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:	**R590-167**	**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:

R590-167. Individual, Small Employer, and Group Health Benefit Plan 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 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-2-212	Section 31A-30-104
Section 31A-30-106	Section 31A-30-106.1	Section 31A-30-117

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:		02/14/2024
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:	02/21/2024
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:**	12/18/2023

R590. Insurance, Administration.
R590-167. Individual, Small Employer, and Group Health Benefit Plan Rule.
[~~R590-167-1. Authority, Purpose and Scope.~~
~~(1) Authority.~~
~~This rule is intended to implement the provisions of Chapter 30, Title 31A, the Individual and Small Employer Health Insurance Act, referred to in this rule as the Act. The commissioner's authority to enforce this rule is provided under Subsections 31A-2-201(3)(a), 31A-30-106(1)(k), and 31A-30-106.1(10).~~
~~(2) Purpose.~~
~~(a) The general purposes of the Act and this rule are:~~
~~(i) to enhance the availability of health insurance coverage to individuals and small employers;~~
~~(ii) to regulate and prevent abuse in insurer rating practices and establish limits on differences in rates between health benefit plans;~~
~~(iii) to ensure renewability of coverage;~~
~~(iv) to establish limitations on the use of preexisting condition exclusions;~~
~~(v) to prescribe the manner in which case characteristics may be used;~~
~~(vi) to regulate the use and establishment of separate classes of business;~~
~~(vii) to provide for portability; and~~
~~(viii) to improve the overall fairness and efficiency of the individual and small employer health insurance market.~~
~~(b) The Act and this rule are intended to:~~
~~(i) promote broader spreading of risk in the individual and small employer marketplace; and~~
~~(ii) regulate rating practices for all health benefit plans sold to individuals and small employers, whether sold directly or through associations or other groupings of individuals and small employers.~~
~~(3) Scope.~~
~~Carriers that provide health benefit plans to individuals and small employers are intended to be subject to all of the provisions of this rule.~~

~~R590-167-2. Definitions.~~
~~In addition to the definitions in Sections 31A-1-301 and 31A-30-103, the following definitions shall apply for the purposes of this rule:~~
~~(1) "Associate member of an employee organization" means any individual who participates in an employee benefit plan, as defined in 29 U.S.C. Section 1002(1), that is a multi-employer plan, as defined in 29 U.S.C. Section 1002(37A), other than the following:~~
~~(a) an individual, or the beneficiary of such individual, who is employed by a participating employer within a bargaining unit covered by at least one of the collective bargaining agreements under or pursuant to which the employee benefit plan is established or maintained; or~~

(b) an individual who is a present or former employee, or a beneficiary of such employee, of the sponsoring employee organization, of an employer who is or was a party to at least one of the collective bargaining agreements under or pursuant to which the employee benefit plan is established or maintained, or of the employee benefit plan, or of a related plan.

(2) "Change in a Rating Factor" means the cumulative change with respect to such factor considered over a 12 month period. If a covered carrier changes rating factors with respect to more than one case characteristic in a 12 month period, the carrier shall consider the cumulative effect of all such changes in applying the 10% test.

(3) "Change in Rating Method" means:

(a) a change in the number of case characteristics used by a covered carrier to determine premium rates for health benefit plans in a class of business;

(b) a change in the manner or procedures by which insureds are assigned into categories for the purpose of applying a case characteristic to determine premium rates for health benefit plans in a class of business;

(c) a change in the method of allocating expenses among health benefit plans in a class of business; or

(d) a change in a rating factor with respect to any case characteristic if the change would produce a change in premium for any individual or small employer that exceeds 10%.

(4) "New entrant" means an eligible employee, or the dependent of an eligible employee, who becomes part of an employer group after the initial period for enrollment in a health benefit plan.

(5) "Risk characteristic" means a rating factor other than a case characteristic allowed under Sections 31A-30-106 or 31A-30-106.1, as applicable, including exact age, gender, family composition, the health status, claims experience, duration of coverage, or any similar characteristic related to the demographics or the health status or experience of an individual, a small employer or of any member of a small employer.

(6) "Risk load" means the percentage above the applicable base premium rate that is charged by a covered carrier to a covered insured to reflect the risk characteristics of the covered individuals.

R590-167-3. Applicability and Scope.

(1) This rule shall apply to any health benefit plan which:

(a) meets one or more of the conditions set forth in Subsections 31A-30-104(1) and (2);

(b) provides coverage to a covered insured located in this state, without regard to whether the policy or certificate was issued in this state; and

(c) is in effect on or after the effective date of this rule.

(2)(a) If a small employer has employees in more than one state, the provisions of the Act and this rule shall apply to a health benefit plan issued to the small employer if:

(i) the majority of eligible employees of such small employer are employed in this state; or

(ii) if no state contains a majority of the eligible employees of the small employer, the primary business location of the small employer is in this state.

(b) In determining whether the laws of this state or another state apply to a health benefit plan issued to a small employer described in Subsection R590-167-3(2)(a), the provisions of the subsection shall be applied as of the date the health benefit plan was issued to the small employer for the period that the health benefit plan remains in effect.

(c) If a health benefit plan is subject to the Act and this rule, the provisions of the Act and this rule shall apply to all individuals covered under the health benefit plan, whether they reside in this state or in another state.

(3) A carrier that is not operating as a covered carrier in this state may not become subject to the provisions of the Act and this rule solely because an individual or a small employer that was issued a health benefit plan in another state by that carrier moves to this state.

R590-167-4. Establishment of Classes of Business.

(1) A covered carrier that establishes more than one class of business pursuant to the provisions of Section 31A-30-105 shall maintain on file for inspection by the commissioner the following information with respect to each class of business so established:

(a) a description of each criterion employed by the carrier, or any of its agents, for determining membership in the class of business;

(b) a statement describing the justification for establishing the class as a separate class of business and documentation that the establishment of the class of business is intended to reflect substantial differences in expected claims experience or administrative costs related to the reasons set forth in Section 31A-30-105; and

(c) a statement disclosing which, if any, health benefit plans are currently available for purchase in the class and any significant limitations related to the purchase of such plans.

(2) For policies issued or renewed on or after January 1, 2011, a covered carrier may not establish a separate class of business without a prior approval of the commissioner.

(3) In order to receive an approval to establish a separate class of business under Subsection R590-167-4(2) the covered carrier shall submit a filing in compliance with R590-220 that includes:

(a) a written request to establish a separate class of business;

(b) description of all criteria employed by the carrier, or any of its agents, for determining membership in the class of business;

(c) disclosure of which health benefit plans will be available for purchase in the class and any significant limitations related to the purchase of such plans; and

(d) demonstrate to the satisfaction of the commissioner that the use of a separate class of business is necessary due to substantial differences in either expected claims experience or administrative costs related to the following reasons:

(i) the covered carrier uses more than one type of system for the marketing and sale of health benefit plans to covered insureds;

(ii) the covered carrier has acquired a class of business from another covered carrier;

(iii) the covered carrier provides coverage to one or more association groups;

(e) a list of previously approved classes of business; and

(f) for each class of business used prior to January 1, 2011, a certification that the continued use of the class of business is necessary due to conditions specified in Subsection R590-167-4(3)(d).

(4) A carrier may not directly or indirectly use group size as a criterion for establishing eligibility for a class of business.

R590-167-5. Transition for Assumptions of Business from Another Carrier.

(1)(a) A covered carrier may not transfer or assume the entire insurance obligation, risk, or both of a health benefit plan covering an individual or a small employer in this state unless:

(i) the transaction has been approved by the commissioner of the state of domicile of the assuming carrier;

(ii) the transaction has been approved by the commissioner of the state of domicile of the ceding carrier;

(iii) the carrier has provided notice to the commissioner of this state at least 60 days prior to the date of the proposed assumption. The notice shall contain the information specified in Subsection R590-167-5(1)(c)(i) for the health benefit plans covering individuals and small employers in this state; and

(iv) the transaction otherwise meets the requirements of this section.

(b) A carrier domiciled in this state that proposes to assume or cede the entire insurance obligation , risk, or both of one or more health benefit plans covering covered individuals from or to another carrier shall make a filing for approval with the commissioner at least 60 days prior to the date of the proposed assumption. The commissioner may approve the transaction, if the commissioner finds that the transaction is in the best interests of the individuals insured under the health benefit plans to be transferred and is consistent with the purposes of the Act and this rule. The commissioner may not approve the transaction until at least 30 days after the date of the filing; except that, if the carrier is in hazardous financial condition, the commissioner may approve the transaction as soon as the commissioner deems reasonable after the filing.

(c)(i) The filing required under Subsection R590-167-5(1)(b) shall:

(A) describe the class of business, including any eligibility requirements, of the ceding carrier from which the health benefit plans will be ceded;

(B) describe whether the assuming carrier intends to maintain the assumed health benefit plans as a separate class of business, pursuant to Subsection R590-167-5(3), or will incorporate them into an existing class of business, pursuant to Subsection R590-167-5(4). If the assumed health benefit plans will be incorporated into an existing class of business, the filing shall describe the class of business of the assuming carrier into which the health benefit plans will be incorporated;

(C) describe whether the health benefit plans being assumed are currently available for purchase by individuals or small employers;

(D) describe the potential effect of the assumption, if any, on the benefits provided by the health benefit plans to be assumed;

(E) describe the potential effect of the assumption, if any, on the premiums for the health benefit plans to be assumed;

(F) describe any other potential material effects of the assumption on the coverage provided to the individuals and small employers covered by the health benefit plans to be assumed; and

(G) include any other information required by the commissioner.

(ii) A covered carrier required to make a filing under Subsection R590-167-5(1)(b) shall also make an informational filing with the commissioner of each state in which there are individual or small employer health benefit plans that would be included in the transaction. The informational filing to each state shall be made concurrently with the filing made under Subsection R590-167-5(1)(b) and shall include at least the information specified in Subsection R590-167-5(1)(c)(i) for the individual or small employer health benefit plans in that state.

(d)(i) If the assumption of a class of business would result in the assuming covered carrier being out of compliance with the limitations related to premium rates contained in Sections 31A-30-106 or 31A-30-106.1, the assuming carrier shall make a filing with the commissioner pursuant to Subsection 31A-30-105(3) seeking an extended transition period.

(ii) An assuming carrier seeking an extended transition period may not complete the assumption of health benefit plans covering individuals or small employers in this state unless the commissioner grants the extended transition period requested pursuant to Subsection R590-167-5(1)(d)(i).

(iii) Unless a different period is approved by the commissioner, an extended transition period shall, with respect to an assumed class of business, be for no more than 15 months and, with respect to each individual small employer, shall last only until the anniversary date of such employer's coverage, except that the period with respect to an individual small employer may be extended beyond its first anniversary date for a period of up to 12 months if the anniversary date occurs within three months of the date of assumption of the class of business.

(2)(a) Except as provided in Subsection R590-167-5(2)(b), a covered carrier may not cede or assume the entire insurance obligation, risk, or both for an individual or small employer health benefit plan unless the transaction includes the ceding to the assuming carrier of the entire class of business which includes such health benefit plan.

(b) A covered carrier may cede less than an entire class of business to an assuming carrier if:

(i) one or more individuals or small employers in the class have exercised their right under contract or state law to reject,

either directly or by implication, the ceding of their health benefit plans to another carrier. In that instance, the transaction shall include each health benefit plan in the class of business except those health benefit plans for which an individual or a small employer has rejected the proposed cession; or

(ii) after a written request from the transferring carrier, the commissioner determines that the transfer of less than the entire class of business is in the best interests of the individual or small employers insured in that class of business.

(3) A covered carrier that assumes one or more health benefit plans from another carrier and intends to maintain such health benefit plans as a separate class of business, shall submit a filing requesting approval to establish a separate class of business as provided in Subsection R590-167-4(3). The assumption shall not take place prior to approval of the request by the commissioner.

(4) A covered carrier that assumes one or more health benefit plans from another carrier and intends to incorporate them into an existing class of business shall comply with the following provisions:

(a) Upon assumption of the health benefit plans, such health benefit plans shall be maintained temporarily as a separate class of business, deemed to be approved by the commissioner under Subsection 31A-30-105(2)(b)(ii). A covered carrier may exceed the limitation contained in Subsection 31A-30-105(4) due solely to such assumption.

(b) During the 15-month period following the assumption, each of the assumed individual or small employer health benefit plans shall be transferred by the assuming covered carrier into a single class of business operated by the assuming covered carrier. The assuming covered carrier shall select the class of business into which the assumed health benefit plans will be transferred in a manner such that the transfer results in the least possible change to the benefits and rating method of the assumed health benefit plans.

(c) The transfers authorized in Subsection R590-167-5(4)(b) shall occur with respect to each individual or small employer on the anniversary date of the individual's or small employer's coverage, except that the period with respect to an individual small employer may be extended beyond its first anniversary date for a period of up to 12 months if the anniversary date occurs within three months of the date of assumption of the class of business.

(d) A covered carrier making a transfer pursuant to Subsection R590-167-5(4)(b) may alter the benefits of the assumed health benefit plans to conform to the benefits currently offered by the carrier in the class of business into which the health benefit plans have been transferred.

(e) The premium rate for an assumed individual or small employer health benefit plan may not be modified by the assuming covered carrier until the health benefit plan is transferred pursuant to Subsection R590-167-5(4)(b). Upon transfer, the assuming covered carrier shall calculate a new premium rate for the health benefit plan from the rate manual established for the class of business into which the health benefit plan is transferred. In making such calculation, the risk load applied to the health benefit plan shall be no higher than the risk load applicable to such health benefit plan prior to the assumption.

(f) During the 15-month period provided in this subsection, the transfer of individual or small employer health benefit plans from the assumed class of business in accordance with this subsection may not be considered a violation of Subsections 31A-30-106(3)(a) or 31A-30-106.1(8)(a), as applicable.

(5) An assuming carrier may not apply eligibility requirements, including minimum participation and contribution requirements, with respect to an assumed health benefit plan, or with respect to any health benefit plan subsequently offered to an individual or small employer covered by such an assumed health benefit plan, that are more stringent than the requirements applicable to such health benefit plan prior to the assumption.

(6) The commissioner may approve a longer period of transition under Subsection R590-167-5(4) upon application of a covered carrier. The application shall be made within 60 days after the date of assumption of the class of business and shall clearly state the justification for a longer transition period.

(7) Nothing in this section or in the Act is intended to:

(a) reduce or diminish any legal or contractual obligation or requirement, including any obligation provided in Section 31A-14-213, of the ceding or assuming carrier related to the transaction;

(b) authorize a carrier that is not admitted to transact the business of insurance in this state to offer or insure health benefit plans in this state; or

(c) reduce or diminish the protections related to an assumption reinsurance transaction provided in Section 31A-14-213 or otherwise provided by law.

R590-167-6. Restrictions Relating to Premium Rates.

(1) A covered carrier shall develop a separate rate manual for each class of business. Base premium rates and new business premium rates charged to individuals and small employers by the covered carrier shall be computed solely from the applicable rate manual developed pursuant to this subsection. To the extent that a portion of the premium rates charged by a covered carrier is based on the carrier's discretion, the manual shall specify the criteria and factors considered by the carrier in exercising such discretion.

(2)(a) A covered carrier may not modify the rating method, as defined in Section R590-167-2, used in the rate manual for a class of business until the change has been approved as provided in this subsection. The commissioner may approve a change to a rating method if the commissioner finds that the change is reasonable, actuarially appropriate, and consistent with the purposes of the Act and this rule.

(b) A carrier may modify the rating method for a class of business only after filing an actuarial certification. The filing shall clearly request approval for a change in rating method and contain at least the following information:

(i) the reasons the change in rating method is being requested;

(ii) a complete description of each of the proposed modifications to the rating method;

(iii) a description of how the change in rating method would affect the premium rates currently charged to individuals and small employers in the class of business, including an estimate from a qualified actuary of the number of groups or individuals, and a

description of the types of groups or individuals, whose premium rates may change by more than 10% due to the proposed change in rating method, not including general increases in premium rates applicable to all individuals and small employers in a health benefit plan;

(iv) a certification from a qualified actuary that the new rating method would be based on objective and credible data and would be actuarially sound and appropriate;

(v) a certification from a qualified actuary that the proposed change in rating method would not produce premium rates for individuals and small employers that would be in violation of Sections 31A-30-106, 31A-30-106.1, and 31A-30-106.5; and

(vi) a request for approval for a change in rating method must be submitted as a separate filing. The filing description must state in the first line of the first paragraph, "REQUEST FOR APPROVAL FOR CHANGE IN RATING METHOD."

(3) The rate manual developed pursuant to Subsections 31A-30-106(4), 31A-30-106.1(13), and R590-167-6(1) shall specify the case characteristics and rate factors to be applied by the covered carrier in establishing premium rates for the class of business.

(a) A covered carrier offering a health benefit plan to an individual may not use case characteristics other than those specified in Subsection 31A-30-106(1)(f) without the prior approval of the commissioner. A covered carrier seeking such an approval shall make a filing with the commissioner for a change in rating method under Subsection R590-167-6(2)(b). Tobacco use is not an allowable case characteristic. Tobacco use is an allowable risk characteristic when utilized in compliance with Subsection 31A-30-106(1)(b).

(b)(i) A covered carrier offering or renewing a health benefit plan to a small employer, may not use case characteristics other than:

(A) age band, as specified in Subsection 31A-30-106.1(6)(a), applicable to the age of the employee;

(B) geographic area;

(C) family composition tier, as specified in Subsection 31A-30-106.1(6)(c);

(D) gender, as specified in in Subsection 31A-30-106.1(6)(d);

(E) Medicare coordination, as specified in Subsection 31A-30-106.1(6)(e); and

(F) wellness programs, as specified in Subsection 31A-30-106.1(6)(f).

(ii) For any geographic area used as a case characteristic by a covered carrier, base rates for any small employer health benefit plan shall be subject to the following limitations:

(A) for any age band, the ratio of the base rate for the family tier to the base rate for employee only tier, shall not exceed the ratio in Subsection 31A-30-106.1(8); and

(B) for any family composition tier, the ratio of the base rate for any age band to the base rate for "less than 20" age band, may not exceed the following:

(I) 1.22 for age band 20 to 24;

(II) 1.34 for age band 25 to 29;

(III) 1.46 for age band 30 to 34;

(IV) 1.60 for age band 35 to 39;

(V) 1.80 for age band 40 to 44;

(VI) 2.20 for age band 45 to 49;

(VII) 2.80 for age band 50 to 54;

(VIII) 3.60 for age band 55 to 59;

(IX) 4.25 for age band 60 to 64; and

(X) 5.00 for age band over 65.

(c) A covered carrier shall use the same case characteristics in establishing premium rates for each health benefit plan in a class of business and shall apply them in the same manner in establishing premium rates for each such health benefit plan. Case characteristics shall be applied without regard to the risk characteristics of an individual or small employer.

(d) The rate manual shall clearly illustrate the relationship among the base premium rates charged for each health benefit plan in the class of business. If the new business premium rate is different than the base premium rate for a health benefit plan, the rate manual shall illustrate the difference.

(e) Differences among base premium rates for health benefit plans shall be based solely on the reasonable and objective differences in the design and benefits of the health benefit plans and may not be based in any way on the nature of an individual or small employer that choose or are expected to choose a particular health benefit plan. A covered carrier shall apply case characteristics and rate factors within a class of business in a manner that assures that premium differences among health benefit plans for identical individuals or small employers vary only due to reasonable and objective differences in the design and benefits of the health benefit plans and are not due to the nature of the individuals or small employers that choose or are expected to choose a particular health benefit plan.

(f) The rate manual shall provide for premium rates to be developed in a two-step process.

(i) In the first step, a base premium rate shall be developed for the individual or small employer without regard to any risk characteristics. The base rates shall reflect only the allowable case characteristics. The base rates for an individual health benefit plan offered to two individuals with the same case characteristics shall be identical. The base rates for a small employer health benefit plan offered to two small employer groups with the same case characteristics shall be identical.

(ii) In the second step, the resulting base premium rate may be adjusted by a risk load, subject to the provisions of Sections 31A-30-106, 31A-30-106.1, and 31A-30-106.5, to reflect the risk characteristics.

(g) Each rate manual developed pursuant to Subsection R590-167-6(1) shall be maintained by the carrier for a period of six years. Updates and changes to the manual shall be maintained with the manual.

(4)(a) Except as provided in Subsection R590-167-6(4)(b), a premium charged to an individual or small employer for a health benefit plan may not include a separate application fee, underwriting fee, or any other separate fee or charge.

(b) A carrier may charge a separate fee with respect to an individual or small employer health benefit plan, but only one fee with respect to such plan, provided the fee is no more than $5 per month per individual or employee and is applied in a uniform manner to each health benefit plan in a class of business.

(5) The restrictions related to changes in premium rates in Subsections 31A-30-106(1)(c) and 31A-30-106.1(3) shall be applied as follows:

(a) A covered carrier shall revise its rate manual each rating period to reflect changes in base premium rates and changes in new business premium rates.

(b)(i) If, for any health benefit plan with respect to any rating period, the percentage change in the new business premium rate is less than or the same as the percentage change in the base premium rate, the change in the new business premium rate shall be deemed to be the change in the base premium rate for the purposes of Subsections 31A-30-106(1)(c) and 31A-30-106.1(3).

(ii) If, for any health benefit plan with respect to any rating period, the percentage change in the new business premium rate exceeds the percentage change in the base premium rate, the health benefit plan shall be considered a health benefit plan into which the covered carrier is no longer enrolling new individuals or small employers for the purposes of Subsections 31A-30-106(1)(c) and 31A-30-106.1(3).

(iii) Trend increases are limited to a 12-month period. If an insurer chooses to use trend in the rate manual, a new filing must be submitted for each 12-month period. The detailing of the rate calculation must specify how trend is being implemented, by plan or calendar year, and how the rates are determined.

(c) If, for any rating period, the change in the new business premium rate for a health benefit plan differs from the change in the new business premium rate for any other health benefit plan in the same class of business by more than 20%, the carrier shall make a filing with the commissioner containing a complete explanation of how the respective changes in new business premium rates were established and the reason for the difference. The filing shall be made 30 days before the beginning of the rating period.

(d) A covered carrier shall keep on file for a period of at least six years the calculations used to determine the change in base premium rates and new business premium rates for each health benefit plan for each rating period.

(6)(a) Except as provided in Subsection R590-167-6(6)(b), a change in premium rate for an individual or small employer shall produce a revised premium rate that is no more than the following:

(i) the base premium rate for the individual or small employer, as shown in the rate manual as revised for the rating period, multiplied by:

(ii) one plus the sum of:

(iii) the risk load applicable to the individual or small employer during the previous rating period; and

(iv) 15% prorated for periods of less than one year.

(b) In the case of a health benefit plan into which a covered carrier is no longer enrolling new individuals or small employers, a change in premium rate for an individual or small employer shall produce a revised premium rate that is no more than the following:

(i) the base premium rate for the individual or small employer, given its present composition and as shown in the rate manual in effect for the individual or small employer at the beginning of the previous rating period, multiplied by:

(ii) one plus the lesser of:

(A) the change in the base rate; or

(B) the percentage change in the new business premium for the most similar health benefit plan into which the covered carrier is enrolling new individuals or small employers, multiplied by:

(iii) one plus the sum of:

(A) the risk load applicable to the individual or small employer during the previous rating period; and

(B) 15%, prorated for periods of less than one year.

(c) Notwithstanding the provisions of Subsections R590-167-6(6)(a) and (b), a change in premium rate for an individual or small employer may not produce a revised premium rate that would exceed the limitations on rates provided in Subsections 31A-30-106(1)(b) and 31A-30-106.1(2)(b).

(7)(a) A representative of a Taft Hartley trust, including a carrier upon the written request of such a trust, may file in writing with the commissioner a request for the waiver of application of the provisions of Subsections 31A-30-106.1(1) through 31A-30-106.1(6) with respect to such trust.

(b) A request made under Subsection R590-167-6(7)(a) shall identify the provisions for which the trust is seeking the waiver and shall describe, with respect to each provision, the extent to which application of such provision would:

(i) adversely affect the participants and beneficiaries of the trust; and

(ii) require modifications to one or more of the collective bargaining agreements under or pursuant to which the trust was or is established or maintained.

(c) A waiver granted under Subsection 31A-30-104(5) shall not apply to an individual who participates in the trust because the individual is an associate member of an employee organization or the beneficiary of such an individual.

R590-167-7. Application to Reenter State.

(1) A carrier that has been prohibited from writing coverage for individuals or small employers in this state pursuant to Subsection 31A-30-107.3 may not resume offering health benefit plans to individuals or small employers in this state until the carrier has made a petition to the commissioner to be reinstated as a covered carrier and the petition has been approved by the commissioner.

In reviewing a petition, the commissioner may ask for such information and assurances as the commissioner finds reasonable and appropriate.

(2) In the case of a covered carrier doing business in only one established geographic service area of the state, if the covered carrier elects to nonrenew a health benefit plan under Subsections 31A-30-107(3)(e) or 107.1(3)(e), the covered carrier shall be prohibited from offering health benefit plans to individuals or small employers in any part of the service area for a period of five years. In addition, the covered carrier may not offer health benefit plans to individuals or small employers in any other geographic area of the state without the prior approval of the commissioner. In considering whether to grant approval, the commissioner may ask for such information and assurances as the commissioner finds reasonable and appropriate.

R590-167-8. Qualifying Previous Coverage.

A covered carrier shall not deny, exclude, or limit benefits because of a preexisting condition without first ascertaining the existence and source of previous coverage. The covered carrier shall have the responsibility to contact the source of such previous coverage to resolve any questions about the benefits or limitations related to such previous coverage. Previous coverage may be coverage that continues after the issuance of the new health benefit plan. The previous carrier shall fully cooperate in furnishing the needed information required by this section.

R590-167-9. Restrictive Riders.

A restrictive rider, endorsement or other provision that violates the provisions of Section 31A-30-107.5 may not remain in force. A covered carrier shall immediately provide written notice to those individuals or small employers whose coverage will be changed pursuant to this section.

R590-167-10. Status of Carriers as Covered Carriers.

(1) Prior to marketing a health benefit plan, a carrier shall make a filing with the commissioner indicating whether the carrier intends to operate as a covered carrier in this state under the terms of the Act and of this rule. Such filing will indicate if the covered carrier intends to market to individuals, small employers or both, and be signed by an officer of the company.

(2) Except as provided by Subsection R590-167-10(3), a carrier may not offer health benefit plans to individuals, small employers, or continue to provide coverage under health benefit plans previously issued to individuals or small employers in this state, unless the filing provided pursuant to Subsection R590-167-10(1) indicates that the carrier intends to operate as a covered carrier in this state.

(3) If a carrier does not intend to operate as a covered carrier in this state, the carrier may continue to provide coverage under health benefit plans previously issued to individuals and small employers in this state only if the carrier complies with the following provisions:

(a) the carrier complies with the requirements of the Act with respect to each of the health benefit plans previously issued to individuals and small employers by the carrier;

(b) the carrier provides coverage to each new entrant to a health benefit plan previously issued to an individual or small employer by the carrier;

(c) the carrier complies with the requirements of Sections 31A-30-106 and 31A-30-106.1 and this rule as they apply to individuals and small employers whose coverage has been terminated by the carrier and to individuals and small employers whose coverage has been limited or restricted by the carrier; and

(d) the carrier files a letter of intent indicating the carrier does not intend to operate as a covered carrier in this state and will maintain the business in compliance with the Act and this rule.

(4) If the filing made pursuant Subsection R590-167-10(3) indicates that a carrier does not intend to operate as a covered carrier in this state, the carrier shall be precluded from operating as a covered carrier in this state, except as provided for in Subsection R590-167-10(3), for a period of five years from the date of the filing. Upon a written request from such a carrier, the commissioner may reduce the period provided for in the previous sentence if the commissioner finds that permitting the carrier to operate as a covered carrier would be in the best interests of the individuals and small employers in the state.

R590-167-11. Actuarial Certification and Additional Filing Requirements.

(1) Actuarial Certification.

(a) An actuarial certification shall be filed annually and meet the requirements of Subsections 31A-30-106(4)(b) or 31A-30-106.1(9)(b), or both, as applicable, and the following:

(i) the actuarial certification shall be a written statement that meets the requirements of Title 31A Chapter 30, R590-167, and the applicable standards of practice as promulgated by the Actuarial Standards Board;

(ii) the actuary must state that he or she meets the qualifications of Subsection 31A-30-103(1);

(iii) the actuarial certification shall:

(A) contain the following statement: "I, (name), certify that (name of covered carrier) is in compliance with the provisions of Title 31A Chapter 30, and R590-167, based upon the examination of (name of covered carrier), including review of the appropriate records and of the actuarial assumptions and methods utilized by (name of covered carrier) in establishing premium rates for applicable health benefit plans;"

(B) list and describe each written demonstration used by the actuary to establish compliance with Title 31A Chapter 30 and R590-167; and

(C) include a list of all affiliated insurers, define each class of business which includes the commissioner's approval date if

~~more than one class of business exists, and the SERFF filing number for each applicable rate manual filing.~~

~~(b) The actuarial certification shall be filed no later than April 1 of each year.~~

~~(c) The actuarial certification required by Subsections 31A-30-106(4)(b) and 31A-30-106.1(13)(b) and this subsection, applies only to an individual or small employer health benefit plan issued prior to March 23, 2010, and has maintained grandfathered status.~~

~~(2) Rating Manual.~~

~~(a) For every health benefit plan subject to the Act and this rule, the carrier shall file with the commissioner a copy of the applicable rating manual, for both new business and renewal rates, which includes:~~

~~(i) signed certification by an actuary that to the best of the actuary's knowledge and judgment the rate filing is in compliance with the applicable laws and rules of the State of Utah;~~

~~(ii) a complete and detailed description of how the final premium, including any fees, is calculated from the rating manual;~~

~~(iii) all changes and updates, which includes a complete and detailed description of how the final premium, including any fees, is calculated from the rating manual;~~

~~(iv) an identification of the carrier's classes of business as described in Subsection R590-167-4(1);~~

~~(v) all information required by 45 CFR 154.215(b)(1);~~

~~(vi) for a rate increase subject to review as required by 45 CFR 154.200(a)(1), all information required by 45 CFR 154.215(b)(2); and~~

~~(vii) all information required by the Utah Accident and Health Comprehensive Health Insurance Rate Filing Checklist.~~

~~(b) The rate manual shall be filed:~~

~~(i) with an initial product filing; or~~

~~(ii) within 30 days prior to use for an existing health benefit plan.~~

~~R590-167-12. Records.~~

~~(1) Except as provided in Subsection R590-167-12(2), records submitted to the commissioner under this rule shall be maintained by the commissioner as protected records under Title 63G, Chapter 2, Government Records Access and Management Act.~~

~~(2) The commissioner finds the following to be considered a public record as defined in Subsection 63G-2-103:~~

~~(a) the status of a filing described herein and submitted to the department; and~~

~~(b) all information submitted as required by Subsections R590-167-11(2)(v) and (vi), and R590-220-10(2)(b)(iii)(I).~~

~~R590-167-13. Penalties.~~

~~A person found, after a hearing or other regulatory process, to be in violation of this rule shall be subject to penalties as provided under Section 31A-2-308.~~

~~R590-167-14. Severability.~~

~~If any provision of this rule or the application of it to any person or circumstance is, for any reason, held to be invalid, the remainder of the rule and the application of the provision to other persons or circumstances will not be affected by the invalid provision.~~]

R590-167-1. Authority.

This rule is promulgated by the commissioner pursuant to Sections 31A-2-201, 31A-2-212, 31A-30-104, 31A-30-106, 31A-30-106.1, and 31A-30-117.

R590-167-2. Purpose and Scope.

(1) The purpose of this rule is to:

(a) enhance the availability of health insurance coverage to individuals and small employers;

(b) regulate and prevent abuse in insurer rating practices and establish limits on differences in rates between health benefit plans;

(c) ensure renewability of coverage;

(d) establish limitations on the use of preexisting condition exclusions;

(e) prescribe the way case characteristics may be used;

(f) regulate the use and establishment of separate classes of business;

(g) provide for portability;

(h) improve the overall fairness and efficiency of the individual and small employer health insurance market;

(i) promote broader spreading of risk in the individual and small employer marketplace; and

(j) regulate rating practices for all health benefit plans sold to an individual and a small employer, whether sold directly or through an association or another group of individuals and small employers.

(2)(a) This rule applies to a health benefit plan that:

(i) meets one or more of the criteria in Subsections 31A-30-104(1) and 31A-30-104(2); and

(ii) provides coverage to a covered insured in Utah.

(b) A carrier that issues a health benefit plan to an individual or small employer is not subject to this rule solely because an individual or a small employer that was issued a health benefit plan in another state moves to Utah.

R590-167-3. Definitions.

Terms used in this rule are defined in Sections 31A-1-301 and 31A-30-103. Additional terms are defined as follows:

(1) "Act" means Title 31A, Chapter 30, Individual, Small Employer, and Group Health Insurance Act.

(2) "Change in a rating factor" means the cumulative change of a rating factor over a 12-month period.

(3) "Change in rating method" means:

(a) a change in the number of case characteristics used to determine health benefit plan premium rates in a class of business;

(b) a change in the manner or procedure by which an insured is assigned into a category for applying a case characteristic to determine health benefit plan premium rates in a class of business;

(c) a change in the method of allocating expenses among health benefit plans in a class of business; or

(d) a change in one or more rating factors for any case characteristic if the change produces a change in premium for an individual or small employer that exceeds 10%.

(4) "New entrant" means an eligible employee, or a dependent of an eligible employee, who becomes part of a small employer group after the initial period for enrollment in a health benefit plan.

(5) "Risk characteristic" means a rating factor related to the demographics, health status, or experience of an individual, a small employer, or a member of a small employer group, other than a case characteristic under Section 31A-30-106 or 31A-30-106.1, as applicable, including:

(a) exact age;

(b) gender;

(c) family composition;

(d) health status;

(e) claims experience;

(f) duration of coverage; or

(g) any similar characteristic.

(6) "Risk load" means the percentage above the base premium rate charged by a covered carrier to a covered insured reflecting the risk characteristics of the covered individual.

R590-167-4. Establishment of Classes of Business.

(1) A covered carrier with more than one class of business under Section 31A-30-105 shall maintain, for inspection by the commissioner, the following information with respect to each class of business:

(a) a description of all criteria used by the covered carrier or its agents to determine membership in the class of business;

(b) a statement justifying the establishment of each separate class of business and documentation that the establishment of each class of business reflects substantial differences in expected claims experience or administrative costs; and

(c) a statement disclosing each health benefit plan currently available for purchase in the class and any significant limitations related to the purchase of such plans.

(2) For policies issued or renewed on or after January 1, 2011, a covered carrier may not establish a separate class of business without the commissioner's prior approval.

(3) To establish a separate class of business under Subsection (2), a covered carrier shall submit a filing in compliance with Rule R590-220 that includes:

(a) a written request to establish a separate class of business;

(b) a description of all criteria used by the covered carrier, or its agents, to determine membership in the class of business;

(c) a disclosure of each health benefit plan that will be available for purchase in the class and any significant limitations related to the purchase of such plans;

(d) a statement demonstrating that the use of a separate class of business is necessary due to substantial differences in either expected claims experience or administrative costs related to the covered carrier:

(i) using more than one system for the marketing and sale of a health benefit plan to covered insureds;

(ii) acquiring a class of business from another covered carrier; or

(iii) providing coverage to one or more association groups;

(e) a list of previously approved classes of business; and

(f) for each class of business used before January 1, 2011, a certification that the continued use of the class of business is necessary under Subsection (3)(d).

(4) A covered carrier may not, directly or indirectly, use group size as a criterion for establishing eligibility for a class of business.

R590-167-5. Transition for Assumptions of Business from Another Carrier.

(1)(a) A covered carrier may not transfer or assume the entire insurance obligation, risk, or both, of a health benefit plan covering an individual or a small employer in Utah unless:

(i) commissioner of the state of domicile of the assuming carrier approves the transaction;

(ii) the commissioner of the state of domicile of the ceding carrier approves the transaction;

(iii) the covered carrier provides notice to the commissioner at least 60 days before the date of the proposed assumption, containing the information specified in Subsection (1)(c)(i) for a health benefit plan covering individuals and small employers in Utah; and

(iv) the transaction meets the requirements of this Section R590-167-5.

(b)(i) A covered carrier domiciled in Utah proposing to assume or cede the entire insurance obligation, risk, or both, of one

or more health benefit plans covering covered individuals from or to another carrier shall file for approval with the commissioner at least 60 days before the date of the proposed assumption.

(ii) The commissioner may approve the transaction if the commissioner finds that the transaction is in the best interest of the individuals insured under the health benefit plans to be transferred and is consistent with the purposes of the act and this rule.

(iii) The commissioner may not approve the transaction until at least 30 days after the date of the filing, except that if the carrier is in a hazardous financial condition, the commissioner may approve the transaction as soon as the commissioner finds reasonable after the filing.

(c)(i) The filing required under Subsection (1)(b) shall:

(A) describe the class of business, including any eligibility requirements of the ceding carrier;

(B) describe whether the assuming carrier will:

(I) maintain the assumed health benefit plans as a separate class of business under Subsection (3); or

(II) incorporate the health benefit plans into an existing class of business under Subsection (4);

(C) describe the class of business the health benefit plans will be incorporated into;

(D) describe whether the assumed health benefit plans are currently available for purchase by individuals or small employers;

(E) describe the effect of the assumption on the benefits provided by the health benefit plans;

(F) describe the effect of the assumption on the health benefit plans' premiums; and

(G) describe any other material effect of the assumption on the coverage provided to the individuals and small employers covered by the assumed health benefit plans.

(ii)(A) A covered carrier required to make a filing under Subsection (1)(b) shall make an informational filing with the commissioner of each state where there is an individual or small employer health benefit plan included in the transaction.

(B) The informational filing to each state shall be made concurrently with the filing made under Subsection (1)(b) and shall include at least the information specified in Subsection (1)(c)(i) for the individual or small employer health benefit plans in that state.

(2)(a) Except as provided in Subsection (2)(b), a carrier may not cede or assume the entire insurance obligation, risk, or both, of an individual or small employer health benefit plan unless the transaction cedes to the assuming carrier the entire class of business.

(b) A covered carrier may cede less than an entire class of business to an assuming carrier if:

(i)(A) one or more individuals or small employers in the class of business exercise their right under contract law or state law to reject the ceding of their health benefit plan to another carrier; and

(B) the transaction includes each health benefit plan in the class of business except those health benefit plans for which an individual or a small employer has rejected the proposed cession; or

(ii) after a written request from the ceding carrier, the commissioner determines that the transfer of less than the entire class of business is in the best interest of the individuals or small employers insured in that class of business.

(3) A carrier that assumes one or more health benefit plans from a covered carrier and maintains the health benefit plans as a separate class of business shall submit a filing requesting approval to establish a separate class of business.

(4) A carrier that assumes one or more health benefit plans from a covered carrier and incorporates the health benefit plans into an existing class of business shall comply with this Subsection (4).

(a) The assumed health benefit plans shall be transferred into a single class of business operated by the assuming carrier.

(b) The assuming carrier shall select the class of business the assumed health benefit plans will be transferred into in a manner that results in the least possible change to the benefits and rating method of the assumed health benefit plans.

(c) A transfer under Subsection (4)(b) shall occur on the anniversary date of a health benefit plan, except that the transfer period may be extended beyond the first anniversary date up to 12 months, if the anniversary date occurs within three months of the date of assumption.

(d) An assuming carrier making a transfer under Subsection (4) may alter the benefits of the assumed health benefit plans to conform with the benefits offered by the carrier in the class of business the health benefit plans are transferred into.

(e)(i) The assuming carrier may not modify the premium rate for the assumed health benefit plans until the health benefit plans are transferred under Subsection (4).

(ii) The assuming carrier shall calculate a new premium rate for the health benefit plans from the rate manual established for the class of business the health benefit plans are transferred into.

(iii) The risk load applied to the health benefit plan may not be higher than the risk load applied to the health benefit plan before the assumption.

(f) During the 15-month period under Subsection (4)(b), the transfer of health benefit plans from the assumed class of business does not violate Subsection 31A-30-106(3)(a) or 31A-30-106.1(8)(a).

(5) An assuming carrier may not apply eligibility requirements, including minimum participation and contribution requirements, to an assumed or subsequently offered health benefit plan, that are more stringent than the requirements applicable to the health benefit plan before assumption.

(6) The act and Section R590-167-5 do not:

(a) reduce any legal or contractual obligation or requirement, including an obligation under Section 31A-14-213, of the ceding or assuming carrier related to the transaction;

(b) authorize a carrier not admitted to transact the business of insurance to offer or insure a health benefit plan in Utah; or

(c) reduce the protections of an assumption reinsurance transaction under Section 31A-14-213 or otherwise provided by law.

(8) Once a health benefit plan has been assumed, the assuming carrier is considered a covered carrier.

R590-167-6. Restrictions on Premium Rates.

(1)(a) A covered carrier shall develop a separate rate manual for each class of business.

(b) Base premium rates and new business premium rates charged to an individual or a small employer shall be computed solely from the applicable rate manual.

(c) To the extent that a portion of the premium rate is based on the carrier's discretion, the rate manual shall specify the criteria and factors considered by the covered carrier in exercising such discretion.

(2)(a)(i) A covered carrier may not modify the rating method used in the rate manual for a class of business until the change has been approved by the commissioner.

(ii) The commissioner may approve a change to a rating method if the commissioner finds that the change is reasonable, actuarially appropriate, and consistent with the purposes of the act and this rule.

(b) A covered carrier may modify the rating method for a class of business after filing an actuarial certification that clearly requests approval for a change in rating method and contains the following information:

(i) the reason for the change in rating method;

(ii) a complete description of each proposed modification to the rating method;

(iii) a description of how the change in rating method will affect the premium rates currently charged in the class of business;

(iv) an estimate from a qualified actuary of the number of individuals and small employers, including a description of the types of individuals and small employers, whose premium rates may change by more than 10% due to the proposed change in rating method, not including general increases in premium rates;

(v) a certification from a qualified actuary that the new rating method is based on objective and credible data and is actuarially sound and appropriate; and

(vi) a certification from a qualified actuary that the proposed change in rating method does not produce premium rates for an individual or small employer that violate Sections 31A-30-106, 31A-30-106.1, and 31A-30-106.5.

(c)(i) A request for approval for a change in rating method shall be submitted as a separate filing.

(ii) The filing description shall state in the first line of the first paragraph, "REQUEST FOR APPROVAL FOR CHANGE IN RATING METHOD."

(3) The rate manual shall specify the case characteristics and rate factors to be applied by the covered carrier in establishing premium rates for the class of business.

(4)(a)(i) A covered carrier may not use case characteristics other than those specified in Sections 31A-30-106 and 31A-30-106.1 without the commissioner's prior approval.

(ii) A covered carrier seeking an approval under this Subsection (4)(a) shall make a filing with the commissioner for a change in rating method under Subsection (2)(b).

(b) Tobacco use is not an allowable case characteristic and may only be used under Subsection 31A-30-106(1)(b).

(c) The ratio of the base rate for any age band case characteristic under Subsection 31A-30-106.1(7) to the base rate for a less than 20 age band may not exceed the following:

(i) 1.22 for age band 20 to 24;

(ii) 1.34 for age band 25 to 29;

(iii) 1.46 for age band 30 to 34;

(iv) 1.60 for age band 35 to 39;

(v) 1.80 for age band 40 to 44;

(vi) 2.20 for age band 45 to 49;

(vii) 2.80 for age band 50 to 54;

(viii) 3.60 for age band 55 to 59;

(ix) 4.25 for age band 60 to 64; and

(x) 5.00 for age band 65 and above.

(d) A covered carrier shall use the same case characteristics in establishing premium rates for each health benefit plan in a class of business and shall apply them in the same manner in establishing premium rates.

(e) Risk characteristics may not be considered when applying case characteristics.

(5)(i) The rate manual shall clearly illustrate the relationship among the base premium rates charged for each health benefit plan in a class of business.

(ii) If the new business premium rate is different from the base premium rate for a health benefit plan, the rate manual shall illustrate the difference.

(6) Differences among base premium rates for health benefit plans shall be based solely on the reasonable and objective differences in the design and benefits of the health benefit plans and may not be based in any way on the nature of an individual or a small employer that chooses or is expected to choose a particular health benefit plan.

(7) A covered carrier shall apply case characteristics and rate factors within a class of business in a manner that assures that premium differences among health benefit plans for identical individuals or small employers vary only due to reasonable and objective differences in the design and benefits of the health benefit plans and are not due to the nature of the individuals or small employers that choose or are expected to choose a particular health benefit plan.

(8) The rate manual shall provide for premium rates to be developed in a two-step process.

(a) In step one, a base premium rate shall be developed to reflect the allowable case characteristics that result in individuals or small employers with identical case characteristics.

(b) In step two, the resulting base premium rate may be adjusted by a risk load to reflect the risk characteristics, subject to

Sections 31A-30-106, 31A-30-106.1, and 31A-30-106.5.

(9)(a) Except as provided in Subsection (4)(b), a premium may not include a separate application fee, underwriting fee, or any other separate fee or charge.

(b) A covered carrier may charge a separate fee for an individual or a small employer health benefit plan, but only one fee per plan, provided the fee is no more than $5 per month per individual or employee and is applied in a uniform manner to each health benefit plan in a class of business.

(10) The premium rate change restrictions in Subsections 31A-30-106(1)(c) and 31A-30-106.1(3) shall be applied as follows:

(a) a covered carrier shall revise its rate manual each rating period to reflect changes in base premium rates and changes in new business premium rates;

(b)(i) if, for any health benefit plan with respect to any rating period, the percentage change in the new business premium rate is less than or the same as the percentage change in the base premium rate, the change in the new business premium rate shall be the change in the base premium rate; or

(ii) if, for any health benefit plan with respect to any rating period, the percentage change in the new business premium rate exceeds the percentage change in the base premium rate, the health benefit plan shall be considered a health benefit plan in which the covered carrier is no longer enrolling new individuals or small employers;

(c) if a covered carrier elects to use a trend increase:

(i) details for the trend rate calculation shall be filed annually in the rate manual; and

(ii) the trend increase is limited to a 12-month period; and

(d) if, for any rating period, the change in the new business premium rate for a health benefit plan differs from the change in the new business premium rate for any other health benefit plan in the same class of business by more than 20%, the covered carrier shall file with the commissioner 30 days before the beginning of the rating period an explanation of how the respective changes in the new business premium rates were established and the reason for the difference.

(11)(a) Except as provided in Subsection (11)(b), a change in premium rate for an individual or small employer shall produce a revised premium rate that is no more than the following:

(i) the base premium rate for the individual or small employer, as shown in the rate manual as revised for the rating period, multiplied by:

(ii) one plus the sum of:

(A) the risk load applicable to the individual or small employer during the previous rating period; and

(B) 15%, prorated for periods of less than one year.

(b) In the case of a health benefit plan into which a covered carrier is no longer enrolling new individuals or small employers, a change in premium rate for an individual or small employer shall produce a revised premium rate that is no more than the following:

(i) the base premium rate for the individual or small employer, given its present composition and as shown in the rate manual in effect for the individual or small employer at the beginning of the previous rating period, multiplied by:

(ii) one plus the lesser of:

(A) the change in the base rate; or

(B) the percentage change in the new business premium for the most similar health benefit plan into which the covered carrier is enrolling new individuals or small employers, multiplied by:

(iii) one plus the sum of:

(A) the risk load applicable to the individual or small employer during the previous rating period; and

(B) 15%, prorated for periods of less than one year.

(c) Except as provided in Subsections (11)(a) and (11)(b), a change in premium rate for an individual or small employer may not produce a revised premium rate that would exceed the limitations on rates provided in Subsections 31A-30-106(1)(b) and 31A-30-106.1(2)(b).

(12) A Taft-Hartley trust requesting a waiver of Subsection 31A-30-106(1) or 31A-30-106.1(1) shall file with the commissioner a request that identifies the provisions for which the trust is seeking the waiver that describes the extent each provision will:

(a) adversely affect the participants and beneficiaries of the trust; and

(b) require modifications to one or more of the collective bargaining agreements under which the trust is established or maintained.

(13) A covered carrier shall maintain, for a period of at least six years, any update or change to a rate manual, including the calculations used to determine the change in base premium rates and new business premium rates for each health benefit plan for each rating period.

R590-167-7. Application to Reenter State.

(1)(a) A carrier that is prohibited from writing new business for an individual or small employer health benefit plan in Utah under Section 31A-22-618.8 may not resume offering an individual or small employer health benefit plan in Utah until the carrier petitions the commissioner to be reinstated as a covered carrier and the petition is approved.

(b) The commissioner may ask for information and assurances the commissioner finds reasonable and appropriate to make a decision.

(2) If a covered carrier is doing business in only one established geographic service area of Utah and the covered carrier

elects to discontinue a health benefit plan under Section 31A-22-618.6 or 31A-22-618.7, the covered carrier is prohibited from offering a health benefit plan to an individual or small employer in any part of the service area for a period of five years.

(a) The covered carrier may not offer a health benefit plan to an individual or small employer in any other geographic area of Utah without the commissioner's prior approval.

(b) The commissioner may ask for information and assurances the commissioner finds reasonable and appropriate to make a decision.

R590-167-8. Qualifying Previous Coverage.

(1) A covered carrier may not deny, exclude, or limit benefits because of a preexisting condition without first ascertaining the existence and source of previous coverage.

(2) A covered carrier has the responsibility to contact the source of previous coverage to resolve any questions about the benefits or limitations related to the previous coverage.

(3) Previous coverage includes coverage that continues after the issuance of the new health benefit plan.

(4) The previous carrier shall fully cooperate in furnishing the information required by this section.

R590-167-9. Restrictive Riders.

(1) A restrictive rider, endorsement, or other provision that violates Section 31A-30-107.5 may not remain in force.

(2) A covered carrier shall immediately provide written notice to any individual or small employer whose coverage will be changed pursuant to this section.

R590-167-10. Status of a Carrier as a Covered Carrier.

(1)(a) Before marketing a health benefit plan, a carrier shall file with the commissioner its intent to operate as a covered carrier in Utah under the terms of the act and of this rule.

(b) The filing shall state if the carrier intends to market to individuals, small employers, or both, and shall be signed by an officer of the company.

(2) Except as provided by Subsection (3), a carrier may not offer a health benefit plan to an individual or a small employer in Utah, or continue to provide coverage under a health benefit plan previously issued to an individual or a small employer in Utah, unless the filing under Subsection (1) indicates that the carrier intends to operate as a covered carrier in Utah.

(3)(a) If a carrier does not intend to operate as a covered carrier in Utah, the carrier may continue to provide coverage under a health benefit plan previously issued to an individual or a small employer in Utah if:

(i) the carrier complies with the act with respect to each health benefit plan previously issued to an individual or a small employer;

(ii) the carrier provides coverage to each new entrant to a health benefit plan previously issued to an individual or a small employer;

(iii) the carrier complies with Sections 31A-30-106 and 31A-30-106.1 and this rule as they apply to an individual or a small employer whose coverage was terminated, limited, or restricted by the carrier; and

(iv) the carrier files a letter of intent indicating the carrier does not intend to operate as a covered carrier in Utah and will maintain the business in compliance with the act and this rule.

(b)(i) If a filing made under Subsection (3) indicates that a carrier does not intend to operate as a covered carrier in Utah, the carrier is precluded from operating as a covered carrier in Utah, except as provided for in Subsection (3), for a period of five years from the date of the filing.

(ii) Upon written request from the carrier, the commissioner may reduce the five-year period if the commissioner finds that permitting the carrier to operate as a covered carrier would be in the best interests of the individuals and small employers in Utah.

R590-167-11. Actuarial Certification and Additional Filing Requirements.

(1)(a) An actuarial certification filing under Subsection 31A-30-106(4)(b) or 31A-30-106.1(13)(b) shall:

(i) include a written statement that meets the requirements of the act, this rule, and the applicable standards of practice promulgated by the Actuarial Standards Board;

(ii) be signed by the actuary and state that the actuary meets the qualifications of Subsection 31A-30-103(1);

(iii) contain the following statement: "I, (name), certify that (name of covered carrier) is in compliance with Title 31A, Chapter 30, Individual, Small Employer, and Group Health Insurance Act, and Rule R590-167, based upon the examination of (name of covered carrier), including review of the appropriate records and of the actuarial assumptions and methods utilized by (name of covered carrier) in establishing premium rates for applicable health benefit plans";

(iv) list and describe each written demonstration used by the actuary to establish compliance with the act and this rule;

(v) list all affiliated insurers, defining each class of business that includes the commissioner's approval date if more than one class of business exists; and

(vi) include the System for Electronic Rates and Forms Filing, SERFF, filing number for each applicable rate manual filing.

(b) The actuarial certification applies to an individual or a small employer health benefit plan issued before March 23, 2010, and maintains grandfathered status.

(2)(a) A covered carrier shall file with the commissioner a copy of the applicable rate manual for a health benefit plan that is subject to the act and this rule, for both new business and renewal rates, and shall include:

(i) a signed certification by an actuary that, to the best of the actuary's knowledge and judgment, the rate filing complies with

the applicable laws and rules of Utah;

(ii) a complete and detailed description of how the final premium, including any fees, is calculated from the rate manual;

(iii) all changes and updates, including a complete and detailed description of how the final premium, including any fees, is calculated from the rate manual;

(iv) an identification of the covered carrier's classes of business under Subsection R590-167-4(1);

(v) all information required by 45 CFR 154.215(b)(1); and

(vi) for a rate increase subject to review by 45 CFR 154.200(a)(1), all information required by 45 CFR 154.215(b)(2).

(b) The rate manual shall be filed:

(i) with an initial product filing; or

(ii) 30 days before use, for an existing health benefit plan.

R590-167-12. Records.

(1) Except as provided in Subsection (2), a record submitted to the commissioner under this rule shall be maintained as a protected record under Title 63G, Chapter 2, Government Records Access and Management Act.

(2) The commissioner classifies the following records as public:

(a) the status of a filing; and

(b) information submitted under Subsections R590-167-11(2)(a)(v) and R590-167-11(2)(a)(vi).

R590-167-13. Severability.

If any provision of this rule, Rule R590-167, 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: health insurance
Date of Last Change: 2024[~~March 23, 2016~~]
Notice of Continuation: August 20, 2019
Authorizing, and Implemented or Interpreted Law: 31A-30-106; 31A-30-106.1

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