

Chapter 31 Insurance Fraud Act

31A-31-101 Title.

This chapter may be cited as the "Insurance Fraud Act."

Enacted by Chapter 243, 1994 General Session

31A-31-102 Definitions.

As used in this chapter:

- (1) "Authorized agency" means:
 - (a) the attorney general;
 - (b) the state fire marshal;
 - (c) any state law enforcement agency;
 - (d) any criminal investigative department or agency of the United States;
 - (e) a district attorney;
 - (f) the prosecuting attorney of any municipality or county;
 - (g) the department; or
 - (h) the disciplinary section of an agency licensing a service provider.
- (2) "Financial loss" includes:
 - (a) out-of-pocket expenses;
 - (b) reasonable attorney fees;
 - (c) repair and replacement costs; or
 - (d) claims payments.
- (3) "Insurer" means any person or aggregation of persons:
 - (a) doing insurance business, as defined in Section 31A-1-301; or
 - (b) subject to the supervision of the commissioner under:
 - (i) this title; or
 - (ii) any equivalent insurance supervisory official of another state.
- (4) "Knowingly" has the same meaning as in Subsection 76-2-103(2).
- (5) "Person" means an individual, firm, company, corporation, association, limited liability company, partnership, organization, society, business trust, service provider, or any other legal entity.
- (6)
 - (a) "Runner" means a person who procures clients at the direction of, or in cooperation with a person who intends to:
 - (i) perform or obtain a service or benefit under a contract of insurance; or
 - (ii) assert a claim against an insured.
 - (b) "Runner" includes:
 - (i) a capper; or
 - (ii) a steerer.
- (7) "Service provider" means:
 - (a) an individual licensed to practice law;
 - (b) an individual licensed or certified by the state under:
 - (i) this title;
 - (ii) Title 41, Chapter 3, Motor Vehicle Business Regulation Act;
 - (iii) Title 58, Occupations and Professions; or
 - (iv) Title 61, Securities Division - Real Estate Division;

- (c) an individual licensed in another jurisdiction in a manner similar to a license described in Subsection (7)(a) or (b);
 - (d) an individual practicing any nonmedical treatment rendered in accordance with a recognized religious method of healing; or
 - (e) a hospital, health care facility, or person whose services are compensated directly or indirectly by insurance.
- (8) "Statement" includes any:
- (a)
 - (i) notice;
 - (ii) statement;
 - (iii) proof of loss;
 - (iv) bill of lading;
 - (v) receipt for payment;
 - (vi) invoice;
 - (vii) account;
 - (viii) estimate of property damage;
 - (ix) bill for services;
 - (x) diagnosis;
 - (xi) prescription;
 - (xii) hospital or doctor record;
 - (xiii) x-ray;
 - (xiv) test result; or
 - (xv) other evidence of loss, injury, or expense; or
 - (b) item listed in Subsection (8)(a) that is a computer-generated document.

Amended by Chapter 104, 2004 General Session

31A-31-103 Fraudulent insurance act.

- (1) A person commits a fraudulent insurance act if that person with intent to deceive or defraud:
- (a) knowingly presents or causes to be presented to an insurer any oral or written statement or representation knowing that the statement or representation contains false, incomplete, or misleading information concerning any fact material to an application for the issuance or renewal of an insurance policy, certificate, or contract, as part of or in support of:
 - (i) obtaining an insurance policy the insurer would otherwise not issue on the basis of underwriting criteria applicable to the person;
 - (ii) a scheme or artifice to avoid paying the premium that an insurer charges on the basis of underwriting criteria applicable to the person; or
 - (iii) a scheme or artifice to file an insurance claim for a loss that has already occurred;
 - (b) presents or causes to be presented to an insurer any oral or written statement or representation:
 - (i)
 - (A) as part of, or in support of, a claim for payment or other benefit pursuant to an insurance policy, certificate, or contract; or
 - (B) in connection with any civil claim asserted for recovery of damages for personal or bodily injuries or property damage; and
 - (ii) knowing that the statement or representation contains false, incomplete, or misleading information concerning any fact or thing material to the claim;
 - (c) knowingly accepts a benefit from the proceeds derived from a fraudulent insurance act;

- (d) intentionally, knowingly, or recklessly devises a scheme or artifice to obtain fees for anything of value, including professional services, by means of false or fraudulent pretenses, representations, promises, or material omissions;
 - (e) knowingly assists, abets, solicits, or conspires with another to commit a fraudulent insurance act;
 - (f) knowingly supplies false or fraudulent material information in any document or statement required by the department;
 - (g) knowingly fails to forward a premium to an insurer in violation of Section 31A-23a-411.1; or
 - (h) knowingly employs, uses, or acts as a runner for the purpose of committing a fraudulent insurance act.
- (2) A service provider commits a fraudulent insurance act if that service provider with intent to deceive or defraud:
- (a) knowingly submits or causes to be submitted a bill or request for payment:
 - (i) containing charges or costs for an item or service that are substantially in excess of customary charges or costs for the item or service; or
 - (ii) containing itemized or delineated fees for what would customarily be considered a single procedure or service;
 - (b) knowingly furnishes or causes to be furnished an item or service to a person:
 - (i) substantially in excess of the needs of the person; or
 - (ii) of a quality that fails to meet professionally recognized standards;
 - (c) knowingly accepts a benefit from the proceeds derived from a fraudulent insurance act; or
 - (d) assists, abets, solicits, or conspires with another to commit a fraudulent insurance act.
- (3) An insurer commits a fraudulent insurance act if that insurer with intent to deceive or defraud:
- (a) knowingly withholds information or provides false or misleading information with respect to an application, coverage, benefits, or claims under a policy or certificate;
 - (b) assists, abets, solicits, or conspires with another to commit a fraudulent insurance act;
 - (c) knowingly accepts a benefit from the proceeds derived from a fraudulent insurance act; or
 - (d) knowingly supplies false or fraudulent material information in any document or statement required by the department.
- (4) An insurer or service provider is not liable for any fraudulent insurance act committed by an employee without the authority of the insurer or service provider unless the insurer or service provider knew or should have known of the fraudulent insurance act.

Amended by Chapter 193, 2019 General Session

31A-31-104 Disclosure of information.

- (1)
- (a) Subject to Subsection (2), upon written request by an insurer to an authorized agency, the authorized agency may release to the insurer information or evidence that is relevant to any suspected insurance fraud.
 - (b) Upon written request by an authorized agency to an insurer, the insurer or an agent authorized by the insurer to act on the insurer's behalf shall release to the authorized agency information or evidence that is relevant to any suspected insurance fraud.
- (2)
- (a) Any information or evidence furnished to an authorized agency under this section may be classified as a protected record in accordance with Subsection 63G-2-305(10).
 - (b) Any information or evidence furnished to an insurer under this section is not subject to discovery in a civil proceeding unless, after reasonable notice to any insurer, agent, or

any authorized agency that has an interest in the information and subsequent hearing, a court determines that the public interest and any ongoing criminal investigation will not be jeopardized by the disclosure.

- (c) An insurer shall report to the department agency terminations based upon a violation of this chapter.

Amended by Chapter 445, 2013 General Session

31A-31-105 Immunity.

- (1)
 - (a) A person, insurer, or authorized agency is immune from civil action, civil penalty, or damages when in good faith that person, insurer, or authorized agency:
 - (i) cooperates with an agency described in Subsection (1)(b);
 - (ii) furnishes evidence to an agency described in Subsection (1)(b);
 - (iii) provides information regarding a suspected fraudulent insurance act to an agency described in Subsection (1)(b);
 - (iv) receives information regarding a suspected fraudulent insurance act from an agency described in Subsection (1)(b); or
 - (v) submits a required report to the department under Section 31A-31-110.
 - (b) An agency referred to in Subsection (1)(a) is one or more of the following:
 - (i) the department or a division of the department;
 - (ii) a federal, state, or government agency established to detect and prevent insurance fraud;
 - (iii) a nonprofit organization established to detect and prevent insurance fraud; or
 - (iv) an agent, employee, or designee of an agency listed in this Subsection (1)(b).
- (2) An insurer, or person employed by an insurer, is immune from civil action, civil penalty, or damages when in good faith the insurer or person employed by an insurer provides or shares information with another insurer or insurer's employee in a good faith effort to discover or prevent a fraudulent insurance act or other criminal conduct.
- (3) A person, insurer, or authorized agency is immune from civil action, civil penalty, or damages if that person, insurer, or authorized agency complies in good faith with a court order to provide evidence or testimony requested by an agency described in Subsection (1)(b).
- (4) This section does not abrogate or modify a common law or statutory right, privilege, or immunity enjoyed by a person.
- (5) Notwithstanding any other provision in this section, a person, insurer, or service provider is not immune from civil action, civil penalty or damages under this section if that person commits the fraudulent insurance act that is the subject of the information.

Amended by Chapter 253, 2012 General Session

31A-31-106 Disciplinary action.

- (1) If, after giving notice and a hearing conducted pursuant to Title 63G, Chapter 4, Administrative Procedures Act, the commissioner finds by a preponderance of the evidence that a person licensed under Title 31A, Insurance Code, has committed a fraudulent insurance act, the commissioner may suspend or revoke the license issued under Title 31A, Insurance Code.
- (2) If the appropriate licensing authority finds by a preponderance of the evidence that a service provider violated Section 31A-31-103, the service provider is subject to revocation or suspension of the service provider's license.

- (3) The commissioner may notify the appropriate licensing authority of conduct by a service provider that the commissioner believes may constitute a fraudulent insurance act.

Amended by Chapter 382, 2008 General Session

31A-31-107 Workers' compensation insurance fraud.

- (1) In any action involving workers' compensation insurance, Section 34A-2-110 supersedes this chapter.
- (2) Nothing in this section prohibits the department from investigating and pursuing civil or criminal penalties in accordance with Section 31A-31-109 and Title 34A, Utah Labor Code, for violations of Section 34A-2-110.

Amended by Chapter 193, 2019 General Session

31A-31-108 Assessment of insurers.

- (1) For purposes of this section:
 - (a) The commissioner shall by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, define:
 - (i) "annuity consideration";
 - (ii) "membership fees";
 - (iii) "other fees";
 - (iv) "deposit-type contract funds"; and
 - (v) "other considerations in Utah."
 - (b) "Insurance fraud provisions" means:
 - (i) this chapter;
 - (ii) Section 34A-2-110; and
 - (iii) Section 76-6-521.
 - (c) "Utah consideration" means:
 - (i) the total premiums written for Utah risks;
 - (ii) annuity consideration;
 - (iii) membership fees collected by the insurer;
 - (iv) other fees collected by the insurer;
 - (v) deposit-type contract funds; and
 - (vi) other considerations in Utah.
 - (d) "Utah risks" means insurance coverage on the lives, health, or against the liability of persons residing in Utah, or on property located in Utah, other than property temporarily in transit through Utah.
- (2) To implement insurance fraud provisions, the commissioner may assess an admitted insurer and a nonadmitted insurer transacting insurance under Chapter 15, Part 1, Unauthorized Insurers and Surplus Lines, and Chapter 15, Part 2, Risk Retention Groups Act, an annual fee as follows:
 - (a) \$200 for an insurer for which the sum of the Utah consideration is less than or equal to \$1,000,000;
 - (b) \$450 for an insurer for which the sum of the Utah consideration is greater than \$1,000,000 but is less than or equal to \$2,500,000;
 - (c) \$800 for an insurer for which the sum of the Utah consideration is greater than \$2,500,000 but is less than or equal to \$5,000,000;

- (d) \$1,600 for an insurer for which the sum of the Utah consideration is greater than \$5,000,000 but less than or equal to \$10,000,000;
 - (e) \$6,100 for an insurer for which the sum of the Utah consideration is greater than \$10,000,000 but less than \$50,000,000; and
 - (f) \$15,000 for an insurer for which the sum of the Utah consideration equals or exceeds \$50,000,000.
- (3) Money received by the state under this section shall be deposited into the Insurance Fraud Investigation Restricted Account created in Subsection (4).
- (4)
- (a) There is created in the General Fund a restricted account known as the "Insurance Fraud Investigation Restricted Account."
 - (b) The Insurance Fraud Investigation Restricted Account shall consist of the money received by the commissioner under this section and Subsections 31A-31-109(1)(a)(ii), (1)(b), (2)(b)(i), (2)(c), and (3)(a). Money ordered paid under Subsections 31A-31-109(1)(a)(i) and (2)(a) shall be deposited in the Insurance Fraud Victim Restitution Fund pursuant to Section 31A-31-108.5.
 - (c) The commissioner shall administer the Insurance Fraud Investigation Restricted Account. Subject to appropriations by the Legislature, the commissioner shall use the money deposited into the Insurance Fraud Investigation Restricted Account to pay for a cost or expense incurred by the commissioner in the administration, investigation, and enforcement of insurance fraud provisions.

Amended by Chapter 319, 2013 General Session

31A-31-108.5 Insurance Fraud Victim Restitution Fund.

- (1) There is created an expendable special revenue fund known as the "Insurance Fraud Victim Restitution Fund."
- (2) The Insurance Fraud Victim Restitution Fund shall consist of money ordered paid under Subsections 31A-31-109(1)(a)(i) and (2)(a).
- (3) The commissioner shall administer the Insurance Fraud Victim Restitution Fund for the sole benefit of insurance fraud victims.

Enacted by Chapter 319, 2013 General Session

31A-31-109 Civil penalties.

- (1) In addition to other penalties provided by law, a person who violates this chapter:
 - (a) is subject to the following civil penalties:
 - (i) the person shall make full restitution; and
 - (ii) the person shall pay the costs of enforcement of this chapter for the case in which the person is found to have violated this chapter:
 - (A) as determined by the one or more authorized agencies involved; and
 - (B) including costs of:
 - (I) investigators;
 - (II) attorneys; and
 - (III) other public employees; and
 - (b) in the discretion of the court, may be required to pay to the state a civil penalty not to exceed three times that amount of value improperly sought or received from the fraudulent insurance act.

- (2)
 - (a) Money paid under Subsection (1)(a)(i) shall be paid to the person damaged by the fraudulent insurance act.
 - (b) Money paid under Subsection (1)(a)(ii) shall be paid to each applicable authorized agency in the following order:
 - (i) to the Insurance Fraud Investigation Restricted Account created in Section 31A-31-108 for the costs of enforcement incurred by the commissioner;
 - (ii) to the General Fund for the costs of enforcement incurred by a state agency other than the commissioner;
 - (iii) to the applicable political subdivision for the costs of enforcement incurred by the political subdivision; and
 - (iv) to the applicable criminal investigative department or agency of the United States for the costs of enforcement incurred by the department or agency.
 - (c) Money paid under Subsection (1)(b) shall be paid into the General Fund.
- (3)
 - (a) A civil penalty assessed under Subsection (1) shall be awarded by the court as part of its judgment in both criminal and civil actions.
 - (b) A criminal action need not be brought against a person in order for that person to be civilly liable under this section.

Amended by Chapter 284, 2011 General Session

31A-31-110 Mandatory reporting of fraudulent insurance acts.

- (1)
 - (a) A person shall report a fraudulent insurance act to the department if:
 - (i) the person has a good faith belief on the basis of a preponderance of the evidence that a fraudulent insurance act is being, will be, or has been committed by a person other than the person making the report; and
 - (ii) the person is:
 - (A) an insurer; or
 - (B) in relation to the business of title insurance, an auditor that is employed by a title insurer.
 - (b) The report required by this Subsection (1) shall:
 - (i) be in writing;
 - (ii) provide information in detail relating to:
 - (A) the fraudulent insurance act; and
 - (B) the perpetrator of the fraudulent insurance act; and
 - (iii)
 - (A) state whether the person required to report under Subsection (1)(a) also reported the fraudulent insurance act in writing to:
 - (I) the attorney general;
 - (II) a state law enforcement agency;
 - (III) a criminal investigative department or agency of the United States;
 - (IV) a district attorney; or
 - (V) the prosecuting attorney of a municipality or county; and
 - (B) if the person reported the fraudulent insurance act as provided in Subsection (1)(b)(iii)(A), state the agency to which the person reported the fraudulent insurance act.
 - (c) A person required to submit a written report under this Subsection (1) shall submit the written report to the department by no later than 90 days from the day on which the person required

- to report the fraudulent insurance act has a good faith belief on the basis of a preponderance of the evidence that the fraudulent insurance act is being, will be, or has been committed.
- (2) An action brought under Section 31A-2-201, 31A-2-308, or 31A-31-109, for failure to comply with Subsection (1) shall be commenced within four years from the date on which a person described in Subsection (1):
 - (a) has a good faith belief on the basis of a preponderance of the evidence that a fraudulent insurance act is being, will be, or has been committed; and
 - (b) willfully fails to report the fraudulent insurance act.
 - (3) The department may by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, provide a process by which a person described in Subsection (1)(a)(ii)(B) may comply with the requirements of Subsection (1) by reporting a fraudulent insurance act to the insurer with whom the person is employed, except that the rule shall provide that if the person reports the fraudulent insurance act to the insurer, the insurer is required to report the fraudulent insurance act to the department.
 - (4) A person described in Subsection (1)(a)(ii) who in good faith makes a report under this section, in accordance with Section 31A-31-105, is immune from civil action, civil penalty, or damages for making that report.

Amended by Chapter 150, 2008 General Session

31A-31-111 Health discount program fraud.

- (1) In addition to any other fraudulent acts prohibited by this chapter, a person commits a fraudulent insurance act if that person with intent to deceive or defraud:
 - (a) accepts fees, dues, charges, or other consideration for providing a health discount program as defined in Section 31A-8a-102 without having health care providers under contract who have agreed to provide the discounts promised to enrollees; or
 - (b) operates a health discount program without complying with the provisions of Section 31A-8a-201.
- (2) In addition to any other civil penalties or remedies provided by law, a person who violates this section is guilty of a third degree felony.

Enacted by Chapter 58, 2005 General Session

31A-31-112 Insurance antifraud plan.

- (1) An insurer, as defined in Section 31A-31-102, shall prepare, implement, and maintain an insurance antifraud plan for its operations in this state.
- (2) The insurance antifraud plan required by Subsection (1) shall outline specific procedures, actions, and safeguards that include how the authorized insurer or health maintenance organization will do each of the following:
 - (a) detect, investigate, and prevent all forms of insurance fraud, including:
 - (i) fraud involving its employees or agents;
 - (ii) fraud resulting from misrepresentations in the application, renewal, or rating of insurance policies;
 - (iii) fraudulent claims; and
 - (iv) breach of security of its data processing systems;
 - (b) educate employees of fraud detection and the insurance antifraud plan;
 - (c) provide for fraud investigations, whether through the use of internal fraud investigators or third-party contractors;

- (d) report a suspected fraudulent insurance act, as described in Section 31A-31-103, to the department as required by Section 31A-31-110; and
 - (e) pursue restitution for financial loss caused by insurance fraud.
- (3) The commissioner may investigate and examine the records and operations of authorized insurers and health maintenance organizations to determine if they have implemented and complied with the insurance antifraud plan.
- (4) The commissioner may:
- (a) direct any modification to the insurance antifraud plan necessary to comply with the requirements of this section; and
 - (b) require action to remedy substantial noncompliance with the insurance antifraud plan.

Enacted by Chapter 138, 2016 General Session