Part 3
Claim Practices

31A-26-301 Timely payment of claims.

(1)
(a) Unless otherwise provided by law, an insurer shall timely pay every valid insurance claim made by an insured.
(b) By rule the commissioner may prescribe:
(i) the kinds of notice and proof of loss that will establish validity;
(ii) the manner in which an insurer may make a bona fide denial of a claim;
(iii) the periods of time within which payment is required to be made to be timely; and
(iv) the reasonable interest rates to be charged upon late claim payments.
(2)
(a) Notwithstanding Subsection (1) and subject to Subsection (2)(b), the payment of a claim is not overdue during any period in which:
(i) the insurer is unable to pay the claim because there is no recipient legally able to give a valid release for the payment; or
(ii) the insurer is unable to determine who is entitled to receive the payment.
(b) Subsection (2)(a) applies only if the insurer:
(i) promptly notifies the claimant of the inability to pay the claim; and
(ii) offers in good faith to pay the claim promptly when the inability to pay the claim is removed.
(3) This section applies only to a claim for first party benefits made by a person who is:
(a) named or defined as an insured under the terms of an insurance policy;
(b) described as a covered person under the terms of a policy of health care insurance as defined in Section 31A-1-301; or
(c) named, defined, or described:
(i) as:
(A) an insured;
(B) a beneficiary;
(C) a policyholder; or
(D) otherwise covered person; and
(ii) under the terms of:
(A) a life insurance policy; or
(B) an annuity.

Amended by Chapter 309, 2002 General Session

31A-26-301.5 Health care claims practices.

(1)
(a) Except as provided in Section 31A-8-407, an insured retains ultimate responsibility for paying for health care services the insured receives.
(b) If a health care 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 health care provider may:
(a) except as provided in Section 31A-22-610.1, bill and collect for any deductible, copayment, or uncovered service; and

(b) bill an insured for services covered by health insurance policies or otherwise notify the insured of the expenses covered by the policies.
(3) Beginning October 31, 1992, all insurers covering the insured shall notify the insured of payment and the amount of payment made to the health care provider.
(4) A health care provider shall return to an insured any amount the insured overpaid, including interest that begins accruing 90 days after the date of the overpayment, if:
(a) the insured has multiple insurers with whom the health care provider has contracts that cover the insured; and
(b) the health care provider becomes aware that the health care provider has received, for any reason, payment for a claim in an amount greater than the health care provider's contracted rate allows.
(5)
(a) 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.
(b) These rules shall be limited to the form and content of the disclosures on the explanation of benefits, and shall include:
(i) a requirement that the method of determination of any specifically referenced customary charges and the range of the customary charges be disclosed; and
(ii) a prohibition against an implication that the health care provider is charging excessively if the health care provider is:
(A) a participating provider; and
(B) prohibited from balance billing.

Amended by Chapter 203, 2018 General Session

31A-26-301.6 Health care claims practices.
(1) As used in this section:
(a) "Health care provider" means a person licensed to provide health care under:
(i)Title 26B, Chapter 2, Part 2, Health Care Facility Licensing and Inspection; or
(ii)Title 58, Occupations and Professions.
(b) "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.
(c) "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) Except as provided in Subsection (4), within 30 days of the day on which the insurer receives a written claim, an insurer shall:
(i) pay the claim; or

(ii) deny the claim and provide a written explanation for the denial.

(b)

(i) Subject to Subsection (3)(b)(ii), the time period described in Subsection (3)(a) may be extended by 15 days if the insurer:

(A) determines that the extension is necessary due to matters beyond the control of the insurer; and

(B) before the end of the 30-day period described in Subsection (3)(a), notifies the provider and insured in writing of:

(I) the circumstances requiring the extension of time; and

(II) the date by which the insurer expects to pay the claim or deny the claim with a written explanation for the denial.

(ii) If an extension is necessary due to a failure of the provider or insured to submit the information necessary to decide the claim:

(A) the notice of extension required by this Subsection (3)(b) shall specifically describe the required information; and

(B) the insurer shall give the provider or insured at least 45 days from the day on which the provider or insured receives the notice before the insurer denies the claim for failure to provide the information requested in Subsection (3)(b)(ii)(A).

(4)

(a) In the case of a claim for income replacement benefits, within 45 days of the day on which the insurer receives a written claim, an insurer shall:

(i) pay the claim; or

(ii) deny the claim and provide a written explanation of the denial.

(b) Subject to Subsections (4)(d) and (e), the time period described in Subsection (4)(a) may be extended for 30 days if the insurer:

(i) determines that the extension is necessary due to matters beyond the control of the insurer; and

(ii) before the expiration of the 45-day period described in Subsection (4)(a), notifies the insured of:

(A) the circumstances requiring the extension of time; and

(B) the date by which the insurer expects to pay the claim or deny the claim with a written explanation for the denial.

(c) Subject to Subsections (4)(d) and (e), the time period for complying with Subsection (4)(a) may be extended for up to an additional 30 days from the day on which the 30-day extension period provided in Subsection (4)(b) ends if before the day on which the 30-day extension period ends, the insurer:

(i) determines that due to matters beyond the control of the insurer a decision cannot be rendered within the 30-day extension period; and

(ii) notifies the insured of:

(A) the circumstances requiring the extension; and

(B) the date as of which the insurer expects to pay the claim or deny the claim with a written explanation for the denial.

(d) A notice of extension under this Subsection (4) shall specifically explain:

(i) the standards on which entitlement to a benefit is based; and

(ii) the unresolved issues that prevent a decision on the claim.

(e) If an extension allowed by Subsection (4)(b) or (c) is necessary due to a failure of the insured to submit the information necessary to decide the claim:

(i) the notice of extension required by Subsection (4)(b) or (c) shall specifically describe the necessary information; and
(ii) the insurer shall give the insured at least 45 days from the day on which the insured receives the notice before the insurer denies the claim for failure to provide the information requested in Subsection (4)(b) or (c).

(5) If a period of time is extended as permitted under Subsection (3)(b), (4)(b), or (4)(c), due to an insured or provider failing to submit information necessary to decide a claim, the period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to the insured or provider until the date on which the insured or provider responds to the request for additional information.

(6) An insurer shall pay all sums to the provider or insured that the insurer is obligated to pay on the claim, and provide a written explanation of the insurer's decision regarding any part of the claim that is denied within 20 days of receiving the information requested under Subsection (3)(b), (4)(b), or (4)(c).

(7)
(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:
(i) a written explanation of the part of the claim that was denied; and
(ii) notice of the adverse benefit determination review process established under Section 31A-22-629.
(c) This Subsection (7) does not apply to a person receiving benefits under the state Medicaid program as defined in Section 26B-3-101, unless required by the Department of Health and Human Services or federal law.

(8)
(a) 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) The late fee described in Subsection (8)(a) shall be determined by multiplying together:
(i) the total amount of the claim the insurer is obliged to pay;
(ii) the total number of days the response or the payment is late; and
(iii) 0.033% daily interest rate.
(c) Any late fee paid or collected under this Subsection (8) shall be separately identified on the documentation used by the insurer to pay the claim.
(d) For purposes of this Subsection (8), "late fee" does not include an amount that is less than $1.

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

(10) An insurer or person representing an insurer may not 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 (8) when a violation has occurred;
(i) threatening to retaliate or actual retaliation against a provider for the provider applying this section;
(j) any material violation of this section; and
(k) any other unfair claim settlement practice established in rule or law.

(11)
(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 (11)(a), this section may not be the basis for a bad faith insurance claim.
(c) Nothing in Subsection (11)(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.

(12)
(a) Pursuant to Chapter 2, Part 2, Duties and Powers of Commissioner, 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) The commissioner may establish rules to facilitate the exchange of electronic confirmations when claims-related information has been received.
(d) Notwithstanding Subsection (12)(b), the commissioner may not adopt rules regarding the review process required by Subsection (9).

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

(14) Nothing in this section may be construed as limiting the ability of an insurer to:
(a) recover any amount improperly paid to a provider or an insured:
(i) in accordance with Section 31A-31-103 or any other provision of state or federal law;
(ii) within 24 months of the amount improperly paid for a coordination of benefits error;
(iii) within 12 months of the amount improperly paid for any other reason not identified in Subsection (14)(a)(i) or (ii); or
(iv) within 36 months of the amount improperly paid when the improper payment was due to a recovery by Medicaid, Medicare, the Children's Health Insurance Program, or any other state or federal health care program;
(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.

(15) A health care provider may only seek recovery from the insurer for an amount improperly paid by the insurer within the same time frames as Subsections (14)(a) and (b).
(16)
(a) An insurer may offer the remittance of payment through a credit card or other similar arrangement.
(b)
(i) A health care provider may elect not to receive remittance through a credit card or other similar arrangement.
(ii) An insurer:
(A) shall permit a health care provider's election described in Subsection (16)(b)(i) to apply to the health care provider's entire practice; and
(B) may not require a health care provider's election described in Subsection (16)(b)(i) to be made on a patient-by-patient basis.
(c) An insurer may not require a health care provider or insured to accept remittance through a credit card or other similar arrangement.

Amended by Chapter 328, 2023 General Session

31A-26-301.7 Dental claim transparency.
(1) As used in this section:
(a) "Bundling" means the practice of combining distinct dental procedures into one procedure for billing purposes.
(b) "Dental plan" means the same as that term is defined in Section 31A-22-646.
(c) "Downcoding" means the adjustment of a claim submitted to a dental plan to a less complex or lower cost procedure code.
(d) "Covered services" means the same as that term is defined in Section 31A-22-646.
(e) "Material change" means a change to:
(i) a dental plan's rules, guidelines, policies, or procedures concerning payment for dental services;
(ii) the general policies of the dental plan that affect a reimbursement paid to providers; or
(iii) the manner by which a dental plan adjudicates and pays a claim for services.
(2) An insurer that contracts or renews a contract with a dental provider shall:
(a) make a copy of the insurer's current dental plan policies available online; and
(b) if requested by a provider, send a copy of the policies to the provider through mail or electronic mail.
(3) Dental policies described in Subsection (2) shall include:
(a) a summary of all material changes made to a dental plan since the policies were last updated;
(b) the downcoding and bundling policies that the insurer reasonably expects to be applied to the dental provider or provider's services as a matter of policy; and
(c) a description of the dental plan's utilization review procedures, including:
(i) a procedure for an enrollee of the dental plan to obtain review of an adverse determination in accordance with Section 31A-22-629; and
(ii) a statement of a provider's rights and responsibilities regarding the procedures described in Subsection (3)(c)(i).
(4) An insurer may not maintain a dental plan that:
(a) based on the provider's contracted fee for covered services, uses downcoding in a manner that prevents a dental provider from collecting the fee for the actual service performed from either the plan or the patient; or

(b) uses bundling in a manner where a procedure code is labeled as nonbillable to the patient unless, under generally accepted practice standards, the procedure code is for a procedure that may be provided in conjunction with another procedure.

(5) An insurer shall ensure that an explanation of benefits for a dental plan includes the reason for any downcoding or bundling result.

Enacted by Chapter 288, 2021 General Session

31A-26-302 Settlement of claims in credit life and accident and health insurance.

(1) The creditor shall promptly report all claims to the insurer or its designated claim representative. The insurer shall maintain adequate claims files. All claims shall be settled as soon as possible in accordance with the terms of the insurance contract.

(2) The insurer shall pay all claims either by draft drawn upon the insurer or by check of the insurer to the order of the claimant to whom payment of the claim is due pursuant to the policy provisions, or upon direction of that claimant to another.

(3) A person other than the insurer or its designated claim representative may not settle or adjust claims. The creditor may not be designated as a claims representative.

Amended by Chapter 116, 2001 General Session

31A-26-303 Unfair claim settlement practices.

(1) No insurer or person representing an insurer may engage in any unfair claim settlement practice under Subsections (2), (3), and (4).

(2) Each of the following acts is an unfair claim settlement practice:

(a) knowingly misrepresenting material facts or the contents of insurance policy provisions at issue in connection with a claim under an insurance contract; however, this provision does not include the failure to disclose information;

(b) attempting to use a policy application which was altered by the insurer without notice to, or knowledge, or consent of, the insured as the basis for settling or refusing to settle a claim; or

(c) failing to settle a claim promptly under one portion of the insurance policy coverage, where liability and the amount of loss are reasonably clear, in order to influence settlements under other portions of the insurance policy coverage, but this Subsection (2)(c) applies only to claims made by persons in direct privity of contract with the insurer.

(3) Each of the following is an unfair claim settlement practice if committed or performed with such frequency as to indicate a general business practice by an insurer or persons representing an insurer:

(a) failing to acknowledge and act promptly upon communications about claims under insurance policies;

(b) failing to adopt and implement reasonable standards for the prompt investigation and processing of claims under insurance policies;

(c) compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by those insureds when the amounts claimed were reasonably near to the amounts recovered;

(d) failing, after payment of a claim, to inform insureds or beneficiaries, upon request by them, of the coverage under which payment was made;

(e) failing to promptly provide to the insured a reasonable explanation of the basis for denial of a claim or for the offer of a compromise settlement;

(f) appealing from substantially all arbitration awards in favor of insureds for the purpose of compelling them to accept settlements or compromises for less than the amount awarded in arbitration;
(g) delaying the investigation or payment of claims by requiring an insured, claimant, or the physician of either to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms which contain substantially the same information; or
(h) not attempting in good faith to effectuate a prompt, fair, and equitable settlement of claims in which liability is reasonably clear.
(4) The commissioner may define by rule, acts or general business practices which are unfair claim settlement practices, after a finding that those practices are misleading, deceptive, unfairly discriminatory, overreaching, or an unreasonable restraint on competition.
(5) This section does not create any private cause of action.

Amended by Chapter 91, 1987 General Session

31A-26-304 Prohibition of conflicting roles.

A person licensed concurrently as both an independent and a public adjuster may not represent both the insurer and the insured in the same transaction.

Enacted by Chapter 242, 1985 General Session

31A-26-305 Request for accepted check.

If an insurance policy claimant entitled to receive money in settlement of a claim makes a timely request to the insurer for payment by accepted check, the insurer shall make payment to the claimant with a check accepted by the drawee under Sections 70A-3-410 through 70A-3-413.

Amended by Chapter 204, 1986 General Session

31A-26-306 Place of business -- Records.

(1)
(a) An insurance adjuster licensed under this chapter shall register and maintain with the commissioner:
(i) the address and telephone number of the licensee's principal place of business;
(ii) a valid business email address at which the commissioner may contact the licensee; and
(iii) if the licensee is an individual, the licensee's residence address and telephone number.
(b) A licensee shall notify the commissioner within 30 days of a change in one of the following required to be registered under Subsection (1)(a):
(i) an address;
(ii) a telephone number; or
(iii) a business email address.
(2) Except as provided under Subsection (3), an insurance adjuster shall keep at the address registered under Subsection (1), a record of the transactions consummated under the insurance adjuster's license, including a record of:
(a) each investigation or adjustment undertaken or consummated; and
(b) a fee, commission, or other compensation received or to be received by the adjuster on account of the investigation or adjustment.

(3) Subsection (2) is satisfied if the records specified in Subsection (2) can be obtained immediately from a central storage place elsewhere by on-line computer terminals located at the registered address.
(4)
(a) A record maintained as to a transaction under Subsection (2) shall be kept available for the inspection of the commissioner during all business hours for a period of time after the date of the transaction specified by the commissioner by rule, but in no case for less than the current calendar year plus three years.
(b) Discarding a record after the then applicable record retention period is passed does not place the licensee in violation of a later-adopted longer record retention period.

Amended by Chapter 284, 2011 General Session

31A-26-307 Claim reports to commissioner.

On the commissioner's request, any insurer or licensed adjuster connected with a loss or claim shall report to the commissioner all facts relative to the loss or claim arising under any insurance contract covering a subject of insurance that is resident, located, or to be performed in this state.

Enacted by Chapter 242, 1985 General Session

31A-26-308 Settlement of liability insurance claim not admission of liability.

No settlement or partial settlement of a claim against any insured under a liability insurance policy is an admission, by either the insured or the insurer, of the liability of the insured on any claim arising from the same event or set of facts, whether the settlement is made by the insured, the insurer, or any other person on behalf of the insured or the insurer.

Enacted by Chapter 242, 1985 General Session

31A-26-309 Adjuster's duty to report illegal insurance.

Section 31A-15-110 applies to the adjuster's duty to report illegal insurance.

Enacted by Chapter 242, 1985 General Session

31A-26-310 Compensation of insurer's or insured's claims adjuster.

(1)
(a) Except as provided in Subsection (2), an insurer or an insured may not pay a person who is representing the insurer or insured in connection with an insurance claim adjustment on any basis that is dependent, in whole or in part, upon the amounts paid an insured or claimant under an insurance policy.
(b) Subsection (1)(a) includes payments to:
(i) an employee of:
(A) the insurer; or
(B) the insured;
(ii) an independent contractor; or
(iii) a public adjuster.
(2) Subsection (1) does not prohibit a compensation arrangement:
(a) based upon the overall profitability of the insurer;
(b) based upon the discovery or proof of fraudulent insurance claims; or

(c) conforming to an order or rule of the commissioner that addresses the compensation of persons engaged in insurance adjusting on behalf of:
(i) an insurer; or
(ii) an insured.

Amended by Chapter 252, 2003 General Session

31A-26-311 Rescission of contracts with public adjusters.

(1) Except as provided in Subsection (2), an insured or claimant under an insurance policy who contracts with a public adjuster to assist in the settlement of a claim may rescind that contract by delivering written notice of rescission to the public adjuster within 10 days of entering into the contract.
(2) Subsection (1) does not apply if prior to the rescission the public adjuster has effected an acceptable settlement of the claim.

Enacted by Chapter 204, 1986 General Session

31A-26-312 Prohibited conduct.

(1) An independent adjuster or public adjuster may not:
(a) participate directly or indirectly in the reconstruction, repair, or restoration of damaged property that is the subject of a claim adjusted by the independent adjuster or public adjuster;
(b) engage in any other activities that may reasonably be construed as presenting a conflict of interest, including soliciting or accepting remuneration from, or having a financial interest in, or deriving any direct or indirect financial benefit from, a salvage firm, repair firm, construction firm, or other firm that obtains business in connection with a claim that the independent adjuster or public adjuster has a contract or agreement to adjust;
(c) subject to Subsection (2), directly or indirectly solicit employment for an attorney or enter into a contract with an insured for the primary purpose of referring an insured to an attorney and without actually performing the services customarily provided by an independent adjuster or public adjuster;
(d) act on behalf of an attorney in having an insured sign an attorney representation agreement; or
(e) accept a fee, commission, or other valuable consideration of any nature, regardless of form or amount, in exchange for the referral by an independent adjuster or public adjuster of an insured to a third-party person, including an attorney, appraiser, umpire, construction company, contractor, repair firm, or salvage company.
(2) Subsection (1)(c) may not be construed to prohibit an independent adjuster or public adjuster from recommending a specific attorney to an insured.
(3) An independent adjuster or public adjuster who violates this section is subject to Section 31A-2-308.

Enacted by Chapter 168, 2017 General Session

31A-26-313 Health care collection actions -- Notification required.

(1) As used in this section:
(a)
(i) "Collection action" means any action taken to recover funds that are past due or accounts that are in default:

(A) for health care services; and
(B) that directly results in an adverse report to a credit bureau.
(ii) "Collection action" includes using the services of a collection agency to engage in collection action.
(iii) "Collection action" does not include:
(A) billing or invoicing for funds that are not past due or accounts that are not in default; or
(B) providing the notice required in this section.
(b) "Credit bureau" means a consumer reporting agency as defined in 15 U.S.C. Sec. 1681a.
(c) "Text message" means a real time or near real time message that consists of text and is transmitted to a device identified by a telephone number.
(2)
(a) Before engaging in a collection action, a health care provider:
(i) shall, after the day on which the period of time for an insurer to pay or deny a claim without penalty, described in Section 31A-26-301.6, expires, send a notice described in Subsection (3) to the insured by certified mail with return receipt requested, priority mail, first class mail, email, or text message; and
(ii) for a Medicare beneficiary or retiree 65 years of age or older, shall, after the date that Medicare determines Medicare's liability for the claim, send a notice described in Subsection (3) to the insured by certified mail with return receipt requested, priority mail, first class mail, or text message.
(b) A health care provider may not engage in a collection action before the date described in Subsection (3)(b) for that collection action.
(3) The notice described in Subsection (2)(a) shall state:
(a) the amount that the insured owes;
(b) the date by which the insured must pay the amount owed that is:
(i) at least 45 days after the day on which the health care provider sends the notice; or
(ii) if the insured is a Medicare beneficiary or retiree 65 years of age or older, at least 60 days after the day on which the health care provider sends the notice;
(c) that if the insured fails to timely pay the amount owed, the health care provider or a third party may make a report to a credit bureau or use the services of a collection agency; and
(d) that each action described in Subsection (3)(c) may negatively impact the insured's credit score.
(4) A health care provider is not subject to the requirements described in Subsection (2) if the health care provider complies with the provisions of 26 C.F.R. Sec. 1.501(r)-6.
(5) A health care provider that contracts with a third party to engage in a collection action is not subject to the requirements described in Subsection (2) if:
(a) entering into the contract does not require a report to a credit bureau by either the health care provider or the third party; and
(b) the third party agrees to provide the notice in accordance with Subsection (2) before the third party may engage in any activity that directly results in a report to a credit bureau.
(6) If a third party fails to comply with the notice requirements described in this section, the health care provider that renders the health care service is liable for any penalty resulting from the noncompliance of the third party.

Amended by Chapter 321, 2019 General Session