Part 1
General Provisions

31A-8-101 Definitions.

For purposes of this chapter:

(1) "Basic health care services" means:
- (a) emergency care;
- (b) inpatient hospital and physician care;
- (c) outpatient medical services; and
- (d) out-of-area coverage.

(2) "Health maintenance organization" means any person:
- (a) other than:
  - (i) an insurer licensed under Chapter 7, Nonprofit Health Service Insurance Corporations; or
  - (ii) an individual who contracts to render professional or personal services that the individual directly performs; and
- (b) that:
  - (i) furnishes at a minimum, either directly or through arrangements with others, basic health care services to an enrollee in return for prepaid periodic payments agreed to in amount prior to the time during which the health care may be furnished; and
  - (ii) is obligated to the enrollee to arrange for or to directly provide available and accessible health care.

(3)
- (a) "Limited health plan" means, except as limited under Subsection (3)(b), a person who furnishes dental or vision services, either directly or through arrangements with others:
  - (i) to an enrollee;
  - (ii) in return for prepaid periodic payments agreed to in amount prior to the time during which the services may be furnished; and
  - (iii) for which the person is obligated to the enrollee to arrange for or directly provide the available and accessible services described in this Subsection (3)(a).
- (b) "Limited health plan" does not include:
  - (i) a health maintenance organization;
  - (ii) an insurer licensed under Chapter 7, Nonprofit Health Service Insurance Corporations; or
  - (iii) an individual who contracts to render professional or personal services that the individual performs.

(4)
- (a) "Nonprofit organization" or "nonprofit corporation" means an organization no part of the income of which is distributable to its members, trustees, or officers, or a nonprofit cooperative association, except in a manner allowed under Section 31A-8-406.
- (b) "Nonprofit health maintenance organization" and "nonprofit limited health plan" are used when referring specifically to one of the types of organizations with "nonprofit" status.

(5) "Organization" means a health maintenance organization and limited health plan, unless used in the context of:
- (a) "organization expenses," which is described in Section 31A-8-208.
- (b) "organization permit," which is described in Sections 31A-8-204 and 31A-8-206; or

(6) "Uncovered expenditures" means the costs of health care services that are covered by an organization for which an enrollee is liable in the event of the organization's insolvency.

(7) "Unusual or infrequently used health services" means those health services that are projected to involve fewer than 10% of the organization's enrollees' encounters with providers, measured on an annual basis over the organization's entire enrollment.

Amended by Chapter 292, 2017 General Session

31A-8-102 Scope and purposes.

(1) No person may operate an organization in this state without complying with and obtaining a certificate of authority under this chapter.

(2) The purposes of this chapter include to:

(a) provide for the establishment of health maintenance organizations which provide readily available, accessible, and quality comprehensive health care to their enrollees;

(b) provide for the establishment of limited health plans which provide readily available, accessible, and quality care to their enrollees;

(c) encourage the development of organizations as an alternative method of health care delivery; and

(d) assure that organizations offering health plans within this state are financially and administratively sound and that these organizations are in fact able to deliver the benefits as promised.

Enacted by Chapter 204, 1986 General Session

31A-8-103 Applicability to other provisions of law.

(1)

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

(b) Notwithstanding any provision of this title, an organization licensed under this chapter:

(i) is wholly exempt from:

(A)Chapter 7, Nonprofit Health Service Insurance Corporations;

(B)Chapter 9, Insurance Fraternals;

(C)Chapter 10, Annuities;

(D)Chapter 11, Motor Clubs;

(E)Chapter 12, State Risk Management Fund; and

(F)Chapter 19a, Utah Rate Regulation Act; and

(ii) is not subject to:

(A)Chapter 3, Department Funding, Fees, and Taxes, except for Part 1, Funding the Insurance Department;

(B) Section 31A-4-107;

(C)Chapter 5, Domestic Stock and Mutual Insurance Corporations, except for provisions specifically made applicable by this chapter;

(D)Chapter 14, Foreign Insurers, except for provisions specifically made applicable by this chapter;

(E)Chapter 17, Determination of Financial Condition, except:

(I)Part 2, Qualified Assets, and Part 6, Risk-Based Capital; or

(II) as made applicable by the commissioner by rule consistent with this chapter;

(F)Chapter 18, Investments, except as made applicable by the commissioner by rule consistent with this chapter; and

(G) Chapter 22, Contracts in Specific Lines, except for Part 6, Accident and Health Insurance, Part 7, Group Accident and Health Insurance, and Part 12, Reinsurance.

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

(3) Title 16, Chapter 6a, Utah Revised Nonprofit Corporation Act, and Title 16, Chapter 10a, Utah Revised Business Corporation Act, do not apply to an organization except as specifically made applicable by:
(a) this chapter;
(b) a provision referenced under this chapter; or
(c) a rule adopted by the commissioner to deal with corporate law issues of health maintenance organizations that are not settled under this chapter.

(4)
(a) Whenever in this chapter, Chapter 5, Domestic Stock and Mutual Insurance Corporations, or Chapter 14, Foreign Insurers, is made applicable to an organization, the application is:
(i) of those provisions that apply to a mutual corporation if the organization is nonprofit; and
(ii) of those that apply to a stock corporation if the organization is for profit.
(b) When Chapter 5, Domestic Stock and Mutual Insurance Corporations, or Chapter 14, Foreign Insurers, is made applicable to an organization under this chapter, "mutual" means nonprofit organization.

(5) Solicitation of enrollees by an organization is not a violation of any provision of law relating to solicitation or advertising by health professionals if that solicitation is made in accordance with:
(a) this chapter; and
(b) Chapter 23a, Insurance Marketing - Licensing Producers, Consultants, and Reinsurance Intermediaries.

(6) This title does not prohibit any health maintenance organization from meeting the requirements of any federal law that enables the health maintenance organization to:
(a) receive federal funds; or
(b) obtain or maintain federal qualification status.

(7) Except as provided in Chapter 45, Managed Care Organizations, an organization is exempt from statutes in this title or department rules that restrict or limit the organization's freedom of choice in contracting with or selecting health care providers, including Section 31A-22-618.

(8) An organization is exempt from the assessment or payment of premium taxes imposed by Sections 59-9-101 through 59-9-104.

Amended by Chapter 391, 2018 General Session

31A-8-104 Determination of ability to provide services.

(1) The commissioner may not issue a certificate of authority to an applicant for a certificate of authority under this chapter unless the applicant demonstrates to the commissioner that the applicant has:
(a) the willingness and potential ability to furnish the proposed health care services in a manner to assure both availability and accessibility of adequate personnel and facilities and continuity of service; and

(b) arrangements for an ongoing quality of health care assurance program concerning health care processes and outcomes.

(2)

(a) In accordance with Sections 31A-2-203 and 31A-2-204, the commissioner may order an independent audit or examination by one or more technical experts to determine an applicant's ability to provide the proposed health care services as described in Subsection (1).

(b) In accordance with Section 31A-2-205, an applicant shall reimburse the commissioner for the reasonable cost of an independent audit or examination.

(3) Licensing under this chapter does not exempt an organization from any licensing requirement applicable under Title 26B, Chapter 2, Part 2, Health Care Facility Licensing and Inspection.

Amended by Chapter 327, 2023 General Session

31A-8-105 General powers of organizations.

Organizations may:

(1) buy, sell, lease, encumber, construct, renovate, operate, or maintain hospitals, health care clinics, other health care facilities, and other real and personal property incidental to and reasonably necessary for the transaction of the business and for the accomplishment of the purposes of the organization;

(2) furnish health care through providers which are under contract with the organization;

(3) contract with insurance companies licensed in this state or with health service corporations authorized to do business in this state for insurance, indemnity, or reimbursement for the cost of health care furnished by the organization;

(4) offer to its enrollees, in addition to health care, insured indemnity benefits, but only for emergency care, out-of-area coverage, unusual or infrequently used health services as defined in Section 31A-8-101, and adoption benefits as provided in Section 31A-22-610.1;

(5) receive from governmental or private agencies payments covering all or part of the cost of the health care furnished by the organization;

(6) lend money to a medical group under contract with it or with a corporation under its control to acquire or construct health care facilities or for other uses to further its program of providing health care services to its enrollees;

(7) be owned jointly by health care professionals and persons not professionally licensed without violating Utah law; and

(8) do all other things necessary for the accomplishment of the purposes of the organization.

Amended by Chapter 329, 1998 General Session

31A-8-105.5 Primary care physicians.

With regard to participating providers who are physicians who are members of the American College of Obstetrics and Gynecology, organizations operating under this chapter shall:

(1) permit a female enrollee to receive at least one outpatient examination per year from the enrollee's choice of one of those participating providers. An organization may not require the enrollee to receive a preapproval, preauthorization, or referral from the enrollee's primary care physician before receiving this examination; and

(2) clearly state in the organization's health benefit plan literature that enrollees may seek the care described in Subsection (1) without preapproval, preauthorization, or referral from the patient's primary care physician.

Amended by Chapter 10, 1997 General Session

31A-8-106 Other business.

No organization may engage, directly or indirectly, in any business other than that of an organization and business reasonably incidental to that business.

Enacted by Chapter 204, 1986 General Session

31A-8-107 Documents as evidence.

Section 31A-5-105 applies to documents as evidence in organizations.

Enacted by Chapter 204, 1986 General Session

31A-8-108 Unauthorized assumption of corporate power.

Section 31A-5-106 applies to the unauthorized assumption of corporate power in organizations.

Enacted by Chapter 204, 1986 General Session