UTAH

POLICIES

State of Utah

GARY R. HERBERT
Governor
GREG BELL
Lieutenant Governor
NEAL T. GOOCH
Insurance Commissioner

Insurance Department

Premium Review Grant

Budget Narrative

The proposed budget totals $1,000,000.00 for the period August 9, 2010 through September 30, 2011, which will enhance the current review efforts for the State of Utah. Utah's current efforts for health insurance rate reviews are performed by the Health Division Director, Ms. Tanji Northrup. Approximately 2% of her time is allocated to review health insurance rates which equates to $1,784 annually. Utah will continue this level for the Maintenance of Effort requirement.

Personnel costs and fringe benefits have been estimated at $170,539, providing for two full time employees:

	FY10	FY11 Q1 (Oct-Dec)	FY11 Q2 (Jan-Mar)	FY11 Q3 (Apr-Jun)	FY11 Q4 (Jul-Sep)		Total	
Personnel	$ 6,943	$ 10,414	$ 10,414	$ 10,414	$ 10,935		$	49,119
	$ 6,943	$ 10,414	$ 10,414	$ 10,414	$ 10,935		$	49,119
		$ 34,713	$ 20,828	$ 20,828	$ 21,869	**Salary Budgeted**	**$**	**98,238**
Fringe	$ 5,065	$ 7,598	$ 7,598	$ 7,598	$ 8,291		$	36,151
Benefits	$ 5,065	$ 7,598	$ 7,598	$ 7,598	$ 8,291		$	36,151
		$ 25,327	$ 15,196	$ 15,196	$ 16,582		$	72,301
						Fringe Budgeted	**$**	**72,301**

Travel costs total $57,000. The estimate provides two out of state trainings for three employees (two rate analysts and the project director); and to be able to send employees to the next four National Association of Insurance Commissioner meetings.

Travel	FY10	FY11 Q1 (Oct-Dec)	FY11 Q2 (Jan-Mar)	FY11 Q3 (Apr-Jun)	FY11 Q4 (Jul-Sep)		Total	
NAIC	$ 6,000	$ 7,500	$ 6,000	$ -	$ 7,500		$	27,000
Rate Seminar/Training	$ -	$ -	$ -	$ 30,000	$ -		$	30,000
		$ 13,500	$ 6,000	$ 30,000	$ 7,500	**Travel Budgeted**	**$**	**57,000**

The equipment has been budgeted at $7,860 to include computers and applicable software licenses for the two rate analysts provided for in the personnel budget. It also includes perpetual costs for computer support and telephone charges.

Equipment	FY10	FY11 Q1 (Oct-Dec)	FY11 Q2 (Jan-Mar)	FY11 Q3 (Apr-Jun)	FY11 Q4 (Jul-Sep)		Total	
DTS Support	$ 480	$ 720	$ 720	$ 720	$ 720		$	3,360
Phone	$ 100	$ 100	$ 100	$ 100	$ 100		$	500
Computer & Programs	$ 4,000	$ -	$ -	$ -	$ -		$	4,000
		$ 5,400	$ 820	$ 820	$ 820	**Equipment Budgeted**	**$**	**7,860**

Supplies have been budgeted at $6000 to account for any miscellaneous supplies that may need to be purchased. There is a large portion of $2000 initially budgeted to purchase any necessary books or manuals.

	FY10	FY11 Q1 (Oct-Dec)	FY11 Q2 (Jan-Mar)	FY11 Q3 (Apr-Jun)	FY11 Q4 (Jul-Sep)		Total	
Supplies	$ 2,000	$ 1,000	$ 1,000	$ 1,000	$ 1,000		$	6,000
		$ 3,000	$ 1,000	$ 1,000	$ 1,000	**Supplies Budgeted**	**$**	**6,000**

The Contractual budget of $742,808 includes: a budget of $224,000 for services from an actuary to train the new rate analysts and develop a rate review manual for future use; a contractual payment of $18,808 to be made to the NAIC for an enhancement to the System for Electronic Rate and Form Filings in order to automate data collection for HHS and transparency publications; and a budget of $500,000 to contract with the State of Utah's Department of Technology Services Utah Interactive to develop and host a website for the transparency and disclosure of health insurance premium rates and rate filings.

Contractual	FY10	FY11 Q1 (Oct-Dec)	FY11 Q2 (Jan-Mar)	FY11 Q3 (Apr-Jun)	FY11 Q4 (Jul-Sep)		Total	
Actuary	$ -	$ 162,000	$ 37,000	$ 25,000			$	224,000
SERFF	$ 18,808	$ -	$ -	$ -	$ -		$	18,808
Utah Interactive	$ -	$ -	$ -	$ 500,000	$ -		$	500,000
		$ 180,808	$ 37,000	$ 525,000	$ -	**Contractual Budgeted**	**$**	**742,808**

A construction budget of $5000 has been included to allow for the redesign of existing office space to accommodate the rate analysts.

	FY10	FY11 Q1 (Oct-Dec)	FY11 Q2 (Jan-Mar)	FY11 Q3 (Apr-Jun)	FY11 Q4 (Jul-Sep)		Total	
Construction	$ 5,000	$ -	$ -	$ -	$ -		$	5,000
		$ 5,000	$ -	$ -	$ -	**Construction Budgeted**	**$**	**5,000**

A budget for the category other in the amount of $10,793 has been included for miscellaneous expenses and for mailing costs and publication to the general public to hold hearings for requests for substantial rate increases.

Other	FY10	FY11 Q1 (Oct-Dec)	FY11 Q2 (Jan-Mar)	FY11 Q3 (Apr-Jun)	FY11 Q4 (Jul-Sep)		Total	
Miscellaneous expense	$ 2,000	$ 800	$ 800	$ 600	$ 593		$	4,793
Rate Hearings:								
Mailing costs	$ -	$ 500	$ 500	$ 500	$ 500		$	2,000
Adverstisements	$ -	$ 1,000	$ 1,000	$ 1,000	$ 1,000		$	4,000
		$ 1,500	$ 1,500	$ 1,500	$ 1,500		$	6,000
		$ 4,300	$ 2,300	$ 2,100	$ 2,093	**Other Budgeted**	**$**	**10,793**

APPLICATION COVER SHEET AND CHECK-OFF LIST

Indentifying Information:

Grant Opportunity: **HHS Health Insurance Rate Review Grants-Cycle I**

DUNS #: **153901889** Grant Award: **$1 million**

Applicant: **Utah Department of Insurance**

Primary Contact Person, Name: **Tanji Northrup**

Telephone Number: **801-538-1801** Fax number: **801-538-3829**

Email address: **tnorthrup@utah.gov**

APPLICATION COVER SHEET AND CHECK-OFF LIST

REQUIRED CONTENTS

A complete proposal consists of the following material organized in the sequence below: Please ensure that the project narrative is page-numbered. The sequence is:

- ☐ Cover Sheet
- ☐ Forms/Mandatory Documents (Grants.gov).

  The following forms must be completed with an original signature and enclosed as part of the proposal:

- ☐ SF-424: Application for Federal Assistance
- ☐ SF-424A: Budget Information
- ☐ SF-424B: Assurances-Non-Construction Programs
- ☐ SF-LLL: Disclosure of Lobbying Activities
- ☐ Additional Assurance Certifications
- ☐ Required Letter of support and Memorandum of Agreement
- ☐ Applicant's Application Cover Letter
- ☐ Project Abstract
- ☐ Project Narrative
- ☐ Work plan and Time Line
- ☐ Proposed Budget (Narrative/Justifications)
- ☐ Required Appendices
- ☐ Resume/Job Description for Project Director and Assistant Director

GARY R. HERBERT
GOVERNOR

STATE OF UTAH
OFFICE OF THE GOVERNOR
SALT LAKE CITY, UTAH
84114-2220

GREG BELL
LIEUTENANT GOVERNOR

July 6, 2010

The Honorable Kathleen Sebelius
Secretary, Department of Health & Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

RE: Endorsement of Grant Application and Rate Review Activities

Dear Secretary Sebelius,

Please accept this letter as my endorsement for the Affordable Care Act (ACA) Grant for Health Insurance Premium Review. I support the Utah Insurance Department's ability to enhance the review process for health insurance premium rates and respectfully urge your careful review of the Utah grant application.

Should you have questions or comments about this matter, please contact Tanji Northrup at tnorthrup@utah.gov or 801-538-3829. Thank you for your attention to this very important grant application.

Sincerely,

Gary R. Herbert
Governor

cc: Tanji Northrup, Health Division Director
Utah Department of Insurance

State of Utah

GARY R. HERBERT
Governor
GREG BELL
Lieutenant Governor
NEAL T. GOOCH
Insurance Commissioner

Insurance Department

July 7, 2010

Office of Consumer Information and Insurance Oversight
200 Independence Avenue S.W.
Washington, D.C. 20201

Re: Grants to States for Health Insurance Premium Review - Cycle 1

Dear Sir/Madam;

Please accept this letter as the Utah Department of Insurance's cover letter for the Affordable Care Act Grant to States for Health Insurance Premium Review project.

The purpose of this grant application is to request a grant in the amount of $1,000,000.00. The Principal Investigator/Project Director for this project will be Tanji Northrup.

Ms. Tanji Northrup
3110 State Office Building
Salt Lake City, Utah 84114
801-538-1801

Our agency has existing authority to oversee and coordinate the proposed activities and is capable of convening a suitable working group of all relevant members. Additionally, I attest that the funds will not be used to supplant existing rate review activities.

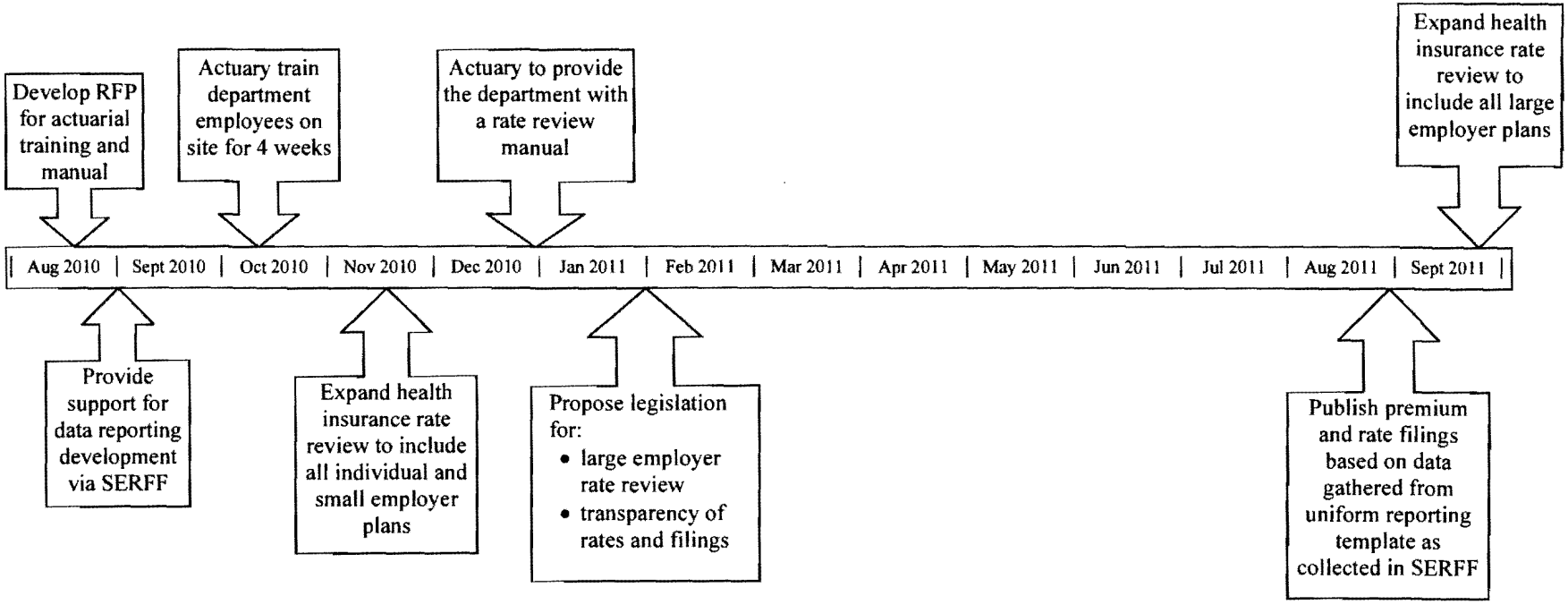
If you have any questions concerning our application please contact Tanji at the information above.

Sincerely,

Neal T. Gooch
Commissioner

Tanji Northrup
Director

Timeline


Develop RFP for actuarial training and manual
Actuary train department employees on site for 4 weeks
Actuary to provide the department with a rate review manual
Expand health insurance rate review to include all large employer plans
Aug 2010
Sept 2010
Oct 2010
Nov 2010
Dec 2010
Jan 2011
Feb 2011
Mar 2011
Apr 2011
May 2011
Jun 2011
Jul 2011
Aug 2011
Sept 2011
Provide support for data reporting development via SERFF
Expand health insurance rate review to include all individual and small employer plans
Propose legislation for:
• large employer rate review
• transparency of rates and filings
Publish premium and rate filings based on data gathered from uniform reporting template as collected in SERFF

State of Utah

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Premium Review Grant

Project Director Job Description and Biography

Job Description

TITLE: DIVISION DIRECTOR, HEALTH INSURANCE

JOB ID: 21034 **STATUS:** Active **EFFECTIVE DATE:** 07/01/2010

BENCHMARKED TO: INSURANCE SPECIALIST

SAFETY SENSITIVE: Personally Identifiable Private Information

SUPERVISORY LEVEL: Administrator

STEP RANGE: 0 - 0 **PAY RANGE:** $25.47 - $37.25 **FLSA EXEMPT:** Yes

EEO DESIGNATION: Officials & Administrators

CAREER SERVICE PROBATIONARY PERIOD: 24 months

WORKING CONDITIONS: Everyday Risks **PHYSICAL REQUIREMENTS:** Sedentary

PURPOSE AND DISTINGUISING CHARACTERISTICS

(Description of the job which distinguishes it from other job(s) in a series or family)

The incumbent in this job directs and manages the activities of the health insurance division in the department of insurance as it administers the laws regulating health insurance.

EXAMPLES OF TASKS

(More specific information about the job can be found in the Purpose and Distinguishing Characteristics. This list contains tasks that are typically associated with the job. It is not all-inclusive and may vary from position to position. Hiring agencies may, depending on the specific nature of the position, modify these tasks and/or identify additional tasks, based on a current position analysis.)

- Plans and manages projects and/or programs. Writes (or discusses) project/program plan(s), recommendation(s) and/or finding(s).
- Analyzes, summarizes and/or reviews data; reports findings, interprets results and/or makes recommendations.
- Supervises subordinate personnel including: hiring, determining workload and delegating assignments, training, monitoring and evaluating performance, and initiating corrective or disciplinary actions.
- Represents agency interests on key legislative issues, task forces, committees, etc., and/or draft legislation, find sponsors, propose amendments, etc.
- Works in a team effort to help the maintenance or service operations become successful.

- Other tasks as assigned.

KNOWLEDGE, SKILLS, AND ABILITIES

(This list contains KSAs that are typically associated with the job. It is not all-inclusive and may vary from position to position. Hiring agencies may, depending on the specific nature of the position, modify these KSAs and/or identify additional KSAs, based on a current position analysis.

- use logic to analyze or identify underlying principles, reasons, or facts associated with information or data to draw conclusions
- provide consultation and/or expert advice or testimony
- make a decision or solve a problem by using logic to identify key facts, explore alternatives, and propose quality solutions
- legal processes and procedures
- establish objectives and specify the strategies and actions to achieve these objectives
- identify the best person for a task, delegate assignments, and direct people as they work
- supervise others by assigning/directing work; conducting employee evaluations, staff training and development, taking appropriate disciplinary/corrective actions, making hiring/termination recommendations, etc.
- principles, theories, and practices of the legislative process

OTHER REQUIREMENTS

- Risks found in the typical office setting, which is adequately lighted, heated and ventilated,

e.g., safe use of office equipment, avoiding trips and falls, observing fire regulations, etc.

- Typically, the employee may sit comfortably to perform the work; however, there may be some walking; standing; bending; carrying light items; driving an automobile, etc. Special physical demands are not required to perform the work.

Biography

Tanji Northrup has 20 years of experience working in the health insurance arena. Tanji is the Director of the Health Insurance Division. As Director, she supervises personnel including; hiring, determining workload and delegations, training, monitoring, evaluating performance, initiating corrective and disciplinary actions, and staff development. She represents department on key legislative issues, task forces, committees, and draft legislation. Tanji drafts proposed legislation, and writes and revises Insurance Administrative Rules based on legislative changes and market adjustments. She advises department personnel, Office of the Commissioner, and the Utah Legislature regarding health insurance related issues. Tanji communicates with insurance companies, producers, consumers and other regulatory agencies regarding Utah and federal health insurance laws.

Tanji Northrup is a current member of the Utah Defined Contribution Board of Directors; and the Affordability and Access Community Working Group, Oversight and Implementation Community Working Group, and Administrative Simplification Technical Advisory Group of the Health System Reform Task Force.

Tanji Northrup started in the insurance industry managing claims of employee benefit plans for small business groups nationwide requiring oversight on payment of claims, determination of medical necessity, and application of state specific mandated health care

benefits. She supervised 17 team members, and acted as liaison between inter-office teams and team leader.

Tanji Northrup attended Salt Lake Community College receiving an Associate in Science in Business Management in 1991 and then continued her education at Westminster College receiving a Bachelor of Science Degree in Business Management with an emphasis in finance. At both colleges she was honored to be on the Dean's list.

Tanji is an active volunteer in the community at the Road Home, YWCA, Girl Scouts of Utah, and Redeemer Lutheran Church and School, where she served both as Secretary and Treasurer.

State of Utah

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Premium Review Grant

Project Assistant Director / Financial Officer Job Description and Biography

Job Description

TITLE: DIRECTOR, AGENCY ADMINISTRATIVE SERVICES

JOB ID: 14350 **STATUS:** Active **EFFECTIVE DATE:** 07/01/2010

BENCHMARKED TO: FINANCIAL ANALYST III

SAFETY SENSITIVE: [None]

SUPERVISORY LEVEL: Manager

STEP RANGE: 0 - 0 **PAY RANGE:** $29.17 - $43.82 **FLSA EXEMPT:** Yes

EEO DESIGNATION: Officials & Administrators

CAREER SERVICE PROBATIONARY PERIOD: 24 months

WORKING CONDITIONS: Everyday Risks **PHYSICAL REQUIREMENTS:** Sedentary

PURPOSE AND DISTINGUISING CHARACTERISTICS

(Description of the job which distinguishes it from other job(s) in a series or family)

This job manages and coordinates administrative support services to include; budget, human resources, finance, purchasing, inventory control and information technology services, etc. Incumbent manages a department which is small enough to require a single incumbent to coordinate the majority of these administrative functions. Duties include: formulating the departmental budget including interpretation of statistical and economical data and/or integration of departmental goals and budget constraints; review and approval of department expenditures, grant applications, contracts, cost alternatives and revenues, and monitors fiscal controls to insure accountability for all funds allocated to the department; determines, forecasts and recommends personnel and equipment needs; ensures department inventory is maintained; acts as liaison with State Human Resource Management, OPB, Legislative Offices, Fiscal Analyst, Purchasing, Finance, Central Stores, etc. Incumbent also supervises subordinate personnel including hiring recommendations, determining workload and delegating assignments, training, monitoring and evaluating performance, and initiating corrective or disciplinary actions to include termination; mediates and recommends solutions for personnel issues; researches answers for department Director/Commissioner concerning department operations and expenditures, etc.

EXAMPLES OF TASKS

(More specific information about the job can be found in the Purpose and Distinguishing Charactersitics. This list contains tasks that are typically associated with the job. It is not all-inclusive and may vary from position to position. Hiring agencies may, depending on the specific

nature of the position, modify these tasks and/or ident ify additional tasks, based on a current position analysis.)

- Manages one or more statewide or agency wide program(s). Determines program goals and objectives and/or chairs committees established to support the program.
- Manages accounting or budget activities and provides fiscal information.
- Manages and cultivates relationships with suppliers; develops alternative sources of supplies and make decisions relative to sources of supply.
- Coordinates and/or acts as a liaison between agency or work unit and other agencies, work units, organizations, suppliers, etc.
- Develops and/or interprets fiscal statements and reports.
- Identifies problems or potential problem areas and recommends solutions.
- Negotiates or mediates issues with internal and/or external agency representatives, and/ or concerned outside parties or their representatives. Settles or resolves issues or complaints.
- Supervises subordinate personnel including: hiring, determining workload and delegating assignments, training, monitoring and evaluating performance, and initiating corrective or disciplinary actions.
- Other tasks as assigned.

KNOWLEDGE, SKILLS, AND ABILITIES

(This list contains KSAs that are typically associated with the job. It is not all-inclusive and may vary from position to position. Hiring agencies may, depending on the specific nature of the position, modify these KSAs and/or identify additional KSAs, based on a current position analysis.

- control or direct the operation of a program or function
- determine how money will be spent to get the work done, and accounting for these expenditures
- principles, theories, and practices of budget management
- principles, theories, and practices of organizational dynamics
- make a decision or solve a problem by using logic to identify key facts, explore alternatives, and propose quality solutions
- speak clearly, concisely and effectively; listen to, and understand, information and ideas as presented verbally
- communicate information and ideas clearly, and concisely, in writing; read and understand information presented in writing
- applicable laws, rules, regulations and/or policies and procedures
- agency and/or organizational program(s)
- deal with people in a manner which shows sensitivity, tact, and professionalism
- coordinate the activities or tasks of people, groups and/or organization(s)

- property valuation
- act as an intermediate agent to help to resolve differences, conflicts or complaints
- supervise others by assigning/directing work; conducting employee evaluations, staff training and development, taking appropriate disciplinary/corrective actions, making hiring/termination recommendations, etc.

OTHER REQUIREMENTS

- Risks found in the typical office setting, which is adequately lighted, heated and ventilated, e.g., safe use of office equipment, avoiding trips and falls, observing fire regulations, etc.
- Typically, the employee may sit comfortably to perform the work; however, there may be some walking; standing; bending; carrying light items; driving an automobile, etc. Special physical demands are not required to perform the work.

Biography

Doyle C. Christensen has been serving as Director of Agency Administrative Services for the Utah Insurance Department since his appointment by Commissioner D. Kent Michie in August of 2007. He is responsible to manage and coordinate administrative support services and fiscal operations to include budget, finance, purchasing, inventory control, human resources and information technology services.

Doyle is a native of Utah having also lived twelve years in San Antonio and Austin, Texas. He is a graduate of the University of Texas at Austin with a Bachelor of Arts degree in

Sociology and Weber State College in Ogden, Utah with a Bachelor of Science degree in Accounting.

Doyle started his career with the State of Utah in June 1977. He worked 12 years for the Department of Human Services as an Eligibility Examiner and Human Services Supervisor responsible for determining eligibility for and supervising and coordinating public welfare programs. He then served 18 years as an Administrative Services Manager for the Department of Human Services and Department of Workforce Services. He was responsible to manage the fiscal operations for the North region within each department with an annual budget of approximately $24 million.

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Premium Review Grant

Total Estimated Time Spent on Project

Position Responsible	Project Activities	Beginning Time Period	Ending Time Period	Estimated Project Hours
Project Manager	Develop RFP for actuarial training and manual. Submit bid. Review bid. Award bid.	Aug 9, 2010	Sept 30, 2010	80
Project Manager	Hire two rate analysts. Provide training for both federal and Utah insurance laws and regulations. Contract actuary to provide four weeks in-depth rate review training.	Aug 9, 2010	Oct 29, 2010	960
Project Manager 2-Rate Analyst	Increase the number of health insurance rate fillings that are thoroughly reviewed and subsequently filed or prohibited.	Nov 1, 2010	Sept 30, 2011	3,840
Project Manager	Transparency of health insurance premiums and rate fillings.	Jan 1, 2011	Sept 30, 2011	740
Estimated Total Project Hours				**5,620**

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	$ 6,943	$ 10,414	$ 10,414	$ 10,414	$ 10,935		$	49,119
		$ 34,713	$ 20,828	$ 20,828	$ 21,869	**Salary Budgeted**	**$**	**98,238**
Fringe	$ 5,065	$ 7,598	$ 7,598	$ 7,598	$ 8,291		$	36,151
Benefits	$ 5,065	$ 7,598	$ 7,598	$ 7,598	$ 8,291		$	36,151
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Rate Seminar/Training	$ -	$ -	$ -	$ 30,000	$ -		$	30,000
		$ 13,500	$ 6,000	$ 30,000	$ 7,500	**Travel Budgeted**	**$**	**57,000**

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DTS Support	$ 480	$ 720	$ 720	$ 720	$ 720		$	3,360
Phone	$ 100	$ 100	$ 100	$ 100	$ 100		$	500
Computer & Programs	$ 4,000	$ -	$ -	$ -	$ -		$	4,000
		$ 5,400	$ 820	$ 820	$ 820	**Equipment Budgeted**	**$**	**7,860**

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Supplies	$ 2,000	$ 1,000	$ 1,000	$ 1,000	$ 1,000		$	6,000
		$ 3,000	$ 1,000	$ 1,000	$ 1,000	**Supplies Budgeted**	**$**	**6,000**

The Contractual budget of $742,808 includes: a budget of $224,000 for services from an actuary to train the new rate analysts and develop a rate review manual for future use; a contractual payment of $18,808 to be made to the NAIC for an enhancement to the System for Electronic Rate and Form Filings in order to automate data collection for HHS and transparency publications; and a budget of $500,000 to contract with the State of Utah's Department of Technology Services Utah Interactive to develop and host a website for the transparency and disclosure of health insurance premium rates and rate filings.

Contractual	FY10	FY11 Q1 (Oct-Dec)	FY11 Q2 (Jan-Mar)	FY11 Q3 (Apr-Jun)	FY11 Q4 (Jul-Sep)		Total	
Actuary	$ -	$ 162,000	$ 37,000	$ 25,000			$	224,000
SERFF	$ 18,808	$ -	$ -	$ -	$ -		$	18,808
Utah Interactive	$ -	$ -	$ -	$ 500,000	$ -		$	500,000
		$ 180,808	$ 37,000	$ 525,000	$ -	**Contractual Budgeted**	**$**	**742,808**

A construction budget of $5000 has been included to allow for the redesign of existing office space to accommodate the rate analysts.

	FY10	FY11 Q1 (Oct-Dec)	FY11 Q2 (Jan-Mar)	FY11 Q3 (Apr-Jun)	FY11 Q4 (Jul-Sep)		Total	
Construction	$ 5,000	$ -	$ -	$ -	$ -		$	5,000
		$ 5,000	$ -	$ -	$ -	**Construction Budgeted**	**$**	**5,000**

A budget for the category other in the amount of $10,792 has been included for miscellaneous expenses and for mailing costs and publication to the general public to hold hearings for requests for substantial rate increases.

Other	FY10	FY11 Q1 (Oct-Dec)	FY11 Q2 (Jan-Mar)	FY11 Q3 (Apr-Jun)	FY11 Q4 (Jul-Sep)		Total	
Miscellaneous expense	$ 2,000	$ 800	$ 800	$ 600	$ 592		$	4,792
Rate Hearings:								
Mailing costs	$ -	$ 500	$ 500	$ 500	$ 500		$	2,000
Adverstisements	$ -	$ 1,000	$ 1,000	$ 1,000	$ 1,000		$	4,000
		$ 1,500	$ 1,500	$ 1,500	$ 1,500		$	6,000
		$ 4,300	$ 2,300	$ 2,100	$ 2,092	**Other Budgeted**	**$**	**10,792**

ATTACHMENTS FORM

Instructions: On this form, you will attach the various files that make up your grant application. Please consult with the appropriate Agency Guidelines for more information about each needed file. Please remember that any files you attach must be in the document format and named as specified in the Guidelines.

Important: Please attach your files in the proper sequence. See the appropriate Agency Guidelines for details.

1) Please attach Attachment 1	1234-Cover Sheet.pdf	Add Attachment	Delete Attachment	View Attachment
2) Please attach Attachment 2	1235-Letter of Support.pdf	Add Attachment	Delete Attachment	View Attachment
3) Please attach Attachment 3	1236-Cover Letter.pdf	Add Attachment	Delete Attachment	View Attachment
4) Please attach Attachment 4	1237-Timeline.pdf	Add Attachment	Delete Attachment	View Attachment
5) Please attach Attachment 5	1238-Project Director Job Des	Add Attachment	Delete Attachment	View Attachment
6) Please attach Attachment 6	1239-Project Assistant Direct	Add Attachment	Delete Attachment	View Attachment
7) Please attach Attachment 7	1240-Time Allocation.pdf	Add Attachment	Delete Attachment	View Attachment
8) Please attach Attachment 8		Add Attachment	Delete Attachment	View Attachment
9) Please attach Attachment 9		Add Attachment	Delete Attachment	View Attachment
10) Please attach Attachment 10		Add Attachment	Delete Attachment	View Attachment
11) Please attach Attachment 11		Add Attachment	Delete Attachment	View Attachment
12) Please attach Attachment 12		Add Attachment	Delete Attachment	View Attachment
13) Please attach Attachment 13		Add Attachment	Delete Attachment	View Attachment
14) Please attach Attachment 14		Add Attachment	Delete Attachment	View Attachment
15) Please attach Attachment 15		Add Attachment	Delete Attachment	View Attachment

Budget Narrative File(s)

*** Mandatory Budget Narrative Filename:** 1241-Budget Narrative Brief.pdf

Add Mandatory Budget Narrative | **Delete Mandatory Budget Narrative** | **View Mandatory Budget Narrative**

To add more Budget Narrative attachments, please use the attachment buttons below.

Add Optional Budget Narrative | Delete Optional Budget Narrative | View Optional Budget Narrative

OMB Number: 4040-0003
Expiration Date: 7/30/2011

Key Contacts Form

*** Applicant Organization Name:**

INSURANCE, UTAH DEPT OF

Enter the individual's role on the project (e.g., project manager, fiscal contact).

*** Contact 1 Project Role:** FINANCIAL OFFICE / ASSISTANT PROJECT MANAGER

Prefix:	Mr.
* First Name:	DOYLE
Middle Name:	
* Last Name:	CHRISTENSEN
Suffix:	
Title:	DIRECTOR

Organizational Affiliation:

* Street1:	3110 STATE OFC BLDG
Street2:	
* City:	SALT LAKE CITY
County:	
* State:	UT: Utah
Province:	
* Country:	USA: UNITED STATES
* Zip / Postal Code:	84114
* Telephone Number:	8015383806
Fax:	8015383829
* Email:	DCHRISTENSEN@UTAH.GOV

OMB Number: 4040-0003
Expiration Date: 7/30/2011

Key Contacts Form

*** Applicant Organization Name:**

INSURANCE, UTAH DEPT OF

Enter the individual's role on the project (e.g., project manager, fiscal contact).

*** Contact 2 Project Role:** PROJECT MANAGER

Prefix:	Ms.
* First Name:	TANJI
Middle Name:	
* Last Name:	NORTHRUP
Suffix:	
Title:	DIRECTOR

Organizational Affiliation:

* Street1:	3110 STATE OFC BLDG
Street2:	
* City:	SALT LAKE CITY
County:	
* State:	UT: Utah
Province:	
* Country:	USA: UNITED STATES
* Zip / Postal Code:	84114
* Telephone Number:	8015381801
Fax:	8015383829
* Email:	TNORTHRUP@UTAH.GOV

OMB Number: 0980-0204
Expiration Date: 12/31/2009

Objective Work Plan

Project:

PREMIUM REVIEW GRANT

* Year: 1

* Funding Agency Goal:

Enhance Utah's current rate review process for health insurance premiums.

* Objective:

Create a comprehensive health insurance premium and rate filing review process. Increase the number of rate filings that are evaluated. Develop a meaningful and transparent process to disclose health insurance premiums and rate filings to the public, enrollees, policyholders and the HHS Secretary. Build infrastructure to collect, analyze, and report to the Secretary critical information about rate filings and the review and the file and prohibit process.

* Results or Benefits Expected:

Health insurance rate reviews by employees who are trained in complex actuarial concepts using a new rate review manual. Number of rate filings thoroughly reviewed increase. Transparency for health insurance premiums and rate filings.

* Activities	* Position Responsible	* Time Period Begin	* Time Period End	* Non-Salary Personnel Hours
Develop RFP for actuarial training and manual. Submit for bid. Review bid. Award bid.	Project Manager	08/09/2010	09/30/2010	80
Hire two rate analysts. Provide training for both federal and Utah insurance laws and regulations. Contract actuary to provide four weeks in-depth rate review training.	Project Manager	08/09/2010	10/29/2010	960
Increase the number of health insurance rate filings that are thoroughly reviewed and subsequently filed or prohibited.	Project Manager	11/01/2010	09/30/2011	3,840
Transparency of health insurance premiums and rate filings.	Project Manager	01/01/2011	09/30/2011	740

OMB Number: 0980-0204
Expiration Date: 12/31/2009

Objective Work Plan

* Activities	* Position Responsible	* Time Period Begin	* Time Period End	* Non-Salary Personnel Hours

* Criteria for Evaluating Results or Benefits Expected:

Two employees to be assigned to health insurance rate reviews. Employees trained by an actuary to assure the most complex concepts are taught. A health insurance rate review manual created. Number of rate filings thoroughly reviewed increase by more than 50% during the previous year. Health insurance premiums and rate filings are transparent to the public, enrollees, policyholders and the HHS Secretary.

OMB Number: 0980-0204
Expiration Date: 12/31/2009

Objective Work Plan

You may attach up to 17 additional Objective Work Plan forms here. To extract, fill and attach each additional form, follow these steps:

- Select the "Select to Extract the Objective Work Plan Attachment" button below.

- Save the file using a descriptive name to help you remember the content of the supplemental form that you are creating. When assigning a name to the file, please remember to give it the extension ".xfd" (for example, "Objective_1.xfd"). If you do not name your file with the ".xfd" extension you will be unable to open it later, using the PureEdge viewer software.

- Use the "Open Form" tool on the PureEdge viewer to open the new form you just saved.

- Enter your additional Objective information in this supplemental form, similar to the Objective Work Plan form that you see in the main body of your application.

- When you have completed entering information in the supplemental form, save and close it.

- Return to this page and attach the saved supplemental form you just filled in, to one of the blocks provided on this "attachments" form.

Important: Attach additional Objective Work Plan forms, using the blocks below. Please remember that the files you attach must be Objective Work Plan Pure Edge forms that were previously extracted using the process outlined above. Attaching any other type of file may result in the inability to submit your application to Grants.gov. Note: It is important to attach completed forms only. Attach ONLY PureEdge (.xfd) forms where ALL required fields are filled out. Incomplete or missing data will cause your application to be rejected.

1) Please attach Attachment 1
2) Please attach Attachment 2
3) Please attach Attachment 3
4) Please attach Attachment 4
5) Please attach Attachment 5
6) Please attach Attachment 6
7) Please attach Attachment 7
8) Please attach Attachment 8
9) Please attach Attachment 9
10) Please attach Attachment 10
11) Please attach Attachment 11
12) Please attach Attachment 12
13) Please attach Attachment 13
14) Please attach Attachment 14
15) Please attach Attachment 15
16) Please attach Attachment 16
17) Please attach Attachment 17

OMB Number: 4040-0010
Expiration Date: 08/31/2011

Project/Performance Site Location(s)

Project/Performance Site Primary Location ☐ I am submitting an application as an individual, and not on behalf of a company, state, local or tribal government, academia, or other type of organization.

Organization Name: UTAH DEPARTMENT OF INSURANCE

DUNS Number: 1539018890000

* Street1: 3110 STATE OFC BLDG

Street2:

* City: SALT LAKE CITY County:

* State: UT: Utah

Province:

* Country: USA: UNITED STATES

* ZIP / Postal Code: 84114-1207 * Project/ Performance Site Congressional District: UT-ALL

Project/Performance Site Location 1 ☐ I am submitting an application as an individual, and not on behalf of a company, state, local or tribal government, academia, or other type of organization.

Organization Name:

DUNS Number:

* Street1:

Street2:

* City: County:

* State:

Province:

* Country: USA: UNITED STATES

* ZIP / Postal Code: * Project/ Performance Site Congressional District:

Additional Location(s) Add Attachment | Delete Attachment | View Attachment

OMB Number: 4040-0003
Expiration Date: 09/30/2011

Project Abstract

The Project Abstract must not exceed one page and must contain a summary of the proposed activity suitable for dissemination to the public. It should be a self-contained description of the project and should contain a statement of objectives and methods to be employed. It should be informative to other persons working in the same or related fields and insofar as possible understandable to a technically literate lay reader. This Abstract must not include any proprietary/confidential information.

* Please click the add attachment button to complete this entry.

Add Attachment | Delete Attachment | View Attachment

1242-Project Abstract.pdf

Close Form

Project Narrative File(s)

*** Mandatory Project Narrative File Filename:** 1243-Project Narrative.pdf

Add Mandatory Project Narrative File | Delete Mandatory Project Narrative File | View Mandatory Project Narrative File

To add more Project Narrative File attachments, please use the attachment buttons below.

Add Optional Project Narrative File | Delete Optional Project Narrative File | View Optional Project Narrative File

OMB Number: 4040-0004
Expiration Date: 03/31/2012

Application for Federal Assistance SF-424

* 1. Type of Submission:
- [ ] Preapplication
- [x] Application
- [ ] Changed/Corrected Application

* 2. Type of Application:
- [x] New
- [ ] Continuation
- [ ] Revision

* If Revision, select appropriate letter(s):

* Other (Specify):

* 3. Date Received: 07/07/2010

4. Applicant Identifier:

5a. Federal Entity Identifier:

5b. Federal Award Identifier:

State Use Only:

6. Date Received by State:

7. State Application Identifier:

8. APPLICANT INFORMATION:

* a. Legal Name: INSURANCE, UTAH DEPT OF

* b. Employer/Taxpayer Identification Number (EIN/TIN): 876000545

* c. Organizational DUNS: 1539018890000

d. Address:

* Street1: 3110 STATE OFC BLDG
Street2:
* City: SALT LAKE CITY
County/Parish:
* State: UT: Utah
Province:
* Country: USA: UNITED STATES
* Zip / Postal Code: 84114-1207

e. Organizational Unit:

Department Name: UTAH DEPARTMENT OF INSURANCE

Division Name: HEALTH

f. Name and contact information of person to be contacted on matters involving this application:

Prefix: Ms.
* First Name: TANJI
Middle Name:
* Last Name: NORTHRUP
Suffix:

Title: HEALTH DIVISION DIRECTOR

Organizational Affiliation:

* Telephone Number: 8015381801
Fax Number: 8015383829

* Email: TNORTHRUP@UTAH.GOV

Application for Federal Assistance SF-424

*** 9. Type of Applicant 1: Select Applicant Type:**

A: State Government

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

* Other (specify):

*** 10. Name of Federal Agency:**

Ofc of Consumer Information & Insurance Oversight

11. Catalog of Federal Domestic Assistance Number:

93.511

CFDA Title:

Affordable Care Act (ACA) Grants to States for Health Insurance Premium Review

*** 12. Funding Opportunity Number:**

RFA-FD-10-999

* Title:

"Grants to States for Health Insurance Premium Review-Cycle I" Office of Consumer Information and Insurance Oversight (OCIIO)

13. Competition Identification Number:

ADOBE-FORMS-B

Title:

14. Areas Affected by Project (Cities, Counties, States, etc.):

Add Attachment | Delete Attachment | View Attachment

*** 15. Descriptive Title of Applicant's Project:**

PREMIUM REVIEW GRANT

Attach supporting documents as specified in agency instructions.

Add Attachments | Delete Attachments | View Attachments

Application for Federal Assistance SF-424

16. Congressional Districts Of:

* a. Applicant: UT-ALL b. Program/Project: UT-ALL

Attach an additional list of Program/Project Congressional Districts if needed.

Add Attachment | Delete Attachment | View Attachment

17. Proposed Project:

* a. Start Date: 08/09/2010 * b. End Date: 09/30/2011

18. Estimated Funding ($):

* a. Federal	1,000,000.00
* b. Applicant	0.00
* c. State	0.00
* d. Local	0.00
* e. Other	0.00
* f. Program Income	0.00
* g. TOTAL	1,000,000.00

*** 19. Is Application Subject to Review By State Under Executive Order 12372 Process?**

☐ a. This application was made available to the State under the Executive Order 12372 Process for review on .

☐ b. Program is subject to E.O. 12372 but has not been selected by the State for review.

☒ c. Program is not covered by E.O. 12372.

*** 20. Is the Applicant Delinquent On Any Federal Debt? (If "Yes," provide explanation in attachment.)**

☐ Yes ☒ No

If "Yes", provide explanation and attach

Add Attachment | Delete Attachment | View Attachment

21. *By signing this application, I certify (1) to the statements contained in the list of certifications and (2) that the statements herein are true, complete and accurate to the best of my knowledge. I also provide the required assurances** and agree to comply with any resulting terms if I accept an award. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties. (U.S. Code, Title 218, Section 1001)**

☒ ** I AGREE

** The list of certifications and assurances, or an internet site where you may obtain this list, is contained in the announcement or agency specific instructions.

Authorized Representative:

Prefix: Mr. * First Name: DOYLE

Middle Name:

* Last Name: CHRISTENSEN

Suffix:

* Title: DIRECTOR

* Telephone Number: 8015383806 Fax Number: 8015383829

* Email: DCHRISTENSEN@UTAH.GOV

* Signature of Authorized Representative: Tanji Northrup * Date Signed: 07/07/2010

BUDGET INFORMATION - Non-Construction Programs

OMB Approval No. 4040-0006
Expiration Date 07/30/2010

SECTION A - BUDGET SUMMARY

Grant Program Function or Activity (a)	Catalog of Federal Domestic Assistance Number (b)	Estimated Unobligated Funds		New or Revised Budget		
		Federal (c)	Non-Federal (d)	Federal (e)	Non-Federal (f)	Total (g)
1. Grants to States for Health Insurance Premium Review - Cycle 1	93.511	$	$	$ 1,000,000.00	$	$ 1,000,000.00
2.						
3.						
4.						
5. Totals		$	$	$ 1,000,000.00	$	$ 1,000,000.00

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Prescribed by OMB (Circular A -102) Page 1

SECTION B - BUDGET CATEGORIES

6. Object Class Categories	GRANT PROGRAM, FUNCTION OR ACTIVITY (1)	(2)	(3)	(4)	Total (5)
	Grants to States for Health Insurance Premium Review - Cycle 1				
a. Personnel	$ 98,238.00	$	$	$	$ 98,238.00
b. Fringe Benefits	72,301.00				72,301.00
c. Travel	57,000.00				57,000.00
d. Equipment	7,860.00				7,860.00
e. Supplies	6,000.00				6,000.00
f. Contractual	742,808.00				742,808.00
g. Construction	5,000.00				5,000.00
h. Other	10,793.00				10,793.00
i. Total Direct Charges (sum of 6a-6h)	1,000,000.00				$ 1,000,000.00
j. Indirect Charges					$
k. TOTALS (sum of 6i and 6j)	$ 1,000,000.00	$	$	$	$ 1,000,000.00
7. Program Income	$	$	$	$	$

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Prescribed by OMB (Circular A -102) Page 1A

SECTION C - NON-FEDERAL RESOURCES

(a) Grant Program	(b) Applicant	(c) State	(d) Other Sources	(e)TOTALS
8. Grants to States for Health Insurance Premium Review - Cycle 1	$ 0.00	$ 0.00	$ 0.00	$ 0.00
9.				
10.				
11.				
12. TOTAL (sum of lines 8-11)	$	$	$	$

SECTION D - FORECASTED CASH NEEDS

	Total for 1st Year	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
13. Federal	$ 1,000,000.00	$ 272,048.00	$ 83,144.00	$ 594,944.00	$ 49,864.00
14. Non-Federal	$	0.00	0.00	0.00	0.00
15. TOTAL (sum of lines 13 and 14)	$ 1,000,000.00	$ 272,048.00	$ 83,144.00	$ 594,944.00	$ 49,864.00

SECTION E - BUDGET ESTIMATES OF FEDERAL FUNDS NEEDED FOR BALANCE OF THE PROJECT

(a) Grant Program	FUTURE FUNDING PERIODS (YEARS) (b)First	(c) Second	(d) Third	(e) Fourth
16. Grants to States for Health Insurance Premium Review - Cycle 1	$ 1,000,000.00	$ 1,000,000.00	$ 1,000,000.00	$ 1,000,000.00
17.				
18.				
19.				
20. TOTAL (sum of lines 16 - 19)	$ 1,000,000.00	$ 1,000,000.00	$ 1,000,000.00	$ 1,000,000.00

SECTION F - OTHER BUDGET INFORMATION

21. Direct Charges:

22. Indirect Charges:

23. Remarks:

OMB Approval No.: 4040-0007
Expiration Date: 07/30/2010

ASSURANCES - NON-CONSTRUCTION PROGRAMS

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

NOTE: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant, I certify that the applicant:

1. Has the legal authority to apply for Federal assistance and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project cost) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States and, if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standards or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standards for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C.§§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U. S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee- 3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to nondiscrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and, (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Titles II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally-assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally-assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetlands pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clean Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended (P.L. 93-523); and, (h) protection of endangered species under the Endangered Species Act of 1973, as amended (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead-based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."

18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations, and policies governing this program.

* SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	* TITLE
Tanji Northrup	DIRECTOR
* APPLICANT ORGANIZATION	* DATE SUBMITTED
INSURANCE, UTAH DEPT OF	07/07/2010

Standard Form 424B (Rev. 7-97) Back

DISCLOSURE OF LOBBYING ACTIVITIES

Complete this form to disclose lobbying activities pursuant to 31 U.S.C.1352

Approved by OMB
0348-0046

1. * Type of Federal Action:
- [ ] a. contract
- [x] b. grant
- [ ] c. cooperative agreement
- [ ] d. loan
- [ ] e. loan guarantee
- [ ] f. loan insurance

2. * Status of Federal Action:
- [ ] a. bid/offer/application
- [x] b. initial award
- [ ] c. post-award

3. * Report Type:
- [x] a. initial filing
- [ ] b. material change

4. Name and Address of Reporting Entity:

[x] Prime [ ] SubAwardee

*Name: UTAH DEPARTMENT OF INSURANCE

*Street 1: 3110 STATE OFC BLDG Street 2:

*City: SALT LAKE CITY State: UT: Utah Zip: 84114

Congressional District, if known:

5. If Reporting Entity in No.4 is Subawardee, Enter Name and Address of Prime:

6. * Federal Department/Agency:

Ofc of Consumer Information & Insurance

7. * Federal Program Name/Description:

Affordable Care Act (ACA) Grants to States for Health Insurance Premium Review

CFDA Number, *if applicable:* 93.511

8. Federal Action Number, *if known:*

9. Award Amount, *if known:*

$

10. a. Name and Address of Lobbying Registrant:

Prefix: *First Name: N/A Middle Name:

*Last Name: N/A Suffix:

*Street 1: Street 2:

*City: State: Zip:

b. Individual Performing Services (including address if different from No. 10a)

Prefix: *First Name: N/A Middle Name:

*Last Name: N/A Suffix:

*Street 1: Street 2:

*City: State: Zip:

11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when the transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

*** Signature:** Tanji Northrup

***Name:** Prefix: *First Name: TANJI Middle Name:

*Last Name: NORTHRUP Suffix:

Title: DIRECTOR **Telephone No.:** 8015381831 **Date:** 07/07/2010

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Standard Form - LLL (Rev. 7-97)

State of Utah

GARY R. HERBERT
Governor
GREG BELL
Lieutenant Governor
NEAL T. GOOCH
Insurance Commissioner

Insurance Department

Premium Review Grant

Project Abstract

The Premium Review Grant Project will enhance Utah's current rate review process for health insurance premiums. The goals for this project are:

- Create a comprehensive health insurance premium and rate filing review process.
- Increase the number of health insurance premiums and rate filings that are evaluated.
- Develop a meaningful and transparent process to disclose health insurance premiums and rate filings to the public, enrollees, policyholders and the HHS Secretary.
- Build infrastructure to collect, analyze, and report to the Secretary critical information about rate filings and the review and the file and prohibit process.

The total budget for this project is $1,000,000.00, to be funded by the grant. There are no additional resources other than what the State currently has in place for health insurance rate review.

This grant will allow Utah to enhance the current health insurance rate review process by providing department employees the knowledge and resources necessary to complete an in-depth review; expanding the scope of reviews to include large employer rates; increasing the number of filings reviewed; developing a system to collect and report data relevant to health insurance rate filings; and creating a process to disclose health insurance premiums and rate filings.

State of Utah
GARY R. HERBERT
Governor
GREG BELL
Lieutenant Governor
NEAL T. GOOCH
Insurance Commissioner

Insurance Department

Project Narrative

The Utah Insurance Department requests approval for the Premium Review Grant to expand and enhance the process for health insurance rate review which includes disclosing rates to the public and to the HHS Secretary. Utah currently reviews individual and small employer health insurance rate filings. The department proposes the grant will provide resources to allow for a thorough review of all individual, small and large group health insurance rate filings.

CURRENT HEALTH INSURANCE RATE REVIEW CAPACITY AND PROCESS

- General health insurance rate regulation information:
    - With the exception of large employer groups, Utah regulates all types of health insurance products.
    - Current rating rules currently combine both the individual and small employer markets. The rating structure is considered a modified adjusted commuting rating model. Base rates established by an insurer are loaded with allowable case characteristics and risk characteristics. The current allowable case characteristics are age, gender, family composition, geographic location, group size (limited to 20%), and industry (limited to 15%). The rate can be adjusted due to the health status of the group and/or individual. The adjustment for health status is limited to an increase of no more than 86% through the use of rating bands. Refer to Appendices 1 and 2 for applicable statute and rule.

- Health insurance rate review and filing requirements:
    - Types of Filings.

      Insurers are required to file rate manuals 30 days prior to use. Rate manuals are accepted by the Department as FILE BEFORE USE filings. 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. Insurers are required to include the following items in their filing:

        - an actuarial certification signed by a qualified actuary;
        - a list of the case characteristics and rate factors to be used, applied in the same manner for all health benefit plans in a class;
        - specific area factor and industry factors applicable in Utah;
        - the method of calculating the risk load, including the method used to determine any experience factors;
        - how the overall rate is reviewed for compliance with the rate restrictions; and
        - detailed description of all classes of business, as provided in Section 31A-30-105.

      Some changes initiated by an insurer are considered a change in the rating methodology. A change in rating methodology requires prior approval by the Commissioner and is submitted as a FILE FOR APPROVAL filing. In addition to the above information, an insurer must also include in a methodology change filing:

        - a complete description of each of the proposed modifications to the rating method;

- a description of how the change in rating method would affect the premium rates currently charged to individuals and small employers in the class of business, including an estimate from a qualified actuary of the number of groups or individuals, and a description of the types of groups or individuals, whose premium rates may change by more than 10% due to the proposed change in rating method, not including general increases in premium rates applicable to all individuals and small employers in a health benefit plan;
- a certification from a qualified actuary that the new rating method would be based on objective and credible data and would be actuarially sound and appropriate; and
- a certification from a qualified actuary that the proposed change in rating method would not produce premium rates for individuals and small employers that would be in violation of Sections 31A-30-106 and 31A-30- 106.5.

A sample rate filing is attached.

- Filing Process.

The rate review process starts when an insurer submits a filing to the state through the System for Electronic Rate and Form Filings (SERFF). The Rate and Form Examiner will open and perform a cursory review of the filing to determine if all required information and forms have been completed and attached.

- If the filing is not complete the Examiner will REJECT the filing. A filing that is rejected means the filing was not submitted in accordance with Utah laws and rules, is being returned to the filer, and is not considered filed with the department.

- If the filing is complete, the Examiner will assign the filing to the Rate Analyst (due to budget cuts the Health Division Director performs the duties of the Rate Analyst). The Rate Analyst will perform another cursory review of the filing. If the filing is acceptable and there are no outstanding issues regarding rates with the insurer, the Rate Analyst will close the filing without further review. If the Rate Analyst identifies an error or problem with the filing during their cursory review, the Rate Analyst will review the filing in greater detail. If there are areas that are non-compliant with laws and rules, the Rate Analyst will issue a Filing Objection Letter. The insurer usually has 30 days to respond to the Filing Objection Letter. If the insurer does not respond to the Filing Objection Letter, an Order to Prohibit Use will be issued. The insurer has 15 days to request a hearing once an order has been issued.
- Consultants are not utilized in the health insurance rate review process. If the Rate Analyst does not have the expertise necessary, the Insurance Department does have an actuary on staff with whom they may consult. However, the department actuary does not perform rate manual reviews.

o Legal authority for rate review and requirements for evaluation are provided in Utah Code Annotated (UCA) § 31A-30-106, Appendix 1, and Utah Administrative Code (UAC) Rule R590-167, Appendix 2.

o Rates requiring approval are approved prospectively, UCA § 31A-2-302, Appendix 3, and UAC Rule R590-220, Appendix 5. Modified or rejected rate filings are applied prospectively or retrospectively pursuant to UCA §§ 31A-21-107, Appendix 4, 31A-21-201, Appendix 6, and UAC Rule R590-220, Appendix 5.

- Many factors can be considered during the review of a rating manual. Factors such as the Rate Analyst's knowledge of the insurer and the actuary who signed the opinion, as well as the wording of the opinion itself, are important. The Rate Analyst should review the manual for compliance with applicable laws and rules.
    - The key element of the rating requirements is that within a given class of business, the highest rate which may be offered cannot exceed the lowest rate which may be offered by more than 86%. This requirement applies to groups with similar case characteristics, which allows the carrier to vary rates by elements such as age, gender, geography, dependent categories, group size, and industry. In addition, insurers are allowed to vary rates for different plan design features. However, for groups with similar case characteristics and plan designs, the variation is limited to plus or minus 30% of the rate range midpoint (with 130% divided by 70% = 1.86, or 86% total variation).
    - Insurers are also allowed to vary rating requirements for different rating periods. A rating period would normally be a six or twelve month period beginning with a given renewal month. The rating process can be described as a two step procedure. First, a premium rate is determined based on case characteristics and plan design, but without regard to other risk characteristics. Second, the rate may be adjusted, subject to the limits, to reflect other such risk characteristics. This adjustment must apply uniformly to all members of the group. In addition to the requirement that the rates within a class of business fall within a band of plus or minus 30%, the rate increase given to any particular group cannot exceed the rate increase for the new business rate or lowest rate available (base premium rate) by more than 15%. Thus, if a

carrier were to hold its rates level for new business and there were no changes in the group's case characteristics, no group could receive an annual rate increase of greater than 15% of the base premium rate. If new business rates were increased by 10%, then carriers could increase other group rates by as much as that 10% plus an additional 15% for a total increase of 25% of the base premium rates.

- The Rate Analyst should also review and test for compliance classes of business and case characteristics including age, gender, family composition, geographic location, industry and group size.

- The department attempts to review all rate manuals prospectively. However, in some cases a retrospective review may be triggered. Retrospective reviews take place when a consumer complaint is received and the company's response suggests that the rates may be non-compliant. If such retrospective review occurs and it is determined that rates are non-compliant, the department pursues rebates or premium credits to be provided to the insured pursuant to UCA § 31A-21-302(3), Appendix 7.

- Information Technology (IT) resources.
  - All form and rate filings must be submitted via SERFF. The Rate Analysts utilize SERFF, Adobe and Microsoft Office and Excel during the review process.
- Budget and staffing
  - The Utah Department of Insurance annual budget is $9,485,600.
  - The current resources allocated to rate review for health insurance coverage in the individual and small employer group markets is limited to 2% of the workload for the Health Division Director, $1,784 annually. This grant application includes a copy of the job description and biography for the Health Division Director, Tanji Northrup.

- The department has received 94 individual and small employer rate filings so far this year, 163 in 2009, and 111 in 2008. It takes approximately 40 hours to complete a thorough review of a rate manual.

- Consumer protections:
  - Health insurance rate filings are currently protected records pursuant to Utah Code Annotated § 31A-30-106(4)(h), Appendix 1.
  - Summaries of rate changes are not required.
  - An insurer is required to provide an individual policyholder 45 days advanced notice prior to a rate change. Notification for group policies, small and large, is governed by the language in the contract.
  - Public meetings and/or hearings on rate filings are not currently held. Therefore, consumers are not provided any type of a comment period to review and comment on proposed rate changes.
  - The department's compliance system does not track the reason codes. We do publish an annual Health Insurance Market Report which summarizes the complaints and is available at http://www.insurance.utah.gov/health/healthreports.html.

Table 6. Complaints Filed with OCHA by Reason: 1999 – 2008

	Total [a]		Claim Handling		Policyholder Services		Marketing & Sales	
Year	Count	Percent of Total	Count	Percent of Total	Count	Percent of Total	Count	Percent of Total
1999	326	100.0%	218	66.9%	80	24.5%	28	8.6%
2000	244	100.0%	163	66.8%	31	12.7%	50	20.5%
2001	265	100.0%	174	65.7%	74	27.9%	17	6.4%
2002	175	100.0%	125	71.4%	44	25.1%	6	3.4%
2003	120	100.0%	77	64.2%	39	32.5%	4	3.3%
2004	136	100.0%	65	47.8%	57	41.9%	14	10.3%
2005	124	100.0%	71	57.3%	44	35.5%	9	7.3%
2006	107	100.0%	56	52.3%	35	32.7%	16	15.0%
2007	72	100.0%	18	25.0%	9	12.5%	45	62.5%
2008	106	100.0%	68	64.2%	27	25.5%	11	10.4%
Average	**168**	**100.0%**	**104**	**61.9%**	**44**	**26.2%**	**20**	**11.9%**

Data Source: Utah Insurance Department

[a] A complaint may have more than one reason code, so totals may be slightly higher than the actual number of complaints

Note. Policyholder Services includes complaints regarding policyholder services and underwriting practices. Percentages may not total exactly due to rounding.

- Examination and Oversight:
    - No formal actions have been taken against insurance companies over the past two plan years regarding health insurance rates.
    - No formal hearings have been held over the past two plan years regarding health insurance rates.

PROPOSED RATE REVIEW ENHANCEMENTS FOR HEALTH INSURANCE

The grant awards will be used to further develop, expand and improve our current existing rate review and approval practices. The Insurance Department will expand and strengthen the existing health insurance rate review process; and propose legislative changes to expand rate review authority to include large employer groups, engage consumers and eliminate barriers to rate transparency.

- **Expanding the scope of current review and approval activities:** Grant funds will be used to increase the number and expand the scope of reviews that are currently being conducted. Health insurance rate filings currently receive very minimal review. The goal is to have at least 50% of all health insurance individual and small employer rate filings thoroughly reviewed.
- **Enhancing rate review process-Staffing & Training:** Grant funds will be used to contract with a qualified actuary to train two new rate analysts, whose duties will focus only on review of health insurance rate filings. Additional funds have been budgeted to provide additional off-site training. Grant funds will be used to contract with a qualified actuary to create a manual. Currently only 2% of the Health Division Director's time is dedicated to review of health insurance rate review. The hiring process will begin immediately after notification of grant approval. The budget also provides for an actuary to spend four weeks

in October 2010 to train the two new rate analysts on actuarial methods, analysis and reviews. One hundred additional hours has been allocated to the actuary to create a rate review manual. It is envisioned the manual will be a resource for current and future analysts.

- **Enhancing rate review process-IT capacity:** Grant funds will be used to improve the IT infrastructure to support data exchange capabilities both within the State as well as with the Federal government in preparation for enhanced data reporting requirements. The grant budget provides for a contract with the NAIC to further develop SERFF. It is anticipated that SERFF will collect the information that is required to be report to the Secretary. Additionally, the enhancement should interact with the web-based transparency database proposed below.
- **Enhancing consumer protection standards-Transparency:** Grant funds have been budgeted to enhance transparency in both the rate filing process and health insurance premium, implementing of a public hearing process; and providing consumers with increased advanced notice before rate changes become effective. The two large hurdles for increased transparency are legislative changes to allow public access to rate filings and creating and populating of a web-based transparency database. It is envisioned that the database will allow consumers to compare health insurance premium rates between insurers, view requested rate changes, and provide meaningful data related to the cost of health insurance. Proposed legislative changes will be provided to the Utah State Legislature to be considered during the 2011 session. Upon grant approval, work will begin immediately on the development of the web-based transparency database. The budget includes $500,000 for the development and support of the database.

REPORTING TO THE SECRETARY ON RATE INCREASE PATTERNS

Utah attests that it will comply with the reporting requirements required by law and the Secretary. It is our intention to contract with SERFF to improve our current IT system. We do not currently collect or report trend data and will use Cycle I grant funds to develop a plan to enhance capacity for data collection. The below information will be collected for each rate filing in the individual, small employer and large group markets.

- Company Name and contact information
- Number of policy forms covered by the filing
- Policy form number(s) covered by the filing
- Product types (HMO; PPO; etc.)
- Market segment (individual; small group; large group)
- Type of insurer (for-profit, non-profit)
- Whether the products are opened or closed
- Enrollment in each policy and rating form
- Member months in each policy form
- Annual rate
- Total earned premiums in each policy form
- Total incurred claims in each policy form
- Average rate increase initially requested
- Rate review category (approved as originally submitted; initially rejected and resubmitted with modifications; initially rejected and not resubmitted; initially rejected and challenged)
- Average rate increase approved
- Effective date of rate increase

- Number of policyholders or members affected by each policy form
- Overall annual medical trend factor assumptions in each rate filing for all benefits and disaggregated by benefit category
- Any changes in member cost-sharing over the prior year associated with the submitted rate filing
- Any changes in member benefits over the prior year associated with the submitted rate filing
- Aggregate data to include:
    - Number and percentage of rate filings reviewed by;
        - Plan Year
        - Segment type (individual market; small group; large group)
        - Product type (PPO, HMO, etc.)
        - Number of Policyholders
        - Number of covered lives affected
    - Report on the average rate increase by;
        - Plan Year
        - Segment type (individual market; small group; large group)
        - Product type (PPO, HMO, etc.)

Appendix 1

Utah
Insurance Code

TITLE 31A -- INSURANCE CODE...Chapter 30 -- INDIVIDUAL, SMALL EMPLOYER, AND GROUP HEALTH INSURANCE ACT...Part 1. Individual and Small Employer Group

31A-30-101

"Individual, small employer, and group health insurance act"

This chapter is known as the "Individual, Small Employer, and Group Health Insurance Act."

31A-30-102

Purpose

The purpose of this chapter is to:

(1) prevent abusive rating practices;

(2) require disclosure of rating practices to purchasers;

(3) establish rules regarding:

(a) a universal individual and small group application; and

(b) renewability of coverage;

(4) improve the overall fairness and efficiency of the individual and small group insurance market;

(5) provide increased access for individuals and small employers to health insurance; and

(6) provide an employer with the opportunity to establish a defined contribution arrangement for an employee to purchase a health benefit plan through the Internet portal created by Section 63M-1-2504.

31A-30-103

Definitions

As used in this chapter:

(1) "Actuarial certification" means a written statement by a member of the American Academy of Actuaries or other individual approved by the commissioner that a covered carrier is in compliance with Section 31A-30-106, based upon the examination of the

covered carrier, including review of the appropriate records and of the actuarial assumptions and methods used by the covered carrier in establishing premium rates for applicable health benefit plans.

(2) "Affiliate" or "affiliated" means any entity or person who directly or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with, a specified entity or person.

(3) "Base premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or that could have been charged under a rating system for that class of business by the covered carrier to covered insureds with similar case characteristics for health benefit plans with the same or similar coverage.

Text of subsection (4) effective until January 1, 2011

(4) "Basic coverage" means the coverage provided in the Basic Health Care Plan under Section 31A-22-613.5.

Text of subsection (4) effective January 1, 2011

(4) "Basic benefit plan" or "basic coverage" means the coverage provided in the Basic Health Care Plan under Section 31A-22-613.5.

(5) "Carrier" means any person or entity that provides health insurance in this state including:

(a) an insurance company;

(b) a prepaid hospital or medical care plan;

(c) a health maintenance organization;

(d) a multiple employer welfare arrangement; and

(e) any other person or entity providing a health insurance plan under this title.

(6) (a) Except as provided in Subsection (6)(b), "case characteristics" means demographic or other objective characteristics of a covered insured that are considered by the carrier in determining premium rates for the covered insured.

(b) "Case characteristics" do not include:

(i) duration of coverage since the policy was issued;

(ii) claim experience; and

(iii) health status.

Text of subsection (7) effective until January 1, 2011

(7) "Class of business" means all or a separate grouping of covered insureds established under Section 31A-30-105.

Text of subsection (7) effective January 1, 2011

(7) "Class of business" means all or a separate grouping of covered insureds that is permitted by the department in accordance with Section 31A-30-105.

(8) "Conversion policy" means a policy providing coverage under the conversion provisions required in Chapter 22, Part 7, Group Accident and Health Insurance.

(9) "Covered carrier" means any individual carrier or small employer carrier subject to this chapter.

(10) "Covered individual" means any individual who is covered under a health benefit plan subject to this chapter.

(11) "Covered insureds" means small employers and individuals who are issued a health benefit plan that is subject to this chapter.

(12) "Dependent" means an individual to the extent that the individual is defined to be a dependent by:

(a) the health benefit plan covering the covered individual; and

(b) Chapter 22, Part 6, Accident and Health Insurance.

(13) "Established geographic service area" means a geographical area approved by the commissioner within which the carrier is authorized to provide coverage.

(14) "Index rate" means, for each class of business as to a rating period for covered insureds with similar case characteristics, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate.

(15) "Individual carrier" means a carrier that provides coverage on an individual basis through a health benefit plan regardless of whether:

(a) coverage is offered through:

(i) an association;

(ii) a trust;

(iii) a discretionary group; or

(iv) other similar groups; or

(b) the policy or contract is situated out-of-state.

(16) "Individual conversion policy" means a conversion policy issued to:

(a) an individual; or

(b) an individual with a family.

(17) "Individual coverage count" means the number of natural persons covered under a carrier's health benefit products that are individual policies.

(18) "Individual enrollment cap" means the percentage set by the commissioner in accordance with Section 31A-30-110.

(19) "New business premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or offered, or that could have been charged or offered, by the carrier to covered insureds with similar case characteristics for newly issued health benefit plans with the same or similar coverage.

Text of subsections (20) to (28) effective until January 1, 2011

(20) "Plan year" means the year that is designated as the plan year in the plan document of a group health plan, except that if the plan document does not designate a plan year or if there is not a plan document, the plan year is:

(a) the deductible or limit year used under the plan;

(b) if the plan does not impose a deductible or limit on a yearly basis, the policy year;

(c) if the plan does not impose a deductible or limit on a yearly basis and either the plan is not insured or the insurance policy is not renewed on an annual basis, the employer's taxable year; or

(d) in any case not described in Subsections (20)(a) through (c), the calendar year.

(21) "Preexisting condition" is as defined in Section 31A-1-301.

(22) "Premium" means all monies paid by covered insureds and covered individuals as a condition of receiving coverage from a covered carrier, including any fees or other contributions associated with the health benefit plan.

(23) (a) "Rating period" means the calendar period for which premium rates established by a covered carrier are assumed to be in effect, as determined by the carrier.

(b) A covered carrier may not have:

(i) more than one rating period in any calendar month; and

(ii) no more than 12 rating periods in any calendar year.

(24) "Resident" means an individual who has resided in this state for at least 12 consecutive months immediately preceding the date of application.

(25) "Short-term limited duration insurance" means a health benefit product that:

(a) is not renewable; and

(b) has an expiration date specified in the contract that is less than 364 days after the date the plan became effective.

(26) "Small employer carrier" means a carrier that provides health benefit plans covering eligible employees of one or more small employers in this state, regardless of whether:

(a) coverage is offered through:

(i) an association;

(ii) a trust;

(iii) a discretionary group; or

(iv) other similar grouping; or

(b) the policy or contract is situated out-of-state.

(27) "Uninsurable" means an individual who:

(a) is eligible for the Comprehensive Health Insurance Pool coverage under the underwriting criteria established in Subsection 31A-29-111(5); or

(b) (i) is issued a certificate for coverage under Subsection 31A-30-108 (3); and

(ii) has a condition of health that does not meet consistently applied underwriting criteria as established by the commissioner in accordance with Subsections 31A-30-106(1)(i) and (j) for which coverage the applicant is applying.

(28) "Uninsurable percentage" for a given calendar year equals UC/CI where, for purposes of this formula:

(a) "CI" means the carrier's individual coverage count as of December 31 of the preceding year; and

(b) "UC" means the number of uninsurable individuals who were issued an individual policy on or after July 1, 1997.

Text of subsections (20) to (26) effective January 1, 2011

(20) "Premium" means all monies paid by covered insureds and covered individuals as a condition of receiving coverage from a covered carrier, including any fees or other contributions associated with the health benefit plan.

(21) (a) "Rating period" means the calendar period for which premium rates established by a covered carrier are assumed to be in effect, as determined by the carrier.

(b) A covered carrier may not have:

(i) more than one rating period in any calendar month; and

(ii) no more than 12 rating periods in any calendar year.

(22) "Resident" means an individual who has resided in this state for at least 12 consecutive months immediately preceding the date of application.

(23) "Short-term limited duration insurance" means a health benefit product that:

(a) is not renewable; and

(b) has an expiration date specified in the contract that is less than 364 days after the date the plan became effective.

(24) "Small employer carrier" means a carrier that provides health benefit plans covering eligible employees of one or more small employers in this state, regardless of whether:

(a) coverage is offered through:

(i) an association;

(ii) a trust;

(iii) a discretionary group; or

(iv) other similar grouping; or

(b) the policy or contract is situated out-of-state.

(25) "Uninsurable" means an individual who:

(a) is eligible for the Comprehensive Health Insurance Pool coverage under the underwriting criteria established in Subsection 31A-29-111 (5); or

(b) (i) is issued a certificate for coverage under Subsection 31A-30-108 (3); and

(ii) has a condition of health that does not meet consistently applied underwriting criteria as established by the commissioner in accordance with Subsections 31A-30-106 (1)(i) and (j) for which coverage the applicant is applying.

(26) "Uninsurable percentage" for a given calendar year equals UC/CI where, for purposes of this formula:

(a) "CI" means the carrier's individual coverage count as of December 31 of the preceding year; and

(b) "UC" means the number of uninsurable individuals who were issued an individual policy on or after July 1, 1997.

Scope; waivers

(1) This chapter applies to any:

(a) health benefit plan that provides coverage to:

(i) individuals;

(ii) small employers; or

(iii) both Subsections (1)(a)(i) and (ii); or

(b) individual conversion policy for purposes of Sections 31A-30-106.5 and 31A-30-107.5.

(2) This chapter applies to a health benefit plan that provides coverage to small employers or individuals regardless of:

(a) whether the contract is issued to:

(i) an association;

(ii) a trust;

(iii) a discretionary group; or

(iv) other similar grouping; or

(b) the situs of delivery of the policy or contract.

(3) This chapter does not apply to:

(a) a large employer health benefit plan, except as specifically provided in Part 2, Defined Contribution Arrangements;

(b) short-term limited duration health insurance; or

(c) federally funded or partially funded programs.

(4)(a) Except as provided in Subsection (4)(b), for the purposes of this chapter:

(i) carriers that are affiliated companies or that are eligible to file a consolidated tax return shall be treated as one carrier; and

(ii) any restrictions or limitations imposed by this chapter shall apply as if all health benefit plans delivered or issued for delivery to covered insureds in this state by the affiliated carriers were issued by one carrier.

(b) Upon a finding of the commissioner, an affiliated carrier that is a health maintenance organization having a certificate of authority under this title may be considered to be a separate carrier for the purposes of this chapter.

(c) Unless otherwise authorized by the commissioner or by Chapter 42, Defined Contribution Risk Adjuster Act, a covered carrier may not enter into one or more ceding arrangements with respect to health benefit plans delivered or issued for delivery to covered insureds in this state if the ceding arrangements would result in less than 50% of the insurance obligation or risk for the health benefit plans being retained by the ceding carrier.

(d) Section 31A-22-1201 applies if a covered carrier cedes or assumes all of the insurance obligation or risk with respect to one or more health benefit plans delivered or issued for delivery to covered insureds in this state.

(5)(a) A Taft Hartley trust created in accordance with Section 302(c)(5) of the Federal Labor Management Relations Act {Footnote 1}, or a carrier with the written authorization of such a trust, may make a written request to the commissioner for a waiver from the application of any of the provisions of Subsection 31A-30-106(1) with respect to a health benefit plan provided to the trust.

(b) The commissioner may grant a trust or carrier described in Subsection (5)(a) a waiver if the commissioner finds that application with respect to the trust would:

(i) have a substantial adverse effect on the participants and beneficiaries of the trust; and

(ii) require significant modifications to one or more collective bargaining arrangements under which the trust is established or maintained.

(c) A waiver granted under this Subsection (5) may not apply to an individual if the person participates in a Taft Hartley trust as an associate member of any employee organization.

(6) Sections 31A-30-106, 31A-30-106.5, 31A-30-106.7, 31A-30-107, 31A-30-108, and 31A-30-111 apply to:

(a) any insurer engaging in the business of insurance related to the risk of a small employer for medical, surgical, hospital, or ancillary health care expenses of the small employer's employees provided as an employee benefit; and

(b) any contract of an insurer, other than a workers' compensation policy, related to the risk of a small employer for medical, surgical, hospital, or ancillary health care expenses of the small employer's employees provided as an employee benefit.

(7) The commissioner may make rules requiring that the marketing practices be consistent with this chapter for:

(a) a small employer carrier;

(b) a small employer carrier's agent;

(c) an insurance producer; and

(d) an insurance consultant.

31A-30-105

Separate classes of business

(1) For policies that go into effect on or after January 1, 2011, a covered carrier may not establish a separate class of business unless:

(a) the covered carrier submits an application to the department to establish a separate class of business;

(b) the covered carrier demonstrates to the satisfaction of the department that a separate class of business is justified under the provisions of this section; and

(c) the department approves the carrier's application for the use of a separate class of business.

(2) (a) The presumption of the department shall be against the use of a separate class of business by a covered insured, except when the covered carrier demonstrates that the provisions of this Subsection (2) apply.

(b) The department may approve the use of a separate class of business only if the covered carrier can demonstrate that the use of a separate class of business is necessary due to substantial differences in either expected claims experience or administrative costs related to the following reasons:

(i) the covered carrier uses more than one type of system for the marketing and sale of health benefit plans to covered insureds;

(ii) the covered carrier has acquired a class of business from another covered carrier; or

(iii) the covered carrier provides coverage to one or more association groups.

(3) The commissioner may establish regulations to provide for a period of transition in order for a covered carrier to come into compliance with Subsection (2) in the instance of acquisition of an additional class of business from another covered carrier.

(4) The commissioner may approve the establishment of up to five classes of business per covered carrier upon application to the commissioner and a finding by the commissioner that such action would substantially enhance the efficiency and fairness of the health insurance marketplace subject to this chapter.

(5) A covered carrier may not establish a class of business based solely on the marketing or sale of a health benefit plan as a defined contribution arrangement health benefit plan, or through the Health Insurance Exchange.

31A-30-106

Individual premiums; rating restrictions; disclosure

Text of section effective until January 1, 2011

(1) Premium rates for health benefit plans under this chapter are subject to the provisions of this Subsection (1).

(a) The index rate for a rating period for any class of business may not exceed the index rate for any other class of business by more than 20%.

(b)(i) For a class of business, the premium rates charged during a rating period to covered insureds with similar case characteristics for the same or similar coverage, or the rates that could be charged to such employers under the rating system for that class of business, may not vary from the index rate by more than 30% of the index rate, except as provided in Section 31A-22-625.

(ii) A covered carrier that offers individual and small employer health benefit plans may use the small employer index rates to establish the rate limitations for individual policies, even if some individual policies are rated below the small employer base rate.

(c) The percentage increase in the premium rate charged to a covered insured for a new rating period, adjusted pro rata for rating periods less than a year, may not exceed the sum of the following:

(i) the percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period;

(ii) any adjustment, not to exceed 15% annually and adjusted pro rata for rating periods of less than one year, due to the claim experience, health status, or duration of coverage of the covered individuals as determined from the covered carrier's rate manual for the class of business, except as provided in Section 31A-22-625; and

(iii) any adjustment due to change in coverage or change in the case characteristics of the covered insured as determined from the covered carrier's rate manual for the class of business.

(d)(i) Adjustments in rates for claims experience, health status, and duration from issue may not be charged to individual employees or dependents.

(ii) Any adjustment described in Subsection (1)(d)(i) shall be applied uniformly to the rates charged for all employees and dependents of the small employer.

(e) A covered carrier may use industry as a case characteristic in establishing premium rates, provided that the highest rate factor associated with any industry classification does not exceed the lowest rate factor associated with any industry classification by more than 15%.

(f)(i) Covered carriers shall apply rating factors, including case characteristics, consistently with respect to all covered insureds in a class of business.

(ii) Rating factors shall produce premiums for identical groups that:

(A) differ only by the amounts attributable to plan design; and

(B) do not reflect differences due to the nature of the groups assumed to select particular health benefit products.

(iii) A covered carrier shall treat all health benefit plans issued or renewed in the same calendar month as having the same rating period.

(g) For the purposes of this Subsection (1), a health benefit plan that uses a restricted network provision may not be considered similar coverage to a health benefit plan that does not use a restricted network provision, provided that use of the restricted network provision results in substantial difference in claims costs.

(h) The covered carrier may not, without prior approval of the commissioner, use case characteristics other than:

(i) age;

(ii) gender;

(iii) industry;

(iv) geographic area;

(v) family composition; and

(vi) group size.

(*i*)(i) The commissioner shall establish rules in accordance with Title 63G Chapter 3 Utah Administrative Rulemaking Act, to:

(A) implement this chapter; and

(B) assure that rating practices used by covered carriers are consistent with the purposes of this chapter.

(ii) The rules described in Subsection (1)(i)(i) may include rules that:

(A) assure that differences in rates charged for health benefit products by covered carriers are reasonable and reflect objective differences in plan design, not including differences due to the nature of the groups assumed to select particular health benefit products;

(B) prescribe the manner in which case characteristics may be used by covered carriers;

(C) implement the individual enrollment cap under Section 31A-30-110, including specifying:

(I) the contents for certification;

(II) auditing standards;

(III) underwriting criteria for uninsurable classification; and

(IV) limitations on high risk enrollees under Section 31A-30-111; and

(D) establish the individual enrollment cap under Subsection 31A-30-110(1).

(j) Before implementing regulations for underwriting criteria for uninsurable classification, the commissioner shall contract with an independent consulting organization to develop industry-wide underwriting criteria for uninsurability based on an individual's expected claims under open enrollment coverage exceeding 325% of that expected for a standard insurable individual with the same case characteristics.

(k) The commissioner shall revise rules issued for Sections 31A-22-602 and 31A-22-605 regarding individual accident and health policy rates to allow rating in accordance with this section.

(2) For purposes of Subsection (1)(c)(i), if a health benefit product is a health benefit product into which the covered carrier is no longer enrolling new covered insureds, the covered carrier shall use the percentage change in the base premium rate, provided that the change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit product into which the covered carrier is actively enrolling new covered insureds.

(3)(a) A covered carrier may not transfer a covered insured involuntarily into or out of a class of business.

(b) A covered carrier may not offer to transfer a covered insured into or out of a class of business unless the offer is made to transfer all covered insureds in the class of business without regard:

(i) to case characteristics;

(ii) claim experience;

(iii) health status; or

(iv) duration of coverage since issue.

(4)(a) Each covered carrier shall maintain at the covered carrier's principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate that the covered carrier's rating methods and practices are:

(i) based upon commonly accepted actuarial assumptions; and

(ii) in accordance with sound actuarial principles.

(b)(i) Each covered carrier shall file with the commissioner, on or before April 1 of each year, in a form, manner, and containing such information as prescribed by the commissioner, an actuarial certification certifying that:

(A) the covered carrier is in compliance with this chapter; and

(B) the rating methods of the covered carrier are actuarially sound.

(ii) A copy of the certification required by Subsection (4)(b)(i) shall be retained by the covered carrier at the covered carrier's principal place of business.

(c) A covered carrier shall make the information and documentation described in this Subsection (4) available to the commissioner upon request.

(d) Records submitted to the commissioner under this section shall be maintained by the commissioner as protected records under Title 63G Chapter 2, Government Records Access and Management Act.

Text of section effective January 1, 2011

(1) Premium rates for health benefit plans for individuals under this chapter are subject to the provisions of this section.

(a) The index rate for a rating period for any class of business may not exceed the index rate for any other class of business by more than 20%.

(b) (i) For a class of business, the premium rates charged during a rating period to covered insureds with similar case characteristics for the same or similar coverage, or the rates that could be charged to the individual under the rating system for that class of business, may not vary from the index rate by more than 30% of the index rate provided in Section 31A-30-106.1.

(ii) A carrier that offers individual and small employer health benefit plans may use the small employer index rates to establish the rate limitations for individual policies, even if some individual policies are rated below the small employer base rate.

(c) The percentage increase in the premium rate charged to a covered insured for a new rating period, adjusted pro rata for rating periods less than a year, may not exceed the sum of the following:

(i) the percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period;

(ii) any adjustment, not to exceed 15% annually for rating periods of less than one year, due to the claim experience, health status, or duration of coverage of the covered individuals as determined from the rate manual for the class of business of the carrier offering an individual health benefit plan; and

(iii) any adjustment due to change in coverage or change in the case characteristics of the covered insured as determined from the rate manual for the class of business of the carrier offering an individual health benefit plan.

(d) (i) A carrier offering an individual health benefit plan shall apply rating factors, including case characteristics, consistently with respect to all covered insureds in a class of business.

(ii) Rating factors shall produce premiums for identical individuals that:

(A) differ only by the amounts attributable to plan design; and

(B) do not reflect differences due to the nature of the individuals assumed to select particular health benefit products.

(iii) A carrier offering an individual health benefit plan shall treat all health benefit plans issued or renewed in the same calendar month as having the same rating period.

(e) For the purposes of this Subsection (1), a health benefit plan that uses a restricted network provision may not be considered similar coverage to a health benefit plan that does not use a restricted network provision, provided that use of the restricted network provision results in substantial difference in claims costs.

(f) A carrier offering a health benefit plan to an individual may not, without prior approval of the commissioner, use case characteristics other than:

(i) age;

(ii) gender;

(iii) geographic area; and

(iv) family composition.

(g) (i) The commissioner shall establish rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to:

(A) implement this chapter; and

(B) assure that rating practices used by carriers who offer health benefit plans to individuals are consistent with the purposes of this chapter.

(ii) The rules described in Subsection (1) (g) (i) may include rules that:

(A) assure that differences in rates charged for health benefit products by carriers who offer health benefit plans to individuals are reasonable and reflect objective differences in plan design, not including differences due to the nature of the individuals assumed to select particular health benefit products;

(B) prescribe the manner in which case characteristics may be used by carriers who offer health benefit plans to individuals;

(C) implement the individual enrollment cap under Section 31A-30-110, including specifying:

(I) the contents for certification;

(II) auditing standards;

(III) underwriting criteria for uninsurable classification; and

(IV) limitations on high risk enrollees under Section 31A-30-111; and

(D) establish the individual enrollment cap under Subsection 31A-30-110 (1).

(h) Before implementing regulations for underwriting criteria for uninsurable classification, the commissioner shall contract with an independent consulting organization to develop industry-wide underwriting criteria for uninsurability based on an individual's expected claims under open enrollment coverage exceeding 325% of that expected for a standard insurable individual with the same case characteristics.

(*i*) The commissioner shall revise rules issued for Sections 31A-22-602 and 31A-22-605 regarding individual accident and health policy rates to allow rating in accordance with this section.

(2) For purposes of Subsection (1)(c)(i), if a health benefit product is a health benefit product into which the covered carrier is no longer enrolling new covered insureds, the covered carrier shall use the percentage change in the base premium rate, provided that the change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit product into which the covered carrier is actively enrolling new covered insureds.

(3) (a) A covered carrier may not transfer a covered insured involuntarily into or out of a class of business.

(b) A covered carrier may not offer to transfer a covered insured into or out of a class of business unless the offer is made to transfer all covered insureds in the class of business without regard to:

(i) case characteristics;

(ii) claim experience;

(iii) health status; or

(iv) duration of coverage since issue.

(4) (a) A carrier who offers a health benefit plan to an individual shall maintain at the carrier's principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate that the carrier's rating methods and practices are:

(i) based upon commonly accepted actuarial assumptions; and

(ii) in accordance with sound actuarial principles.

(b) (i) Each carrier subject to this section shall file with the commissioner, on or before April 1 of each year, in a form, manner, and containing such information as prescribed by the commissioner, an actuarial certification certifying that:

(A) the carrier is in compliance with this chapter; and

(B) the rating methods of the carrier are actuarially sound.

(ii) A copy of the certification required by Subsection (4)(b)(i) shall be retained by the carrier at the carrier's principal place of business.

(c) A carrier shall make the information and documentation described in this Subsection (4) available to the commissioner upon request.

(d) Records submitted to the commissioner under this section shall be maintained by the commissioner as protected records under Title 63G, Chapter 2, Government Records Access and Management Act.

31A-30-106.1

Small employer; premiums; rating restrictions; disclosure

(1) Premium rates for small employer health benefit plans under this chapter are subject to the provisions of this section for a health benefit plan that is issued or renewed, on or after January 1, 2011.

(2) (a) The index rate for a rating period for any class of business may not exceed the index rate for any other class of business by more than 20%.

(b) For a class of business, the premium rates charged during a rating period to covered insureds with similar case characteristics for the same or similar coverage, or the rates that could be charged to an employer group under the rating system for that class of business, may not vary from the index rate by more than 30% of the index rate, except when catastrophic mental health coverage is selected as provided in Subsection 31A-22-625 (2)(d).

(3) The percentage increase in the premium rate charged to a covered insured for a new rating period, adjusted pro rata for rating periods less than a year, may not exceed the sum of the following:

(a) the percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period;

(b) any adjustment, not to exceed 15% annually for rating periods of less than one year, due to the claim experience, health status, or duration of coverage of the covered individuals as determined from the small employer carrier's rate manual for the class of business, except when catastrophic mental health coverage is selected as provided in Subsection 31A-22-625 (2)(d); and

(c) any adjustment due to change in coverage or change in the case characteristics of the covered insured as determined for the class of business from the small employer carrier's rate manual.

(4) (a) Adjustments in rates for claims experience, health status, and duration from issue may not be charged to individual employees or dependents.

(b) Rating adjustments and factors, including case characteristics, shall be applied uniformly and consistently to the rates charged for all employees and dependents of the small employer.

(c) Rating factors shall produce premiums for identical groups that:

(i) differ only by the amounts attributable to plan design; and

(ii) do not reflect differences due to the nature of the groups assumed to select particular health benefit products.

(d) A small employer carrier shall treat all health benefit plans issued or renewed in the same calendar month as having the same rating period.

(5) A health benefit plan that uses a restricted network provision may not be considered similar coverage to a health benefit plan that does not use a restricted network provision, provided that use of the restricted network provision results in substantial difference in claims costs.

(6) The small employer carrier may not use case characteristics other than the following:

(a) age, as determined at the beginning of the plan year, limited to:

(i) the following age bands:

(A) less than 20;

(B) 20-24;

(C) 25-29;

(D) 30-34;

(E) 35-39;

(F) 40-44;

(G) 45-49;

(H) 50-54;

(I) 55-59;

(J) 60-64; and

(K) 65 and above; and

(ii) a standard slope ratio range for each age band, applied to each family composition tier rating structure under Subsection (6)(c):

(A) as developed by the department by administrative rule;

(B) not to exceed an overall ratio of 5:1; and

(C) the age slope ratios for each age band may not overlap;

(b) geographic area; and

(c) family composition, limited to:

(i) an overall ratio of 5:1 or less; and

(ii) a four tier rating structure that includes:

(A) employee only;

(B) employee plus spouse;

(C) employee plus a dependent or dependents; and

(D) a family, consisting of an employee plus spouse, and a dependent or dependents.

(7) If a health benefit plan is a health benefit plan into which the small employer carrier is no longer enrolling new covered insureds, the small employer carrier shall use the percentage change in the base premium rate, provided that the change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit product into which the small employer carrier is actively enrolling new covered insureds.

(8) (a) A covered carrier may not transfer a covered insured involuntarily into or out of a class of business.

(b) A covered carrier may not offer to transfer a covered insured into or out of a class of business unless the offer is made to transfer all covered insureds in the class of business without regard to:

(i) case characteristics;

(ii) claim experience;

(iii) health status; or

(iv) duration of coverage since issue.

(9) (a) Each small employer carrier shall maintain at the small employer carrier's principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate that the small employer carrier's rating methods and practices are:

(i) based upon commonly accepted actuarial assumptions; and

(ii) in accordance with sound actuarial principles.

(b) (i) Each small employer carrier shall file with the commissioner on or before April 1 of each year, in a form and manner and containing information as prescribed by the commissioner, an actuarial certification certifying that:

(A) the small employer carrier is in compliance with this chapter; and

(B) the rating methods of the small employer carrier are actuarially sound.

(ii) A copy of the certification required by Subsection (9)(b)(i) shall be retained by the small employer carrier at the small employer carrier's principal place of business.

(c) A small employer carrier shall make the information and documentation described in this Subsection (9) available to the commissioner upon request.

(10) (a) The commissioner shall, by July 1, 2010, establish rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to:

(i) implement this chapter; and

(ii) assure that rating practices used by small employer carriers under this section and carriers for individual plans under Section 31A-30-106, as effective on January 1, 2011, are consistent with the purposes of this chapter.

(b) The rules may:

(i) assure that differences in rates charged for health benefit plans by carriers are reasonable and reflect objective differences in plan design, not including differences due to the nature of the groups or individuals assumed to select particular health benefit plans; and

(ii) prescribe the manner in which case characteristics may be used by small employer and individual carriers.

(11) Records submitted to the commissioner under this section shall be maintained by the commissioner as protected records under Title 63G, Chapter 2, Government Records Access and Management Act.

31A-30-106.5

Conversion policy; premiums; rating restrictions

(1) All provisions of Section 31A-30-106.1 apply to conversion policies.

(2) Conversion policy premium rates may not exceed by more than 35% the index rate for small employers with similar case characteristics for any class of business in which the policy form has been approved.

(3) An insurer may not consider pregnancy of a covered insured in determining its conversion policy premium rates.

31A-30-106.6

Repealed

§ 31A-30-106.6 Repealed. Laws 2004, ch. 329 (HB 106), § 9, eff. 5-3-2004.

31A-30-106.7

Surcharge for groups changing carriers

(1)(a) Except as provided in Subsection (1)(b), if prior notice is given, a covered carrier may impose upon a small group that changes coverage to that carrier from another carrier a one-time surcharge of up to 25% of the annualized premium that the carrier could otherwise charge under Section 31A-30-106.

(b) A covered carrier may not impose the surcharge described in Subsection (1)(a) if:

(i) the change in carriers occurs on the anniversary of the plan year, as defined in Section 31A-1-301;

(ii) the previous coverage was terminated under Subsection 31A-30-107(3)(e); or

(iii) employees from an existing group form a new business.

(2) A covered carrier may not impose the surcharge described in Subsection (1) if the offer to cover the group occurs at a time other than t he anniversary of the plan year because:

(a)(i) the application for coverage is made prior to the anniversary date in accordance with the covered carrier's published policies; and

(ii) the offer to cover the group is not issued until after the anniversary date; or

(b)(i) the application for coverage is made prior to the anniversary date in accordance with the covered carrier's published policies; and

(ii) additional underwriting or rating information requested by the covered carrier is not received until after the anniversary date.

(3) If a covered carrier chooses to apply a surcharge under Subsection (1), the application of the surcharge and the criteria for incurring or avoiding the surcharge shall be clearly stated in the:

(a) written application materials provided to the applicant at the time of application; and

(b) written producer guidelines.

(4) The commissioner shall adopt rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to ensure compliance with this section.

31A-30-107

Renewal of health benefit plan

(1) Except as otherwise provided in this section, a small employer health benefit plan is renewable and continues in force:

(a) with respect to all eligible employees and dependents; and

(b) at the option of the plan sponsor.

(2) A small employer health benefit plan may be discontinued or nonrenewed:

(a) for a network plan, if:

(i) there is no longer any enrollee under the group health plan who lives, resides, or works in:

(A) the service area of the covered carrier; or

(B) the area for which the covered carrier is authorized to do business; and

(ii) in the case of the small employer market, the small employer carrier applies the same criteria the small employer carrier would apply in denying enrollment in the plan under Subsection 31A-30-108(7); or

(b) for coverage made available in the small or large employer market only through an association, if:

(i) the employer's membership in the association ceases; and

(ii) the coverage is terminated uniformly without regard to any health status-related factor relating to any covered individual.

(3) A small employer health benefit plan may be discontinued if:

(a) a condition described in Subsection (2) exists;

(b) except as prohibited by Section 31A-30-206, the plan sponsor fails to pay premiums or contributions in accordance with the terms of the contract;

(c) the plan sponsor:

(i) performs an act or practice that constitutes fraud; or

(ii) makes an intentional misrepresentation of material fact under the terms of the coverage;

(d) the covered carrier:

(i) elects to discontinue offering a particular small employer health benefit product delivered or issued for delivery in this state; and

(ii)(A) provides notice of the discontinuation in writing:

(I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee; and

(II) at least 90 days before the date the coverage will be discontinued;

(B) provides notice of the discontinuation in writing:

(I) to the commissioner; and

(II) at least three working days prior to the date the notice is sent to the affected plan sponsors, employees, and dependents of the plan sponsors or employees;

(C) offers to each plan sponsor, on a guaranteed issue basis, the option to purchase all other small employer health benefit products currently being offered by the small employer carrier in the market; and

(D) in exercising the option to discontinue that product and in offering the option of coverage in this section, acts uniformly without regard to:

(I) the claims experience of a plan sponsor;

(II) any health status-related factor relating to any covered participant or beneficiary; or

(III) any health status-related factor relating to any new participant or beneficiary who may become eligible for the coverage; or

(e) the covered carrier:

(i) elects to discontinue all of the covered carrier's small employer health benefit plans in:

(A) the small employer market;

(B) the large employer market; or

(C) both the small employer and large employer markets; and

(ii)(A) provides notice of the discontinuation in writing:

(I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee; and

(II) at least 180 days before the date the coverage will be discontinued;

(B) provides notice of the discontinuation in writing:

(I) to the commissioner in each state in which an affected insured individual is known to reside; and

(II) at least 30 working days prior to the date the notice is sent to the affected plan sponsors, employees, and the dependents of the plan sponsors or employees;

(C) discontinues and nonrenews all plans issued or delivered for issuance in the market; and

(D) provides a plan of orderly withdrawal as required by Section 31A-4-115.

(4) A small employer health benefit plan may be discontinued or nonrenewed:

(a) if a condition described in Subsection (2) exists; or

(b) except as prohibited by Section 31A-30-206, for noncompliance with the insurer's employer contribution requirements.

(5) A small employer health benefit plan may be nonrenewed:

(a) if a condition described in Subsection (2) exists; or

(b) except as prohibited by Section 31A-30-206, for noncompliance with the insurer's minimum participation requirements.

(6)(a) Except as provided in Subsection (6)(d), an eligible employee may be discontinued if after issuance of coverage the eligible employee:

(i) engages in an act or practice that constitutes fraud in connection with the coverage; or

(ii) makes an intentional misrepresentation of material fact in connection with the coverage.

(b) An eligible employee that is discontinued under Subsection (6)(a) may reenroll:

(i) 12 months after the date of discontinuance; and

(ii) if the plan sponsor's coverage is in effect at the time the eligible employee applies to reenroll.

(c) At the time the eligible employee's coverage is discontinued under Subsection (6)(a), the covered carrier shall notify the eligible employee of the right to reenroll when coverage is discontinued.

(d) An eligible employee may not be discontinued under this Subsection (6) because of a fraud or misrepresentation that relates to health status.

(7) For purposes of this section, a reference to "plan sponsor" includes a reference to the employer:

(a) with respect to coverage provided to an employer member of the association; and

(b) if the small employer health benefit plan is made available by a covered carrier in the employer market only through:

(i) an association;

(ii) a trust; or

(iii) a discretionary group.

(8) A covered carrier may modify a small employer health benefit plan only:

(a) at the time of coverage renewal; and

(b) if the modification is effective uniformly among all plans with that product.

31A-30-107.1

Grounds for nonrenewal or discontinuation of coverage: individual health insurance

(1)(a) Except as otherwise provided in this section, a health benefit plan offered on an individual basis is renewable and continues in force:

(i) with respect to all individuals or dependents; and

(ii) at the option of the individual.

(b) Subsection (1)(a) applies regardless of:

(i) whether the contract is issued through:

(A) a trust;

(B) an association;

(C) a discretionary group; or

(D) other similar grouping; or

(ii) the situs of delivery of the policy or contract.

(2) A health benefit plan may be discontinued or nonrenewed:

(a) for a network plan, if:

(i) the individual no longer lives, resides, or works in:

(A) the service area of the covered carrier; or

(B) the area for which the covered carrier is authorized to do business; and

(ii) coverage is terminated uniformly without regard to any health status-related factor relating to any covered individual; or

(b) for coverage made available through an association, if:

(i) the individual's membership in the association ceases; and

(ii) the coverage is terminated uniformly without regard to any health status-related factor of covered individuals.

(3) A health benefit plan may be discontinued if:

(a) a condition described in Subsection (2) exists;

(b) the individual fails to pay premiums or contributions in accordance with the terms of the health benefit plan, including any timeliness requirements;

(c) the individual:

(i) performs an act or practice that constitutes fraud in connection with the coverage; or

(ii) makes an intentional misrepresentation of material fact under the terms of the coverage;

(d) the covered carrier:

(i) elects to discontinue offering a particular health benefit product delivered or issued for delivery in this state; and

(ii)(A) provides notice of the discontinuance in writing:

(I) to each individual provided coverage; and

(II) at least 90 days before the date the coverage will be discontinued;

(B) provides notice of the discontinuation in writing:

(I) to the commissioner; and

(II) at least three working days prior to the date the notice is sent to the affected individuals;

(C) offers to each covered individual on a guaranteed issue basis the option to purchase all other individual health benefit products currently being offered by the covered carrier for individuals in that market; and

(D) acts uniformly without regard to any health status-related factor of a covered individual or dependent of a covered individual who may become eligible for coverage; or

(e) the covered carrier:

(i) elects to discontinue all of the covered carrier's health benefit plans in the individual market; and

(ii)(A) provides notice of the discontinuation in writing:

(I) to each covered individual; and

(II) at least 180 days before the date the coverage will be discontinued;

(B) provides notice of the discontinuation in writing:

(I) to the commissioner in each state in which an affected insured individual is known to reside; and

(II) at least 30 working days prior to the date the notice is sent to the affected individuals;

(C) discontinues and nonrenews all health benefit plans the covered carrier issues or delivers for issuance in the individual market; and

(D) acts uniformly without regard to any health status-related factor of a covered individual or a dependent of a covered individual who may become eligible for coverage.

31A-30-107.3

Withdrawal from market

(1)(a) A carrier that elects to discontinue offering a health benefit plan under Subsection 31A-30-107(3)(e) or 31A-30-107.1(3)(e) is prohibited from writing new business:

(i) in the small employer and individual market in this state; and

(ii) for a period of five years beginning on the date of discontinuation of the last coverage that is discontinued.

(b) The prohibition described in Subsection (1)(a) may be waived if the commissioner finds that waiver is in the public interest:

(i) to promote competition; or

(ii) to resolve inequity in the marketplace.

(2)(a) If the Comprehensive Health Insurance Pool as set forth under Title 31A, Chapter 29, is dissolved or discontinued, or if enrollment is capped or suspended, an individual carrier:

(i) may elect to discontinue offering new individual health benefit plans, except to HIPAA eligibles, but must keep existing individual health benefit plans in effect, except those individual plans that are not renewed under the provisions of Subsection 31A-30-107(2) or 31A-30-107.1(2);

(ii) may elect to continue to offer new individual and small employer health benefit plans; or

(iii) may elect to discontinue all of the covered carrier's health benefit plans in the individual or small group market under the provisions of Subsection 31A-30-107(3)(e) or 31A-30-107.1(3)(e).

(b) A carrier that makes an election under Subsection (2)(a)(i):

(i) is prohibited from writing new business:

(A) in the individual market in this state; and

(B) for a period of five years beginning on the date of discontinuation;

(ii) may continue to write new business in the small employer market; and

(iii) must provide written notice of the election under Subsection (2)(a)(i) within two calendar days of the election to the Utah Insurance Department.

(c) The prohibition described in Subsection (2)(b)(i) may be waived if the commissioner finds that waiver is in the public interest:

(i) to promote competition; or

(ii) to resolve inequity in the marketplace.

(d) A carrier that makes an election under Subsection (2)(a)(iii) is subject to the provisions of Subsection (1).

(3) If a carrier is doing business in one established geographic service area of the state, Sections 31A-30-107 and 31A-30-107.1 apply only to the carrier's operations in that geographic service area.

(4) If a small employer employs less than two eligible employees, a carrier may not discontinue or not renew the health benefit plan until the first renewal date following the beginning of a new plan year, even if the carrier knows as of the beginning of the plan year that the employer no longer has at least two current employees.

31A-30-107.5

Preexisting conditions

(1) A health benefit plan may impose a preexisting condition exclusion only if the provision complies with Subsection 31A-22-605.1(4).

(2)(a) In accordance with Subsection (2)(b), an individual carrier:

(i) may, when the individual carrier and the insured mutually agree in writing to a condition-specific exclusion rider, offer to issue an individual policy that excludes all treatment and prescription drugs related to:

(A) a specific physical condition;

(B) a specific disease or disorder; and

(C) any specific or class of prescription drugs; and

(ii) may offer an individual policy that may establish separate cost sharing requirements including, deductibles and maximum limits that are specific to covered services and supplies, including drugs, when utilized for the treatment and care of the conditions, diseases, or disorders listed in Subsection (2)(b).

(b)(i) Except as provided in Section 31A-22-630 and Subsection (2)(b)(ii), the following may be the subject of a condition-specific exclusion rider:

(A) conditions, diseases, and disorders of the bones or joints of the ankle, arm, elbow, fingers, foot, hand, hip, knee, leg, mandible, mastoid, wrist, shoulder, spine, and toes, including bone spurs, bunions, carpal tunnel syndrome, club foot, cubital tunnel syndrome, hammertoe, syndactylism, and treatment and prosthetic devices related to amputation;

(B) anal fistula, anal fissure, anal stricture, breast implants, breast reduction, chronic cystitis, chronic prostatitis, cystocele, rectocele, enuresis, hemorrhoids, hydrocele, hypospadius, interstitial cystitis, kidney stones, uterine leiomyoma, varicocele, spermatocele, endometriosis;

(C) allergic rhinitis, nonallergic rhinitis, hay fever, dust allergies, pollen allergies, deviated nasal septum, and sinus related conditions, diseases, and disorders;

(D) hemangioma, keloids, scar revisions, and other skin related conditions, diseases, and disorders;

(E) goiter and other thyroid related conditions, diseases, or disorders;

(F) cataracts, cornea transplant, detached retina, glaucoma, keratoconus, macular degeneration, strabismus and other eye related conditions, diseases, and disorders;

(G) otitis media, cholesteatoma, otosclerosis, and other internal/external ear conditions, diseases, and disorders;

(H) Baker's cyst, ganglion cyst;

(I) abdominoplasty, esophageal reflux, hernia, Meniere's disease, migraines, TIC Doulourex, varicose veins, vestibular disorders;

(J) sleep disorders and speech disorders; and

(K) any specific or class of prescription drugs.

(ii) Subsection (2)(b)(i) does not apply:

(A) for the treatment of asthma; or

(B) when the condition is due to cancer.

(iii) A condition-specific exclusion rider:

(A) shall be limited to the excluded condition, disease, or disorder and any complications from that condition, disease, or disorder;

(B) may not extend to any secondary medical condition; and

(C) must include the following informed consent paragraph: "I agree by signing below, to the terms of this rider, which excludes coverage for all treatment, including medications, related to the specific condition(s), disease(s), and/or disorder(s) stated herein and that if treatment or medications are received that I have the responsibility for payment for those services and items. I further understand that this rider does not extend to any secondary medical condition, disease, or disorder."

(c) If an individual carrier issues a condition-specific exclusion rider, the condition-specific exclusion rider shall remain in effect for the duration of the policy at the individual carrier's option.

(d) An individual policy issued in accordance with this Subsection (2) is not subject to Subsection 31A-26-301.6(7).

(3) Notwithstanding the other provisions of this section, a health benefit plan may impose a limitation period if:

(a) each policy that imposes a limitation period under the health benefit plan specifies the physical condition, disease, or disorder that is excluded from coverage during the limitation period;

(b) the limitation period does not exceed 12 months;

(c) the limitation period is applied uniformly; and

(d) the limitation period is reduced in compliance with Subsections 31A-22-605.1(4)(a) and (4)(b).

31A-30-108

Eligibility for small employer and individual market

(1)(a) Small employer carriers shall accept residents for small group coverage as set forth in the Health Insurance Portability and Accountability Act {Footnote 1} , P.L. 104-191, 110 Stat. 1962, Sec. 2701(f) and 2711(a).

(b) Individual carriers shall accept residents for individual coverage pursuant:

(i) to P.L. 104-191, 110 Stat. 1979, Sec. 2741(a) — (b); and

(ii) Subsection (3).

(2)(a) Small employer carriers shall offer to accept all eligible employees and their dependents at the same level of benefits under any health benefit plan provided to a small employer.

(b) Small employer carriers may:

(i) request a small employer to submit a copy of the small employer's quarterly income tax withholdings to determine whether the employees for whom coverage is provided or requested are bona fide employees of the small employer; and

(ii) deny or terminate coverage if the small employer refuses to provide documentation requested under Subsection (2)(b)(i).

(3) Except as provided in Subsections (5) and (6) and Section 31A-30-110, individual carriers shall accept for coverage individuals to whom all of the following conditions apply:

(a) the individual is not covered or eligible for coverage:

(i)(A) as an employee of an employer;

(B) as a member of an association; or

(C) as a member of any other group; and

(ii) under:

(A) a health benefit plan; or

(B) a self-insured arrangement that provides coverage similar to that provided by a health benefit plan as defined in Section 31A-1-301;

(b) the individual is not covered and is not eligible for coverage under any public health benefits arrangement including:

(i) the Medicare program established under Title XVIII of the Social Security Act;

(ii) any act of Congress or law of this or any other state that provides benefits comparable to the benefits provided under this chapter; or

(iii) coverage under the Comprehensive Health Insurance Pool Act created in Chapter 29, Comprehensive Health Insurance Pool Act;

(c) unless the maximum benefit has been reached the individual is not covered or eligible for coverage under any:

(i) Medicare supplement policy;

(ii) conversion option;

(iii) continuation or extension under COBRA; or

(iv) state extension;

(d) the individual has not terminated or declined coverage described in Subsection (3)(a), (b), or (c) within 93 days of application for coverage, unless the individual is eligible for individual coverage under P.L. 104-191, 110 Stat. 1979, Sec. 2741(b), in which case, the requirement of this Subsection (3)(d) does not apply; and

(e) the individual is certified as ineligible for the Health Insurance Pool if:

(i) the individual applies for coverage with the Comprehensive Health Insurance Pool within 30 days after being rejected or refused coverage by the covered carrier and reapplies for coverage with that covered carrier within 30 days after the date of issuance of a certificate under Subsection 31A-29-111(5)(c); or

(ii) the individual applies for coverage with any individual carrier within 45 days after:

(A) notice of cancellation of coverage under Subsection 31A-29-115 (1); or

(B) the date of issuance of a certificate under Subsection 31A-29-111(5)(c) if the individual applied first for coverage with the Comprehensive Health Insurance Pool.

(4)(a) If coverage is obtained under Subsection (3)(e)(i) and the required premium is paid, the effective date of coverage shall be the first day of the month following the individual's submission of a completed insurance application to that covered carrier.

(b) If coverage is obtained under Subsection (3)(e)(ii) and the required premium is paid, the effective date of coverage shall be the day following the:

(i) cancellation of coverage under Subsection 31A-29-115(1); or

(ii) submission of a completed insurance application to the Comprehensive Health Insurance Pool.

(5)(a) An individual carrier is not required to accept individuals for coverage under Subsection (3) if the carrier issues no new individual policies in the state after July 1, 1997.

(b) A carrier described in Subsection (5)(a) may not issue new individual policies in the state for five years from July 1, 1997.

(c) Notwithstanding Subsection (5)(b), a carrier may request permission to issue new policies after July 1, 1999, which may only be granted if:

(i) the carrier accepts uninsurables as is required of a carrier entering the market under Subsection 31A-30-110; and

(ii) the commissioner finds that the carrier's issuance of new individual policies:

(A) is in the best interests of the state; and

(B) does not provide an unfair advantage to the carrier.

(6)(a) If the Comprehensive Health Insurance Pool as set forth under Title 31A, Chapter 29, is dissolved or discontinued, or if enrollment is capped or suspended, an individual carrier may decline to accept individuals applying for individual enrollment, other than individuals applying for coverage as set forth in P.L. 104-191, 110 Stat. 1979, Sec. 2741 (a) — (b).

(b) Within two calendar days of taking action under Subsection (6)(a), an individual carrier will provide written notice to the Utah Insurance Department.

(7)(a) If a small employer carrier offers health benefit plans to small employers through a network plan, the small employer carrier may:

(i) limit the employers that may apply for the coverage to those employers with eligible employees who live, reside, or work in the service area for the network plan; and

(ii) within the service area of the network plan, deny coverage to an employer if the small employer carrier has demonstrated to the commissioner that the small employer carrier:

(A) will not have the capacity to deliver services adequately to enrollees of any additional groups because of the small employer carrier's obligations to existing group contract holders and enrollees; and

(B) applies this section uniformly to all employers without regard to:

(I) the claims experience of an employer, an employer's employee, or a dependent of an employee; or

(II) any health status-related factor relating to an employee or dependent of an employee.

(b)(i) A small employer carrier that denies a health benefit product to an employer in any service area in accordance with this section may not offer coverage in the small employer market within the service area to any employer for a period of 180 days after the date the coverage is denied.

(ii) This Subsection (7)(b) does not:

(A) limit the small employer carrier's ability to renew coverage that is in force; or

(B) relieve the small employer carrier of the responsibility to renew coverage that is in force.

(c) Coverage offered within a service area after the 180-day period specified in Subsection (7)(b) is subject to the requirements of this section.

31A-30-109

Basic coverage required

(1) An individual carrier who offers individual coverage pursuant to Section 31A-30-108:

(a) shall offer in the individual market under this chapter:

(i) a choice of coverage that is at least equal to or greater than basic coverage; and

(ii) beginning January 1, 2010, the Utah NetCare Plan described in Subsection 31A-22-724(2); and

(b) may offer a choice of coverage that:

(i) costs less than or equal to the plan described in Subsection (1)(a)(ii); and

(ii) excludes some or all of the mandates described in Subsection 31A-22-724(3).

(2) Beginning January 1, 2010, a small employer group carrier who offers small employer group coverage pursuant to Section 31A-30-108:

(a) shall offer in the small employer group market under this part:

(i) a choice of coverage that is at least equal to or greater than basic coverage; and

(ii) coverage under the Utah NetCare Plan described in Section 31A-22-724; and

(b) may offer in the small employer group market under this part, a choice of coverage that:

(i) costs less than or equal to the coverage in Subsection (2)(a); and

(ii) excludes some or all of the mandates described in Subsection 31A-22-724(3).

(3) Nothing in this section limits the number of health benefit plans an insurer may offer.

31A-30-110

Individual enrollment cap; reports

(1) The commissioner shall set the individual enrollment cap at .5% on July 1, 1997.

(2) The commissioner shall raise the individual enrollment cap by .5% at the later of the following dates:

(a) six months from the last increase in the individual enrollment cap; or

(b) the date when CCI/TI is greater than .90, where:

(i) " CCI " is the total individual coverage count for all carriers certifying that their uninsurable percentage has reached the individual enrollment cap; and

(ii) " TI " is the total individual coverage count for all carriers.

(3) The commissioner may establish a minimum number of uninsurable individuals that a carrier entering the market who is subject to this chapter must accept under the individual enrollment provisions of this chapter.

(4) Beginning July 1, 1997, an individual carrier may decline to accept individuals applying for individual enrollment under Subsection 31A-30-108(3), other than individuals applying for coverage as set forth in P.L. 104-191, 110 Stat. 1979, Sec. 2741 (a) — (b), if:

(a) the uninsurable percentage for that carrier equals or exceeds the cap established in Subsection (1); and

(b) the covered carrier has certified on forms provided by the commissioner that its uninsurable percentage equals or exceeds the individual enrollment cap.

(5) The department may audit a carrier's records to verify whether the carrier's uninsurable classification meets industry standards for underwriting criteria as established by the commissioner in accordance with Subsection 31A-30-106(1)(*i*).

(6)(a) If the commissioner determines that individual enrollment is causing a substantial adverse effect on premiums, enrollment, or experience, the commissioner may suspend, limit, or delay further individual enrollment for up to 12 months.

(b) The commissioner shall adopt rules to establish a uniform methodology for calculating and reporting loss ratios for individual policies for determining whether the individual enrollment provisions of Section 31A-30-108 should be waived for an individual carrier experiencing significant and adverse financial impact as a result of complying with those provisions.

31A-30-111

Financially impaired insurers

(1)(a) The requirements of this chapter do not apply to any carrier that is currently in a state of supervision, insolvency, or liquidation.

(b) If a carrier demonstrates to the satisfaction of the commissioner that the requirements of this chapter would place the carrier in a state of supervision, insolvency, or liquidation the commissioner may waive or modify the requirements of Sections 31A-30-108 and 31A-30-110.

(2)(a) A modification or waiver by the commissioner under Subsection (1)(b) shall be effective for a period of not more than one year.

(b) At the end of the period described in Subsection (2)(a), a carrier is subject to Sections 31A-30-108 and 31A-30-110 unless the carrier demonstrates to the satisfaction of the commissioner the need for a modification or waiver in accordance with Subsection (1)(b).

(3) Notwithstanding the requirements of this chapter, a carrier may deny health benefit plan coverage in the small employer and individual market if the carrier demonstrates to the satisfaction of the commissioner that the carrier:

(a) does not have the financial reserves necessary to underwrite additional coverage;

(b) is applying this section uniformly to all small employers and individuals without regard to:

(i) any health status-related factor of the individuals; or

(ii) whether the individuals are eligible individuals.

31A-30-112

Minimum employee participation; minimum employer contributions

(1)(a) Except as provided in Subsection (2) and Section 31A-30-206, a requirement used by a covered carrier in determining whether to provide coverage to a small employer, including a requirement for minimum participation of eligible employees and minimum employer contributions, shall be applied uniformly among all small employers with the same number of eligible employees applying for coverage or receiving coverage from the covered carrier.

(b) In addition to applying Subsection 31A-1-301(121), a covered carrier may require that a small employer have a minimum of two eligible employees to meet participation requirements.

(2) A covered carrier may not increase a requirement for minimum employee participation or a requirement for minimum employer contribution applicable to a small employer at any time after the small employer is accepted for coverage.

31A-30-113

Repealed

§ 31A-30-113. Repealed. Laws 1997, ch. 265, § 18, eff. 5-1-97.

31A-30-114

Information disclosure

(1) A covered carrier shall make the information described in Subsection (2) available:

(a) to:

(i) a small employer; or

(ii) an individual; and

(b)(i) at the time of solicitation; or

(ii) upon the request of:

(A) a small employer; or

(B) an individual;

(c) as part of the covered carrier's solicitation and sales materials.

(2) The following information is required to be disclosed or made available under Subsection (1):

(a) the provisions of the coverage concerning the covered carrier's right to change premium rates; and

(b) the factors that may effect changes in premium rates;

(c) the provisions of the coverage relating to renewability of coverage; and

(d) the provisions of the coverage relating to any preexisting condition exclusion.

31A-30-201

Title

This part is known as "Defined Contribution Arrangements."

31A-30-202

Definitions

For purposes of this part:

(1) "Defined benefit plan" means an employer group health benefit plan in which:

(a) the employer selects the health benefit plan or plans from a single insurer;

(b) employees are not provided a choice of health benefit plans on the Health Insurance Exchange; and

(c) the employer is subject to contribution requirements in Section 31A-30-112.

(2) "Defined contribution arrangement":

(a) means a defined contribution arrangement employer group health benefit plan that:

(i) complies with this part; and

(ii) is sold through the Health Insurance Exchange in accordance with Title 63M, Chapter 1, Part 25, Health System Reform Act; and

(b) beginning January 1, 2011, includes an employer choice of either a defined contribution arrangement health benefit plan or a defined benefit plan offered through the Health Insurance Exchange.

(3) "Health reimbursement arrangement" means an employer provided health reimbursement arrangement in which reimbursements for medical care expenses are excluded from an employee's gross income under the Internal Revenue Code.

(4) "Producer" is as defined in Subsection 31A-23a-501 (4)(a).

(5) "Section 125 Cafeteria plan" means a flexible spending arrangement that qualifies under Section 125, Internal Revenue Code, which permits an employee to contribute pre-tax dollars to a health benefit plan.

(6) "Small employer" is defined in Section 31A-1-301.

31A-30-202.5

Small employer insurer participation in defined contribution arrangement market

(1) A small employer carrier who chooses to participate in the defined contribution arrangement market:

(a) shall offer the defined contribution arrangement health benefit plans required by Section 31A-30-205;

(b) may:

(i) offer additional defined contribution arrangement health benefit plans in the Health Insurance Exchange as permitted by Section 31A-30-205;

(ii) offer a defined benefit plan in the Health Insurance Exchange if the small employer carrier offers a defined contribution arrangement health benefit plan that is actuarially equivalent to the defined benefit plan that is offered in the Health Insurance Exchange; and

(iii) continue to offer defined benefit plans outside of the Health Insurance Exchange and the defined contribution arrangement market, if the carrier uses the same rating and underwriting practices in both the defined contribution arrangement market in the Health Insurance Exchange and the defined benefit market outside the Health Insurance Exchange.

(2) A carrier that does not elect to participate in the defined contribution arrangement market by January 1, 2011, may not participate in the defined contribution arrangement market in the Health Insurance Exchange until January 1, 2013.

31A-30-203

Eligibility for defined contribution arrangement market; enrollment

(1) (a) An eligible small employer may choose to participate in:

(i) the defined contribution arrangement market in the Health Insurance Exchange under this part; or

(ii) the traditional defined benefit market under Part 1, Individual and Small Employer Group.

(b) A small employer may choose to offer its employees one of the following through the defined contribution arrangement market in the Health Insurance Exchange:

(i) a defined contribution arrangement health benefit plan; or

(ii) a defined benefit plan.

(c) (i) Beginning January 1, 2011, and during the enrollment period, an eligible large employer participating in the demonstration project under Subsection 31A-30-208 (1)(c) may choose to offer its employees a defined contribution arrangement health benefit plan.

(ii) Beginning January 1, 2012, an eligible large employer may choose to offer its employees a defined contribution arrangement health benefit plan.

(d) Defined contribution arrangement health benefit plans are employer group health plans individually selected by an employee of an employer.

(2) (a) Participating insurers shall offer to accept all eligible employees of an employer described in Subsection (1), and their dependents, at the same level of benefits as anyone else who has the same health benefit plan in the defined contribution arrangement market on the Health Insurance Exchange.

(b) A participating insurer may:

(i) request an employer to submit a copy of the employer's quarterly wage list to determine whether the employees for whom coverage is provided or requested are bona fide employees of the employer; and

(ii) deny or terminate coverage if the employer refuses to provide documentation requested under Subsection (2)(b)(i).

31A-30-204

Employer responsibilities for defined contribution arrangements

(1) (a) An employer participating in the defined contribution arrangement market on the Health Insurance Exchange shall make an initial election to offer its employees either a defined benefit plan or a defined contribution arrangement health benefit plan.

(b) If an employer elects to offer a defined benefit plan:

(i) the employer or the employer's producer shall enroll the employer in the Health Insurance Exchange;

(ii) the employees shall submit the uniform application required for the Health Insurance Exchange; and

(iii) the employer shall select the defined benefit plan in accordance with Section 31A-30-208.

(c) When an employer makes an election under Subsections (1)(a) and (b):

(i) the employer may not offer its employees a defined contribution arrangement health benefit plan; and

(ii) the employees may not select a defined contribution arrangement health benefit plan in the Health Insurance Exchange.

(d) If an employer elects to offer its employees a defined contribution arrangement health benefit plan, the employer shall comply with the provisions of Subsections (2) through (5).

(2) (a) (i) An employer that chooses to participate in a defined contribution arrangement health benefit plan may not offer to an employee a health benefit plan that is not a defined contribution arrangement health benefit plan in the Health Insurance Exchange.

(ii) Subsection (2) (a)(i) does not prohibit the offer of supplemental or limited benefit policies such as dental or vision coverage, or other types of federally qualified savings accounts for health care expenses.

(b) (i) To the extent permitted by Sections 31A-1-301, 31A-30-112, and 31A-30-206, and the risk adjustment plan adopted under Section 31A-42-204, the employer reserves the right to determine:

(A) the criteria for employee eligibility, enrollment, and participation in the employer's health benefit plan; and

(B) the amount of the employer's contribution to that plan.

(ii) The determinations made under Subsection (2) (b) may only be changed during periods of open enrollment.

(3) An employer that chooses to establish a defined contribution arrangement health benefit plan to provide a health benefit plan for its employees shall:

(a) establish a mechanism for its employees to use pre-tax dollars to purchase a health benefit plan from the defined contribution arrangement market on the Health Insurance Exchange created in Section 63M-1-2504, which may include:

(i) a health reimbursement arrangement;

(ii) a Section 125 Cafeteria plan; or

(iii) another plan or arrangement similar to Subsection (3) (a)(i) or (ii) which is excluded or deducted from gross income under the Internal Revenue Code;

(b) before the employee's health benefit plan selection period:

(i) inform each employee of the health benefit plan the employer has selected as the default health benefit plan for the employer group;

(ii) offer each employee a choice of any of the defined contribution arrangement health benefit plans available through the defined contribution arrangement market on the Health Insurance Exchange; and

(iii) notify the employee that the employee will be enrolled in the default health benefit plan selected by the employer and payroll deductions initiated for premium payments, unless the employee, before the employee's selection period ends:

(A) selects a different defined contribution arrangement health benefit plan available in the Health Insurance Exchange;

(B) provides proof of coverage from another health benefit plan; or

(C) specifically declines coverage in a health benefit plan.

(4) An employer shall enroll an employee in the default defined contribution arrangement health benefit plan selected by the employer if the employee does not make one of the choices described in Subsection (3)(b)(iii) before the end of the employee selection period, which may not be less than 14 calendar days.

(5) The employer's notice to the employee under Subsection (3) (b)(iii) shall inform the employee that the failure to act under Subsections (3) (b)(iii)(A) through (C) is considered an affirmative election under pre-tax payroll deductions for the employer to begin payroll deductions for health benefit plan premiums.

31A-30-205

Health benefit plan offerings in the defined contribution market

(1) An insurer who offers a defined contribution arrangement health benefit plan shall offer the following health benefit plans as defined contribution arrangements:

(a) the basic benefit plan;

(b) one health benefit plan with an aggregate actuarial value at least 15% greater than the actuarial value of the basic benefit plan;

(c) on or before January 1, 2011, one health benefit plan that is a federally qualified high deductible health plan that has an individual deductible of $2,500 and a deductible of $5,000 for coverage including two or more individuals, and does not exceed an annual out-of-pocket maximum equal to three times the amount of the annual deductible;

(d) on or before January 1, 2011, one health benefit plan that is a federally qualified high deductible health plan that has a deductible that is within $250 of the highest deductible that qualifies as a federally qualified high deductible health plan as adjusted by federal law, and does not exceed an annual out-of-pocket maximum equal to three times the amount of the annual deductible; and

(e) the insurer's five most commonly selected health benefit plans that:

(i) include:

(A) the provider panel;

(B) the deductible;

(C) co-payments;

(D) co-insurance; and

(E) pharmacy benefits; and

(ii) are currently being marketed by the carrier to new groups for enrollment.

(2) (a) The provisions of Subsection (1) do not limit the number of defined contribution arrangement health benefit plans an insurer may offer in the defined contribution arrangement market.

(b) An insurer who offers the health benefit plans required by Subsection (1) may also offer any other health benefit plan as a defined contribution arrangement if:

(i) the health benefit plan provides benefits that are of greater actuarial value than the benefits required in the basic benefit plan; or

(ii) the health benefit plan provides benefits with an aggregate actuarial value that is no lower than the actuarial value of the plan required in Subsection (1)(c).

31A-30-206

Participation and contribution levels; premium payments

An insurer who offers a health benefit plan for which an employer has established a defined contribution arrangement under the provisions of this part:

(1) shall not:

(a) establish an employer minimum contribution level for the health benefit plan premium under Section 31A-30-112, or any other law; or

(b) discontinue or non-renew a policy under Subsection 31A-30-107 (4) for failure to maintain a minimum employer contribution level;

(2) shall accept premium payments for an enrollee from multiple sources through the Internet portal, including:

(a) government assistance programs;

(b) contributions from a Section 125 Cafeteria plan, a health reimbursement arrangement, or other qualified mechanism for pre-tax payments established by any employer of the enrollee;

(c) contributions from a Section 125 Cafeteria plan, a health reimbursement arrangement, or other qualified mechanism for pre-tax payments established by an employer of a spouse or dependent of the enrollee; and

(d) contributions from private sources of premium assistance; and

(3) may require, as a condition of coverage, a minimum participation level for eligible employees of an employer, which for purposes of the defined contribution arrangement market may not exceed 75% participation.

31A-30-207

Rating and underwriting restrictions for health plans in the defined contribution arrangement market

(1) The rating and underwriting restrictions for defined benefit plans and for the defined contribution arrangement health benefit plans offered in the Health Insurance Exchange defined contribution arrangement market shall be:

(a) for small employer groups, in accordance with Section 31A-30-106.1;

(b) for large employer groups, as determined by the risk adjuster board for participation in the risk adjustment mechanism under Chapter 42, Defined Contribution Risk Adjuster Act; and

(c) established in accordance with the plan adopted under Chapter 42, Defined Contribution Risk Adjuster Act.

(2) All insurers who participate in the defined contribution market shall:

(a) participate in the risk adjuster mechanism developed under Chapter 42, Defined Contribution Risk Adjuster Act for all defined contribution arrangement health benefit plans;

(b) provide the risk adjuster board with:

(i) an employer group's risk factor; and

(ii) carrier enrollment data; and

(c) submit rates to the exchange that are net of commissions.

(3) When an employer group of any size enters the defined contribution arrangement market for either a defined contribution arrangement health benefit plan, or a defined benefit plan, and the employer group has a health plan with an insurer who is participating in the defined contribution arrangement market, the risk factor applied to the employer group when it enters the defined contribution market may not be greater than the employer group's renewal risk factor for the same group of covered employees and the same effective date, as determined by the employer group's insurer.

31A-30-208

Enrollment periods

(1) An insurer offering a health benefit plan in the defined contribution arrangement market:

(a) beginning on or after January 1, 2011, shall allow an employer to enroll in a small employer defined contribution arrangement plan;

(b) may not impose a surcharge under Section 31A-30-106.7 for a small employer group selecting a defined contribution arrangement health benefit plan on or before January 1, 2012;

(c) shall offer a limited pilot program in which a large employer group may enroll in a defined contribution arrangement market plan that takes effect January 1, 2011;

(d) beginning January 1, 2012, shall allow a large employer group to enroll in the defined contribution arrangement market; and

(e) shall otherwise comply with the requirements of this part, Chapter 42, Defined Contribution Risk Adjuster Act, and Title 63M, Chapter 1, Part 25, Health System Reform Act.

(2) (a) Except as provided in Subsection 31A-30-202.5 (2), in accordance with Subsection (2)(b), on January 1 of each year, an insurer may enter or exit the defined contribution arrangement market.

(b) An insurer may offer new or modify existing products in the defined contribution arrangement market:

(i) on January 1 of each year;

(ii) when required by changes in other law; and

(iii) at other times as established by the risk adjuster board created in Section 31A-42-201.

(c) (i) An insurer shall give the department, the Health Insurance Exchange, and the risk adjuster board 90 days' advance written notice of any event described in Subsection (2)(a) or (b).

(ii) When an insurer elects to participate in the defined contribution arrangement market, the insurer shall participate in the defined contribution arrangement market for no less than two years.

31A-30-209

Procedure for appointment of insurance producers to health insurance exchange

(1) A producer may be listed on the Health Insurance Exchange as a producer for the defined contribution arrangement market in accordance with Section 63M-1-2504, if the

producer is designated as an appointed agent for the defined contribution arrangement market in accordance with Subsection (2).

(2) A producer whose license under this title authorizes the producer to sell defined contribution arrangement health benefit plans may be appointed to the defined contribution arrangement market on the Health Insurance Exchange by the Insurance Department, if the producer:

(a) submits an application to the Insurance Department to be appointed as a producer for the defined contribution arrangement market on the Health Insurance Exchange;

(b) is an appointed agent with the majority of the carriers that offer a defined contribution arrangement health benefit plan on the Health Insurance Exchange; and

(c) has completed a defined contribution arrangement training session that is an approved training session as designated by the commissioner.

31A-30-209 (HB 20)

State contract requirements; employer default plans

Text of section effective May 11, 2010

(1) This section applies to an employer who is required to offer its employees a health benefit plan as a condition of qualifying for a state contract under:

(a) Section 17B-2a-818.5;

(b) Section 19-1-206;

(c) Subsection 63A-5-205 (3);

(d) Section 63C-9-403;

(e) Section 72-6-107.5; and

(f) Section 79-2-404.

(2) An employer described in Subsection (1) shall, when selecting the default plan required in Section 31A-30-204, select a default plan that is "qualified health insurance coverage" as defined in the sections listed in Subsections (1)(a) through (f).

Appendix 2

Utah
Insurance Regulations

UTAH ADMINISTRATIVE RULES...INSURANCE...R590. Insurance, Administration...Rule R590-167 -- INDIVIDUAL, SMALL EMPLOYER, AND GROUP HEALTH BENEFIT PLAN RULE

Administrative Rules of Utah renumbered and recodified in 1992 from R540 to R590

Rule R590-167-1

Authority, purpose and scope

(1) Authority.

This rule is intended to implement the provisions of Chapter 30, Title 31A, the Individual and Small Employer Health Insurance Act, referred to in this rule as the Act. The commissioner's authority to enforce this rule is provided under Subsections 31A-2-201(3)(a) and 31A-30-106(1)(k).

(2) Purpose.

(a) The general purposes of the Act and this rule are:

(i) to enhance the availability of health insurance coverage to individuals and small employers;

(ii) to regulate and prevent abuse in insurer rating practices and establish limits on differences in rates between health benefit plans;

(iii) to ensure renewability of coverage;

(iv) to establish limitations on the use of preexisting condition exclusions;

(v) to provide for portability; and

(vi) to improve the overall fairness and efficiency of the individual and small employer health insurance market.

(b) The Act and this rule are intended to:

(i) promote broader spreading of risk in the individual and small employer marketplace; and

(ii) regulate rating practices for all health benefit plans sold to individuals and small employers, whether sold directly or through associations or other groupings of individuals and small employers.

(3) Scope. Carriers that provide health benefit plans to individuals and small employers are intended to be subject to all of the provisions of this rule.

Rule R590-167-2

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) " Associate member of an employee organization " means any individual who participates in an employee benefit plan, as defined in 29 U.S.C. Section 1002(1), that is a multi-employer plan, as defined in 29 U.S.C. Section 1002(37A), other than the following:

(a) an individual, or the beneficiary of such individual, who is employed by a participating employer within a bargaining unit covered by at least one of the collective bargaining agreements under or pursuant to which the employee benefit plan is established or maintained; or

(b) an individual who is a present or former employee, or a beneficiary of such employee, of the sponsoring employee organization, of an employer who is or was a party to at least one of the collective bargaining agreements under or pursuant to which the employee benefit plan is established or maintained, or of the employee benefit plan, or of a related plan.

(2) " Change in a Rating Factor " means the cumulative change with respect to such factor considered over a 12 month period. If a covered carrier changes rating factors with respect to more than one case characteristic in a 12 month period, the carrier shall consider the cumulative effect of all such changes in applying the 10% test.

(3) " Change in Rating Method " means:

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

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

(d) a 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%.

(4) " New entrant " means an eligible employee, or the dependent of an eligible employee, who becomes part of an employer group after the initial period for enrollment in a health benefit plan.

(5) " Risk characteristic " means the health status, claims experience, duration of coverage, or any similar characteristic related to the health status or experience of an individual, a small employer or of any member of a small employer.

(6) " Risk load " means the percentage above the applicable base premium rate that is charged by a covered carrier to a covered insured to reflect the risk characteristics of the covered individuals.

Rule R590-167-3

Applicability and scope

(1) This rule shall apply to any health benefit plan which:

(a) meets one or more of the conditions set forth in Subsections 31A-30-104(1) and (2);

(b) provides coverage to a covered insured located in this state, without regard to whether the policy or certificate was issued in this state; and

(c) is in effect on or after the effective date of this rule.

(2)(a) If a small employer has employees in more than one state, the provisions of the Act and this rule shall apply to a health benefit plan issued to the small employer if:

(i) the majority of eligible employees of such small employer are employed in this state; or

(ii) if no state contains a majority of the eligible employees of the small employer, the primary business location of the small employer is in this state.

(b) In determining whether the laws of this state or another state apply to a health benefit plan issued to a small employer described in Subsection R590-167-3(2)(a), the provisions of the subsection shall be applied as of the date the health benefit plan was issued to the small employer for the period that the health benefit plan remains in effect.

(c) If a health benefit plan is subject to the Act and this rule, the provisions of the Act and this rule shall apply to all individuals covered under the health benefit plan, whether they reside in this state or in another state.

(3) A carrier that is not operating as a covered carrier in this state may not become subject to the provisions of the Act and this rule solely because an individual or a small employer that was issued a health benefit plan in another state by that carrier moves to this state.

Rule R590-167-4

Establishment of classes of business

(1) A covered carrier that establishes more than one class of business pursuant to the provisions of Section 31A-30-105 shall maintain on file for inspection by the commissioner the following information with respect to each class of business so established:

(a) a description of each criterion employed by the carrier, or any of its agents, for determining membership in the class of business;

(b) a statement describing the justification for establishing the class as a separate class of business and documentation that the establishment of the class of business is intended to reflect substantial differences in expected claims experience or administrative costs related to the reasons set forth in Section 31A-30-105; and

(c) a statement disclosing which, if any, health benefit plans are currently available for purchase in the class and any significant limitations related to the purchase of such plans.

(2) A carrier may not directly or indirectly use group size as a criterion for establishing eligibility for a class of business.

Rule R590-167-5

Transition for assumptions of business from another carrier

(1)(a) A covered carrier may not transfer or assume the entire insurance obligation, risk, or both of a health benefit plan covering an individual or a small employer in this state unless:

(i) the transaction has been approved by the commissioner of the state of domicile of the assuming carrier;

(ii) the transaction has been approved by the commissioner of the state of domicile of the ceding carrier; and

(iii) the transaction otherwise meets the requirements of this section.

(b) A carrier domiciled in this state that proposes to assume or cede the entire insurance obligation, risk, or both of one or more health benefit plans covering covered individuals from or to another carrier shall make a filing for approval with the commissioner at least 60 days prior to the date of the proposed assumption. The commissioner may approve the transaction, if the commissioner finds that the transaction is in the best interests of the individuals insured under the health benefit plans to be transferred and is consistent with the purposes of the Act and this rule. The commissioner may not approve the transaction until at least 30 days after the date of the filing; except that, if the carrier is in hazardous financial condition, the commissioner may approve the transaction as soon as the commissioner deems reasonable after the filing.

(c)(i) The filing required under Subsection R590-167-5(1)(b) shall:

(A) describe the class of business, including any eligibility requirements, of the ceding carrier from which the health benefit plans will be ceded;

(B) describe whether the assuming carrier will maintain the assumed health benefit plans as a separate class of business, pursuant to Subsection R590-167-5(3), or will incorporate them into an existing class of business, pursuant to Subsection R590-167-5(4). If the assumed health benefit plans will be incorporated into an existing class of business, the filing shall describe the class of business of the assuming carrier into which the health benefit plans will be incorporated;

(C) describe whether the health benefit plans being assumed are currently available for purchase by individuals or small employers;

(D) describe the potential effect of the assumption, if any, on the benefits provided by the health benefit plans to be assumed;

(E) describe the potential effect of the assumption, if any, on the premiums for the health benefit plans to be assumed;

(F) describe any other potential material effects of the assumption on the coverage provided to the individuals and small employers covered by the health benefit plans to be assumed; and

(G) include any other information required by the commissioner.

(ii) A covered carrier required to make a filing under Subsection R590-167-5(1)(b) shall also make an informational filing with the commissioner of each state in which there are individual or small employer health benefit plans that would be included in the transaction. The informational filing to each state shall be made concurrently with the filing made under Subsection R590-167-5(1)(b) and shall include at least the information specified in Subsection R590-167-5(1)(b)(ii) for the individual or small employer health benefit plans in that state.

(d) A covered carrier may not transfer or assume the entire insurance obligation and/or risk of a health benefit plan covering an individual or a small employer in this state unless it complies with the following provisions:

(i) The carrier has provided notice to the commissioner at least 60 days prior to the date of the proposed assumption. The notice shall contain the information specified in Subsection R590-167-5(1)(c) for the health benefit plans covering individuals and small employers in this state.

(ii) If the assumption of a class of business would result in the assuming covered carrier being out of compliance with the limitations related to premium rates contained in Section 31A-30-106, the assuming carrier shall make a filing with the commissioner pursuant to Subsection 31A-30-105(3) seeking an extended transition period.

(iii) An assuming carrier seeking an extended transition period may not complete the assumption of health benefit plans covering individuals or small employers in this state unless the commissioner grants the extended transition period requested pursuant to Subsection R590-167-5(1)(d)(ii).

(iv) Unless a different period is approved by the commissioner, an extended transition period shall, with respect to an assumed class of business, be for no more than 15 months and, with respect to each individual small employer, shall last only until the anniversary date of such employer's coverage, except that the period with respect to an individual small employer may be extended beyond its first anniversary date for a period of up to 12 months if the anniversary date occurs within three months of the date of assumption of the class of business.

(2)(a) Except as provided in Subsection R590-167-5(2)(b), a covered carrier may not cede or assume the entire insurance obligation, risk, or both for an individual or small employer health benefit plan unless the transaction includes the ceding to the assuming carrier of the entire class of business which includes such health benefit plan.

(b) A covered carrier may cede less than an entire class of business to an assuming carrier if:

(i) one or more individuals or small employers in the class have exercised their right under contract or state law to reject, either directly or by implication, the ceding of their health benefit plans to another carrier. In that instance, the transaction shall include each health benefit plan in the class of business except those health benefit plans for which an individual or a small employer has rejected the proposed cession; or

(ii) after a written request from the transferring carrier, the commissioner determines that the transfer of less than the entire class of business is in the best interests of the individual or small employers insured in that class of business.

(3) Except as provided in Subsection R590-167-5(4), a covered carrier that assumes one or more health benefit plans from another carrier shall maintain such health benefit plans as a separate class of business.

(4) A covered carrier that assumes one or more health benefit plans from another carrier may exceed the limitation contained in Section 31A-30-105 relating to the maximum number of classes of business a carrier may establish, due solely to such assumption for a period of up to 15 months after the date of the assumption, provided that the carrier complies with the following provisions:

(a) Upon assumption of the health benefit plans, such health benefit plans shall be maintained as a separate class of business. During the 15-month period following the assumption, each of the assumed individual or small employer health benefit plans shall be transferred by the assuming covered carrier into a single class of business operated by the assuming covered carrier. The assuming covered carrier shall select the class of business into which the assumed health benefit plans will be transferred in a manner such that the transfer results in the least possible change to the benefits and rating method of the assumed health benefit plans.

(b) The transfers authorized in Subsection R590-167-5(4)(a) shall occur with respect to each individual or small employer on the anniversary date of the individual's or small employer's coverage, except that the period with respect to an individual small employer may be extended beyond its first anniversary date for a period of up to 12 months if the anniversary date occurs within three months of the date of assumption of the class of business.

(c) A covered carrier making a transfer pursuant to Subsection R590-167-5(4)(a) may alter the benefits of the assumed health benefit plans to conform to the benefits currently offered by the carrier in the class of business into which the health benefit plans have been transferred.

(d) The premium rate for an assumed individual or small employer health benefit plan may not be modified by the assuming covered carrier until the health benefit plan is transferred pursuant to Subsection R590-167-5(4)(a). Upon transfer, the assuming covered carrier shall calculate a new premium rate for the health benefit plan from the rate manual established for the class of business into which the health benefit plan is transferred. In making such calculation, the risk load applied to the health benefit plan shall be no higher than the risk load applicable to such health benefit plan prior to the assumption.

(e) During the 15 month period provided in this subsection, the transfer of individual or small employer health benefit plans from the assumed class of business in accordance with this subsection may not be considered a violation of the first sentence of Subsection 31A-30-106(2).

(5) An assuming carrier may not apply eligibility requirements, including minimum participation and contribution requirements, with respect to an assumed health benefit plan, or with respect to any health benefit plan subsequently offered to an individual or small employer covered by such an assumed health benefit plan, that are more stringent than the requirements applicable to such health benefit plan prior to the assumption.

(6) The commissioner may approve a longer period of transition upon application of a covered carrier. The application shall be made within 60 days after the date of assumption of the class of business and shall clearly state the justification for a longer transition period.

(7) Nothing in this section or in the Act is intended to:

(a) reduce or diminish any legal or contractual obligation or requirement, including any obligation provided in Section 31A-14-213, of the ceding or assuming carrier related to the transaction;

(b) authorize a carrier that is not admitted to transact the business of insurance in this state to offer or insure health benefit plans in this state; or

(c) reduce or diminish the protections related to an assumption reinsurance transaction provided in Section 31A-14-213 or otherwise provided by law.

Rule R590-167-6

Restrictions relating to premium rates

(1) A covered carrier shall develop a separate rate manual for each class of business. Base premium rates and new business premium rates charged to individuals and small employers by the covered carrier shall be computed solely from the applicable rate manual developed pursuant to this subsection. To the extent that a portion of the premium rates charged by a covered carrier is based on the carrier's discretion, the manual shall specify the criteria and factors considered by the carrier in exercising such discretion.

(2)(a) A covered carrier may not modify the rating method, as defined in Section R590-167-2, used in the rate manual for a class of business until the change has been approved as provided in this subsection. The commissioner may approve a change to a rating method if the commissioner finds that the change is reasonable, actuarially appropriate, and consistent with the purposes of the Act and this rule.

(b) A carrier may modify the rating method for a class of business only after filing an actuarial certification. The filing shall clearly request approval for a change in rating method and contain at least the following information:

(i) the reasons the change in rating method is being requested;

(ii) a complete description of each of the proposed modifications to the rating method;

(iii) a description of how the change in rating method would affect the premium rates currently charged to individuals and small employers in the class of business, including an estimate from a qualified actuary of the number of groups or individuals, and a description of the types of groups or individuals, whose premium rates may change by more than 10% due to the proposed change in rating method, not including general increases in premium rates applicable to all individuals and small employers in a health benefit plan;

(iv) a certification from a qualified actuary that the new rating method would be based on objective and credible data and would be actuarially sound and appropriate; and

(v) a certification from a qualified actuary that the proposed change in rating method would not produce premium rates for individuals and small employers that would be in violation of Sections 31A-30-106 and 31A-30-106.5.

(3) The rate manual developed pursuant to Subsections 31A-30-106(4) and R590-167-6(1) shall specify the case characteristics and rate factors to be applied by the covered carrier in establishing premium rates for the class of business.

(a) A covered carrier may not use case characteristics other than those specified in Subsection 31A-30-106(1)(h) without the prior approval of the commissioner. A covered carrier seeking such an approval shall make a filing with the commissioner for a change in rating method under Subsection R590-167-6(2)(b). Tobacco use is not an allowable case characteristic. Tobacco use is an allowable risk characteristic when utilized in compliance with Section 31A-30-106(1)(b).

(b) A covered carrier shall use the same case characteristics in establishing premium rates for each health benefit plan in a class of business and shall apply them in the same manner in establishing premium rates for each such health benefit plan. Case characteristics shall be applied without regard to the risk characteristics of an individual or small employer.

(c) The rate manual shall clearly illustrate the relationship among the base premium rates charged for each health benefit plan in the class of business. If the new business premium rate is different than the base premium rate for a health benefit plan, the rate manual shall illustrate the difference.

(d) Differences among base premium rates for health benefit plans shall be based solely on the reasonable and objective differences in the design and benefits of the health benefit plans and may not be based in any way on the nature of an individual or small employer that choose or are expected to choose a particular health benefit plan. A covered carrier shall apply case characteristics and rate factors within a class of business in a manner that assures that premium differences among health benefit plans for identical individuals or small employers vary only due to reasonable and objective differences in the design and benefits of the health benefit plans and are not due to the nature of the individuals or small employers that choose or are expected to choose a particular health benefit plan.

(e) The rate manual shall provide for premium rates to be developed in a two step process.

(i) In the first step, a base premium rate shall be developed for the individual or small employer without regard to any risk characteristics.

(ii) In the second step, the resulting base premium rate may be adjusted by a risk load, subject to the provisions of Sections 31A-30-106 and 31A-30-106.5, to reflect the risk characteristics.

(f) Each rate manual developed pursuant to Subsection R590-167-6(1) shall be maintained by the carrier for a period of six years. Updates and changes to the manual shall be maintained with the manual.

(4)(a) Except as provided in Subsection R590-167-6(4)(b), a premium charged to an individual or small employer for a health benefit plan may not include a separate application fee, underwriting fee, or any other separate fee or charge.

(b) A carrier may charge a separate fee with respect to an individual or small employer health benefit plan, but only one fee with respect to such plan, provided the fee is no more than $5 per month per individual or employee and is applied in a uniform manner to each health benefit plan in a class of business.

(5) If group size is used as a case characteristic by a covered carrier, the highest rate factor associated with a group size classification may not exceed the lowest rate factor associated with such a classification by more than 20% without prior approval of the commissioner.

(6) The restrictions related to changes in premium rates in Subsections 31A-30-106(1)(c) and 31A-30-106(1)(f) shall be applied as follows:

(a) A covered carrier shall revise its rate manual each rating period to reflect changes in base premium rates and changes in new business premium rates.

(b)(i) If, for any health benefit plan with respect to any rating period, the percentage change in the new business premium rate is less than or the same as the percentage change in the base premium rate, the change in the new business premium rate shall be deemed to be the change in the base premium rate for the purposes of Subsections 31A-30-106(1)(c) and 31A-30-106(1)(f).

(ii) If, for any health benefit plan with respect to any rating period, the percentage change in the new business premium rate exceeds the percentage change in the base premium rate, the health benefit plan shall be considered a health benefit plan into which the covered carrier is no longer enrolling new individuals or small employers for the purposes of Subsections 31A-30-106(1)(c) and 31A-30-106(1)(f).

(c) If, for any rating period, the change in the new business premium rate for a health benefit plan differs from the change in the new business premium rate for any other health benefit plan in the same class of business by more than 20%, the carrier shall make a filing with the commissioner containing a complete explanation of how the respective changes in new business premium rates were established and the reason for the difference. The filing shall be made 30 days before the beginning of the rating period.

(d) A covered carrier shall keep on file for a period of at least six years the calculations used to determine the change in base premium rates and new business premium rates for each health benefit plan for each rating period.

(7)(a) Except as provided in Subsection R590-167-6(7)(b), a change in premium rate for an individual or small employer shall produce a revised premium rate that is no more than the following:

(i) the base premium rate for the individual or small employer, as shown in the rate manual as revised for the rating period, multiplied by:

(ii) one plus the sum of:

(iii) the risk load applicable to the individual or small employer during the previous rating period; and

(iv) 15% prorated for periods of less than one year.

(b) In the case of a health benefit plan into which a covered carrier is no longer enrolling new individuals or small employers, a change in premium rate for an individual or small employer shall produce a revised premium rate that is no more than the following:

(i) the base premium rate for the individual or small employer, given its present composition and as shown in the rate manual in effect for the individual or small employer at the beginning of the previous rating period, multiplied by:

(ii) one plus the lesser of:

(A) the change in the base rate; or

(B) the percentage change in the new business premium for the most similar health benefit plan into which the covered carrier is enrolling new individuals or small employers, multiplied by:

(iii) one plus the sum of:

(A) the risk load applicable to the individual or small employer during the previous rating period; and

(B) 15%, prorated for periods of less than one year.

(C) Notwithstanding the provisions of Subsections R590-167-6(7)(a) and (b), a change in premium rate for an individual or small employer may not produce a revised premium rate that would exceed the limitations on rates provided in Subsection 31A-30-106(1)(b).

(8)(a) A representative of a Taft Hartley trust, including a carrier upon the written request of such a trust, may file in writing with the commissioner a request for the waiver of application of the provisions of Subsection 31A-30-106(1) with respect to such trust.

(b) A request made under Subsection R590-167-6(8)(a) shall identify the provisions for which the trust is seeking the waiver and shall describe, with respect to each provision, the extent to which application of such provision would:

(i) adversely affect the participants and beneficiaries of the trust; and

(ii) require modifications to one or more of the collective bargaining agreements under or pursuant to which the trust was or is established or maintained.

(c) A waiver granted under Subsection 31A-30-104(5) shall not apply to an individual who participates in the trust because the individual is an associate member of an employee organization or the beneficiary of such an individual.

Rule R590-167-7

Application to reenter state

(1) A carrier that has been prohibited from writing coverage for individuals or small employers in this state pursuant to Subsection 31A-30-107.3 may not resume offering health benefit plans to individuals or small employers in this state until the carrier has made a petition to the commissioner to be reinstated as a covered carrier and the petition has been approved by the commissioner. In reviewing a petition, the commissioner may ask for such information and assurances as the commissioner finds reasonable and appropriate.

(2) In the case of a covered carrier doing business in only one established geographic service area of the state, if the covered carrier elects to nonrenew a health benefit plan under Subsections 31A-30-107(3)(e) or 107.1(3)(e), the covered carrier shall be prohibited from offering health benefit plans to individuals or small employers in any part of the service area for a period of five years. In addition, the covered carrier may not offer health benefit plans to individuals or small employers in any other geographic area of the state without the prior approval of the commissioner. In considering whether to grant approval, the commissioner may ask for such information and assurances as the commissioner finds reasonable and appropriate.

Rule R590-167-8

Qualifying previous coverage

A covered carrier shall not deny, exclude, or limit benefits because of a preexisting condition without first ascertaining the existence and source of previous coverage. The covered carrier shall have the responsibility to contact the source of such previous coverage to resolve any questions about the benefits or limitations related to such previous coverage. Previous coverage may be coverage that continues after the issuance of the new health benefit plan. The previous carrier shall fully cooperate in furnishing the needed information required by this section.

Rule R590-167-9

Restrictive riders

A restrictive rider, endorsement or other provision that violates the provisions of Subsection 31A-30-107.5 may not remain in force. A covered carrier shall immediately provide written notice to those individuals or small employers whose coverage will be changed pursuant to this section.

Rule R590-167-10

Status of carriers as covered carriers

Former Citations Rule R590-167-11

(1) Prior to marketing a health benefit plan, a carrier shall make a filing with the commissioner indicating whether the carrier intends to operate as a covered carrier in this state under the terms of the Act and of this rule. Such filing will indicate if the covered carrier intends to market to individuals, small employers or both, and be signed by an officer of the company.

(2) Except as provided by Subsection R590-167-10(3), a carrier may not offer health benefit plans to individuals, small employers, or continue to provide coverage under health benefit plans previously issued to individuals or small employers in this state, unless the filing provided pursuant to Subsection R590-167-10(1) indicates that the carrier intends to operate as a covered carrier in this state.

(3) If a carrier does not intend to operate as a covered carrier in this state, the carrier may continue to provide coverage under health benefit plans previously issued to individuals and small employers in this state only if the carrier complies with the following provisions:

(a) the carrier complies with the requirements of the Act with respect to each of the health benefit plans previously issued to individuals and small employers by the carrier;

(b) the carrier provides coverage to each new entrant to a health benefit plan previously issued to an individual or small employer by the carrier;

(c) the carrier complies with the requirements of Section 31A-30-106 and this rule as they apply to individuals and small employers whose coverage has been terminated by the carrier and to individuals and small employers whose coverage has been limited or restricted by the carrier; and

(d) the carrier files a letter of intent indicating the carrier does not intend to operate as a covered carrier in this state and will maintain the business in compliance with the Act and this rule.

(4) If the filing made pursuant Subsection R590-167-10(3) indicates that a carrier does not intend to operate as a covered carrier in this state, the carrier shall be precluded from operating as a covered carrier in this state, except as provided for in Subsection R590-167-10(3), for a period of five years from the date of the filing. Upon a written request from such a carrier, the commissioner may reduce the period provided for in the previous sentence if the commissioner finds that permitting the carrier to operate as a covered carrier would be in the best interests of the individuals and small employers in the state.

Rule R590-167-11

Actuarial certification and additional filing requirements

Former Citations Rule R590-167-12,Rule R590-167-13

(1) Actuarial Certification.

(a) An actuarial certification shall be filed annually and meet the requirements of Section 31A-30-106(4)(b) and the following:

(i) the actuarial certification shall be a written statement that meets the requirements of Title 31A Chapter 30, R590-167, and the applicable standards of practice as promulgated by the Actuarial Standards Board;

(ii) the actuary must state that he or she meets the qualifications of Subsection 31A-30-103(1);

(iii) the actuarial certification shall contain the following statement: "I, (name), certify that (name of covered carrier) is in compliance with the provisions of Title 31A Chapter 30, and R590-167, based upon the examination of (name of covered carrier), including review of the appropriate records and of the actuarial assumptions and methods utilized by (name of covered carrier) in establishing premium rates for applicable health benefit plans;" and

(iv) the actuarial certification shall list and describe each written demonstration used by the actuary to establish compliance with Title 31A Chapter 30 and R590-167.

(b) The actuarial certification shall be filed no later than April 1 of each year.

(2) Rating Manual.

(a) For every health benefit plan subject to the Act and this rule, the carrier shall file with the commissioner a copy of the applicable rating manual, for both new business and renewal rates, which includes:

(i) signed certification by an actuary that to the best of the actuary's knowledge and judgment the rate filing is in compliance with the applicable laws and rules of the State of Utah;

(ii) a complete and detailed description of how the final premium, including any fees, is calculated from the rating manual;

(iii) all changes and updates, which includes a complete and detailed description of how the final premium, including any fees, is calculated from the rating manual; and

(iv) a description of the carrier's classes of business as described in Subsection R590-167-4(1).

(b) The rate manual shall be filed:

(i) with an initial product filing; or

(ii) within 30 days prior to use for an existing health benefit plan

(3) Index Premium Rates.

(a) A small employer carrier shall file annually the index premium rate information required by Section 31A-29-117(2). The report shall include:

(i) the small employer index premium rate as of January 1 of the previous year;

(ii) the small employer index premium rate as of January 1 of the current year; and

(iii) the average percentage change in the index premium rate as of January 1 of the current and preceding year.

(b) The information described in Subsection R590-167-11(3)(a) shall be filed no later than February 1 of each year.

Authority - 31A-30-106.

Rule R590-167-12

Records

Former Citations Rule R590-167-13

Records submitted to the commissioner under this rule shall be maintained by the commissioner as protected records under Title 63, Chapter 2, Government Records Access and Management Act.

Rule R590-167-13

Penalties

A person found, after a hearing or other regulatory process, to be in violation of this rule shall be subject to penalties as provided under Section 31A-2-308.

Rule R590-167-14

Enforcement date

The commissioner will begin enforcing the revised provisions of this rule 45 days from the rule's effective date.

Rule R590-167-15

Severability

If any provision of this rule or the application of it to any person or circumstance is, for any reason, held to be invalid, the remainder of the rule and the application of the provision to other persons or circumstances will not be affected by the invalid provision.

Appendix 3

Utah
Insurance Code

TITLE 31A -- INSURANCE CODE...Chapter 2 -- ADMINISTRATION OF THE INSURANCE LAWS...Part 3. Procedures and Enforcement

31A-2-302

Commissioner approval

(1) When the law requires the commissioner's approval for a certain action without a deemer clause, that approval must be express. The commissioner's disapproval of an action is assumed if the commissioner does not act within 60 days after receiving the application for approval or give notice of the comissioner's reasonable extension of that time period with the commissioner's reasons for the extension. Assumed disapproval under this subsection entitles the aggrieved person to request agency action under Section 63G-4-201.

(2) When the law provides that a certain action is not effective if disapproved by the commissioner within a certain period, the affirmative approval by the commissioner may make the action effective at a designated earlier date, but not earlier than the date of the commissioner's affirmative approval.

(3) Subsections (1) and (2) do not apply to the extent that the law specifically provides otherwise.

********** END DOCUMENT **********

Appendix 4

Utah
Insurance Code

TITLE 31A -- INSURANCE CODE...Chapter 21 -- INSURANCE CONTRACTS IN GENERAL...Part 1. General Rules

31A-21-107

Noncomplying policies

(1) Except as otherwise specifically provided by this title, a policy is enforceable against the insurer according to its terms, even if it exceeds the authority of the insurer.

(2) Any insurance policy, rider, or endorsement issued after July 1, 1986, and which is otherwise valid, which contains any condition or provision not in compliance with the requirements of this title, is not rendered invalid by this title. However, those conditions and provisions shall be construed and applied as if the policy, rider, or endorsement was in full compliance with this title.

(3) Upon written request of the policyholder or an insured whose rights under the policy are continuing and not transitory, an insurer shall reform and reissue or amend by a clearly stated rider its written policy to comply with the requirements of the law existing at the date of issuance of the policy. Subject to this section and Section 31A-21-102, a person seeking to reform a written insurance agreement by complaint or petition to a judicial authority shall show by clear and convincing evidence the existence of facts establishing the reformation.

********** END DOCUMENT **********

Appendix 5

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 Section 31A-2-201.1 and Subsections 31A-2-201(3), 31A-2-202(2), 31A-22-605(4), 31A-22-620(3)(f), and 31A-30-106(1)(i) and (k).

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;

(e) basic health care plan filings required by Section 31A-22-613.5 and Rule R590-175; and

(f) health benefit plan filings required by 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 Coding Matrix," effective July 1, 2009, 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(1)(b).

(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 definition

in Subsection 31A-22-701(1)(a).

(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; or

(n) an advertisement.

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

(16) "Rating methodology change" for the purpose of a 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.

(17) "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.

(18) "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.

(19) "Utah Filed Date" means the date provided to a filer by the Utah Insurance Department, that indicates a filing has been accepted.

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 or an Order to Prohibit Use, refer to Section R590-220-16 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;

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

(D) does not include the base policy; if so, provide the Utah Filed Date of the base policy 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 or Discretionary Group Authorization

Letter. A group filing must attach to the Supporting Documentation tab either a:

(i) signed and fully completed Utah Accident and Health Insurance Group Questionnaire; or

(ii) copy of the Utah Accident and Health Insurance Discretionary Group Authorization letter.

(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.

(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) Utah Accident and Health Insurance Intake Survey.

(i) The intake survey must be properly completed, signed and attached to the Supporting Documentation tab for filings submitted with the type of insurance of "H15G," "H15I," "H16G," "H16I," "HOrg02G," or "HOrg02I."

(ii) If the intake survey is incomplete or not attached, the filing will be rejected.

(h) 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.

(i) Reports are exempt from the filing submission requirement listed in Subsections R590-220-6(4)(c), (d), (f) and (g).

(5) Refer to each applicable section of this rule for additional procedures on how to submit forms, rates, and reports.

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 printed form or printer's proof

format. 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.

(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) Up to three 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; 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; and

(c) Rules R590-85, R590-126, R590-131, and R590-192.

(2) This section does not apply to filings for individual health benefit plans that are subject to Title 31A, Chapter 30, Individual, Small Employer, and Group Health Insurance Act, and Rule R590-167. Individual health benefit plan filings are discussed in Section R590-220-10.

(3) 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.

(4) Every 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.

(5) 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.

(6) 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) Rules R590-76, R590-126, R590-131, R590-146, R590-148, R590-192, R590-233, and Section R590-220-10.

(2) Determine whether the group is an eligible group or a discretionary group.

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

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

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

(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 filings subject to Title 31A, Chapter 30, Individual, Small Employer, and Group Health Insurance Act.

(1) A filer submitting health benefit plan filings that are subject to Title 31A, Chapter 30, is advised to review:

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

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

(c) Title 31A, Chapter 30; and

(d) Rules R590-76, R590-131, R590-167, R590-175, R590-176, R590-233, and R590-247.

(2)(a) Form Filing.(i) A health benefit plan form filing must include a rate manual.

(ii) If the rate manual was previously filed, provide documentation indicating the department's receipt.

(b) Rate Manual Filing.

(i) A rate manual that does not request a change in rating methodology is a File Before Use filing.

(ii) A change in rating methodology filing is a File for Approval filing.

(iii) A new and revised rate manual must:

(A) include an actuarial certification signed by a qualified actuary;

(B) be filed 30 days prior to use;

(C) list the case characteristics and rate factors to be used;

(D) be applied in the same manner for all health benefit plans in a class;

(E) contain specific area factor and industry factors applicable in Utah;

(F) include the method of calculating the risk load, including the method used to determine any experience factors;

(G) include how the overall rate is reviewed for compliance with the rate restrictions; and

(H) include detailed description of all classes of business, as provided in Section 31A-30-105.

(iv) Any case characteristic not listed in Subsection

31A-30-106(1)(h) requires prior approval of the commissioner.

(3) Health Benefit Plan Reports.

(a) Actuarial Certification.

(i) All individual and small employer licensees must file an actuarial certification as described in Section 31A-30-106 and Subsection R590-167-11(1)(a).

(ii) The report is due April 1 each year.

(b) Small Employer Index Rates Report.

All small employer licensees must file their index rates as of January 1 of the current year and preceding year, as required by Subsection 31A-29-117(2).

(i) The report must include:

(A) the actual index rates; and

(B) calculate the percentage change in these rates between the two years.

(ii) The report is due February 1 each year.

(c) Each report must be filed separately and be properly identified.

(d)(i) All health benefit plan reports must be filed with SERFF 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. A Medicare supplement form filing that affects rates must be filed with all required rating documentation.

(1)(a) A licensee must file its Medicare Supplement Buyers Guide.

(b) If previously filed, indicate the filed date in the filing description.

(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) 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.

(3) Annual Medicare Supplement Reports.

(a) Medicare supplement reports are File and Use filings.

(b) Reports are due May 31 each year.

(c) 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."

(d) 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.

(e) 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.

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

(g) 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."

(h) If Medicare supplement reports are not submitted 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 health and life combination policies, or health endorsements or riders, to life policies, 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; an endorsement or rider, or an integrated policy.

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

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

(1) A filer submitting long-term care product filings is advised to review:

(a) Title 31A, Chapter 22, Part 14, Long Term Care Insurance

Standards;
(b) Rule R590-148; and
(c) Section R590-220-12.
(2) A long-term care form filing that affects rates must be filed with all required rating documentation.
(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) 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.
(4) 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.
(b) If all four 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) The four reports shown below are required by Section R590-148-25.
(i) Replacement and Lapse Reporting Form.
(ii) Claims Denial Reporting Form.
(iii) Rescission Reporting Form.
(iv) Suitability Report Form.
(f) All long term care reports must be filed with SERFF 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 via SERFF 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. Correspondence and Status Checks.
(1) Correspondence. When corresponding with the department, provide sufficient information to identify the original filing:
(a) type of insurance;
(b) date of filing;
(c) form numbers; and
(d) SERFF tracking number.
(2) Status Checks.
(a) A complete filing is usually processed within 45 days of receipt.
(b) A filer can request the status of its filing 60 days after the date of submission. A response will not be provided to a status request prior to 60 days.

R590-220-16. 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 R590-220-16(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 not later than the date specified in the Order.

(c) To contest an Order to Prohibit Use, the commissioner must receive 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.

R590-220-17. Penalties.

A person found to be in violation of this rule shall be subject to penalties as provided under Section 31A-2-308.

R590-220-18. Enforcement Date.

The commissioner will begin enforcing the revised provisions of this rule 15 days from the effective date of this rule.

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.

KEY: health insurance filings
Date of Enactment or Last Substantive Amendment: February 22, 2010
Notice of Continuation: March 12, 2009
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

Appendix 6

Utah
Insurance Code

TITLE 31A -- INSURANCE CODE...Chapter 21 -- INSURANCE CONTRACTS IN GENERAL...Part 2. Approval of Forms

31A-21-201

Filing and approval of forms

Text of section effective until May 11, 2010

(1)(a) Except as exempted under Subsections 31A-21-101(2) through (6), a form may not be used, sold, or offered for sale unless the form has been filed with the commissioner.

(b) A form is considered filed with the commissioner when the commissioner receives:

(i) the form;

(ii) the applicable filing fee as prescribed under Section 31A-3-103; and

(iii) the applicable transmittal forms as required by the commissioner.

(2) In filing a form for use in this state the insurer is responsible for assuring that the form is in compliance with this title and rules adopted by the commissioner.

(3)(a) The commissioner may prohibit the use of a form at any time upon a finding that:

(i) the form is:

(A) inequitable;

(B) unfairly discriminatory;

(C) misleading;

(D) deceptive;

(E) obscure;

(F) unfair;

(G) encourages misrepresentation; or

(H) not in the public interest;

(ii) the form provides benefits or contains other provisions that endanger the solidity of the insurer;

(iii) in the case of the basic policy and the application for a basic policy, the basic policy or application for the basic policy fails to conspicuously, as defined by rule, provide:

(A) the exact name of the insurer;

(B) the state of domicile of the insurer filing the basic policy or application for the basic policy; and

(C) for life insurance and annuity policies only, the address of the administrative office of the insurer filing the basic policy or application for the basic policy;

(iv) the form violates a statute or a rule adopted by the commissioner; or

(v) the form is otherwise contrary to law.

(b) Subsection (3)(a)(iii) does not apply to riders and endorsements to a basic policy.

(c)(i) Whenever the commissioner prohibits the use of a form under Subsection (3)(a), the commissioner may order that, on or before a date not less than 15 days after the order, the use of the form be discontinued.

(ii) Once a form has been prohibited, the form may not be used unless appropriate changes are filed with and reviewed by the commissioner.

(iii) Whenever the commissioner prohibits the use of a form under Subsection (3)(a), the commissioner may require the insurer to disclose contract deficiencies to existing policyholders.

(d) If the commissioner prohibits use of a form under this Subsection (3), the prohibition shall:

(i) be in writing;

(ii) constitute an order; and

(iii) state the reasons for the prohibition.

(4)(a) If, after a hearing, the commissioner determines that it is in the public interest, the commissioner may require by rule or order that certain forms be subject to the commissioner's approval prior to their use.

(b) The rule or order described in Subsection (4)(a) shall prescribe the filing procedures for the forms if the procedures are different than the procedures stated in this section.

(c) The types of forms that may be addressed under Subsection (4)(a) include:

(i) a form for a particular class of insurance;

(ii) a form for a specific line of insurance;

(iii) a specific type of form; or

(iv) a form for a specific market segment.

(5)(a) An insurer shall maintain a complete and accurate record of the following for the time period described in Subsection (5)(b):

(i) any form:

(A) filed under this section for use; and

(B) that is in use; and

(ii) any document filed under this section with a form described in Subsection (5)(a)(i).

(b) The insurer shall maintain a record required under Subsection (5)(a) for the balance of the current year, plus five years from:

(i) the last day on which the form is used; or

(ii) the last day any policy that is issued using the form is in effect.

Text of section effective May 11, 2010

(1) (a) Except as exempted under Subsections 31A-21-101 (2) through (6), a form may not be used, sold, or offered for sale until the form is filed with the commissioner.

(b) A form is considered filed with the commissioner when the commissioner receives:

(i) the form;

(ii) the applicable filing fee as prescribed under Section 31A-3-103; and

(iii) the applicable transmittal forms as required by the commissioner.

(2) In filing a form for use in this state the insurer is responsible for assuring that the form is in compliance with this title and rules adopted by the commissioner.

(3) (a) The commissioner may prohibit the use of a form at any time upon a finding that:

(i) the form:

(A) is inequitable;

(B) is unfairly discriminatory;

(C) is misleading;

(D) is deceptive;

(E) is obscure;

(F) is unfair;

(G) encourages misrepresentation; or

(H) is not in the public interest;

(ii) the form provides benefits or contains another provision that endangers the solidity of the insurer;

(iii) except an application required by Section 31A-22-635, the form is an insurance policy or application for an insurance policy that fails to conspicuously, as defined by rule, provide:

(A) the exact name of the insurer;

(B) the state of domicile of the insurer filing the insurance policy or application for the insurance policy; and

(C) for a life insurance and annuity insurance policy only, the address of the administrative office of the insurer filing the insurance policy or application for the insurance policy;

(iv) the form violates a statute or a rule adopted by the commissioner; or

(v) the form is otherwise contrary to law.

(b) Subsection (3)(a)(iii) does not apply to an endorsement to an insurance policy.

(c) (i) When the commissioner prohibits the use of a form under Subsection (3)(a), the commissioner may order that, on or before a date not less than 15 days after the order, the use of the form be discontinued.

(ii) Once use of a form is prohibited, the form may not be used until appropriate changes are filed with and reviewed by the commissioner.

(iii) When the commissioner prohibits the use of a form under Subsection (3)(a), the commissioner may require the insurer to disclose contract deficiencies to the existing policyholders.

(d) If the commissioner prohibits use of a form under this Subsection (3), the prohibition shall:

(i) be in writing;

(ii) constitute an order; and

(iii) state the reasons for the prohibition.

(4) (a) If, after a hearing, the commissioner determines that it is in the public interest, the commissioner may require by rule or order that a form be subject to the commissioner's approval before its use.

(b) The rule or order described in Subsection (4)(a) shall prescribe the filing procedures for a form if the procedures are different from the procedures stated in this section.

(c) The type of form that under Subsection (4)(a) the commissioner may require approval of before use includes:

(i) a form for a particular class of insurance;

(ii) a form for a specific line of insurance;

(iii) a specific type of form; or

(iv) a form for a specific market segment.

(5) (a) An insurer shall maintain a complete and accurate record of the following for the time period described in Subsection (5)(b):

(i) a form:

(A) filed under this section for use; or

(B) that is in use; and

(ii) a document filed under this section with a form described in Subsection (5)(a)(i).

(b) The insurer shall maintain a record required under Subsection (5)(a) for the balance of the current year, plus five years from:

(i) the last day on which the form is used; or

(ii) the last day an insurance policy that is issued using the form is in effect.

********** END DOCUMENT **********

Appendix 7

Utah Code
Title 31A Insurance Code
Chapter 21 Insurance Contracts in General
Section 302 Premiums.

31A-21-302. Premiums.

(1) Subject to Section **31A-21-310** and Subsection **31A-21-106**(1), the policy shall clearly state the amount of the total premium or shall explain in detail how it is calculated. Any fee, charge, or other consideration that is not part of the premium shall be disclosed and explained in writing to the insured. The disclosure and explanation shall be clearly stated either on the policy, or on the insurer's billing to the insured. The premium need not be contained in a certificate issued under a group policy. This Subsection (1) does not preclude premium adjustments or changes upon the renewal or endorsement of an existing policy. However, the renewal or endorsement notice shall contain or be accompanied by a statement of the renewal or endorsement premium or credit.

(2) Except as provided in Chapter 23a, Insurance Marketing - Licensing Producers, Consultants, and Reinsurance Intermediaries, no person may charge or receive any consideration for the insurance policy which is not stated in Subsection (1).

(3) No person may knowingly collect any excessive amount as a premium or any amount for insurance which is not in the course of processing. Any amount unknowingly collected shall be returned immediately on learning of the mistake. Prepayment of premiums pursuant to the policy is not an excessive collection. Insurance is in the course of processing if an application has been made for it which is being considered by the insurer, even though it has not yet been accepted or rejected.

Amended by Chapter 298, 2003 General Session

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