State of Utah
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Insurance Department

JONATHAN T. PIKE
Insurance Commissioner

BULLETIN 2021-2

To: Health Insurers Offering a Health Benefit Plan or Stand-Alone Dental Plan

From: Jonathan T. Pike, Utah Insurance Commissioner

Date: April 14, 2021

Subject: **PY2022 Health Benefit Plan and Stand-Alone Dental Plan Filing Requirements**

The purpose of this Bulletin is for the Utah Insurance Department (Department) to notify insurers of the filing requirements for a health benefit plan or a certified stand-alone dental plan (SADP) to be available in the 2022 plan year. This Bulletin applies to all SADPs and health benefit plans available in the individual or small employer market, including grandfathered, transitional, and Patient Protection and Affordable Care Act (PPACA) compliant plans, regardless of marketplace participation.

An insurer is advised to review and be aware of changes to the U.S. Department of Health and Human Services' (HHS) Center for Consumer Information and Insurance Oversight (CCIIO) 2022 Letter to Issuers in the Federally-facilitated Exchanges, Notice of Benefit and Payment Parameters for 2022, and state law in conjunction with this Bulletin to ensure full compliance.

Extension of Transitional Plans

A health insurer that has renewed policies continually since 2014 may continue to renew such policies provided the transitional coverage does not extend past December 31, 2022, as permitted by guidance issued by CCIIO on January 19, 2021, and pursuant to Section 31A-30-117.

Filing Deadlines – Regardless of Marketplace Status

Health Benefit Plans (grandfathered, transitional, PPACA)

- Forms, binders, and associated documents
  - Small Employer - **May 14, 2021**, no later than **10 a.m. MDT**
  - Individual - **June 11, 2021**, no later than **10 a.m. 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)
  - Small Employer - **June 14, 2021**, no later than **10 a.m. MDT**
  - Individual - **July 7, 2021**, no later than **10 a.m. MDT**
  - HIOS deadline for a rate submission to be considered an initial rate submission - **July 21, 2021**, no later than **11:59 p.m. MDT**
  - HIOS deadline for finalizing a rate submission - **August 18, 2021**, no later than

1 p.m. MDT

Certified Stand-Alone Dental Plans for Individual and Small Employer

- **June 4, 2021**, no later than **10 a.m. MDT**: Forms, rates, binders, and associated documents

An insurer is responsible to ensure 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, Section R590-220-5.

Binder, Form, and Rate Filing Guidance

A filing shall meet the requirements of Sections R590-85, R590-220, and R590-277.

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

Binder Filing

- An insurer is required to file a 2022 plan management binder if offering a PPACA plan or an SADP, even if no changes are being made.
- A separate binder is required for each single risk pool: small employer health benefit plan; individual health benefit plans; individual SADPs; and small employer SADPs.
- The binder shall include all products and plans offered within a pool.
- If a filing includes a new product or a revised plan, supporting documentation and justification is required.
- The Associated Schedule Items tab shall include the following, at a minimum: policy (individual), certificate (group), schedule of benefits, and the unredacted actuarial memorandum.

Health Benefit Plan Form Filing

- Do NOT submit rate information in a health benefit plan form filing.
- An insurer shall submit a separate form filing for each grandfathered policy and each transitional policy.
- An insurer shall submit one form filing for each distinct PPACA HIOS Product ID. Each distinct HIOS Product ID form filing shall include all plans within the single product.
- A form filing is not required if no change is applicable for the 2022 plan year

Health Benefit Plan Rate Filing

- Do NOT submit a form in a health benefit plan rate filing.
- A grandfathered and transitional rate filing shall be submitted under a separate tracking number in the System for Electronic Rate and Form Filing (SERFF) for each business class: individual or small employer; transitional or grandfathered.
  - An insurer shall submit the Rate Review Justification Module to the Department, and in HIOS, if applicable.
  - A rate filing is not required if there is not a rate change for the 2022 plan year.
- A PPACA rate filing shall be submitted under a separate SERFF tracking number for each risk pool; individual or small employer.

- An insurer shall submit the URRT Parts I, II, and III to the Department and in HIOS as listed above.
  - The SERFF filing shall include a Note to Reviewer that confirms the HIOS filing.
  - The HIOS filing shall include the rate filing SERFF tracking number in the field "Filing Tracking Number."
- The Department requires that a rate filing attribute the cost of the Cost Sharing Reduction (CSR) to a silver on-exchange plan.
  - The actuarial memorandum shall clearly indicate the assumptions leading to the CSR adjustment.
  - The factor adjustment shall be outlined by Plan ID in the actuarial memorandum.
  - An insurer shall provide a single factor adjustment that provides an estimate of the rate impact to silver on-exchange plans if CSRs were funded.
  - The Department encourages an insurer to offer an off-exchange only silver plan which does not incorporate the effects of the CSR adjustment.
- The Department requires a screen shot of the AV Calculator for ALL plans on the rate/rule schedule tab.
- Actuarial Considerations:
  - An insurer offering Unique Plan Designs (UPD), alternate method to arrive at the Actuarial Value (AV), shall include in the rate filing.
    - An attestation describing which plan is a UPD, why the AV Calculator was inadequate to capture the plan design, and the method 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 projection 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 in "Wksh 1- Market Experience", Section I. The table shall include: Allowed Claims, Incurred Claims, Earned Premium, and Member Months.
    - A description of the remaining transitional business, if any, and the expectation to continue offering a transitional plan.

Stand-Alone Dental Plan Form and Rate Filing

- A dental form AND rate filing shall be submitted as one filing for each market; individual and small employer.
  - If an insurer chooses to use a previously filed form and rate, and not submit a new form and rate filing:
    - The binder shall include a Note to Reviewer attesting there are no changes in the form and rate;
    - Include the SERFF tracking number under which the form and rate filing was submitted; and
    - Including any filed updates to the originally filed form and rate.
  - If an insurer chooses to use a previously filed form or rate, the filing shall provide the corresponding form and rate in the filing description.

The Department will utilize the 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.

Market Reform Rules with Qualified Health Plan (QHP) and 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 CMS Guidance Rules	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; (8) notify customers of the effective date of coverage; (9) participate in initial and annual open enrollment periods, as well as special enrollment periods; (10) collect enrollment information, transmit such to a marketplace and reconcile enrollment files with the marketplace enrollment files monthly; (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; (12) segregate funds if abortion is offered as a benefit, other than in the case of an abortion provided under the Hyde Amendment exception; (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; (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; (15) upon plan renewal, provide standardized notice to consumers using the HHS standard notice of renewal; (16) comply with market reform rules, including premium rating rules, guaranteed availability, guaranteed renewability, and single risk pool requirements; (17) per guaranteed availability, provide a matching benefit plan and price off of the marketplace for any plan certified as a QHP; (18) meet all readability and accessibility standards.
State Standard	The Department will review a binder, form, and rate filing for compliance with federal and state laws and regulations. (1) The Department will provide a recommendation for certification to the marketplace, final certification is provided by the marketplace, all plans must be recertified each year. (2) The exchange administrative user fee is set at 2.25%. (3) An insurer shall uphold all state laws and rules.
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	An insurer shall ensure that a provider network for each plan is available to all enrollees, and: • 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; • 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, to assure that all services will be accessible without unreasonable delay; and • make 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	(1) An insurer shall ensure that all plans, offered on and off marketplace, have an adequate provider network available for the geographic area for each plan offered. (2) The network shall 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 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. (3) A current provider directory shall be maintained that: indicates providers 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. (4) An insurer shall attest all applicable network adequacy requirements are met. (5) An insurer offering a marketplace plan shall include in their attestation one of the following: • 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 the network meets the minimum federal requirements. (6) A health benefit plan shall comply with Section 31A-45-501. (7) An insurer using a managed care organization contract shall comply with Section 31A-45-303. (8) An insurer shall make their access plan and criteria available, upon request, to demonstrate the insurer has standards and procedures in place to maintain an adequate network, pursuant to Section 31A-2-202.
Accreditation	
Federal Standard 45 CFR 155.1045 45 CFR 156.275	(1) An insurer 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. (2) An insurer without existing commercial or marketplace health plan accreditation, from an HHS recognized accrediting entity, shall schedule an accreditation review during their first year of certification and receive accreditation prior to their second year of certification. (3) Prior to the insurer's fourth year of certification and every subsequent year of certification, an insurer shall be accredited in accordance with 45 CFR 156.275. (4) An insurer will be required to authorize the release of their accreditation survey data and any official correspondence related to accreditation status to the Department.
State Standard	(1) The Department will follow the federal requirements related to accreditation and requires the authorized release of all accreditation data. (2) For a new insurer entering the marketplace, not already accredited, the Department will require an attestation that the insurer has entered into an accreditation process. Such accreditation shall 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. (3) Accreditation shall be documented in the Companies and Contact tab in SERFF.
Service Area	
Federal Standard 45 CFR 155.1055	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.
State Standard	An insurer may choose their service area as long as the service area is not smaller than a county. A change in service area will not be permitted except in limited circumstances and upon approval by the Department.
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 an insurer can adjust premiums.
State Standard	The Department has adopted a configuration of six rating areas to be utilized in Utah, Subsection R590-277-7(2)(b). 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 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: • 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 an insurer 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	(1) An insurer offering a QHP shall offer at least one QHP at the silver coverage level and at least one QHP at the gold coverage level in each covered service area. (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 Small Business Health Options Program 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 the insurer will accept child-only enrollees. (3) A catastrophic plan may be sold to individuals who have not attained the age of 30 before the beginning of the plan year; or an individual by reason of lack of affordable coverage or hardship. A catastrophic plan may only be offered on the individual marketplace. (4) Pediatric benefits shall be provided until the end of the month in which the enrollee turns 19, including pediatric dental and vision benefits.

	(5) Emergency services shall be covered with no prior authorization and at the in-network cost-sharing level. (6) 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 shall demonstrate that annual out of pocket cost sharing under the plan does not exceed the limits established by federal regulations. (7) An insurer shall contain no lifetime limits on the dollar value of any Essential Health Benefit (EHB), including the specific benefits and services covered under the EHB Benchmark Plan. Reasonable dollar limits for services are allowed, as long as there is no associated service or visit limit. (9) An insurer is required to accept premiums from Ryan White HIV/AIDS programs, Indian tribal organizations, and state and federal government programs. (10) An insurer shall comply with all federal and state laws related to rating rules, factors and tables used to determine rates. Rates shall be based upon the analysis of the plan rating assumptions and rate increase justifications.
State Standard	An insurer shall ensure compliance with applicable state and federal laws, regulations and standards, meet all filing requirements outlined in Section R590-220, this Bulletin, and SERFF general instructions.
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	(1) An insurer shall offer coverage that is substantially equal to the coverage offered by the state's benchmark plan. This may be done by substituting benefits only if an insurer demonstrates the actuarial value of the substituted benefits. (2) An insurer is not permitted to offer abortion coverage within their benefit plan except for meeting requirements of the Hyde Amendment. If an insurer chooses to offer abortion benefits apart from the Hyde Amendment, 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. (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 a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF); certain immunizations; and screenings provided for in Health Resources & Services Administration 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). (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 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: • 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	(1) Section R590-266, Utah Essential Health Benefits Package, adopts PEHP's 2013 Basic Plus Plan as Utah's EHB Benchmark Plan effective January 1, 2017.

	(2) Autism spectrum disorder, a state mandated provision for an individual health benefit plan shall provide coverage for the diagnosis and treatment of autism spectrum disorder pursuant to Section 31A-22-642. (3) Pursuant to Section 31A-22-726, a health benefit plan may not offer abortion coverage unless the coverage is a type of permitted abortion coverage. • 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. (4) The Plan and Benefits template shall list Utah's state mandated benefits. A detailed list of benefits in the Utah EHB plan and Utah's mandated benefits is posted in SERFF Plan Management General Instructions. (5) Mental health and substance abuse NQTLs may not be more stringent than as provided for medical / surgical benefits. (5) An insurer shall submit the Utah Mental Health and Substance Abuse Parity Attestation on the Supporting Documentation tab of their form filing. (6) An insurer shall make proper modifications to the URRT and the Plan and Benefits Template in accordance with Section R590-283-4.
Essential Health Benefit Formulary Review	
Federal Standard 45 CFR 156.122 45 CFR 156.295	(1) An insurer shall cover at least the greater of one drug in every U.S. Pharmacopeia Convention category and class or the same number of drugs in each category and class as the benchmark plan. (2) An insurer shall utilize a pharmacy and therapeutics committee. (3) An insurer shall report data 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. (4) An insurer shall implement standard, expedited, and external exception review processes. (5) An insurer shall make its' formulary drug list URL available and easily accessible in accordance with guidance from the marketplace and potential enrollees.
State Standard	The Department will require compliance with Sections 31A-22-626, 31A-46-301 through 31A-46-304, EHB formulary standards, clinical appropriateness, utilization management or step therapy, and drug exception processes. The Department shall publish the price of insulin available under a discount program no later than June 1, 2021, pursuant to Subsection 31A-22-626(10).
Non-Discrimination Standards in Marketing and Benefit Design	
Federal Standard 42 USC § 300gg-3 45 CFR 92 45 CFR 148.180 45 CFR 156.125 45 CFR 156.200 45 CFR 156.225	(1) An insurer shall: • pass a review and an outlier analysis or other 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: o adjusting premiums based on genetic information; o 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; o utilizing any preexisting condition exclusions; o requesting/requiring genetic testing; or o 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.

	(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.
State Standard	An insurer shall comply with all applicable laws and regulations regarding marketing. Non-discrimination reviews may be conducted to identify outliers in benefit design, prescription drugs, and marketing practices.
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): • 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	An insurer shall comply with the federal actuarial value standards. The Department will require an attestation of compliance with actuarial value standards. An insurer offering expanded bronze plans shall have justification and documentation disclosed in the actuarial memorandum. The justification for each expanded bronze plan shall state the plan is a high deductible health plan, or provide evidence the plan has reasonable cost sharing (e.g. plan pays at least 50%) for at least one of the major services (primary care visits, specialists visits, emergency department, inpatient hospital, generic drugs, preferred brand drugs, or specialty drugs).
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. An insurer that meets the participation criteria shall comply with these standards and requirements. (2) An insurer shall provide plain language information / data on claim 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 to the marketplace, HHS, and the state insurance commissioner.
State Standard	In addition to federal quality reporting requirements, an insurer is required to comply with R590-271, Data Reporting for Consumer Quality Comparison.
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) Premium may vary by geographic rating area. (2) A premium rate for the same plan shall be the same on and off the marketplace. (3) Rating is on a per member basis, optional for SADP. (4) A premium rate 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 premium, average enrollee premium, is allowed in small employer as long as the plan 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 shall comply with all federal and state laws and regulations related to rating rules, factors, and tables used to determine rates, Section R590-277-7. (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, Small Employer Composite Rating – 2014 PPACA Compliant Health Benefit Plans, is the only method allowed in Utah and shall meet the following requirements: • 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 shall be the

	same as the non-tobacco rate for each age and geographic area combination; • a composite option shall be uniformly available to any small employer group without regard to size; • rates shall be based on enrollment at the beginning of the plan year and may not vary until renewal; • composite rates for more than one plan shall be based on the entire enrollment of the small employer group; • an attestation to the compliance of an alternate tiered-methodology shall be included in the rate filing. (4) The Department will consider small employer group quarterly index rate changes based on Bulletin 2015-3, Submitting Quarterly Changes for Small Employer 2014 PPACA Compliant Health Benefit Plans and Stand-Alone Dental Plans, and prior approval.
Plan Variations for Individuals Eligible for Cost Sharing	
Federal Standard 45 CFR 155.1030 45 CFR 156.420	(1) For plans in the individual market only, a QHP insurer 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 minims range of ± 1%. Benefits, networks, non-EHB cost-sharing, out-of-network cost sharing, and premiums shall be consistent with the corresponding standard silver plan. (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. (3) The zero cost sharing variation plan is intended for American Indian/Alaska Natives with income up to 300% of the federal poverty level. Both in-network and out-of-network EHB cost sharing shall be eliminated for the zero cost sharing plan variation. Out-of-network cost sharing for non-EHBs shall be equivalent to the corresponding standard plan. (4) Limited cost sharing plans shall 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. (5) SADPs are excluded from cost-sharing reduction (CSR) requirements.
State Standard	To ensure a consistent approach to cost sharing across all plan variations, the Department will require a QHP insurer conform to prescribed cost sharing amounts.
Stand Alone Dental Plans	
Federal Standard ACA 2791 45 CFR 155 & 156 45 CFR 155.1065 45 CFR 156.150 45 CFR 156.440	(1) A SADP shall meet the same QHP certification standards as a health benefit plan unless noted in the above sections. Additionally, a SADP is not subject to the insurance market reform provisions of PPACA, such as guaranteed availability and renewability of coverage. (2) A SADP shall demonstrate there is a reasonable annual limitation on cost sharing for the pediatric EHB. "Reasonable" means any annual limitation on cost sharing that is at or below $375 for a plan with one child enrollee, and at or below $750 for a plan with two or more child enrollees. (3) If a SADP is intended to be utilized outside the marketplace only, to supplement a health benefit plan to comply with federal requirement of offering all 10 EHBs, the SADP shall follow the marketplace certification filing process as described within this Bulletin.
State Standard	A SADP shall comply with the Utah EHB Benchmark Plan that includes the following as pediatric dental EHB services; oral examinations, cleanings, fluoride, sealants, and x-rays.

If you have any questions or comments, please contact Heidi Clausen at (801)957-9278 or hclausen@utah.gov.

DATED this 14th day of April 2021.

Jonathan T. Pike
Insurance Commissioner