State of Utah

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Insurance Department

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Insurance Commissioner

BULLETIN 2024-6

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

From: Jonathan T. Pike, Insurance Commissioner

Date: April 24, 2024

Subject: **PY2025 Health Benefit Plan and Stand-Alone Dental Plan Filing Requirements**

The Utah Insurance Department (Department) issues this Bulletin to notify an insurer of the filing requirements for a health benefit plan or a certified stand-alone dental plan (SADP) to be available during the 2025 plan year. This Bulletin applies to all individual and small employer SADPs and health benefit plans, including grandfathered, transitional, and Patient Protection and Affordable Care Act (PPACA) plans.

An insurer is encouraged 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) 2025 Letter to Issuers in the Federally-facilitated Exchanges, Notice of Benefit and Payment Parameters for 2025, and state law in conjunction with this Bulletin to ensure full compliance. An insurer is required to use the Health Insurance and Oversight System (HIOS) to access the Plan Validation Workspace of the Marketplace Plan Management System (MPMS) to validate and cross validate templates for compliance with a variety of federal standards. An insurer is expected to run the CCIIO review tools to resolve any validation errors before submission to assure compliance.

<u>Filing Deadlines</u>

Health Benefit Plans

- Forms, binders, and associated documents
  - Small Employer - May 8, 2024, no later than 10 a.m. MDT
  - Individual - May 29, 2024, no later than 10 a.m. MDT
  - Request for a network or service area change - June 26, 2024, no later than 10 a.m. MDT
- Rates, Rate Data Template, and Unified Rate Review Template (URRT) Parts I, II, and III
  - Small Employer - June 12, 2024, no later than 10 a.m. MDT
  - Individual - June 26, 2024, no later than 10 a.m. MDT
  - Initial rate submission for transparency - July 16, 2024, no later than 10 a.m. MDT
  - Final rate submission - August 13, 2024, no later than 10 a.m. MDT

Certified Stand-Alone Dental Plans for Individual and Small Employer

- Forms, rates, binders, and associated documents - June 3, 2024, no later than 10 a.m. MDT

An insurer is responsible for ensuring a filing is accurate, complete, and compliant with all federal and state laws, regulations, and standards. A filing that is incomplete or non-compliant may be rejected, Section R590-220-5.

Binder, Form, and Rate Filing Guidance

Review Rules R590-85, R590-126, R590-220, and R590-277 for filing requirements.

A binder and its corresponding form filing needs to be submitted within three business days of each other and within the filing deadlines.

Plan Management Binder Filing

- A 2025 binder is required if offering a PPACA plan or an SADP, even if a change is not being made.
- Each risk pool is required to have a separate binder: small employer health benefit plan; individual health benefit plan; individual SADP; and small employer SADP.
- A binder is required to include all products and plans offered within a pool.
- If a filing includes a new product or a new plan revising a prior plan, include supporting documentation and justification.
- The associated schedule items tab needs to include at a minimum: policy (individual), certificate (group), schedule of benefits, and the unredacted actuarial memorandum.
- A binder is required to include an attestation for completion of the:
  - CCIIO Review Tool Checklist, including a correction to any deficiency error or supporting documentation and justification if a known deficiency is not corrected;
  - Network Adequacy Review, including required narratives ; and
  - Uniform Modification Review, including a summary exhibit of changes, if applicable.
- The binder is required to include a financial and quantitative analysis, or a comparative analysis, by plan to demonstrate compliance with the Mental Health Parity and Addiction Equity Act.

Health Benefit Plan Form Filing

- A form filing may not include any rate information.
- A separate form filing is necessary for each grandfathered policy and each transitional policy.
- A separate form filing is required for each PPACA HIOS Product ID that includes all plans and cost share variants within the distinct product.
- Advise in the filing description how the insurer complies with surprise billing disclosure requirements.
- A form filing is not required if there is no change being made for the 2025 plan year.

Health Benefit Plan Rate Filing

- A filing may not include any forms.
- A separate rate filing is necessary for a grandfathered policy and a transitional policy for each business class, individual or small employer.
    - Submit the Rate Review Justification to the Department and in HIOS, if applicable.
    - A rate filing is not required if there is no change being made for the 2025 plan year.
- A separate rate filing is required for each PPACA risk pool, individual or small employer.
    - The rate filing needs to attribute the cost of the cost sharing reduction (CSR) to the silver on-exchange plan of the same product.
        - Clearly indicate any assumption leading to the CSR adjustment in the actuarial memorandum.
        - Outline the factor adjustment by Plan ID in the actuarial memorandum.
        - Provide a single factor adjustment that estimates the rate impact to silver on-exchange plans if CSRs were funded.
        - An insurer is encouraged to offer an off-exchange only silver plan that does not incorporate any CSR adjustment effects.
    - Include on the rate/rule schedule tab a screenshot of the AV Calculator for all plans, including the cost share variants.
    - An insurer offering a unique plan design (UPD) needs to include an attestation as part of the actuarial memorandum, or a separate document, that describes which plan is a UPD, why the AV Calculator was inadequate to capture the plan design, and the method used to determine the actuarial value.
    - Transitional experience or projection may not be included in the URRT. Instead, provide the following in the actuarial memorandum:
        - a table showing the insurer's transitional experience, for the experience period that corresponds to the URRT in "Wksh 1- Market Experience", Section I, including: Allowed Claims, Incurred Claims, Earned Premium, and Member Months; and
        - a description of the remaining transitional business and the expectation to continue offering a transitional plan.

Stand-Alone Dental Plan Form and Rate Filing

- Submit one filing that includes both the dental form and corresponding rate information for each market; individual and small employer.
    - If an insurer chooses to use a previously filed form and rate, include in the binder filing:
        - a Note to Reviewer attesting there are no changes in the form and rate;
        - provide the System for Electronic Rate and Form Filing (SERFF) tracking number under which the form and rate filing was submitted; and
        - any filed updates to the original filed form and rate.
    - If an insurer chooses to use a previously filed form or rate, include in the filing description the corresponding form or rate SERFF tracking number.

The Department utilizes the CCIIO standard templates and application review tools, and may use other resources recommended or developed by CCIIO. Additional filing guidance and resources may be found in the content standards for Accident and Health, on the Department's website, and in SERFF's Plan Management General Instructions.

Market Reform Requirements for a Health Benefit Plan and SADP Certification

General Filing Requirements	
Federal Standard PPACA §1002 PPACA §1311 PPACA §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 is required to: (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, directly from the insurer, or through a producer; (6) pay any applicable user fee assessed; (7) participate in and comply with the standards related to the risk adjustment program; (8) notify a consumer 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 the marketplace, and reconcile enrollment files monthly; (11) provide and maintain a notice of nonrenewal or discontinuation of coverage, established by a standard policy and include a grace period for an enrollee that is applied uniformly, including a notice of payment delinquency; (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) notify the marketplace timely if it plans to not seek recertification, fulfill coverage obligations through the end of the plan/benefit year, fulfill all data reporting obligations, provide written notices to an enrollee of nonrenewal and discontinuation; (14) if a Qualified Health Plan (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 risk pool requirements; (17) recommend an equivalent QHP plan on the marketplace for a discontinued plan for guaranteed availability; (18) meet all readability and accessibility standards.
State Standard	(1) The Department will review a binder, form, and rate filing for compliance with federal and state laws and regulations. (2) The Department will provide a certification recommendation to the marketplace. The marketplace makes the final certification determination. (3) An insurer will comply with all applicable federal and state laws.
Licensure and Solvency	
Federal Standard 45 CFR 156.200	An insurer is required to be licensed and in good standing with the State.
State Standard	An insurer is required to be licensed, meet state solvency requirements, have unrestricted authority to write its authorized general lines of insurance, and have no outstanding sanctions in Utah in order to be considered “in good standing.” The Department will determine if an insurer is in good standing and may, as necessary, restrict the insurer’s ability to issue new coverage or renew existing coverage.
Network Adequacy	
Federal Standard ACA § 2702c 42 USC § 300gg-113	An insurer and its provider network are required to be available to all enrollees, and: • include essential community providers (ECP) in sufficient numbers 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

45 CFR 155.1050 45 CFR 156.230 45 CFR 156.235	area; 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 services, to ensure that all services will be accessible without unreasonable delay; • timely notify a continuing care patient of a provider termination and the right to receive transitional care for a limited time; and • make its provider directory available 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 is required to have an adequate provider network available for the geographic area of each plan offered. (2) A network should include a broad range of providers in sufficient numbers and geographic distribution to ensure reasonable and timely access to an enrollee, including providers that specialize in mental health services, substance use disorder services, and pediatric appropriate services. (3) An insurer needs to maintain a current provider directory that: is accessible online to an enrollee, including a potential enrollee; identifies if a provider is not accepting new patients; and is available in hard copy, upon request. (4) An insurer is required to attest all applicable network adequacy requirements are met. (5) If requested, an insurer will need to demonstrate it has a standard and procedure in place to maintain an adequate network.
Accreditation	
Federal Standard 45 CFR 155.1045 45 CFR 156.275	(1) An insurer is required to maintain accreditation based on 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 an existing commercial, Medicaid, or marketplace health plan accreditation, from an HHS recognized accrediting entity, will need to initiate an accreditation review 90 days before open enrollment their first year 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 must be accredited in accordance with 45 CFR 156.275. (4) An insurer is 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 that is not already accredited, an attestation that the insurer has entered into an accreditation process is required. Accreditation needs to be completed prior to any application for recertification.
Service Area	
Federal Standard 45 CFR 155.1055	A service area is a geographic area in which an individual is required to reside or be employed to enroll in a plan. An insurer specifies the service areas it will be utilizing. The service area is required to 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 less than a county.
Quality Improvement	
Federal Standard PPACA §1311 PPACA §2717 45 CFR 156.20 45 CFR 156.200 45 CFR 156.275 45 CFR 156.1130	An insurer is required to implement and report on a quality improvement strategy or strategies consistent with standards of the PPACA, disclose and report information on health care quality and outcomes, and implement appropriate enrollee satisfaction surveys which include: • a payment structure for a health care provider that provides incentives for improving health outcomes through the implementation of activities that include quality reporting, effective case management, care coordination, chronic disease management,

	medication, and care compliance initiatives, including the use of the medical home model for treatment or service 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 care disparities, including the use of language services, community outreach, and cultural competency training.
State Standard	The Department relies on an insurer's attestation to compliance with quality improvement standards and regulatory requirements as provided 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 is required to offer at least one QHP at the silver metal level and at least one QHP at the gold metal level in each covered service area. (2) An insurer is required to include a child-only plan at the same level of coverage as a QHP offered through the individual marketplace or Small Business Health Options Program to an individual who, as of the beginning of the plan year, has not attained the age of 21. This requirement may be met by submitting an attestation that there is no substantive difference between having a child-only plan and issuing a child-only policy and that the insurer accepts child-only enrollees. (3) A catastrophic plan may be sold to an individual who has not attained the age of 30 before the beginning of the plan year or an individual because of the lack of affordable coverage or hardship; offered on the individual marketplace. (4) Pediatric benefits are required to be provided until the end of the month in which the enrollee turns 19, including pediatric dental and vision benefits. (5) Emergency services are covered with no prior authorization and at the in-network cost sharing level. (6) An insurer is required to meet annual limits and cost share requirements without affecting the actuarial value of a plan within each metal tier. An insurer needs to demonstrate that the annual out-of-pocket cost sharing under a plan does not exceed the limit established by federal regulation. (7) An Essential Health Benefit (EHB) may not have a lifetime dollar value limit, including a benefit or service covered under the EHB Benchmark Plan. A reasonable dollar limit for a service is allowable as long as there is no associated service or visit limit. (8) An insurer is required to accept premiums from a Ryan White HIV/AIDS program, an Indian tribal organization, and a state or federal government program. (9) An insurer is expected to comply with all federal and state laws related to rating rules, factors, and tables used to determine rates. Rates need to be based on the analysis of the plan rating assumptions and rate increase justifications.
State Standard	An insurer is expected to comply with applicable state and federal laws, regulations, and standards, including filing requirements outlined in Rule 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 is required to offer coverage that is substantially equal to the coverage offered by the state's benchmark plan. Benefits may be substituted if an insurer demonstrates the actuarial value of the substituted benefits. (2) An insurer may not offer abortion coverage except as allowed by the Hyde Amendment. If an insurer chooses to offer abortion benefits, apart from the Hyde Amendment, funds need to be segregated as public funding is prohibited for these services. The summary of benefits should indicate if such benefits are available. (3) Coverage is required to include preventive services without a cost share requirement including a deductible, a co-payment, or co-insurance. Preventive service coverage includes: evidence-based items or services having a rating of A or B in the current recommendations of the U.S. Preventive Services Task Force (USPSTF); immunizations

	recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and screenings provided for in comprehensive guidelines supported by the Health Resources & Services Administration 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 treatment of mental illness and substance use disorder is required to comply with the federal Mental Health Parity and Addiction Equity Act and applicable federal regulations. Nonquantitative treatment limitations (NQTL) need to be comparable to and may not be more stringent in application with respect to medical/surgical benefits. NQTLs include: • 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 policy 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) Rule R590-266 adopts PEHP's 2013 Basic Plus Plan as Utah's EHB Benchmark Plan. (2) The Plan and Benefits template is required to list Utah's state-required benefits. A detailed list of benefits in the Utah EHB plan and Utah's state-required benefits is posted in SERFF Plan Management General Instructions.
Essential Health Benefit Formulary Review	
Federal Standard 45 CFR 156.122 45 CFR 156.295	(1) Coverage is required for at least the greater of one drug in every U.S. Pharmacopeia category and class or the same number of drugs in each category and class as the benchmark plan. (2) An insurer is required to utilize a pharmacy and therapeutics (P&T) committee. (3) An insurer is required to provide a report on prescription drug distribution and costs to HHS (paid by a Pharmacy Benefit Management (PBM) or insurer) including: the percentage of prescriptions provided through a retail pharmacy compared to a mail-order pharmacy; the percentage of prescriptions for which a generic drug was available and dispensed compared to all drugs dispensed, broken down by pharmacy type; the 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; and the total number of prescriptions that were dispensed; the aggregate amount of the difference between the amount the insurer pays its contracted PBM and the amounts that the PBM pays a retail pharmacy and mail-order pharmacy. (4) An insurer is required to have a standard, expedited, and external exception review process. (5) An insurer is required to make its formulary drug list URL available and easily accessible to an enrollee and potential enrollee according to guidance from the marketplace.
State Standard	An insurer is expected to comply with Sections 31A-22-613.5, 31A-22-626, 31A-22-641, 31A-22-643, 31A-22-650, 31A-22-659 and 31A-46-302 through 31A-46-310, EHB formulary standards, clinical appropriateness, adverse tiering, utilization management or step therapy, and drug exception processes.
Non-Discrimination Standards in Marketing and Benefit Design	
Federal Standard 42 USC § 300gg-3 45 CFR 92 45 CFR 148.180 45 CFR 155.120	(1) An insurer is required to: • 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:

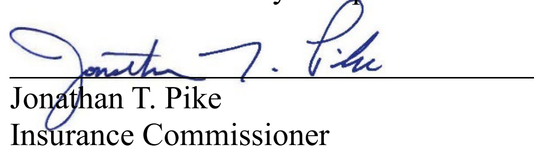
45 CFR 156.125 45 CFR 156.200 45 CFR 156.225	○ adjusting premiums based on genetic information; ○ discriminating on the basis of race, color, national origin, disability, age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, sex, gender identity, sexual orientation, or other health conditions; ○ utilizing a preexisting condition exclusion; ○ requesting/requiring genetic testing or 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 higher cost tiers. (2) An insurer may not employ a marketing practice or benefit design that will have the effect of discouraging the enrollment of an individual with significant health needs.
State Standard	All applicable laws and regulations regarding marketing apply. Non-discrimination reviews may be conducted to identify an outlier in benefit design, prescription drugs, and marketing practices.
Quality Rating Standards	
Federal Standard PPACA 2794 45 CFR 156.200 45 CFR 156.1105 45 CFR 156.1120 45 CFR 156.1125	(1) An insurer that meets the required participation criteria is subject to the quality reporting standard HHS has implemented. (2) An insurer is expected to provide data and plain language information on claim payment policies and practices, periodic financial disclosures, enrollment, and disenrollment data, claim denial numbers, rating practices, cost sharing, 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 Rule R590-271, Data Reporting for Consumer Quality Comparison.
No Surprises Act	
Federal Standard 42 USC § 300gg-111(b)(1) 42 USC § 300gg-112 42 USC § 300gg-113 PHSA 2719(A)(b); 2746; 2799A-1(a), (b), (d), and (f); 2799A-1(c); 2799A-2(a); and 2799A-3 thru 5	An insurer is required to have in place and comply with the No Surprises Act including the following: (1) External review for adverse benefit determinations by an insurer. (2) Disclosure of compensation for individual health insurance. (3) Limitations on out-of-pocket costs for out-of-network emergency services, including air ambulance bills. (4) Cost sharing and out-of-network payment amounts. (5) Expanded emergency services definition and non-emergency services provided by an out-of-network provider at an in-network facility. (6) Consumer protections related to price transparency and other information. (7) Independent dispute resolution process. (8) Continuity of care. (9) Price comparison tool. (10) Accurate provider directory information.
State Standard	An insurer is required to comply with the provisions of the No Surprises Act. The Department will enforce the provisions applicable to an insurer.
Actuarial Value	
Federal Standard 45 CFR 156.135 45 CFR 156.140	The actuarial value, or allowable variation, determines the metal level of a plan, excluding a catastrophic plan. The levels of coverage are: • Bronze plan: 60% (58 to 62%) • Expanded Bronze plan: 60% (58 to 65%) • Silver plan off-exchange: 70% (68 to 72%) • Silver plan on-exchange: 70% (70 to 72%) • Gold plan: 80% (78 to 82%) • Platinum plan: 90% (88 to 92%)
State Standard	(1) Compliance with the federal actuarial values, including an insurer's compliance attestation. (2) Expanded bronze plans need to include justification and documentation in the actuarial memorandum. The justification for each expanded bronze plan should indicate if 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 major service (primary care visits, specialist visits, emergency department, inpatient hospital, generic drugs, preferred brand drugs, or specialty drugs).

	• The Department evaluates reasonable cost sharing by ensuring the insured pays ≤ 50% of the cost share based on a demonstration from the insurer that the copay or coinsurance in at least one category results in the insured paying ≤ 50% of the eligible amount for the service, before the deductible. • Example: The plan has a generic copay of $15 before the deductible. The insurer needs to demonstrate the expected average eligible amount for generic drugs is $30 or less for that plan.
Plan Variations for Individuals Eligible for Cost Sharing	
Federal Standard 45 CFR 155.1030 45 CFR 156.420	(1) An insurer offering a QHP plan in the individual market is required to offer three silver plan cost sharing variations, 73%, 87%, and 94%. Silver plan variations are required to have a reduced annual cost sharing limitation, cost sharing requirements, and actuarial values that meet the required levels within a de minimis range of +1/0%. Benefits, networks, non-EHB cost sharing, out-of-network cost sharing, and premiums need to be consistent with the corresponding standard silver plan. (2) All plans, except catastrophic plans, on 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 is to be eliminated for the zero cost sharing plan variation. Out-of-network cost sharing for non-EHBs should be equivalent to the corresponding standard plan. (4) Limited cost sharing plans need to 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, an insurer offering a QHP is required to conform to prescribed cost sharing amounts and requirements.
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 is required to be the same on and off the marketplace. (3) Rating is on a per member basis, optional for an SADP. (4) A premium rate may vary by individual/family, rating area, age (3:1), and tobacco use (1.5:1) (5) Rates filed in the individual market are set for an entire plan year and cannot be changed. Small employer quarterly index rate changes are subject to state acceptance. (6) Composite premium, average enrollee premium, is allowed in the small employer market as long as the plan meets 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 an SADP.
State Standard	(1) An insurer is expected to comply with federal and state law, including Section R590-277-7, for rating rules, factors, and tables. (2) The Department will continue to review all rate filings and rate changes. Rate filing information is required with any rate change prior to the implementation and justification for an increase that exceeds the threshold. (3) Utah has an approved defined alternate tiered-composite rating methodology for small employer plans. Utah's alternate tiered-composite methodology, as indicated in Bulletin 2015-4, Small Employer Composite Rating – 2014 PPACA Compliant Health Benefit Plans, is the only method that may be used in Utah: • composite premiums are offered in a four-tiered rating structure: employee, employee + spouse, employee + child(ren), employee + spouse + child(ren); • an additional tobacco load may not be included in premiums, the tobacco rate is required to be the same as the non-tobacco rate for each age and geographic area combination;

	• a composite option should be uniformly available to any small employer group without regard to size; • rates need to be based on enrollment at the beginning of the plan year and may not vary until renewal; • composite rates for more than one plan need to be based on the entire enrollment of the small employer group; • an attestation to the compliance of an alternate tiered-methodology needs to be included in the rate filing. (4) The Department reviews 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.
Rating Area	
Federal Standard 45 CFR 156.255	A rating area is a geographic area established by a state that provides boundaries by which an insurer can adjust premiums.
State Standard	Utah has six rating areas, refer to Section R590-277. An insurer's service area may contain more than one rating area, allowing an insurer to offer a plan with a statewide service area to have different rates based on allowed rating areas within that service area.
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 has the same certification standards as a health benefit plan on the marketplace unless noted in the above sections. A SADP is not subject to the insurance market reform provisions of PPACA, such as guaranteed availability and renewability of coverage. (2) A SADP is required to 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 $425 for a plan with one child enrollee, and at or below $850 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 in order to comply with the federal requirement of offering all 10 EHBs, the SADP is expected to follow the marketplace certification filing process as described within this Bulletin.
State Standard	A SADP is required to comply with the Utah EHB Benchmark Plan that includes the following 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 24th day of April 2024.



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Insurance Commissioner