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₡ 02-21-02 10:28 AM ₡

1 # HEALTH INSURANCE PROMPT PAY
2 # AMENDMENTS

3 2002 GENERAL SESSION

4 STATE OF UTAH

5 **Sponsor: Peter C. Knudson**

6 **This act amends the Insurance Code. The act amends provisions related to health care**
7 **provider claims practices. The act amends the definition of provider to include a general**
8 **acute hospital to whom an insurer has an indirect obligation to pay. This act makes**
9 **technical amendments to the calculations of penalties for failure to timely pay a claim.**
10 This act affects sections of Utah Code Annotated 1953 as follows:
11 AMENDS:
12 **31A-26-301.6**, as enacted by Chapter 240, Laws of Utah 2001
13 *Be it enacted by the Legislature of the state of Utah:*
14 Section 1. Section **31A-26-301.6** is amended to read:
15 **31A-26-301.6. Health care provider claims practices.**
16 (1) As used in this section:
17 (a) "Articulable reason" may include a determination regarding:
18 (i) eligibility for coverage;
19 (ii) preexisting conditions;
20 (iii) applicability of other public or private insurance;
21 (iv) medical necessity; and
22 (v) any other reason that would justify an extension of the time to investigate a claim.
23 (b) "Health care provider" means a person licensed to provide health care under Title 26,
24 Chapter 21, Health Care Facility Licensing and Inspection Act, or Title 58, Occupations and
25 Professions.
26 (c) "Insurer" means an admitted or authorized insurer, as defined in Section 31A-1-301,
27 and includes:

28 (i) a health maintenance organization; and
29 (ii) a third-party administrator that is subject to this title, provided that nothing in this
30 section may be construed as requiring a third party administrator to use its own funds to pay claims
31 that have not been funded by the entity for which the third party administrator is paying claims.
32 (d) (i) "Provider" means a health care provider to whom an insurer is obligated to pay
33 directly in connection with a claim by virtue of:
34 [~~(i)~~] (A) an agreement between the insurer and the provider;
35 [~~(ii)~~] (B) a health insurance policy or contract of the insurer; or
36 [~~(iii)~~] (C) state or federal law[~~.~~]; and
37 (ii) a general acute hospital as defined in Section 26-21-2 to whom an insurer is obligated
38 to pay indirectly in connection with a claim by virtue of any of the factors described in Subsections
39 (1)(d)(i)(A) through (C).
40 (2) An insurer shall timely pay every valid insurance claim submitted by a provider in
41 accordance with this section.
42 (3) (a) Within 30 days of receiving a written claim, an insurer shall do one of the
43 following:
44 (i) pay the claim unless Subsection (3)(a)(ii), (iii), (iv), or (v) applies;
45 (ii) provide a written explanation if the claim is denied;
46 (iii) specifically describe and request any additional information from the provider that is
47 necessary to process the claim;
48 (iv) inform the provider, pursuant to Subsection (4), of the 30-day extension of the
49 insurer's investigation of the claim; or
50 (v) request additional information and inform the provider of the 30-day extension if both
51 Subsections (3)(a)(iii) and (iv) apply.
52 (b) A provider shall respond to each request by an insurer for additional necessary
53 information made under Subsection (3)(a)(iii) or (v) within 30 days of receipt of the request by
54 providing the requested information that is in the possession of the provider, unless:
55 (i) the provider has requested and received the permission of the insurer to extend the
56 30-day period; or
57 (ii) the provider explains to the insurer in writing that additional time, which may not
58 exceed 30 days, is necessary to comply with the request for information.

59 (c) Subsection (7) shall apply after an insurer has received the information requested.
60 (4) The time to investigate a claim may be extended by the insurer for an additional
61 30-days if:
62 (a) the investigation of the claim cannot reasonably be completed within the initial 30-day
63 period of Subsection (3)(a);
64 (b) before the end of the 30-day period in Subsection (3)(a), the insurer informs the
65 provider in writing of the reason for the payment delay, the nature of the investigation, the
66 timelines for investigations established in this section, and the anticipated completion date.
67 (5) Notwithstanding Subsection (4), the time to investigate a claim may be extended
68 beyond the initial 30-day period and the extended 30-day period if:
69 (a) due to matters beyond the control of the insurer, the investigation cannot reasonably
70 be completed within 60 days as to some part or all of the claim;
71 (b) before the end of the combined 60-day period, the insurer makes a written request to
72 the commissioner for an extension, including the reason for the delay, the nature of the
73 investigation, the anticipated completion date, and the amount of any partial payment of the claim
74 made pursuant to Subsection (5)(d);
75 (c) before the end of the combined 60-day period, the commissioner informs the insurer
76 that the request for an extension has been granted, based on a finding that:
77 (i) there is a good faith and articulable reason to believe that the insurer is not obligated
78 to pay some part or all of the claim; and
79 (ii) the investigation cannot reasonably be completed within 60 days; and
80 (d) the insurer identifies and pays all sums the insurer is obligated to pay on the claim and
81 which are not subject to the extension requested under this Subsection (5).
82 (6) An extension granted by the commissioner under Subsection (5)(c) shall include the
83 completion date for the investigation.
84 (7) (a) An insurer shall pay all sums to the provider that the insurer is obligated to pay on
85 the claim, and provide a written explanation of any part of the claim that is denied within 20 days
86 of:
87 (i) receiving the information requested under Subsection (3)(a)(iii);
88 (ii) completing an investigation under Subsection (4) or (5); or
89 (iii) the latter of Subsection (3)(a)(iii) or (iv), if Subsection (3)(a)(v) applies.

90 (b) (i) Except as provided in Subsection (7)(c), an insurer may send a follow-up request
91 for additional information within the 20-day time period in Subsection (7)(a) if the previous
92 response of the provider was not sufficient for the insurer to make a decision on the claim.
93 (ii) A follow-up request for additional necessary information shall state with specificity:
94 (A) the reason why the previous response was insufficient;
95 (B) the information that is necessary to comply with the request for information; and
96 (C) the reason why the requested information is necessary to process the claim.
97 (c) Unless an insurer has an extension for an investigation pursuant to Subsection (4) or
98 (5), the insurer shall pay all sums it is obligated to pay on a claim and provide a written
99 explanation of any part of the claim that is denied within 15 days of receiving a notice from the
100 provider that the provider has submitted all requested information in the provider's possession that
101 is related to the claim.
102 (8) (a) Whenever an insurer makes a payment to a provider on any part of a claim under
103 this section, the insurer shall also send to the insured an explanation of benefits paid.
104 (b) Whenever an insurer denies any part of a claim under this section, the insurer shall also
105 send to the insured a written explanation of the part of the claim that was denied and notice of the
106 grievance review process established under Section 31A-22-629.
107 (c) This Subsection (8) does not apply to a person receiving benefits under the state
108 Medicaid program as defined in Section 26-18-2, unless required by the Department of Health or
109 federal law.
110 (9) (a) Beginning with health care claims submitted on or after January 1, 2002, a late fee
111 shall be imposed on:
112 (i) an insurer that fails to timely pay a claim in accordance with this section; and
113 (ii) a provider that fails to timely provide information on a claim in accordance with this
114 section.
115 (b) For the first 90 days that a claim payment or a provider response to a request for
116 information is late, the late fee shall be determined by multiplying together:
117 (i) the total amount of the claim;
118 (ii) the total number of days the response or the payment was late; and
119 (iii) .1%.
120 (c) For a claim payment or a provider response to a request for information that is 91 or

121 more days late, the late fee shall be determined by adding together:
122 (i) the late fee for a 90-day period under Subsection (9)(b); and
123 (ii) the following [~~sum~~] multiplied together:
124 (A) the total amount of the claim;
125 (B) the total number of days the response or payment was late beyond the initial 90-day
126 period; and
127 (C) the rate of interest set in accordance with Section 15-1-1.
128 (d) Any late fee paid or collected under this section shall be separately identified on the
129 documentation used by the insurer to pay the claim.
130 (e) For purposes of this Subsection (9), "late fee" does not include an amount that is less
131 than $1.
132 (10) Each insurer shall establish a grievance review process to resolve claims-related
133 disputes between the insurer and providers.
134 (11) No insurer or person representing an insurer may engage in any unfair claim
135 settlement practice with respect to a provider. Unfair claim settlement practices include:
136 (a) knowingly misrepresenting a material fact or the contents of an insurance policy in
137 connection with a claim;
138 (b) failing to acknowledge and substantively respond within 15 days to any written
139 communication from a provider relating to a pending claim;
140 (c) denying or threatening to deny the payment of a claim for any reason that is not clearly
141 described in the insured's policy;
142 (d) failing to maintain a payment process sufficient to comply with this section;
143 (e) failing to maintain claims documentation sufficient to demonstrate compliance with
144 this section;
145 (f) failing, upon request, to give to the provider written information regarding the specific
146 rate and terms under which the provider will be paid for health care services;
147 (g) failing to timely pay a valid claim in accordance with this section as a means of
148 influencing, intimidating, retaliating, or gaining an advantage over the provider with respect to an
149 unrelated claim, an undisputed part of a pending claim, or some other aspect of the contractual
150 relationship;
151 (h) failing to pay the sum when required and as required under Subsection (9) when a

152 violation has occurred;
153 (i) threatening to retaliate or actual retaliation against a provider for availing himself of
154 the provisions of this section;
155 (j) any material violation of this section; and
156 (k) any other unfair claim settlement practice established in rule or law.
157 (12) (a) The provisions of this section shall apply to each contract between an insurer and
158 a provider for the duration of the contract.
159 (b) Notwithstanding Subsection (12)(a), this section may not be the basis for a bad faith
160 insurance claim.
161 (c) Nothing in Subsection (12)(a) may be construed as limiting the ability of an insurer and
162 a provider from including provisions in their contract that are more stringent than the provisions
163 of this section.
164 (13) (a) Pursuant to Chapter 2, Part 2, Duties and Powers of Commissioner, and beginning
165 January 1, 2002, the commissioner may conduct examinations to determine an insurer's level of
166 compliance with this section and impose sanctions for each violation.
167 (b) The commissioner may adopt rules only as necessary to implement this section.
168 (c) After December 31, 2002, the commissioner may establish rules to facilitate the
169 exchange of electronic confirmations when claims-related information has been received.
170 (d) Notwithstanding the provisions of Subsection (13)(b), the commissioner may not adopt
171 rules regarding the grievance process required by Subsection (10).
172 (14) Nothing in this section may be construed as limiting the collection rights of a provider
173 under Section 31A-26-301.5.
174 (15) Nothing in this section may be construed as limiting the ability of an insurer to:
175 (a) recover any amount improperly paid to a provider:
176 (i) in accordance with Section 31A-31-103 or any other provision of state or federal law;
177 (ii) within 36 months for a coordination of benefits error; or
178 (iii) within 18 months for any other reason not identified in Subsection (15)(a)(i) or (ii);
179 (b) take any action against a provider that is permitted under the terms of the provider
180 contract and not prohibited by this section;
181 (c) report the provider to a state or federal agency with regulatory authority over the
182 provider for unprofessional, unlawful, or fraudulent conduct; or

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

Legislative Review Note
as of 2-21-02 8:36 AM

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

Office of Legislative Research and General Counsel