R590. Insurance, Administration.

R590-262. Health Data Authority Health Insurance Claims Reporting.

R590-262-1. Authority.

This rule is promulgated pursuant to Subsection 31A-22-614.5(3)(a) to coordinate with the provision of Subsection 26-1-37(2)(b) and Utah Department of Health rules R428-1 and R428-15.

R590-262-2. Purpose and Scope.

(1) This rule establishes requirements for certain entities that pay for health care to submit data to the Utah Department of Health.

(2) This rule allows the data to be shared with the state's designated secure health information master index person index, Clinical Health Information Exchange (cHIE), to be used:

(a) in compliance with data security standards established by:

(i) the federal Health Insurance Portability and Accountability Act of 1996, Pub. L. 104-191, 110 Stat. 1936: and

(ii) the electronic commerce agreements established in a business associate agreement;

(b) for the purpose of coordination of health benefit plans; and

(c) for the enrollment data elements identified in Utah Administrative Rule R428-15, Health Data Authority Health Insurance Claims Reporting.

(3)(a) This rule applies to an insurer offering:

(i) a health benefit plan; or

(ii) a dental plan.

(b) This rule does not apply to:

(i) an insurer that as of the first day of the reporting period:

(A) covers fewer than 2,500 individual Utah residents; or

(B) provides administrative services for fewer than 2,500 individual Utah residents covered under self-funded employee plans;

(ii) a fully insured employer group or self-funded employee plan whose primary place of business is outside the state of Utah and no more than 25% of the employees are residents of Utah;

(iii) a long-term care insurance policy; or

(iv) an income replacement policy.

(c) Except as provided in Subsection (4), this rule does not require a person to provide information concerning a self-funded employee plan.

(4)(a) The submission of health care claims data by an insurer on behalf of a self-funded employee plan is considered mandatory if and only if the self-funded employee plan opts-in under R590-262-7.

(b) An insurer is not obligated to submit data on behalf of a self-funded employee plan that fails to respond to opt-in requests required in R590-262-7.

R590-262-3. Definitions.

In addition to the definitions in Section 31A-1-301, the following definitions shall apply for the purpose of this rule:

(1) "Claim" means a request or demand on an insurer for payment of a benefit.

(2) "Health care claims data" means information consisting of, or derived directly from, member enrollment, medical claims, and pharmacy claims that this rule requires an insurer to report.

(3) "Insurer" means:

(a) a person engaged in the business of offering a health benefit plan or a dental plan, including a business under an administrative services organization or administrative services contract arrangement;

(b) a third party administrator that collects premiums or settles claims for health care insurance policies;

(c) a governmental plan as defined in Section 414(d), Internal Revenue Code;

(d) a non-electing church plan as described in Section 410 (d), Internal Revenue Code; or

(e) a licensed professional employer organization that is acting as an administrator of a health care insurance policy.

(4) "Office" means the Office of Health Care Statistics within the Utah Department of Health, which serves as staff to the Utah Health Data Committee.

(5) "Reporting period" means a calendar year.

(6)(a) "Self-funded employee plan" means an employee welfare benefit plan as defined in 29 U.S.C. Section 1002(1) whose health coverage is provided other than through an insurance policy.

(b) Self-funded employee plan does not include:

(i) a governmental plan as defined in Section 414 (d), Internal Revenue Code;

(ii) a non-electing church plan as described in Section 410 (d), Internal Revenue Code; or

(iii) the Public Employees' Benefit and Insurance Program created in Section 49-20-103.

(7) "Technical specifications" means the technical specifications document published by the Health Data Committee describing the variables and formats of the data that are to be submitted as well as submission directions and guidelines.

R590-262-4. Reporting Requirements.

(1) Each insurer shall submit enrollment, medical claims,

and pharmacy data described in R428-15-3 and R590-262-5, where Utah is the patient's primary residence, for services provided in or out of the state of Utah.

(2) Each insurer shall permit the Utah Department of Health to redisclose the enrollment and eligibility information with the state designated entity for the purpose of coordination of benefits.

(3) Each insurer shall submit monthly health care claims data. Each monthly submission is due no later than the last day of the following month.

R590-262-5. Reporting Process.

Submission procedures and guidelines are described in detail in the technical specifications published by the Health Data Committee. The health care claims data shall be formatted and submitted according to the technical specifications.

R590-262-6. Required Data Elements.

(1) The enrollment, medical claims, dental claims, and pharmacy data elements are described in detail in the technical specifications published by the Health Data Committee. Each insurer shall submit data for all fields contained in the submission specifications if the data are available to the insurer.

(2) Each insurer must submit the enrollment files, provider files, professional medical claims, institutional medical claims, and pharmacy claims data elements as required in R428-15.

R590-262-7. Voluntary Opt-In for Self-Funded Employee Plans.

(1)(a) Each insurer providing claim administration services for an employer who maintains a self-funded employee plan shall provide an employer a copy of the APCD Self-funded Employee Health Plan Opt-In form for purposes of determining whether an employer agrees to opt-in to submission of its self-funded employee plan's health care claims data as described in this rule.

(b) An insurer may use a form that they have developed for multi-state use instead of the form referenced in Subsection (1)(a) if the form is substantially similar and is approved by the Office in advance.

(c) Each insurer shall provide the APCD Self-funded Employee Health Plan Opt-In form:

(i) by December 15, 2016 for existing clients; or

(ii) within 15 days after claims administration services are retained and it is determined the employer meets the requirements of this section, for clients retained after December 1, 2016.

(2)(a) Except as provided in Subsections (b) and (c), an opt-in is effective for the reporting period in which it is signed and all future reporting periods. An employer may not opt-in for a partial reporting period.

(b) An opt-in signed by an employer and received by an insurer before March 1, 2017 shall be effective for the claims adjudicated in 2016 and not previously submitted to the Office, if otherwise required by this rule.

(c) An employer that has opted-in may opt-out for subsequent reporting periods by notifying the insurer in writing at least 30 days before the beginning of the next reporting period.

(3) For a self-funded employee plan whose employer has made an affirmative election for the submission of health care claims data, the insurer shall:

(a) include the self-funded employee plan data as part of the insurer's data submission otherwise required by this rule; and

(b) for plans that opt-in before March 1, 2017 as provided in Subsection (2)(b), include claims adjudicated in 2016 that were not previously submitted to the Office.

(4) Each insurer shall file with the Office, annually by January 31 of each year the following for the prior calendar year:

(a) a list of the self-funded employee plans whose employer made an affirmative election for the submission of their health care claim data;

(b) a list of employers who previously filed an opt-in request and have elected to opt-out for future reporting periods as provided under Subsection (2)(c); and

(c) a certification from an officer of the insurer that the insurer has taken reasonable efforts to provide the form to all known required employers; and

(d) a list identifying the employers to whom the form was provided and their contact information.

(5) The APCD Self-funded Employee Health Plan Opt-In form is for use only with self-funded employee plans and does not affect the mandatory reporting otherwise required by this rule.

(6) Nothing in this section requires an insurer to submit claims processed before the insurer was contracted to provide services.

R590-262-8. Third-party Contractors.

The Office may contract with a third party to collect and process the health care claims data and will prohibit it from using the data in any way but those specifically designated in the scope of work.

R590-262-9. Insurer Registration.

Each insurer shall register with the Office by completing the registration online at http://health.utah.gov/hda/apd/ no later than 30 days after becoming subject to this rule and annually thereafter by no later than September 1.

R590-262-10. Testing of Files.

Insurers that become subject to this rule shall submit to the Office a dataset for determining compliance with the standards for data submission no later than 90 days after the first date of becoming subject to the rule.

R590-262-11. Rejection of Files.

The Office or its designee may reject and return any data submission that fails to conform to the submission requirements. Paramount among submission requirements are: First Name, Last Name, Member ID, Relationship to Subscriber, Date of Birth, Address, City, State, Zip Code, Sex, which are key data fields that the insurer must submit for each enrolled member and claim. An insurer whose submission is rejected shall resubmit the data in the appropriate, corrected format to the Office, or its designee within ten state business days of notice that the data does not meet the submission requirements.

R590-262-12. Replacement of Data Files.

An insurer may replace a complete dataset submission if no more than one year has passed since the end of the month in which the file was submitted. However, the Office may allow a later submission if the insurer can establish exceptional circumstances for the replacement.

R590-262-13. Provider Notification.

(1) The following notification must be provided to a person that receives shared data, "This shared data is provided for informational purposes only. Contact the insurer for current, specific eligibility, or benefits coverage determination."

(2) The notification in this Section shall be provided in coordination with provider participation in the master index patient index and the cHIE programs.

R590-262-14. Limitation of Liability.

(1) A person furnishing information of the kind described in this rule is immune from liability and civil action if the information is furnished to or received from:

(a) the commissioner of the Insurance Department, the executive director of the Department of Health, or their employees or representatives;

(b) federal, state, or local law enforcement or regulatory officials or their employees or representatives; or

(c) the insurer that issued the policy connected with the data set.

(2) As provided in Section 26-25-1, any insurer that submits data pursuant to this rule cannot be held liable for having provided the required information to the Office.

R590-262-15. Exemptions and Extensions.

(1) The Office may grant exemptions or extensions from reporting requirements in this rule under certain circumstances.

(2) The Office may grant an exemption to an insurer when the insurer demonstrates that compliance imposes an unreasonable cost.

(a) An insurer may request an exemption from any particular requirement or set of requirements of this rule. The insurer must submit a request for exemption no less than 30 calendar days before the date the insurer would have to comply with the requirement.

(b) The Office may grant an exemption for a maximum of one calendar year. An insurer wishing an additional exemption must submit an additional, separate request.

(3) The Office may grant an extension to an insurer when the insurer demonstrates that technical or unforeseen difficulties prevent compliance.

(a) An insurer may request an extension for any deadline required in this rule. For each deadline for which the insurer requests an extension, the insurer must submit its request no less than seven calendar days before the deadline in question.

(b) The Office may grant an extension for a maximum of 30 calendar days. An insurer wishing an additional extension must submit an additional, separate request.

(4) The insurer requesting an extension or exemption shall include:

(a) The insurer's name, mailing address, telephone number, and contact person;

(b) the dates the exemption or extension is to start and end;

(c) a description of the relief sought, including reference to specific sections or language of the requirement;

(d) a statement of facts, reasons, or legal authority in support of the request; and

(e) a proposed alternative to the requirement or deadline.

R590-262-16. Penalties.

A person found to be in violation of this rule shall be subject to penalties as provided in Section 31A-2-308.

R590-262-17. Enforcement Date.

The commissioner will begin enforcing this rule upon the rule's effective date.

R590-262-18. Severability.

If any provision of this rule or its application to any person or situation is held to be invalid, that 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.

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