**R590. Insurance, Administration.**

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

**R590-262-1. Authority.**

This rule is promulgated by the commissioner pursuant to Sections 31A-2-201 and 31A-22-614.5.

**R590-262-2. Purpose and Scope.**

(1) The purpose of this rule is to:

(a) establish the requirements for entities that pay for health care to submit data to the Utah Department of Health and Human Services;

(b) coordinate with:

(i) Sections 26B-8-411 and 26B-85-504; and

(ii) Rules R428-1 and R428-15;

(c) allow the data to be shared with the state's designated secure health information master patient index, Clinical Health Information Exchange (cHIE), to be used:

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

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

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

(ii) for coordination of health insurance benefits; and

(iii) for the enrollment data elements identified in Rule R428-15.

(2) This rule applies to an insurer offering or administering health insurance, including a self-funded employee health plan that opts-in under Section R590-262-7.

(3) This rule does not apply to:

(a) an insurer that, as of the first day of the reporting period, covers fewer than 2,500 individual Utah residents;

(b) a long-term care insurance policy;

(c) an income replacement policy; or

(d) except as provided in Subsection (2)(c), a self-funded employee health plan.

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

(b) An insurer is not obligated to submit data on behalf of a self-funded employee health plan that opts-out or fails to respond to an opt-in request required in Section R590-262-7.

**R590-262-3. Definitions.**

Terms used in this rule are defined in Sections 31A-1-301 and 26B-8-501. Additional terms are defined as follows:

(1) "Data" means information consisting of, or derived directly from, enrollment, medical claims, dental claims, and pharmacy claims that this rule requires an insurer to report.

(2) "Insurer," for purposes of this rule, means:

(a) a person engaged in the business of offering health insurance;

(b) a third-party administrator that settles claims for:

(i) health insurance policies; or

(ii) a self-funded employee health plan if the employer of the self-funded employee health plan opts-in under Section R590-262-7;

(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 insurance policy.

(3) "Office" means the Healthcare Information and Analysis Program within the Utah Department of Health and Human Services Division of Data, Systems, and Evaluation.

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

(5)(a) "Self-funded employee health plan" means:

(i) 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; and

(ii) the plan has opted-in under Section R590-262-7.

(b) Self-funded employee health 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.

(6) "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) An insurer shall submit the data described in this rule and Section R428-15-3, if Utah is the patient's primary residence, for a service provided in or out of Utah.

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

(3) An insurer shall submit monthly data no later than the last day of the following month.

**R590-262-5. Reporting Process.**

(1) Submission procedures and guidelines are described in detail in the technical specifications published by the Health Data Committee.

(2) The data shall be formatted and submitted according to the technical specifications in Subsection (1).

**R590-262-6. Required Data Elements.**

(1) An insurer shall submit the data required by Rule R428-15 and the Utah All-Payer Claims Database Data Submission Guide if the data are available to the insurer.

(2) The Utah All-Payer Claims Database Data Submission Guide is available on the Utah Department of Health and Human Services website at https://healthcarestats.utah.gov.

**R590-262-7. Voluntary Opt-In for a Self-Funded Employee Health Plan.**

(1)(a) An insurer providing claim administration services for a self-funded employee health plan shall provide the employer for the self-funded employee health plan a copy of the APCD Self-funded Employee Health Plan Opt-In Form, available on the department's website, https://insurance.utah.gov, to determine if the employer agrees to opt-in to submission of its self-funded employee health plan's data as described in this rule.

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

(c) An insurer shall provide the APCD Self-funded Employee Health Plan Opt-In Form within 15 days after claims administration services are retained and it is determined the employer meets the requirements of this section.

(2)(a) Except as provided in Subsection (c), an opt-in is effective for the reporting period in which it is signed and all future reporting periods.

(b) An employer may not opt-in for a partial reporting period.

(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 health plan whose employer has made an affirmative election for the submission of data, the insurer shall include the self-funded employee health plan data as part of the insurer's data submission otherwise required by this rule.

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

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

(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 health plans and does not affect the mandatory reporting otherwise required by this rule.

(6) Nothing in this section requires an insurer to submit data for 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 data and shall prohibit the third party from using the data in any way not specifically designated in the scope of work.

**R590-262-9. Insurer Registration.**

An insurer shall register with the office by completing the registration on the office's website, https://healthcarestats.utah.gov/, 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.**

An insurer that becomes 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.**

(1) The office or its designee may reject and return any data submission that fails to conform to the submission requirements.

(2) 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.**

(1) 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.

(2) 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 shall 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 patient index and the cHIE programs.

**R590-262-14. Limitation of Liability.**

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

(a) the commissioner, the executive director of the Utah Department of Health and Human Services, or employees or representatives of the Utah Insurance Department or the Utah Department of Health and Human Services;

(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 26B-1-229, an 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 an exemption or extension from reporting requirements in this rule under certain circumstances.

(2) The office may grant an exemption from a reporting requirement in this rule to an insurer when the insurer demonstrates that compliance imposes an unreasonable cost.

(a)(i) An insurer may request an exemption from any particular requirement or set of requirements of this rule.

(ii) 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)(i) The office may grant an exemption for a maximum of one calendar year.

(ii) An insurer wishing an additional exemption must submit an additional, separate request.

(3) The office may grant an extension from a reporting requirement in this rule to an insurer when the insurer demonstrates that technical or unforeseen difficulties prevent compliance.

(a)(i) An insurer may request an extension for any deadline required in this rule.

(ii) 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)(i) The office may grant an extension for a maximum of 30 calendar days.

(ii) An insurer wishing an additional extension must submit an additional, separate request.

(4) An 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. Severability.**

If any provision of this rule, Rule R590-262, 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: health insurance claims reporting**

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