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. The act defines an unfair claim settlement practice. The act authorizes the**
9 **Insurance Commissioner to audit compliance, impose sanctions, and adopt rules necessary**
10 **to enforce the act.**

11 This act affects sections of Utah Code Annotated 1953 as follows:
12 ENACTS:
13 **31A-26-301.6**, Utah Code Annotated 1953
14 *Be it enacted by the Legislature of the state of Utah:*
15 Section 1. Section **31A-26-301.6** is enacted to read:
16 **31A-26-301.6. Health care provider claims practices.**
17 (1) As used in this section:
18 (a) "Articulable reason" may include a determination regarding:
19 (i) eligibility for coverage;
20 (ii) preexisting conditions;
21 (iii) applicability of other public or private insurance; and
22 (iv) any other reason that would justify an extension of the time to investigate a claim.
23 (b) "Insurer" is as defined in Section 31A-1-301 and includes:
24 (i) a health maintenance organization; and
25 (ii) a third-party administrator that offers, sells, manages, or administers a health insurance
26 policy or health maintenance organization contract that is subject to this title.
27 (c) "Medical treatment protocol" means a preferred, standardized course of medical

28 treatment for a particular health condition, and does not include utilization review or
29 preauthorization requirements.
30 (d) "Provider" means a health care provider to whom an insurer is obligated to pay directly
31 in connection with a claim by virtue of:
32 (i) an agreement between the insurer and the provider;
33 (ii) a health insurance policy or contract of the insurer; or
34 (iii) state or federal law.
35 (2) An insurer shall timely pay every valid insurance claim submitted by a provider in
36 accordance with this section.
37 (3) (a) Within 30 days of receiving a written claim, an insurer shall:
38 (i) pay all sums to the provider that the insurer is obligated to pay on a claim that is not
39 subject to:
40 (A) a request for information under Subsection (3)(a)(iii); or
41 (B) an investigation that cannot be reasonably completed within 30 days under Subsection
42 (4);
43 (ii) provide a complete explanation in writing of any part of the claim that is denied;
44 (iii) specifically describe and request any additional information from the provider that is
45 necessary to process some part or all of the claim that is unpaid; and
46 (iv) investigate the claim if the insurer has a good faith and articulable reason to believe
47 that the insurer is not obligated to pay some part or all of the claim.
48 (b) A provider shall respond to each request by an insurer for additional necessary
49 information made under Subsection (3)(a)(iii) within 30 days of receipt of the request by providing
50 the requested information that is in the possession of the provider, unless the provider has
51 requested and received the permission of the insurer to extend the 30-day period.
52 (4) Notwithstanding Subsection (3)(a)(iv), the time to investigate a claim may be extended
53 by the insurer for an additional 30 days if:
54 (a) the investigation cannot reasonably be completed within 30 days; and
55 (b) before the end of the 30-day period in Subsection (3)(a)(iv), the insurer informs the
56 provider in writing of the reason for the payment delay, the nature of the investigation, the
57 timelines for investigations established in this section, and the anticipated completion date.
58 (5) Notwithstanding Subsections (3)(a)(iv) and (4), the time to investigate a claim may be

59 extended beyond the initial 30-day period and the extended 30-day period if:
60 (a) due to matters beyond the control of the insurer, the investigation cannot reasonably
61 be completed within 60 days;
62 (b) before the end of the combined 60-day period, the insurer makes a written request to
63 the commissioner for an extension, including the reason for the delay, the nature of the
64 investigation, and the anticipated completion date; and
65 (c) before the end of the combined 60-day period, the commissioner informs the insurer
66 that the request for an extension has been granted, based on a finding that:
67 (i) there is a good faith and articulable reason to believe that the insurer is not obligated
68 to pay some part or all of the claim; and
69 (ii) the investigation cannot reasonably be completed within 60 days.
70 (6) An extension granted by the commissioner under Subsection (5)(c) shall include the
71 completion date for the investigation.
72 (7) Within 15 days of receiving the information requested under Subsection (3)(a)(ii) or
73 within 15 days of completing an investigation under Subsection (4) or (5), an insurer shall:
74 (a) pay all sums to the provider that the insurer is obligated to pay on the claim; and
75 (b) provide a complete explanation in writing of any part of the claim that is denied.
76 (8) (a) Whenever an insurer makes a payment to a provider on any part of a claim under
77 this section, the insurer shall also send to the insured an explanation of benefits paid.
78 (b) Whenever an insurer denies any part of a claim under this section, the insurer shall also
79 send to the insured a complete explanation in writing of the part of the claim that was denied and
80 notice of the grievance review process established under Section 31A-22-629.
81 (9) (a) A late fee shall be imposed on:
82 (i) an insurer that fails to timely pay a claim in accordance with this section; and
83 (ii) a provider that fails to timely provide information on a claim in accordance with this
84 section.
85 (b) For the first 90 days that a claim or a response to a request for information is
86 delinquent, the late fee shall be determined by multiplying together:
87 (i) the total amount of the claim;
88 (ii) the total number of days the claim was delinquent; and
89 (iii) .1%.

90 (c) For a claim that is delinquent for 91 or more days, the late fee shall be determined by
91 adding together:
92 (i) the late fee for a 90-day delinquency under Subsection (9)(b); and
93 (ii) the following sum multiplied together:
94 (A) the total amount of the claim;
95 (B) the total number of days the claim was delinquent beyond 90 days; and
96 (C) the rate of interest set in accordance with Section 15-1-1.
97 (d) Any late fee paid or collected under this section shall be separately identified on the
98 documentation used by the insurer to pay the claim.
99 (10) No insurer or person representing an insurer may engage in any unfair claim
100 settlement practice with respect to a provider. Unfair claim settlement practices include:
101 (a) knowingly misrepresenting a material fact or the contents of an insurance policy or
102 provider contract in connection with a claim;
103 (b) failing to acknowledge and substantively respond within 15 days to any written
104 communication from a provider relating to a pending claim;
105 (c) denying or threatening to deny the payment of a claim for any reason that is not clearly
106 described in the insured's policy or the provider agreement;
107 (d) rescinding, cancelling, or threatening to rescind or cancel a provider agreement for any
108 reason that is not clearly described as a ground for denial, cancellation, or rescission in the
109 agreement;
110 (e) failing to maintain a payment process sufficient to comply with this section;
111 (f) failing to maintain claims documentation sufficient to demonstrate compliance with
112 this section;
113 (g) requesting additional information from a provider that:
114 (i) is not necessary to process a claim; and
115 (ii) is intended to materially delay payment of the claim; or
116 (iii) has the effect of imposing an unreasonable and unjustifiable burden on the provider;
117 (h) failing to disclose in a provider contract the specific rate and terms under which the
118 provider will be paid for health care services;
119 (i) failing to timely pay a valid claim in accordance with this section as a means of
120 influencing, intimidating, retaliating, or gaining an advantage over the provider with respect to an

121 unrelated claim or some other aspect of the contractual relationship;
122 (j) connecting provider claims reimbursement to compliance with medical treatment
123 protocols or the performance or utilization patterns of noneconomically integrated providers;
124 (k) conditioning the payment of an undisputed part of a claim on the provider's acceptance
125 to forgo payment on all or part of the disputed part of a claim;
126 (l) failing to pay the sum when required and as required under Subsection (9) when a
127 violation has occurred;
128 (m) threatening to retaliate or actual retaliation against a provider for availing himself of
129 the provisions of this section;
130 (n) any material violation of this section; and
131 (o) any other unfair claim settlement practice established in rule or otherwise recognized
132 by a court or administrative body.
133 (11) (a) Pursuant to Chapter 2, Part 2, Duties and Powers of Commissioner and within
134 existing legislative appropriations, the commissioner may conduct examinations to determine an
135 insurer's level of compliance with this section and impose sanctions for each violation.
136 (b) The commissioner may adopt rules as necessary to implement this section, which may
137 include any one or more of the following:
138 (i) confirmations between insurers and providers when electronic claims-related
139 information has been received; and
140 (ii) an independent review process for resolving payment-related disputes between insurers
141 and providers.
142 (12) Nothing in this section may be construed as limiting the collection rights of a provider
143 under Section 31A-26-301.5.
144 (13) Nothing in this section may be construed as limiting the ability of an insurer to:
145 (a) recover within 12 months any amount improperly paid to a provider pursuant to Section
146 31A-31-103 or any other provision of state or federal law;
147 (b) consistent with due process requirements for notice and an opportunity to be heard,
148 take any action against a provider that is permitted under the terms of the provider contract for
149 violations of the contract;
150 (c) report the provider to a state or federal agency with regulatory authority over the
151 provider for unprofessional, unlawful, or fraudulent conduct; or

152 (d) enter into a mutual agreement with a provider to resolve alleged violations of this
153 section through mediation or binding arbitration.
154 (14) (a) The provisions of this section shall be included in each contract between an insurer
155 and a contracting provider and shall remain in full force and effect for the duration of the contract.
156 (b) Nothing in Subsection (14)(a) may be construed as limiting an insurer and a provider
157 from including provisions in their contract that exceed the provisions of this section.

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## Legislative Review Note
**as of 1-9-01 1:32 PM**

A limited legal review of this legislation raises no obvious constitutional or statutory concerns.

**Office of Legislative Research and General Counsel**