Senator Leonard M. Blackham proposes to substitute the following bill:

1 # MEDICAL CLAIMS AMENDMENTS

2 2001 GENERAL SESSION

3 STATE OF UTAH

4 **Sponsor: Leonard M. Blackham**

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

12 This act affects sections of Utah Code Annotated 1953 as follows:
13 AMENDS:
14 **31A-26-301.5**, as last amended by Chapter 198, Laws of Utah 2000
15 ENACTS:
16 **31A-26-301.6**, Utah Code Annotated 1953
17 *Be it enacted by the Legislature of the state of Utah:*
18 Section 1. Section **31A-26-301.5** is amended to read:
19 **31A-26-301.5. Health care claims practices.**
20 (1) Except as provided in Section 31A-8-407, an insured retains ultimate responsibility for
21 paying for health care services the insured receives. If a service is covered by one or more
22 individual or group health insurance policies, all insurers covering the insured have the
23 responsibility to pay valid health care claims in a timely manner according to the terms and limits
24 specified in the policies.
25 (2) (a) Except as provided in Section 31A-22-610.1, a health care provider may bill and

26 collect for any deductible, copayment, or uncovered service.
27 (b) A health care provider may bill an insured for services covered by health insurance
28 policies or may otherwise notify the insured of the expenses covered by the policies. However,
29 a provider may not make any report to a credit bureau, use the services of a collection agency, or
30 use methods other than routine billing or notification until the later of:
31 [~~(i) 15 days after the date all insurance companies covering the insured have paid their~~
32 ~~portion of the claim covered by the policies;~~]
33 [~~(ii) 60 days from the date all insurers covering the insured are billed for the covered~~
34 ~~service; or~~]
35 (i) the expiration of the time afforded to an insurer under Section 31A-26-301.6 to
36 determine its obligation to pay or deny the claim without penalty; or
37 [~~(iii)~~] (ii) in the case of medicare beneficiaries or retirees 65 years of age or older, 60 days
38 from the date medicare determines its liability for the claim.
39 (c) Beginning October 31, 1992, all insurers covering the insured shall notify the insured
40 of payment and the amount of payment made to the provider.
41 (3) The commissioner shall make rules consistent with this chapter governing disclosure
42 to the insured of customary charges by health care providers on the explanation of benefits as part
43 of the claims payment process. These rules shall be limited to the form and content of the
44 disclosures on the explanation of benefits, and shall include:
45 (a) a requirement that the method of determination of any specifically referenced
46 customary charges and the range of the customary charges be disclosed; and
47 (b) a prohibition against an implication that the provider is charging excessively if the
48 provider is:
49 (i) a participating provider; and
50 (ii) prohibited from balance billing.
51 Section 2. Section **31A-26-301.6** is enacted to read:
52 **31A-26-301.6. Health care provider claims practices.**
53 (1) As used in this section:
54 (a) "Articulable reason" may include a determination regarding:
55 (i) eligibility for coverage;
56 (ii) preexisting conditions;

57 (iii) applicability of other public or private insurance;
58 (iv) medical necessity; and
59 (v) any other reason that would justify an extension of the time to investigate a claim.
60 (b) "Health care provider" means a person licensed to provide health care under Title 26,
61 Chapter 21, Health Care Facility Licensing and Inspection Act, or Title 58, Occupations and
62 Professions.
63 (c) "Insurer" means an admitted or authorized insurer, as defined in Section 31A-1-301,
64 and includes:
65 (i) a health maintenance organization; and
66 (ii) a third-party administrator that is subject to this title.
67 (d) "Provider" means a health care provider to whom an insurer is obligated to pay directly
68 in connection with a claim by virtue of:
69 (i) an agreement between the insurer and the provider;
70 (ii) a health insurance policy or contract of the insurer; or
71 (iii) state or federal law.
72 (2) An insurer shall timely pay every valid insurance claim submitted by a provider in
73 accordance with this section.
74 (3) (a) Within 30 days of receiving a written claim, an insurer shall do one of the
75 following:
76 (i) pay the claim unless Subsection (3)(a)(ii), (iii), (iv), or (v) applies;
77 (ii) provide a written explanation if the claim is denied;
78 (iii) specifically describe and request any additional information from the provider that is
79 necessary to process the claim;
80 (iv) inform the provider, pursuant to Subsection (4), of the 30-day extension of the
81 insurer's investigation of the claim; or
82 (v) request additional information and inform the provider of the 30-day extension if both
83 Subsections (3)(a)(iii) and (iv) apply.
84 (b) A provider shall respond to each request by an insurer for additional necessary
85 information made under Subsection (3)(a)(iii) or (v) within 30 days of receipt of the request by
86 providing the requested information that is in the possession of the provider, unless:
87 (i) the provider has requested and received the permission of the insurer to extend the

88 30-day period; or
89 (ii) the provider explains to the insurer in writing that additional time, which may not
90 exceed 30 days, is necessary to comply with the request for information.
91 (c) Subsection (7) shall apply after an insurer has received the information requested.
92 (4) The time to investigate a claim may be extended by the insurer for an additional
93 30-days if:
94 (a) the investigation of the claim cannot reasonably be completed within the initial 30-day
95 period of Subsection (3)(a);
96 (b) before the end of the 30-day period in Subsection (3)(a), the insurer informs the
97 provider in writing of the reason for the payment delay, the nature of the investigation, the
98 timelines for investigations established in this section, and the anticipated completion date.
99 (5) Notwithstanding Subsection (4), the time to investigate a claim may be extended
100 beyond the initial 30-day period and the extended 30-day period if:
101 (a) due to matters beyond the control of the insurer, the investigation cannot reasonably
102 be completed within 60 days as to some part or all of the claim;
103 (b) before the end of the combined 60-day period, the insurer makes a written request to
104 the commissioner for an extension, including the reason for the delay, the nature of the
105 investigation, the anticipated completion date, and the amount of any partial payment of the claim
106 made pursuant to Subsection (5)(d);
107 (c) before the end of the combined 60-day period, the commissioner informs the insurer
108 that the request for an extension has been granted, based on a finding that:
109 (i) there is a good faith and articulable reason to believe that the insurer is not obligated
110 to pay some part or all of the claim; and
111 (ii) the investigation cannot reasonably be completed within 60 days; and
112 (d) the insurer identifies and pays all sums the insurer is obligated to pay on the claim and
113 which are not subject to the extension requested under this Subsection (5).
114 (6) An extension granted by the commissioner under Subsection (5)(c) shall include the
115 completion date for the investigation.
116 (7) (a) An insurer shall pay all sums to the provider that the insurer is obligated to pay on
117 the claim, and provide a written explanation of any part of the claim that is denied within 15 days
118 of:

119 (i) receiving the information requested under Subsection (3)(a)(iii);
120 (ii) completing an investigation under Subsection (4) or (5); or
121 (iii) the latter of Subsection (3)(a)(iii) or (iv), if Subsection (3)(a)(v) applies.
122 (b) (i) Except as provided in Subsection (7)(c), an insurer may send a follow-up request
123 for additional information within the 15-day time period in Subsection (7)(a) if the previous
124 response of the provider was insufficient.
125 (ii) A follow-up request for additional necessary information shall state with specificity:
126 (A) the reason why the previous response was insufficient;
127 (B) the information that is necessary to comply with the request for information; and
128 (C) the reason why the requested information is necessary to process the claim.
129 (c) Unless an insurer has an extension for an investigation pursuant to Subsection (4) or
130 (5), the insurer shall pay all sums it is obligated to pay on a claim and provide a written
131 explanation of any part of the claim that is denied within 15 days of receiving a notice from the
132 provider that the provider has submitted all requested information in the provider's possession that
133 is related to the claim.
134 (8) (a) Whenever an insurer makes a payment to a provider on any part of a claim under
135 this section, the insurer shall also send to the insured an explanation of benefits paid.
136 (b) Whenever an insurer denies any part of a claim under this section, the insurer shall also
137 send to the insured a written explanation of the part of the claim that was denied and notice of the
138 grievance review process established under Section 31A-22-629.
139 (c) This Subsection (8) does not apply to a person receiving benefits under the state
140 Medicaid program as defined in Section 26-18-2, unless required by the Department of Health or
141 federal law.
142 (9) (a) A late fee shall be imposed on:
143 (i) an insurer that fails to timely pay a claim in accordance with this section; and
144 (ii) a provider that fails to timely provide information on a claim in accordance with this
145 section.
146 (b) For the first 90 days that a claim payment or a provider response to a request for
147 information is late, the late fee shall be determined by multiplying together:
148 (i) the total amount of the claim;
149 (ii) the total number of days the response or the payment; and

150 (iii) .1%.
151 (c) For a claim payment or a provider response to a request for information that is 91 or
152 more days late, the late fee shall be determined by adding together:
153 (i) the late fee for a 90-day period under Subsection (9)(b); and
154 (ii) the following sum multiplied together:
155 (A) the total amount of the claim;
156 (B) the total number of days the response or payment was late beyond the initial 90-day
157 period; and
158 (C) the rate of interest set in accordance with Section 15-1-1.
159 (d) Any late fee paid or collected under this section shall be separately identified on the
160 documentation used by the insurer to pay the claim.
161 (e) For purposes of this Subsection (9), "late fee" does not include an amount that is less
162 than $1.
163 (10) Each insurer shall establish a grievance review process to resolve claims-related
164 disputes between the insurer and providers.
165 (11) No insurer or person representing an insurer may engage in any unfair claim
166 settlement practice with respect to a provider. Unfair claim settlement practices include:
167 (a) knowingly misrepresenting a material fact or the contents of an insurance policy in
168 connection with a claim;
169 (b) failing to acknowledge and substantively respond within 15 days to any written
170 communication from a provider relating to a pending claim;
171 (c) denying or threatening to deny the payment of a claim for any reason that is not clearly
172 described in the insured's policy;
173 (d) failing to maintain a payment process sufficient to comply with this section;
174 (e) failing to maintain claims documentation sufficient to demonstrate compliance with
175 this section;
176 (f) failing, upon request, to give to the provider written information regarding the specific
177 rate and terms under which the provider will be paid for health care services;
178 (g) failing to timely pay a valid claim in accordance with this section as a means of
179 influencing, intimidating, retaliating, or gaining an advantage over the provider with respect to an
180 unrelated claim, an undisputed part of a pending claim, or some other aspect of the contractual

181 relationship;
182 (h) failing to pay the sum when required and as required under Subsection (9) when a
183 violation has occurred;
184 (i) threatening to retaliate or actual retaliation against a provider for availing himself of
185 the provisions of this section;
186 (j) any material violation of this section; and
187 (k) any other unfair claim settlement practice established in rule or law.
188 (12) (a) The provisions of this section shall apply to each contract between an insurer and
189 a provider for the duration of the contract.
190 (b) Notwithstanding Subsection (12)(a), a provider may not use this section as the basis
191 for a bad faith insurance claim.
192 (c) Nothing in Subsection (12)(a) may be construed as limiting the ability of an insurer and
193 a provider from including provisions in their contract that are more stringent than the provisions
194 of this section.
195 (13) (a) Pursuant to Chapter 2, Part 2, Duties and Powers of Commissioner and within
196 existing legislative appropriations, the commissioner may conduct examinations to determine an
197 insurer's level of compliance with this section and impose sanctions for each violation.
198 (b) The commissioner may adopt rules only as necessary to implement this section.
199 (c) After December 31, 2002, the commissioner may establish rules to facilitate the
200 exchange of electronic confirmations when claims-related information has been received.
201 (d) Notwithstanding the provisions of Subsection (13)(b), the commissioner may not adopt
202 rules regarding the grievance process required by Subsection (10).
203 (14) Nothing in this section may be construed as limiting the collection rights of a provider
204 under Section 31A-26-301.5.
205 (15) Nothing in this section may be construed as limiting the ability of an insurer to:
206 (a) recover any amount improperly paid to a provider:
207 (i) in accordance with Section 31A-31-103 or any other provision of state or federal law;
208 (ii) within 36 months for a coordination of benefits error; or
209 (iii) within 18 months for any other reason not identified in Subsection (15)(a)(i) or (ii);
210 (b) take any action against a provider that is permitted under the terms of the provider
211 contract and not prohibited by this section;

212 (c) report the provider to a state or federal agency with regulatory authority over the
213 provider for unprofessional, unlawful, or fraudulent conduct; or
214 (d) enter into a mutual agreement with a provider to resolve alleged violations of this
215 section through mediation or binding arbitration.
216 Section 3. **Effective date.**
217 This act takes effect on September 1, 2001.