

R590. Insurance, Administration.

R590-76. Health Maintenance Organizations and Limited Health Plans.

R590-76-1. Authority.

This rule is issued pursuant to the authority set forth in Title 31A, Chapter 8, Health Maintenance Organizations (HMOs) and Limited Health Plans.

R590-76-2. Purpose.

The purpose of this rule is to implement Chapter 8 of Title 31A to assure the availability, accessibility and quality of services provided by HMOs and to provide reasonable standards for terms and provisions contained in HMO group and individual contracts and evidences of coverage.

R590-76-3. Applicability and Scope.

This rule applies to all organizations defined in 31A-8-101(8). In the event of conflict between the provisions of this regulation and the provisions of any other regulation issued by the commissioner, the provisions of this regulation shall be controlling. This rule also applies to all HMO contracts covering individuals and groups issued or renewed and effective on or after January 1, 2003.

R590-76-4. HMO Definitions.

A group or individual contract and evidence of coverage delivered or issued for delivery to any person in this state by an HMO required to obtain a certificate of authority in this state shall contain definitions respecting the matters set forth below.

The definitions shall comply with the requirements of this section. Definitions other than those set forth in this regulation may be used as appropriate providing that they do not contradict these requirements. As used in this regulation and as used in the group or individual contract and evidence of coverage:

(1) "Coinsurance" is the enrollee's cost-sharing amount expressed as a percentage of covered charges.

(2) "Copayment" means, other than coinsurance, the amount an enrollee must pay in order to receive a specific service that is not fully prepaid.

(3) "Deductible" means the amount an enrollee is responsible to pay out-of-pocket before the HMO begins to pay the costs or provide the services associated with treatment.

(4) "Directors" mean the executive director of Department of Health or his authorized representative, and the director of the Health Division of the Utah Insurance Department.

(5) "Eligible dependent" means any member of an enrollee's family who meets the eligibility requirements set forth in the contract.

(6) "Emergency care services" means services for an emergency medical condition as defined in 31A-22-627(3).

(a) Within the service area, emergency care services shall include covered health care services from non-affiliated providers only when delay in receiving care from the HMO could reasonably be expected to cause severe jeopardy to the enrollee's condition.

(b) Outside the service area, emergency care services include medically necessary health care services that are immediately required because of unforeseen illness or injury while the enrollee is outside the geographical limits of the HMO's service area.

(7) "Evidence of coverage" means a certificate or a statement of the essential features and services of the HMO coverage that is given to the subscriber by the HMO or by the group contract holder.

(8) "Facility" means an institution providing health care services or a health care setting, including but not limited to hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings which operate within their specific licensure requirements.

(9) "Grievance" means a written complaint submitted in accordance with the HMO's formal grievance procedure by or on behalf of the enrollee regarding any aspect of the HMO relative to the enrollee.

(10) "Group contract" means a contract for health care services by which its terms limit eligibility to enrollees of a specified group.

(11) "Group contract holder" means the person to which a group contract has been issued.

(12) "Incidental coverage" means a contract or endorsement offered by an HMO that provides limited health plan benefits as defined in Subsection 31A-8-101(6)(a).

(13) "Individual contract" means a contract for health care services issued to and covering an individual. The individual contract may include coverage for dependents of the subscriber.

~~(14)~~ [(13)] "Medical necessity" or "medically necessary" means:

(a) Health care services or products that a prudent health care professional would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is:

(i) in accordance with generally accepted standards of medical practice in the United States;

(ii) clinically appropriate in terms of type, frequency, extent, site, and duration;

(iii) not primarily for the convenience of the patient, physician, or other health care provider; and

(iv) covered under the contract; and

(b) when a medical question-of-fact exists medical necessity shall include the most appropriate available supply or level of service for the individual in question, considering potential benefits and harms to the individual, and known to be effective.

(i) For interventions not yet in widespread use, the effectiveness shall be based on scientific evidence.

(ii) For established interventions, the effectiveness shall be based on:

(a) scientific evidence;

(b) professional standards; and

(c) expert opinion.

(15) [~~(14)~~] "Out-of-area services" means the health care services that an HMO covers when its enrollees are outside of the service area.

(16) [~~(15)~~] "Physician" means a duly licensed doctor of medicine or osteopathy practicing within the scope of the license.

(17) [~~(16)~~] "Primary care physician" means a physician who supervises, coordinates, and provides initial and basic care to enrollees, and who initiates their referral for specialist care and maintains continuity of patient care.

(18) [~~(17)~~] "Scientific evidence" means:

(a) scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff; or

(b) findings, studies or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes.

(c) Scientific evidence shall not include published peer-reviewed literature sponsored to a significant extent by a pharmaceutical manufacturing company or medical device manufacturer or a single study without other supportable studies.

(19) [~~(18)~~] "Service area" means the geographical area within a 40-mile radius of the HMO's health care facility.

(20) [~~(19)~~] "Subscriber" means an individual whose employment or other status, except family dependency, is the basis for eligibility for enrollment in the HMO, or in the case of an individual contract, the person in whose name the contract is issued.

R590-76-5. Requirements for HMO Contracts and Evidence of Coverage.

(1)(a) Individual contracts. Each subscriber shall be entitled to receive an individual contract and evidence of coverage in a form that has been filed with the commissioner.

(b) Group contracts. Each group contract holder shall be entitled to receive a group contract that has been filed with the commissioner.

(c) Group contracts, individual contracts and evidences of coverage shall be delivered or issued for delivery to subscribers or group contract holders within a reasonable time after enrollment, but not more than 30 days from the later of the effective date of coverage or the date on which the HMO is notified of enrollment.

(2) HMO information. The group or individual contract and evidence of coverage shall contain the name, address and telephone number of the HMO, and where and in what manner information is available as to how services may be obtained. A telephone number within the service area for calls, without charge to members, to the HMO's administrative office shall be made available and disseminated to enrollees to adequately provide telephone access for enrollee services, problems or questions. The group or individual contract and evidence of coverage may indicate the

manner in which the number will be disseminated rather than list the number itself.

(3) Eligibility requirements. The group or individual contract and evidence of coverage shall contain eligibility requirements indicating the conditions that shall be met to enroll. The forms shall include a clear statement regarding coverage of dependents and newborn children.

(4) Benefits and services within the service area. The group or individual contract and evidence of coverage shall contain a specific description of benefits and services available within the service area.

(5) Emergency care benefits and services. The group or individual contract and evidence of coverage shall contain a specific description of benefits and services available for emergencies 24 hours a day, 7 days a week, including disclosure of any restrictions on emergency care services. No group or individual contract and evidence of coverage shall limit the coverage of emergency services within the service area to affiliated providers only.

(6) Out-of-area benefits and services. Other than emergency care, if benefits and services are covered outside the service area, a group or individual contract and evidence of coverage shall contain a specific description of that coverage.

(7) Copayments, coinsurance, and deductibles. The group or individual contract and evidence of coverage shall contain a description of any copayments, coinsurance, or deductibles that must be paid by enrollees.

(8) Limitations and exclusions. The group or individual contract and evidence of coverage shall contain a description of any limitations or exclusions on the services or benefits, including any limitations or exclusions due to preexisting conditions or waiting periods.

(9) Claims procedures. The group or individual contract and evidence of coverage shall contain procedures for filing claims that include:

- (a) any required notice to the HMO;
- (b) any required claim forms, including how, when and where to obtain them;
- (c) any requirements for filing proper proofs of loss;
- (d) any time limit of payment of claims;
- (e) notice of any provisions for resolving disputed claims, including arbitration; and
- (f) a statement of restrictions, if any, on assignment of sums payable to the enrollee by the HMO.

(10) Enrollee grievance procedures and arbitration. In compliance with R590-76-8(4), the group or individual contract and evidence of coverage shall contain a description of the HMO's method for resolving enrollee grievances, including procedures to be followed by the enrollee in the event any dispute arises under the contract, including any provisions for arbitration.

(11) Extension and conversion of coverage. A group contract, and evidence of coverage shall contain a conversion provision which provides each enrollee the right to a conversion policy and/or extend coverage to a contract as set forth in Chapter 22 of

Title 31A, Part VII.

(12) Coordination of benefits. The group or individual contract and evidence of coverage may contain a provision for coordination of benefits that shall be consistent with that applicable to other carriers in the jurisdiction. Any provisions or rules for coordination of benefits established by an HMO shall not relieve an HMO of its duty to provide or arrange for a covered health care service to an enrollee because the enrollee is entitled to coverage under any other contract, policy or plan, including coverage provided under government programs.

(13) Description of the service area. The group or individual contract and evidence of coverage shall contain a description of the service area.

(14) Entire contract provision. The group or individual contract shall contain a statement that the contract, all applications and any amendments thereto shall constitute the entire agreement between the parties. No portion of the charter, bylaws or other document of the HMO shall be part of the contract unless set forth in full in the contract or attached to it. However, the evidence of coverage may be attached to and made a part of the group contract.

(15) Term of coverage. The group or individual contract and evidence of coverage shall contain the time and date or occurrence upon which coverage takes effect, including any applicable waiting periods, or describe how the time and date or occurrence upon which coverage takes effect is determined. The contract and evidence of coverage shall also contain the time and date or occurrence upon which coverage will terminate.

(16) Cancellation or termination. The group or individual contract and evidence of coverage shall contain the conditions upon which cancellation or termination may be effected by the HMO, the group contract holder or the subscriber.

(17) Renewal. The group or individual contract and evidence of coverage shall contain the conditions for, and any restrictions upon, the subscriber's right to renewal.

(18) Reinstatement of group or individual contract holder. If an HMO permits reinstatement of a group or individual, the contract and evidence of coverage shall include any terms and conditions concerning reinstatement. The contract and evidence of coverage may state that all reinstatements are at the option of the HMO and that the HMO is not obligated to reinstate any terminated contract.

(19) Conformity with State Law. A group or individual contract and evidence of coverage delivered or issued for delivery in this state shall include a provision that states that any provision not in conformity with Chapter 8 of Title 31A, this regulation or any other applicable law or regulation in this state shall not be rendered invalid but shall be construed and applied as if it were in full compliance with the applicable laws and regulations of this state.

(20) Definitions. All definitions used in the group or individual contract and evidence of coverage shall be in alphabetical order.

R590-76-6. Unfair Discrimination.

An HMO shall not unfairly discriminate against an enrollee or applicant for enrollment on the basis of the age, sex, race, color, creed, national origin, ancestry, religion, marital status or lawful occupation of an enrollee, or because of the frequency of utilization of services by an enrollee. An HMO shall not expel or refuse to re-enroll any enrollee nor refuse to enroll individual members of a group on the basis of an individual's or enrollee's health status or health care needs, except for a policy which contains a lifetime policy maximum and such maximum has been reached. However, nothing shall prohibit an HMO from setting rates, establishing a schedule of charges in accordance with actuarially sound and appropriate data, or appropriately applying policy provisions in compliance with the Utah Insurance Code.

R590-76-7. HMO Services.

(1) Access to Care.

(a) An HMO shall establish and maintain adequate arrangements to provide health services for its enrollees, including:

(i) reasonable proximity to the business or personal residences of the enrollees so as not to result in unreasonable barriers to accessibility;

(ii) reasonable hours of operation and after-hours services;

(iii) emergency care services available and accessible within the service area 24 hours a day, 7 days a week; and

(iv) sufficient providers, personnel, administrators and support staff to assure that all services contracted for will be accessible to enrollees on an appropriate basis without delays detrimental to the health of enrollees.

(b) If a primary care physician is required in order to obtain covered services, an HMO shall make available to each enrollee a primary care physician and provide accessibility to medically necessary specialists through staffing, contracting or referral.

(c) An HMO shall have written procedures governing the availability of services utilized by enrollees, including at least the following:

(i) well-patient examinations and immunizations;

(ii) treatment of emergencies;

(iii) treatment of minor illness; and

(iv) treatment of chronic illnesses.

(2) Basic health care services. An HMO shall provide, or arrange for the provision of, as a minimum, basic health care services, which shall include the following:

(a) emergency care services;

(b) inpatient hospital services, meaning medically necessary hospital services including:

(i) room and board;

(ii) general nursing care;

(iii) special diets when medically necessary;

(iv) use of operating room and related facilities;

(v) use of intensive care units and services;

(vi) x-ray, laboratory and other diagnostic tests;

(vii) drugs, medications, biologicals;

- (viii) anesthesia and oxygen services;
- (ix) special nursing when medically necessary;
- (x) physical therapy, radiation therapy and inhalation therapy;
- (xi) administration of whole blood and blood plasma; and
- (xii) short-term rehabilitation services;
- (c) inpatient physician care services, meaning medically necessary health care services performed, prescribed, or supervised by physicians or other providers including diagnostic, therapeutic, medical, surgical, preventive, referral and consultative health care services;
- (d) Outpatient medical services, meaning preventive and medically necessary health care services provided in a physician's office, a non-hospital-based health care facility or at a hospital. Outpatient medical services shall include:
 - (i) diagnostic services;
 - (ii) treatment services;
 - (iii) laboratory services;
 - (iv) x-ray services;
 - (v) referral services;
 - (vi) physical therapy, radiation therapy and inhalation therapy; and
 - (vii) preventive health services, which shall include at least a range of services for the diagnosis of infertility, well-child care from birth, periodic health evaluations for adults, screening to determine the need for vision and hearing correction, and pediatric and adult immunizations in accordance with accepted medical practice;
- (e) Coverage of inborn metabolic errors as required by 31A-22-623 and Rule R590-194, Coverage of Dietary Products for Inborn Errors of Amino Acid or Urea Cycle Metabolism, and benefits for diabetes as required by 31A-22-626 and Rule R590-200, Diabetes Treatment and Management.

(3) Out-of-area benefits and services. Other than emergency care, if the contract provides out-of-area services, they shall be subject to the same copayment, coinsurance, and deductible requirements set forth in R590-76-5(7).

(4)(a) An HMO may offer a contract or endorsement that provides incidental coverage.

(b) An incidental coverage contract or endorsement is exempt from the basic health care services and emergency care requirements set forth in this rule.

(c) An HMO offering an incidental benefit contract or endorsement may offer all of the basic health care services.

R590-76-8. Other HMO Requirements.

(1) Provider lists.

(a) An HMO shall provide its subscribers with a list of the names and locations of all of its providers no later than the time of enrollment or the time the group or individual contract and evidence of coverage are issued and upon reenrollment.

(b) Upon notification to an HMO that a provider is no longer affiliated, the HMO shall within 30 days:

(i) notify enrollees who are receiving ongoing care; and

(ii) update any applicable web site provider lists.

(c) Subject to the approval of the commissioner, an HMO may provide its subscribers with a list of providers or provider groups for a segment of the service area. However, a list of all providers shall be made available to subscribers upon request.

(d) Provider lists shall contain a notice regarding the availability of the listed primary care physicians. The notice shall be in not less than 12-point type and be placed in a prominent place on the list of providers. The notice shall contain the following or similar language:

"Enrolling in (name of HMO) does not guarantee services by a particular provider on this list. If you wish to receive care from specific providers listed, you should contact those providers to be sure that they are accepting additional patients for (name of HMO)."

(2) Description of the services area. An HMO shall provide its subscribers with a description of its service area no later than the time of enrollment or the time the group or individual contract and evidence of coverage are issued and upon request thereafter. If the description of the service area is changed, the HMO shall provide at such time a new description of the service area to its affected subscribers within 30 days.

(3) Copayments, coinsurance, and deductibles. An HMO may require copayments, coinsurance, or deductibles of enrollees as a condition for the receipt of health care services. Copayments, coinsurance, and deductibles shall be the only allowable charge, other than premiums, insurers may assess to subscribers, unless otherwise allowed by law.

(4) Grievance procedure. A grievance procedure in compliance with 31A-22-629 and Rule R590-203, Health Care Benefit Plans-Grievance and Voluntary Independent Review Procedures Rule, to resolve an adverse benefit determination, shall be established and maintained by an HMO to provide reasonable procedures for the prompt and effective resolution of written grievances.

(5) Provider contracts. All provider contracts must be on file and available for review by the commissioner and the director of the UDOH.

R590-76-9. Quality Assurance.

(1) Quality assurance plan.

(a) Each HMO shall develop a quality assurance plan. The plan shall be designed to objectively and systematically monitor and evaluate the quality and appropriateness of patient care, pursue opportunities to improve patient care, and resolve identified problems.

(b) Certification of quality assurance plan.

(i) A new HMO shall arrange and pay for a review and certification of its quality assurance plan no later than 18 months after receiving a Certificate of Authority and commencing operation.

(ii) An existing HMO shall arrange a pay for a review and certification of its quality assurance plan every three years unless required sooner by the certifying entity.

(iii) Reviews shall be conducted by the National Committee

of Quality Assurance (NCQA), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the American Accreditation HealthCare Commission (URAC), formerly known as the Utilization Review Accreditation Commission, Health Insight, or other entities as approved by the commissioner. Reviews conducted for the federal government shall satisfy these requirements if the requirements of this subsection are met.

(iv) Each HMO shall arrange for the directors to receive a copy of the review findings, recommendations, and certification, or notice of non-approval, of the quality assurance plan. This material shall be sent directly from the certifying entity to the directors. Certification status and review materials will be maintained as a protected record by the directors.

(v) Each HMO shall implement clinical and procedural requirements made by the certifying entity after the findings are received by the HMO.

(c) Each year on or before July 1, an HMO shall file to the directors a written report of the effectiveness of its internal quality control. The report must include a copy of the HMO's quality assurance plan.

(2) Quality assurance audits. The commissioner may audit an HMO's quality control system. Such audit shall be performed by qualified persons designated by the commissioner.

(a) The HMO shall comply with reasonable requests for information required for the audit and necessary to:

(i) measure health care outcomes according to established medical standards;

(ii) evaluate the process of providing or arranging for the provision of patient care;

(iii) evaluate the system the HMO uses to conduct concurrent reviews and preauthorized medical care;

(iv) evaluate the system the HMO uses to conduct retrospective reviews of medical care; and

(v) evaluate the accessibility and availability of medical care provided or arranged for by the HMO.

(b) Information furnished shall only be used in accordance with 31A-8-404.

(3) Internal peer review. The HMO shall show written evidence of continuing internal peer reviews of medical care given. The program must provide for review by physicians and other health professionals; have direct accountability to senior management; and have resources specifically budgeted for quality assessment, monitoring, and remediation.

R590-76-10. Reporting Requirements and Fee Payments.

Section 31A-3-103 and 31A-4-113 apply to organizations. Both types of entities shall submit their annual reports on the National Association of Insurance Commissioner's (NAIC) blanks that have been adopted for HMOs. In addition, all HMOs shall submit the information asked for in the annual statistical report required by the UDOH. The annual statement blank will be filed with the Insurance Department and the UDOH by March 1 each year.

R590-76-11. Financial Condition.

(1) Qualified assets. In determining the financial condition of any organization, only the following assets may be used:

(a) assets as determined to be admitted in the Accounting Practices and Procedures Manual published by the NAIC; and

(b) other assets, not inconsistent with the foregoing provisions, deemed by the commissioner available for the provision of health care, at values determined by him/her.

(2) Investments. Investments of organizations shall be consistent with Title 31A, Chapter 18.

(3) Liability insurance. Evidence of adequate general liability and professional liability insurance, or a plan for self-insurance approved by the commissioner, must be maintained by the organization. Organizations may only contract with providers of health services that have liability insurance.

R590-76-12. Enforcement Date.

The commissioner will begin enforcing the revised provisions of this rule 45 days from the rule's effective date. [~~Effective January 1, 2003, the department will enforce this rule.~~]

R590-76-13. Severability.

If any provision or clause of this rule or its application to any person or situation is held invalid, such invalidity shall not affect any other provision or application of this rule which can be given effect without the invalid provision or application, and to this end the provisions of this rule are declared to be severable.

KEY: HMO insurance

Date of Enactment or Last Substantive Amendment: [~~February 26, 2003~~] **2009**

Notice of Continuation: September 23, 2004

Authorizing, and Implemented or Interpreted Law: 31A-2-201