Effective 5/9/2017

Chapter 45
Managed Care Organizations

Part 1
General Provisions

31A-45-101 Title.

This chapter is known as "Managed Care Organizations."

Enacted by Chapter 292, 2017 General Session

31A-45-102 Definitions.

As used in this chapter:

(1) "Covered benefit" or "benefit" means the health care services to which a covered person is entitled under the terms of a health care insurance plan offered by a managed care organization.

(2) "Managed care organization" means:

(a) a managed care organization as that term is defined in Section 31A-1-301; and

(b) a third party administrator as that term is defined in Section 31A-1-301.

Amended by Chapter 193, 2019 General Session

31A-45-103 Managed care contract standards.

The commissioner shall adopt rules relating to standards for the manner and content of policy provisions, and disclosures to be made in connection with the sale of policies covered by this chapter, dealing with at least the following matters:

(1) terms of renewability;

(2) initial and subsequent conditions of eligibility;

(3) nonduplication of coverage provisions;

(4) coverage of dependents;

(5) termination of insurance;

(6) limitations;

(7) exceptions;

(8) reductions;

(9) definition of terms; and

(10) rating practices.

Enacted by Chapter 292, 2017 General Session

Part 2
Applicability to Other Provisions of Law

31A-45-201 Applicability to other provisions of law -- Commissioner discretion.

(1) Except for exemptions specifically granted under this title, a managed care organization is subject to regulation under all of the provisions of this title.

(2) The commissioner may by rule waive other specific provisions of this title that the commissioner considers inapplicable to managed care organizations, upon a finding that the waiver will not endanger the interests of:
(a) enrollees;
(b) investors;
(c) the public; or
(d) health care providers.

Enacted by Chapter 292, 2017 General Session

Part 3
Relationships with Providers

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

(1) A managed care organization may not contract with a health care provider for treatment of illness or injury unless the health care provider is licensed to perform that treatment. Every contract between a managed care organization and a network provider shall be in writing and shall set forth that if the managed care organization:
(a) fails to pay for health care services as set forth in the contract, the enrollee is not liable to the health care provider for any sums owed by the managed care organization; and
(b) becomes insolvent, the rehabilitator or liquidator may require the network provider to:
(i) continue to provide health care services under the contract between the network provider and the managed care organization until the earlier of:
(A) 90 days after the date of the filing of a petition for rehabilitation or a petition for liquidation; or
(B) the date the term of the contract ends; and
(ii) subject to Subsection (3), reduce the fees the network provider is otherwise entitled to receive from the managed care organization under the contract between the network provider and the managed care organization during the time period described in Subsection (1)(b)(i).

(2) If the conditions of Subsection (3) are met, the network provider:
(a) shall accept the reduced payment as payment in full; and
(b) as provided in Subsection (1)(a), may not collect additional amounts from the insolvent managed care organization's enrollee, except as may be owed under Subsection (3)(b).

(3) Notwithstanding Subsection (1)(b)(ii):
(a) the rehabilitator or liquidator may not reduce a fee to less than 75% of the regular fee set forth in the network provider contract; and
(b) the enrollee shall continue to pay the same copayments, deductibles, and other payments for services received from the network provider that the enrollee was required to pay before the filing of:
(i) the petition for rehabilitation; or
(ii) the petition for liquidation.

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

(a) is not in writing as required in Subsection (1); or
(b) fails to contain the language required by Subsection (1).
(5)
(a) A person listed in Subsection (5)(b) may not bill or maintain any action at law against an enrollee to collect:
(i) sums owed by the organization; or
(ii) the amount of the regular fee reduction authorized under Subsection (1)(b)(ii).
(b) Subsection (5)(a) applies to:
(i) a network provider;
(ii) an agent;
(iii) a trustee; or
(iv) an assignee of a person described in Subsections (5)(b)(i) through (iii).
(c) In any dispute involving a network provider's claim for reimbursement, the network provider's claim shall be determined in accordance with applicable law, the network provider contract, the enrollee contract, and the managed care organization's written payment policies in effect at the time services were rendered.
(d) If the parties are unable to resolve their dispute, the matter shall be subject to binding arbitration by a jointly selected arbitrator. Each party shall bear its own expense except that the cost of the jointly selected arbitrator shall be equally shared. This Subsection (5)(d) does not apply to the claim of a general acute hospital to the extent the claim is inconsistent with the hospital's provider agreement.
(e) A managed care organization may not penalize a network provider solely for pursuing a claims dispute or otherwise demanding payment for a sum believed owing.
(6) If a managed care organization permits another private entity with which the managed care organization does not share common ownership or control to use or otherwise lease one or more of the organization's networks that include network providers, the managed care organization shall ensure, at a minimum, that the entity pays the network providers included in the managed care organization's network in accordance with the same fee schedule and general payment policies as the managed care organization would pay for those network providers, unless payment for services is governed by a public program's fee schedule.

Enacted by Chapter 292, 2017 General Session

31A-45-302 Provider payment information -- Notice of admissions.
(1)
(a) A managed care organization shall provide the managed care organization's network providers access to current information necessary for the network 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 network provider is subject to as part of the contract with the managed care organization; and
(iii) in accordance with Subsection 31A-26-301.6(10)(f), the specific rate and terms under which the network provider will be paid for health care services.
(b) The information required by Subsection (1)(a) may be provided through a website, and if requested by the network provider, notice of the updated website shall be provided by the managed care organization.
(2)

(a) A managed care organization may not require a health care provider by contract, reimbursement procedure, or otherwise to notify the managed care organization of a hospital inpatient emergency admission within a period of time that is less than one business day of the hospital inpatient admission, if compliance with the notification requirement would result in notification by the health care provider on a weekend or federal holiday.
(b) Subsection (2)(a) does not prohibit the applicability or administration of other contract provisions between a managed care organization and a network provider that require preauthorization for scheduled inpatient admissions.

Enacted by Chapter 292, 2017 General Session

31A-45-303 Network provider contract provisions.

(1) Managed care organizations may provide for enrollees to receive services or reimbursement in accordance with this section.
(2)
(a) Subject to restrictions under this section, a managed care organization may enter into contracts with health care providers under which the health care providers agree to be a network provider and supply services, at prices specified in the contracts, to enrollees.
(b) A network provider contract shall require the network provider to accept the specified payment in this Subsection (2) as payment in full, relinquishing the right to collect amounts other than copayments, coinsurance, and deductibles from the enrollee.
(c) The insurance contract may reward the enrollee for selection of network providers by:
(i) reducing premium rates;
(ii) reducing deductibles;
(iii) coinsurance;
(iv) other copayments; or
(v) any other reasonable manner.
(3)
(a) When reimbursing for services of health care providers that are not network providers, the managed care organization may:
(i) make direct payment to the enrollee; and
(ii) impose a deductible on coverage of health care providers not under contract.
(b)
(i) Subsections (3)(b)(iii) and (c) apply to a managed care organization licensed under:
(A)Chapter 5, Domestic Stock and Mutual Insurance Corporations;
(B)Chapter 7, Nonprofit Health Service Insurance Corporations; or
(C)Chapter 14, Foreign Insurers; and
(ii) Subsections (3)(b)(iii) and (c) and Subsection (6)(b) do not apply to a managed care organization licensed under Chapter 8, Health Maintenance Organizations and Limited Health Plans.
(iii) When selecting health care providers with whom to contract under Subsection (2), a managed care organization described in Subsection (3)(b)(i) may not unfairly discriminate between classes of health care providers, but may discriminate within a class of health care providers, subject to Subsection (6).
(c) 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 managed care organization; and
(C) within the scope of practice of the class of health care providers.

(4) Before the enrollee consents to the insurance contract, the managed care organization shall fully disclose to the enrollee that the managed care organization has entered into network provider contracts. The managed care organization shall provide sufficient detail on the network provider contracts to permit the enrollee to agree to the terms of the insurance contract. The managed care organization 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 (5); and
(d) a description of the adverse benefit determination procedures required under Section 31A-22-629.

(5)
(a) A managed care organization using network provider contracts shall maintain a quality assurance program for assuring that the care provided by the network providers 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 managed care organization and the managed care organization's 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.

(6)
(a) A health care provider or managed care organization may not discriminate against a network provider for agreeing to a contract under Subsection (2).
(b)
(i) Subsections (6)(b) and (c) apply to a managed care organization that is described in Subsection (3)(b)(i) and do not apply to a managed care organization described in Subsection (3)(b)(ii).
(ii) A health care provider licensed to treat an illness or injury within the scope of the health care provider's practice, that is willing and able to meet the terms and conditions established by the managed care organization for designation as a network provider, shall be able to apply for and receive the designation as a network provider. Contract terms and conditions may include reasonable limitations on the number of designated network providers based upon substantial objective and economic grounds, or expected use of particular services based upon prior provider-patient profiles.
(c) Upon the written request of a provider excluded from a network provider contract, the commissioner may hold a hearing to determine if the managed care organization's exclusion of the provider is based on the criteria set forth in Subsection (6)(b).

(7) Nothing in this section is to be construed as to require a managed care organization to offer a certain benefit or service as part of a health benefit plan.
(8) Notwithstanding Subsection (2) or (6)(b), a managed care organization described in Subsection (3)(b)(i) 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 193, 2019 General Session

31A-45-304 Objective criteria for adding or terminating network providers -- Termination of contracts -- Review process.

(1)
(a) A managed care organization shall establish criteria for adding health care providers to a new or existing network provider panel.
(b) Criteria under Subsection (1)(a) may include:
(i) training, certification, and hospital privileges;
(ii) number of health care providers needed to adequately serve the managed care organization'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 managed care organization.
(c) A managed care organization 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, a managed care organization shall make a decision on a provider's application for participation within 120 days.
(e) If the provider applicant is rejected, the managed care organization shall inform the provider of the reason for the rejection relative to the criteria established in accordance with Subsection (1)(b).
(f) A managed care organization 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 managed care organization; or
(ii) the provider's referral patterns for patients who are not covered by the managed care organization.
(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 managed care organization 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, a managed care organization 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 managed care organization 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) Before termination for cause, the managed care organization:
(i) shall inform the provider of the intent to terminate and the grounds for doing so;

(ii) shall at the request of the provider, meet with the provider to discuss the reasons for termination;

(iii) if the managed care organization has a reasonable basis to believe that the provider may correct the conduct giving rise to the notice of termination, 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 managed care organization has a reasonable basis to believe that the provider has engaged in fraudulent conduct or poses a significant risk to patient care or safety, 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 managed care organization 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 managed care organization; or

(ii) the provider's referral patterns for patients who are not covered by the managed care organization.

(3) Notwithstanding any other section of this title, a managed care organization may not take adverse action against or reduce reimbursement to a network provider who is not under a capitated reimbursement arrangement because of the decision of an enrollee to access health care services from a non-network provider in a manner permitted by the enrollee's health insurance plan, regardless of how the plan is designated.

Renumbered and Amended by Chapter 292, 2017 General Session

31A-45-305 Prohibition on certain age-based physician testing.

A managed care organization or other third party may not require for purposes of reimbursement that a physician, as defined in Section 58-67-102, take a cognitive test when the physician reaches a specified age, unless the test reflects the standards described in Subsections 58-67-302(5)(b)(i) through (x).

Amended by Chapter 445, 2019 General Session

Part 4
Access to Services for Managed Care Enrollees

31A-45-401 Court ordered coverage for minor children who reside outside the service area.

(1)

(a) The requirements of Subsection (2) apply to a managed care organization if the managed care organization:
(i) restricts coverage for nonemergency services to services provided by contracted providers within the organization's service area; and
(ii) does not offer a benefit that permits members the option of obtaining covered services from a non-network provider.
(b) The requirements of Subsection (2) do not apply to a managed care organization if:
(i) the child is no longer the subject of a court or administrative support order; or
(ii) a parent's employer offers the parent a choice to select health insurance coverage that is not a managed care organization plan either at the time of the court or administrative support order, or at a subsequent open enrollment period. This exemption from Subsection (2) applies even if the parent ultimately chooses the managed care organization plan.
(2) If a parent is required by a court or administrative support order to provide health insurance coverage for a child who resides outside of a managed care organization's service area, the managed care organization shall:
(a) comply with the provisions of Section 31A-22-610.5;
(b) allow the enrollee parent to enroll the child on the organization plan;
(c) pay for otherwise covered health care services rendered to the child outside of the service area by a non-network provider:
(i) if the child, noncustodial parent, or custodial parent has complied with prior authorization or utilization review otherwise required by the organization; and
(ii) in an amount equal to the dollar amount the organization pays under a noncapitated arrangement for comparable services to a network provider in the same class of health care providers as the provider who rendered the services; and
(d) make payments on claims submitted in accordance with Subsection (2)(c) directly to the provider, custodial parent, the child who obtained benefits, or state Medicaid agency.
(3)
(a) The parents of the child who is the subject of the court or administrative support order are responsible for any charges billed by the provider in excess of those paid by the organization.
(b) This section does not affect any court or administrative order regarding the responsibilities between the parents to pay any medical expenses not covered by accident and health insurance or a managed care organization plan.
(4) The commissioner shall adopt rules as necessary to administer this section and Section 31A-22-610.5.

Amended by Chapter 193, 2019 General Session

31A-45-402 Alcohol and drug dependency treatment.
(1) A managed care organization offering a health benefit plan providing coverage for alcohol or drug dependency treatment may require an inpatient facility to be licensed by:
(a)
(i) the Department of Health and Human Services, under Title 26B, Chapter 2, Part 1, Human Services Programs and Facilities; or
(ii) the Department of Health and Human Services; or
(b) for an inpatient facility located outside the state, a state agency similar to one described in Subsection (1)(a).
(2) For inpatient coverage provided pursuant to Subsection (1), a managed care organization may require an inpatient facility to be accredited by the following:

(a) the Joint Commission; and
(b) one other nationally recognized accrediting agency.

Amended by Chapter 328, 2023 General Session

31A-45-403 Essential health benefits.

(1) The state designates the state's own essential health benefits and does not accept a federal determination of the essential health benefits under the PPACA.
(2) Subject to Subsections (3) and (4), the commissioner shall make rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, that designate the essential health benefits for the state.
(3) Before the commissioner makes rules in accordance with Subsection (2):
(a) the commissioner shall present a summary of the commissioner's planned rules to the Health Reform Task Force; and
(b) the Health Reform Task Force shall recommend whether the commissioner makes rules in accordance with the presented summary.
(4) The essential health benefits plan:
(a) may not include a state mandate if the inclusion of the state mandate would require the state to contribute to premium subsidies under the PPACA; and
(b) may add benefits in addition to the benefits included in a benchmark plan adopted in accordance with this section if the additional benefits are mandated under the PPACA.

Enacted by Chapter 319, 2018 General Session

Part 5
Network Adequacy

31A-45-501 Access to health care providers.

(1) As used in this section:
(a) "Class of health care provider" means a health care provider or a health care facility regulated by the state within the same professional, trade, occupational, or certification category established under Title 58, Occupations and Professions, or within the same facility licensure category established under Title 26B, Chapter 2, Part 2, Health Care Facility Licensing and Inspection.
(b) "Covered health care services" or "covered services" means health care services for which an enrollee is entitled to receive under the terms of a managed care organization contract.
(c) "Credentialed staff member" means a health care provider with active staff privileges at an independent hospital or federally qualified health center.
(d) "Federally qualified health center" means as defined in the Social Security Act, 42 U.S.C. Sec. 1395x.
(e) "Independent hospital" means a general acute hospital or a critical access hospital that:
(i) is either:
(A) located 20 miles or more from any other general acute hospital or critical access hospital; or
(B) licensed as of January 1, 2004;

(ii) is licensed pursuant to Title 26B, Chapter 2, Part 2, Health Care Facility Licensing and Inspection;
(iii) is controlled by a board of directors of which 51% or more reside in the county where the hospital is located; and
(iv)
(A) the hospital's board of directors is ultimately responsible for the policy and financial decisions of the hospital; or
(B) the hospital is licensed for 60 or fewer beds and is not owned, in whole or in part, by an entity that owns or controls a health maintenance organization if the hospital is a contracting facility of the organization.
(f) "Noncontracting provider" means an independent hospital, federally qualified health center, or credentialed staff member that has not contracted with a managed care organization to provide health care services to enrollees of the managed care organization.
(2) Except for a managed care organization that is under the common ownership or control of an entity with a hospital located within 10 paved road miles of an independent hospital, a managed care organization shall pay for covered health care services rendered to an enrollee by an independent hospital, a credentialed staff member at an independent hospital, or a credentialed staff member at his local practice location if:
(a) the enrollee:
(i) lives or resides within 30 paved road miles of the independent hospital; or
(ii) if Subsection (2)(a)(i) does not apply, lives or resides in closer proximity to the independent hospital than a contracting hospital;
(b) the independent hospital is located prior to December 31, 2000 in a county with a population density of less than 100 people per square mile, or the independent hospital is located in a county with a population density of less than 30 people per square mile; and
(c) the enrollee has complied with the prior authorization and utilization review requirements otherwise required by the managed care organization contract.
(3) A managed care organization shall pay for covered health care services rendered to an enrollee at a federally qualified health center if:
(a) the enrollee:
(i) lives or resides within 30 paved road miles of the federally qualified health center; or
(ii) if Subsection (3)(a)(i) does not apply, lives or resides in closer proximity to the federally qualified health center than a contracting provider;
(b) the federally qualified health center is located in a county with a population density of less than 30 people per square mile; and
(c) the enrollee has complied with the prior authorization and utilization review requirements otherwise required by the managed care organization contract.
(4)
(a) A managed care organization shall reimburse a noncontracting provider or the enrollee for covered services rendered pursuant to Subsection (2) a like dollar amount as the managed care organization pays to contracting providers under a noncapitated arrangement for comparable services.
(b) A managed care organization shall reimburse a federally qualified health center or the enrollee for covered services rendered pursuant to Subsection (3) a like amount as paid by the managed care organization under a noncapitated arrangement for comparable services to a contracting provider in the same class of health care providers as the provider who rendered the service.
(5)

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

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

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

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

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

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

(ii) is within 30 paved road miles of:

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

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

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

(8)

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

(b) Violations of this section include:

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

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

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

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

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

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

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

(ii) identify in rule:

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

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

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

(d)

(i) A managed care organization shall:

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

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

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

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

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

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

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

Amended by Chapter 328, 2023 General Session