

R590. Insurance, Administration. (Effective 6-15-2011)

R590-167. Individual, Small Employer, and Group Health Benefit Plan 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), 31A-30-106(1)(k), and 31A-30-106.1(10).

(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 prescribe the manner in which case characteristics may be used;

(vi) to regulate the use and establishment of separate classes of business;

(vii) to provide for portability; and

(viii) 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.

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 a rating factor other than a case characteristic allowed under Section 31A-30-106 or 31A-30-106.1, as applicable, including exact age, gender, family composition, the health status, claims experience, duration of coverage, or any similar characteristic related to the demographics or 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.

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.

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) For policies issued or renewed on or after January 1, 2011, a covered carrier may not establish a separate class of business without a prior approval of the commissioner.

(3) In order to receive an approval to establish a separate class of business under Subsection R590-167-4(2) the covered carrier shall submit a filing in compliance with R590-220 that includes:

(a) a written request to establish a separate class of business;

(b) description of all criteria employed by the carrier, or any of its agents, for determining membership in the class of business;

(c) disclosure of which health benefit plans will be available for purchase in the class and any significant limitations related to the purchase of such plans; and

(d) demonstrate to the satisfaction of the commissioner 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;

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

(e) a list of previously approved classes of business; and

(f) for each class of business used prior to January 1, 2011,

a certification that the continued use of the class of business is necessary due to conditions specified in Subsection R590-167-4(3)(d).

(4) A carrier may not directly or indirectly use group size as a criterion for establishing eligibility for a class of business.

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;

(iii) the carrier has provided notice to the commissioner of this state 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)(i) for the health benefit plans covering individuals and small employers in this state; and

(iv) 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 intends to 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)(c)(i) for the individual or small employer health benefit plans in that state.

(d)(i) 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 or 31A-30-106.1, the assuming carrier shall make a filing with the commissioner pursuant to Subsection 31A-30-105(3) seeking an extended transition period.

(ii) 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)(i).

(iii) 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) A covered carrier that assumes one or more health benefit plans from another carrier and intends to maintain such health benefit plans as a separate class of business, shall submit a filing requesting

approval to establish a separate class of business as provided in Subsection R590-167-4(3). The assumption shall not take place prior to approval of the request by the commissioner.

(4) A covered carrier that assumes one or more health benefit plans from another carrier and intends to incorporate them into an existing class of business shall comply with the following provisions:

(a) Upon assumption of the health benefit plans, such health benefit plans shall be maintained temporarily as a separate class of business, deemed to be approved by the commissioner under Subsection 31A-30-105(2)(b)(ii). A covered carrier may exceed the limitation contained in Subsection 31A-30-105(4) due solely to such assumption.

(b) 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.

(c) The transfers authorized in Subsection R590-167-5(4)(b) 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.

(d) A covered carrier making a transfer pursuant to Subsection R590-167-5(4)(b) 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.

(e) 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)(b). 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.

(f) 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 Subsections 31A-30-106(3)(a) or 31A-30-106.1(8)(a), as applicable.

(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

under Subsection R590-167-5(4) 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.

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, 31A-30-106.1, and 31A-30-106.5.

(3) The rate manual developed pursuant to Subsections 31A-30-106(4), 31A-30-106.1(9), 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 offering a health benefit plan to an individual may not use case characteristics other than those specified in Subsection 31A-30-106(1)(f) 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 Subsection 31A-30-106(1)(b).

(b)(i) A covered carrier offering or renewing a health benefit plan to a small employer on or after January 1, 2011, may not use case characteristics other than:

(A) age band, as specified in Subsection 31A-30-106.1(6)(a), applicable to the age of the employee;

(B) geographic area;

(C) family composition tier, as specified in 31A-30-106.1(6)(c); and

(D) for plans issued or renewed on or after July 1, 2011, gender of the employee or the spouse.

(ii) For any geographic area used as a case characteristic by a covered carrier, base rates for any small employer health benefit plan offered or renewed on or after January 1, 2011 shall be subject to the following limitations:

(A) for any age band, the ratio of the base rate for the family tier to the base rate for employee only tier, shall not exceed 5; and

(B) for any family composition tier, the ratio of the base rate for any age band to the base rate for "less than 20" age band, may not exceed the following:

(I) 1.22 for age band 20 to 24;

(II) 1.34 for age band 25 to 29;

(III) 1.46 for age band 30 to 34;

(IV) 1.60 for age band 35 to 39;

(V) 1.80 for age band 40 to 44;

(VI) 2.20 for age band 45 to 49;

(VII) 2.80 for age band 50 to 54;

(VIII) 3.60 for age band 55 to 59;

(IX) 4.25 for age band 60 to 64; and

(X) 5.00 for age band over 65.

(c) 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.

(d) 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.

(e) 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.

(f) 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. The base rates shall reflect only the allowable case characteristics. The base rates for an individual health benefit plan offered to two individuals with the same case characteristics shall be identical. The base rates for a small employer health benefit plan offered to two small employer groups with the same case characteristics shall be identical.

(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, 31A-30-106.1, and 31A-30-106.5, to reflect the risk characteristics.

(g) 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) The restrictions related to changes in premium rates in Subsections 31A-30-106(1)(c) and 31A-30-106.1(3) 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(3).

(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(3).

(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.

(6) (a) Except as provided in Subsection R590-167-6(6) (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(6) (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 Subsections 31A-30-106(1) (b) and 31A-30-106.1(2) (b).

(7) (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 Subsections 31A-30-106.1(1) through 31A-30-106.1(6) with respect to such trust.

(b) A request made under Subsection R590-167-6(7) (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.

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.

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.

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.

R590-167-10. Status of Carriers as Covered Carriers.

(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 Sections 31A-30-106 and 31A-30-106.1 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.

R590-167-11. Actuarial Certification and Additional Filing Requirements.

(1) Actuarial Certification.

(a) An actuarial certification shall be filed annually and meet the requirements of Subsections 31A-30-106(4)(b) or 31A-30-106.1(9)(b), or both, as applicable, 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.

R590-167-12. Records.

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

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.

R590-167-14. Enforcement Date.

The commissioner will begin enforcing the revised provisions of this rule 45 days after the effective date.

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.

KEY: health insurance

Date of Enactment or Last Substantive Amendment: June 15, 2011

Notice of Continuation: September 10, 2009

Authorizing, and Implemented or Interpreted Law: 31A-30-106