# MEDICAL CLAIMS AMENDMENTS

2001 GENERAL SESSION

STATE OF UTAH

## Sponsor: Leonard M. Blackham

**This act modifies the Insurance Code to establish a health care provider claims practice. The act establishes the duties of an insurer to timely pay providers and the duty of providers to respond to insurer request for information. The act provides for penalties for failure to timely pay a claim or failure to timely provide information on a claim. The act defines an unfair claim settlement practice. The act authorizes the Insurance Commissioner to audit compliance, impose sanctions, and adopt rules necessary to enforce the act. The act provides an effective date.**

This act affects sections of Utah Code Annotated 1953 as follows:

AMENDS:

**31A-26-301.5**, as last amended by Chapter 198, Laws of Utah 2000

ENACTS:

**31A-26-301.6**, Utah Code Annotated 1953

*Be it enacted by the Legislature of the state of Utah:*

Section 1. Section **31A-26-301.5** is amended to read:

**31A-26-301.5. Health care claims practices.**

(1) Except as provided in Section 31A-8-407, an insured retains ultimate responsibility for paying for health care services the insured receives. If a service is covered by one or more individual or group health insurance policies, all insurers covering the insured have the responsibility to pay valid health care claims in a timely manner according to the terms and limits specified in the policies.

(2) (a) Except as provided in Section 31A-22-610.1, a health care provider may bill and collect for any deductible, copayment, or uncovered service.

(b) A health care provider may bill an insured for services covered by health insurance policies or may otherwise notify the insured of the expenses covered by the policies. However, a provider may not make any report to a credit bureau, use the services of a collection agency, or

use methods other than routine billing or notification until the later of:

[~~(i) 15 days after the date all insurance companies covering the insured have paid their portion of the claim covered by the policies;~~]

[~~(ii) 60 days from the date all insurers covering the insured are billed for the covered service; or~~]

(i) the expiration of the time afforded to an insurer under Section 31A-26-301.6 to determine its obligation to pay or deny the claim without penalty; or

[~~(iii)~~] (ii) in the case of medicare beneficiaries or retirees 65 years of age or older, 60 days from the date medicare determines its liability for the claim.

(c) Beginning October 31, 1992, all insurers covering the insured shall notify the insured of payment and the amount of payment made to the provider.

(3) The commissioner shall make rules consistent with this chapter governing disclosure to the insured of customary charges by health care providers on the explanation of benefits as part of the claims payment process. These rules shall be limited to the form and content of the disclosures on the explanation of benefits, and shall include:

(a) a requirement that the method of determination of any specifically referenced customary charges and the range of the customary charges be disclosed; and

(b) a prohibition against an implication that the provider is charging excessively if the provider is:

(i) a participating provider; and

(ii) prohibited from balance billing.

Section 2. Section **31A-26-301.6** is enacted to read:

**31A-26-301.6. Health care provider claims practices.**

(1) As used in this section:

(a) "Articulable reason" may include a determination regarding:

(i) eligibility for coverage;

(ii) preexisting conditions;

(iii) applicability of other public or private insurance;

(iv) medical necessity; and

(v) any other reason that would justify an extension of the time to investigate a claim.

(b) "Health care provider" means a person licensed to provide health care under Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act, or Title 58, Occupations and Professions.

(c) "Insurer" means an admitted or authorized insurer, as defined in Section 31A-1-301, and includes:

(i) a health maintenance organization; and

(ii) a third-party administrator that is subject to this title, provided that nothing in this section may be construed as requiring a third party administrator to use its own funds to pay claims that have not been funded by the entity for which the third party administrator is paying claims.

(d) "Provider" means a health care provider to whom an insurer is obligated to pay directly in connection with a claim by virtue of:

(i) an agreement between the insurer and the provider;

(ii) a health insurance policy or contract of the insurer; or

(iii) state or federal law.

(2) An insurer shall timely pay every valid insurance claim submitted by a provider in accordance with this section.

(3) (a) Within 30 days of receiving a written claim, an insurer shall do one of the following:

(i) pay the claim unless Subsection (3)(a)(ii), (iii), (iv), or (v) applies;

(ii) provide a written explanation if the claim is denied;

(iii) specifically describe and request any additional information from the provider that is necessary to process the claim;

(iv) inform the provider, pursuant to Subsection (4), of the 30-day extension of the insurer's investigation of the claim; or

(v) request additional information and inform the provider of the 30-day extension if both Subsections (3)(a)(iii) and (iv) apply.

(b) A provider shall respond to each request by an insurer for additional necessary

information made under Subsection (3)(a)(iii) or (v) within 30 days of receipt of the request by providing the requested information that is in the possession of the provider, unless:

(i) the provider has requested and received the permission of the insurer to extend the 30-day period; or

(ii) the provider explains to the insurer in writing that additional time, which may not exceed 30 days, is necessary to comply with the request for information.

(c) Subsection (7) shall apply after an insurer has received the information requested.

(4) The time to investigate a claim may be extended by the insurer for an additional 30-days if:

(a) the investigation of the claim cannot reasonably be completed within the initial 30-day period of Subsection (3)(a);

(b) before the end of the 30-day period in Subsection (3)(a), the insurer informs the provider in writing of the reason for the payment delay, the nature of the investigation, the timelines for investigations established in this section, and the anticipated completion date.

(5) Notwithstanding Subsection (4), the time to investigate a claim may be extended beyond the initial 30-day period and the extended 30-day period if:

(a) due to matters beyond the control of the insurer, the investigation cannot reasonably be completed within 60 days as to some part or all of the claim;

(b) before the end of the combined 60-day period, the insurer makes a written request to the commissioner for an extension, including the reason for the delay, the nature of the investigation, the anticipated completion date, and the amount of any partial payment of the claim made pursuant to Subsection (5)(d);

(c) before the end of the combined 60-day period, the commissioner informs the insurer that the request for an extension has been granted, based on a finding that:

(i) there is a good faith and articulable reason to believe that the insurer is not obligated to pay some part or all of the claim; and

(ii) the investigation cannot reasonably be completed within 60 days; and

(d) the insurer identifies and pays all sums the insurer is obligated to pay on the claim and

which are not subject to the extension requested under this Subsection (5).

(6) An extension granted by the commissioner under Subsection (5)(c) shall include the completion date for the investigation.

(7) (a) An insurer shall pay all sums to the provider that the insurer is obligated to pay on the claim, and provide a written explanation of any part of the claim that is denied within 20 days of:

(i) receiving the information requested under Subsection (3)(a)(iii);

(ii) completing an investigation under Subsection (4) or (5); or

(iii) the latter of Subsection (3)(a)(iii) or (iv), if Subsection (3)(a)(v) applies.

(b) (i) Except as provided in Subsection (7)(c), an insurer may send a follow-up request for additional information within the 20-day time period in Subsection (7)(a) if the previous response of the provider was not sufficient for the insurer to make a decision on the claim.

(ii) A follow-up request for additional necessary information shall state with specificity:

(A) the reason why the previous response was insufficient;

(B) the information that is necessary to comply with the request for information; and

(C) the reason why the requested information is necessary to process the claim.

(c) Unless an insurer has an extension for an investigation pursuant to Subsection (4) or (5), the insurer shall pay all sums it is obligated to pay on a claim and provide a written explanation of any part of the claim that is denied within 15 days of receiving a notice from the provider that the provider has submitted all requested information in the provider's possession that is related to the claim.

(8) (a) Whenever an insurer makes a payment to a provider on any part of a claim under this section, the insurer shall also send to the insured an explanation of benefits paid.

(b) Whenever an insurer denies any part of a claim under this section, the insurer shall also send to the insured a written explanation of the part of the claim that was denied and notice of the grievance review process established under Section 31A-22-629.

(c) This Subsection (8) does not apply to a person receiving benefits under the state Medicaid program as defined in Section 26-18-2, unless required by the Department of Health or

federal law.

(9) (a) Beginning with health care claims submitted on or after January 1, 2002, a late fee shall be imposed on:

(i) an insurer that fails to timely pay a claim in accordance with this section; and

(ii) a provider that fails to timely provide information on a claim in accordance with this section.

(b) For the first 90 days that a claim payment or a provider response to a request for information is late, the late fee shall be determined by multiplying together:

(i) the total amount of the claim;

(ii) the total number of days the response or the payment; and

(iii) .1%.

(c) For a claim payment or a provider response to a request for information that is 91 or more days late, the late fee shall be determined by adding together:

(i) the late fee for a 90-day period under Subsection (9)(b); and

(ii) the following sum multiplied together:

(A) the total amount of the claim;

(B) the total number of days the response or payment was late beyond the initial 90-day period; and

(C) the rate of interest set in accordance with Section 15-1-1.

(d) Any late fee paid or collected under this section shall be separately identified on the documentation used by the insurer to pay the claim.

(e) For purposes of this Subsection (9), "late fee" does not include an amount that is less than $1.

(10) Each insurer shall establish a grievance review process to resolve claims-related disputes between the insurer and providers.

(11) No insurer or person representing an insurer may engage in any unfair claim settlement practice with respect to a provider. Unfair claim settlement practices include:

(a) knowingly misrepresenting a material fact or the contents of an insurance policy in

connection with a claim;

(b) failing to acknowledge and substantively respond within 15 days to any written communication from a provider relating to a pending claim;

(c) denying or threatening to deny the payment of a claim for any reason that is not clearly described in the insured's policy;

(d) failing to maintain a payment process sufficient to comply with this section;

(e) failing to maintain claims documentation sufficient to demonstrate compliance with this section;

(f) failing, upon request, to give to the provider written information regarding the specific rate and terms under which the provider will be paid for health care services;

(g) failing to timely pay a valid claim in accordance with this section as a means of influencing, intimidating, retaliating, or gaining an advantage over the provider with respect to an unrelated claim, an undisputed part of a pending claim, or some other aspect of the contractual relationship;

(h) failing to pay the sum when required and as required under Subsection (9) when a violation has occurred;

(i) threatening to retaliate or actual retaliation against a provider for availing himself of the provisions of this section;

(j) any material violation of this section; and

(k) any other unfair claim settlement practice established in rule or law.

(12) (a) The provisions of this section shall apply to each contract between an insurer and a provider for the duration of the contract.

(b) Notwithstanding Subsection (12)(a), this section may not be the basis for a bad faith insurance claim.

(c) Nothing in Subsection (12)(a) may be construed as limiting the ability of an insurer and a provider from including provisions in their contract that are more stringent than the provisions of this section.

(13) (a) Pursuant to Chapter 2, Part 2, Duties and Powers of Commissioner, and beginning

January 1, 2002, the commissioner may conduct examinations to determine an insurer's level of compliance with this section and impose sanctions for each violation.

(b) The commissioner may adopt rules only as necessary to implement this section.

(c) After December 31, 2002, the commissioner may establish rules to facilitate the exchange of electronic confirmations when claims-related information has been received.

(d) Notwithstanding the provisions of Subsection (13)(b), the commissioner may not adopt rules regarding the grievance process required by Subsection (10).

(14) Nothing in this section may be construed as limiting the collection rights of a provider under Section 31A-26-301.5.

(15) Nothing in this section may be construed as limiting the ability of an insurer to:

(a) recover any amount improperly paid to a provider:

(i) in accordance with Section 31A-31-103 or any other provision of state or federal law;

(ii) within 36 months for a coordination of benefits error; or

(iii) within 18 months for any other reason not identified in Subsection (15)(a)(i) or (ii);

(b) take any action against a provider that is permitted under the terms of the provider contract and not prohibited by this section;

(c) report the provider to a state or federal agency with regulatory authority over the provider for unprofessional, unlawful, or fraudulent conduct; or

(d) enter into a mutual agreement with a provider to resolve alleged violations of this section through mediation or binding arbitration.

Section 3. **Effective date.**

This act takes effect on September 1, 2001.