State of Utah
Administrative Rule Analysis
Revised June 2022

NOTICE OF PROPOSED RULE		
TYPE OF RULE: New ___; Amendment ___; Repeal ___; Repeal and Reenact _x_		
Title No. - Rule No. - Section No.		
Rule or Section Number:	**R590-220**	**Filing ID: Office Use Only**

Agency Information

1. Department:	Insurance	
Agency:	Administration	
Room number:	Suite 2300	
Building:	Taylorsville State Office Building	
Street address:	4315 S. 2700 W.	
City, state and zip:	Taylorsville, UT 84129	
Mailing address:	PO Box 146901	
City, state and zip:	Salt Lake City, UT 84114-6901	
Contact persons:		
Name:	**Phone:**	**Email:**
Steve Gooch	801-957-9322	sgooch@utah.gov
Please address questions regarding information on this notice to the agency.		

General Information

2. Rule or section catchline:

R590-220. Submitting Accident and Health Insurance Filings

3. Purpose of the new rule or reason for the change (Why is the agency submitting this filing?)**:**

The rule is being changed in compliance with Executive Order 2021-12. During the review of this rule, the department discovered a number of minor issues that needed to be amended.

4. Summary of the new rule or change (What does this filing do? If this is a repeal and reenact, explain the substantive differences between the repealed rule and the reenacted rule)**:**

The majority of the changes are being done to fix style issues to bring the rule text more in line with current rulewriting standards. Other changes make the language of the rule more clear, remove the Penalties section, and update the Severability section to use the department's current language. The changes do not add, remove, or change any regulations or requirements.

Fiscal Information

5. Provide an estimate and written explanation of the aggregate anticipated cost or savings to:

A) State budget:

There is no anticipated cost or savings to the state budget. The changes are largely clerical in nature, and will not change how the department functions.

B) Local governments:

There is no anticipated cost or savings to local governments. The changes are largely clerical in nature, and will not affect local governments.

C) Small businesses ("small business" means a business employing 1-49 persons)**:**

There is no anticipated cost or savings to small businesses. The changes are largely clerical in nature, and will not affect small businesses.

D) Non-small businesses ("non-small business" means a business employing 50 or more persons)**:**

There is no anticipated cost or savings to non-small businesses. The changes are largely clerical in nature, and will not affect non-small businesses.

E) Persons other than small businesses, non-small businesses, state, or local government entities ("person" means any individual, partnership, corporation, association, governmental entity, or public or private organization of any character other than an ***agency***)**:**

There is no anticipated cost or savings to any other persons. The changes are largely clerical in nature.

F) Compliance costs for affected persons (How much will it cost an impacted entity to adhere to this rule or its changes?)**:**

There are no compliance costs for any affected persons. The changes are largely clerical in nature.

G) Regulatory Impact Summary Table (This table only includes fiscal impacts that could be measured. If there are inestimable fiscal impacts, they will not be included in this table. Inestimable impacts will be included in narratives above.)

Regulatory Impact Table

Fiscal Cost	**FY2023**	**FY2024**	**FY2025**
State Government	$0	$0	$0
Local Governments	$0	$0	$0
Small Businesses	$0	$0	$0
Non-Small Businesses	$0	$0	$0
Other Persons	$0	$0	$0
Total Fiscal Cost	**$0**	**$0**	**$0**
Fiscal Benefits	**FY2023**	**FY2024**	**FY2025**
State Government	$0	$0	$0
Local Governments	$0	$0	$0
Small Businesses	$0	$0	$0
Non-Small Businesses	$0	$0	$0
Other Persons	$0	$0	$0
Total Fiscal Benefits	**$0**	**$0**	**$0**
Net Fiscal Benefits	**$0**	**$0**	**$0**

H) Department head comments on fiscal impact and approval of regulatory impact analysis:

The Commissioner of Insurance, Jonathan T. Pike, has reviewed and approved this regulatory impact analysis.

Citation Information

6. Provide citations to the statutory authority for the rule. If there is also a federal requirement for the rule, provide a citation to that requirement:

Section 31A-2-201	Section 31A-2-201.1	Section 31A-2-202
Section 31A-2-212	Section 31A-22-605	Section 31A-22-620
Section 31A-22-1404	Section 31A-22-2006	Section 31A-30-106
Section 31A-30-106.1	Section 31A-43-304	Section 31A-45-103

Incorporations by Reference Information

7. Incorporations by Reference (if this rule incorporates more than two items by reference, please include additional tables)**:**

A) This rule adds, updates, or removes the following title of materials incorporated by references (a copy of materials incorporated by reference must be submitted to the Office of Administrative Rules; *if none, leave blank*)**:**

Official Title of Materials Incorporated (from title page)	
Publisher	
Issue Date	
Issue or Version	

B) This rule adds, updates, or removes the following title of materials incorporated by references (a copy of materials incorporated by reference must be submitted to the Office of Administrative Rules; *if none, leave blank*)**:**

Official Title of Materials Incorporated (from title page)	

Publisher	
Issue Date	
Issue or Version	

Public Notice Information

8. The public may submit written or oral comments to the agency identified in box 1. (The public may also request a hearing by submitting a written request to the agency. See Section 63G-3-302 and Rule R15-1 for more information.)		
A) Comments will be accepted until:		**05/31/2023**
B) A public hearing (optional) will be held:		
On (mm/dd/yyyy)**:**	**At** (hh:mm AM/PM)**:**	**At** (place)**:**

9. This rule change MAY become effective on:	**06/07/2023**
NOTE: The date above is the date the agency anticipates making the rule or its changes effective. It is NOT the effective date.	

Agency Authorization Information

To the agency: Information requested on this form is required by Sections 63G-3-301, 302, 303, and 402. Incomplete forms will be returned to the agency for completion, possibly delaying publication in the *Utah State Bulletin* and delaying the first possible effective date.			
Agency head or designee and title:	Steve Gooch, Public Information Officer	**Date:**	**04/14/2023**

R590. Insurance, Administration.
R590-220. Submission of Accident and Health Insurance Filings.
~~[R590-220-1. Authority.~~
~~This rule is promulgated by the insurance commissioner pursuant to Sections 31A-2-201.1 and 31A-22-1404, and Subsections 31A-2-201(3), 31A-2-202(2), 31A-2-212(5), 31A-22-605(4), 31A-22-620(3)(f), 31A-30-106(1) and (4), and 31A-30-106.1(13) and (14).~~

~~R590-220-2. Purpose and Scope.~~
~~(1) The purpose of this rule is to set forth procedures for submitting:~~
~~(a) accident and health filings required by Section 31A-21-201;~~
~~(b) individual accident and health filings in accordance with Section 31A-22-605 and Rule R590-85;~~
~~(c) Medicare supplement filings in accordance with Sections 31A-22-605 and 31A-22-620, and Rules R590-85 and R590-146;~~
~~(d) long term care filings required by Section 31A-22-1404 and Rule R590-148; and~~
~~(e) health benefit plan filings required by Subsection 31A-2-212(5); Title 31A, Chapter 30, Individual, Small Employer, and Group Health Insurance Act; and Rule R590-167.~~
~~(2) This rule applies to:~~
~~(a) all types of accident and health insurance products; and~~
~~(b) group accident and health contracts issued to nonresident policyholders, including trusts, when Utah residents are provided coverage by certificates of insurance.~~

~~R590-220-3. Documents Incorporated by Reference.~~
~~(1) The department requires that the documents described in this rule shall be used for all filings.~~
~~(a) Actual copies may be used or you may adapt them to your word processing system.~~
~~(b) If adapted, the content, size, font, and format must be similar.~~
~~(2) The NAIC Uniform Life, Accident and Health, Annuity, and Credit Product Coding Matrix, effective January, 1, 2015, is hereby incorporated by reference and is available on the department's web site, www.insurance.utah.gov.~~

~~R590-220-4. Definitions.~~
~~In addition to the definitions in Sections 31A-1-301 and 31A-30-103, the following definitions shall apply for the purposes of this rule.~~
~~(1) "Certification" means a statement that the filing being submitted is in compliance with Utah laws and rules.~~

(2) "Discretionary group" means a group that has been specifically authorized by the commissioner under Subsection 31A-22-701(2)(c).

(3) "Electronic filing" means a filing submitted via the Internet by using the System for Electronic Rate and Form Filings, SERFF.

(4) "Eligible group" means a group that meets the requirements in Section 31A-22-701.

(5) "File And Use" means a filing can be used, sold, or offered for sale after it has been filed with the department.

(6) "File Before Use" means a filing can be used, sold, or offered for sale after it has been filed with the department and a stated period of time has elapsed from the date filed.

(7) "File For Acceptance" means a filing can be used, sold, or offered for sale after it has been filed and the filer has received written confirmation that the filing was accepted.

(8) "File for Approval" means a filing can be used, sold, or offered for sale after it has been filed and the filer has received written confirmation that the filing was approved.

(9) "Filer" means a person who submits a filing.

(10) "Filing," when used as a noun, means an item required to be filed with the department including:

a) a policy;

(b) a rate, rate manual, or rate methodologies;

(c) a form;

(d) a document;

(e) a plan;

(f) a manual;

(g) an application;

(h) a report;

(i) a certificate;

(j) an endorsement or rider;

(k) an actuarial memorandum, demonstration, and certification;

(l) a licensee annual statement;

(m) a licensee renewal application;

(n) an advertisement;

(o) a binder; or

(p) an outline of coverage.

(11) "Filing Objection Letter" means a letter issued by the commissioner when a review has determined the filing fails to comply with Utah law and rules. The filing objection letter, in addition to requiring correction of non-compliant items, may request clarification or additional information pertaining to the filing.

(12) "Filing status information" means a list of the states to which the filing was submitted, the date submitted, and the states' actions, including their responses.

(13) "Letter of authorization" means a letter signed by an officer of the licensee on whose behalf the filing is submitted that designates filing authority to the filer.

(14) "Market type" means the type of policy that indicates the targeted market such as individual or group.

(15) "Non-2014 PPACA compliant health benefit plan" means a health benefit plan that is either:

(a) a grandfathered health plan as defined in 45 CFR 147.140(a); or

(b) a transitional health benefit plan as outlined by the letter to Insurance Commissioners from the Centers for Medicare and Medicaid Services dated November 14, 2013 and extended by the Insurance Standards Bulletin Series, Extension of Transitional Policy through October 1, 2016 dated March 5, 2014. A transitional plan is also known as a grandmothered health plan.

(16) "Order to Prohibit Use" means an order issued by the commissioner that prohibits the use of a filing.

(17) "Rating methodology change" for the purpose of a non-2014 PPACA compliant health benefit plan means a:

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

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

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

(d) change in a rating factor, with respect to any case characteristic, if the change would produce a change in premium for any individual or small employer that exceeds 10%. A change in a rating factor shall mean the cumulative change with respect to such factor considered over a 12-month period. If a covered licensee changes rating factors with respect to more than one case characteristic in a 12-month period, the licensee shall consider the cumulative effect of all such changes in applying the 10% test.

(18) "Rejected" means a filing is:

(a) not submitted in accordance with Utah laws and rules;

(b) returned to the filer by the department with the reasons for rejection; and

(c) not considered filed with the department.

(19) "SERFF" means the System for Electronic Rate and Form Filings.

(20) "Type of insurance" means a specific accident and health product including dental, health benefit plan, long-term care, Medicare supplement, income replacement, specified disease, or vision.

(21) "Utah Filed Date" means the date provided to a filer by the Utah Insurance Department that indicates a paper filing has

been accepted. If the Utah Filed Date is used for compliance with any section of this rule, a complete copy of the paper filing with the filed date stamped on the filing must be attached as a supporting document. In addition, if the filing was amended at any time, the amendment filing must also be attached as a supporting document.

R590-220-5. General Filing Information.

(1) Each filing submitted must be accurate, consistent, complete and contain all required documents in order for the filing to be processed in a timely and efficient manner. The commissioner may request any additional information deemed necessary.

(2) A licensee and filer are responsible for assuring that a filing is in compliance with Utah laws and rules. A filing not in compliance with Utah laws and rules is subject to regulatory action under Section 31A-2-308.

(3) A filing that does not comply with this rule will be rejected and returned to the filer. A rejected filing:

(a) is not considered filed with the department;

(b) must be submitted as a new filing; and

(c) will not be reopened for purposes of resubmission.

(4) A prior filing will not be researched to determine the purpose of the current filing.

(5) The department does not review or proofread every filing.

(a) A filing may be reviewed:

(i) when submitted;

(ii) as a result of a complaint;

(iii) during a regulatory examination or investigation; or

(iv) at any other time the department deems necessary.

(b) If a filing is reviewed and is not in compliance with Utah laws and rules, a Filing Objection Letter or an Order to Prohibit Use will be issued to the filer. The commissioner may require the licensee to disclose deficiencies in forms or rating practices to affected insureds.

(6) Filing correction.

(a) Filing corrections are considered informational.

(b) Filing corrections must be submitted within 15 days of the date the original filing was submitted to the department. The filer shall include a description of the filing corrections.

(c) A new filing is required if a filing correction is made more than 15 days after the date the original filing was submitted to the department. The filer must reference the original filing in the filing description and include a description of the filing corrections.

(7) If responding to a Filing Objection Letter, an Order to Prohibit Use, or a Filing Rejection, review Section R590-220-17 for instructions.

(8) Filing withdrawal. A filer must notify the department when withdrawing a previously filed form, rate, or supplementary information.

R590-220-6. Filing Submission Requirements.

(1) All filings must be submitted as an electronic filing.

(2) A filing must be submitted by market type and type of insurance.

(3) A filing may not include more than one type of insurance, or request filing for more than one licensee.

(4)(a) Filing Description. Do not submit a cover letter. On the General Information tab, complete the Filing Description section with the following information, presented in the order shown below.

(i) Provide a description of the filing including:

(A) the intent of the filing; and

(B) the purpose of each document within the filing.

(ii) Indicate if the filing:

(A) is new;

(B) is replacing or modifying a previous submission; if so, describe the changes made, if previously rejected the reasons for rejection, and the previous filing's Utah Filed Date or SERFF tracking number;

(C) includes documents for informational purposes; if so, provide the Utah Filed Date or SERFF tracking number; or

(D) does not include the base policy; if so, provide the Utah Filed Date or SERFF tracking number for the base policy and all amendments and describe the effect on the base policy.

(iii) Identify if any of the provisions are unusual, controversial, or have been previously objected to, or prohibited, and explain why the provision is included in the filing.

(iv) Explain any change in benefits or premiums that may occur while the contract is in force.

(v) List the issue ages, which means the range of minimum and maximum ages for which a policy will be issued.

(b) Certification. The filer must certify that a filing has been properly completed AND is in compliance with Utah laws and rules. The Utah Accident and Health Insurance Filing Certification must be properly completed, signed, and attached to the Supporting Documentation tab. A false certification may subject the licensee to administrative action.

(c) Domiciliary Approval and Filing Status Information. All filings for a foreign licensee must include on the Supporting Documentation tab:

(i) copy of domicile approval for the exact same filing;

(ii) filing status information which includes:

(A) a list of the states to which the filing was submitted;

(B) the date submitted; and
(C) summary of the states' actions and their responses; or
(iii) if the filing is specific to Utah and only filed in Utah, then state, "UTAH SPECIFIC - NOT SUBMITTED TO ANY OTHER STATE."
(d) Group Questionnaire, Utah Bona Fide Employer Association Group Questionnaire, or Discretionary Group Authorization Letter. A group filing must have attached to the Supporting Documentation tab either a:
(i) signed and fully completed Utah Accident and Health Insurance Group Questionnaire;
(ii) copy of the Utah Accident and Health Insurance Discretionary Group Authorization letter; or
(iii) signed and fully completed Utah Bona Fide Employer Association Group Questionnaire.
(e) Letter of Authorization.
(i) When the filer is not the licensee, a letter of authorization from the licensee must be attached to the Supporting Documentation tab.
(ii) The licensee remains responsible for the filing being in compliance with Utah laws and rules.
(f) Variable data.
(i) A statement of variability must be attached to the Supporting Documentation tab and certify:
(A) the final form will not contain brackets denoting variable data;
(B) the use of variable data will be administered in a uniform and non-discriminatory manner and will not result in unfair discrimination;
(C) the variable data included in this statement will be used on the referenced forms;
(D) any changes to variable data will be submitted prior to implementation; and
(E) all possible variations of the variable data are shown in the statement, such as "Deductible is $(x-xxxx) in $xx increments."
(ii) Variable data are denoted in brackets and are defined, either by imbedding in the form, or by a separate form identified by its own form number and edition date. Variable data submitted as a separate form must be in a manner that follows the construction of the form, by page and paragraph, or page and footnote.
(iii) Variable data must be reasonable, appropriate and compliant.
(iv) Use of unauthorized variable data is prohibited.
(g) Items being submitted for filing.
(i) All forms must be attached to the Form Schedule tab.
(ii) All rating documentation, including actuarial memorandums and rate schedules, must be attached to the Rate/Rule Schedule tab.
(h) Reports are exempt from the filing submission requirement listed in Subsections R590-220-6(4)(c), (d), and (f).
(i) Underline and Strikethrough Version. A filing submitted for a correction, modification, or replacement of existing language shall have an underline and strikethrough version of the form included with the corrected, modified, or replacement form on the Form Schedule tab.
(5) Refer to each applicable section of this rule for additional procedures on how to submit forms, rates, and reports.
(6) All filings must be submitted in SERFF correctly utilizing the NAIC Uniform Life, Accident and Health, Annuity, and Credit Product Coding Matrix.

R590-220-7. Procedures for Form Filings.
(1) Forms in General.
(a) Forms are File and Use filings.
(b) Each form must be identified by a unique form number. The form number may not be variable.
(c) A form must be in final form. A draft may not be submitted.
(d) Blank spaces within the forms must be completed in John Doe fashion to accurately represent the intended market, purpose, and use.
(2) Application Filing.
(a) Each application or enrollment form may be submitted as a separate filing or may be filed with its related policy or certificate filing.
(b) If an application has been previously filed or is filed separately, an informational copy of the application must be included with the policy or certificate filing. Include the Utah Filed Date or SERFF tracking number for the application in the Filing Description.
(3) Policy Filing.
(a) Each type of insurance must be filed separately.
(b) A policy filing consists of one policy form, including its related forms, such as the application, outline of coverage, certificate, rider, endorsement, and actuarial memorandum.
(c) Only one policy filing for a single type of insurance may be filed, except as stated in Subsection R590-220-7(3)(d).
(d) A Medicare supplement filing may include more than one policy filing but each filing is limited to only one of each of the Medicare supplement plans A through N.
(4) Rider or Endorsement Only Filing.
(a) Related riders or endorsements may be filed together.
(b) A single rider or endorsement that affects multiple forms may be filed, if the Filing Description references all affected

~~forms.~~

~~(c) The filing must include:~~

~~(i) a listing of all base policy form numbers, title and Utah Filed Dates or SERFF tracking numbers; and~~

~~(ii) a description of how each filed rider or endorsement affects the base policy.~~

~~(d) Unrelated riders or endorsements may not be filed together.~~

~~(5) Outline of Coverage. If an outline of coverage is required to be issued with a policy, rider, or an endorsement, the outline of coverage must be filed when the policy, rider or endorsement is filed.~~

~~R590-220-8. Additional Procedures for Individual Accident and Health Market Filings.~~

~~(1) A filer submitting an individual accident and health filing is advised to review:~~

~~(a) Title 31A, Chapter 8, Health Maintenance Organizations and Limited Health Plans;~~

~~(b) Title 31A, Chapter 22, Part 6, Accident and Health Insurance;~~

~~(c) Rules R590-76, R590-85, R590-122, R590-126, R590-131, R590-192, R590-203, R590-215, and R590-218; and~~

~~(d) for health benefit plan submissions, additionally review:~~

~~(i) Title 31A, Chapter 30, Individual, Small Employer, and Group Health Insurance Act; and~~

~~(ii) Rules R590-167, R590-176, R590-194, R590-200, R590-233, R590-237, R590-247, R590-259, R590-261, R590-266, R590-269, R590-271 and R590-220-10.~~

~~(2) Rate and rate documentation filings.~~

~~(a) Rates and rate documentation submitted with a new form filing are a File and Use filing.~~

~~(b) A rate revision filing is a File for Acceptance filing.~~

~~(3) An individual accident and health policy, rider, or endorsement affecting benefits shall be accompanied by a rate filing with an actuarial memorandum signed by a qualified actuary.~~

~~(a) A rate filing need not be submitted if the filing does not require a change in premiums, however the reason why there is not a change in premium must be explained in the Filing Description.~~

~~(b) Rates must be filed in accordance with the requirements of Section 31A-22-602, Rules R590-85, and R590-220.~~

~~(c) This subsection does not apply to a rate filing for a health benefit plan. A filer submitting a rate filing for a health benefit plan should review R590-220-10.~~

~~(4) A filer submitting a long term care filing, including an endorsement or rider attached to a life insurance policy, is advised to review Title 31A, Chapter 22, Part 14, Long Term Care Insurance Standards, Rule R590-148, and Sections R590-220-12 and 13.~~

~~(5) A filer submitting a Medicare supplement filing is advised to review Section 31A-22-620, Rule R590-146, and Section R590-220-11.~~

~~R590-220-9. Additional Procedures for Group Market Form Filings.~~

~~(1) A filer submitting a group accident and health filing is advised to review:~~

~~(a) Title 31A, Chapter 8, Health Maintenance Organizations and Limited Health Plans;~~

~~(b) Title 31A, Chapter 22, Parts 6 and 7;~~

~~(c) Title 31A, Chapter 30, Individual, Small Employer, and Group Health Insurance Act; and~~

~~(d)(i) Rules R590-76, R590-85, R590-122, R590-126, R590-131, R590-146, R590-148, R590-192, R590-203, and R590-215.~~

~~(ii) Filers submitting group health benefit plans should also review Rules R590-167, R590-176, R590-194, R590-200, R590-218, R590-233, R590-237, R590-247, R590-259, R590-261, R590-266, R590-271 and Section R590-220-10.~~

~~(2) A filer must determine if the group is an allowable group. An allowable group must meet the parameters of an eligible group or a discretionary group. All groups, except a group formed under a Taft Hartley trust in accordance with Section 302(c)(5) of the Federal Labor Management Relations Act, must be formed and maintained for purposes other than obtaining insurance.~~

~~(a) Eligible Group.~~

~~(i) A filing for an eligible group must include a signed and fully completed Utah Accident and Health Insurance Group Questionnaire.~~

~~(A) A questionnaire must be completed for each eligible group under Sections 31A-22-503 through 507, and Subsection 31A-22-701(2).~~

~~(B) When a filing applies to multiple employee-employer groups under Section 31A-22-502, only one questionnaire is required to be completed.~~

~~(ii) A filing for an eligible Bona Fide Employer Association must include a signed and fully completed Utah Bona Fide Employer Association Group Questionnaire.~~

~~(b) Discretionary Group. If the group is not an eligible group, then specific discretionary group authorization must be obtained prior to filing.~~

~~(i) To obtain discretionary group authorization a Utah Accident and Health Insurance Request for Discretionary Group Authorization must be submitted and include all required information.~~

~~(ii) Evidence or proof of the following items are some factors considered in determining acceptability of a discretionary group:~~

~~(A) the existence of a verifiable group;~~

~~(B) that granting permission is not contrary to public policy;~~

~~(C) the proposed group would be actuarially sound;~~

(D) the group would result in economies of acquisition and administration which justify a group rate; and
(E) the group would not present hazards of adverse selection.
(iii) A discretionary group filing that does not provide authorization documentation will be rejected.
(iv) A change to an authorized discretionary group, such as change of name, trustee or domicile state, must be submitted to the department within 30 days of the change.
(v) Adding additional types of insurance products to be offered, requires that the discretionary group be reauthorized. The discretionary group authorization will specify the types of products that a discretionary group may offer.
(vi) The commissioner may periodically re-evaluate the group's authorization.
(vii) A filer may not submit a rate or form filing prior to receiving discretionary group authorization. If a rate or form filing is submitted without discretionary group authorization, the filing will be rejected.
(3) A filer submitting a long-term care filing, including a long-term care endorsement or rider attached to a life insurance policy, is advised to review Title 31A, Chapter 22, Part 14, Long Term Care Insurance Standards, Rule R590-148, and Sections R590-220-12 and 13.
(4) A filer submitting a Medicare supplement filing is advised to review Section 31A-22-620, Rule R590-146, and Section R590-220-11.

R590-220-10. Additional Procedures for Individual, Small Employer, and Group Health Benefit Plan Filings.
This section contains instructions for health benefit plan filings subject to Title 31A, Chapter 30, Individual, Small Employer, and Group Health Insurance Act.
(1) Form Filing.
(a) A health benefit plan form filing must include in the Filing Description the SERFF tracking number for the form's applicable rate manual.
(b) Grandfathered and transitional plans must be filed separate from 2014 PPACA compliant health benefit plans.
(c) Provide documentation for the department's receipt of the form filing's corresponding rate filing.
(2) Rate Manual Filing for non-2014 PPACA Compliant Health Benefit Plans.
(a) A rate manual that does not request a change in rating methodology is a File Before Use filing.
(b) A change in rating methodology filing is a File for Approval filing.
(c) A new and revised rate manual must:
(i) include an actuarial certification signed by a qualified actuary;
(ii) be filed 30 days prior to use;
(iii) list the case characteristics and rate factors to be used;
(iv) be applied in the same manner for all health benefit plans in a class;
(v) contain specific area factors applicable in Utah;
(vi) include the method of calculating the risk load, including the method used to determine any experience factors;
(vii) include how the overall rate is reviewed for compliance with the rate restrictions;
(viii) include detailed description of all classes of business, as provided in Section 31A-30-105;
(ix) fully complete the Company Rate Information on the Rate/Rule Schedule tab; and
(x) comply with all information required by Section R590-167-6.
(3) Rate Filing for 2014 PPACA Compliant Health Benefit Plans.
(a) Rate filings shall be filed in accordance with the department's annual Bulletin to insurance carriers.
b) Quarterly changes to a rate filing shall be filed in accordance with Bulletin 2015-3.
(c) Fully complete the Company Rate Information on the Rate/Rule Schedule tab.
(4) Actuarial Certification Report.
(a) All individual and small employer licensees who maintain a non-2014 PPACA compliant health benefit plan must file an actuarial certification as described in Sections 31A-30-106, 31A-30-106.1, and Subsection R590-167-11(1)(a).
(b) The report is due April 1 each year.
(c) Each report must be filed separately and be properly identified.
(d)(i) Except as provided in R590-220-10(4)(d)(ii), a health benefit plan report must be filed using a type of insurance of "H16I" or "H16G," and a filing type of "Report."
(ii) A Health Maintenance Organization must use "HOrg02I" or "HOrg02G" as the type of insurance and the filing type of "Report."

R590-220-11. Additional Procedures for Medicare Supplement Filings.
A filer submitting Medicare supplement filings is advised to review Section 31A-22-620 and Rule R590-146.
(1) A Medicare supplement form filing that affects rates must be filed with all required rating documentation.
(2)(a) A licensee must file its Medicare Supplement Buyers Guide.
(b) If previously filed, indicate the Utah Filed Date or SERFF tracking number in the filing description.
3) Rates.
(a) Rates and rate documentation submitted with a new form filing are a File and Use filing.
(b) A rate revision filing is a File for Acceptance filing.
(c) Medicare supplement rates must comply with Section 31A-22-602, and Rules R590-146 and R590-85.
(d) A licensee shall not use or change premium rates for a Medicare supplement policy or certificate unless the rates, rating

schedule and supporting documentation have been filed.

(e) A rate revision request may not be used to satisfy the annual filing requirements of Subsection R590-146-14.C.

(4) Annual Medicare Supplement Reports.

(a) Reports are due May 31 each year.

(b) Report of Multiple Policies.

(i) As required by Section R590-146-22, an issuer of Medicare supplement policies shall annually submit a report of multiple policies the licensee has issued to a single insured.

(ii) The report is required each year listing each insured with multiple policies or must state "NO MULTIPLE POLICIES WERE ISSUED."

(c) Annual Filing of Rates and Supporting Documentation.

(i) An issuer of Medicare supplement policies and certificates shall file annually its rates, rating schedule and supporting documentation, including ratios of incurred losses to earned premiums by policy duration, in accordance with Subsection R590-146-14.C.

(ii) The NAIC Medicare Supplement Insurance Model Regulations Manual details what should be included in the annual rate filing.

(iii) Annual reports submitted with a request or any type of reference to a rate revision will be rejected.

d) Refund Calculation and Benchmark Ratio. An issuer shall file the Medicare Supplement Refund Calculation Form and Reporting Form for the Calculation of Benchmark Ratio Since Inception for Group Policies reports according to Subsection R590-146-14.B.

(e) Reports for Pre-Standardized Medicare supplement benefit plans and 1990 Standardized Medicare supplement benefit plans must be submitted together as one filing using a type of insurance of "MS06," and a filing type of "Report."

(f) Reports for 2010 Standardized Medicare supplement benefit plans must be submitted together as one filing with SERFF using a type of insurance of "MS09," and a filing type of "Report."

(g) If all Medicare supplement reports are not submitted together as one filing, the filing is considered incomplete and will be rejected.

R590-220-12. Additional Procedures for Combination Policies or Endorsements and Riders Providing Life and Accident and Health Benefits.

A filer submitting a health and life combination policy or a health endorsement or rider to a life policy is advised to review Rule R590-226.

(1) A combination filing is a policy, rider, or endorsement, which creates a product that provides both life and accident and health insurance benefits.

(a) The two types of acceptable combination filings are:

(i) an endorsement or rider; or

(ii) an integrated policy.

(b) Combination filings take considerable time to process, and will be processed by both the Health Section and the Life Section of the Health and Life Insurance Division.

(2) A combination filing must be submitted separately to both the Health Section and Life Section of the Health and Life Insurance Division.

(3)(a) For an integrated policy, the filing must be submitted to the appropriate division based on benefits provided in the base policy.

(b) For an endorsement or rider, the filing must be submitted to the appropriate division based on benefits provided in the endorsement or rider.

(4) The Filing Description must identify the filing as having a combination of insurance types, such as:

a) whole life policy with a long-term care benefit rider; or

(b) major medical health policy that includes a life insurance benefit.

R590-220-13. Additional Procedures for Long Term Care Products.

A filer submitting long-term care product filings is advised to review Title 31A, Chapter 22, Part 14, Long-Term Care Insurance Standards and Rule R590-148.

(1) A long-term care form filing that affects rates must be filed with all required rating documentation.

2) Rates.

(a) Rates and rate documentation submitted with a new form filing are a File and Use filing.

(b) A rate revision filing is a File for Acceptance filing.

(c) Long-term care rates must comply with Rules R590-148 and R590-85.

(d) A licensee shall not use or change premium rates for a long-term care policy or certificate unless the rates, rating schedule and supporting documentation have been filed.

(3) Annual Long-term Care Reports.

(a) All four long-term care reports required by Section R590-148-25 must be submitted together as one filing:

(i) Replacement and Lapse Reporting Form;

(ii) Claims Denial Reporting Form;

(iii) Rescission Reporting Form; and

(iv) Suitability Report Form.
(b) If all reports are not submitted as one filing, the filing is considered incomplete and will be rejected.
(c) If there is no information to report, the reporting form must state "NONE."
(d) Reports are due June 30 each year.
(e) All long term care reports must be electronically filed using a type of insurance of "LTC06," and a filing type of "Report."

R590-220-14. Criteria for Adding or Terminating Participating Providers.
(1) Criteria for adding or terminating participating providers must be submitted electronically using a type of insurance of "H21" and a filing type of "Report."
(2) The Filing Description must state "Preferred Provider Agreement," as required by Subsection 31A-22-617.1(1)(c).

R590-220-15. Binders.
Binder filings for 2014 PPACA compliant health benefit plans and certified stand-alone dental plans shall be in accordance with the department's annual Bulletin to insurance carriers.

R590-220-16. Classification of Documents.
(1) Except as provided in R590-167-12, the commissioner shall maintain as a protected record the records submitted under Sections 31A-30-106 and 31A-30-106.1.
(2) In accordance with Section 63G-2-305, the only information the commissioner may classify as protected is:
(a) information deemed to be a trade secret. Trade secret means information, including a formula, pattern, compilation, program, device, method, technique, or process, that:
(i) derives independent economic value, actual or potential, from not being generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value from its disclosure or use; and
(ii) is the subject of efforts that are reasonable under the circumstances to maintain its secrecy; or
(b) commercial information and non-individual financial information obtained from a person if:
(i) disclosure of the information could reasonably be expected to result in unfair competitive injury to the person submitting the information or would impair the ability of the commissioner to obtain necessary information in the future; and
(ii) the person submitting the information has a greater interest in prohibiting access than the public has in obtaining access.
(3) The person submitting the information under Subsection (2)(a) or (b) and claiming that such is or should be protected shall provide the commissioner with the information in Subsection 63G-2-309(1)(a)(i).
(a) The filer shall request protected classification for the specific document the filer believes qualifies under Subsections 63G-2-305(1) or (2) when the filing is submitted; and
(b) the request shall include a written statement of reasons supporting the request that the information should be classified as protected.
(4) Once the filing has been received, the commissioner will review the documents the filer has requested to be classified as protected to determine if the request meets the requirements of Subsections 63G-2-305(1) or (2).
(a) If all the information in the document meets the requirements for being classified as protected and the required statement is included, the document will be classified as protected and the information will not be available to the public.
(b) If all the information in the document does not meet the requirements for being classified as protected, the commissioner will notify the filer of the denial, the reasons for the denial, and the filer's right to appeal the denial. The filer has 30 days to appeal the denial as allowed by Section 63G-2-401.
(c)(i) Despite the denial of protected classification, the commissioner shall treat the information as if it had been classified as protected until:
(A) the 30 day time limit for an appeal to the commissioner has expired; or
(B) the filer has exhausted all appeals available under Title 63G, Chapter 2, Part 4 and the document has been found to be a public document.
(ii) During the 30 day time limit to appeal or during the appeal process, the filer may withdraw:
(A) the filing; or
(B) the request for protected classification.
(d) If the filer combines, in a document, information it wishes to be classified as protected with information that is public, the document will be classified as public.

R590-220-17. Responses.
(1) Response to a Filing Objection Letter. When responding to a Filing Objection Letter, a filer must:
a) provide an explanation identifying all changes made;
(b) include an underline and strikeout version for each revised document;
(c) a final version of revised documents that incorporates all changes; and
(d) attach the documents in Subsections R590-220-17(1)(b) and (c) to the appropriate Form Schedule or Rate/Rule Schedule tabs.
(2) Response to an Order to Prohibit Use.
(a) An Order to Prohibit Use becomes final 15 days after the date of the Order.

~~(b) Use of the filing must be discontinued no later than the date specified in the Order.~~
~~(c) To contest an Order to Prohibit Use, the commissioner must receive by mail or electronic mail a written request for a hearing not later than 15 days after the date of the Order.~~
~~(d) A new filing is required if the licensee chooses to make the requested changes addressed in the Filing Objection Letter. The new filing must reference the previously prohibited filing.~~
~~(3) Response to a Filing Rejection. A Filing Rejection is not considered filed with the department. A filer may choose to submit as a new filing. The new filing must reference the previously rejected filing.~~

~~**R590-220-18. Penalties.**~~
~~A person found to be in violation of this rule shall be subject to penalties as provided under Section 31A-2-308.~~

~~**R590-220-19. Severability.**~~
~~If any provision of this rule or its application to any person or situation is held to be invalid, that invalidity shall not affect any other provision or application of this rule which can be given effect without the invalid provision or application, and to this end the provisions of this rule are declared to be severable.~~]

R590-220-1. Authority.
This rule is promulgated by the commissioner pursuant to Sections 31A-2-201, 31A-2-201.1, 31A-2-202, 31A-2-212, 31A-22-605, 31A-22-620, 31A-22-1404, 31A-22-2006, 31A-30-106, 31A-30-106.1, 31A-43-304, and 31A-45-103.

R590-220-2. Purpose and Scope.
(1) The purpose of this rule is to establish procedures for submitting:
(a) an accident and health insurance filing including a stop-loss insurance filing; and
(b) a report filing.
(2) This rule applies to an insurer offering accident and health insurance, including a group accident and health insurance policy issued to a nonresident when a Utah resident is covered under the policy.

R590-220-3. Definitions.
Terms used in this rule are defined in Sections 31A-1-301 and 31A-30-103. Additional terms are defined as follows:
(1) "Certification" means a statement that a submitted filing is compliant.
(2) "Compliant" means a filing that is complete and that complies with Title 31A, Insurance Code, and this rule.
(3) "Discretionary group" means a group that is authorized by the commissioner under Subsection 31A-22-701(1)(b).
(4) "Electronic filing" means a filing submitted using SERFF.
(5) "Eligible group" means a group that meets the requirements in Section 31A-22-701.
(6) "File and use" means a filing is used, sold, or offered for sale after it is filed with the department.
(7) "File before use" means a filing is used, sold, or offered for sale after it is filed with the department and a stated period of time elapses from the date filed.
(8) "File for acceptance" means a filing is used, sold, or offered for sale after receiving written confirmation that the filing is accepted.
(9) "File for approval" means a filing is used, sold, or offered for sale after receiving written confirmation that the filing is approved.
(10) "Filing objection letter" means a letter issued by the commissioner when a review of the filing determines the filing is not compliant and may require:
(a) correction of non-compliant items;
(b) clarification; or
(c) additional information related to the filing.
(11) "Filing status information" means a list of states a similar filing was submitted to, the date submitted, and the action taken by each state, including their responses.
(12) "Letter of authorization" means a letter signed by an officer of the insurer giving authority to a third party to submit a filing on behalf of the insurer.
(13) "Market type" means a policy that specifies a targeted market.
(14) "NAIC Product Coding Matrix" means a numerical coding system developed by the NAIC that provides uniform naming convention, uniform terminology, and uniform description for a type of insurance product in a filing.
(15) "Non-2014 PPACA compliant health benefit plan" means a health benefit plan that is:
(a) a grandfathered health plan under 45 CFR 147.140(a); or
(b) a transitional health benefit plan, also known as a grandmothered plan, under:
(i) the letter from the Centers for Medicare and Medicaid Services dated November 14, 2013; and
(ii) Subsection 31A-30-117(3).
(16) "Order to prohibit use" means an order issued by the commissioner prohibiting the use of a filing.
(17) "Change in rating methodology," for the purposes of a non-2014 PPACA compliant health benefit plan, means a change in:
(a) the number of case characteristics used by an insurer to determine premium rates in a class of business;
(b) the manner or procedures used to assign an insured into categories for the purpose of applying a case characteristic to

determine premium rates in a class of business;

(c) the method of allocating expenses in a class of business; or

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

(18) "Rejected" means a filing is:

(a) not compliant;

(b) returned to the insurer stating the reason for rejection; and

(c) not considered filed with the department.

(19) "Resubmission" means a correction, modification, or replacement of a previously rejected, withdrawn, or prohibited filing.

(20) "SERFF" means the System for Electronic Rates and Form Filings.

(21) "Stop-loss insurance" means insurance purchased by an employer for which the stop-loss insurer assumes all loss amounts of the employer's plan in excess of a stated amount, subject to the policy limit.

(22) "Type of insurance" or "TOI" means a specific accident and health insurance product identified by the NAIC Product Coding Matrix that can be selected in SERFF when submitting a filing in Utah.

(23) "Utah filed date" means the date the department indicates a paper filing is accepted.

R590-220-4. Documents Used in a Filing.

The documents designated in this rule are required for all filings.

(1) An actual copy or a created version may be used.

(2) If created, the content, size, font, and format shall be similar to the actual copy.

(3) The documents referenced in this rule are found on the department's website, https://insurance.utah.gov.

R590-220-5. General Filing Information.

(1)(a) A filing shall be accurate, consistent, complete, and contain all required documents.

(b) The commissioner may request additional information, as necessary.

(2)(a) An insurer is responsible for assuring that any document in a filing is compliant.

(b) A filing that is not compliant is subject to regulatory action.

(3)(a) A filing that is not compliant shall be rejected.

(b) A rejected filing:

(i) may be resubmitted under a new filing; and

(ii) may not be reopened for purposes of resubmission.

(4) A prior filing will not be researched to determine the purpose of the current filing.

(5) The department does not review every filing.

(a) A filing may be reviewed:

(i) when submitted;

(ii) when a complaint is received;

(iii) during a regulatory examination or investigation; or

(iv) when the department considers a review necessary.

(b) If a filing is reviewed and is found not compliant, the commissioner:

(i) shall issue a filing objection letter or an order to prohibit use; and

(ii) may require an insurer to disclose deficiencies in a form or a rating practice to each affected insured.

(6)(a) A correction to a filing in an open status may be made at any time.

(b) A correction to a filing in a closed status:

(i) may not be made;

(ii) requires a new filing; and

(iii) shall reference the original filing in the filing description of the new filing.

(7) An insurer shall notify the department when discontinuing or withdrawing a previously filed form, rate, or supplementary information.

(8) If the Utah filed date is used for compliance with this rule, a complete copy with all subsequent amendments, including the Utah filed date, shall be attached as a supporting document.

R590-220-6. Filing Submission Requirements.

(1) General Filing Requirements.

(a) A filing shall be submitted:

(i) electronically through SERFF; and

(ii) using the NAIC Product Coding Matrix, including the:

(A) TOI; and

(B) sub-TOI.

(b) A filing may not include more than one:

(i) TOI; or

(ii) insurer.

(c) A cover letter may not be submitted with a filing.

(2) SERFF Filing.

(a) Filing Description. The filing description on the general information tab shall contain the following information, in the sequence listed.

(i) Provide a description of the filing, including:

(A) the intent of the filing; and

(B) the purpose of each document within the filing.

(ii) Indicate if the filing:

(A) is a first-time filing;

(B) is a new form revising an existing form;

(C) is a new form that is substantially similar to an existing form;

(D) is a resubmission that includes a summary of the changes made and the previous filing's Utah filed date or SERFF tracking number;

(E) includes informational documents, referencing the Utah filed date or SERFF tracking number; or

(F) does not include the policy, and if so, provide the Utah filed date or SERFF tracking number of the policy and each amendment, summarizing the effect on the policy.

(iii) Identify any provision that is unusual, innovative, controversial, or that was previously objected to or prohibited, and explain why the provision is included in the filing.

(iv) List the range of minimum and maximum ages for which the policy will be issued.

(v) If any of the information required under Subsection (2)(a) is not available, provide a detailed explanation of why the information is not available.

(b) Filing Certification.

(i) The insurer shall certify that a filing and all related documents are complaint.

(ii) The following statement shall be included in the filing description: "BY SUBMITTING THIS FILING I CERTIFY THAT THE ATTACHED FILING HAS BEEN COMPLETED IN ACCORDANCE WITH UTAH ADMINISTRATIVE RULE R590-220 AND IS COMPLIANT WITH APPLICABLE UTAH LAW."

(iii)(a) The Utah Accident and Health Insurance Filing Certification shall be fully completed and attached to the supporting documentation tab.

(b) If an item on the Utah Accident and Health Insurance Filing Certification does not apply to the filing being submitted, mark the item as not applicable.

(iv) A filing may be rejected if the filing certification is false, missing, or incomplete.

(v) A false certification may subject the insurer to administrative action.

(c) Domiciliary Approval and Filing Status Information. A filing for a foreign insurer shall include on the supporting documentation tab:

(i) filing status information, including:

(A) a list of states where a similar filing is submitted;

(B) the date of submission; and

(C) the disposition status or exemption; or

(ii) if the filing is specific to Utah and only filed in Utah, include:

(A) the phrase "NO SIMILAR FILING HAS BEEN SUBMITTED TO ANY OTHER STATE"; and

(B) the reason the filing is only filed in Utah.

(d) Group Questionnaire or Authorization Letter. A group filing shall attach to the supporting documentation tab:

(i) a complete Utah Accident and Health Insurance Group questionnaire;

(ii) a copy of the discretionary group authorization letter; or

(iii) a copy of the bona fide employer association group authorization letter.

(e) Letter of Authorization.

(i) A filing submitted by a third party shall have a letter of authorization from the insurer attached to the supporting documentation tab.

(ii) The insurer is responsible for the filing being complaint.

(f) Variable Data.

(i)(A) Variable data is denoted by brackets and is defined either by embedding the variable data in the form or in a separate form with a unique form number and an edition date.

(B) Variable data submitted as a separate form shall be in a manner that follows the construction of the form, by page and paragraph, or page and footnote.

(ii) A certification statement of variability shall be attached to the supporting documentation tab and shall certify that:

(A) the final form will not contain brackets;

(B) the use of variable data is administered in a uniform and non-discriminatory manner that will not result in unfair discrimination;

(C) the variable data is used on the referenced forms; and

(D) any changes to variable data shall be filed before implementation.

(iii) Any variation of the variable data shall be disclosed, for example "Deductible is $(xxx.xx) in $(xxx.xx) increments."

(iv) Variable data shall be reasonable, appropriate, and compliant.

(v) The use of unfiled variable data is prohibited.
(g) Items Submitted for Filing.
(i) A form shall be attached to the form schedule tab.
(ii) All rating documentation, including actuarial memoranda and rate schedules, shall be attached to the rate/rule schedule tab.
(h) A report is exempt from a filing submission requirement under:
(i) Subsections (2)(a)(ii) through (2)(a)(v);
(ii) Subsection (2)(c);
(iii) Subsection (2)(d); and
(iv) Subsection (2)(f).
(i) Underlining and Strikethrough. A resubmission or a new form revising an existing form shall include an underline and strikethrough version of the form and the final form on the form schedule tab.

R590-220-7. Procedures for Form Filings.
(1) Forms in General.
(a) A form is a file and use filing.
(b) A form shall be identified by a unique form number that may not be variable.
(c) A form shall be in final printed form and may not be submitted as a draft.
(d) Blank spaces within a form shall be completed to accurately represent the purpose and use.
(2) Application Filing.
(a) An application or enrollment form may be submitted as a separate filing or filed with its related policy or certificate filing.
(b) If an application was previously filed or is filed separately, an informational copy of the application shall be included with the policy or certificate filing.
(c) The Utah filed date or SERFF tracking number for the application shall be included in the filing description.
(3) Policy Filing.
(a) Each TOI shall be filed separately.
(b) A policy filing consists of one policy form, including the application, outline of coverage, certificate, and rider or endorsement.
(c) Only one policy filing for a single TOI may be filed.
(d) Notwithstanding Subsections (3)(a) through (3)(c), a Medicare supplement filing may include more than one policy but is limited to only one of each of the Medicare supplement policies A through N.
(4) Rider or Endorsement Filing.
(a) Related riders or endorsements may be filed together.
(b) A single rider or endorsement that affects multiple forms may be filed if the filing description references each affected form.
(c) The filing description shall include:
(i) a list of each policy form number, title, and Utah filed date or SERFF tracking number; and
(ii) a description of how each rider or endorsement affects the policy.
(d) Unrelated riders or endorsements may not be filed together.
(5) Outline of Coverage. If an outline of coverage is required to be issued with a policy, a rider, or an endorsement, the outline of coverage shall be filed when the policy, rider, or endorsement is filed.

R590-220-8. Additional Procedures for Individual Accident and Health Market Filings.
(1)(a) An insurer filing an individual accident and health insurance filing shall comply with:
(i) Title 31A, Chapter 22, Part 6, Accident and Health Insurance;
(ii) Rule R590-85;
(iii) Rule R590-122;
(iv) Rule R590-126;
(v) Rule R590-131;
(vi) Rule R590-192;
(vii) Rule R590-203;
(viii) Rule R590-215; and
(ix) Rule R590-286.
(b) An insurer filing a health benefit plan filing shall comply with:
(i) Title 31A, Chapter 30, Individual, Small Employer, and Group Health Insurance Act;
(ii) Title 31A, Chapter 45, Managed Care Organizations;
(iii) Rule R590-167;
(iv) Rule R590-176;
(v) Rule R590-194;
(vi) Rule R590-200;
(vii) Rule R590-233;

(viii) Rule R590-237;
(ix) Rule R590-247;
(x) Rule R590-259;
(xi) Rule R590-261;
(xii) Rule R590-266;
(xiii) Rule R590-269;
(xiv) Rule R590-271;
(xv) Rule R590-277; and
(xvi) Rule R590-283.
(2) Rate Filings.
(a) A rate filing submitted with a new form filing is a file and use filing.
(b) A rate revision filing is a file for acceptance filing.
(c)(i) An individual accident and health insurance policy, rider, or endorsement affecting a benefit shall be accompanied by a rate filing with an actuarial memorandum signed by a qualified actuary.
(ii) A rate filing is not required if the form filing does not impact the premium, however the filing description shall explain the reason there is not a change in the premium.
(3) A long-term care insurance filing, including an endorsement or rider attached to a life insurance policy, shall comply with:
(a) Title 31A, Chapter 22, Part 14, Long-Term Care Insurance Standards;
(b) Rule R590-148; and
(c) Sections R590-220-12, R590-220-13, and R590-220-15.
(4) A limited long-term care insurance filing shall comply with:
(a) Title 31A, Chapter 22, Part 20, Limited Long-Term Care Insurance Act;
(b) Rule R590-285; and
(c) Sections R590-220-12, R590-220-14, and R590-220-15.
(5) A Medicare supplement filing shall comply with:
(a) Section 31A-22-620;
(b) Rule R590-85;
(c) Rule R590-146; and
(d) Sections R590-220-11 and R590-220-15.

R590-220-9. Additional Procedures for Group Market Form Filings.
(1) An insurer filing a group accident and health insurance filing shall comply with:
(a) Title 31A, Chapter 22, Part 6, Accident and Health Insurance;
(b) Title 31A, Chapter 22, Part 7, Group Accident and Health Insurance;
(c) Title 31A, Chapter 22, Part 14, Long-Term Care Insurance Standards;
(d) Title 31A, Chapter 22, Part 20, Limited Long-Term Care Insurance Act;
(e) Title 31A, Chapter 30, Individual, Small Employer, and Group Health Insurance Act;
(f) Title 31A, Chapter 45, Managed Care Organizations;
(g) Rule R590-85;
(h) Rule R590-122;
(i) Rule R590-126;
(j) Rule R590-131;
(k) Rule R590-146;
(l) Rule R590-148;
(m) Rule R590-192;
(n) Rule R590-203;
(o) Rule R590-215;
(p) Rule R590-277;
(q) Rule R590-283; and
(r) Rule R590-285.
(2) An insurer filing a group health benefit plan filing shall comply with:
(a) Rule R590-167;
(b) Rule R590-176;
(c) Rule R590-194;
(d) Rule R590-200;
(e) Rule R590-233;
(f) Rule R590-237;
(g) Rule R590-247;
(h) Rule R590-259;
(i) Rule R590-261;
(j) Rule R590-266;

(k) Rule R590-271;
(l) Rule R590-277; and
(m) Section R590-220-10.
(3) An insurer shall determine if a group is an eligible group or a discretionary group.
(a) Eligible Group.
(i) A filing for an eligible group shall include a compliant Utah Accident and Health Insurance Group Questionnaire.
(ii) A questionnaire shall be completed for each eligible group under Section 31A-22-701.
(iii) When a filing applies to more than one employer or employee group, only one questionnaire is required.
(iv) A filing for a bona fide employer association shall include a compliant Utah Bona Fide Employer Association Group Authorization Questionnaire.
(v) A filing for a non-employer group shall comply with Rule R590-126.
(b) Discretionary Group.
(i) If a group is not an eligible group, specific discretionary group authorization shall be obtained.
(ii) If a form filing is submitted without discretionary group authorization, the filing shall be rejected.
(A) A filing may not include a rate or form filing before receiving discretionary group authorization.
(B) If a rate or form filing is submitted without discretionary group authorization, the filing shall be rejected.
(C) A discretionary group authorization filing may include a copy of the policy or certificate for informational purposes only, and such an inclusion does not satisfy a form filing requirement.
(iii) To obtain discretionary group authorization, a compliant Utah Accident and Health Insurance Request for Discretionary Group Authorization shall be submitted.
(iv) A change to an authorized discretionary group shall be submitted to the department within 30 days of the change.
(v) The commissioner may periodically re-evaluate a group's authorization.
(vi)(A) An insurer shall file a separate discretionary group authorization to add another TOI to a previously authorized group.
(B) The discretionary group authorization shall specify the TOI products that a discretionary group may offer.

R590-220-10. Additional Procedures for Individual, Small Employer, and Group Health Benefit Plan Filings.
(1) An insurer filing a health benefit plan filing shall comply with:
(a) Title 31A, Chapter 30, Individual, Small Employer, and Group Health Insurance Act;
(b) Title 31A, Chapter 45, Managed Care Organizations;
(c) Rule R590-167; and
(d) Rule R590-277.
(2) Form Filing.
(a) A non-2014 PPACA compliant health benefit plan form filing shall include the SERFF tracking number for the form's applicable rate manual filing.
(b) A grandfathered or transitional plan shall be filed separate from a 2014 PPACA compliant health benefit plan.
(3) Rate Manual Filing for a Non-2014 PPACA Compliant Health Benefit Plan.
(a) A rate manual filing that does not request a change in rating methodology is a file before use filing.
(b) A change in a rating methodology filing is a file for approval filing.
(c) A new or revised rate manual shall:
(i) include an actuarial certification signed by a qualified actuary; and
(ii) be filed 30 days before use.
(d) The company rate information on the rate/rule schedule tab shall be compliant.
(4) Rate Filing for a 2014 PPACA Compliant Health Benefit Plan.
(a) A rate filing shall be filed according to the department's annual bulletin to insurers.
(b) Quarterly changes to a rate filing shall be filed according to Bulletin 2015-3.

R590-220-11. Additional Procedures for Medicare Supplement Filings.
(1)(a) An insurer filing a Medicare supplement filing shall comply with:
(i) Section 31A-22-620;
(ii) Rule R590-85; and
(iii) Rule R590-146.
(b) A Medicare supplement form filing that affects rates shall include all required rating documentation.
(2) Rates.
(a) Rate and rate documentation submitted with a new form filing are a file and use filing.
(b) A rate revision filing is a file for acceptance filing.
(c) An insurer filing a Medicare supplement rate shall comply with:
(i) Section 31A-22-602;
(ii) Rule R590-85; and
(iii) Rule R590-146.
(d) An insurer may not use or change a premium rate for a Medicare supplement policy or certificate unless the rate, rating schedule, and supporting documentation are filed.

(e) A rate revision request may not be used to satisfy the annual filing requirements of Rule R590-146.

R590-220-12. Additional Procedures for a Policy, Endorsement, or Rider Providing Life Insurance and Accident and Health Insurance Benefits.

(1) An accident and health insurance filing that includes a life insurance benefit or an accident and health insurance endorsement or rider to a life insurance policy shall comply with Rule R590-226.

(2)(a) A combination filing is a policy, rider, or endorsement that creates a product providing both life insurance and accident and health insurance benefits.

(b) The acceptable combination filings are:

(i) a rider or endorsement; or

(ii) an integrated policy.

(c) A combination filing shall be submitted separately to both the health instance and the life instance in SERFF, as both instances will process the filing.

(d) A rider or endorsement shall be submitted to the appropriate instance in SERFF based on the benefits provided in the rider or endorsement.

(3) The filing description shall include the Utah filed date or SERFF tracking number and shall identify the filing as a combination of TOIs, such as:

(a) a whole life insurance policy with a long-term care insurance benefit; or

(b) a major medical health policy that includes a life insurance benefit.

R590-220-13. Additional Procedures for Long-Term Care Insurance Products.

(1)(a) An insurer filing a long-term care insurance filing shall comply with:

(i) Title 31A, Chapter 22, Part 14, Long-Term Care Insurance Standards; and

(ii) Rule R590-148.

(b) A long-term care insurance form filing that affects rates shall be filed with all required rating documentation.

(2) Rates.

(a) Rate and rate documentation submitted with a new form filing are a file and use filing.

(b) A rate revision filing is a file for acceptance filing.

(c) A long-term care insurance rate shall comply with Rule R590-148.

(d) An insurer may not use or change a premium rate for a long-term care insurance policy or certificate unless the rate, rating schedule, and supporting documentation are filed.

R590-220-14. Additional Procedures for Limited Long-Term Care Insurance Products.

(1)(a) An insurer filing a limited long-term care insurance filing shall comply with:

(i) Title 31A, Chapter 22, Part 20, Limited Long-Term Care Insurance Act; and

(ii) Rule R590-285.

(b) A limited long-term care insurance form filing that affects rates shall be filed with all required rating documentation.

(2) Rates.

(a) Rate and rate documentation submitted with a new form filing are a file and use filing.

(b) A rate revision filing is a file for acceptance filing.

(c) A limited long-term care insurance rate shall comply with Rule R590-285.

(d) An insurer may not use or change a premium rate for a limited long-term care insurance policy or certificate unless the rate, rating schedule, and supporting documentation are filed.

R590-220-15. Reports.

(1) Health Benefit Plan Reports.

(a) Actuarial Certification Report.

(i) An individual or a small employer insurer maintaining a non-2014 PPACA compliant health benefit plan shall file an actuarial certification under Sections 31A-30-106 and 31A-30-106.1, and Subsection R590-167-11(1)(a).

(ii) The report is due annually on April 1.

(iii) Each report shall be filed by market type and shall be properly identified.

(iv) A report shall be submitted using the appropriate TOI and the filing type of "Report."

(b) Defrayal of State-Required Benefits Report.

(i) An insurer anticipating a defrayal of state-required benefits shall file a request under Section 31A-30-118 and Subsection R590-283-6(3).

(A) The report is due quarterly on February 15, May 15, August 15, and November 15.

(B) Each report shall be filed by market type and shall be properly identified.

(C) Reports shall be submitted using the appropriate TOI and the filing type of "Report."

(ii) An insurer seeking a defrayal of state-required benefits shall file a request under Section 31A-30-118 and Subsection R590-283-4(2).

(A) The report is due annually on September 1.

(B) Each report shall be filed by market type and shall be properly identified.

(C) The report shall be submitted using the appropriate TOI and the filing type of "Report."
(2) Medicare Supplement Reports.
(a) Annual Medicare Supplement Reports.
(i) The report is due annually on May 31.
(ii) The report shall include the sub-reports outlined in this subsection.
(A) Report of Multiple Policies.
(I) An issuer of a Medicare supplement policy shall submit a report of multiple policies issued to a single insured under Section R590-146-22.
(II) The report shall list each insured with multiple policies or state "NO MULTIPLE POLICIES WERE ISSUED."
(B) Annual Filing of Rates and Supporting Documentation.
(I) An issuer of Medicare supplement policies and certificates shall file its rates, rating schedule, and supporting documentation, including ratios of incurred losses to earned premiums by policy duration, under Section R590-146-14.
(II) The NAIC Medicare Supplement Insurance Model Regulations Manual sets forth the requirements of the annual rate filing.
(III) An annual report submitted with a request or any type of reference to a rate revision shall be rejected.
(C) Refund Calculation and Benchmark Ratio. An issuer shall file the Medicare Supplement Refund Calculation Form and Reporting Form for the calculation of benchmark ratios since inception under Section R590-146-14.
(iii) A report for pre-standardized Medicare supplement benefit plans and 1990 standardized Medicare supplement benefit plans shall be submitted together as one filing using a TOI of "MS06" and a filing type of "Report."
(iv) A report for 2010 standardized Medicare supplement benefit plans shall be submitted together as one filing using a TOI of "MS09" and a filing type of "Report."
(v) If all Medicare supplement reports are not submitted together as one filing, the filing is considered incomplete and shall be rejected.
(b) Medicare Select Reports.
(i) An issuer offering a Medicare Select policy or certificate shall file a grievance report required under Section R590-14-10.
(A) The report is due annually on March 31.
(B) A report shall be filed by market type and shall be properly identified.
(C) The report shall be submitted using the appropriate Medicare Select TOI and a filing type of "Report."
(ii) An issuer offering a Medicare Select policy or certificate shall submit any change to the list of network providers under Section R590-146-10.
(A) The report is due within 30 days of the change.
(B) A report shall be filed by market type and shall be properly identified.
(C) The report shall be submitted using the appropriate Medicare Select TOI and a filing type of "Report."
(3) Long-Term Care Insurance Reports.
(a) The long-term care reports required under Section R590-148-25 shall be submitted together as one filing.
(b) If the reports are not submitted as one filing, the filing is considered non-compliant and shall be rejected.
(c) If there is no information to report, the form shall state "NONE."
(d) The report is due annually on June 30.
(e) All long-term care reports shall be filed using a TOI of "LTC06" and a filing type of "Report."
(4) Limited Long-Term Care Insurance Reports.
(a) Annual Limited Long-Term Care Report.
(i) The following limited long-term care reports required by Section R590-285-14 shall be submitted together as one filing.
(ii) If the reports are not submitted as one filing, the filing is considered non-compliant and shall be rejected.
(iii) If there is no information to report, the form shall state "NONE."
(iv) The report is due annually on June 30.
(v) The limited long-term care reports shall be filed using a TOI of "LTC06" and a filing type of "Report."
(b) Independent Review Organization Certification for a Limited Long-Term Care Insurance Report Under Section R590-285-25.
(i) The report is due annually on June 1.
(ii) The report shall be properly identified.
(iii) The report shall be filed using a TOI of "LTC06" and a filing type of "Report."
(5) Miscellaneous Reports.
(a)(i) Reporting criteria for adding or terminating participating providers shall be submitted using a TOI of "H21" and a filing type of "Report."
(ii) The filing description shall state "Preferred Provider Agreement" as required by Section 31A-45-304.
(b) Stop-Loss Certification of Compliance.
(i) An insurer making available a small employer stop-loss plan shall file an actuarial certification and experience report under Sections 31A-43-302 and R590-268-8.
(ii) The report is due annually on April 1.
(iii) The report shall be submitted using a TOI of "H12" and a filing type of "Report."
(c) All Other Reports Not Specified in This Rule.
(i) A report shall be filed by market type and properly identified.

(ii) Each report shall be submitted using the appropriate TOI and the filing type of "Report."

R590-220-16. Binders.

A binder filing for a 2014 PPACA compliant health benefit plan or a certified stand-alone dental plan shall be filed in accordance with the department's annual bulletin to an insurer offering a health benefit plan or stand-alone dental plan.

R590-220-17. Classification of Documents.

(1) A record submitted under this rule is subject to Title 63G, Chapter 2, Government Records Access and Management Act.

(2) Notwithstanding Subsection (1), a record provided under 45 CFR 154.200(a)(1), 45 CFR 154.215(b)(1), or 45 CFR 154.215(b)(2) is classified as public.

(3) A record submitted under Section 31A-2-201.2, 31A-30-106, or 31A-30-106.1 is classified as protected.

(4) Notwithstanding Subsections (1) through (3), a record may be classified as protected if:

(a) requested under Section 63G-2-309;

(b) the request in Subsection (4)(a) includes each required element of Subsections 63G-2-309(1)(a)(i)(A) and 63G-2-309(1)(a)(i)(B); and

(c) the department notifies the requester that the record has been classified as protected.

(5) A filing may not be reopened to reclassify a previously filed document.

(6) A pattern of requesting that non-qualifying documents be protected, including putting both protected and public information in one document, may violate this rule.

R590-220-18. Objection Letter and Disposition Procedures.

(1) Response to a Filing Objection Letter.

(a) A response to a filing objection letter shall:

(i) address each objection;

(ii) include an explanation identifying each change made;

(iii) include an underline and strikeout version of each revised document;

(iv) provide a final version of the revised document, incorporating all changes;

(v) attach each document under the appropriate tab; and

(vi) reference any additional document attached under the supporting documentation tab if the content is not included in the response.

(b) An attachment or separate letter as a response may not be filed.

(2) Order to Prohibit Use.

(a) An order to prohibit use is final 15 days after the date of the order to prohibit use.

(b) A filing that is prohibited pursuant to an order to prohibit use shall be discontinued by the date specified in the order to prohibit use.

(c) To contest an order to prohibit use, the insurer shall request a hearing, in writing, no later than 15 days after the date of the order to prohibit use.

(d) Notwithstanding Subsection (2)(c), an insurer may submit a resubmission that shall:

(i) make the requested changes addressed in the filing objection letter; and

(ii) reference the previously prohibited filing.

(3) Filing Rejection.

(a) An insurer may submit a resubmission.

(b) A resubmission shall reference the previously rejected filing.

R590-220-19. Severability.

If any provision of this rule, Rule R590-220, or its application to any person or situation is held invalid, such invalidity does not affect any other provision or application of this rule that can be given effect without the invalid provision or application. The remainder of this rule shall be given effect without the invalid provision or application.

KEY: health insurance filings
Date of Last Change: 2023[~~March 23, 2016~~]
Notice of Continuation: February 13, 2019
Authorizing, and Implemented or Interpreted Law: 31A-2-201; 31A-2-201.1; 31A-2-202; 31A-22-605; 31A-22-620; 31A-30-106

!--dar--