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:	**R590-192**	**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:

R590-192. Unfair Accident and Health 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 Enforcement Date section, 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-2-216	Section 31A-21-312
Section 31A-22-629	Section 31A-26-301	Section 31A-26-301.6
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.

[~~R590-192. Unfair Accident and Health Claims Settlement Practices.~~

~~R590-192-1. 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 Title 31A and to make rules to implement the provisions of Title 31A. Further authority to provide for timely settlement 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, accurate, and complete response to the commissioner is provided by Subsections 31A-2-202(4) and (6).~~

~~R590-192-2. Purpose.~~

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

~~R590-192-3. Applicability and Scope.~~

~~(1) This rule applies to all accident and health insurance policies, as defined by Section 31A-1-301.~~

~~(2) This rule incorporates by reference 29 CFR 2560.503-1, excluding 2560.503-1(a).~~

~~R590-192-4. Definitions.~~

~~For the purpose of this rule the commissioner adopts the definitions as set forth in Section 31A-1-301, 29 CFR 2560.503-1(m), and the following:~~

~~(1)(a) "Adverse benefit determination" means, for an accident and health insurance policy other than a health benefit plan, any of the following: a denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of an insured's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of or failure to provide or make payment, in whole or in part, for a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise experimental or investigational or not medically necessary or appropriate; and~~

~~(b)(i) "Adverse benefit determination" means, for a health benefit plan:~~

~~(A) based on the insurer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, the:~~

(I) denial of a benefit;
(II) reduction of a benefit;
(III) termination of a benefit; or
(IV) failure to provide or make payment, in whole or part, for a benefit; or
(B) rescission of coverage.
(ii) "Adverse benefit determination" includes:
(A) denial, reduction, termination, or failure to provide or make payment that is based on a determination of an insured's eligibility to participate in a health benefit plan;
(B) failure to provide or make payment, in whole or part, for a benefit resulting from the application of a utilization review; and
(C) failure to cover an item or service for which benefits are otherwise provided because it is determined to be:
(I) experimental;
(II) investigational; or
(III) not medically necessary or appropriate.
(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, whether or not licensed within the State of Utah to do so.
(4) "Claimant" means an insured, or legal representative of the insured, including a member of the insured's immediate family designated by the insured, making a claim under a policy.
(5) "Ongoing" or "Concurrent care" decision means an insurer has approved an ongoing course of treatment to be provided over a period of time or number of treatments.
(6) "Days" means calendar days.
(7) "Documentation" means a document, record, or other information that is considered relevant to a claimant's claim because such document, record, or other information:
(a) was relied upon in making the benefit determination;
(b) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; and
(c) in the case of an insurer providing disability income benefits, constitutes a statement of policy or guidance with respect to the insurer concerning the denied treatment option or benefit for the insured's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.
(8) "General business practice" means a pattern of conduct.
(9) "Investigation" means all activities of an insurer directly or indirectly related to the determination of liabilities under coverage afforded by an insurance policy.
(10) "Medical necessity" means:
(a) health care services or product that a prudent health care professional would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is:
(i) in accordance with generally accepted standards of medical practice in the United States;
(ii) clinically appropriate in terms of type, frequency, extent, site, and duration;
(iii) not primarily for the convenience of the patient, physician, or other health care provider; and
(iv) covered under the contract; and
(b) when a medical question of fact exists, medical necessity shall include the most appropriate available supply or level of service for the individual in question, considering potential benefits and harms to the individual, and known to be effective.
(i) For an intervention not yet in widespread use, the effectiveness shall be based on scientific evidence.
(ii) For an established intervention, the effectiveness shall be based on:
(A) scientific evidence;
(B) professional standards; and
(C) expert opinion.
(11) "Notice of Loss" means that notice which is in accordance with policy provisions and insurer practices. Such notice shall include any notification, whether in writing or other means, which reasonably apprizes the insurer of the existence of or facts relating to a claim.
(12) "Pre-service claim" means any claim for a benefit under an accident and health policy with respect to which the terms of the plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.
(13) "Post-service claim" means any claim for a benefit that is not a pre-service claim or urgent care claim.
(14) "Scientific evidence" is:
(a)(i) scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff; or
(ii) findings, studies or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes;
(b) scientific evidence shall not include published peer-reviewed literature sponsored to a significant extent by a pharmaceutical manufacturing company or medical device manufacturer or a single study without other supportable studies.

(15) "Urgent care claim" means any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determination:
(a) could seriously jeopardize the life or health of the insured or the ability of the insured to regain maximum function; or
(b) in the opinion of a physician with knowledge of the insured's medical condition, would subject the insured to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

R590-192-5. File and Record Documentation.
Each insurer's claim files are subject to examination by the commissioner. To aid in such examination:
(1) Sufficient detailed documentation shall be contained in each claim file in order to reconstruct the benefit determination, and the calculation of the claim settlement for each claim.
(2) Each document within the claim file shall be noted as to date received, date processed and notification date.
(3) The insurer shall maintain claim data that is accessible and retrievable for examination. An insurer shall be able to provide:
(a) the claim number;
(b) copy of all applicable forms;
(c) date of loss;
(d) date of claim receipt;
(e) date of benefit determination;
(f) date of settlement of the claim; and
(g) type of settlement indicated as:
(i) payment, including the amount paid;
(ii) settled without payment; or
(iii) denied.

R590-192-6. Disclosure of Policy Provisions.
(1) An insurer, or the insurer's claim representative, shall fully disclose to a claimant the benefits, limitations, and exclusions of an insurance policy which relate to the diagnoses and services relating to the particular claim being presented.
(2) An insurer, or the insurer's claim representative, must disclose to a claimant provisions of an insurance policy when receiving inquiries regarding such coverage.

R590-192-7. Notice of Loss.
(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.
(2) Notice of loss may be given to the insurer or its claim representative unless the insurer clearly directs otherwise by means of policy provisions or 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 any authorized claim representative of the insurer.
(4) The general business practice of the insurer when accepting a notice of loss or notice of claim shall be consistent for all policyholders in accordance with the terms of the policy.

R590-192-8. Notification.
(1) The insurer shall provide notification of the benefit determination to the claimant which includes:
(a) the specific reason or reasons for the benefit determination, adverse or not;
(b) reference to the specific plan provisions on which the benefit determination is based;
(c) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; and
(d) a description of the insurer's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring civil action.
(2) For a health benefit plan, except for a grandfathered health benefit plan as defined in 45 CFR 147.140, a notice of adverse benefit determination shall provide:
(a) starting with the plan year that begins on or after July 1, 2011:
(i) sufficient information to identify the claim involved, including the date of service, the health care provider, and the claim amount, if applicable; and
(ii) notification of assistance available at the Utah Insurance Department, Office of Consumer Health Assistance, Suite 3110, State Office Building, Salt Lake City UT 84114; and
(b) starting with the plan year that begins on or after January 1, 2012:
(i) the availability, upon request, of the diagnosis code and treatment code with the corresponding meaning for each; and
(ii) the content in a culturally and linguistically appropriate manner as required by 45 CFR 147.136 (e).
(3) An insurer and the insurer's claim representative, in the case of a failure by a claimant to follow the individual or group health plan's procedures for filing a pre-service claim, shall notify the claimant, of the failure and provide the proper procedures to be followed in filing a claim for benefits. This notification shall be provided to the claimant as soon as possible, but not later than five days, or 24 hours for a claim involving urgent care, following the failure. Notification may be oral, unless written notification is

requested by the claimant.

(4) Disability income adverse benefit determinations must:

(a) if an internal rule, guideline, protocol, or other criterion was relied upon in making the adverse determination, provide either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request; or

(b) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, provide either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the insured's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

(5) Urgent care adverse benefit determination must:

(a) provide written or electronic notification to the claimant no later than three days after the oral notification; and

(b) provide a description of the expedited review process applicable to such claims.

R590-192-9. Minimum Standards for Claim Benefit Determination and Settlement.

(1) All benefit determination time limits begin once the insurer receives a claim, without regard to whether all necessary information was filed with the original claim. If the insurer requires an extension due to the claimant's failure to submit necessary information, the time for making a decision is tolled from the date the notice is sent to the claimant through:

(a) the date that the claimant provides the necessary information; or

(b) 48 hours after the end of the period afforded the claimant to provide the specified additional information.

(2) Urgent Care Claims:

(a) In a case of urgent care, an insurer shall notify the claimant of the insurer's benefit decision, adverse or not, as soon as possible, taking into account the medical exigencies of the situation, but no later than 72 hours after the receipt of the claim

(b)It is the insurer's duty to determine whether a claim is urgent based on the information provided by the claimant. If the claimant does not provide sufficient information for the plan to make a decision, the plan must notify the claimant as soon as possible, but not later than 24 hours after receipt of the claim, of the specific information that is required. The claimant shall be given reasonable time, but not less than 48 hours, to provide that information.

(ii) The insurer must notify the claimant of the insurer's decision as soon as possible but not later than 48 hours after the earlier of the plan's receipt of the requested information or the end of the time given to the claimant to provide the information.

(3) Concurrent Care Decision:

(a) Reduction or termination of concurrent care:

(i) Any reduction in the course of treatment is considered an adverse benefit determination.

(ii) The insurer must give the claimant notice, with sufficient time to appeal that adverse benefit determination and sufficient time to receive a decision of the appeal before any reduction or termination of care occurs.

(b) Extension of concurrent care:

(i) A claimant may request an extension of treatment beyond what has already been approved.

(ii) If the request for an extension is made at least 24 hours before the end of the approved treatment, the insurer must notify the claimant of the insurer's decision as soon as possible but no later than 24 hours after receipt of the claim.

(iii) If the request for extension does not involve urgent care, the insurer must notify the claimant of the insurer's benefit decision using the response times for a post-service claim.

(4) Pre-Service Benefit Determination:

(a) An insurer must notify the claimant of the insurer's benefit decision within 15 days of receipt of the request for care.

(b) If the insurer is unable to make a decision within that time due to circumstances beyond the insurer's control, such as late receipt of medical records, it must notify the claimant before expiration of the original 15 days that it intends to extend the time and then the insurer may take as long as 15 additional days to reach a decision.

(c) If the extension is due to failure of the claimant to submit necessary information, the extension notice of delay must give specific information about what the claimant has to provide and the claimant must be given at least 45 days to submit the requested information.

(d) once the pre-service claim determination has been made and the medical care rendered, the actual claim filed for payment will be processed according to the time requirements of a post-service claim.

(5) Post-Service Claims:

(a) An insurer must notify the claimant of the insurer's benefit decision within 30 days of receipt of the request for claim.

(b) If the insurer is unable to make a decision within that time due to circumstances beyond the insurer's control, such as late receipt of medical records, it must notify the claimant before expiration of the original 30 days that it intends to extend the time and then the insurer may take as long as 15 additional days to reach a decision.

(c) If the extension is due to failure of the claimant to submit necessary information, the extension notice of delay must give specific information about what the claimant has to provide and the claimant must be given at least 45 days to submit the requested information.

(6) A health benefit plan is required to provide continued coverage for an ongoing course of treatment pending the outcome of an internal appeal.

(7) Except for a grandfathered individual health benefit plan as defined in 45 CFR 147.140, an insurer offering an individual health benefit plan shall provide only one level of internal appeal before the final determination is made.

R590-192-10. Minimum Standards for Disability Income Benefit Determination and Settlement.

In the case of a claim for disability income benefits, the insurer shall notify the claimant, of the insurer's adverse benefit determination within a reasonable period of time, but not later than 45 days after receipt of the claim by the insurer.

(1) This period may be extended by the insurer for up to 30 days, provided that the insurer determines that such an extension is necessary due to matters beyond the control of the insurer and notifies the claimant, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which the insurer expects to render a decision.

(2) If, prior to the end of the first 30-day extension period, the insurer determines that, due to matters beyond the control of the insurer, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided the insurer notifies the claimant prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date at which the insurer expects to render a decision.

(3) Each notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and the claimant shall be afforded at least 45 days within which to provide the specified information.

R590-192-11. Minimum Standards for Responses to the Commissioner.

(1) Every insurer, upon receipt of an inquiry from the commissioner regarding a claim, shall furnish the commissioner with a substantive response to the inquiry within the appropriate number of days indicated by such inquiry. If it is determined by the insurer that they are unable to respond in the time frame requested, the insurer may contact the commissioner to request an extension.

(2) The insurer shall acknowledge and substantively respond within 15 days to any written communication from the claimant relating to a pending claim.

R590-192-12. Unfair Methods, Deceptive Acts and Practices Defined.

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

(1) denying or threatening the denial of the payment of claims or rescinding, canceling or threatening the rescission or cancellation of coverage under a policy for any reason which is not clearly described in the policy as a reason for such denial, cancellation or rescission;

(2)(a) 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 alleged misrepresentation is the basis for the denial.

(b) For a health benefit plan, misrepresentation means an intentional misrepresentation of a material fact;

(3) compensation by an insurer of its employees, producers or contractors of any amounts which are based on savings to the insurer as a result of denying or reducing the payment of claims, unless compensation relates to the discovery of billing or processing errors;

(4) failing to deliver a copy of standards for prompt investigation of claims to the commissioner when requested to do so;

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

(6) denying a claim or making a claim payment to the claimant not accompanied by a notification, statement or explanation of benefits setting forth the exclusion or benefit under which the denial or payment is being made and how the payment amount was calculated;

(7) failing to make payment of a claim following notice of loss when liability is reasonably clear under one coverage in order to influence settlements under other portions of the insurance policy coverage or under other policies of insurance;

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

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

(10) deducting from a loss or claims payment made under one policy those premiums owed by the claimant on another policy, unless the claimant consents to such arrangement;

(11) failing to settle a claim on the basis that responsibility for payment of the claim should be assumed by others, except as may otherwise be provided by policy provisions;

(12) 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 or its insured from total liability;

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

(14) refusing to pay reasonably incurred expenses to the claimant when such expenses resulted from a delay, as prohibited by this rule, in the claim settlement;

(15) failing to pay interest at the legal rate in Title 15:

(a) upon amounts that are due and unpaid within 20 days of completion of investigation; or

(b) to a health care provider on amounts that are due and unpaid after the time limits allowed under 31A-26-301.6 ;

(16) failing to provide a claimant with an explanation of benefits; and

(17) for a health benefit plan:

(a) failing to allow a claimant to review the claim file and to present evidence and testimony as part of the claim and appeal processes;

(b) failing to provide the claimant, at no cost, with any new or additional evidence considered, relied upon, or generated by the insurer in connection with the claim; or

~~(c) failing to ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision.~~

~~**R590-192-13. 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.~~

~~**R590-192-14. Enforcement Date.**~~

~~The commissioner will begin enforcing the revised provisions of this rule on the effective date.~~]

R590-192. Unfair Accident and Health Insurance Claim Settlement Practice Rule.

R590-192-1. Authority.

This rule is promulgated by the commissioner pursuant to Sections 31A-2-201, 31A-2-216, 31A-21-312, 31A-22-629, 31A-26-301, 31A-26-301.6, and 31A-26-303.

R590-192-2. Purpose and Scope.

(1) The purpose of this rule is to:

(a) set standards for the investigation and disposition of an accident and health insurance claim; and

(b) identify an unfair claim practice.

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

R590-192-3. Definitions.

Terms used in this rule are defined in Sections 31A-1-301, 31A-22-629, and 29 CFR 2560.503-1(m). 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) "Claim file" means a record that can accurately and reliably reproduce the original material regarding a claim, its investigation, adjustment, and settlement.

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

(4) "Concurrent care" or "ongoing care" means an insurer approves an ongoing course of treatment over a specific period or number of treatments.

(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) "Medical necessity" means:

(a) a health care service or product that a prudent health care professional would provide to a patient to prevent, diagnose, or treat an illness, injury, disease, or its symptoms in a manner that is:

(i) in accordance with generally accepted standards of medical practice in the United States;

(ii) clinically appropriate in terms of type, frequency, extent, site, and duration;

(iii) not primarily for the convenience of the patient, physician, or other health care provider; and

(iv) covered under the policy; and

(b) if a medical question-of-fact exists, "medical necessity" shall include the most appropriate available supply or level of service for the individual in question, considering potential benefits and harms to the individual, and known to be effective.

(i) For an intervention not yet in widespread use, the effectiveness shall be based on scientific evidence.

(ii) For an established intervention, the effectiveness shall be based on:

(A) scientific evidence;

(B) professional standards; and

(C) expert opinion.

(10) "Misrepresentation" for a health benefit plan means an intentional misrepresentation of a material fact.

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

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

(13)(a) "Scientific evidence" means:

(i) a scientific study published or accepted by a medical journal that meets nationally recognized standards for a scientific manuscript and that submits its published articles for review by experts who are not part of the editorial staff; or

(ii) a finding, a study, or research conducted by or under the auspices of the federal government or a nationally recognized federal research institute.

(b) "Scientific evidence" does not include:

(i) published peer-reviewed literature sponsored by:

(A) a pharmaceutical manufacturing company; or

(B) a medical device manufacturer; or

(ii) a single study without other supportable studies.

R590-192-4. 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, if required;

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

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

(ix) the date of a benefit determination;

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

(xi) the type of settlement, indicated as:

(A) payment, including the amount paid;

(B) settled without payment; or

(C) denied;

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

(xiii) other documentation relied upon for claim settlement;

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

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

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

(a) be available for all open and closed files 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 commissioner.

R590-192-5. 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 diagnosis or service of 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.

R590-192-6. 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.

(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.

R590-192-7. Notification.

(1) An insurer shall notify a claimant of a benefit determination and include:

(a) the specific reason or reasons for the benefit determination;

(b) reference to the specific policy provision that the benefit determination is based upon;

(c) a description of additional information needed and an explanation of why such information is necessary; and

(d) with a notice of an adverse benefit determination:

(i) a description of the appeal procedures and any time limitations;

(ii) a description of how to initiate an appeal along with the address and telephone number;

(iii) the claimant's right to bring civil action; and

(iv) a statement regarding assistance available at the Utah Insurance Department, Office of Consumer Health Assistance.

(2)(a) If a claimant fails to follow an insurer's procedure for filing a pre-service claim, an insurer or authorized agent shall:

(i) notify the claimant of the failure;

(ii) provide the claimant with the proper procedure to file a claim for benefits; and

(iii) provide notification to the claimant:

(A) no later than five days from the failure; or

(B) within 24 hours of the failure for a claim involving urgent care.

(b) Notification of a failure may be oral unless written notification is requested by a claimant.

(3)(a) A notice of adverse benefit determination for a health benefit plan shall comply with Rule R590-261.

(b) Subsection (3)(a) does not apply to a grandfathered health plan defined in 45 CFR 147.140.

(4)(a) A notice of an adverse benefit determination for income replacement insurance shall:

(i) provide the criteria relied upon in making the adverse determination; and

(ii) disclose that a copy of the criteria will be provided free of charge upon request.

(b) If an adverse benefit determination is based on medical necessity, experimental treatment, or similar exclusion or limit, an insurer shall provide either:

(i) an explanation of the scientific or clinical judgment for the determination that applies the terms of the plan to the insured's medical circumstances; or

(ii) a statement that the explanation in Subsection (3)(b)(i) will be provided free of charge upon request.

(5) An adverse benefit determination for a claim involving urgent care shall:

(a) provide written or electronic notification to the claimant no later than three days after an oral notification; and

(b) provide a description of the expedited review process applicable to each claim.

R590-192-8. 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)(a) When a claim involves urgent care, an insurer shall notify a claimant of the insurer's benefit decision as soon as possible, considering the medical exigencies of the situation, but no later than 72 hours after receipt of the claim.

(b) An insurer shall determine whether a claim is urgent based on the information provided by the claimant.

(c) If a claimant does not provide sufficient information for an insurer to make a decision, the insurer must notify the claimant as soon as possible, but not later than 24 hours after receipt of the claim, and specify the information that is required.

(d) A claimant shall be given reasonable time, but not less than 48 hours, to provide the required information.

(e) An insurer shall notify a claimant of the insurer's decision as soon as possible, but not later than 48 hours after the earlier of:

(i) the insurer's receipt of the requested information; or

(ii) the end of the time given to the claimant to provide the information.

(3)(a) A reduction or termination of concurrent care during treatment is considered an adverse benefit determination.

(b) Before a reduction or termination of concurrent care occurs, an insurer shall provide a claimant notice, with sufficient time to appeal and receive a decision on the adverse benefit determination.

(c)(i) A claimant may request an extension of concurrent care beyond what is approved.

(ii) If a request for an extension is made at least 24 hours before the end of the concurrent care, the insurer shall notify the claimant of the insurer's decision as soon as possible, but not later than 24 hours after receipt of the request.

(iii) If the request for extension does not involve urgent care, the insurer shall notify the claimant of the insurer's benefit decision using the response times for a post-service claim.

(4)(a) An insurer shall notify a claimant of the insurer's pre-service benefit decision within 15 days of receipt of the request for care.

(b)(i) If an insurer cannot make a decision within 15 days due to circumstances beyond the insurer's control, such as late receipt of medical records, the insurer may extend the time up to 15 additional days.

(ii) If an insurer chooses to extend up to 15 days, the insurer shall notify the claimant before the expiration of the original 15 days.

(c) If an extension is due to a claimant's failure to submit necessary information, the notice of extension shall:

(i) state what information the claimant must submit; and

(ii) give the claimant at least 45 days to submit the requested information.

(d) If a pre-service claim determination is made and the medical care is rendered, the claim shall be processed according to the time requirements of a post-service claim.

(5)(a) For a post-service claim, an insurer shall notify a claimant of the insurer's benefit decision within 30 days of receipt of a notice of loss.

(b)(i) If an insurer is unable to make a decision within 30 days due to circumstances beyond the insurer's control, such as late receipt of medical records, the insurer may extend the time up to 15 additional days.

(ii) If an insurer chooses to extend up to 15 days, the insurer shall notify the claimant before the expiration of the original 30 days.

(c) If an extension is due to a claimant's failure to submit necessary information, the notice of extension shall:

(i) state what information the claimant must submit; and

(ii) give the claimant at least 45 days to submit the requested information.

(6) An insurer offering a health benefit plan shall provide continued coverage for an ongoing course of treatment pending the outcome of an internal appeal.

(7) Except for a grandfathered individual health benefit plan as defined in 45 CFR 147.140, an insurer offering an individual health benefit plan shall provide only one level of internal appeal before the final determination is made.

R590-192-9. Additional Standards for Prompt, Fair, and Equitable Benefit Determination and Settlement for Income Replacement Insurance.

(1) An insurer shall notify a claimant of an adverse benefit determination of an income replacement insurance benefit within 45 days of receipt of a claim.

(a)(i) If an insurer is unable to make a decision within 45 days due to circumstances beyond the insurer's control, the insurer may extend the time up to 30 additional days.

(ii) If an insurer chooses to extend up to 30 days, the insurer shall notify the claimant before the expiration of the original 45 days.

(iii) The notification shall include:

(A) the circumstances requiring the extension; and

(B) the date by which the insurer expects to render a decision.

(b)(i) If an insurer cannot render a decision within the first 30-day extension due to circumstances beyond the insurer's control, the insurer may extend the time up to 30 additional days.

(ii) If an insurer chooses to extend up to 30 days, the insurer shall notify the claimant before the expiration of the first 30-day extension.

(iii) The notification shall include:

(A) the circumstances requiring the extension; and

(B) the date by which the insurer expects to render a decision.

(c) Each notice of extension shall explain:

(i) the basis for the extension;

(ii) each unresolved issue that prevents a decision on the claim;

(iii) the information needed to resolve each unresolved issue; and

(iv) that the claimant is given at least 45 days to provide the information.

R590-192-10. 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 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 any reason that is not clearly described in a policy as a reason for denial, cancellation, or rescission;

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

(4) denying or paying a claim without:

(a) providing a notification or an explanation of benefits describing the exclusion or benefit; and

(b) explaining how the denial or payment is calculated;

(5) failing to provide a claimant 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 denying or reducing payment of a claim, unless the compensation relates to the discovery of a billing or processing error;

(7) failing to pay a claim following receipt of a proof of loss if liability is reasonably clear under one coverage to influence settlement:

(a) under another portion of the policy; or

(b) under another policy;

(8) 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;

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

(10) deducting from a claim payment made under one policy the premium owed by the claimant on another policy, unless the claimant consents;

(11) failing to pay a claim on the basis that responsibility for payment of the claim should be assumed by someone else, except as provided by a policy provision;

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

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

(14) refusing to pay a reasonable incurred expense to a claimant if the expense resulted from a delay, prohibited by this rule, in a claim settlement or claim payment;

(15) failing to pay interest at the legal rate under Title 15, Chapter 1, Interest:

(a) on an amount that is overdue and unpaid within 20 days of completing an investigation; or

(b) to a health care provider on an amount that is overdue under Section 31A-26-301.6;

(16) failing to provide a claimant with an explanation of benefits; and

(17) for a health benefit plan, failing to:

(a) permit a claimant to review the claim file and present evidence as part of the claim and appeal process;

(b) provide a claimant, at no cost, new or additional evidence considered, relied upon, or generated by the insurer in connection with the claim; or

(c) ensure that all claims and appeals are adjudicated in an independent and impartial manner.

R590-192-11. Severability.

If any provision of this rule, Rule R590-192, 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.

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