1 **HEALTH INSURANCE PROMPT PAY**
2 **AMENDMENTS**
3 2006 GENERAL SESSION
4 STATE OF UTAH
5 **Chief Sponsor: Stephen H. Urquhart**
6 Senate Sponsor: ____________
7
8 **LONG TITLE**
9 **General Description:**
10 This bill amends claims practices related to health care providers under the Insurance
11 Code.
12 **Highlighted Provisions:**
13 This bill:
14 ▸ amends the definition of provider in the health care providers claims practices act;
15 and
16 ▸ makes technical amendments.
17 **Monies Appropriated in this Bill:**
18 None
19 **Other Special Clauses:**
20 None
21 **Utah Code Sections Affected:**
22 AMENDS:
23 **31A-26-301.6**, as last amended by Chapter 308, Laws of Utah 2002
24
25 *Be it enacted by the Legislature of the state of Utah:*
26 Section 1. Section **31A-26-301.6** is amended to read:
27 **31A-26-301.6. Health care provider claims practices.**

28 (1) As used in this section:
29 (a) "Articulable reason" may include a determination regarding:
30 (i) eligibility for coverage;
31 (ii) preexisting conditions;
32 (iii) applicability of other public or private insurance;
33 (iv) medical necessity; and
34 (v) any other reason that would justify an extension of the time to investigate a claim.
35 (b) "Health care provider" means a person licensed to provide health care under:
36 (i) Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act; or
37 (ii) Title 58, Occupations and Professions.
38 (c) "Insurer" means an admitted or authorized insurer, as defined in Section
39 31A-1-301, and includes:
40 (i) a health maintenance organization; and
41 (ii) a third-party administrator that is subject to this title, provided that nothing in this
42 section may be construed as requiring a third-party administrator to use its own funds to pay
43 claims that have not been funded by the entity for which the third-party administrator is paying
44 claims.
45 (d) "Provider" means:
46 (i) a health care provider to whom an insurer is obligated to pay directly in connection
47 with a claim by virtue of:
48 [~~(i)~~] (A) an agreement between the insurer and the provider;
49 [~~(ii)~~] (B) a health insurance policy or contract of the insurer; or
50 [~~(iii)~~] (C) state or federal law[~~.~~]; and
51 (ii) a general acute hospital as defined in Section 26-21-2 and a critical access hospital
52 as designated by 42 U.S.C. 1395-4(c)(2) (1998) to whom an insurer is obligated to pay
53 indirectly in connection with a claim by virtue of any of the factors described in Subsections
54 (1)(d)(i)(A) through (C).
55 (2) An insurer shall timely pay every valid insurance claim submitted by a provider in
56 accordance with this section.
57 (3) (a) Within 30 days of receiving a written claim, an insurer shall do one of the
58 following:

59 (i) pay the claim unless Subsection (3)(a)(ii), (iii), (iv), or (v) applies;
60 (ii) provide a written explanation if the claim is denied;
61 (iii) specifically describe and request any additional information from the provider that
62 is necessary to process the claim;
63 (iv) inform the provider, pursuant to Subsection (4), of the 30-day extension of the
64 insurer's investigation of the claim; or
65 (v) request additional information and inform the provider of the 30-day extension if
66 both Subsections (3)(a)(iii) and (iv) apply.
67 (b) A provider shall respond to each request by an insurer for additional necessary
68 information made under Subsection (3)(a)(iii) or (v) within 30 days of receipt of the request by
69 providing the requested information that is in the possession of the provider, unless:
70 (i) the provider has requested and received the permission of the insurer to extend the
71 30-day period; or
72 (ii) the provider explains to the insurer in writing that additional time, which may not
73 exceed 30 days, is necessary to comply with the request for information.
74 (c) Subsection (7) shall apply after an insurer has received the information requested.
75 (4) The time to investigate a claim may be extended by the insurer for an additional
76 30-days if:
77 (a) the investigation of the claim cannot reasonably be completed within the initial
78 30-day period of Subsection (3)(a); and
79 (b) before the end of the 30-day period in Subsection (3)(a), the insurer informs the
80 provider in writing of the reason for the payment delay, the nature of the investigation, the
81 timelines for investigations established in this section, and the anticipated completion date.
82 (5) Notwithstanding Subsection (4), the time to investigate a claim may be extended
83 beyond the initial 30-day period and the extended 30-day period if:
84 (a) due to matters beyond the control of the insurer, the investigation cannot reasonably
85 be completed within 60 days as to some part or all of the claim;
86 (b) before the end of the combined 60-day period, the insurer makes a written request
87 to the commissioner for an extension, including the reason for the delay, the nature of the
88 investigation, the anticipated completion date, and the amount of any partial payment of the
89 claim made pursuant to Subsection (5)(d);

90 (c) before the end of the combined 60-day period, the commissioner informs the
91 insurer that the request for an extension has been granted, based on a finding that:
92 (i) there is a good faith and articulable reason to believe that the insurer is not obligated
93 to pay some part or all of the claim; and
94 (ii) the investigation cannot reasonably be completed within 60 days; and
95 (d) the insurer identifies and pays all sums the insurer is obligated to pay on the claim
96 and which are not subject to the extension requested under this Subsection (5).
97 (6) An extension granted by the commissioner under Subsection (5)(c) shall include the
98 completion date for the investigation.
99 (7) (a) An insurer shall pay all sums to the provider that the insurer is obligated to pay
100 on the claim, and provide a written explanation of any part of the claim that is denied within 20
101 days of:
102 (i) receiving the information requested under Subsection (3)(a)(iii);
103 (ii) completing an investigation under Subsection (4) or (5); or
104 (iii) the latter of Subsection (3)(a)(iii) or (iv), if Subsection (3)(a)(v) applies.
105 (b) (i) Except as provided in Subsection (7)(c), an insurer may send a follow-up request
106 for additional information within the 20-day time period in Subsection (7)(a) if the previous
107 response of the provider was not sufficient for the insurer to make a decision on the claim.
108 (ii) A follow-up request for additional necessary information shall state with
109 specificity:
110 (A) the reason why the previous response was insufficient;
111 (B) the information that is necessary to comply with the request for information; and
112 (C) the reason why the requested information is necessary to process the claim.
113 (c) Unless an insurer has an extension for an investigation pursuant to Subsection (4)
114 or (5), the insurer shall pay all sums it is obligated to pay on a claim and provide a written
115 explanation of any part of the claim that is denied within 20 days of receiving a notice from the
116 provider that the provider has submitted all requested information in the provider's possession
117 that is related to the claim.
118 (8) (a) Whenever an insurer makes a payment to a provider on any part of a claim
119 under this section, the insurer shall also send to the insured an explanation of benefits paid.
120 (b) Whenever an insurer denies any part of a claim under this section, the insurer shall

121 also send to the insured a written explanation of the part of the claim that was denied and
122 notice of the adverse benefit determination review process established under Section
123 31A-22-629.
124 (c) This Subsection (8) does not apply to a person receiving benefits under the state
125 Medicaid program as defined in Section 26-18-2, unless required by the Department of Health
126 or federal law.
127 (9) (a) Beginning with health care claims submitted on or after January 1, 2002, a late
128 fee shall be imposed on:
129 (i) an insurer that fails to timely pay a claim in accordance with this section; and
130 (ii) a provider that fails to timely provide information on a claim in accordance with
131 this section.
132 (b) For the first 90 days that a claim payment or a provider response to a request for
133 information is late, the late fee shall be determined by multiplying together:
134 (i) the total amount of the claim;
135 (ii) the total number of days the response or the payment [~~is~~] was late; and
136 (iii) .1%.
137 (c) For a claim payment or a provider response to a request for information that is 91 or
138 more days late, the late fee shall be determined by adding together:
139 (i) the late fee for a 90-day period under Subsection (9)(b); and
140 (ii) the following multiplied together:
141 (A) the total amount of the claim;
142 (B) the total number of days the response or payment was late beyond the initial 90-day
143 period; and
144 (C) the rate of interest set in accordance with Section 15-1-1.
145 (d) Any late fee paid or collected under this section shall be separately identified on the
146 documentation used by the insurer to pay the claim.
147 (e) For purposes of this Subsection (9), "late fee" does not include an amount that is
148 less than $1.
149 (10) Each insurer shall establish a review process to resolve claims-related disputes
150 between the insurer and providers.
151 (11) No insurer or person representing an insurer may engage in any unfair claim

152 settlement practice with respect to a provider. Unfair claim settlement practices include:
153 (a) knowingly misrepresenting a material fact or the contents of an insurance policy in
154 connection with a claim;
155 (b) failing to acknowledge and substantively respond within 15 days to any written
156 communication from a provider relating to a pending claim;
157 (c) denying or threatening to deny the payment of a claim for any reason that is not
158 clearly described in the insured's policy;
159 (d) failing to maintain a payment process sufficient to comply with this section;
160 (e) failing to maintain claims documentation sufficient to demonstrate compliance with
161 this section;
162 (f) failing, upon request, to give to the provider written information regarding the
163 specific rate and terms under which the provider will be paid for health care services;
164 (g) failing to timely pay a valid claim in accordance with this section as a means of
165 influencing, intimidating, retaliating, or gaining an advantage over the provider with respect to
166 an unrelated claim, an undisputed part of a pending claim, or some other aspect of the
167 contractual relationship;
168 (h) failing to pay the sum when required and as required under Subsection (9) when a
169 violation has occurred;
170 (i) threatening to retaliate or actual retaliation against a provider for availing himself of
171 the provisions of this section;
172 (j) any material violation of this section; and
173 (k) any other unfair claim settlement practice established in rule or law.
174 (12) (a) The provisions of this section shall apply to each contract between an insurer
175 and a provider for the duration of the contract.
176 (b) Notwithstanding Subsection (12)(a), this section may not be the basis for a bad
177 faith insurance claim.
178 (c) Nothing in Subsection (12)(a) may be construed as limiting the ability of an insurer
179 and a provider from including provisions in their contract that are more stringent than the
180 provisions of this section.
181 (13) (a) Pursuant to Chapter 2, Part 2, Duties and Powers of Commissioner, and
182 beginning January 1, 2002, the commissioner may conduct examinations to determine an

183 insurer's level of compliance with this section and impose sanctions for each violation.
184 (b) The commissioner may adopt rules only as necessary to implement this section.
185 (c) After December 31, 2002, the commissioner may establish rules to facilitate the
186 exchange of electronic confirmations when claims-related information has been received.
187 (d) Notwithstanding the provisions of Subsection (13)(b), the commissioner may not
188 adopt rules regarding the review process required by Subsection (10).
189 (14) Nothing in this section may be construed as limiting the collection rights of a
190 provider under Section 31A-26-301.5.
191 (15) Nothing in this section may be construed as limiting the ability of an insurer to:
192 (a) recover any amount improperly paid to a provider:
193 (i) in accordance with Section 31A-31-103 or any other provision of state or federal
194 law;
195 (ii) within 36 months for a coordination of benefits error; or
196 (iii) within 18 months for any other reason not identified in Subsection (15)(a)(i) or
197 (ii);
198 (b) take any action against a provider that is permitted under the terms of the provider
199 contract and not prohibited by this section;
200 (c) report the provider to a state or federal agency with regulatory authority over the
201 provider for unprofessional, unlawful, or fraudulent conduct; or
202 (d) enter into a mutual agreement with a provider to resolve alleged violations of this
203 section through mediation or binding arbitration.

Legislative Review Note
as of 1-26-06 2:33 PM

Based on a limited legal review, this legislation has not been determined to have a high probability of being held unconstitutional.

Office of Legislative Research and General Counsel

Fiscal Note

Bill Number HB0343

Health Insurance Prompt Pay Amendments

07-Feb-06

11:19 AM

State Impact

Any additional effort required by this bill can be handled within existing budgets. State and local governments that own and operate certain types of hospitals could realize increased revenue collections.

Individual and Business Impact

Some hospitals could realize increased revenue collections.

Office of the Legislative Fiscal Analyst