State of Utah
Administrative Rule Analysis
Revised November 2021

NOTICE OF PROPOSED RULE		
TYPE OF RULE: New ___; Amendment _x_; Repeal ___; Repeal and Reenact ___		
	Title No. - Rule No. - Section No.	
Utah Admin. Code Ref (R no.):	**R590-203**	**Filing ID (Office Use Only)**
Changed to Admin. Code Ref. (R no.):	**R**	

Agency Information

1. Department:	Insurance	
Agency:	Administration	
Room no.:	Suite 2300	
Building:	Taylorsville State Office Building	
Street address:	4315 S. 2700 W.	
City, state and zip:	Taylorsville, UT 84129	
Mailing address:	PO Box 146901	
City, state and zip:	Salt Lake City, UT 84114-6901	
Contact person(s):		
Name:	**Phone:**	**Email:**
Steve Gooch	801-957-9322	sgooch@utah.gov
Please address questions regarding information on this notice to the agency.		

General Information

2. Rule or section catchline:

R590-203. Health Grievance Review Process

3. Purpose of the new rule or reason for the change (Why is the agency submitting this filing?)**:**

The rule is being changed in compliance with Executive Order 2021-12. During the review of this rule, the department discovered a number of minor issues that needed to be amended.

4. Summary of the new rule or change (What does this filing do? If this is a repeal and reenact, explain the substantive differences between the repealed rule and the reenacted rule)**:**

The majority of the changes are being done to fix style issues to bring the rule text more in line with current rulewriting standards. Other changes make the language of the rule more clear and update the Severability section to use the department's current language. The Enforcement Date section is removed because the rule is already in force. The changes do not add, remove, or change any regulations or requirements.

Fiscal Information

5. Provide an estimate and written explanation of the aggregate anticipated cost or savings to:

A) State budget:

There is no anticipated cost or savings to the state budget. The changes are largely clerical in nature, and will not change how the department functions.

B) Local governments:

There is no anticipated cost or savings to local governments. The changes are largely clerical in nature, and will not affect local governments.

C) Small businesses ("small business" means a business employing 1-49 persons)**:**

There is no anticipated cost or savings to small businesses. The changes are largely clerical in nature, and will not affect small businesses.

D) Non-small businesses ("non-small business" means a business employing 50 or more persons)**:**

There is no anticipated cost or savings to non-small businesses. The changes are largely clerical in nature, and will not affect non-small businesses.

E) Persons other than small businesses, non-small businesses, state, or local government entities ("person" means any individual, partnership, corporation, association, governmental entity, or public or private organization of any character other than an ***agency***)**:**

There is no anticipated cost or savings to any other persons. The changes are largely clerical in nature.

F) Compliance costs for affected persons (How much will it cost an impacted entity to adhere to this rule or its changes?)**:**

There are no compliance costs for any affected persons. The changes are largely clerical in nature.

G) Comments by the department head on the fiscal impact this rule may have on businesses (Include the name and title of the department head):

After conducting a thorough analysis, it was determined that this proposed rule amendment will not result in a fiscal impact to businesses. — Jonathan T. Pike, Insurance Commissioner

6. A) Regulatory Impact Summary Table (This table only includes fiscal impacts that could be measured. If there are inestimable fiscal impacts, they will not be included in this table. Inestimable impacts will be included in narratives above.)

Regulatory Impact Table

Fiscal Cost	**FY2022**	**FY2023**	**FY2024**
State Government	$0	$0	$0
Local Governments	$0	$0	$0
Small Businesses	$0	$0	$0
Non-Small Businesses	$0	$0	$0
Other Persons	$0	$0	$0
Total Fiscal Cost	**$0**	**$0**	**$0**
Fiscal Benefits			
State Government	$0	$0	$0
Local Governments	$0	$0	$0
Small Businesses	$0	$0	$0
Non-Small Businesses	$0	$0	$0
Other Persons	$0	$0	$0
Total Fiscal Benefits	**$0**	**$0**	**$0**
Net Fiscal Benefits	**$0**	**$0**	**$0**

B) Department head approval of regulatory impact analysis:

The Commissioner of Insurance, Jonathan T. Pike, has reviewed and approved this fiscal analysis.

Citation Information

7. Provide citations to the statutory authority for the rule. If there is also a federal requirement for the rule, provide a citation to that requirement:

Section 31A-2-201	Section 31A-2-203	Section 31A-22-629

Incorporations by Reference Information

(If this rule incorporates more than two items by reference, please include additional tables.)

8. A) This rule adds, updates, or removes the following title of materials incorporated by references (a copy of materials incorporated by reference must be submitted to the Office of Administrative Rules; *if none, leave blank*)**:**

	First Incorporation
Official Title of Materials Incorporated (from title page)	
Publisher	
Date Issued	

Issue, or version	

B) This rule adds, updates, or removes the following title of materials incorporated by references (a copy of materials incorporated by reference must be submitted to the Office of Administrative Rules; *if none, leave blank*)**:**	
	Second Incorporation
Official Title of Materials Incorporated (from title page)	
Publisher	
Date Issued	
Issue, or version	

Public Notice Information

9. The public may submit written or oral comments to the agency identified in box 1. (The public may also request a hearing by submitting a written request to the agency. See Section 63G-3-302 and Rule R15-1 for more information.)		
A) Comments will be accepted until (mm/dd/yyyy)**:**		05/16/2022
B) A public hearing (optional) will be held:		
On (mm/dd/yyyy)**:**	**At** (hh:mm AM/PM)**:**	**At** (place)**:**

10. This rule change MAY become effective on (mm/dd/yyyy)**:**	05/23/2022
NOTE: The date above is the date the agency anticipates making the rule or its changes effective. It is NOT the effective date. To make this rule effective, the agency must submit a Notice of Effective Date to the Office of Administrative Rules on or before the date designated in Box 10.	

Agency Authorization Information

To the agency: Information requested on this form is required by Sections 63G-3-301, 302, 303, and 402. Incomplete forms will be returned to the agency for completion, possibly delaying publication in the *Utah State Bulletin* and delaying the first possible effective date.			
Agency head or designee, and title:	Steve Gooch, Public Information Officer	**Date** (mm/dd/yyyy)**:**	04/01/2022

R590. Insurance, Administration.
R590-203. Health Grievance Review Process.
R590-203-1. Authority.

This rule is [~~specifically authorized by Subsections 31A-22-629(4) and 31A-4-116, which requires the commissioner to establish minimum standards for grievance review procedures. The rule is also promulgated pursuant to Subsections 31A-2-201(1) and 31A-2-201(3)(a) in which the commissioner is empowered to administer and enforce this title and to make rules to implement the provisions of this title. The authority to examine carrier records, files, and documentation is provided by Section 31A-2-203~~]promulgated by the commissioner pursuant to Sections 31A-2-201, 31A-2-203, and 31A-22-629.

R590-203-2. Purpose and Scope.

(1) The purpose of this rule is to ensure that a carrier's grievance review procedure[~~s~~] for an individual and a group health insurance and disability income insurance plan[~~s comply~~] complies with 29 CFR 2560.503-1, and Sections 31A-4-116 and 31A-22-629.

[

~~**R590-203-3. Applicability and Scope.**~~**]**

[~~(1)~~](2) This rule applies to individual and group:

(a) health [~~care~~]insurance;

(b) disability income [~~policies~~]insurance; and

(c) health maintenance organization contracts.

[~~(2)~~](3) Long [~~Term Care~~]term care and Medicare supplement policies are not considered health insurance [~~for the purpose of~~]under this rule.

[~~(3)~~](4) [~~D~~]A disability income [~~policies are~~]insurance policy is exempt from R590-203-[~~6~~]5.

[~~(4)~~](5) This rule does not apply to a health benefit plan that complies with R590-261, Health Benefit Plan Adverse Benefit Determinations.

R590-203-[~~4~~]3. Definitions.

[~~In addition to the definitions in Section 31A-1-301, the following definitions shall apply for the purposes of this rule~~]Terms used in this rule are defined in Sections 31A-1-301 and 31A-22-629. Additional terms are defined as follows:

[~~(1)(a) "Adverse benefit determination" means the:~~

~~(i) denial of a benefit;~~

~~(ii) reduction of a benefit;~~

~~(iii) termination of a benefit; or~~

~~(iv) failure to provide or make payment, in whole or in part, for a benefit.~~

~~(b) "Adverse benefit determination" includes:~~

~~(i) denial, reduction, termination, or failure to provide or make payment that is based on a determination of an insured's eligibility to participate in a plan;~~

~~(ii) a 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; and~~

~~(iii) failure to cover an item or service for which benefits are otherwise provided because it is determined to be:~~

~~(A) experimental;~~

~~(B) investigational; or~~

~~(C) not a medical necessity or appropriate.~~]

[~~(2)~~](1) "Carrier" means [~~any~~]a person or entity [~~that provides~~]providing health insurance or disability income insurance [~~in this state~~]including:

(a) an insurance company;

(b) a prepaid hospital or medical care plan;

(c) a health maintenance organization;

(d) a multiple employer welfare arrangement;

(e) a managed care organization; and

[~~(e)~~](f) any other person or entity providing a health insurance or disability income insurance plan under Title 31A, Insurance Code.

[~~(3)~~](2) "Consumer [~~Representative" may be~~]representative" means an employee of [~~the~~]a carrier who [~~is~~]represents a consumer [~~of a health insurance or a disability income policy, as long as~~]perspective, if the employee is not:

(a) the individual who made the adverse benefit determination; or

(b) [~~a~~]subordinate to the individual who made the adverse benefit determination.

(3)(a) "Health insurance" means insurance providing:

(i) a health care benefit; or

(ii) payment of an incurred health care expense.

(b) Health insurance includes an accident and health insurance policy allowing for an adverse benefit determination on the basis of medical necessity, rather than a specified event.

(4)(a) "Independent review organization" means an entity that conducts independent external reviews of adverse determinations and final adverse determinations.

(b) The independent review organization chosen may not own or control, be a subsidiary of, or in any way be owned or controlled by, or exercise control with a health insurance plan, a national, state, or local trade association of health insurance plans, and a national, state, or local trade association of health care providers.

(5)(a) "Medical [~~Necessity~~]necessity" means[~~:~~

~~(a)~~] a health care service[~~s~~] or product[~~s~~] that a prudent health care professional would provide to a patient [~~for the purpose of preventing, diagnosing or treating~~]to prevent, diagnose, or treat 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) [~~that when~~]When a medical question-of-fact exists, medical necessity [~~shall~~]includes the most appropriate available supply or level of service that is known to be effective[~~ for the individual in question~~], considering potential benefits and harms to the individual in question[~~, and known to be effective~~].

(i) For an intervention[~~s~~] not yet in widespread use, the effectiveness [~~shall be~~]is based on scientific evidence.

(ii) For an established intervention[~~s~~], the effectiveness [~~shall be~~]is based on:

(A) scientific evidence;

(B) professional standards; and

(C) expert opinion.

[~~(5)~~](6)(a) "Scientific evidence" means:

(i) a scientific [~~studies~~]study published in or accepted for publication by a medical journal[~~s~~] that meets nationally recognized requirements for scientific manuscripts and that submits most of [~~their~~]its published articles for review by experts who are not part of the

editorial staff; or

(ii) [~~findings, studies~~]a finding, study, or research conducted by or under the auspices of a federal government [~~agencies and~~]agency or nationally recognized federal research institute[~~s~~].

(b) Scientific evidence [~~shall~~]does not include:

(i) published peer-reviewed literature sponsored to a significant extent by a pharmaceutical manufacturing company or medical device manufacturer; or

(ii) a single study without other supportable studies.

[~~(6)~~](7)(a) "Urgent care claim" means a request for a health care service or course of treatment [~~with respect to~~]for which the time period[~~s~~] for making non-urgent care request determination:

(i) could seriously jeopardize the life or health of [~~the~~]an insured or the ability of [~~the~~]an insured to regain maximum function; or

(ii) in the opinion of a physician with knowledge of the insured's medical condition, would subject [~~the~~]an insured to severe pain that cannot be adequately managed without the health care service or treatment that is the subject of the request.

(b)(i) Except as provided in Subsection [~~(6)~~](7)(a)(ii), [~~in determining whether a request is to be treated as an urgent care request,~~]an individual acting on behalf of [~~the~~]a carrier shall apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine to determine whether a request is an urgent care claim.

(ii) [~~Any request that~~]If a physician with knowledge of [~~the~~]an insured's medical condition determines that a request is an urgent care request within the meaning of Subsection [~~(6)~~](7)(a), the request shall be treated as an urgent care claim.

R590-203-[~~5~~]4. Adverse Benefit Determination.

(1) [~~A carrier's~~]An adverse benefit determination review procedure shall [~~be compliant~~]comply with the adverse benefit determination review requirements set forth in 29 CFR 2560.503-1[~~, effective January 20, 2001. This document is incorporated by reference and available for inspection at the Insurance Department~~].

(2) A carrier's adverse benefit determination appeal board or body shall include at least one consumer representative [~~that shall be~~]who is present at every meeting.

R590-203-[~~6~~]5. Independent and Expedited Adverse Benefit Determination Reviews for Health Insurance.

(1) A carrier shall provide an independent review procedure as a voluntary option [~~for the resolution of~~]to resolve an adverse benefit determination[~~s~~] of medical necessity.

(2) An independent review procedure shall be conducted by an independent review organization, person, or entity other than the carrier, the plan, the plan's fiduciary, the employer, or any employee or agent of any of the foregoing, that do not have any material professional, familial, or financial conflict of interest with the health plan, any officer, director, or management employee of the health plan, the enrollee, the enrollee's health care provider, the provider's medical group or independent practice association, the health care facility where service would be provided and the developer or manufacturer of the service being provided.

(3)[~~Independent~~](a) An independent review organization[~~s shall be~~] is designated by the carrier[~~, and the~~] or the commissioner.

(b) The independent review organization chosen [~~shall~~]may not[~~own or control, be a subsidiary of, or in any way be owned or controlled by, or exercise control with a health insurance plan, a national, state, or local trade association of health insurance plans, and a national, state, or local trade association of health care providers~~] be owned or controlled by, or exercise control with:

(i) the insurer;

(ii) the health plan;

(iii) the health plan's fiduciary;

(iv) a national, state, or local trade association of:

(A) health insurance plans; or

(B) trade association of health care providers;

(v) the employer; or

(vi) an employee or agent of any person listed in Subsections (3)(b)(i) through (v).

(c) An independent review organization chosen 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.

(4) [~~The s~~]Submission to an independent review procedure is [~~purely~~]voluntary and [~~left to~~]at the discretion of the claimant.

(5)(a) A [~~carrier's~~]voluntary independent review procedure shall:

[~~(a)~~](i) waive any right to assert that a claimant has failed to exhaust administrative remedies because the claimant did not elect to submit a dispute of medical necessity to a voluntary level of appeal provided by the plan;

[~~(b)~~](ii) agree that any statute of limitation[~~s~~] or other defense based on timeliness is tolled [~~during the time~~]while a voluntary appeal is pending;

[~~(c)~~](iii) allow a claimant to submit a dispute of medical necessity to a voluntary level of appeal only after exhaustion of the appeals

permitted under 29 CFR [~~Subsection~~]2560.503-1(c)(2);

[~~(d)~~](iv) upon request from [~~any~~]a claimant, provide sufficient information relating to the voluntary level of appeal to enable the claimant to make an informed decision about whether to submit a dispute of medical necessity to the voluntary level of appeal[~~. This information shall contain a statement that the decision to use a voluntary level of appeal will not affect the claimant's rights to any other benefits under the plan and information about the applicable rules, the claimant's right to representation, and the process for selecting the decision maker.~~]; and

[~~(e)~~](v) [~~An~~]disclose that:

(A) an independent review conducted [~~in compliance with~~]under Section 31A-22-629[~~,~~] and this rule[~~, can~~] may be binding on both parties[~~. A~~]; and

(B) a claimant's submission to a binding independent review is [~~purely~~]voluntary and [~~appropriate~~]disclosure and notification must be given [~~as required by~~]under 29 CFR 2560.503-1.

(b) If requested, the information to be provided under Subsection (5)(a)(iv) shall contain:

(i) a statement that the decision to use a voluntary level of appeal will not affect the claimant's right to any other benefit under the plan; and

(ii) information about the applicable rules, the claimant's right to representation, and the process for submitting an independent review.

(6) Standards for voluntary independent review:

(a) [~~The~~]A carrier's internal adverse benefit determination process must be exhausted unless the carrier and claimant [~~mutually~~]agree to waive the internal process.

(b) Any adverse benefit determination of medical necessity may be the subject of an independent review.

(c) The claimant has 180 calendar days from the date of the final internal review decision to request an independent review.

(d) A carrier shall use the same minimum standard[~~s~~] and [~~times of~~]notification requirement for an independent review that [~~are~~]is used for internal levels of review, as set forth in 29 CFR [~~Subsection~~]2560.503-1(h)(3), 29 CFR 2560.503-1(i)(2) and 29 CFR 2560.503-1(j).

(7) A carrier shall provide an expedited review process for [~~cases involving~~]urgent care claims.

(8)(a) A request for [~~an~~]expedited review of an adverse benefit determination of medical necessity may be submitted either orally or in writing.

(b) If [~~the~~]a request is made orally, a carrier shall[~~, within 24 hours,~~] send written confirmation to the claimant acknowledging the receipt of the request[~~ for an expedited review~~] within 24 hours.

(9) An expedited review shall require[~~s~~] a carrier to:

(a) transmit all necessary information between the plan and the claimant electronically, including the plan's original adverse benefit determination[~~, be transmitted between the plan and the claimant by telephone, facsimile, or other available similarly expeditious method~~];

(b) [~~a carrier to~~]notify the claimant of the adverse benefit [~~review~~]determination review, as soon as possible, [~~taking into account~~]considering the medical urgency, but not later than 72 hours after receipt of the claimant's request for review of an adverse benefit determination; and

(c) [~~a carrier to~~]use the same minimum standard for timing and notification as set forth in 29 CFR [~~Subsection~~]2560.503-1(h), 29 CFR 2560.503-1(i)(2)(i), and 29 CFR 2560.503-1(j)[~~.~~

~~(10) This section, R590-203-6, does not apply to disability income policies~~].

R590-203-[~~7~~]6. Disability Income Insurance Adverse Benefit Determination Review.

(1) A carrier [~~will~~]shall notify a claimant of [~~the~~]an adverse benefit determination review within 45 days of receipt of the claimant's request for review of an adverse benefit determination.

(2) The time [~~period~~]for making an adverse benefit determination [~~on~~]review may be extended for up to 45 days [~~when~~]if necessary due to matters beyond the carrier's control[~~ of the carrier~~].

(3) If the response time [~~period~~]is extended due to the claimant's failure to submit information necessary to decide a claim, the time [~~period~~]for making the benefit determination on an adverse benefit determination review shall be tolled from the date on which the notification of the extension is sent until the date on which the claimant responds to the request for additional information.

(4) Upon request, relevant information[~~, free of charge,~~] must be provided to the claimant on any adverse benefit determination free of charge.

R590-203-[~~8~~]7. File and Record Documentation.

A carrier shall:

(1) [~~make available~~]upon request by the commissioner, make available all adverse benefit determination review files and related documentation; and

(2) [~~shall~~]maintain these records for the current calendar year plus five years.

R590-203-[~~9. Enforcement Date.~~

~~The commissioner shall begin enforcing the revised provisions of this rule on the effective date.~~

~~R590-203-10~~]8. Severability.

[~~If a provision or clause of this rule or its application to any person or circumstance is for any reason held to be invalid, the remainder of the rule and the application of these provisions shall not be affected~~]If any provision of this rule, Rule R590-203, or its application to any person or situation is held invalid, such invalidity does not affect any other provision or application of this rule that can be given effect without the invalid provision or application. The remainder of this rule shall be given effect without the invalid provision or application.

KEY: insurance
Date of Enactment or Last Substantive Amendment: December 8, 2011
Notice of Continuation: April 4, 2017
Authorizing, and Implemented or Interpreted Law: 31A-2-201; 31A-2-203; 31A-4-116; 31A-22-629