UTAH ACCIDENT & HEALTH SURVEY INSTRUCTIONS

All Fraternal, Health, Life and Property & Casualty insurers in Utah who report accident and health business on the Utah State page of the NAIC Annual Statement are required to complete and file this annual survey. All other insurers are exempt. Send the completed survey form to the Utah Insurance Department **by April 1, 2023**. Send all submissions to the Utah Insurance Department (UID) secure file upload website at https://forms.uid.utah.gov/fileUploads/. Any other forms of data submission are not acceptable. Failure to file by the deadline may subject your company to the enforcement penalties under Utah Code § 31A-2-308. Any questions on completing this survey form should be directed to the Research Assistant via email to uid.healthresearch@utah.gov.

The designed survey collects accident and health data in greater detail than is reported on the Utah State page of the NAIC Annual Statement. The survey follows definitions and categories used in the NAIC Annual Statement as much as possible. All data values reported on the survey form should represent the year-end totals of the report year (December 31, 2022) and be consistent with the Utah specific data reported on the NAIC Annual Statement for 2022.

Please note that direct insured business means business where the insurance company bears the underwriting risk prior to ceding or assumption and should include all Utah residents (even if your company wrote the policy in another state and the insured member later moved into Utah). If your company did not report any direct accident and health insurance business in Utah (i.e., zero reported for direct accident and health business in Utah on the Utah State page), then your company is exempt from filing the survey form.

The survey form is divided into sixteen major parts:

In part 1, companies report detailed information regarding all of the fully insured accident & health business in Utah during 2022. The information reported here should balance to the Utah State page of the NAIC Annual Statement as of December 31, 2022.

In part 2, companies report the various lines of accident & health business that were being actively marketed in Utah during 2022.

In part 3, companies with Medicare product business in Utah report detailed membership data for Medicare Supplement, Medicare Advantage (Part C), and Medicare Drug Plan (Part D) plans. The information reported here should balance to the information reported in part 1.

In part 4, companies with Long-Term Care business in Utah report additional detail and membership data for their Long-Term Care plans. The information reported here should balance to the information reported in part 1.

In part 5-A, companies report membership and claim data for administrative services of self-funded health benefit plans.

In part 5-B, companies report additional detail for certain types of administrative services. This category was created for a select number of companies with special circumstances. Most companies will not need to use this category.

In part 6, all health insurers or Health Maintenance Organizations licensed under the Utah State Insurance Code shall file annually with the Utah Insurance Department a list of all value-added benefits offered at no cost to its enrollees. Submit a copy of your company's list of value-added benefits along with the survey.

In part 7, companies with Comprehensive Hospital & Medical business provide additional detail regarding Non-ACA Off-Exchange Plans, ACA Compliant Off-Exchange Plans, and ACA Compliant Federally Facilitated Marketplace (FFM) Plans. The information reported here should balance to the information reported in part 1. Companies that do not have any Comprehensive Hospital & Medical business may disregard parts 7 through 16.

In part 8, companies provide a breakout of their Comprehensive Hospital & Medical business by ACA plan type.

In parts 9 and 10, companies with Comprehensive Hospital & Medical business provide additional detail regarding Non-ACA Off-Exchange Plans. The information reported here should balance to the information reported in part 7, and be internally consistent. Companies that do not have any Non-ACA Off-Exchange Plans may disregard parts 9 and 10.

In parts 11 and 12 companies with Comprehensive Hospital & Medical business provide additional detail regarding ACA Compliant Off-Exchange Plans. The information reported here should balance to the information reported in part 7, and be internally consistent. Companies that do not have any ACA Compliant Off-Exchange Plans may disregard parts 11 and 12.

In parts 13, 14, 15, and 16 companies with Comprehensive Hospital & Medical business provide additional detail regarding ACA Compliant Federally Facilitated Marketplace (FFM) Plans. The information reported here should balance to the information reported in part 7, and be internally consistent. Companies that do not have any ACA Federally Facilitated Marketplace (FFM) Plans may disregard parts 13, 14, 15, and 16.

SIGNATURE FORM

The Utah Accident & Health Survey includes a business confidentiality signature form. The Utah Insurance Department collects the Utah Accident & Health Survey with the intent and understanding that these records are classified as protected records under § 63G-2-305(2). The Signature Form is being made available from the website along with the instructions and survey form. The Signature Form should be filed along with the survey. This signature form ensures that the data is properly classified as a protected record under § 63G-2-305(2). In order to ensure this data is properly classified, please sign and date the Signature Form and return it to the Utah Insurance Department. This year's signature form covers data your company may have sent to the Utah Insurance Department during 2012 to 2022 for the Utah Accident & Health Survey and any Short-Term Limited Duration Supplement, Stop-Loss Supplement, or ASO Supplement data filed along with the survey.

A version of this signature form will be a standard part of the annual Utah Accident & Health Survey going forward. Any representative of your company can sign the form. Please sign the form and send an electronic copy (e.g., Adobe PDF format), along with the survey form to the Utah Insurance Department (see Secure Transmission of Survey Data). A copy will be kept on file along with your survey.

SECURE TRANSMISSION OF SURVEY DATA

In an effort to increase the security of electronic transmissions, the Utah Insurance Department requires all survey data to be submitted using an encrypted file upload site. All data sent in any other format will not be accepted. In order to use the UID secure file upload website, you will need to set up a UtahID user account. Go to https://forms.uid.utah.gov/fileUploads/. The first time you go to this site, you will be redirected to a login screen with the option to create a new account. Click on *Create Account* (see Figure 1).

Figure 1: Utah-ID Log In Screen

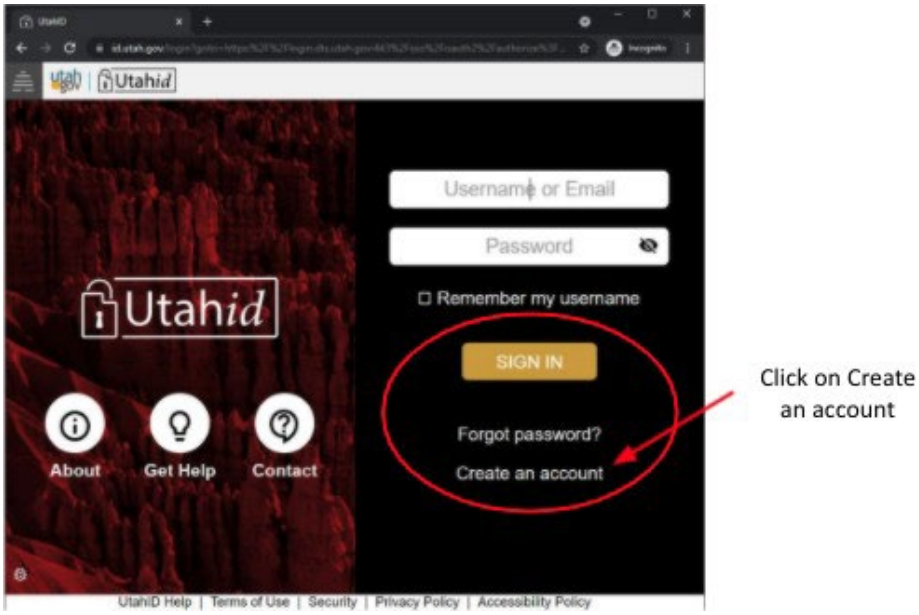
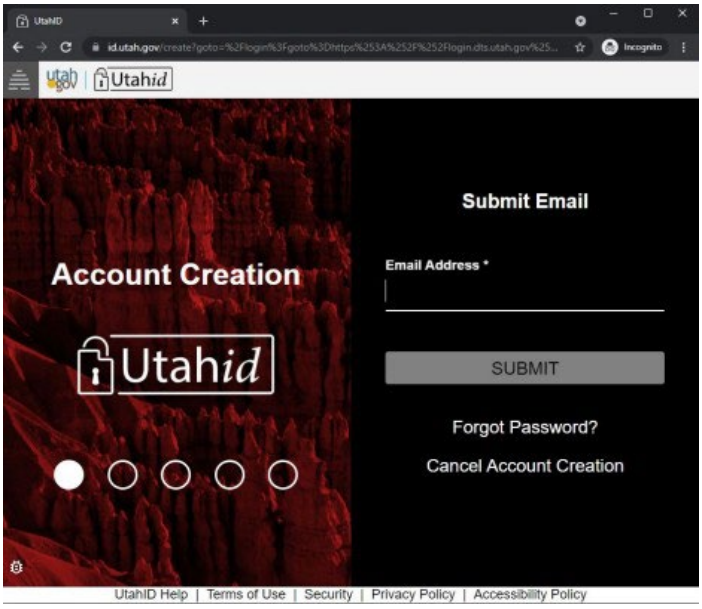


Figure 2: Utah-ID Creation Screen



Follow the prompts to create a new UtahID user account. Provide an email address for your new account (see Figure 2).

An email with a validation code will be sent to the email you provided. Open the email, copy the validation code, and paste it into the validation screen (see Figure 3). With your email validated, you'll be asked to provide your First Name, Last Name, and Username (see Figure 4).

Figure 3: Validate Email

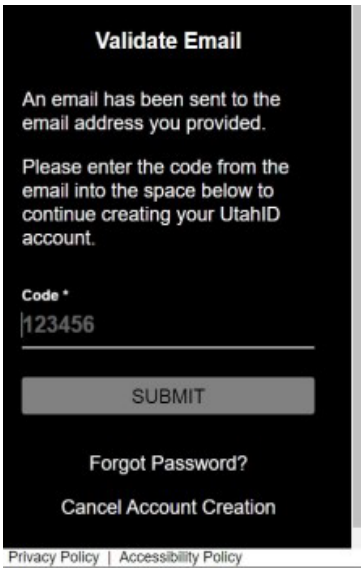
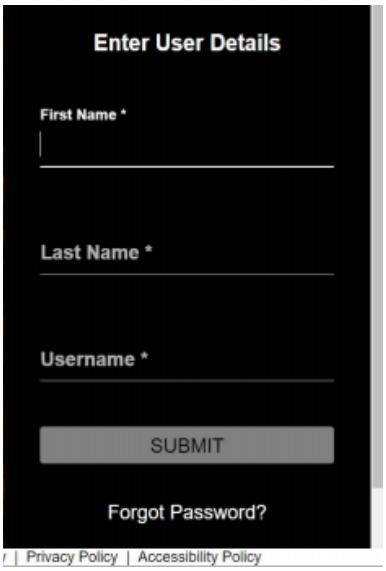


Figure 4: Enter User Details

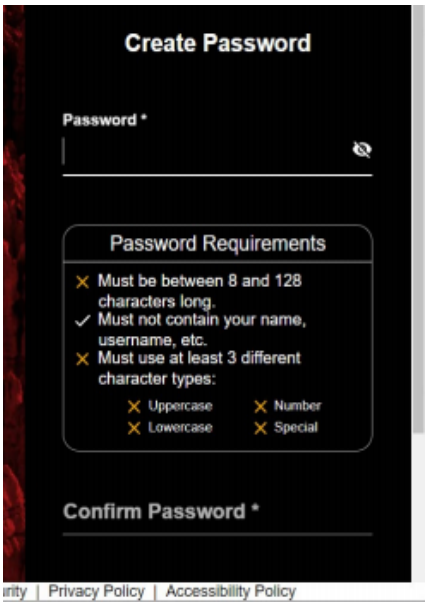


You'll be asked to create a password. Once all of the listed criteria have been met, you'll need to confirm the password (see Figure 5).

Once your UtahID account has been created, please return to the login screen by using the UID secure upload website address: http://forms.uid.utah.gov/fileUploads/. Enter your login information. It may take up to 15 minutes after activating your UtahID before you see the upload web page shown in Figure 6.

The State of Utah supports and recommends the use of Google Chrome web browser when accessing this site. If you have difficulties creating a UtahID, support is available by calling the Department of Technology Services at (801) 538-3440.

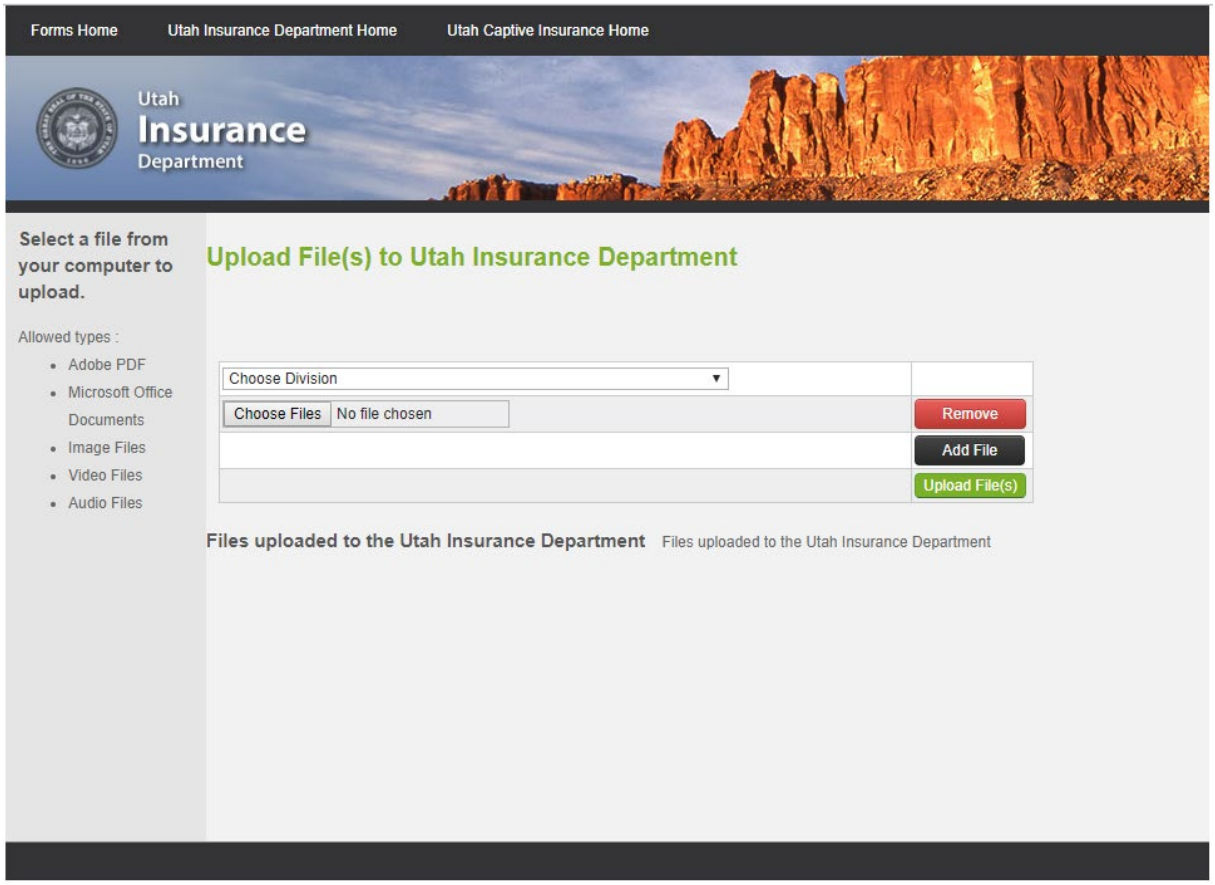
Figure 5: Create Password



Once logged in, you will see the site that allows you to securely upload your survey files (see Figure 6). Select “Health Research” from the *Choose Division* drop-down menu, click on *Add File* to select the signature form and survey form, using your NAIC company code in the file name, and click on “Upload Files”. Files submitted to any other division will not be accepted.

The file naming convention is “<Your NAIC Cocode>-Utah-<form file name>”. If your NAIC Cocode is “99999” your file names would resemble the following examples (e.g. 99999-Utah-AHSurvey.xlsx; 99999-Utah-STLDSurvey; 99999-Utah-SLSurvey.xlsx; 99999-Utah-ASOSurvey.xlsx; 99999-Utah-AHSignature.pdf).

Figure 6: Utah ID File Upload webpage



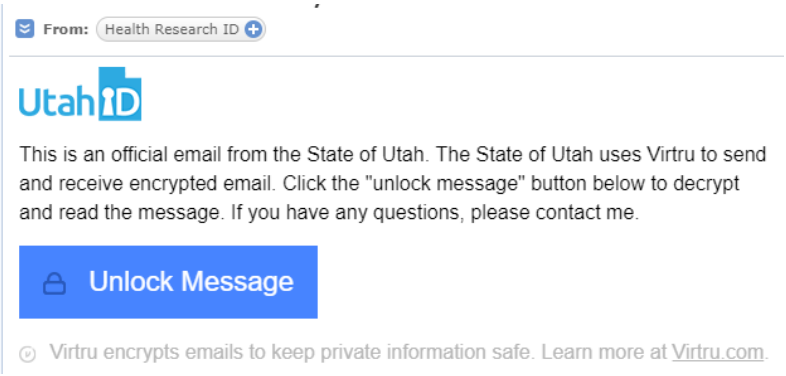
Please contact us if you have any problems or questions with uploading your files. Emailed documents will not be accepted.

VIRTU EMAIL ENCRYPTION SYSTEM

The State of Utah has adopted the Virtu platform for email encryption. In the case that we need to send you information securely, you may receive an encrypted email from the Utah Insurance Department using the Virtu encrypted email system. You will be able to identify the email using the following criteria (see Figure 7):

- The From address will normally be from uid.healthresearch@utah.gov or a utah.gov email address.
- Look for the Utah-ID logo
- Look for the *Unlock Message* button
- Look for the following text: "Virtu encrypts emails to keep private information safe. Learn more at Virtru.com"

Figure 7: UtahID Secure Email



Click *Unlock Message* to unlock the email and view the email content. If you experience problems, assistance is available through the Department of Technology Services at (801) 538-3440. Please contact the Research Assistant at uid.healthresearch@utah.gov, if you are experiencing problems in viewing the message.

PART 1: UTAH INSURED ACCIDENT & HEALTH BUSINESS

COLUMN DEFINITIONS

NUMBER OF INSURED MEMBERS: For individual policies, the number of insured members must include dependents. For group policies, the number of insured members must equal the number of subscribers (certificate holders) plus dependents.

NUMBER OF INSURED POLICIES: For individual policies, enter the number of insured policyholders. For group policies, enter the number of subscribers (certificate holders).

DIRECT PREMIUMS WRITTEN: Enter the total premiums collected for policies written during the report year for each A&H insurance category.

DIRECT PREMIUMS EARNED: Enter the portion of the premium paid by the insured that was allocated to the insurer's loss experience, expenses, and profit during the report year for each A&H insurance category.

DIRECT LOSSES PAID: Enter the actual amount of losses paid by the insurer during the report year for each A&H insurance category.

DIRECT LOSSES INCURRED: Enter the total amount of losses incurred by the insurer during the report year for each A&H insurance category.

ROW DEFINITIONS

COMPREHENSIVE HOSPITAL & MEDICAL: Business that includes major medical, comprehensive medical and other hospital-surgical-medical benefit plans designed to be the insured member's primary health benefit plan. This category includes H16 Major Medical health benefit plans filed via SERFF as H16I, H16G, HOrg02I, or HOrg02G. Exclude all H15 Hospital, Medical, Surgical expense plans that are designed to function as a supplement to a primary health benefit plan (see Hosp-Med-Surgical (Supplement Only)). Also, exclude all Short-Term Limited Duration plans (see Short-Term Limited Duration).

HOSP-MED-SURGICAL (SUPPLEMENT ONLY): Business that includes any hospital only expense, medical only expense, surgical only expense, hospital and medical expense, hospital and surgical expense, medical and surgical expense, and hospital, medical and surgical expense (supplement). This category includes H15I or H15G Hospital, Medical, Surgical expense plans that are designed to function as a supplement to a primary health benefit plan (e.g., H16 Major Medical). Exclude all Comprehensive Hospital & Medical plans. Also, exclude all Short-Term Limited Duration plans.

SHORT-TERM LIMITED DURATION: Business that complies with the definition of short-term limited duration plans under § 31A-1-301(175). "Short-term limited duration health insurance" means a health benefit product that: (a) after taking into account any renewals and extensions, has a total duration of no more than 36 months; and (b) has an expiration date specified in the contract that is less than 12 months after the original effective date of coverage under the health benefit product. Short-term limited duration plans have limited medical benefits and are not considered a "health benefit plan" under Chapter 30 of the Utah Code. This category includes short-term limited duration plans filed via SERFF as H16I, H16G, H15I, or H15G product with a State Sub-TOI – Short Term. Exclude all Comprehensive Hospital & Medical plans or Hospital-Medical-Surgical (Supplement Only) plans.

MEDICARE SUPPLEMENT: Business reported in the Medicare Supplement Insurance Experience Exhibit of the annual statement. Includes all standardized and pre-standardized plans that are sold as a supplement to Medicare Part A and Part B. These plans serve only as a supplement to Medicare and do not cover the full cost of Medicare subscribers. Exclude all Medicare Advantage policies. If Medicare Supplement is reported, parts 3-A and 3-B must also be completed.

MEDICARE ADVANTAGE (PART C): Policies that qualify as Medicare Part C plans. Includes all full replacement policies that cover the full medical cost of Medicare subscribers. These plans are not sold as a supplement to Medicare, but are sold as a full replacement of Medicare coverage and provide additional benefits including pharmacy, hospital, and medical coverage beyond what Medicare typically covers. Exclude all Medicare Supplement policies. In some cases, these plans have been reported under Title XVIII Medicare (see Title XVIII Medicare) or under Medicare Supplement (see Medicare Supplement). For the purposes of this survey, all Medicare Advantage polices are to be reported as a separate, unique product. If Medicare Advantage is reported, parts 3-C and 3-D must also be completed.

UTAH INSURED ACCIDENT & HEALTH BUSINESS (CONTINUED)

MEDICARE DRUG PLAN (PART D):	Policies that qualify as Medicare Part D plans. Includes all stand-alone pharmacy products that provide coverage for Medicare Part D, as well as plans that provide additional drug benefits beyond the minimum requirements for Medicare Part D. Exclude all Medicare Supplement and Medicare Advantage policies. If Medicare Part D is reported, part 3-E must also be completed.
DENTAL ONLY:	Policies providing for dental only coverage issued as a stand-alone dental or as a rider to a medical policy that is not related to the medical policy through deductibles or out-of-pocket limits.
VISION ONLY:	Policies providing for vision only coverage issued as stand-alone vision or as a rider to a medical policy that is not related to the medical policy through deductibles or out-of-pocket limits.
FEDERAL EMPLOYEES (FEHBP):	Business allocable to the Federal Employees Health Benefit Plan premium.
Title XVIII MEDICARE:	Business where a premium is collected and the insurer covers the full medical costs of Medicare subscribers. Includes all specialized coverage that covers the full medical costs of Medicare subscribers, except for Medicare Advantage plans. Although Medicare Advantage plans technically qualify under this category, for the purposes of this survey, Medicare Advantage plans should be excluded from this section. Instead, report all Medicare Advantage plans under “Medicare Advantage (Part C)” (see Medicare Advantage (PART C)) for details).
Title XIX MEDICAID and/or CHIP:	Business where a premium is collected and the insurer covers the full medical costs of Medicaid subscribers and/or CHIP (Children’s Health Insurance Program) subscribers. If your company has both Medicaid and CHIP business, add the total Medicaid and CHIP business together and report it on line 10.
STOP-LOSS:	Stop-loss insurance policies providing coverage for a self-insured group plan, or non-proportional reinsurance of a medical insurance product. These policies provide coverage to insure against the risk that any one claim or an entire plan’s losses will exceed a specified dollar amount.
DISABILITY INCOME:	Policies providing coverage for loss of income resulting from a disability.
LONG-TERM CARE:	Business allocable to Long-Term Care coverage. If Long-Term Care is reported, parts 4-A and 4-B must also be completed.
CREDIT A&H:	Policies providing for credit disability insurance. Excludes credit unemployment, credit life, and credit property insurance.
ALL OTHER A&H:	Other coverage not specifically addressed in any of the other categories.
TOTAL ACCIDENT AND HEALTH:	Sum total of all of the A&H categories listed previously. This line (part 1, line 17) must balance with the total accident and health premium and losses reported on the Utah State page of the Annual Statement. Please remember to complete the total lines in the survey. The spreadsheet will not calculate them for you.

PART 2: MARKETING OF ACCIDENT & HEALTH BUSINESS

In addition to reporting the accident & health business your company had in Utah during 2022, please note that your company must also provide information on the specific lines of accident & health business your company marketed in Utah during 2022.

COMPREHENSIVE HOSPITAL & MEDICAL	Selling a policy that includes major medical, comprehensive medical and other hospital and medical plans designed to be the insured member's primary health benefit plan.
HOSP-MED-SURGICAL (SUPPLEMENT ONLY):	Selling hospital, medical, medical expense plans such as hospital only, medical only, surgical only, which are designed as a supplement to a primary health benefit plan.
SHORT-TERM LIMITED DURATION:	Selling short-term limited duration plans that comply with the definition of short-term limited duration plans under § 31A-1-301(175).
MEDICARE SUPPLEMENT: (AGE 0 to 64):	Selling Medicare Supplement policies that would be reported in the Medicare Supplement Insurance Experience Exhibit of the annual statement. Selling to people age 64 and younger.
MEDICARE SUPPLEMENT (AGE 65 and older):	Selling Medicare Supplement policies that would be reported in the Medicare Supplement Insurance Experience Exhibit of the annual statement. Selling to people age 65 and older.
MEDICARE ADVANTAGE (PART C) (AGE 0 to 64):	Selling Medicare Advantage policies that qualify as Medicare Part C plans, and act as full replacement policies for Medicare, i.e., covers the full cost of Medicare subscribers in exchange for a premium. Insurance Experience Exhibit of the annual statement. Selling to people age 64 and younger.
MEDICARE ADVANTAGE (PART C) (AGE 65 and older):	Selling Medicare Advantage policies that qualify as Medicare Part C plans, and act as full replacement policies for Medicare, i.e., covers the full cost of Medicare subscribers in exchange for a premium. Insurance Experience Exhibit of the annual statement. Selling to people age 65 and older.
MEDICARE DRUG PLAN (PART D):	Selling policies providing stand-alone pharmacy only coverage that qualifies as a Medicare Part D plan.
DENTAL ONLY:	Selling policies providing for dental only coverage issued as a stand-alone dental or as a rider to a medical policy that is not related to the medical policy through deductibles or out-of-pocket limits.
VISION ONLY:	Selling policies providing for vision only coverage issued as stand-alone vision or as a rider to a medical policy that is not related to the medical policy through deductibles or out-of-pocket limits.
STOP LOSS:	Selling stop-loss insurance policies providing coverage for a self-insured group plan, a provider/provider group or non-proportional reinsurance of a medical insurance product. These policies provide coverage to insure against the risk that any one claim or an entire plan's losses will exceed a specified dollar amount.
DISABILITY INCOME:	Selling policies providing coverage for loss of income resulting from a disability.
LONG-TERM CARE:	Selling policies that provide Long-Term Care coverage.
CREDIT A&H:	Selling policies providing for credit disability insurance. Excludes credit unemployment, credit life, and credit property insurance.
ALL OTHER A&H:	Selling accident & health coverage not specifically addressed in any of the other categories.
COMPANY NOT SELLING A&H:	If your company is not actively selling any form of accident & health insurance (e.g., all previous categories are "NO"), enter "YES" in this category. Otherwise, enter "NO".

PART 3: MEDICARE PRODUCT BUSINESS

This section provides additional detail on Medicare Product business in Utah. If your company reports Medicare Supplement business in part 1, line 4; Medicare Advantage business in part 1, line 5; or Medicare Part D business in part 1, line 6, then your company must complete this section.

PART 3-A: AGE STATISTICS FOR MEDICARE SUPPLEMENT BUSINESS IN UTAH

To complete this section, take the total membership in Utah with Medicare Supplement coverage and divide the members by age. To calculate each member's age, start with all of the members that were enrolled in a Medicare Supplement plan in Utah as of December 31, 2022. There should be the same number of members that were reported in part 1, line 4, column 1. Use the member's date of birth to determine the age of the member (in years) as of December 31, 2022. Most database software currently in use has a function that will count the number of years between two dates (e.g., between the date of birth and December 31, 2022). Use the calculated age in years for each member to classify the membership into the following categories.

COLUMN CATEGORIES

NUMBER OF INSURED MEMBERS:	The total number of members with Medicare Supplement coverage. Lines 1 and 2 should total to line 3. The total number of members reported here should balance to the number of insured members reported in part 1, line 4, column 1.

ROW CATEGORIES

Age 0-64:	Members age 64 and younger.
Age 65 and older:	Members age 65 and older.
Total Members:	Total members regardless of age. Lines 1 and 2 should total to line 3 (this category). The total number of members reported here should balance to the number of insured members reported in part 1, line 4, column 1.

PART 3-B: MEDICARE SUPPLEMENT MEMBERSHIP IN UTAH BY PLAN TYPE

To complete this section, take the total membership in Utah with Medicare Supplement coverage as of December 31, 2022, and classify the members by the standardized Medicare Supplement plans listed on the survey form. The total number of members reported here should balance to the number of insured members reported in part 1, line 4, column 1.

PART 3-C: AGE STATISTICS FOR MEDICARE ADVANTAGE (PART C) BUSINESS IN UTAH

To complete this section, take the total membership in Utah with Medicare Advantage (Part C) coverage and divide the members by age. To calculate each member's age, start with all of the members that were enrolled in a Medicare Advantage (Part C) plan in Utah as of December 31, 2022. There should be the same number of members that were reported in part 1, line 5, column 1. Use the member's date of birth to determine the age of the member (in years) as of December 31, 2022. Most database software currently in use has a function that will count the number of years between two dates (e.g., between the date of birth and December 31, 2022). Use the calculated age in years for each member to classify the membership into the following categories.

COLUMN CATEGORIES

NUMBER OF INSURED MEMBERS:	The total number of members with Medicare Advantage (Part C) coverage. Lines 1 and 2 should total to line 3. The total number of members reported here should balance to the number of insured members reported in part 1, line 5, column 1.

ROW CATEGORIES

Age 0-64:	Members age 64 and younger.
Age 65 and older:	Members age 65 and older.
Total Members:	Total members regardless of age. Lines 1 and 2 should total to line 3 (this category). The total number of members reported here should balance to the number of insured members reported in part 1, line 5, column 1.

PART 3-D: MEDICARE ADVANTAGE (PART C) MEMBERSHIP IN UTAH BY PLAN TYPE

To complete this section, take the total membership in Utah with Medicare Advantage (Part C) coverage as of December 31, 2022, and classify the members by the standardized Medicare Advantage (Part C) plans listed on the survey form. The total number of members reported here should balance to the number of insured members reported in part 1, line 5, column 1.

PART 3-E: AGE STATISTICS FOR MEDICARE DRUG PLAN (PART D) BUSINESS IN UTAH

To complete this section, take the total membership in Utah with Medicare Drug Plan (Part D) coverage and divide the members by age. To calculate each member's age, start with all of the members that were enrolled in a Medicare Drug Plan (Part D) in Utah as of December 31, 2022. There should be the same number of members that were reported in part 1, line 6, column 1. Use the member's date of birth to determine the age of the member (in years) as of December 31, 2022. Most database software currently in use has a function that will count the number of years between two dates (e.g., between the date of birth and December 31, 2022). Use the calculated age in years for each member to classify the membership into the following categories.

COLUMN CATEGORIES

NUMBER OF INSURED MEMBERS:	The total number of members with Medicare Drug Plan (Part D) coverage. Lines 1 and 2 should total to line 3. The total number of members reported here should balance to the number of insured members reported in part 1, line 6, column 1.

ROW CATEGORIES

Age 0-64:	Members age 64 and younger.
Age 65 and older:	Members age 65 and older.
Total Members:	Total members regardless of age. Lines 1 and 2 should total to line 3 (this category). The total number of members reported here should balance to the number of insured members reported in part 1, line 6, column 1.

PART 4: LONG-TERM CARE BUSINESS

This section provides additional detail on Long-Term Care business in Utah. If your company reports Long-Term Care business in part 1, line 14, then your company must complete this section.

PART 4-A: UTAH INSURED LONG-TERM CARE BUSINESS ONLY

COLUMN DEFINITIONS

NUMBER OF INSURED MEMBERS:	For individual policies, the number of insured members must include dependents. For group policies, the number of insured members must equal the number of subscribers (certificate holders) plus dependents.
NUMBER OF INSURED POLICIES:	For individual policies, enter the number of insured policyholders. For group policies, enter the number of subscribers (certificate holders).
DIRECT PREMIUMS WRITTEN:	Enter the total premiums collected for policies written during the report year.
DIRECT PREMIUMS EARNED:	Enter the portion of the premium paid by the insured that was allocated to the insurer's loss experience, expenses, and profit during the report year.
DIRECT LOSSES PAID:	Enter the actual amount of losses paid by the insurer during the report year.
DIRECT LOSSES INCURRED:	Enter the total amount of losses incurred by the insurer during the report year.

ROW DEFINITIONS

INDIVIDUAL:	Long-Term Care policies issued to an individual person.
GROUP (2 or more):	Long-Term Care policies issued to a group organization.
TOTAL:	Sum total of individual and group Long-Term Care policies.

PART 4-B: AGE STATISTICS FOR LONG-TERM CARE BUSINESS IN UTAH

To complete this section, take the total membership in Utah with Long-Term Care coverage and divide the members by age. To calculate each member's age, start with all of the members that were enrolled in a Long-Term Care plan in Utah as of December 31, 2022. There should be the same number of members that were reported in part 1, line 14, column 1. Use the member's date of birth to determine the age of the member (in years) as of December 31, 2022. Most database software currently in use has a function that will count the number of years between two dates (e.g., between the date of birth and December 31, 2022). Use the calculated age in years for each member to classify the membership into the following categories.

LONG-TERM CARE BUSINESS (CONTINUED)

COLUMN CATEGORIES

NUMBER OF INSURED MEMBERS:	The total number of members with Long-Term Care coverage. Lines 1 through 7 should total to line 8. The total number of members reported here should balance to the number of insured members reported in part 1, line 14, column 1.

ROW CATEGORIES

Age 0-59:	Members age 59 and younger.
Age 60-64:	Members between the ages of 60 to 64.
Age 65-69:	Members between the ages of 65 to 69.
Age 70-74:	Members between the ages of 70 to 74.
Age 75-79:	Members between the ages of 75 to 79.
Age 80-84:	Members between the ages of 80 to 84.
Age 85 and older:	Members age 85 and older.
Total Members:	Total members regardless of age. Lines 1 through 7 (the previous 7 categories) should total to line 8 (this category). The total number of members reported here should balance to the number of insured members reported in part 1, line 14, column 1.

PART 5-A: ADMINISTRATIVE SERVICES FOR UTAH SELF-FUNDED HEALTH BENEFIT PLANS

SELF-FUNDED HEALTH BENEFIT PLANS:	This category refers to any administrative business (third party administration, administrative services only or administrative services contract) with a self-funded or ERISA eligible employer-sponsored health benefit plan in the State of Utah.

COLUMN DEFINITIONS

NUMBER OF MEMBERS:	Enter the total number of members in self-funded health benefit plans administered by the insurer. The number of members must include dependents. For group policies, the number of members must equal the number of subscribers (certificate holders) plus dependents.
ADMIN. INCOME:	Enter the total dollar amount of administrative income received by the insurer for administrating self-funded health benefit plans.
TOTAL CLAIMS PAID:	Enter the total dollar amount of claims processed by the insurer while administrating self-funded health benefit plans.

ROW DEFINITIONS

(See "Plan Categories" in the Comprehensive Hospital & Medical Supplement")

PART 5-B: ADMINISTRATIVE SERVICES FOR FEHBP, MEDICARE, MEDICAID, DENTAL AND VISION

You should only complete this section if your company provides administrative services only (ASO), administrative services contracts (ASC) and other non-underwritten administrative business related to the Federal Employee Health Benefit Plan (FEHBP), Utah Medicaid, Federal Medicare programs, self-funded dental benefit plans, self-funded vision benefit plans, or other type of administrative services that the Utah Insurance Department needs additional information on. Exclude all business reported under self-funded health benefit plans. All data should be current as of December 31, 2022. Most companies that need this category have already been instructed to use it. If you have questions on whether you should use this category, contact the Research Assistant at uid.healthresearch@utah.gov.

PART 6: VALUE-ADDED BENEFITS (see § 31A-8a-207)

All health insurers or Health Maintenance Organizations licensed under the Utah State Insurance Code shall file annually with the Utah Insurance Department a list of all value-added benefits offered at no cost to its enrollees. Please submit a copy of your company's list of value-added benefits along with this survey.

PARTS 7-16: COMPREHENSIVE HOSPITAL & MEDICAL SUPPLEMENT

This section provides additional detail on Comprehensive Hospital & Medical business in Utah. If your company reports Comprehensive Hospital & Medical business in part 1, line 1, then your company must complete parts 7 and 8, and then, depending on the nature of your business you may also need to complete additional tables in parts 9 through 16.

Part 7 provides a breakout of the comprehensive hospital & medical market into three market segments, Non-ACA Off-Exchange Plans, ACA Compliant Off-Exchange Plans (includes any plans sold through private exchanges), and ACA Complaint Federally Facilitated Marketplace (FFM) Plans (includes all plans sold through Utah's federally facilitated health exchange for individuals).

Part 8 provides a breakout of the comprehensive hospital & medical market by ACA plan type.

Parts 9 and 10 provide additional detail regarding Non-ACA Off-Exchange Plans. The information reported here should balance to the information reported in part 7, and be internally consistent.

Parts 11 and 12 provide additional detail regarding ACA Compliant Off-Exchange Plans. The information reported here should balance to the information reported in part 7, and be internally consistent.

Parts 13, 14, 15, and 16 provide additional detail regarding ACA Compliant Federally Facilitated Marketplace (FFM) Plans. The information reported here should balance to the information reported in part 7, and be internally consistent.

Use the column and definitions listed below to complete each section. Please contact us if you any questions.

COLUMN DEFINITIONS

NUMBER OF INSURED MEMBERS:	For individual policies, the number of insured members must include dependents. For group policies, the number of insured members must equal the number of subscribers (certificate holders) plus dependents.
CUMULATIVE MEMBER MONTHS:	Enter the cumulative year-end member months for each comprehensive hospital & medical plan category. If you report comprehensive premium, you must report member months, even if the insured members is zero at the end of the calendar year. To calculate member months, first count the number of insured members during each month of the year. This produces 12 member counts (one for each month). Then sum total all 12-member counts. This total is the cumulative member months for the year. For example, if your company had 10 insured members during each of the 12 months of the year, the cumulative member months would be calculated as follows: 10 members x 12 months = 120 member months.
DIRECT PREMIUMS WRITTEN:	Enter the total premiums collected for policies written during the report year.
DIRECT PREMIUMS EARNED:	Enter the portion of premium paid by the insured that was allocated to the insurer's loss experience, expenses, and profit during the report year.
DIRECT LOSSES PAID:	Enter the actual amount of losses paid by the insurer during the report year.
DIRECT LOSSES INCURRED:	Enter the total amount of losses incurred by the insurer during the report year.

COMPREHENSIVE HOSPITAL & MEDICAL SUPPLEMENT (CONTINUED)

ROW DEFINITIONS

NON-ACA OFF-EXCHANGE PLANS: Plans that are not fully ACA Compliant and operate on regulatory criteria available during 2010-2013. If your company reports Non-ACA Off-Exchange Plans in part 7, you must also complete parts 9 and 10.

GRANDFATHERED PLANS (NON-ACA OFF-EXCHANGE): Grandfathered Plans are Comprehensive Hospital & Medical Plans filed for use in Utah under the regulatory rules created prior to the ACA regulations. Grandfathered Plans must have been in effect prior to March 23, 2010, and can have a range of effective dates (Jan-Dec), and are exempt from most ACA regulations; however, these plans must include Coverage until Age 26 (Adult Children), Pre-existing Condition Exemptions, and have no Lifetime Limits.

TRANSITIONAL PLANS (NON-ACA OFF-EXCHANGE): Transitional Plans are Comprehensive Hospital & Medical Plans filed for use in Utah for those who may have lost coverage due to plan cancelation or would have otherwise been terminated or cancelled. Transitional Plans have a range of renewal dates and may carry over in some cases. These plans are exempt from most ACA regulations; however, these plans must include Pre-existing Condition Exemptions, Mental Health Parity, Waiting Periods, and have no Annual Limits. Transitional Plans in Utah are not an option for Large Group under the Utah Insurance Code, and in most cases should only be reported for Individual or Small Group Only. The only exceptions to this are situations where a small group started out with a Transitional Plan and then grew into a large group (see TRANSITIONAL / EARLY RENEWAL PLANS (SPECIAL CASE)).

EARLY RENEWAL PLANS (NON-ACA OFF-EXCHANGE): Early Renewal Plans are Comprehensive Hospital & Medical Plans filed for use in Utah under the ACA regulatory rules implemented during 2010 to 2013, but do not include the ACA regulatory rules implemented after January 1, 2014. There should be very few, if any, of these plans. Early Renewal Plans in Utah are not an option for Large Group under the Utah Insurance Code. The only exceptions to this are situations where a small group started out with an Early Renewal Plan and then grew into a large group (see TRANSITIONAL / EARLY RENEWAL PLANS (SPECIAL CASE)). Report all Early Renew Plans under the Transitional Plans category (see TRANSITIONAL PLANS).

TRANSITIONAL / EARLY RENEWAL PLANS (SPECIAL CASE) (NON-ACA OFF-EXCHANGE): As indicated in the TRANSITIONAL PLANS and EARLY RENEWAL PLANS definitions above, Transitional and Early Renewal Plans are not an option for large groups under the Utah Insurance Code. The exception to this may be situations where a small group filed a plan in Utah as a transitional policy and then grew into a large group with 51 or more employees. Review your large group policies to see if any of these plans fall under a transitional plan or an early renewal plan because they started out as a small group and then kept the transitional or early renewal plan as they grew into a large group. If so, report the total membership under this category. If you have a large group policy that appears to meet the definition of a Transitional Plan or an Early Renewal Plan and was not issued in Utah, please contact the Research Assistant at uid.healthresearch@utah.gov for guidance as to which category to use.

COMPREHENSIVE HOSPITAL & MEDICAL SUPPLEMENT (CONTINUED)

ACA COMPLIANT PLANS:	Plans that are fully compliant with the ACA regulations, including all of the new requirements effective as of January 1, 2014.
OFF-EXCHANGE PLANS (ACA COMPLIANT):	Off-Exchange Plans are Comprehensive Hospital & Medical Plans filed for use under Utah's standard state and federal regulatory rules and are not sold either through the Avenue H (SHOP) marketplace or the new Federal Health Exchange. Most plans in existence qualify under this definition. Off-Exchange Plans may also include Qualified Health Plans (QHP) that are offered off the exchanges by carriers who provide QHP plans for Avenue H (SHOP) and the Federal Health Exchange. Any business sold through private company health exchanges should be reported in this category. If your company reports ACA Complaint Off-Exchange plans, you must also complete parts 11 and 12.
FEDERALLY FACILITATED MARKETPLACE (FFM) PLANS (ACA COMPLIANT):	Federally Facilitated Marketplace (FFM) Plans are Comprehensive Hospital & Medical Plans filed for use under the specialized regulatory rules of the individual federal exchange also known as the Federally Facilitated Marketplace. Your company must be registered with the Federally Facilitated Marketplace (FFM) to sell these plans, and the plans must meet the ACA definition of Qualified Health Plans (QHP). Companies that offer QHP plans through the Federally Facilitated Marketplace (FFM) may also offer a QHP plan as an Off-Exchange Plan. Federally Facilitated Marketplace (FFM) plans in Utah are individual only. If your company reports ACA Complaint Federally Facilitated Marketplace (FFM) plans, you must also complete parts 13, 14, 15, and 16.

Group Categories

INDIVIDUAL:	Insured policies issued to an individual person.
SMALL GROUP (1 to 50):	Insured policies issued to a group organization of 1 to 50 employees.
LARGE GROUP (51 or more):	Insured policies issued to a group organization of 51 employees or more.
TOTAL:	Total of Individual, Small Group, and Large Group Comprehensive Hospital & Medical.

COMPREHENSIVE HOSPITAL & MEDICAL SUPPLEMENT (CONTINUED)

Plan Categories

INDEMNITY / FEE FOR SERVICE PLAN (FFS):

Under a Traditional Indemnity or Fee For Service plan (FFS), the insured member can use any provider they choose (as long as the services are a covered benefit under the insurance plan). There are no preferred provider networks and all services are reimbursed at the same cost sharing level (usually a fixed percentage of billed charges) regardless of which provider they choose. The insured member usually has a fixed coinsurance rate above the deductible. Only licensed Accident & Health insurers can offer FFS plans in Utah.

However, if the FFS plan includes a PPO rider that allows individuals to pay a lower co-payment or coinsurance rate when they visit doctors or obtain medical services from a network of preferred providers, then the plan should be classified as a PPO for the purposes of the survey (see "Preferred Provider Organization Plan (PPO):").

PREFERRED PROVIDER ORGANIZATION PLAN (PPO):

Under a Preferred Provider Organization plan (PPO), the insured member has lower deductibles and coinsurance if they use physicians or hospitals in the preferred provider network. PPOs cannot limit members to the preferred provider network only, as this would an EPO arrangement and PPOs are prohibited from doing this under Utah code. Rather, members have a financial incentive to stay within the preferred provider network, as costs are lower if they use preferred providers. Members are free to use any provider outside the network, but services are reimbursed at a lower rate and typically, members must pay higher costs to do so. Only licensed Accident & Health insurers can offer PPO plans in Utah.

In the past, if the PPO plan required permission from a primary physician or gatekeeper, or required some other form of pre-authorization prior to receiving services from a non-preferred provider that is outside of the network, then the plan was classified as a PPO with POS feature for the purposes of the survey. Any PPO with POS feature plans should be classified as a PPO plan. Do not put PPO with POS feature plans in "Other"; classify them as "PPO".

EXCLUSIVE PROVIDER ORGANIZATION PLAN (EPO):

Under an Exclusive Provider Organization plan (EPO), the insured member must use the EPO network providers exclusively, except in the case of an emergency. No services outside of the EPO network are covered. EPO plans are similar to HMO plans in that services are limited to an exclusive set of network providers. EPO plans differ from HMO plans in that they are being offered by a standard accident & health insurance carrier that may offer PPO plans along with EPO plans and does not qualify as a licensed HMO (see "Preferred Provider Organization Plan (PPO):" and also "Health Maintenance Organization Plan (HMO):").

HEALTH MAINTENANCE ORGANIZATION PLAN (HMO):

Under a Health Maintenance Organization plan (HMO), the member must use the HMO network providers exclusively, except in the case of an emergency. No services provided outside of the HMO network are covered. Only licensed HMOs can offer HMO plans in Utah. However, if the HMO plan has a point-of-service, indemnity carve out, out-of-network rider, or other option where members may use providers who are outside of the HMO network for routine medical services (not emergencies), but at a lower reimbursement rate (e.g., costs the member more to use non-network providers), then the plan should be classified as HMO with POS feature for the purposes of the survey.

HEALTH MAINTENANCE ORGANIZATION PLAN WITH POINT OF SERVICE FEATURE (POS):

Special category for certain types of HMOs. Use this category if the HMO plan has a point -of-service, indemnity carve out, out-of-network rider, or other option where members may use providers who are outside of the HMO network for routine medical services (not emergencies), but at a lower reimbursement rate (e.g., costs the member more to use non-network providers). See also "Health Maintenance Organization Plan (HMO):"

OTHER PLANS:

Use the all other category for plans that do not fit into any of the previous categories. If this category is used, you should include a brief description of the plan features and explain why the other categories are not applicable. PPO with POS feature plans should not go in this category, put them in the PPO category. This category should not be used at all in most cases, as comprehensive hospital and medical plans filed for use in Utah should qualify for one of the other categories.

COMPREHENSIVE HOSPITAL & MEDICAL SUPPLEMENT (CONTINUED)

Product Categories

STANDARD:	These are standard health benefit plans that have been traditionally sold in Utah. These plans do not omit mandates or adjust benefits to create specialized insurance products described by specific statutes under the Utah Insurance Code. Exclude HSA-Qualified HDHP plans.
HSA-QUALIFIED HDHP:	Any High Deductive Health Plan that is eligible for use with a Health Savings Account (HSA). Exclude any plan that is not a HSA-Qualified HDHP plan (e.g., All traditional health plans).

Actuarial Value Categories

ACTUARIAL VALUE:	"Actuarial Value" means the relative cost of benefits covered under a health benefit plan. A health benefit plan's actuarial value describes the estimated share of medical spending for eligible health care services that are paid for by the plan compared to the amount paid out of pocket by the consumer. The calculation takes into account the health benefit plan's cost-sharing features, such as deductibles, coinsurance, copayments, and out of pocket limits.
METAL TIERS:	Under the ACA, actuarial values are used to categorize ACA compliant health benefit plans in the individual and small group markets into different benefit tiers. The Federal HHS Actuarial Value Calculator is used to determine the metal tier category. There are five possible categories or tiers. Platinum, Gold, Silver, Bronze, and Catastrophic (see below).
PLATINUM TIER:	ACA Compliant Plans in the individual or small group market with an actuarial value of 90 percent (plus or minus 2 percent).
GOLD TIER:	ACA Compliant Plans in the individual or small group market with an actuarial value of 80 percent (plus or minus 2 percent).
SILVER TIER:	ACA Compliant Plans in the individual or small group market with an actuarial value of 70 percent (plus or minus 2 percent).
BRONZE TIER:	ACA Compliant Plans in the individual or small group market with an actuarial value of 60 percent (plus or minus 2 percent).
CATASTROPHIC TIER:	ACA Complaint Plans in the individual or small group market that qualify for a higher deductible health benefit plan. The individual must be under age 30, or qualify for a hardship exemption. Catastrophic plans are not eligible for premium subsidies through a state or federal health exchange.

UTAH INSURANCE
DEPARTMENT

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