

R590. Insurance Administration.

R590-277. Managed Care Health Benefit Plan Policy Standards.

R590-277-1. Authority.

This rule is promulgated by the commissioner pursuant to Subsections 31A-2-201(3)(a), 31A-2-202, 31A-23a-402(8), 31A-23a-412, and 31A-45-103.

R590-277-2. Purpose and Scope.

(1) The purpose of this rule is to provide reasonable standardization and simplification of terms and coverages of a managed care health benefit plan policy in order to:

(a) facilitate public understanding and comparison;
(b) prohibit provisions which may be misleading or confusing in connection either with the purchase of such coverages or with the settlement of claims; and

(c) provide for full disclosure.

(2) This rule applies to any health benefit plan issued by a managed care organization to an individual or group, including policies issued to an association, trust, discretionary group, or other similar group.

(3) This rule does not apply to short-term limited duration health insurance that complies with both R590-85, Individual Accident and Health Insurance and Individual and Group Medicare Supplement rates, and R590-126, Accident and Health Insurance Standards.

R590-277-3. Definitions.

The definitions in Sections 31A-1-301, 31A-22-625, 31A-30-103 and 31A-45-102, and Rules R590-126, R590-192, R590-261 and R590-266, shall apply for the purposes of this rule.

R590-277-4. Prohibited Policy Provisions.

(1) A health benefit plan may not impose any preexisting condition limitation or exclusion provisions.

(2) Limitations or exclusions. Unless otherwise required by law, a policy may not limit or exclude coverage or benefits by type of illness, accident, treatment, or medical condition, except as follows:

(a) abortion;

(b) acupuncture and acupressure services;

(c) administrative charges for completing insurance forms, duplication services, interest, finance charges, or other administrative charges;

(d) administrative exams and services;

(e) applied behavioral analysis therapy, except as required by Section 31A-22-642;

(f) aviation;

(g) axillary hyperhidrosis;

(h) benefits provided under:

(i) Medicare or other governmental program, except Medicaid;

(ii) state or federal worker's compensation; or

(iii) employer's liability or occupational disease law;

(i) fitness training, exercise equipment, or membership fees to a spa or health club;

(j) charges for appointments scheduled and not kept;

(k) chiropractic care;

(l) complementary and alternative medicine;

(m) corrective lenses, and examination for the prescription or fitting thereof, except lens implant following cataract surgery and as required by Rule R590-266;

(n) cosmetic surgery; reversal, revision, repair, complications, or treatment related to a non-covered cosmetic surgery. This exclusion does not apply to reconstructive surgery when the service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved party; or reconstructive surgery because of congenital disease or anomaly of a covered dependent child that has resulted in a functional defect;

(o) custodial care;

(p) dental care or treatment;

(q) dietary products, except as required by Rule R590-194;

(r) educational and nutritional training, except as required by Rule R590-200;

(s) experimental or investigational services;

(t) expenses before coverage begins or after coverage ends;

(u) felony, riot or insurrection, when it has been determined the covered person was a voluntary participant;

(v) foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet, including orthotics. The exclusion of routine foot care does not apply to cutting or removal of corns, calluses, or nails when provided to a person who has a systemic disease, such as diabetes with peripheral neuropathy or circulatory insufficiency, of such severity that unskilled performance of the procedure would be hazardous;

(w) gastric or intestinal bypass services including lap banding, gastric stapling, and other similar procedures to facilitate weight loss; the reversal, or revision of such procedures; or services required for the treatment of complications from such procedures;

- (x) gender reassignment, except as required by Section 1557 of the Patient Protection and Affordable Care Act;
- (y) gene therapy;
- (z) genetic testing;
- (aa) hearing aids, and examination for the prescription or fitting thereof;
- (bb)(i) except as provided in Subsection R590-277-4(2)(cc), a loss directly related to the insured's voluntary participation in an activity where the insured:
 - (A) is found guilty of an illegal activity in a criminal proceeding; or
 - (B) is found liable for the activity in a civil proceeding.
 - (ii) A guilty finding includes a plea of guilty, a no contest plea, and a plea in abeyance;
 - (cc)(i) a loss directly related to the insured or dependent violating:
 - (A) Section 41-6a-502; or
 - (B) a law that prohibits operating a motor vehicle, in a state other than Utah, while exceeding the legal limit of concentration of alcohol, drugs, or a combination of both in the blood;
 - (ii) Violations of Subsection R590-277-4(2)(cc)(i) shall be established:
 - (A) in a criminal proceeding in which the insured or dependent is found guilty, enters a no contest plea or a plea in abeyance, or enters into a diversion agreement; or
 - (B) a managed care organization's request for an independent review where the findings support a decision to deny coverage based on the exclusions of Subsection R590-277-4(2)(cc)(i);
 - (iii) For purposes of Subsection R590-277-4(2)(cc)(i):
 - (A) An independent review means a process that:
 - (I) is conducted by an independent entity designated by the managed care organization;
 - (II) renders an independent and impartial decision on a decision to deny coverage based on the exclusion in Subsection R590-277-4(2)(cc)(i); and
 - (III) is paid for by the insurer.
 - (B) The independent review entity may not have a material professional, familial, or financial conflict of interest with:
 - (I) the managed care organization;
 - (II) an officer, director, or management employee of the managed care organization;
 - (III) the enrollee;
 - (IV) the enrollee's health care provider;
 - (V) the health care provider's medical group or independent practice association; or
 - (VI) a health care facility where services were provided;
 - (iv) this exclusion does not apply to an insured or dependent who is under 18 years of age;
 - (dd) infertility services;
 - (ee) mental health and substance use disorder services, except as required by Section 31A-22-625 and Rule R590-266;
 - (ff) injury as a result of a motor vehicle, to the extent the covered person is required by law to have no-fault coverage, up to the minimum coverage required by law, whether or not such coverage is in effect;
 - (gg) nuclear release;
 - (hh) refractive eye surgery;
 - (ii) rehabilitation or habilitative therapy services, such as physical, speech, and occupational, except as required to correct an impairment caused by a covered accident or illness, or as required by Rule R590-266;
 - (jj) respite care;
 - (kk) rest cures;
 - (ll) service in the armed forces or units auxiliary to it;
 - (mm) services that are not medically necessary;
 - (nn) services performed by the covered person's parent, spouse, sibling or child, including a step or in-law relationship;
 - (oo) services for which no charge is normally made in the absence of insurance;
 - (pp) services in connection with a prearranged surrogacy agreement, except for services for the baby, where the covered person relinquishes a baby and receives payment or other compensation arising out of such services;
 - (qq) sexual dysfunction procedures, equipment and drugs;
 - (rr) shipping and handling;
 - (ss) telephone/electronic consultations;
 - (tt) territorial limitations outside the United States;
 - (uu) terrorism, including acts of terrorism;
 - (vv) transplants, except as required by Rule R590-266;
 - (ww) transportation, except medically necessary ambulance services;
 - (xx) war or act of war, whether declared or undeclared; or
 - (yy) others that in the opinion of the commissioner are not inequitable, misleading, deceptive, obscure, unjust, unfair or unfairly discriminatory to the policyholder, beneficiary, or covered person under the policy.

R590-277-5. General Requirements.

(1) Policy definitions. No policy subject to this rule may contain definitions respecting the matters defined in R590-277-3 unless such definitions comply with the requirements of that section.

- (2) Rights of spouse and dependents. Except for an employer sponsored health plan, a policy;
 - (a) may not provide for termination of coverage of the spouse or a dependent solely because of the occurrence of an event specified for termination of coverage of the policyholder, other than for nonpayment of premium; and
 - (b) shall provide that in the event of the policyholder's death the spouse of the insured shall become the insured.
- (3) Cancellation, renewability, and termination. A policy cancellation, renewability and termination provision shall comply with Sections 31A-22-618.6 or 31A-22-618.7.
- (4) Transplant donor coverage. A policy providing coverage for the recipient in a transplant operation shall also provide reimbursement of any medically necessary transplant expenses of a live donor.
- (5) Notice of premium change. A notice of change in premium shall be given no fewer than 45 days before the renewal date.
- (6)(a) Except as provided in Subsection (b), a completed application shall be made part of the policy. A copy of the completed application shall be provided to the applicant prior to, or upon delivery, of the policy.
 - (b) Subsection (6)(a) does not apply to:
 - (i) an employer sponsored health benefit plan; or
 - (ii) an individual policy where application was effectuated directly through healthcare.gov.
- (7) A managed care organization offering a health benefit plan to an individual or small employer:
 - (a) shall offer coverage to all individuals and eligible employees on a guaranteed basis without regard to health status;
 - (b) may modify coverage at the time of renewal to the extent that such modification is consistent with federal and state law and effective on a uniform basis among all individuals in the health benefit plan; and
 - (c) must renew or continue coverage at the option of the policyholder, subject to Subsections 31A-22-618.6 and 618.7.

R590-277-6. Required Provisions.

- (1) A policy and certificate shall include a renewal, continuation, and nonrenewal provision. The provision shall be appropriately captioned, appear on the first page of the policy and certificate, and clearly state the duration of coverage.
- (2) Endorsement acceptance.
 - (a) Except for an endorsement by which the insurer effectuates a request made in writing by the policyholder or exercises a specifically reserved right under the policy, an endorsement added to a policy after date of issue or at reinstatement or renewal that reduces or eliminates benefits or coverage in the policy shall require signed acceptance by the policyholder.
 - (b) After the date of policy issue, an endorsement that increases benefits or coverage with a concurrent increase in premium during the policy term, must be agreed to in writing signed by the policyholder, except if the increased benefits or coverage is required by law.
- (3) Additional premium. Where a separate additional premium is charged for benefits provided in connection with an endorsement, the premium charge shall be set forth in the policy or certificate.
- (4) Benefit payment standard. A policy or certificate that provides for the payment of benefits based on standards described as usual and customary, reasonable and customary, or words of similar import, shall include a definition of the terms and an explanation of the terms in its accompanying outline of coverage or certificate.

R590-277-7. Restrictions Relating to Premium Rates.

- (1) The premium charged shall not be adjusted more frequently than annually, except that the premium rates may be changed:
 - (a) to reflect changes to the enrollment;
 - (b) to reflect changes to the health benefit plan; or
 - (c) as expressly permitted by federal or state law.
- (2) Premium rates may vary only with respect to the particular coverage involved on the basis of the following:
 - (a) whether the plan covers an individual or family:
 - (i) the total family premium shall include only the premiums for all covered family members over the age of twenty-one and the three oldest children under the age of twenty one; and
 - (ii) any rating variation on the basis of age or tobacco use must be applied separately to the portion of the premium attributable to each covered family member;
 - (b) geographic rating area, determined by the policyholder's primary address, as follows:
 - (i) Area 1, comprised of Cache and Rich counties;
 - (ii) Area 2, comprised of Box Elder, Morgan, and Weber counties;
 - (iii) Area 3, comprised of Davis, Salt Lake, Summit, Tooele, and Wasatch counties;
 - (iv) Area 4, comprised of Utah county;
 - (v) Area 5, comprised of Iron and Washington counties; and
 - (vi) Area 6, comprised of Beaver, Carbon, Daggett, Duchesne, Emery, Garfield, Grand, Juab, Kane, Millard, Piute, San Juan, Sanpete, Sevier, Uintah, and Wayne counties;
 - (c) age of each enrollee, as of the date of the policy issuance or renewal, in accordance with the Utah Individual and Small Employer Health Benefit Plan Age Curve; and
 - (d) tobacco rate factor, not greater than 1.5.
- (3) R590-277-7(2) does not apply to:
 - (a) a large employer health benefit plan; or

(b) an individual or small employer health benefit plan issued prior to January 1, 2014 in which the policy rating complies with:

- (i) Title 31A-30, Individual, Small Employer, and Group Health Insurance Act; and
- (ii) Rule R590-167, Individual, Small Employer, and Group Health Benefit Plan Rule.

R590-277-8. Existing Policies.

A policy issued prior to the effective date of this rule shall be amended to comply with this rule on the first policy anniversary following the effective date of this rule.

R590-277-9. Penalties.

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

R590-277-10. Enforcement Date.

The commissioner will begin enforcing the provisions of this rule for policies issued or renewed on or after January 1, 2020.

R590-277-11. Severability.

If any provision or clause of this rule or its application to any person or situation is held invalid, that invalidity may 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: insurance, health insurance

Date of Enactment or Last Substantive Amendment: April 22, 2020

Authorizing, and Implemented or Interpreted Law: 31A-45-103; 31A-2-201(3)(a); 31A-23a-402(8); 31A-23a-412; 31A-2-202