**State of Utah**
SPENCER J. COX
*Governor*

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**Insurance Department**

JONATHAN T. PIKE
*Insurance Commissioner*

# BULLETIN 2022-3(a)

To: Health Insurers Offering Health Benefit Plans or Stand-Alone Dental Plans

From: Jonathan T. Pike, Insurance Commissioner

Date: April 25, 2022

Subject: **PY2023 Health Benefit Plan and Stand-Alone Dental Plan Filing Requirements**

The Utah Insurance Department (Department) issues this Bulletin to notify insurers of the filing requirements for a health benefit plan or a certified stand-alone dental plan (SADP) to be available during the 2023 plan year. This Bulletin applies to all SADPs and health benefit plans available in the individual or small employer market, including grandfathered, transitional, and Patient Protection and Affordable Care Act (PPACA) compliant plans, regardless of marketplace participation.

An insurer is encouraged to review and be apprised of changes to the U.S. Department of Health and Human Services' (HHS) Center for Consumer Information and Insurance Oversight (CCIIO) 2023 Letter to Issuers in the Federally-facilitated Exchanges, Notice of Benefit and Payment Parameters for 2023, and state law in conjunction with this Bulletin to ensure full compliance.

## Extension of Transitional Plans

Transitional plans may be continued to the extent permitted by CCIIO.

## Filing Deadlines – On or Off Marketplace

**Health Benefit Plans** (grandfathered, transitional, PPACA)

- Forms, binders, and associated documents
  - Small Employer - May 16, 2022, no later than 10 a.m. MDT
  - Individual - June 1, 2022, no later than 10 a.m. MDT
  - Request for a network or service area change - July 1, 2022, no later than 5 p.m. MDT
- Rates, Rate Data Template, and Unified Rate Review Template (URRT) Parts I, II, and III
  - Small Employer - June 15, 2022, no later than 10 a.m. MDT
  - Individual - July 1, 2022, no later than 10 a.m. MDT
  - Initial rate submission - July 20, 2022, no later than 5 p.m. MDT
  - Final rate submission - August 16, 2022, no later than 1 p.m. MDT

**Certified Stand-Alone Dental Plans for Individual and Small Employer**

- Forms, rates, binders, and associated documents - June 6, 2022, no later than 10 a.m. MDT

An insurer is responsible to ensure all filings are complete and compliant with all federal and state laws, regulations, and standards. A submitted filing that is incomplete or non-compliant be may be rejected, Section R590-220-5.

**Binder, Form, and Rate Filing Guidance**

Review Sections 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 listed above.

**Binder Filing**

- A 2023 plan management binder if offering a PPACA plan or an SADP, even when changes are not being made.
- Each risk pool must have a separate binder: small employer health benefit plan; individual health benefit plans; individual SADPs; and small employer SADPs.
- The binder needs to include all products and plans offered within a pool.
- If a filing includes a new product or a revised 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.
- The binder filing must include an attestation that all CCIIO review tools have been completed and any deficiency has been corrected. If a known deficiency is not corrected, include supporting documentation and justification.

**Health Benefit Plan Form Filing**

- A health benefit plan form filing should not include any rate information.
- A separate form filing for each grandfathered policy and each transitional policy is required.
- A separate SERFF tracking number is necessary for each distinct HIOS Product ID that includes all plans and cost sharing variants within the single product.
- A form filing is not required when no change is being made for the 2023 plan year.

**Health Benefit Plan Rate Filing**

- A health benefit plan rate filing should not include any forms.
- A separate System for Electronic Rate and Form Filing (SERFF) tracking number is necessary for a grandfathered rate filing and a transitional rate in each business class: individual or small employer; transitional, or grandfathered.
    - Submit the Rate Review Justification Module to the Department and in HIOS, if applicable.
    - A rate filing is not required when no change is being made for the 2023 plan year.

- A separate SERFF tracking number is necessary for each risk pool; individual or small employer.
    - The rate filing must attribute the cost of the Cost Sharing Reduction (CSR) to the silver on-exchange plan.
        - Clearly indicate the assumptions leading to the CSR adjustment in the actuarial memorandum.
        - The factor adjustment should be outlined by Plan ID in the actuarial memorandum.
        - Include a single factor adjustment that provides an estimate of the rate impact to silver on-exchange plans if CSRs were funded.
        - Insurers are encouraged to offer an off-exchange only silver plan that does not incorporate the effects of any CSR adjustment.
    - 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), an alternate method to arrive at the Actuarial Value (AV), 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 AV
    - Transitional experience or projection should not be included in the URRT. Instead, provide the following in the actuarial memorandum:
        - a table showing the insurer's transitional experience, if any, for the experience period that corresponds to the URRT in "Wksh 1- Market Experience", Section I, include at a minimum; Allowed Claims, Incurred Claims, Earned Premium, and Member Months; and
        - a description of the remaining transitional business, if any, and the expectation to continue offering a transitional plan.

**Stand-Alone Dental Plan Form and Rate Filing**

- Submit one filing that includes both the dental form and the corresponding rate filing 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;
    - the 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 the corresponding form and rate in the filing description.

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

## Market Reform Requirements for a Health Benefit Plan and SADP Certification

| General Filing Requirements | |
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| **Federal Standard**<br>ACA §1002<br>ACA §1311<br>ACA §1341<br>42 USC § 18021<br>42 USC § 18022<br>42 USC § 18031<br>45 CFR 147.104<br>45 CFR 147.106<br>45 CFR 153.400<br>45 CFR 153.410<br>45 CFR 153.610<br>45 CFR 155 & 156<br>CMS Guidance<br>Rules | An insurer is required to:<br>(1) comply with all market reforms and certification requirements on an ongoing basis;<br>(2) comply with benefit design standards;<br>(3) be licensed and in good standing to offer health insurance coverage in Utah;<br>(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;<br>(5) agree to charge the same premium rate without regard to whether the plan is offered through a marketplace or whether the plan is offered directly from the insurer or through an agent;<br>(6) pay any applicable user fees assessed;<br>(7) participate in and comply with the standards related to the risk adjustment program;<br>(8) notify customers of the effective date of coverage;<br>(9) participate in initial and annual open enrollment periods, as well as special enrollment periods;<br>(10) collect enrollment information, transmit such to a marketplace and reconcile enrollment files with the marketplace enrollment files monthly;<br>(11) provide and maintain notice of termination of coverage, established by a standard policy and include a grace period for certain enrollees that is applied uniformly, notice of payment delinquency must be provided;<br>(12) segregate funds if abortion is offered as a benefit, other than in the case of an abortion provided under the Hyde Amendment exception;<br>(13) timely notify the marketplace if it plans to not seek recertification, fulfill coverage obligations through the end of the plan/benefit year, fulfill data reporting obligations from the last plan/benefit year, provide notice to enrollees, and terminate coverage for enrollees, providing written notice;<br>(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;<br>(15) upon plan renewal, provide standardized notice to consumers using the HHS standard notice of renewal;<br>(16) comply with market reform rules, including premium rating rules, guaranteed availability, guaranteed renewability, and single risk pool requirements;<br>(17) per guaranteed availability, provide a matching benefit plan and price off of the marketplace for any plan certified as a QHP;<br>(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.<br>(2) The Department will provide a certification recommendation to the marketplace. The final certification determination is made by the marketplace.<br>(3) An insurer will comply with all state laws. |
| **Licensure and Solvency** | |
| **Federal Standard**<br>45 CFR 156.200 | An insurer must be licensed and in good standing with the State. |
| **State Standard** | An insurer must 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**<br>ACA § 2702c<br>45 CFR 155.1050<br>45 CFR 156.230 | A provider network for each plan must be available to all enrollees, and:<br>• include essential community providers (ECP) in sufficient number and geographic distribution where available to ensure reasonable and timely access to a broad range of such providers for low income and medically underserved individuals in the QHP service |

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| 45 CFR 156.235 | area utilizing CMS established requirements for inclusion of ECPs in QHPs based on CMS's Annual Letter to Issuers;<br>• maintain a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance use disorder treatment services, to assure that all services will be accessible without unreasonable delay; and<br>• make its provider directory available to the marketplace for publication online in accordance with guidance from the marketplace and to potential enrollees in hard copy upon request noting which providers are not accepting new patients. |
| **State Standard** | (1) An insurer must have an adequate provider network available for the geographic area for each plan offered.<br>(2) A network should include a sufficient number and geographic distribution to ensure reasonable and timely access to a broad range of providers in an insurer's service area, and maintain a network that is sufficient in number and types of providers that specialize in mental health and substance use disorder treatment services and pediatric appropriate services, to assure that all services are accessible without unreasonable delay.<br>(3) An insurer needs to maintain a current provider directory that: indicates if providers not accepting new patients; is available online to all enrollees, including potential enrollees; and provided to an enrollee as a hard copy upon request.<br>(4) An insurer is required to attest all applicable network adequacy requirements are met. An attestation for a marketplace plan must include:<br>• evidence that it has accreditation from an HHS approved accrediting organization that reviews network adequacy as a part of accreditation; or<br>• sufficient information related to its policies and procedures to determine the network meets the minimum federal requirements.<br>(5) If requested, an insurer must demonstrate it has standards and procedures in place to maintain an adequate network. |
| **Accreditation** | |
| **Federal Standard**<br>45 CFR 155.1045<br>45 CFR 156.275 | (1) An insurer must 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.<br>(2) An insurer without existing commercial or marketplace health plan accreditation, from an HHS recognized accrediting entity, must schedule an accreditation review during their first year of certification and receive accreditation prior to their second year of certification.<br>(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.<br>(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.<br>(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 must be completed prior to any application for recertification. |
| **Service Area** | |
| **Federal Standard**<br>45 CFR 155.1055 | Service area is the 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 must be established without regard to racial, ethnic, language, or health status-related factors or other factors that exclude specific high utilization, high cost, or medically underserved populations. |
| **State Standard** | An insurer may choose their service area as long as the service area is not smaller than a county. An insurer may seek authorization for a service area smaller than a county by submitting the information necessary for the Department to conduct a thorough review. Any request must be received by the Department at least 45 days prior to the form and binder filing deadlines. |
| **Rating Area** | |

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| **Federal Standard**<br>45 CFR 156.255 | The 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 Subsection R590-277-7(2)(b). An insurer's service area may contain more than one rating area, allowing an insurer to offer plans with a statewide service area while modifying rates based on allowed rating areas within that service area. |
| **Quality Improvement** | |
| **Federal Standard**<br>ACA §1311<br>ACA §2717<br>45 CFR 156.20<br>45 CFR 156.200<br>45 CFR 156.275<br>45 CFR 156.1130 | An insurer is required to implement and report on a quality improvement strategy or strategies consistent with standards of PPACA to disclose and report information on healthcare quality and outcomes and implement appropriate enrollee satisfaction surveys which include but are not limited to the implementation of:<br>• a payment structure for health care providers that provides incentives for improving health outcomes through the implementation of activities that includes quality reporting, effective case management, care coordination, chronic disease management, medication, and care compliance initiatives, including through the use of the medical home model, for treatment or services under the plan or coverage;<br>• 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;<br>• 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;<br>• wellness and health promotion activities; and<br>• activities to reduce health and health care disparities, including through 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**<br>42 USC § 18022<br>45 CFR 147.120<br>45 CFR 147.126<br>45 CFR 147.138<br>45 CFR 155 & 156<br>CMS Guidance Rules | (1) An insurer offering a QHP must offer at least one QHP at the silver coverage level and at least one QHP at the gold coverage level in each covered service area.<br>(2) An insurer must include a child-only plan at the same level of coverage as any QHP offered through either the individual marketplace or Small Business Health Options Program to individuals who, as of the beginning of the plan year, have not attained the age of 21. This requirement may be met by submitting an attestation that there is no substantive difference between having a child-only plan and issuing child-only policies, and the insurer accepts child-only enrollees.<br>(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.; and only be offered on the individual marketplace.<br>(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.<br>(5) Emergency services are covered with no prior authorization and at the in-network cost sharing level.<br>(6) An insurer is required to meet all annual limitations and cost sharing requirements without affecting the actuarial value of the plans within each of the metal tiers. An insurer must demonstrate that annual out of pocket cost sharing under the plan does not exceed the limits established by federal regulations.<br>(7) No lifetime limits on the dollar value of any Essential Health Benefit (EHB), including the specific benefits and services covered under the EHB Benchmark Plan may be included. Reasonable dollar limits for services are allowed, as long as there is no associated service or visit limit.<br>(9) An insurer must accept premiums from Ryan White HIV/AIDS programs, Indian tribal organizations, and state and federal government programs.<br>(10) An insurer is expected to comply with all federal and state laws related to rating rules, factors and tables used to determine rates. Rates must be based upon the analysis of the plan rating assumptions and rate increase justifications. |

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| **State Standard** | An insurer is expected to comply with applicable state and federal laws, regulations, and standards, meet all filing requirements outlined in Section R590-220, this Bulletin, and SERFF general instructions. |
| **Essential Health Benefits** | |
| **Federal Standard**<br>42 USC. § 18022<br>45 CFR 146.136<br>45 CFR 147.130<br>45 CFR 148.170<br>45 CFR 155.170<br>45 CFR 156.110<br>45 CFR 156.115<br>45 CFR 156.125<br>45 CFR 156.280 | (1) An insurer must offer coverage that is substantially equal to the coverage offered by the state's benchmark plan. This may be done by substituting benefits only if an insurer demonstrates the actuarial value of the substituted benefits.<br>(2) An insurer may not offer abortion coverage within their benefit plan except for meeting requirements of the Hyde Amendment. If an insurer chooses to offer abortion benefits apart from the Hyde Amendment, public funds are not allowed to be used to pay for these services. The summary of benefits should indicate if such benefit is being made available.<br>(3) Coverage must include preventive services without cost sharing requirements including deductibles, co-payments, and co-insurance. Covered preventive services include evidence-based items or services that have a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF); certain immunizations; and screenings provided for in Health Resources & Services Administration guidelines for infants, children, adolescents, and women (including compliance with standards related to benefits for and current recommendations of the USPSTF regarding breast cancer screening, mammography, and prevention).<br>(4) Coverage for the medical treatment of mental illness and substance use disorder must comply with the federal Mental Health Parity and Addiction Equity Act and applicable federal regulations. Any non-quantitative treatment limitations (NQTL) used in mental health and substance abuse disorders may not be more stringent than those used in applying limitations with respect to medical/surgical benefits. NQTLs include, but are not limited to:<br>• 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);<br>• formulary design for prescription drugs;<br>• network tier design;<br>• standards for provider admission to participate in a network, including reimbursement rates;<br>• plan methods for determining usual, customary, and reasonable charges;<br>• fail-first policies or step therapy protocols;<br>• exclusions based on failure to complete a course of treatment; and<br>• restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan or coverage. |
| **State Standard** | (1) Section R590-266, Utah Essential Health Benefits Package, adopts PEHP's 2013 Basic Plus Plan as Utah's EHB Benchmark Plan effective January 1, 2017.<br>(2) The Plan and Benefits template must list Utah's state mandated benefits. A detailed list of benefits in the Utah EHB plan and Utah's mandated benefits is posted in SERFF Plan Management General Instructions.<br>(3) Include the Utah Mental Health and Substance Abuse Parity Attestation on the Supporting Documentation tab of the form filing. |
| **Essential Health Benefit Formulary Review** | |
| **Federal Standard**<br>45 CFR 156.122<br>45 CFR 156.295 | (1) Coverage is required for at least the greater of one drug in every U.S. Pharmacopeia Convention category and class or the same number of drugs in each category and class as the benchmark plan.<br>(2) A pharmacy and therapeutics committee must be utilized.<br>(3) An insurer is required report data to HHS on prescription drug distribution and costs (paid by Pharmacy Benefit Management (PBM) or insurer): percentage of all prescriptions that were provided through retail pharmacies compared to mail-order pharmacies; percentage of prescriptions for which a generic drug was available and dispensed compared to all drugs dispensed, broken down by pharmacy type; aggregate amount and type of rebates, discounts or price concessions that the insurer or its contracted PBM negotiates that are attributable to patient utilization and passed through to the insurer; the total number |

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| | 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 retail pharmacies and mail-order pharmacies.<br>(4) An insurer must have standard, expedited, and external exception review processes.<br>(5) A insurer must make its' formulary drug list URL available and easily accessible in accordance with guidance from the marketplace and potential enrollees. |
| **State Standard** | (1) Compliance with Sections 31A-22-626, 31A-46-301 through 31A-46-304, EHB formulary standards, clinical appropriateness, utilization management or step therapy, and drug exception processes is expected<br>(2) Refer to the Department Bulletin 2022-1, Calendar Year 2023 Insulin Prescription Caps, for the price of insulin under a health benefit plan. |
| **Non-Discrimination Standards in Marketing and Benefit Design** | |
| **Federal Standard**<br>42 USC § 300gg-3<br>45 CFR 92<br>45 CFR 148.180<br>45 CFR 155.120<br>45 CFR 156.125<br>45 CFR 156.200<br>45 CFR 156.225 | (1) An insurer is required to:<br>• 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<br>• refrain from:<br>o adjusting premiums based on genetic information;<br>o discriminating on the basis of race, color, national origin, disability, age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, sex, gender identity, sexual orientation, or other health conditions;<br>o utilizing any preexisting condition exclusions;<br>o requesting/requiring genetic testing; or<br>o collecting genetic information from an individual prior to, or in connection with, enrollment in a plan or at any time for underwriting purposes; and placing all or most drugs for a specific condition on the highest cost tiers.<br>(2) An insurer may not employ marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs. |
| **State Standard** | All applicable laws and regulations regarding marketing apply. Non-discrimination reviews may be conducted to identify outliers in benefit design, prescription drugs, and marketing practices. |
| **Actuarial Value** | |
| **Federal Standard**<br>45 CFR 156.135<br>45 CFR 156.140 | Plans being offered at the various metal tiers, excluding catastrophic plans, need to meet the specified levels of actuarial value (or fall within the allowable variation):<br>• Bronze plan: 60% (58 to 62%)<br>• Expanded Bronze plan: 60% (58 to 65%)<br>• Silver plan: 70% (68 to 72%)<br>• Gold plan: 80% (78 to 82%)<br>• Platinum plan: 90% (88 to 92%) |
| **State Standard** | (1) Compliance with the federal actuarial values, including an insurer's compliance attestation.<br>(2) Expanded bronze plans must include justification and documentation in the actuarial memorandum. The justification for each expanded bronze plan should indicate the plan is a high deductible health plan, or provide evidence the plan has reasonable cost sharing (e.g. plan pays at least 50%) for at least one of the major services (primary care visits, specialists visits, emergency department, inpatient hospital, generic drugs, preferred brand drugs, or specialty drugs).<br>• The Department evaluates reasonable cost sharing by ensuring the insured pays ≤ 50% of the cost sharing based on a demonstration from an 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.<br>• For example: The plan has a generic copay of $15 before the deductible. The insurer should demonstrate the expected average eligible amount for generic drugs is $30 or less for that plan. |
| **Quality Rating Standards** | |
| **Federal Standard**<br>ACA 2794 | (1) For an insurer that meets the required participation criteria, HHS has implemented a quality reporting standard for all marketplaces with reporting requirements. |

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| 45 CFR 156.200<br>45 CFR 156.1105<br>45 CFR 156.1120<br>45 CFR 156.1125 | (2) An insurer is expected to provide plain language information / data on claim payment policies and practices, periodic financial disclosures, data on enrollment and disenrollment, number of denied claims, rating practices, cost sharing, and payments for out-of-network coverage, and enrollee rights to the marketplace, HHS, and the state insurance commissioner. |
| **State Standard** | In addition to federal quality reporting requirements, an insurer is required to comply with R590-271, Data Reporting for Consumer Quality Comparison. |
| **Rate Filing** | |
| **Federal Standard**<br>45 CFR 147.102<br>45 CFR 154.215<br>45 CFR 155.1020<br>45 CFR 156.80<br>45 CFR 156.210<br>45 CFR 156.255 | (1) Premium may vary by geographic rating area.<br>(2) A premium rate for the same plan is required to be the same on and off the marketplace.<br>(3) Rating is on a per member basis, optional for an SADP.<br>(4) A premium rate may vary by individual/family, rating area, age (3:1), and tobacco use (1.5:1)<br>(5) All rates filed in the individual market are set for an entire plan year and cannot be changed during the year. Small employer quarterly index rate changes are subject to state approval and guidance.<br>(6) Composite premium, average enrollee premium, is allowed in the small employer market as long as the plan meets specific requirements.<br>(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.<br>(8) A URRT is not applicable to an SADP. |
| **State Standard** | (1) An insurer's compliance with all federal and state laws and regulations related to rating rules, factors, and tables used to determine rates, Section R590-277-7.<br>(2) The Department will continue to effectuate its rate review program and will 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.<br>(3) Utah has an approved defined alternate tiered-composite rating methodology for small employer plans. The Utah alternate tiered-composite methodology, as indicated in Bulletin 2015-4, Small Employer Composite Rating – 2014 PPACA Compliant Health Benefit Plans, is the only method allowed in Utah:<br>• composite premiums are offered in a four-tiered rating structure: employee, employee + spouse, employee + child(ren), employee + spouse + child(ren);<br>• no additional tobacco load may be included in premiums, the tobacco rate must be the same as the non-tobacco rate for each age and geographic area combination;<br>• a composite option should be uniformly available to any small employer group without regard to size;<br>• rates must be based on enrollment at the beginning of the plan year and may not vary until renewal;<br>• composite rates for more than one plan must be based on the entire enrollment of the small employer group;<br>• an attestation to the compliance of an alternate tiered-methodology needs to be included in the rate filing.<br>(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. |
| **Plan Variations for Individuals Eligible for Cost Sharing** | |
| **Federal Standard**<br>45 CFR 155.1030<br>45 CFR 156.420 | (1) For plans in the individual market only, a QHP insurer is required to offer three silver plan cost sharing variations, 73%, 87%, and 94%. Silver plan variations must have a reduced annual limitation on cost sharing, cost sharing requirements, and actuarial values that meet the required levels within a de minimis range of +1/0%. Benefits, networks, non-EHB cost sharing, out-of-network cost sharing, and premiums must be consistent with the corresponding standard silver plan.<br><br>(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. |

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| | (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.<br>(4) Limited cost sharing plans must be equivalent to the standard plan in all benefits and cost sharing, except when the plan is used by an American Indian/Alaska Native enrolled in a QHP receiving services from an Urban Indian Organization or through referral under contract health services.<br>(5) SADPs are excluded from cost sharing reduction (CSR) requirements. |
| **State Standard** | To ensure a consistent approach to cost sharing across all plan variations, a QHP insurer to required to conform to prescribed cost sharing amounts. |
| **Stand Alone Dental Plans** | |
| **Federal Standard**<br>ACA 2791<br>45 CFR 155 & 156<br>45 CFR 155.1065<br>45 CFR 156.150<br>45 CFR 156.440 | (1) A SADP has the same QHP certification standards as a health benefit plan unless noted in the above sections. An SADP is not subject to the insurance market reform provisions of PPACA, such as guaranteed availability and renewability of coverage.<br>(2) A SADP must demonstrate there is a reasonable annual limitation on cost sharing for the pediatric EHB. "Reasonable" means any annual limitation on cost sharing that is at or below $375 for a plan with one child enrollee, and at or below $750 for a plan with two or more child enrollees.<br>(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 follow the marketplace certification filing process as described within this Bulletin. |
| **State Standard** | A SADP must comply with the Utah EHB Benchmark Plan that includes the following as pediatric dental EHB services; oral examinations, cleanings, fluoride, sealants, and x-rays. |

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

DATED this 25th day of April 2022.

Jonathan T. Pike
Insurance Commissioner