchange of uniform:
        - (I) claim forms;
        - (II) billing and claim codes;
        - (III) insurance eligibility and coverage information; and
        - (IV) coordination of benefits information; and
      - (B) meet federal mandatory minimum standards following the adoption of national requirements for transaction and data elements in the federal Health Insurance Portability and Accountability Act;
    - (ii) may not require an insurer or administrator to use a specific software product or vendor; and
    - (iii) may require an insurer who participates in the all payer database created under Section 26-33a-106.1 to allow data regarding demographic and insurance coverage information to be electronically shared with the state's designated secure health information master person index to be used:
      - (A) in compliance with data security standards established by:
        - (I) the federal Health Insurance Portability and Accountability Act; and
        - (II) the electronic commerce agreements established in a business associate agreement; and
      - (B) for the purpose of coordination of health benefit plans.
- (3)

- (a) The commissioner shall coordinate the administrative rules adopted under the provisions of this section with the administrative rules adopted by the Department of Health for the implementation of the standards for the electronic exchange of clinical health information under Section 26-1-37. The department shall establish procedures for developing the rules adopted under this section, which ensure that the Department of Health is given the opportunity to comment on proposed rules.
- (b)
  - (i) The commissioner may provide information to health care providers regarding resources available to a health care provider to verify whether a health care provider's practice management software system meets the uniform electronic standards for data exchange required by this section.
  - (ii) The commissioner may provide the information described in Subsection (3)(b)(i) by partnering with:
    - (A) a not-for-profit, broad based coalition of state health care insurers and health care providers who are involved in the electronic exchange of the data required by this section; or
    - (B) some other person that the commissioner determines is appropriate to provide the information described in Subsection (3)(b)(i).
- (c) The commissioner shall regulate any fees charged by insurers to the providers for:
  - (i) uniform claim forms;
  - (ii) electronic billing; or
  - (iii) the electronic exchange of clinical health information permitted by Section 26-1-37.

Amended by Chapter 284, 2011 General Session

**31A-22-614.7 Uniform claims processing -- Electronic exchange of prescription drug pre-authorization.**

- (1) The commissioner shall consult with national and state organizations involved with the standardized exchange of health data, and the electronic exchange of health data, to study and review:
  - (a) the process of prior authorization of prescription drugs; and
  - (b) the standards for the use and electronic exchange of a uniform prescription drug prior authorization form that meet federal mandatory minimum standards and follow the adoption of national requirements for transaction and data elements in the federal Health Insurance Portability and Accountability Act.
- (2) The commissioner and the organization described in Subsection (1) shall report their progress and findings to the Legislature's Business and Labor Interim Committee before October 1, 2013 and before November 1, 2014.

Enacted by Chapter 361, 2013 General Session

**31A-22-617 Preferred provider contract provisions.**

Health insurance policies may provide for insureds to receive services or reimbursement under the policies in accordance with preferred health care provider contracts as follows:

- (1) Subject to restrictions under this section, an insurer or third party administrator may enter into contracts with health care providers as defined in Section 78B-3-403 under which the health care providers agree to supply services, at prices specified in the contracts, to persons insured by an insurer.

- (a)
  - (i) A health care provider contract may require the health care provider to accept the specified payment in this Subsection (1) as payment in full, relinquishing the right to collect additional amounts from the insured person.
  - (ii) In a 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 insurer's written payment policies in effect at the time services were rendered.
  - (iii) 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 (1)(a)(iii) does not apply to the claim of a general acute hospital to the extent it is inconsistent with the hospital's provider agreement.
  - (iv) An organization may not penalize a provider solely for pursuing a claims dispute or otherwise demanding payment for a sum believed owing.
  - (v) If an insurer permits another entity with which it does not share common ownership or control to use or otherwise lease one or more of the organization's networks of 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.
- (b) The insurance contract may reward the insured for selection of preferred health care providers by:
  - (i) reducing premium rates;
  - (ii) reducing deductibles;
  - (iii) coinsurance;
  - (iv) other copayments; or
  - (v) any other reasonable manner.
- (c) If the insurer is a managed care organization, as defined in Subsection 31A-27a-403(1)(f):
  - (i) the insurance contract and the health care provider contract shall provide that in the event the managed care organization becomes insolvent, the rehabilitator or liquidator may:
    - (A) require the health care provider to continue to provide health care services under the contract 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)(v), reduce the fees the provider is otherwise entitled to receive from the managed care organization during the time period described in Subsection (1)(c)(i)(A);
  - (ii) the provider is required to:
    - (A) accept the reduced payment under Subsection (1)(c)(i)(B) as payment in full; and
    - (B) relinquish the right to collect additional amounts from the insolvent managed care organization's enrollee, as defined in Subsection 31A-27a-403(1)(b);
  - (iii) if the contract between the health care provider and the managed care organization has not been reduced to writing, or the contract fails to contain the requirements described in Subsection (1)(c)(i), the provider may not collect or attempt to collect from the enrollee:
    - (A) sums owed by the insolvent managed care organization; or
    - (B) the amount of the regular fee reduction authorized under Subsection (1)(c)(i)(B);

- (iv) the following may not bill or maintain an action at law against an enrollee to collect sums owed by the insolvent managed care organization or the amount of the regular fee reduction authorized under Subsection (1)(c)(i)(B):
    - (A) a provider;
    - (B) an agent;
    - (C) a trustee; or
    - (D) an assignee of a person described in Subsections (1)(c)(iv)(A) through (C); and
  - (v) notwithstanding Subsection (1)(c)(i):
    - (A) a rehabilitator or liquidator may not reduce a fee by less than 75% of the provider's regular fee set forth in the contract; and
    - (B) the enrollee shall continue to pay the copayments, deductibles, and other payments for services received from the provider that the enrollee was required to pay before the filing of:
      - (I) a petition for rehabilitation; or
      - (II) a petition for liquidation.
- (2)
- (a) Subject to Subsections (2)(b) through (2)(e), an insurer using preferred health care provider contracts is subject to the reimbursement requirements in Section 31A-8-501 on or after January 1, 2014.
  - (b) When reimbursing for services of health care providers not under contract, the insurer may make direct payment to the insured.
  - (c) An insurer using preferred health care provider contracts may impose a deductible on coverage of health care providers not under contract.
  - (d) 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).
  - (e) 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 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 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) A health care provider licensed to treat an 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) 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.
- (10) This section does not apply to catastrophic mental health coverage provided in accordance with Section 31A-22-625.
- (11) Notwithstanding Subsection (1), Subsection (7)(b), and Section 31A-22-618, an insurer 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.

Amended by Chapter 290, 2014 General Session

Amended by Chapter 300, 2014 General Session

**31A-22-617.1 Objective criteria for adding or terminating participating providers --  
Termination of contracts -- Review process.**

- (1)
- (a) Every insurer, including a health maintenance organization governed by Chapter 8, Health Maintenance Organizations and Limited Health Plans, shall establish criteria for adding health care providers to a new or existing provider panel.

- (b) Criteria under Subsection (1)(a) may include, but are not limited to:
    - (i) training, certification, and hospital privileges;
    - (ii) number of physicians needed to adequately serve the insurer's population; and
    - (iii) any other factor that is reasonably related to promote or protect good patient care, address costs, take into account on-call and cross-coverage relationships between providers, or serve the lawful interests of the insurer.
  - (c) An insurer shall make such criteria available to any provider upon request and shall file the same with the department.
  - (d) Upon receipt of a provider application and upon receiving all necessary information, an insurer shall make a decision on a provider's application for participation within 120 days.
  - (e) If the provider applicant is rejected, the insurer shall inform the provider of the reason for the rejection relative to the criteria established in accordance with Subsection (1)(b).
  - (f) An insurer may not reject a provider applicant based solely on:
    - (i) the provider's staff privileges at a general acute care hospital not under contract with the insurer; or
    - (ii) the provider's referral patterns for patients who are not covered by the insurer.
  - (g) Criteria set out in Subsection (1)(b) may be modified or changed from time to time to meet the business needs of the market in which the insurer operates and, if modified, will be filed with the department as provided in Subsection (1)(c).
  - (h) With the exception of Subsection (1)(f), this section does not create any new or additional private right of action for redress.
- (2)
- (a) For the first two years, an insurer may terminate its contract with a provider with or without cause upon giving the requisite amount of notice provided in the agreement, but in no case shall it be less than 60 days.
  - (b) An agreement may be terminated for cause as provided in the contract established between the insurer and the provider. Such contract shall contain sufficiently certain criteria so that the provider can be reasonably informed of the grounds for termination for cause.
  - (c) Prior to termination for cause, the insurer shall:
    - (i) inform the provider of the intent to terminate and the grounds for doing so;
    - (ii) at the request of the provider, meet with the provider to discuss the reasons for termination;
    - (iii) if the insurer has a reasonable basis to believe that the provider may correct the conduct giving rise to the notice of termination, the insurer may, at its discretion, place the provider on probation with corrective action requirements, restrictions, or both, as necessary to protect patient care; and
    - (iv) if the insurer has a reasonable basis to believe that the provider has engaged in fraudulent conduct or poses a significant risk to patient care or safety, the insurer may immediately suspend the provider from further performance under the contract, provided that the remaining provisions of this Subsection (2) are followed in a timely manner before termination may become final.
  - (d) Each insurer shall establish an internal appeal process for actions that may result in terminated participation with cause and make known to the provider the procedure for appealing such termination.
    - (i) Providers dissatisfied with the results of the appeal process may, if both parties agree, submit the matters in dispute to mediation.
    - (ii) If the matters in dispute are not mediated, or should mediation be unsuccessful, the dispute shall be subject to binding arbitration by an arbitrator jointly selected by the parties, the cost of which shall be jointly shared. Each party shall bear its own additional expenses.

- (e) A termination under Subsection (2)(a) or (b) may not be based on:
  - (i) the provider's staff privileges at a general acute care hospital not under contract with the insurer; or
  - (ii) the provider's referral patterns for patients who are not covered by the insurer.
- (3) Notwithstanding any other section of this title, an insurer may not take adverse action against or reduce reimbursement to a contracted provider who is not under a capitated reimbursement arrangement because of the decision of an insured to access health care services from a noncontracted provider in a manner permitted by the insured's health insurance plan, regardless of how the plan is designated.

Enacted by Chapter 3, 2005 Special Session 1

Enacted by Chapter 3, 2005 Special Session 1

**31A-22-618 Nondiscrimination among health care professionals.**

- (1) Except as provided under Section 31A-22-617 and Subsection (3) of this section, and except as to insurers licensed under Chapter 8, Health Maintenance Organizations and Limited Health Plans, no insurer may unfairly discriminate against any licensed class of health care providers by structuring contract exclusions which exclude payment of benefits for the treatment of any illness, injury, or condition by any licensed class of health care providers when the treatment is within the scope of the licensee's practice and the illness, injury, or condition falls within the coverage of the contract. Upon the written request of an insured alleging an insurer has violated this section, the commissioner shall hold a hearing to determine if the violation exists. The commissioner may consolidate two or more related alleged violations into a single hearing.
- (2) This section does not apply to catastrophic mental health coverage provided in accordance with Section 31A-22-625.
- (3) Coverage for licensed providers for behavioral analysis may be limited by a insurer in accordance with Section 58-61-714. Nothing in this section prohibits an insurer from electing to provide coverage for other licensed professionals whose scope of practice includes behavior analysis.

Amended by Chapter 367, 2015 General Session

**31A-22-618.5 Health benefit plan offerings.**

- (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) the limitation on point of service products in Subsections 31A-8-408(3) through (6);
      - (C) except as provided in Subsection (2)(b)(ii), basic health care services as defined in Section 31A-8-101; or
      - (D) 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 as follows:
  - (A) within the organization's service area, covered services shall include health care services from nonaffiliated providers when medically necessary to stabilize an emergency medical condition; and
  - (B) outside the organization's service area, covered services shall include medically necessary health care services for the treatment of an emergency medical condition that are immediately required while the enrollee is outside the geographic limits of the organization's service area.
- (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;
  - (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.

Amended by Chapter 290, 2014 General Session

Amended by Chapter 300, 2014 General Session

**31A-22-619 Coordination of benefits.**

- (1) The commissioner shall:
  - (a) adopt rules concerning the coordination of benefits between accident and health insurance policies;
  - (b) publish a coordination of benefits guide;
  - (c) post the coordination of benefits guide on the state insurance exchange; and
  - (d) work with the Health Data Authority, health care provider groups, and with state and national organizations that are developing uniform standards for the electronic exchange of health insurance claims to develop standardized language regarding coordination of benefits for the purpose of including the standardized language in an insurer's explanation of benefits.
- (2) Rules adopted by the commissioner under Subsection (1):
  - (a) may not prohibit coordination of benefits with individual accident and health insurance policies;
  - (b) shall apply equally to all accident and health insurance policies without regard to whether the policies are group or individual policies; and
  - (c) shall include standardized language regarding the coordination of benefits process that shall be included in each insurer's accident and health insurance policy.

Amended by Chapter 285, 2010 General Session

**31A-22-619.6 Coordination of benefits with workers' compensation claim -- Health insurer's duty to pay.**

- (1) As used in this section:
- (a) "Employee" means an employee, worker, or operative as defined in Section 34A-2-104.
  - (b) "Employer" is as enumerated and defined in Section 34A-2-103.
  - (c) "Health benefit plan":
    - (i) means the same as that term is defined in Section 31A-1-301;
    - (ii) includes:
      - (A) a health maintenance organization;
      - (B) a third party administrator that offers, sells, manages, or administers a health benefit plan; and
      - (C) the Public Employees' Benefit and Insurance Program created in Section 49-20-103; and
    - (iii) excludes a health benefit plan offered by an insurer that has a market share in the state's fully insured market that is less than 2%, as determined in the department's annual Market Share Report published by the department.
  - (d) "Workers' compensation carrier" means any of the entities an employer may use to provide workers' compensation benefits for its employees under Section 34A-2-201.
  - (e) "Workers' compensation claim" means a claim for compensation for medical benefits under Title 34A, Chapter 2, Workers' Compensation Act, or Title 34A, Chapter 3, Utah Occupational Disease Act.
- (2)
- (a) For medical claims incurred on or after July 1, 2014, an employee's health benefit plan may not delay or deny payment of benefits due to the employee under the terms of a health benefit plan by claiming that treatment for the employee's injury or disease is the responsibility of the employer's workers' compensation carrier if:
    - (i) the employee or a health care provider on behalf of an employee files an application for hearing regarding the workers' compensation claim with the Division of Adjudication under Section 34A-2-801; and
    - (ii) the health benefit plan received a notice from the Labor Commission that an application for hearing was filed in accordance with Subsection (2)(a)(i).
  - (b) The Labor Commission shall provide the notice required by Subsection (2)(a)(ii) in accordance with Subsection 34A-2-213(2).
- (3) A health benefit plan that receives a medical claim from the employee or a health care provider and a notice from the Labor Commission in accordance with Subsection (2):
- (a) shall pay the medical claim directly to the health care provider in the dollar amount paid under the limits, terms, and conditions of the employee's health benefit plan; and
  - (b) may send a notice to the Labor Commission or the attorney for the injured worker informing the parties that the health benefit plan paid a claim under the provisions of this section.
- (4) If the claims for medical services paid pursuant to Subsection (3) are determined to be compensable by the workers' compensation carrier in a final order under Section 34A-2-801 or under the terms of a settlement agreement under Section 34A-2-420, the workers' compensation carrier shall pay the health benefit plan and employee in accordance with Subsection 34A-2-213(3)(b).
- (5)
- (a) A health care provider who receives payment for a medical claim from a health benefit plan under the provisions of Subsection (3) may not request additional payment for the medical claim from the workers' compensation carrier if the final order under Section 34A-2-801 or

terms of the settlement agreement under Section 34A-2-420 determine that the medical claim was compensable by the workers' compensation carrier.

- (b) A health benefit plan that is reimbursed under the provisions of Subsection 34A-2-213(3) for a medical claim may not seek reimbursement or autorecovery from the health care provider for any difference between the amount of the claim paid by the health benefit plan and the reimbursement to the health benefit plan by the workers' compensation carrier under Subsection 34A-2-213(3).
  - (c) If a final order of the Labor Commission under Section 34A-2-801 or the terms of a settlement agreement under Section 34A-2-420 determines that a medical claim is compensable by the workers' compensation carrier, the workers' compensation carrier may not seek reimbursement or autorecovery from a health care provider for any part of the medical claim that is the responsibility of the workers' compensation carrier under the order or settlement agreement.
- (6) This section sunsets in accordance with Section 63I-1-231.

Amended by Chapter 348, 2016 General Session

**31A-22-620 Medicare Supplement Insurance Minimum Standards Act.**

(1) As used in this section:

(a) "Applicant" means:

- (i) in the case of an individual Medicare supplement policy, the person who seeks to contract for insurance benefits; and
- (ii) in the case of a group Medicare supplement policy, the proposed certificate holder.

(b) "Certificate" means any certificate delivered or issued for delivery in this state under a group Medicare supplement policy.

(c) "Certificate form" means the form on which the certificate is delivered or issued for delivery by the issuer.

(d) "Issuer" includes insurance companies, fraternal benefit societies, health care service plans, health maintenance organizations, and any other entity delivering, or issuing for delivery in this state, Medicare supplement policies or certificates.

(e) "Medicare" means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

(f) "Medicare Supplement Policy":

- (i) means a group or individual policy of health insurance, other than a policy issued pursuant to a contract under Section 1876 of the federal Social Security Act, 42 U.S.C. Sec. 1395 et seq., or an issued policy under a demonstration project specified in 42 U.S.C. Sec. 1395ss(g)(1), that is advertised, marketed, or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical, or surgical expenses of persons eligible for Medicare; and
- (ii) does not include Medicare Advantage plans established under Medicare Part C, outpatient prescription drug plans established under Medicare Part D, or any health care prepayment plan that provides benefits pursuant to an agreement under Section 1833(a)(1)(A) of the Social Security Act.

(g) "Policy form" means the form on which the policy is delivered or issued for delivery by the issuer.

(2)

(a) Except as otherwise specifically provided, this section applies to:

- (i) all Medicare supplement policies delivered or issued for delivery in this state on or after the effective date of this section;
  - (ii) all certificates issued under group Medicare supplement policies, that have been delivered or issued for delivery in this state on or after the effective date of this section; and
  - (iii) policies or certificates that were in force prior to the effective date of this section, with respect to requirements for benefits, claims payment, and policy reporting practice under Subsection (3)(d), and loss ratios under Subsection (4).
- (b) This section does not apply to a policy of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or a combination of employers and labor unions, for employees or former employees or a combination of employees and former employees, or for members or former members of the labor organizations, or a combination of members and former members of labor organizations.
- (c) This section does not prohibit, nor does it apply to insurance policies or health care benefit plans, including group conversion policies, provided to Medicare eligible persons that are not marketed or held out to be Medicare supplement policies or benefit plans.
- (3)
- (a) A Medicare supplement policy or certificate in force in the state may not contain benefits that duplicate benefits provided by Medicare.
  - (b) Notwithstanding any other provision of law of this state, a Medicare supplement policy or certificate may not exclude or limit benefits for loss incurred more than six months from the effective date of coverage because it involved a preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than: "A condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage."
  - (c) The commissioner shall adopt rules to establish specific standards for policy provisions of Medicare supplement policies and certificates. The standards adopted shall be in addition to and in accordance with applicable laws of this state. A requirement of this title relating to minimum required policy benefits, other than the minimum standards contained in this section, may not apply to Medicare supplement policies and certificates. The standards may include:
    - (i) terms of renewability;
    - (ii) initial and subsequent conditions of eligibility;
    - (iii) nonduplication of coverage;
    - (iv) probationary periods;
    - (v) benefit limitations, exceptions, and reductions;
    - (vi) elimination periods;
    - (vii) requirements for replacement;
    - (viii) recurrent conditions; and
    - (ix) definitions of terms.
  - (d) The commissioner shall adopt rules establishing minimum standards for benefits, claims payment, marketing practices, compensation arrangements, and reporting practices for Medicare supplement policies and certificates.
  - (e) The commissioner may adopt rules to conform Medicare supplement policies and certificates to the requirements of federal law and regulations, including:
    - (i) requiring refunds or credits if the policies do not meet loss ratio requirements;
    - (ii) establishing a uniform methodology for calculating and reporting loss ratios;

- (iii) assuring public access to policies, premiums, and loss ratio information of issuers of Medicare supplement insurance;
  - (iv) establishing a process for approving or disapproving policy forms and certificate forms and proposed premium increases;
  - (v) establishing a policy for holding public hearings prior to approval of premium increases;
  - (vi) establishing standards for Medicare select policies and certificates; and
  - (vii) nondiscrimination for genetic testing or genetic information.
- (f) The commissioner may adopt rules that prohibit policy provisions not otherwise specifically authorized by statute that, in the opinion of the commissioner, are unjust, unfair, or unfairly discriminatory to any person insured or proposed to be insured under a Medicare supplement policy or certificate.
- (4) Medicare supplement policies shall return to policyholders benefits that are reasonable in relation to the premium charged. The commissioner shall make rules to establish minimum standards for loss ratios of Medicare supplement policies on the basis of incurred claims experience, or incurred health care expenses where coverage is provided by a health maintenance organization on a service basis rather than on a reimbursement basis, and earned premiums in accordance with accepted actuarial principles and practices.
- (5)
- (a) To provide for full and fair disclosure in the sale of Medicare supplement policies, a Medicare supplement policy or certificate may not be delivered in this state unless an outline of coverage is delivered to the applicant at the time application is made.
  - (b) The commissioner shall prescribe the format and content of the outline of coverage required by Subsection (5)(a).
  - (c) For purposes of this section, "format" means style arrangements and overall appearance, including such items as the size, color, and prominence of type and arrangement of text and captions. The outline of coverage shall include:
    - (i) a description of the principal benefits and coverage provided in the policy;
    - (ii) a statement of the renewal provisions, including any reservation by the issuer of a right to change premiums; and disclosure of the existence of any automatic renewal premium increases based on the policyholder's age; and
    - (iii) a statement that the outline of coverage is a summary of the policy issued or applied for and that the policy should be consulted to determine governing contractual provisions.
  - (d) The commissioner may make rules for captions or notice if the commissioner finds that the rules are:
    - (i) in the public interest; and
    - (ii) designed to inform prospective insureds that particular insurance coverages are not Medicare supplement coverages, for all accident and health insurance policies sold to persons eligible for Medicare, other than:
      - (A) a medicare supplement policy; or
      - (B) a disability income policy.
  - (e) The commissioner may prescribe by rule a standard form and the contents of an informational brochure for persons eligible for Medicare, that is intended to improve the buyer's ability to select the most appropriate coverage and improve the buyer's understanding of Medicare. Except in the case of direct response insurance policies, the commissioner may require by rule that the informational brochure be provided concurrently with delivery of the outline of coverage to any prospective insureds eligible for Medicare. With respect to direct response insurance policies, the commissioner may require by rule that the prescribed brochure be

provided upon request to any prospective insureds eligible for Medicare, but in no event later than the time of policy delivery.

- (f) The commissioner may adopt reasonable rules to govern the full and fair disclosure of the information in connection with the replacement of accident and health policies, subscriber contracts, or certificates by persons eligible for Medicare.
- (6) Notwithstanding Subsection (1), Medicare supplement policies and certificates shall have a notice prominently printed on the first page of the policy or certificate, or attached to the front page, stating in substance that the applicant has the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason. Any refund made pursuant to this section shall be paid directly to the applicant by the issuer in a timely manner.
- (7) Every issuer of Medicare supplement insurance policies or certificates in this state shall provide a copy of any Medicare supplement advertisement intended for use in this state, whether through written or broadcast medium, to the commissioner for review.
- (8) The commissioner may adopt rules to conform Medicare and Medicare supplement policies and certificates to the marketing requirements of federal law and regulation.

Amended by Chapter 244, 2015 General Session

**31A-22-623 Coverage of inborn metabolic errors.**

- (1) As used in this section:
  - (a) "Dietary products" means medical food or a low protein modified food product that:
    - (i) is specifically formulated to treat inborn errors of amino acid or urea cycle metabolism;
    - (ii) is not a natural food that is naturally low in protein; and
    - (iii) is used under the direction of a physician.
  - (b) "Inborn errors of amino acid or urea cycle metabolism" means a disease caused by an inherited abnormality of body chemistry which is treatable by the dietary restriction of one or more amino acid.
- (2) The commissioner shall establish, by rule, minimum standards of coverage for dietary products used for the treatment of inborn errors of amino acid or urea cycle metabolism at levels consistent with the major medical benefit provided under an accident and health insurance policy.

Amended by Chapter 116, 2001 General Session

**31A-22-624 Primary care physician.**

An accident and health insurance policy that requires an insured to select a primary care physician to receive optimum coverage:

- (1) shall permit an insured to select a participating provider who:
  - (a) is an:
    - (i) obstetrician;
    - (ii) gynecologist; or
    - (iii) pediatrician; and
  - (b) is qualified and willing to provide primary care services, as defined by the health care plan, as the insured's provider from whom primary care services are received;
- (2) shall clearly state in literature explaining the policy the option available to insureds under Subsection (1); and

- (3) may not impose a higher premium, higher copayment requirement, or any other additional expense on an insured because the insured selected a primary care physician in accordance with Subsection (1).

Amended by Chapter 308, 2002 General Session

**31A-22-625 Catastrophic coverage of mental health conditions.**

(1) As used in this section:

(a)

- (i) "Catastrophic mental health coverage" means coverage in a health benefit plan that does not impose a lifetime limit, annual payment limit, episodic limit, inpatient or outpatient service limit, or maximum out-of-pocket limit that places a greater financial burden on an insured for the evaluation and treatment of a mental health condition than for the evaluation and treatment of a physical health condition.
- (ii) "Catastrophic mental health coverage" may include a restriction on cost sharing factors, such as deductibles, copayments, or coinsurance, before reaching a maximum out-of-pocket limit.
- (iii) "Catastrophic mental health coverage" may include one maximum out-of-pocket limit for physical health conditions and another maximum out-of-pocket limit for mental health conditions, except that if separate out-of-pocket limits are established, the out-of-pocket limit for mental health conditions may not exceed the out-of-pocket limit for physical health conditions.

(b)

- (i) "50/50 mental health coverage" means coverage in a health benefit plan that pays for at least 50% of covered services for the diagnosis and treatment of mental health conditions.
- (ii) "50/50 mental health coverage" may include a restriction on:
  - (A) episodic limits;
  - (B) inpatient or outpatient service limits; or
  - (C) maximum out-of-pocket limits.

(c) "Large employer" is as defined in 42 U.S.C. Sec. 300gg-91.

(d)

- (i) "Mental health condition" means a condition or disorder involving mental illness that falls under a diagnostic category listed in the Diagnostic and Statistical Manual, as periodically revised.
- (ii) "Mental health condition" does not include the following when diagnosed as the primary or substantial reason or need for treatment:
  - (A) a marital or family problem;
  - (B) a social, occupational, religious, or other social maladjustment;
  - (C) a conduct disorder;
  - (D) a chronic adjustment disorder;
  - (E) a psychosexual disorder;
  - (F) a chronic organic brain syndrome;
  - (G) a personality disorder;
  - (H) a specific developmental disorder or learning disability; or
  - (I) an intellectual disability.

(e) "Small employer" is as defined in 42 U.S.C. Sec. 300gg-91.

(2)

- (a) At the time of purchase and renewal, an insurer shall offer to a small employer that it insures or seeks to insure a choice between:
    - (i)
      - (A) catastrophic mental health coverage; or
      - (B) federally qualified mental health coverage as described in Subsection (3); and
    - (ii) 50/50 mental health coverage.
  - (b) In addition to complying with Subsection (2)(a), an insurer may offer to provide:
    - (i) catastrophic mental health coverage, 50/50 mental health coverage, or both at levels that exceed the minimum requirements of this section; or
    - (ii) coverage that excludes benefits for mental health conditions.
  - (c) A small employer may, at its option, regardless of the employer's previous coverage for mental health conditions, choose either:
    - (i) coverage offered under Subsection (2)(a)(i);
    - (ii) 50/50 mental health coverage; or
    - (iii) coverage offered under Subsection (2)(b).
  - (d) An insurer is exempt from the 30% index rating restriction in Section 31A-30-106.1 and, for the first year only that the employer chooses coverage that meets or exceeds catastrophic mental health coverage, the 15% annual adjustment restriction in Section 31A-30-106.1, for a small employer with 20 or less enrolled employees who chooses coverage that meets or exceeds catastrophic mental health coverage.
- (3)
- (a) An insurer shall offer a large employer mental health and substance use disorder benefit in compliance with Section 2705 of the Public Health Service Act, 42 U.S.C. Sec. 300gg-26, and federal regulations adopted pursuant to that act.
  - (b) An insurer shall provide in an individual or small employer health benefit plan, mental health and substance use disorder benefits in compliance with Sections 2705 and 2711 of the Public Health Service Act, 42 U.S.C. Sec. 300gg-26, and federal regulations adopted pursuant to that act.
- (4)
- (a) An insurer may provide catastrophic mental health coverage to a small employer through a managed care organization or system in a manner consistent with Chapter 8, Health Maintenance Organizations and Limited Health Plans, regardless of whether the insurance policy uses a managed care organization or system for the treatment of physical health conditions.
  - (b)
    - (i) Notwithstanding any other provision of this title, an insurer may:
      - (A) establish a closed panel of providers for catastrophic mental health coverage; and
      - (B) refuse to provide a benefit to be paid for services rendered by a nonpanel provider unless:
        - (I) the insured is referred to a nonpanel provider with the prior authorization of the insurer; and
        - (II) the nonpanel provider agrees to follow the insurer's protocols and treatment guidelines.
    - (ii) If an insured receives services from a nonpanel provider in the manner permitted by Subsection (4)(b)(i)(B), the insurer shall reimburse the insured for not less than 75% of the average amount paid by the insurer for comparable services of panel providers under a noncapitated arrangement who are members of the same class of health care providers.
    - (iii) This Subsection (4)(b) may not be construed as requiring an insurer to authorize a referral to a nonpanel provider.

- (c) To be eligible for catastrophic mental health coverage, a diagnosis or treatment of a mental health condition shall be rendered:
  - (i) by a mental health therapist as defined in Section 58-60-102; or
  - (ii) in a health care facility:
    - (A) licensed or otherwise authorized to provide mental health services pursuant to:
      - (I) Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act; or
      - (II) Title 62A, Chapter 2, Licensure of Programs and Facilities; and
    - (B) that provides a program for the treatment of a mental health condition pursuant to a written plan.
- (5) The commissioner may prohibit an insurance policy that provides mental health coverage in a manner that is inconsistent with this section.
- (6) The commissioner may adopt rules, in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, as necessary to ensure compliance with this section.

Amended by Chapter 290, 2014 General Session

Amended by Chapter 300, 2014 General Session

**31A-22-626 Coverage of diabetes.**

- (1) As used in this section, "diabetes" includes individuals with:
  - (a) complete insulin deficiency or type 1 diabetes;
  - (b) insulin resistant with partial insulin deficiency or type 2 diabetes; and
  - (c) elevated blood glucose levels induced by pregnancy or gestational diabetes.
- (2) The commissioner shall establish, by rule, minimum standards of coverage for diabetes for accident and health insurance policies that provide a health insurance benefit before July 1, 2000.
- (3) In making rules under Subsection (2), the commissioner shall require rules:
  - (a) with durational limits, amount limits, deductibles, and coinsurance for the treatment of diabetes equitable or identical to coverage provided for the treatment of other illnesses or diseases; and
  - (b) that provide coverage for:
    - (i) diabetes self-management training and patient management, including medical nutrition therapy as defined by rule, provided by an accredited or certified program and referred by an attending physician within the plan and consistent with the health plan provisions for self-management education:
      - (A) recognized by the federal Centers for Medicare and Medicaid Services; or
      - (B) certified by the Department of Health; and
    - (ii) the following equipment, supplies, and appliances to treat diabetes when medically necessary:
      - (A) blood glucose monitors, including those for the legally blind;
      - (B) test strips for blood glucose monitors;
      - (C) visual reading urine and ketone strips;
      - (D) lancets and lancet devices;
      - (E) insulin;
      - (F) injection aides, including those adaptable to meet the needs of the legally blind, and infusion delivery systems;
      - (G) syringes;
      - (H) prescriptive oral agents for controlling blood glucose levels; and
      - (I) glucagon kits.

Amended by Chapter 258, 2015 General Session

**31A-22-627 Coverage of emergency medical services.**

- (1) A health insurance policy or health maintenance organization contract:
  - (a) shall provide, at a minimum, coverage of emergency services as required in 29 C.F.R. Sec. 2590.715-2719A; and
  - (b) may not:
    - (i) require any form of preauthorization for treatment of an emergency medical condition until after the insured's condition has been stabilized; or
    - (ii) 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.
- (5) Notwithstanding Section 31A-2-308, if the commissioner finds an insurer has violated this section, the commissioner may:
  - (a) work with the insurer to improve the insurer's compliance with this section; or
  - (b) impose the following fines:
    - (i) not more than \$5,000; or
    - (ii) twice the amount of any profit gained from violations of this section.

Amended by Chapter 295, 2016 General Session

**31A-22-628 Standing referral to a specialist.**

- (1) With respect to a health insurance policy or health maintenance organization contract that does not allow an insured to have direct access to a health care specialist, the insurer shall establish and implement a procedure by which an insured may obtain a standing referral to a health care specialist.

- (2) The procedure established under Subsection (1):
- (a) shall provide for a standing referral to a specialist if the insured's primary care provider determines, in consultation with the specialist, that the insured needs continuing care from the specialist; and
  - (b) may require the insurer's approval of a treatment plan designed by the specialist, in consultation with the primary care provider and the insured, which may include:
    - (i) a limit on the number of visits to the specialist;
    - (ii) a time limit on the duration of the referral; and
    - (iii) mandatory updates on the insured's condition.

Enacted by Chapter 37, 2000 General Session

**31A-22-629 Adverse benefit determination review process.**

- (1) As used in this section:
- (a)
    - (i) "Adverse benefit determination" means the:
      - (A) denial of a benefit;
      - (B) reduction of a benefit;
      - (C) termination of a benefit; or
      - (D) failure to provide or make payment, in whole or in part, for a benefit.
    - (ii) "Adverse benefit determination" includes:
      - (A) denial, reduction, termination, or failure to provide or make payment that is based on a determination of an insured's or a beneficiary's eligibility to participate in a plan;
      - (B) denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for, a benefit resulting from the application of a utilization review; or
      - (C) failure to cover an item or service for which benefits are otherwise provided because it is determined to be:
        - (I) experimental;
        - (II) investigational; or
        - (III) not medically necessary or appropriate.
  - (b) "Independent review" means a process that:
    - (i) is a voluntary option for the resolution of an adverse benefit determination;
    - (ii) is conducted at the discretion of the claimant;
    - (iii) is conducted by an independent review organization designated by the insurer;
    - (iv) renders an independent and impartial decision on an adverse benefit determination submitted by an insured; and
    - (v) may not require the insured to pay a fee for requesting the independent review.
  - (c) "Independent review organization" means a person, subject to Subsection (6), who conducts an independent external review of adverse determinations.
  - (d) "Insured" is as defined in Section 31A-1-301 and includes a person who is authorized to act on the insured's behalf.
  - (e) "Insurer" is as defined in Section 31A-1-301 and includes:
    - (i) a health maintenance organization; and
    - (ii) a third party administrator that offers, sells, manages, or administers a health insurance policy or health maintenance organization contract that is subject to this title.
  - (f) "Internal review" means the process an insurer uses to review an insured's adverse benefit determination before the adverse benefit determination is submitted for independent review.

- (2) This section applies generally to health insurance policies, health maintenance organization contracts, and income replacement or disability income policies.
- (3)
  - (a) An insured may submit an adverse benefit determination to the insurer.
  - (b) The insurer shall conduct an internal review of the insured's adverse benefit determination.
  - (c) An insured who disagrees with the results of an internal review may submit the adverse benefit determination for an independent review if the adverse benefit determination involves:
    - (i) payment of a claim regarding medical necessity; or
    - (ii) denial of a claim regarding medical necessity.
- (4) The commissioner shall adopt rules that establish minimum standards for:
  - (a) internal reviews;
  - (b) independent reviews to ensure independence and impartiality;
  - (c) the types of adverse benefit determinations that may be submitted to an independent review; and
  - (d) the timing of the review process, including an expedited review when medically necessary.
- (5) Nothing in this section may be construed as:
  - (a) expanding, extending, or modifying the terms of a policy or contract with respect to benefits or coverage;
  - (b) permitting an insurer to charge an insured for the internal review of an adverse benefit determination;
  - (c) restricting the use of arbitration in connection with or subsequent to an independent review; or
  - (d) altering the legal rights of any party to seek court or other redress in connection with:
    - (i) an adverse decision resulting from an independent review, except that if the insurer is the party seeking legal redress, the insurer shall pay for the reasonable attorney fees of the insured related to the action and court costs; or
    - (ii) an adverse benefit determination or other claim that is not eligible for submission to independent review.
- (6)
  - (a) An independent review organization in relation to the insurer may not be:
    - (i) the insurer;
    - (ii) the health plan;
    - (iii) the health plan's fiduciary;
    - (iv) the employer; or
    - (v) an employee or agent of any one listed in Subsections (6)(a)(i) through (iv).
  - (b) An independent review organization may not have a material professional, familial, or financial conflict of interest with:
    - (i) the health plan;
    - (ii) an officer, director, or management employee of the health plan;
    - (iii) the enrollee;
    - (iv) the enrollee's health care provider;
    - (v) the health care provider's medical group or independent practice association;
    - (vi) a health care facility where service would be provided; or
    - (vii) the developer or manufacturer of the service that would be provided.

Amended by Chapter 253, 2012 General Session

**31A-22-630 Mastectomy coverage.**

- (1) If an insured has coverage that provides medical and surgical benefits with respect to a mastectomy, it shall provide coverage, with consultation of the attending physician and the patient, for:
  - (a) reconstruction of the breast on which the mastectomy has been performed;
  - (b) surgery and reconstruction of the breast on which the mastectomy was not performed to produce symmetrical appearance; and
  - (c) prostheses and physical complications with regards to all stages of mastectomy, including lymphedemas.
- (2)
  - (a) This section does not prevent an accident and health insurer from imposing cost-sharing measures for health benefits relating to this coverage, if cost-sharing measures are not greater than those imposed on any other medical condition.
  - (b) For purposes of this Subsection (2), cost-sharing measures include imposing a deductible or coinsurance requirement.
- (3) Written notice of the availability of the coverage described in Subsection (1) shall be delivered to the participant:
  - (a) upon enrollment; and
  - (b) annually after the enrollment.

Amended by Chapter 116, 2001 General Session

**31A-22-631 Policy summary or illustration.**

- (1)
  - (a) Except as provided in Subsection (1)(b), at the time a life insurance policy is delivered, a policy summary or illustration shall be delivered for the life insurance policy if:
    - (i) the life insurance policy includes riders or supplemental benefits, including accelerated benefits; and
    - (ii) receipt of benefits under the life insurance policy is contingent upon morbidity requirements.
  - (b) In the case of a direct response solicitation, the insurer shall deliver the policy summary or illustration at the sooner of:
    - (i) the applicant's request; or
    - (ii) at the time of policy delivery regardless of whether the applicant requests a policy summary or illustration.
- (2) In addition to complying with all applicable requirements, the policy summary or illustration shall include:
  - (a) a clear and prominent disclosure of how the rider or supplemental benefit interacts with other components of the policy, including deductions from death benefits and policy values;
  - (b) an illustration for each covered person of:
    - (i) the amount of benefits;
    - (ii) the length of benefits; and
    - (iii) the guaranteed lifetime benefits, if any;
  - (c) a disclosure of the maximum premiums for the rider or supplemental benefit;
  - (d) any exclusions, reductions, or limitations on the benefits of the rider or supplemental benefit; and
  - (e) if applicable to the policy type:
    - (i) a disclosure of the effects of exercising other rights under the policy; and
    - (ii) guaranteed maximum lifetime benefits.

Enacted by Chapter 116, 2001 General Session

**31A-22-632 Report to policy holder.**

- (1) An insurer shall provide the policyholder a monthly report if an accident and health rider or supplemental benefit is:
  - (a) funded through a life insurance vehicle by acceleration of the death benefit; and
  - (b) in benefit payment status.
- (2) The report required by Subsection (1) shall include:
  - (a) any rider or supplemental benefits paid out during the month;
  - (b) an explanation of any changes in the policy due to rider or supplemental benefits being paid out such as:
    - (i) death benefits; or
    - (ii) cash values; and
  - (c) the amount of the rider or supplemental benefits existing or remaining.

Enacted by Chapter 116, 2001 General Session

**31A-22-633 Exemptions from standards.**

Notwithstanding the provisions of Title 31A, Insurance Code, any accident and health insurer or health maintenance organization may offer a choice of coverage that is less or different than is otherwise required by applicable state law if:

- (1) the Department of Health offers a choice of coverage as part of a Medicaid waiver under Title 26, Chapter 18, Medical Assistance Act, which includes:
  - (a) less or different coverage than the basic coverage;
  - (b) less or different coverage than is otherwise required in an insurance policy or health maintenance organization contract under applicable state law; or
  - (c) less or different coverage than required by Subsection 31A-22-605(4)(b); and
- (2) the choice of coverage offered by the carrier:
  - (a) is the same or similar coverage as the coverage offered by the Department of Health under Subsection (1);
  - (b) is offered to the same or similar population as the coverage offered by the Department of Health under Subsection (1); and
  - (c) contains an explanation for each insured of coverage exclusions and limitations.

Amended by Chapter 167, 2013 General Session

**31A-22-634 Prohibition against certain use of Social Security number -- Exceptions -- Applicability of section.**

- (1) As used in this section:
  - (a) "Insurer" means:
    - (i) insurers governed by this part as described in Section 31A-22-600, and includes:
      - (A) a health maintenance organization; and
      - (B) a third-party administrator that is subject to this title; and
    - (ii) notwithstanding Subsection 31A-1-103(3)(f) and Section 31A-22-600, a health, dental, medical, Medicare supplement, or conversion program offered under Title 49, Chapter 20, Public Employees' Benefit and Insurance Program Act.
  - (b) "Publicly display" or "publicly post" means to intentionally communicate or otherwise make available to the general public.

- (2) An insurer or its subcontractors, including a pharmacy benefit manager, may not do any of the following:
  - (a) publicly display or publicly post in any manner an individual's Social Security number; or
  - (b) print an individual's Social Security number on any card required for the individual to access products or services provided or covered by the insurer.
- (3) This section does not prevent the collection, use, or release of a Social Security number as required by state or federal law, or the use of a Social Security number for internal verification or administrative purposes, or the release of a Social Security number to a health care provider for claims administration purposes, or as part of the verification, eligibility, or payment process.
- (4) If a federal law takes effect requiring the United States Department of Health and Human Services to establish a national unique patient health identifier program, an insurer that complies with the federal law shall be considered in compliance with this section.
- (5) An insurer shall comply with the provisions of this section by July 1, 2004.
- (6)
  - (a) An insurer may obtain an extension for compliance with the requirements of this section in accordance with Subsections (6)(b) and (c).
  - (b) The request for extension:
    - (i) shall be submitted in writing to the department prior to July 1, 2004; and
    - (ii) shall provide an explanation as to why the insurer cannot comply with the requirements of this section by July 1, 2004.
  - (c) The commissioner shall grant a request for extension:
    - (i) for a period of time not to exceed March 1, 2005; and
    - (ii) if the commissioner finds that the explanation provided under Subsection (6)(b)(ii) is a reasonable explanation.

Amended by Chapter 297, 2011 General Session

**31A-22-635 Uniform application -- Uniform waiver of coverage -- Information on Health Insurance Exchange.**

- (1) For purposes of this section, "insurer":
  - (a) is defined in Subsection 31A-22-634(1); and
  - (b) includes the state employee's risk pool under Section 49-20-202.
- (2)
  - (a) Insurers offering a health benefit plan to an individual or small employer shall use a uniform application form.
  - (b) The uniform application form:
    - (i) may not include questions about an applicant's health history; and
    - (ii) shall be shortened and simplified in accordance with rules adopted by the commissioner.
  - (c) Insurers offering a health benefit plan to a small employer shall use a uniform waiver of coverage form, which may not include health status related questions, and is limited to:
    - (i) information that identifies the employee;
    - (ii) proof of the employee's insurance coverage; and
    - (iii) a statement that the employee declines coverage with a particular employer group.
- (3) Notwithstanding the requirements of Subsection (2)(a), the uniform application and uniform waiver of coverage forms may, if the combination or modification is approved by the commissioner, be combined or modified to facilitate a more efficient and consumer friendly experience for:
  - (a) enrollees using the Health Insurance Exchange; or

- (b) insurers using electronic applications.
- (4) The uniform application form, and uniform waiver form, shall be adopted and approved by the commissioner in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.
- (5)
  - (a) An insurer who offers a health benefit plan on the Health Insurance Exchange created in Section 63N-11-104, shall:
    - (i) accept and process an electronic submission of the uniform application or uniform waiver from the Health Insurance Exchange using the electronic standards adopted pursuant to Section 63N-11-107;
    - (ii) if requested, provide the applicant with a copy of the completed application either by mail or electronically;
    - (iii) post all health benefit plans offered by the insurer in the defined contribution arrangement market on the Health Insurance Exchange; and
    - (iv) post the information required by Subsection (6) on the Health Insurance Exchange for every health benefit plan the insurer offers on the Health Insurance Exchange.
  - (b) Except as provided in Subsection (5)(c), an insurer who posts health benefit plans on the Health Insurance Exchange may not directly or indirectly offer products on the Health Insurance Exchange that are not health benefit plans.
  - (c) Notwithstanding Subsection (5)(b):
    - (i) an insurer may offer a health savings account on the Health Insurance Exchange;
    - (ii) an insurer may offer dental plans on the Health Insurance Exchange; and
    - (iii) the department may make administrative rules to regulate the offer of dental plans on the Health Insurance Exchange.
- (6) An insurer shall provide the commissioner and the Health Insurance Exchange with the following information for each health benefit plan submitted to the Health Insurance Exchange, in the electronic format required by Subsection 63N-11-107(1):
  - (a) plan design, benefits, and options offered by the health benefit plan including state mandates the plan does not cover;
  - (b) information and Internet address to online provider networks;
  - (c) wellness programs and incentives;
  - (d) descriptions of prescription drug benefits, exclusions, or limitations;
  - (e) the percentage of claims paid by the insurer within 30 days of the date a claim is submitted to the insurer for the prior year; and
  - (f) the claims denial and insurer transparency information developed in accordance with Subsection 31A-22-613.5(4).
- (7) The department shall post on the Health Insurance Exchange the department's solvency rating for each insurer who posts a health benefit plan on the Health Insurance Exchange. The solvency rating for each insurer shall be based on methodology established by the department by administrative rule and shall be updated each calendar year.
- (8)
  - (a) The commissioner may request information from an insurer under Section 31A-22-613.5 to verify the data submitted to the department and to the Health Insurance Exchange.
  - (b) The commissioner shall regulate the fees charged by insurers to an enrollee for a uniform application form or electronic submission of the application forms.

Amended by Chapter 283, 2015 General Session

**31A-22-636 Standardized health benefit plan cards.**

- (1) As used in this section, "insurer" means:
  - (a) an insurer governed by this part as described in Section 31A-22-600;
  - (b) a health maintenance organization governed by Chapter 8, Health Maintenance Organizations and Limited Health Plans;
  - (c) a third party administrator; and
  - (d) notwithstanding Subsection 31A-1-103(3)(f) and Section 31A-22-600, a health, medical, or conversion policy offered under Title 49, Chapter 20, Public Employees' Benefit and Insurance Program Act.
- (2) In accordance with Subsection (3), an insurer shall use and issue a health benefit plan information card for the insurer's enrollees upon the purchase or renewal of, or enrollment in, a health benefit plan on or after July 1, 2010.
- (3) The health benefit plan card shall include:
  - (a) the covered person's name;
  - (b) the name of the carrier and the carrier network name;
  - (c) the contact information for the carrier or health benefit plan administrator;
  - (d) general information regarding copayments and deductibles; and
  - (e) an indication of whether the health benefit plan is regulated by the state.
- (4)
  - (a) The commissioner shall work with the Department of Health, the Health Data Authority, health care providers groups, and with state and national organizations that are developing uniform standards for the electronic exchange of health insurance claims or uniform standards for the electronic exchange of clinical health records.
  - (b) When the commissioner determines that the groups described in Subsection (4)(a) have reached a consensus regarding the electronic technology and standards necessary to electronically exchange insurance enrollment and coverage information, the commissioner shall begin the rulemaking process under Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to adopt standardized electronic interchange technology.
  - (c) After rules are adopted under Subsection (4)(a), health care providers and their licensing boards under Title 58, Occupations and Professions, and health facilities licensed under Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act, shall work together to implement the adoption of card swipe technology.

Amended by Chapter 297, 2011 General Session

**31A-22-637 Health care provider payment information -- Notice of admissions.**

- (1) For purposes of this section, "insurer" is as defined in Section 31A-22-636.
- (2)
  - (a) An insurer shall provide its health care providers who are under contract with the insurer access to current information necessary for the health care provider to determine:
    - (i) the effect of procedure codes on payment or compensation before a claim is submitted for a procedure;
    - (ii) the plans and carrier networks that the health care provider is subject to as part of the contract with the carrier; and
    - (iii) in accordance with Subsection 31A-26-301.6(10)(f), the specific rate and terms under which the provider will be paid for health care services.
  - (b) The information required by Subsection (2)(a) may be provided through a website, and if requested by the health care provider, notice of the updated website shall be provided by the carrier.

- (3)
  - (a) An insurer may not require a health care provider by contract, reimbursement procedure, or otherwise to notify the insurer of a hospital in-patient emergency admission within a period of time that is less than one business day of the hospital in-patient admission, if compliance with the notification requirement would result in notification by the health care provider on a weekend or federal holiday.
  - (b) Subsection (3)(a) does not prohibit the applicability or administration of other contract provisions between an insurer and a health care provider that require pre-authorization for scheduled in-patient admissions.

Amended by Chapter 297, 2011 General Session

**31A-22-638 Coverage for prosthetic devices.**

- (1) For purposes of this section:
  - (a) "Orthotic device" means a rigid or semirigid device supporting a weak or deformed leg, foot, arm, hand, back, or neck, or restricting or eliminating motion in a diseased or injured leg, foot, arm, hand, back, or neck.
  - (b)
    - (i) "Prosthetic device" means an artificial limb device or appliance designed to replace in whole or in part an arm or a leg.
    - (ii) "Prosthetic device" does not include an orthotic device.
- (2)
  - (a) Beginning January 1, 2011, an insurer, other than an insurer described in Subsection (2)(b), that provides a health benefit plan shall offer at least one plan, in each market where the insurer offers a health benefit plan, that provides coverage for benefits for prosthetics that includes:
    - (i) a prosthetic device;
    - (ii) all services and supplies necessary for the effective use of a prosthetic device, including:
      - (A) formulating its design;
      - (B) fabrication;
      - (C) material and component selection;
      - (D) measurements and fittings;
      - (E) static and dynamic alignments; and
      - (F) instructing the patient in the use of the prosthetic device;
    - (iii) all materials and components necessary to use the prosthetic device; and
    - (iv) any repair or replacement of a prosthetic device that is determined medically necessary to restore or maintain the ability to complete activities of daily living or essential job-related activities and that is not solely for comfort or convenience.
  - (b) Beginning January 1, 2011, an insurer that is subject to Title 49, Chapter 20, Public Employees' Benefit and Insurance Program Act, shall offer to a covered employer at least one plan that:
    - (i) provides coverage for prosthetics that complies with Subsections (2)(a)(i) through (iv); and
    - (ii) requires an employee who elects to purchase the coverage described in Subsection (2)(b)(i) to pay an increased premium to pay the costs of obtaining that coverage.
  - (c) At least one of the plans with the prosthetic benefits described in Subsections (2)(a) and (b) that is offered by an insurer described in this Subsection (2) shall have a coinsurance rate, that applies to physical injury generally and to prosthetics, of 80% to be paid by the insurer

and 20% to be paid by the insured, if the prosthetic benefit is obtained from a person that the insurer contracts with or approves.

- (d) For policies issued on or after July 1, 2010 until July 1, 2015, an insurer is exempt from the 30% index rating restrictions in Section 31A-30-106.1, and for the first year only that coverage under this section is chosen, the 15% annual adjustment restriction in Section 31A-30-106.1, for any small employer with 20 or less enrolled employees who chooses coverage that meets or exceeds the coverage under this section.
- (3) The coverage described in this section:
  - (a) shall, except as otherwise provided in this section, be made subject to cost-sharing provisions, including dollar limits, deductibles, copayments, and co-insurance, that are not less favorable to the insured than the cost-sharing provisions of the health benefit plan that apply to physical illness generally; and
  - (b) may limit coverage for the purchase, repair, or replacement of a microprocessor component for a prosthetic device to \$30,000, per limb, every three years.
- (4) If the coverage described in this section is provided through a managed care plan, offered under Chapter 8, Health Maintenance Organizations and Limited Health Plans, or under a preferred provider plan under this chapter, the insured shall have access to medically necessary prosthetic clinical care, and to prosthetic devices and technology, from one or more prosthetic providers in the managed care plan's provider network.

Enacted by Chapter 360, 2010 General Session

**31A-22-639 Statement of preauthorization.**

- (1) An insurer who requires preauthorization or preapproval for coverage under accident and health insurance shall, beginning January 1, 2011, provide an enrollee with a statement of preauthorization if:
  - (a) the applicable CPT codes have been submitted to the insurer to determine whether a particular procedure is covered under the terms of the accident and health insurance policy;
  - (b) the enrollee has met the requirements for preauthorization of the procedure or encounter; and
  - (c) the enrollee requests a statement of preauthorization.
- (2) A statement of preauthorization under Subsection (1) may be sent:
  - (a) by mail; or
  - (b) electronically.
- (3) A statement of preauthorization shall include a statement that the preauthorization is:
  - (a) not a guarantee of payment by an insurer; and
  - (b) subject to the policy and contract provisions of the accident and health insurance contract.

Enacted by Chapter 204, 2010 General Session

**31A-22-640 Insurer and pharmacy benefit management services -- Registration -- Maximum allowable cost -- Audit restrictions.**

- (1) For purposes of this section:
  - (a) "Maximum allowable cost" means:
    - (i) a maximum reimbursement amount for a group of pharmaceutically and therapeutically equivalent drugs; or
    - (ii) any similar reimbursement amount that is used by a pharmacy benefit manager to reimburse pharmacies for multiple source drugs.

- (b) "Obsolete" means a product that may be listed in national drug pricing compendia but is no longer available to be dispensed based on the expiration date of the last lot manufactured.
- (c) "Pharmacy benefit manager" means a person or entity that provides pharmacy benefit management services as defined in Section 49-20-502 on behalf of an insurer as defined in Subsection 31A-22-636(1).
- (2) An insurer and an insurer's pharmacy benefit manager is subject to the pharmacy audit provisions of Section 58-17b-622.
- (3) A pharmacy benefit manager shall not use maximum allowable cost as a basis for reimbursement to a pharmacy unless:
  - (a) the drug is listed as "A" or "B" rated in the most recent version of the United States Food and Drug Administration's approved drug products with therapeutic equivalent evaluations, also known as the "Orange Book," or has an "NR" or "NA" rating or similar rating by a nationally recognized reference; and
  - (b) the drug is:
    - (i) generally available for purchase in this state from a national or regional wholesaler; and
    - (ii) not obsolete.
- (4) The maximum allowable cost may be determined using comparable and current data on drug prices obtained from multiple nationally recognized, comprehensive data sources, including wholesalers, drug file vendors, and pharmaceutical manufacturers for drugs that are available for purchase by pharmacies in the state.
- (5) For every drug for which the pharmacy benefit manager uses maximum allowable cost to reimburse a contracted pharmacy, the pharmacy benefit manager shall:
  - (a) include in the contract with the pharmacy information identifying the national drug pricing compendia and other data sources used to obtain the drug price data;
  - (b) review and make necessary adjustments to the maximum allowable cost, using the most recent data sources identified in Subsection (5)(a), at least once per week;
  - (c) provide a process for the contracted pharmacy to appeal the maximum allowable cost in accordance with Subsection (6); and
  - (d) include in each contract with a contracted pharmacy a process to obtain an update to the pharmacy product pricing files used to reimburse the pharmacy in a format that is readily available and accessible.
- (6)
  - (a) The right to appeal in Subsection (5)(c) shall be:
    - (i) limited to 21 days following the initial claim adjudication; and
    - (ii) investigated and resolved by the pharmacy benefit manager within 14 business days.
  - (b) If an appeal is denied, the pharmacy benefit manager shall provide the contracted pharmacy with the reason for the denial and the identification of the national drug code of the drug that may be purchased by the pharmacy at a price at or below the price determined by the pharmacy benefit manager.
- (7) The contract with each pharmacy shall contain a dispute resolution mechanism in the event either party breaches the terms or conditions of the contract.
- (8)
  - (a) To conduct business in the state, a pharmacy benefit manager shall register with the Division of Corporations and Commercial Code within the Department of Commerce and annually renew the registration. To register under this section, the pharmacy benefit manager shall submit an application which shall contain only the following information:
    - (i) the name of the pharmacy benefit manager;

- (ii) the name and contact information for the registered agent for the pharmacy benefit manager; and
- (iii) if applicable, the federal employer identification number for the pharmacy benefit manager.
- (b) The Department of Commerce may establish a fee in accordance with Title 63J, Chapter 1, Budgetary Procedures Act, for the initial registration and the annual renewal of the registration, which may not exceed \$100 per year.
- (c) The following entities do not have to register as a pharmacy benefit manager under Subsection (8)(a) when the entity is providing formulary services to its own patients, employees, members, or beneficiaries:
  - (i) a health care facility licensed under Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act;
  - (ii) a pharmacy licensed under Title 58, Chapter 17b, Pharmacy Practice Act;
  - (iii) a health care professional licensed under Title 58, Occupations and Professions;
  - (iv) a health insurer; and
  - (v) a labor union.
- (9) This section does not apply to a pharmacy benefit manager when the pharmacy benefit manager is providing pharmacy benefit management services on behalf of the state Medicaid program.

Amended by Chapter 258, 2015 General Session

**31A-22-641 Cancer treatment parity.**

- (1) For purposes of this section:
  - (a) "Cost sharing" means the enrollee's maximum out-of-pocket costs as defined by the health benefit plan.
  - (b) "Health insurer" is as defined in Subsection 31A-22-634(1).
  - (c) "Intravenously administered chemotherapy" means a physician-prescribed cancer treatment that is used to kill or slow the growth of cancer cells, that is administered through injection directly into the patient's circulatory system by a physician, physician assistant, nurse practitioner, nurse, or other medical personnel under the supervision of a physician, and in a hospital, medical office, or other clinical setting.
  - (d) "Oral chemotherapy" means a United States Food and Drug Administration-approved, physician-prescribed cancer treatment that is used to kill or slow the growth of cancer cells, that is taken orally in the form of a tablet or capsule, and may be administered in a hospital, medical office, or other clinical setting or may be delivered to the patient for self-administration under the direction or supervision of a physician outside of a hospital, medical office, or other clinical setting.
- (2) This section applies to health benefit plans renewed or entered into on or after October 1, 2013.
- (3) A health benefit plan that covers prescribed oral chemotherapy and intravenously administered chemotherapy shall:
  - (a) except as provided in Subsection (3)(b), ensure that the cost sharing applied to the covered oral chemotherapy is no more restrictive than the cost sharing applied to the covered intravenously administered chemotherapy; or
  - (b) if the cost sharing for oral chemotherapy is more restrictive than the cost sharing for intravenous chemotherapy, the health benefit plan may not apply cost sharing for the oral chemotherapy that exceeds \$300 per filled prescription.
- (4)

- (a) A health insurer shall not increase the cost sharing for intravenously administered chemotherapy for the purpose of achieving compliance with this section.
- (b) The commissioner may adopt administrative rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to enforce the provisions of this section.

Enacted by Chapter 164, 2013 General Session

**31A-22-642 Insurance coverage for autism spectrum disorder.**

(1) As used in this section:

- (a) "Applied behavior analysis" means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.
- (b) "Autism spectrum disorder" means pervasive developmental disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM).
- (c) "Behavioral health treatment" means counseling and treatment programs, including applied behavior analysis, that are:
  - (i) necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual; and
  - (ii) provided or supervised by a:
    - (A) board certified behavior analyst; or
    - (B) person licensed under Title 58, Chapter 1, Division of Occupational and Professional Licensing Act, whose scope of practice includes mental health services.
- (d) "Diagnosis of autism spectrum disorder" means medically necessary assessments, evaluations, or tests:
  - (i) performed by a licensed physician who is board certified in neurology, psychiatry, or pediatrics and has experience diagnosing autism spectrum disorder, or a licensed psychologist with experience diagnosing autism spectrum disorder; and
  - (ii) necessary to diagnose whether an individual has an autism spectrum disorder.
- (e) "Pharmacy care" means medications prescribed by a licensed physician and any health-related services considered medically necessary to determine the need or effectiveness of the medications.
- (f) "Psychiatric care" means direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices.
- (g) "Psychological care" means direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices.
- (h) "Therapeutic care" means services provided by licensed or certified speech therapists, occupational therapists, or physical therapists.
- (i) "Treatment for autism spectrum disorder":
  - (i) means evidence-based care and related equipment prescribed or ordered for an individual diagnosed with an autism spectrum disorder by a physician or a licensed psychologist described in Subsection (1)(d) who determines the care to be medically necessary; and
  - (ii) includes:
    - (A) behavioral health treatment, provided or supervised by a person described in Subsection (1)(c)(ii);
    - (B) pharmacy care;
    - (C) psychiatric care;
    - (D) psychological care; and

- (E) therapeutic care.
- (2) Notwithstanding the provisions of Section 31A-22-618.5, a health benefit plan offered in the individual market or the large group market and entered into or renewed on or after January 1, 2016, shall provide coverage for the diagnosis and treatment of autism spectrum disorder:
- (a) for a child who is at least two years old, but younger than 10 years old; and
  - (b) in accordance with the requirements of this section and rules made by the commissioner.
- (3) The commissioner may adopt rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to set the minimum standards of coverage for the treatment of autism spectrum disorder.
- (4) Subject to Subsection (5), the rules described in Subsection (3) shall establish durational limits, amount limits, deductibles, copayments, and coinsurance for the treatment of autism spectrum disorder that are similar to, or identical to, the coverage provided for other illnesses or diseases.
- (5)
- (a) Coverage for behavioral health treatment for a person with an autism spectrum disorder shall cover at least 600 hours a year. Other terms and conditions in the health benefit plan that apply to other benefits covered by the health benefit plan apply to coverage required by this section.
  - (b) Notwithstanding Subsection 31A-22-617(6), a health benefit plan providing treatment under Subsection (5)(a) shall include in the plan's provider network both board certified behavior analysts and mental health providers qualified under Subsection (1)(c)(ii).
- (6) A health care provider shall submit a treatment plan for autism spectrum disorder to the insurer within 14 business days of starting treatment for an individual. If an individual is receiving treatment for an autism spectrum disorder, an insurer shall have the right to request a review of that treatment not more than once every six months. A review of treatment under this Subsection (6) may include a review of treatment goals and progress toward the treatment goals. If an insurer makes a determination to stop treatment as a result of the review of the treatment plan under this subsection, the determination of the insurer may be reviewed under Section 31A-22-629.
- (7)
- (a) In accordance with Subsection (7)(b), the commissioner shall waive the requirements of this section for all insurers in the individual market or the large group market, if an insurer demonstrates to the commissioner that the insurer's entire pool of business in the individual market or the large group market has incurred claims for the autism coverage required by this section in a 12 consecutive month period that will cause a premium increase for the insurer's entire pool of business in the individual market or the large group market in excess of 1% over the insurer's premiums in the previous 12 consecutive month period.
  - (b) The commissioner shall waive the requirements of this section if:
    - (i) after a public hearing in accordance with Title 63G, Chapter 4, Administrative Procedures Act, the commissioner finds that the insurer has demonstrated to the commissioner based on generally accepted actuarial principles and methodologies that the insurer's entire pool of business in the individual market or the large group market will experience a premium increase of 1% or greater as a result of the claims for autism services as described in this section; or
    - (ii) the attorney general issues a legal opinion that the limits under Subsection (5)(a) cannot be implemented by an insurer in a manner that complies with federal law.
- (8) If a waiver is granted under Subsection (7), the insurer may:
- (a) continue to offer autism coverage under the existing plan until the next renewal period for the plan, at which time the insurer:

- (i) may delete the autism coverage from the plan without having to re-apply for the waiver under Subsection (7); and
  - (ii) file the plan with the commissioner in accordance with guidelines issued by the commissioner;
  - (b) discontinue offering plans subject to Subsection (2), no earlier than the next calendar quarter following the date the waiver is granted, subject to filing guidelines issued by the commissioner; or
  - (c) nonrenew existing plans that are subject to Subsection (2), in compliance with Subsection 31A-30-107(3)(d).
- (9) This section sunsets in accordance with Section 63I-1-231.

Enacted by Chapter 379, 2014 General Session

**31A-22-643 Prescription synchronization -- Copay and dispensing fee restrictions.**

- (1) For purposes of this section:
- (a) "Copay" means the copay normally charged for a prescription drug.
  - (b) "Health insurer" means an insurer, as defined in Subsection 31A-22-634(1).
  - (c) "Network pharmacy" means a pharmacy included in a health insurance plan's network of pharmacy providers.
  - (d) "Prescription drug" means a prescription drug, as defined in Section 58-17b-102, that is prescribed for a chronic condition.
- (2) A health insurance plan may not charge an amount in excess of the copay for the dispensing of a prescription drug in a quantity less than the prescribed amount if:
- (a) the pharmacy dispenses the prescription drug in accordance with the health insurer's synchronization policy; and
  - (b) the prescription drug is dispensed by a network pharmacy.
- (3) A health insurance plan that includes a prescription drug benefit:
- (a) shall implement a synchronization policy for the dispensing of prescription drugs to the plan's enrollees; and
  - (b) may not base the dispensing fee for an individual prescription on the quantity of the prescription drug dispensed to fill or refill the prescription unless otherwise agreed to by the plan and the contracted pharmacy at the time the individual requests synchronization.
- (4) This section applies to health benefit plans renewed or entered into on or after January 1, 2015.

Enacted by Chapter 111, 2014 General Session

**31A-22-644 Denial of coverage under a health benefit plan because of life expectancy or terminal condition.**

- (1) As used in this section:
- (a) "Health benefit plan" means the same as that term is defined in Section 31A-1-301.
  - (b) "Terminal condition" means an irreversible condition:
    - (i) caused by disease, illness, or injury; and
    - (ii) if:
      - (A) the irreversible condition will result in imminent death within a six-month period after the date the condition is diagnosed; and
      - (B) the application of life-sustaining treatment only prolongs the process of dying.
- (2) This section applies to a health benefit plan under:
- (a) this part; or

(b) Chapter 8, Health Maintenance Organizations and Limited Health Plans.

(3) Except as provided by law, and subject to the other provisions of this section, a health benefit plan may not deny coverage for medically necessary treatment if the medically necessary treatment is:

(a) prescribed by a physician;

(b) agreed to:

(i) by a person who is:

(A) insured under the health benefit plan; and

(B) fully informed regarding the person's life expectancy or diagnosis with a terminal condition; or

(ii) if the person described in Subsection (3)(b)(i) lacks legal capacity to consent, by another person who:

(A) has legal authority to consent on behalf of the person described in Subsection (3)(b)(i); and

(B) is fully informed regarding the life expectancy or diagnosis with a terminal condition of the person described in Subsection (3)(b)(i); and

(c) denied solely because:

(i) of the life expectancy of the person described in Subsection (3)(b)(i); or

(ii) the person has been diagnosed with a terminal condition.

(4) A denial of coverage described in Subsection (3) for medically necessary treatment is a violation of this section.

(5) Whether treatment is considered to be medically necessary treatment is determined by the defined standards and policies of the health benefit plan.

(6) This section may not be interpreted to:

(a) require an insurer to offer a particular benefit or service as part of a health benefit plan; or

(b) alter the clinical policies of a health benefit plan regarding the appropriate location for services.

(7) This section does not create a new or additional private right of action.

Enacted by Chapter 375, 2015 General Session