State of Utah
Administrative Rule Analysis
Revised May 2023

NOTICE OF PROPOSED RULE		
TYPE OF FILING: Repeal and Reenact		
Title No. - Rule No. - Section No.		
Rule or Section Number:	**R590-191**	**Filing ID: Office Use Only**

Agency Information

1. Department:	Insurance	
Agency:	Administration	
Room number:	Suite 2300	
Building:	Taylorsville State Office Building	
Street address:	4315 S. 2700 W.	
City, state and zip:	Taylorsville, UT 84129	
Mailing address:	PO Box 146901	
City, state and zip:	Salt Lake City, UT 84114-6901	
Contact persons:		
Name:	**Phone:**	**Email:**
Steve Gooch	801-957-9322	sgooch@utah.gov
Please address questions regarding information on this notice to the persons listed above.		

General Information

2. Rule or section catchline:

R590-191. Unfair Life Insurance Claim Settlement Practice Rule

3. Purpose of the new rule or reason for the change:

The rule is being changed in compliance with Executive Order 2021-12. During the review of this rule, the department discovered a number of minor issues that needed to be amended.

4. Summary of the new rule or change:

The majority of the changes are being done to fix style issues to bring the rule text more in line with current rulewriting standards. Other changes make the language of the rule more clear, remove the Penalties and Enforcement Date sections, and update the Severability section to use the department's current language. The changes do not add, remove, or change any regulations or requirements.

Fiscal Information

5. Provide an estimate and written explanation of the aggregate anticipated cost or savings to:

A) State budget:

There is no anticipated cost or savings to the state budget. The changes are largely clerical in nature, and will not change how the department functions.

B) Local governments:

There is no anticipated cost or savings to local governments. The changes are largely clerical in nature, and will not affect local governments.

C) Small businesses ("small business" means a business employing 1-49 persons)**:**

There is no anticipated cost or savings to small businesses. The changes are largely clerical in nature, and will not affect small businesses.

D) Non-small businesses ("non-small business" means a business employing 50 or more persons)**:**

There is no anticipated cost or savings to non-small businesses. The changes are largely clerical in nature, and will not affect non-small businesses.

E) Persons other than small businesses, non-small businesses, state, or local government entities ("person" means any individual, partnership, corporation, association, governmental entity, or public or private organization of any character other than an ***agency***)**:**

There is no anticipated cost or savings to any other persons. The changes are largely clerical in nature.

F) Compliance costs for affected persons (How much will it cost an impacted entity to adhere to this rule or its changes?)**:**

There are no compliance costs for any affected persons. The changes are largely clerical in nature.

G) Regulatory Impact Summary Table (This table only includes fiscal impacts that could be measured. If there are inestimable fiscal impacts, they will not be included in this table. Inestimable impacts will be included in narratives above.)

Regulatory Impact Table

Fiscal Cost	**FY2024**	**FY2025**	**FY2026**
State Government	$0	$0	$0
Local Governments	$0	$0	$0
Small Businesses	$0	$0	$0
Non-Small Businesses	$0	$0	$0
Other Persons	$0	$0	$0
Total Fiscal Cost	**$0**	**$0**	**$0**
Fiscal Benefits	**FY2024**	**FY2025**	**FY2026**
State Government	$0	$0	$0
Local Governments	$0	$0	$0
Small Businesses	$0	$0	$0
Non-Small Businesses	$0	$0	$0
Other Persons	$0	$0	$0
Total Fiscal Benefits	**$0**	**$0**	**$0**
Net Fiscal Benefits	**$0**	**$0**	**$0**

H) Department head comments on fiscal impact and approval of regulatory impact analysis:

The Commissioner of Insurance, Jonathan T. Pike, has reviewed and approved this regulatory impact analysis.

Citation Information

6. Provide citations to the statutory authority for the rule. If there is also a federal requirement for the rule, provide a citation to that requirement:

Section 31A-2-201	Section 31A-21-312	Section 31A-26-301
Section 31A-26-303		

Incorporations by Reference Information

7. Incorporations by Reference (if this rule incorporates more than two items by reference, please include additional tables)**:**

A) This rule adds, updates, or removes the following title of materials incorporated by references (a copy of materials incorporated by reference must be submitted to the Office of Administrative Rules; *if none, leave blank*)**:**

Official Title of Materials Incorporated (from title page)	
Publisher	
Issue Date	
Issue or Version	

B) This rule adds, updates, or removes the following title of materials incorporated by references (a copy of materials incorporated by reference must be submitted to the Office of Administrative Rules; *if none, leave blank*)**:**

Official Title of Materials Incorporated (from title page)	
Publisher	
Issue Date	

Issue or Version	

Public Notice Information

8. The public may submit written or oral comments to the agency identified in box 1. (The public may also request a hearing by submitting a written request to the agency. See Section 63G-3-302 and Rule R15-1 for more information.)		
A) Comments will be accepted until:		08/14/2023
B) A public hearing (optional) will be held:		
Date (mm/dd/yyyy)**:**	**Time** (hh:mm AM/PM)**:**	**Place** (physical address or URL)**:**
To the agency: If more space is needed for a physical address or URL, refer readers to Box 4 in General Information. If more than two hearings will take place, continue to add rows.		

9. This rule change MAY become effective on:	08/21/2023
NOTE: The date above is the date the agency anticipates making the rule or its changes effective. It is NOT the effective date.	

Agency Authorization Information

To the agency: Information requested on this form is required by Sections 63G-3-301, 63G-3-302, 63G-3-303, and 63G-3-402. Incomplete forms will be returned to the agency for completion, possibly delaying publication in the *Utah State Bulletin* and delaying the first possible effective date.			
Agency head or designee and title:	Steve Gooch, Public Information Officer	**Date:**	06/29/2023

R590. Insurance, Administration.

[~~R590-191. Unfair Life Insurance Claims Settlement Practices Rule.~~

~~R590-191-1. Authority.~~

~~This rule is promulgated pursuant to Subsections 31A-2-201(1) and 31A-2-201(3)(a) in which the commissioner is empowered to administer and enforce this title and to make rules to implement the provisions of this title. Further authority to provide for timely payment of claims is provided by Subsection 31A-26-301(1). Matters relating to proof and notice of loss are promulgated pursuant to Section 31A-26-301 and Subsection 31A-21-312(5). Authority to promulgate rules defining unfair claims settlement practices or acts is provided in Subsection 31A-26-303(4). The authority to require a timely response to the Insurance Department is provided by Section 31A-2-202(4). Authority to require payment of interest on death proceeds is provided in Section 31A-22-428.~~

~~R590-191-2. Purpose.~~

~~This rule sets forth minimum standards for the investigation and disposition of life insurance claims arising under policies or certificates issued to residents of the State of Utah. These standards include fair and rapid settlement of claims, protecting claimants under insurance policies from unfair claims settlement practices and promoting the professional competence of those engaged in processing claims. The various provisions of this rule are intended to define procedures and practices which constitute unfair claim settlement practices. This rule is regulatory in nature and is not intended to create a private right of action.~~

~~R590-191-3. Definitions.~~

~~For the purpose of this rule the Commissioner adopts the definitions as set forth in Section 31A-1-301, and the following:~~

~~(1) "Beneficiary" means the party entitled to receive the proceeds or benefits occurring under the policy.~~

~~(2) "Claim File" means any record either in its original form or as recorded by any process which can accurately and reliably reproduce the original material regarding the claim, its investigation, adjustment and settlement.~~

~~(3) "Claim Representative" means any individual, corporation, association, organization, partnership, or other legal entity authorized to represent an insurer with respect to a claim.~~

~~(4) "Claimant" means a person making a claim under a policy, including an insured, policyholder, beneficiary, or the claimant's legal representative, including a member of the claimant's immediate family.~~

~~(5) "Days" means calendar days.~~

~~(6) "Documentation" includes, but is not limited to, all written and electronic communication records, transactions, notes, work papers, claim forms, and explanation of benefits forms relative to the claim.~~

~~(7) "Investigation" means all activities of an insurer related to the determination of liabilities under coverages afforded by an insurance policy or insurance contract.~~

~~(8) "Notice of Loss" means any notification, whether in writing or other means acceptable under the terms of an insurance policy to an insurer or its representative, by a claimant, which reasonably apprises the insurer of the facts pertinent to a claim.~~

~~(9) "Proof of Loss" means written proofs, such as claim forms, medical authorizations or other reasonable evidence of the claim~~

that is ordinarily required of all claimants submitting claims.

R590-191-4. Minimum Standards for Prompt, Fair and Equitable Claim Handling Processes and Communications.

(1) Notice of loss to an insurer, if required, shall be considered timely if made according to the terms of the policy, subject to the definitions and provisions of this rule, and the provisions of Section 31A-21-312.

(2) Notice of loss may be given to the insurer or its representative unless the insurer clearly directs otherwise in accordance with policy provisions or in a separate written notice mailed or delivered to the claimant.

(3) Subject to policy provisions, a requirement of any notice of loss may be waived by an authorized representative of the insurer.

(4) Insurance policies may not require notice of loss to be given in a manner which is inconsistent with the actual practice of the insurer. For example, if the practice of the insurer is to accept notice of loss by telephone, the policy shall reflect that practice, and not require that the claimant furnish "immediate written notice" of loss.

(5) Within 15 days of receipt of notice of loss from a claimant, the insurer shall provide necessary claim forms, instructions, and reasonable assistance so the claimant can properly comply with company requirements for filing a claim.

(6) Proof of loss to an insurer, if required, shall be considered timely if made according to the terms of the policy, subject to the definitions and provisions of this rule, and the provisions of Section 31A-21-312. Proof of loss requirements may not be unreasonable and should consider all of the circumstances surrounding a given claim.

(7) Within 15 days of receipt of proof of loss from a claimant, the insurer shall:

(a) provide written acknowledgment of the receipt of the proof of loss;

(b) request any necessary additional information from claimant; and

(c) commence any necessary investigation of the claim, including requesting additional information from other parties having documentation or information relating to the claim; or

(d) provide the claim settlement and a written explanation of benefits to the claimant if no additional information or investigation is necessary.

(8) Within 15 days of receipt of any communications relating to a claim which reasonably suggests that a response is expected, the insurer shall substantively respond to such communication.

(9) Within 30 days of receipt of proof of loss from the claimant, the insurer shall complete the investigation of a claim, unless such investigation cannot reasonably be completed within such time. It shall be the burden of the insurer to establish, by adequate records, that the investigation could not be completed within 30 days of its receipt of proof of loss. If the investigation cannot be completed within 30 days, the insurer shall communicate to the claimant a written explanation as to the reasons for the delay and shall continue to so communicate at least every 30 days until the claim is either settled or denied.

(10) Within 15 days of completion of the investigation, the insurer shall either:

(a) provide the claim settlement and a written explanation of benefits to the claimant; or

(b) provide, in writing, a denial of the claim and an explanation to the claimant as to the reasons for the denial.

(11) Closing a claim file without settlement is considered a denial and must be so communicated in writing to the claimant and according to the provisions of the policy.

(12) If recalculation/revisitation of a claim becomes necessary subsequent to either denial or settlement, the insurer shall again comply with the initial claim handling process requirements as described in this section.

(13) Upon receipt of an inquiry from the Insurance Department regarding a claim, every licensee shall furnish a substantive response to the Insurance Department within the time period specified in the inquiry.

R590-191-5. Unfair Claims Settlement Practices.

The commissioner, pursuant to 31A-26-303(4), hereby finds the following acts or failure to perform required acts to be misleading, deceptive, unfairly discriminatory, or overreaching in the settlement of claims:

(1) concealing from or failing to fully disclose to a claimant any benefits, limitations, exclusions, coverages, or other relevant provisions of an insurance policy or insurance contract under which a claim is presented;

(2) denying or threatening the denial of a claim for any reason which is not clearly described in the policy;

(3) refusing to settle claims without conducting a reasonable and complete investigation;

(4) refusing to provide a written basis for the denial of a claim upon demand of the claimant;

(5) failing to provide the claimant with a written explanation of the evidence of any investigation or file materials giving rise to the denial of a claim based on misrepresentation or fraud on an insurance application, when such misrepresentation is the basis for the denial;

(6) compensating employees, agents or contractors of any amounts which are based on savings to the insurer as a result of reducing or denying claims;

(7) making a claim settlement to the claimant not accompanied by a statement or explanation of benefits setting forth the coverage under which the settlement is being made and how the settlement amount was calculated;

(8) failing to settle a claim following receipt of proof of loss when liability is reasonably clear in order to influence other claim settlements under other portions of the insurance policy coverage or under other policies of insurance;

(9) advising a claimant not to obtain the services of an attorney or other advocate or suggesting the claimant will receive less money if an attorney is used to pursue or advise on the merits of a claim;

(10) misleading a claimant as to the applicable statute of limitations;

(11) issuing a check or draft in partial settlement of a loss or a claim under a specified coverage when such check or draft contains

~~language which purports to release the insurer from total liability;~~

~~(12)(a) for policies issued prior to May 5, 2008, failing to pay interest at the legal rate, as provided in Title 15 of the Utah Code upon amounts that are overdue under these rules. A claim shall be considered overdue if not settled within 15 days of completion of the investigation; or~~

~~(b) for policies issued on or after May 5, 2008, failing to pay interest in accordance with Section 31A-22-428; and~~

~~(13) failing to deliver a copy of the insurer's guidelines for prompt investigation of claims to the Insurance Department when requested to do so.~~

~~**R590-191-6. File and Record Documentation.**~~

~~Each insurer's claim files for policies or certificates are subject to examination by the commissioner of insurance or by the commissioner's duly appointed designees. To aid in such examination:~~

~~(1) The insurer shall maintain accessible and retrievable claim file data for examination. The insurer shall be able to provide the policy number, certificate number if any, duplicate of the policy as issued, date of loss, date notice of loss was received, date proof of loss was received, date any investigation commenced, date the investigation was completed, date of settlement or denial of the claim or date the claim was closed without settlement, documentation as to how the claim was settled and how any payments were calculated, and any other documentation relied upon for claim settlement by the insurer. This data shall be available for all open and closed files for at least the most recent three year period, or, for a Utah domiciled insurer, since the date of the previous examination by the department, whichever is longer.~~

~~(2) Detailed documentation shall be contained in each claim file in order to permit reconstruction of the insurer's activities relative to each claim.~~

~~(3) Each document within the claim file shall be noted as to date received, date processed or date mailed.~~

~~(4) The claim file records must be maintained either in hard copy files, or some other format that has the capability of duplication to hard copy.~~

~~**R590-191-7. Penalties.**~~

~~A person found, after an administrative proceeding, to be in violation of this rule, shall be subject to penalties as provided under Section 31A-2-308.~~

~~**R590-191-8. Enforcement Date.**~~

~~The commissioner will begin enforcing the provisions of this rule immediately upon the effective date.~~

~~**R590-191-9. Severability.**~~

~~If any provision or clause of this rule or its application to any person or situation is held invalid, such invalidity may not affect any other provision or application of this rule which can be given effect without the invalid provision or application, and to this end the provisions of this rule are declared to be severable.~~]

R590-191. Unfair Life Insurance Claim Settlement Practice Rule.

R590-191-1. Authority.

This rule is promulgated by the commissioner pursuant to Sections 31A-2-201, 31A-21-312, 31A-26-301, and 31A-26-303.

R590-191-2. Purpose and Scope.

(1) The purpose of this rule is to:

(a) set standards for the investigation and disposition of an annuity contract or life insurance claim; and

(b) identify an unfair claim practice.

(2) This rule applies to an insurer and an authorized agent.

R590-191-3. Definitions.

Terms used in this rule are defined in Section 31A-1-301. Additional terms are defined as follows:

(1) "Authorized agent" means an individual, corporation, association, organization, partnership, or other legal entity authorized to represent an insurer with respect to a claim.

(2) "Beneficiary" means a party entitled to receive proceeds or benefits under a contract or policy.

(3) "Claim file" means a record that can accurately and reliably reproduce the original material regarding a claim, its investigation, adjustment, and settlement.

(4) "Claimant" means an insured or an insured's legal representative, including an immediate family member designated by the insured.

(5) "Days" means calendar days.

(6) "Documentation" means a physical or an electronic record related to a claim.

(7) "General business practice" means a pattern of conduct in a business.

(8) "Investigation" means an activity of an insurer related to the determination of liability of a claim.

(9) "Notice of loss" means a claimant's notice that reasonably informs an insurer of the facts related to a claim.

(10) "Proof of loss" means a claimant's reasonable documentation in support of a claim.

R590-191-4. File and Record Documentation.

(1) An insurer's claim file is subject to examination by the commissioner.

(2) To aid in an examination, an insurer shall maintain:

(a) claim data that is accessible and retrievable for examination, including:

(i) the policy number;

(ii) the certificate number, if any;

(iii) a duplicate of the policy, as issued;

(iv) the claim number;

(v) the date of loss;

(vi) the date the notice of loss was received;

(vii) the date the proof of loss was received;

(viii) the date an investigation began and was complete;

(ix) the date of the settlement of the claim;

(x) the type of settlement, indicated as:

(A) payment, including the amount paid;

(B) settled without payment; or

(C) denied;

(xi) documentation supporting how the claim was settled and how any payments were calculated; and

(xii) other documentation relied upon for claim settlement;

(b) detailed documentation in each claim file permitting the reconstruction of the insurer's activities relative to the claim; and

(c) the claim file record in a hard copy file or other format that has the capability of duplication to hard copy.

(3) The data in Subsection (2) shall:

(a) be available for each open and closed file for at least the most recent three-year period; or

(b) for a Utah domiciled insurer, be available from the date of the previous examination by the department.

R590-191-5. Disclosure of Policy Provisions.

(1) An insurer or an authorized agent shall disclose to a claimant any benefit, limitation, or exclusion of a policy that relates to a particular claim presented.

(2) An insurer or an authorized agent shall disclose to a claimant any provision of a policy that relates to an inquiry regarding coverage.

R590-191-6. Notice and Proof of Loss.

(1)(a) A notice of loss to an insurer, if required, is considered timely if made according to the terms of the policy, this rule, and Section 31A-21-312.

(b) A notice of loss may be given to an insurer or an authorized agent.

(c) A notice of loss requirement may be waived by an authorized agent.

(d) The general business practice of an insurer when accepting a notice of loss shall be consistent for all policyholders.

(e) Within 15 days of receiving a notice of loss from a claimant, an insurer shall provide necessary claim forms, instructions, and reasonable assistance so the claimant can properly comply with the insurer's requirements for filing a claim.

(2)(a) A proof of loss to an insurer is considered timely if made according to the terms of the policy, this rule, and Section 31A-21-312.

(b) A proof of loss requirement may not be unreasonable and shall consider the circumstances surrounding a given claim.

R590-191-7. Minimum Standards for Prompt, Fair, and Equitable Benefit Determination and Settlement.

(1)(a) A benefit determination time period begins once an insurer receives a claim, regardless of whether all necessary information was filed with the original claim.

(b) If an insurer requires an extension due to a claimant's failure to submit necessary information, the time period for making a decision is tolled from the date the notice is sent to the claimant through:

(i) the date the claimant provides the necessary information; or

(ii) 48 hours after the end of the time period for the claimant to provide the additional information.

(2) Within 15 days of receiving a proof of loss from a claimant, an insurer shall:

(a) provide written acknowledgment of receipt of the proof of loss;

(b) request any necessary additional information from the claimant; and

(c) begin any necessary investigation of the claim, including requesting additional information from other parties having documentation or information relating to the claim.

(3) If no additional information or investigation is necessary under Subsection (2), an insurer shall provide the claim settlement and a written explanation of benefits to the claimant.

(4) Within 15 days of receiving any communication relating to a claim that reasonably suggests that a response is expected, an insurer shall substantively respond to the communication.

(5)(a) Within 30 days of receiving a proof of loss from a claimant, an insurer shall complete the investigation of the claim.

(b) If the investigation cannot reasonably be completed within 30 days, an insurer shall:

(i) establish, with adequate records, that the investigation could not be completed within 30 days of its receipt of the proof of loss;

(ii) communicate to the claimant, in writing, the reasons for the delay; and

(iii) continue to communicate in writing at least every 30 days until the claim is either settled or denied.

(6) Within 15 days of completing an investigation, an insurer shall:

(a) provide a claim settlement and a written explanation to the claimant; or

(b) provide, in writing, a denial of the claim and an explanation to the claimant of the reason for the denial.

(7) Closing a claim file without settlement is a denial and must be communicated, in writing, to the claimant according to this rule and the policy provisions.

(8) If recalculation or revisitation of a claim is necessary, the insurer shall comply with the initial claim handling process requirements described in this section.

R590-191-8. Unfair Claim Settlement Practices.

The commissioner finds that the following acts or general business practices are unfair claim settlement practices and are misleading, deceptive, unfairly discriminatory, overreaching, or an unreasonable restraint on competition:

(1) concealing from or failing to fully disclose to a claimant a benefit, limitation, exclusion, coverage, or other relevant provision of a contract or policy under which a claim is presented;

(2) denying or threatening to deny a claim, rescinding, canceling, or threatening to rescind or cancel coverage under a policy for a reason that is not clearly described in the contract or policy as a reason for denial, cancellation, or rescission;

(3) refusing to settle a claim without conducting a reasonable investigation;

(4) refusing to provide a written basis for denying a claim upon demand of a claimant;

(5) failing to provide a claimant with a written explanation of the evidence of an investigation or the claim file materials supporting a denial of a claim based on misrepresentation or fraud, if misrepresentation or fraud is the basis for the denial;

(6) compensating an employee, producer, or contractor an amount based on savings to the insurer due to reducing or denying a claim;

(7) making a claim settlement to a claimant without a statement or explanation that describes the coverage under which the settlement is made and how the settlement amount was calculated;

(8) failing to settle a claim following receipt of a proof of loss if liability is reasonably clear to influence another claim settlement under another portion of the policy or under another policy;

(9) advising a claimant not to obtain the services of an attorney or other advocate, or suggesting a claimant will receive less money if an attorney is used to:

(a) pursue a claim; or

(b) advise on the merits of a claim;

(10) misleading a claimant about applicable statutes of limitation;

(11) issuing a check or a draft in partial settlement that contains language that releases an insurer from total liability;

(12)(a) a policy issued before May 5, 2008, that fails to pay interest at the legal rate, under Title 15, Chapter 1, Interest, on an amount that is overdue;

(b) a claim is overdue if not settled within 15 days of completing the investigation; and

(13) a policy issued on or after May 5, 2008, that fails to pay interest under Section 31A-22-428.

R590-191-9. Severability.

If any provision of this rule, Rule R590-191, or its application to any person or situation is held invalid, such invalidity does not affect any other provision or application of this rule that can be given effect without the invalid provision or application. The remainder of this rule shall be given effect without the invalid provision or application.

KEY: insurance law
Date of Enactment or Last Substantive Amendment: May 29, 2008
Notice of Continuation: April 3, 2019
Authorizing, and Implemented or Interpreted Law: 31A-2-201; 31A-2-204; 31A-2-308; 31A-21-312; 31A-22-428; 31A-26-301; 31A-26-303