



State of Utah

GARY R. HERBERT
Governor

SPENCER J. COX
Lieutenant Governor

Insurance Department

TODD E. KISER
Insurance Commissioner

BULLETIN 2019-1

TO: Health Insurers Offering Health Benefit Plans or Stand-Alone Dental Plans
FROM: Todd E. Kiser, Utah Insurance Commissioner
DATE: April 25, 2019
SUBJECT: **Plan Year 2020 Filing Requirements for Health Benefit Plans and Stand-Alone Dental Plans**

This Bulletin is issued as guidance for the 2020 plan year for an insurer offering a health benefit plan or a certified stand-alone dental plan (SADP) in the individual or small employer market, regardless of marketplace participation. This Bulletin is a source of information for both state and federal filing requirements. Insurers are advised to review the U.S. Department of Health and Human Services' Center for Consumer Information and Insurance Oversight (CCIIO) 2020 Letter to Issuers in the Federally-facilitated Exchanges, Notice of Benefit and Payment Parameters for 2020, and state law in conjunction with this Bulletin to ensure full compliance.

Transitional Plan Extension

An individual or small employer health insurer may continue transitional health benefit plan coverage as permitted by guidance issued by CCIIO and pursuant to Utah Code § 31A-30-117. A health insurer, which has renewed policies under the transitional policy continually since 2014, may continue to renew such policies provided the transitional coverage does not extend past December 31, 2020.

Filing Deadlines – Regardless of Marketplace Status

Health Benefit Plans for Individual and Small Employer

Form and rate submissions must be submitted in separate filings.

- **June 10, 2019, 11:59 PM MDT:** Forms, binders, and associated documents.
- **July 1, 2019, 11:59 PM MDT:** Rates, Rate Data Template, and Unified Rate Review Template (URRT) Parts I, II, and III. Including the initial rate submission in Health Insurance Oversight System (HIOS)
- **July 23, 2019, 11:59 PM MDT:** HIOS deadline for revisions to rate submission to be considered an initial rate submission

Certified Stand-Alone Dental Plans for Individual and Small Employer

Form and rate submissions must be submitted in one filing.

- **June 3, 2019, 11:59 PM MDT:** Forms, rates, binders, and associated documents

It is the insurer's responsibility to ensure that all filings are complete and compliant with all federal and state laws, regulations, and standards. A submitted filing that does not comply with laws, regulations, or standards will be rejected and not considered filed with the Department, Utah Admin. Code R590-220-5.

Binder, Form, and Rate Filing Guidance

An insurer is required to file a 2020 binder filing with all applicable templates, even if no changes are being made. If a filing includes new products or plans, supporting documentation and justification is required. Filings must meet the requirements of R590-220.

A binder and corresponding form filing must be submitted within three business days of each other but no later than the filing deadline listed above, and as instructed below:

Binder Filings

- A separate binder is required for each single risk pool: individual health benefit plans, small employer health benefit plans, individual SADPs, and small employer SADPs.
- The binder must include all products and plans offered within a pool.
- Associated Schedule Items tab must include the following, as applicable, at a minimum: policy, outline of coverage, certificate, summary of benefits, and un-redacted actuarial memorandum.

Stand-Alone Dental Plan Form and Rate Filings

- Dental form AND rate filings must be submitted as one filing for each market; individual and small employer.
- Each form must be identified by a unique form number and the form number cannot be variable.
 - If an insurer chooses to use a previously filed form and/or rate, and not submit a new form or rate filing, the binder must include a note to reviewer attesting that there are no changes in the form or rate and must include the SERFF tracking number under which the form/rate filing was submitted, including any filed updates to the originally filed form and/or rate.
 - If an insurer chooses to use a previously filed form or rate, the filing must provide the corresponding form and/or rate in the filing description.

Health Benefit Plan Form Filings

- Do NOT submit rate information in a health benefit plan form filing.
- An insurer must submit one form filing for each distinct **HIOS Product ID**.
 - If an insurer chooses to use a previously filed form, the insurer must attach under the Supporting Documentation tab a list of the previously submitted form number(s) and corresponding SERFF tracking number(s) with an attestation there are no changes to the form. The previously filed form does not need to be re-filed.
- Each distinct HIOS Product ID form filing must include all plans within the single product.
- Each form must be identified by a unique form number and the form number cannot be variable.

Health Benefit Plan Rate Filings

- Do NOT submit forms in a health benefit plan rate filing.
- Rate filings must be submitted under separate SERFF tracking numbers for each risk pool; individual or small employer.
- Insurers must submit the URRT Parts I, II, and III to the Department and in HIOS no later than the filing deadlines listed above.
 - The SERFF filing must include documentation via a note to reviewer that confirms the HIOS filing.
 - The HIOS filing must include the *rate filing* SERFF tracking number in the field “Filing Tracking Number.”
- The Department requires that filings attribute the cost of the Cost Sharing Reductions (CSRs) to the silver on-exchange plans.
 - The actuarial memorandum should clearly indicate the assumptions leading to the CSR adjustments.
 - The factor adjustments should be outlined by Plan ID in the actuarial memorandum.
 - Insurers must provide a single factor adjustment that provides an estimate of the rate impact to silver on-exchange plans and overall if CSRs were funded.
 - The Department encourages insurers to offer a silver plan off-exchange only that does not incorporate the effects of the CSR adjustment.
- Actuarial Considerations:
 - If an insurer has Unique Plan Designs (UPD) that use alternate methods to arrive at the Actuarial Value (AV), the following must be included in the rate filing.
 - Screen shots of the AV Calculator for the UPD plans in the rate/rule schedule tab.
 - An attestation describing which plans are UPD, why the AV Calculator was inadequate to capture the plan design, and what methods were used to determine the AV. This attestation can be part of the actuarial memorandum or a separate document in the rate/rule schedule tab.
 - Do NOT include transitional experience or projections in the URRT. Instead, provide the following in the actuarial memorandum.
 - A table showing the insurer’s transitional experience (if any) for the experience period that corresponds to the URRT experience period in "Wksh 1- Market Experience", Section I. The table should include: Allowed Claims, Incurred Claims, Earned Premium, and Member Months.
 - A description of the remaining transitional business (if any) and the insurer’s expectations for transitional plans (e.g. does the insurer intend to continue offering transitional as long as it is allowed).

The Department will utilize CCIIO standard templates, application review tools, and may use other resources recommended or developed by CCIIO. Additional filing guidance may be found in SERFF’s Plan Management General Instructions.

Age Slope

Utah has established a state age slope pursuant to 45 CFR 147.102(e), and remains unchanged for PY2020.

Age Band	Slope Factor	Age Band	Slope Factor	Age Band	Slope Factor
0-20	0.793	35	1.390	50	2.127
21	1.000	36	1.390	51	2.212
22	1.050	37	1.404	52	2.300
23	1.113	38	1.425	53	2.392
24	1.191	39	1.450	54	2.488
25	1.298	40	1.479	55	2.588
26	1.363	41	1.516	56	2.691
27	1.390	42	1.562	57	2.799
28	1.390	43	1.616	58	2.911
29	1.390	44	1.681	59	3.000
30	1.390	45	1.748	60	3.000
31	1.390	46	1.818	61	3.000
32	1.390	47	1.891	62	3.000
33	1.390	48	1.966	63	3.000
34	1.390	49	2.045	64	3.000

Geographic Rating Areas

Utah's geographic rating areas are based on counties. Counties are assigned to the following areas:

- Area 1: Cache and Rich
- Area 2: Box Elder, Morgan, and Weber
- Area 3: Davis, Salt Lake, Summit, Tooele, and Wasatch
- Area 4: Utah
- Area 5: Iron and Washington
- Area 6: Beaver, Carbon, Daggett, Duchesne, Emery, Garfield, Grand, Juab, Kane, Millard, Piute, San Juan, Sanpete, Sevier, Uintah, and Wayne

Market Reform Rules and QHP & SADP Certification Requirements

General Filing Requirements	
Federal Standard ACA §1002 ACA §1311 ACA §1341 42 USC § 18021 42 USC § 18022 42 USC § 18031 45 CFR 147.104 45 CFR 147.106 45 CFR 153.400 45 CFR 153.410 45 CFR 153.610 45 CFR 155 & 156	An insurer shall: (1) comply with all market reforms and certification requirements on an ongoing basis; (2) comply with benefit design standards; (3) be licensed and in good standing to offer health insurance coverage in Utah; (4) implement and report on a quality improvement strategy or strategies consistent with the standards described within the PPACA, disclose and report information on health care quality and outcomes as defined by the Centers for Medicaid and Medicare Services (CMS), and implement appropriate enrollee satisfaction surveys as required by the PPACA; (5) agree to charge the same premium rate without regard to whether the plan is offered through a marketplace or whether the plan is offered directly from the insurer or through an agent; (6) pay any applicable user fees assessed; (7) participate in and comply with the standards related to the risk adjustment program;

CMS Guidance Rules	<p>(8) notify customers of the effective date of coverage;</p> <p>(9) participate in initial and annual open enrollment periods, as well as special enrollment periods;</p> <p>(10) collect enrollment information, transmit such to a marketplace and reconcile enrollment files with the marketplace enrollment files monthly;</p> <p>(11) provide and maintain notice of termination of coverage. A standard policy shall be established and include a grace period for certain enrollees that is applied uniformly. Notice of payment delinquency shall be provided;</p> <p>(12) segregate funds if abortion is offered as a benefit, other than in the case of an abortion provided under the Hyde Amendment exception;</p> <p>(13) timely notify the marketplace if it plans to not seek recertification, fulfill coverage obligations through the end of the plan/benefit year, fulfill data reporting obligations from the last plan/benefit year, provide notice to enrollees, and terminate coverage for enrollees, providing written notice;</p> <p>(14) in the event that the QHP becomes decertified, terminate coverage after the notification to enrollees and after enrollees have had an opportunity to enroll in other coverage;</p> <p>(15) upon plan renewal, provide standardized notice to consumers using the HHS standard notice of renewal;</p> <p>(16) comply with market reform rules, including premium rating rules, guaranteed availability, guaranteed renewability, and single risk pool requirements;</p> <p>(17) per guaranteed availability, provide a matching benefit plan and price off of the marketplace for any plan certified as a QHP;</p> <p>(18) participate in the reinsurance program, including making reinsurance contributions and receiving reinsurance payments; and</p> <p>(19) meet all readability and accessibility standards.</p>
State Standard	<p>The Department will review binder, form, and rate filings for compliance with federal and state laws and regulations.</p> <p>(1) The Department provides a recommendation for certification to the marketplaces. Final certification is provided by the marketplaces. All plans must be recertified each year.</p> <p>(2) Exchange administrative user fees are set at 3%.</p> <p>(3) An insurer shall uphold all state laws and regulations.</p>
Licensure and Solvency	
Federal Standard 45 CFR 156.200	An insurer shall be licensed and in good standing with the State.
State Standard	An insurer shall be licensed, meet state solvency requirements, have unrestricted authority to write its authorized lines of business, and have no outstanding sanctions in Utah in order to be considered “in good standing.” The Department is the sole source of a determination of whether an insurer is in good standing and may, as part of that finding, restrict the insurer’s ability to issue new coverage or renew existing coverage.
Network Adequacy	
Federal Standard ACA § 2702c 45 CFR 155.1050 45 CFR 156.230 45 CFR 156.235	<p>An insurer shall ensure that a provider network for each of its plans is available to all enrollees, and:</p> <ul style="list-style-type: none"> • includes essential community providers (ECP) in sufficient number and geographic distribution where available to ensure reasonable and timely access to a broad range of such providers for low income and medically underserved individuals in the QHP service area. This shall be instituted utilizing CMS established requirements for inclusion of ECPs in QHPs based on CMS’s Annual Letter to Issuers; • maintains a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance use disorder treatment services, to assure that all services will be accessible without unreasonable delay; and • makes its provider directory available to the marketplace for publication online in accordance with guidance from the marketplace and to potential enrollees in hard copy upon request noting which providers are not accepting new patients.

State Standard	<p>(1) An insurer shall ensure that all plans, offered on or off marketplace, have an adequate provider network available for the geographic area(s) in which a plan is offered.</p> <p>(2) The network must include a sufficient number and geographic distribution to ensure reasonable and timely access to a broad range of such providers in an insurer’s service area, maintain a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance use disorder treatment services and pediatric appropriate services, to assure that all services are accessible without unreasonable delay.</p> <p>(3) A current provider directory shall be maintained which: indicates providers that are not accepting new patients; is available online to all enrollees including potential enrollees; and shall be provided to an enrollee as a hard copy upon request.</p> <p>(4) An insurer shall attest that it complies with all applicable network adequacy requirements.</p> <p>(5) An insurer offering marketplace plans shall include in their attestation one of the following:</p> <ul style="list-style-type: none"> • evidence that it has accreditation from an HHS approved accrediting organization that reviews network adequacy as a part of accreditation; or • sufficient information related to its policies and procedures to determine that the insurer’s network meets the minimum federal requirements. <p>(6) Health benefit plans must comply with §31A-45-501.</p> <p>(7) Insurers using preferred health care provider contracts shall comply with § 31A-45-303.</p> <p>(8) An insurer shall make their access plan and criteria available, upon request to the Department, to demonstrate the insurer has standards and procedures in place to maintain an adequate network, pursuant to § 31A-2-202.</p>
Accreditation	
Federal Standard 45 CFR 155.1045 45 CFR 156.275	<p>(1) Insurers shall maintain accreditation on the basis of local performance in the following categories by an accrediting entity recognized by HHS: clinical quality measures, such as HEDIS; patient experience ratings on a standardized CAHPS survey; consumer access; utilization management; quality assurance; provider credentialing; complaints and appeals; network adequacy and access; and patient information programs.</p> <p>(2) Insurers without existing commercial or marketplace health plan accreditation, from HHS recognized accrediting entities, shall schedule an accreditation review during their first year of certification and receive accreditation on the insurer’s policies and procedures prior to their second year of certification.</p> <p>(3) Prior to the insurer’s fourth year of certification and in every subsequent year of certification, an insurer shall be accredited in accordance with 45 CFR 156.275.</p> <p>(4) Insurers will be required to authorize the release of their accreditation survey data and any official correspondence related to accreditation status to the Department.</p>
State Standard	<p>(1) The Department follows the federal requirements related to accreditation and requires the authorized release of all accreditation data.</p> <p>(2) For a new insurer entering the marketplaces that is not already accredited, the Department requires an attestation that the insurer has entered into an accreditation process. Such accreditation must be completed prior to submission of any application for recertification. The Department may not re-certify an insurer who has not achieved appropriate accreditation upon application for recertification.</p> <p>(3) Accreditation shall be documented in the Company and Contact section of SERFF.</p>
Service Area	
Federal Standard 45 CFR 155.1055	<p>Service area is the geographic area in which an individual shall reside or be employed in order to enroll in a plan. An insurer shall specify what service areas it will be utilizing. The service area shall be established without regard to racial, ethnic, language or health status related factors or other factors that exclude specific high utilization, high cost or medically underserved populations.</p>
State Standard	<p>The insurer may choose their service area as long as the service area(s) are not smaller than a county. Changes in service area will not be permitted except in limited circumstances and upon approval by the Department.</p>

Rating Area	
Federal Standard 45 CFR 156.255	PPACA defines a “rating area” as a geographic area established by a state that provides boundaries by which insurers can adjust premiums.
State Standard	The Department has adopted a configuration of six rating areas to be utilized in Utah. An insurer’s service area may contain more than one rating area, thus an insurer may offer plans with a statewide service area while modifying rates based on allowed rating areas within that service area.
Quality Improvement	
Federal Standard ACA §1311 ACA §2717 45 CFR 156.20 45 CFR 156.200 45 CFR 156.275 45 CFR 156.1130	An insurer shall implement and report on a quality improvement strategy or strategies consistent with standards of the PPACA to disclose and report information on healthcare quality and outcomes and implement appropriate enrollee satisfaction surveys which include but are not limited to the implementation of: <ul style="list-style-type: none"> • a payment structure for health care providers that provides incentives for improving health outcomes through the implementation of activities that shall include quality reporting, effective case management, care coordination, chronic disease management, medication, and care compliance initiatives, including through the use of the medical home model, for treatment or services under the plan or coverage; • activities to prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient centered education and counseling, comprehensive discharge planning, and cost discharge reinforcement by an appropriate health care professional; • activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine, and health information technology under the plan or coverage; • wellness and health promotion activities; and • activities to reduce health and health care disparities, including through the use of language services, community outreach, and cultural competency trainings.
State Standard	The Department will require a QHP issuer to comply and attest to compliance with quality improvement standards and regulatory requirements outlined in CMS’s Annual Letter to Issuers.
General Offering Requirements	
Federal Standard 42 USC § 18022 45 CFR 147.120 45 CFR 147.126 45 CFR 147.138 45 CFR 155 & 156 CMS Guidance Rules	<p>(1) An insurer offering a health benefit plan shall offer at least one QHP at the silver coverage level and at least one QHP at the gold coverage level in each of their covered service area(s).</p> <p>(2) An insurer shall include a child-only plan at the same level of coverage as any QHP offered through either the individual marketplace or SHOP to individuals who, as of the beginning of the plan year, have not attained the age of 21. This requirement may also be met by submitting an attestation that there is no substantive difference between having a child-only plan and issuing child-only policies, and that the insurer will accept child-only enrollees.</p> <p>(3) Catastrophic plans can be sold to individuals who have not attained the age of 30 before the beginning of the plan year; or an individual who has a certification in effect for any plan year exempt from the Shared Responsibility Payment by reason of lack of affordable coverage or hardship. A catastrophic plan may only be offered on the individual marketplace, not on the SHOP.</p> <p>(4) All health benefit plan QHP offerings shall show a meaningful difference between the plans within a single metal tier, and comply with standards in the best interest of the consumer.</p> <p>(5) Pediatric benefits shall be provided until the end of the month in which the enrollee turns 19, including pediatric dental and vision benefits.</p> <p>(6) Emergency services shall be covered with no prior authorization and no limitation to participating or in-network providers. Emergency services shall be covered at in-network cost-sharing level.</p> <p>(7) An insurer will be required to meet all annual limitations and cost sharing requirements without affecting the actuarial value of the plans within each of the metal tiers. An insurer</p>

	<p>shall demonstrate, in an exhibit filed with the plan, that annual out of pocket cost sharing under the plan does not exceed the limits established by federal regulations.</p> <p>(8) The insurer shall contain no lifetime limits on the dollar value of any Essential Health Benefits (EHB), including the specific benefits and services covered under the EHB-Benchmark Plan. Note that reasonable dollar limits for services are allowed, as long as there is no associated service or visit limit.</p> <p>(9) Insurers are required to accept premiums from Ryan White HIV/AIDS programs, Indian tribal organizations, and state and federal government programs.</p> <p>(10) All insurers shall comply with all federal and state laws related to rating rules, factors and tables used to determine rates. Such rates shall be based upon the analysis of the plan rating assumptions and rate increase justifications.</p>
State Standard	In addition to specific state and federal laws and rules, rate and form filing process requirements are included in SERFF's general instructions, outlined in this Bulletin, and R590-220.
Essential Health Benefits	
Federal Standard 42 USC. § 18022 45 CFR 146.136 45 CFR 147.130 45 CFR 148.170 45 CFR 155.170 45 CFR 156.110 45 CFR 156.115 45 CFR 156.125 45 CFR 156.280	<p>(1) An insurer shall offer coverage that is substantially equal to the coverage offered by the state's base benchmark plan. This may be done by substituting benefits only if an insurer demonstrates the actuarial value of the substituted benefits.</p> <p>(2) An insurer is not permitted to offer abortion coverage within their benefit plans except for meeting requirements of the Hyde Amendment. If the insurer chooses to offer abortion benefits covered as part of the Hyde Amendment exceptions, public funds may not be used to pay for these services. The insurer shall provide notice through its summary of benefits if such benefit is being made available.</p> <p>(3) An insurer shall cover preventive services without cost sharing requirements including deductibles, co-payments, and co-insurance. Covered preventive services include evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF); certain immunizations, screenings provided for in HRSA guidelines for infants, children, adolescents, and women (including compliance with standards related to benefits for and current recommendations of the USPSTF regarding breast cancer screening, mammography, and prevention).</p> <p>(4) Coverage for the medical treatment of mental illness and substance use disorder shall comply with the federal Mental Health Parity and Addiction Equity Act (MHPAEA) and applicable federal regulations. Any non-quantitative treatment limitations (NQTL) used in mental health and substance abuse disorders may not be more stringent than those used in applying limitations with respect to medical /surgical benefits. NQTLs include, but are not limited to:</p> <ul style="list-style-type: none"> • medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative (including standards for concurrent review); • formulary design for prescription drugs; • network tier design; • standards for provider admission to participate in a network, including reimbursement rates; • plan methods for determining usual, customary, and reasonable charges; • fail-first policies or step therapy protocols; • exclusions based on failure to complete a course of treatment; and • restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan or coverage
State Standard	<p>(1) R590-266, Utah Essential Health Benefits Package, adopts PEHP's 2013 Basic Plus Plan as the EHB benchmark plan effective January 1, 2017.</p> <p>(2) Autism spectrum disorder is a mandated provision of a health benefit plan offered in the individual market and shall provide coverage for the diagnosis and treatment of autism spectrum disorder pursuant to § 31A-22-642.</p>

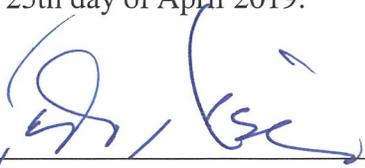
	<p>(3) Pursuant to § 31A-22-726, a health benefit plan may not offer abortion coverage unless the coverage is a type of permitted abortion coverage.</p> <ul style="list-style-type: none"> • A portion of this provision is outside of the Hyde Amendment and requires an insurer to segregate funds. • The Abortion Premium Segregation Attestation form shall be submitted with the binder. • Refer to the URR instructions for calculating and reporting the EHB percentage of total premium. <p>(4) The Plan and Benefits template shall list Utah’s state mandated benefits. A detailed checklist of benefits in the Utah EHB plan and Utah’s mandated benefits is posted in SERFF’s Plan Management General Instructions.</p> <p>(5) Mental health and substance abuse NQTLs may not be more stringent than as provided for medical /surgical benefits.</p>
Essential Health Benefit Formulary Review	
<p>Federal Standard 45 CFR 156.122 45 CFR 156.295</p>	<p>(1) An insurer shall cover at least the greater of one drug in every U.S. Pharmacopeia Convention (USP) category and class or the same number of drugs in each category and class as the benchmark plan.</p> <p>(2) Utilizes a pharmacy and therapeutics (P&T) committee.</p> <p>(3) Insurers shall report data such as the following to HHS on prescription drug distribution and costs (paid by Pharmacy Benefit Management (PBM) or insurer): percentage of all prescriptions that were provided through retail pharmacies compared to mail order pharmacies; percentage of prescriptions for which a generic drug was available and dispensed compared to all drugs dispensed, broken down by pharmacy type; aggregate amount and type of rebates, discounts or price concessions that the insurer or its contracted PBM negotiates that are attributable to patient utilization and passed through to the insurer; total number of prescriptions that were dispensed; aggregate amount of the difference between the amount the insurer pays its contracted PBM and the amounts that the PBM pays retail pharmacies, and mail order pharmacies.</p> <p>(4) Implements standard, expedited, and external exception review processes.</p> <p>(5) Makes its formulary drug list URLs available and easily accessible in accordance with guidance from the marketplace and to potential enrollees.</p>
<p>State Standard</p>	<p>The Department will require compliance with EHB formulary standards, clinical appropriateness, and drug exception processes.</p>
Non-Discrimination Standards in Marketing and Benefit Design	
<p>Federal Standard 42 USC § 300gg-3 45 CFR 92 45 CFR 148.180 45 CFR 155.1045 45 CFR 156.125 45 CFR 156.200 45 CFR 156.225</p>	<p>(1) An insurer shall:</p> <ul style="list-style-type: none"> • pass a review and an outlier analysis or other automated test to identify possible discriminatory benefits, including a review across multiple benefit categories that are associated with the treatment of specific medical conditions; and • refrain from: <ul style="list-style-type: none"> ○ adjusting premiums based on genetic information; ○ discriminating on the basis of race, color, national origin, disability, age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, sex, gender identity, sexual orientation, or other health conditions; ○ utilizing any preexisting condition exclusions; ○ requesting/requiring genetic testing; ○ collecting genetic information from an individual prior to, or in connection with, enrollment in a plan or at any time for underwriting purposes; and placing all or most drugs for a specific condition on the highest cost tiers. <p>(2) An insurer may not employ marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs.</p>
<p>State Standard</p>	<p>The insurer shall comply with all applicable laws and regulations regarding marketing. Non-discrimination reviews may be conducted to identify outliers in benefit design, including prescription drugs, with regards to cost sharing, clinical appropriateness, utilization management or step therapy, and other marketing practices.</p>

Actuarial Value	
Federal Standard 45 CFR 156.135 45 CFR 156.140	Plans being offered at the various metal tiers, excluding catastrophic plans, shall meet the specified levels of actuarial value (or fall within the allowable variation): <ul style="list-style-type: none"> • Bronze plan: 60% (56 to 65%) • Silver plan: 70% (66 to 72%) • Gold plan: 80% (76 to 82%) • Platinum plan: 90% (86 to 92%)
State Standard	Insurers must comply with the federal actuarial value standards. Compliance will be reviewed and the Department will require an attestation of compliance with actuarial value standards. The insurer shall provide justification and documentation in the actuarial memorandum on all expanded bronze plans.
Quality Rating Standards	
Federal Standard ACA 2794 45 CFR 156.200 45 CFR 156.1105 45 CFR 156.1120 45 CFR 156.1125	(1) HHS has implemented a quality reporting standard for all marketplaces with reporting requirements. All insurers that meet participation criteria shall comply with these standards and requirements. (2) QHP insurers shall also provide plain language information/data on claims payment policies and practices, periodic financial disclosures, data on enrollment and disenrollment, number of denied claims, rating practices, cost-sharing, and payments for out-of-network coverage, and enrollee rights shall be submitted to the marketplace, HHS, and the state insurance commissioner.
State Standard	In addition to federal quality reporting requirements, insurers are required to comply with § 31A-22-613.5 and R590-271.
Rate Filing	
Federal Standard 45 CFR 147.102 45 CFR 154.215 45 CFR 155.1020 45 CFR 156.80 45 CFR 156.210 45 CFR 156.255	(1) Premiums may vary by geographic rating area. (2) Premium rates for the same plan shall be the same on and off the marketplace. (3) Rating is allowed on a per member basis. (4) Premium rates may vary by individual/family, rating area, age (3:1), and tobacco use (1.5:1) (5) All rates filed in the individual market will be set for an entire plan year and cannot be changed during the year. Small employer quarterly index rate changes are subject to state approval and guidance. (6) Composite premiums, average enrollee premiums, are allowed in small employer as long as the plans meet specific requirements. (7) Outlier identification of rates will be conducted to identify rates that are relatively high or low compared to other rates in the same rating area. Identification of a rate as an outlier does not necessarily indicate inappropriate rate development. (8) A URRT is not applicable to a SADP.
State Standard	(1) An insurer must comply with all federal and state laws and regulations related to rating rules, factors, and tables used to determine rates. (2) The Department will continue to effectuate its rate review program and will review all rate filings and rate increases. Rate filing information shall be submitted with any rate increase justification prior to the implementation of an increase. (3) Utah has an approved defined alternate tiered-composite rating methodology for small employer plans. The Utah alternate tiered-composite methodology, as indicated in Bulletin 2015-4, is the only method allowed in Utah and must meet the following requirements: <ul style="list-style-type: none"> • composite premiums are offered in a four-tiered rating structure: employee, employee + spouse, employee + child(ren), employee + spouse + child(ren); • no additional tobacco load can be included in premiums. The tobacco rate must be the same as the non-tobacco rate for each age and geographic area combination; • composite option must be uniformly available to all small employer groups without regard to size; • rates shall be based on enrollment at the beginning of the plan year and may not vary until renewal;

	<ul style="list-style-type: none"> • composite rates for more than one plan shall be based on the entire enrollment of the small employer group; and • attest to the compliance of the alternate tiered-methodology in the rate filing. <p>(4) The Department will consider small employer group quarterly index rate changes based on Bulletin 2015-3 and prior approval.</p>
Plan Variations for Individuals Eligible for Cost Sharing	
Federal Standard 45 CFR 155.1030 45 CFR 156.420	<p>(1) For plans in the individual market only, QHP insurers shall offer three silver plan cost-sharing variations, 73%, 87% and 94%. Silver plan variations shall have a reduced annual limitation on cost sharing, cost sharing requirements, and actuarial values that meet the required levels within a de minimis range of $\pm 1\%$. Benefits, networks, non-EHB cost-sharing, out-of-network cost sharing, and premiums must be consistent with the corresponding standard silver plan.</p> <p>(2) All plans, except catastrophic plans, in the individual marketplace are required to include a zero cost sharing variation and a limited cost sharing variation.</p> <p>(3) The zero cost sharing variation plan is intended for American Indian/Alaska Natives with income up to 300% FPL. Both in-network and out-of-network EHB cost sharing must be eliminated for the zero cost sharing plan variation. Out-of-network cost sharing for non-EHBs must be equivalent to the corresponding standard plan.</p> <p>(4) Limited cost sharing plans must be equivalent to the standard plan in all benefits and cost-sharing, except when the plan is used by an American Indian/Alaska Native enrolled in a QHP receiving services from an Urban Indian Organization or through referral under contract health services.</p> <p>(5) SADPs are excluded from cost-sharing reduction (CSR) requirements.</p>
State Standard	To ensure a consistent approach to cost sharing across all plan variations, the Department will require that all QHP insurers conform to prescribed cost sharing amounts. An attestation of compliance will be required with plan variation standards.
Stand Alone Dental Plans (SADP)	
Federal Standard ACA 2791 45 CFR 155 & 156 45 CFR 155.1065 45 CFR 156.150 45 CFR 156.440	<p>(1) SADPs must meet the same QHP certification standards as a health benefit plan unless noted in the above sections. Additionally, SADPs are not subject to the insurance market reform provisions of PPACA, such as guaranteed availability and renewability of coverage.</p> <p>(2) SADPs must demonstrate they have a reasonable annual limitation on cost sharing for the pediatric EHB. "Reasonable" means any annual limitation on cost sharing that is at or below \$350 for a plan with one child enrollee, and at or below \$700 for a plan with two or more child enrollees.</p> <p>(3) SADPs intended to be utilized outside the marketplace only, to supplement a health benefit plan to comply with federal requirement of offering all 10 EHBs, must follow the marketplace certification filing process as described within this Bulletin.</p>
State Standard	SADPs must comply with the Utah EHB benchmark plan that has the following as pediatric dental EHB services; oral examinations, cleanings, fluoride, sealants, and x-rays.

If you have any questions or comments, please call the Health and Life Division at 801-538-3077 or email us at health.uid@utah.gov.

DATED this 25th day of April 2019.



Todd E. Kiser
Insurance Commissioner