Part 1
Individual and Small Employer Group

31A-30-101 Title.

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

Amended by Chapter 108, 2004 General Session

31A-30-102 Purpose statement.

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; and

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

Amended by Chapter 292, 2017 General Session

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 this chapter, 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 a person who directly or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with, a specified 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.

(4)

(a) "Bona fide employer association" means an association of employers:

(i) that meets the requirements of Section 31A-22-505;

(ii) in which the employers of the association, either directly or indirectly, exercise control over the plan;

(iii) that is organized:

(A) based on a commonality of interest between the employers and their employees that participate in the plan by some common economic or representation interest or genuine organizational relationship unrelated to the provision of benefits; and

(B) to act in the best interests of its employers to provide benefits for the employer's employees and their spouses and dependents, and other benefits relating to employment; and

(iv) whose association sponsored health plan complies with 45 C.F.R. 146.121.

(b) The commissioner shall consider the following with regard to determining whether an association of employers is a bona fide employer association under Subsection (4)(a):
(i) how association members are solicited;
(ii) who participates in the association;
(iii) the process by which the association was formed;
(iv) the purposes for which the association was formed, and what, if any, were the pre-existing relationships of its members;
(v) the powers, rights and privileges of employer members; and
(vi) who actually controls and directs the activities and operations of the benefit programs.
(5) "Carrier" means a person 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) another person 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.
(7) "Class of business" means all or a separate grouping of covered insureds that is permitted by the commissioner in accordance with Section 31A-30-105.
(8) "Covered carrier" means an individual carrier or small employer carrier subject to this chapter.
(9) "Covered individual" means an individual who is covered under a health benefit plan subject to this chapter.
(10) "Covered insureds" means small employers and individuals who are issued a health benefit plan that is subject to this chapter.
(11) "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.
(12) "Established geographic service area" means a geographical area approved by the commissioner within which the carrier is authorized to provide coverage.
(13) "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.
(14) "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.
(15) "Individual conversion policy" means a conversion policy issued to:

(a) an individual; or
(b) an individual with a family.
(16) "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.
(17) "Premium" means money paid by covered insureds and covered individuals as a condition of receiving coverage from a covered carrier, including fees or other contributions associated with the health benefit plan.
(18)
(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.
(19) "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.

Amended by Chapter 198, 2022 General Session

31A-30-104 Applicability and scope.
(1) This chapter applies to any:
(a) health benefit plan that provides coverage to:
(i) individuals;
(ii) small employers, except as provided in Subsection (3); 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, except as provided in Subsection (3);
(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) short-term limited duration health insurance;
(b) federally funded or partially funded programs; or
(c) a bona fide employer association.
(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 or Section 31A-22-618.6 or 31A-22-618.7 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, 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, 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 Subsections 31A-30-106(1) and 31A-30-106.1(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) The provisions of Chapter 45, Managed Care Organizations, and Sections 31A-22-618.6, 31A-30-106, 31A-30-106.1, 31A-30-106.5, 31A-30-106.7, and 31A-30-108, 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;

(d) an insurance consultant; and

(e) a navigator.

Amended by Chapter 193, 2019 General Session

31A-30-105 Establishment of classes of business.

Effective January 1, 2014, a covered carrier may establish up to four separate classes of business:
(1) one class of business for individual health benefit plans that are not grandfathered under PPACA;
(2) one class of business for small employer health benefit plans that are not grandfathered under PPACA;
(3) one class of business for individual health benefit plans that are grandfathered under PPACA; and
(4) one class of business for small employer health benefit plans that are grandfathered under PPACA.

Amended by Chapter 341, 2013 General Session

31A-30-106 Individual premiums -- Rating restrictions -- Disclosure.
(1) Premium rates for health benefit plans for individuals under this chapter are subject to 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 except as provided under Subsection (1)(b)(ii).
(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 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 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 plans.
(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;

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

(C) promote transparency of rating practices of health benefit plans, except that a carrier may not be required to disclose proprietary information.

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

(A) assure that differences in rates charged for health benefit plans 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 plans; and

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

(h) 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 plan is a health benefit plan 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) A 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) Except as provided in Subsection (1)(g) or required by PPACA, a record submitted to the commissioner under this section shall be maintained by the commissioner as a protected record under Title 63G, Chapter 2, Government Records Access and Management Act.

Amended by Chapter 168, 2017 General Session

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 this section.
(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 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 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 plans.
(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 of the employee, in accordance with Subsection (7);
(b) geographic area;
(c) family composition in accordance with Subsection (9);
(d) for plans renewed or effective on or after July 1, 2011, gender of the employee and spouse;
(e) for an individual age 65 and older, whether the employer policy is primary or secondary to Medicare; and
(f) a wellness program, in accordance with Subsection (12).
(7) Age limited to:
(a) the following age bands:
(i) less than 20;
(ii) 20-24;
(iii) 25-29;
(iv) 30-34;
(v) 35-39;
(vi) 40-44;
(vii) 45-49;
(viii) 50-54;
(ix) 55-59;
(x) 60-64; and
(xi) 65 and above; and
(b) a standard slope ratio range for each age band, applied to each family composition tier rating structure under Subsection (9)(b):
(i) as developed by the commissioner by administrative rule; and
(ii) not to exceed an overall ratio as provided in Subsection (8).
(8)
(a) The overall ratio permitted in Subsection (7)(b)(ii) may not exceed:
(i) 5:1 for plans renewed or effective before January 1, 2012; and
(ii) 6:1 for plans renewed or effective on or after January 1, 2012; and
(b) the age slope ratios for each age band may not overlap.
(9) Family composition is limited to:
(a) an overall ratio of:
(i) 5:1 or less for plans renewed or effective before January 1, 2012; and
(ii) 6:1 or less for plans renewed or effective on or after January 1, 2012; and
(b) a tier rating structure that includes:
(i) four tiers that include:
(A) employee only;
(B) employee plus spouse;
(C) employee plus a child or children; and
(D) a family, consisting of an employee plus spouse, and a child or children;

(ii) for plans renewed or effective on or after January 1, 2012, five tiers that include:
(A) employee only;
(B) employee plus spouse;
(C) employee plus one child;
(D) employee plus two or more children; and
(E) employee plus spouse plus one or more children; or
(iii) for plans renewed or effective on or after January 1, 2012, six tiers that include:
(A) employee only;
(B) employee plus spouse;
(C) employee plus one child;
(D) employee plus two or more children;
(E) employee plus spouse plus one child; and
(F) employee plus spouse plus two or more children.

(10) 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 plan into which the small employer carrier is actively enrolling new covered insureds.

(11)
(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.

(12) Notwithstanding Subsection (4)(b), a small employer carrier may:
(a) offer a wellness program to a small employer group if:
(i) the premium discount to the employer for the wellness program does not exceed 20% of the premium for the small employer group; and
(ii) the carrier offers the wellness program discount uniformly across all small employer groups;
(b) offer a premium discount as part of a wellness program to individual employees in a small employer group:
(i) to the extent allowed by federal law; and
(ii) if the employee discount based on the wellness program is offered uniformly across all small employer groups; and
(c) offer a combination of premium discounts for the employer and the employee, based on a wellness program, if:
(i) the employer discount complies with Subsection (12)(a); and
(ii) the employee discount complies with Subsection (12)(b).

(13)
(a) A 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) A 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 (13)(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 (13) available to the commissioner upon request.

(14)

(a) The commissioner shall 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 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.

(15) 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.

Amended by Chapter 354, 2020 General Session

31A-30-106.5 Conversion policy -- Premiums -- Rating restrictions.

(1) Section 31A-30-106 applies 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 filed.

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

Amended by Chapter 284, 2011 General Session

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-30-106.1.

(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-22-618.6(5);
(iii) employees from an existing group form a new business; and
(iv) the surcharge is not applied uniformly to all similarly situated small groups.
(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 the 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.

Amended by Chapter 292, 2017 General Session

31A-30-107.5 Preexisting condition exclusion -- Condition-specific exclusion riders -- Limitation periods.
(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) shall 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).

Amended by Chapter 297, 2011 General Session

31A-30-108 Eligibility for small employer and individual market.

(1)
(a) A small employer carrier shall accept a small employer that applies for small group coverage as set forth in the Health Insurance Portability and Accountability Act, Sec. 2701(f) and 2711(a), and PPACA, Sec. 2702.
(b) An individual carrier shall accept an individual that applies for individual coverage as set forth in PPACA, Sec. 2702.
(2)
(a) A small employer carrier 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) A small employer carrier 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).

Amended by Chapter 290, 2014 General Session
Amended by Chapter 300, 2014 General Session
Amended by Chapter 425, 2014 General Session

31A-30-112 Employee participation levels.
(1)
(a) For purposes of this section, "participation" means the same as that term is defined in Section 31A-1-301.
(b) Except as provided in Subsection (2), a requirement used by a covered carrier in determining whether to provide coverage to a small employer, including a participation requirement and a minimum employer contribution requirement, 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.
(2) A covered carrier may not increase a participation requirement or a requirement for minimum employer contribution, applicable to a small employer, at any time after the small employer is accepted for coverage.

Amended by Chapter 354, 2020 General Session

31A-30-114 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.

Enacted by Chapter 308, 2002 General Session

31A-30-115 Actuarial review of health benefit plans.

(1)
(a) The department shall conduct an actuarial review of rates submitted by a carrier that offers a small employer plan and a carrier that offers an individual plan under this chapter:
(i) to verify the validity of the rates, risk factors, and premiums of the plans; and
(ii) as the department determines is necessary to oversee market conduct.
(b) The actuarial review by the department shall be funded from a fee:
(i) established by the department in accordance with Section 63J-1-504; and
(ii) paid by a carrier offering a health benefit plan subject to this chapter.
(c) The department shall contact carriers, if the department determines it is appropriate, to:
(i) inform a carrier of the department's findings regarding the rates of a particular carrier; and
(ii) request a carrier to recalculate or verify base rates, rating factors, and premiums.
(d) A carrier shall comply with the department's request under Subsection (1)(c)(ii).

(2)
(a) There is created in the General Fund a restricted account known as the "Health Insurance Actuarial Review Restricted Account."
(b) The Health Insurance Actuarial Review Restricted Account shall consist of money received by the commissioner under this section.
(c) The commissioner shall administer the Health Insurance Actuarial Review Restricted Account. Subject to appropriations by the Legislature, the commissioner shall use money deposited into the Health Insurance Actuarial Review Restricted Account to pay for the actuarial review conducted by the department under this section.

Amended by Chapter 354, 2020 General Session

31A-30-117 Patient Protection and Affordable Care Act -- Market transition.

(1)
(a) The commissioner may adopt administrative rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, that change the rating and underwriting requirements of this chapter as necessary to transition the insurance market to meet federal qualified health plan standards and rating practices under PPACA.
(b) Administrative rules adopted by the commissioner under this section may include:
(i) the regulation of health benefit plans as described in Subsection 31A-2-212(5); and
(ii) disclosure of records and information required by PPACA and state law.
(c)
(i) The commissioner shall establish by administrative rule one statewide open enrollment period that applies to the individual insurance market that is not on the PPACA certified individual exchange.
(ii) The statewide open enrollment period:

(A) may be shorter, but no longer than the open enrollment period established for the individual insurance market offered in the PPACA certified exchange; and
(B) may not be extended beyond the dates of the open enrollment period established for the individual insurance market offered in the PPACA certified exchange.
(2) A carrier that offers health benefit plans in the individual market that is not part of the individual PPACA certified exchange:
(a) shall open enrollment:
(i) during the statewide open enrollment period established in Subsection (1)(c); and
(ii) at other times, for qualifying events, as determined by administrative rule adopted by the commissioner; and
(b) may open enrollment at any time.
(3) To the extent permitted by the Centers for Medicare and Medicaid Services policy, or federal regulation, the commissioner shall allow a health insurer to choose to continue coverage and individuals and small employers to choose to re-enroll in coverage in nongrandfathered health coverage that is not in compliance with market reforms required by PPACA.

Amended by Chapter 32, 2020 General Session
Amended by Chapter 354, 2020 General Session

31A-30-118 Patient Protection and Affordable Care Act -- State insurance mandates -- Cost of additional benefits.

(1)
(a) The commissioner shall identify a new mandated benefit that is in excess of the essential health benefits required by PPACA.
(b) The state shall quantify the cost attributable to each additional mandated benefit specified in Subsection (1)(a) based on a qualified health plan issuer's calculation of the cost associated with the mandated benefit, which shall be:
(i) calculated in accordance with generally accepted actuarial principles and methodologies;
(ii) conducted by a member of the American Academy of Actuaries; and
(iii) reported to the commissioner and to the individual exchange operating in the state.
(c) The commissioner may require a proponent of a new mandated benefit under Subsection (1)(a) to provide the commissioner with a cost analysis conducted in accordance with Subsection (1)(b). The commissioner may use the cost information provided under this Subsection (1)(c) to establish estimates of the cost to the state under Subsection (2).
(2) If the state is required to defray the cost of additional required benefits under the provisions of 45 C.F.R. 155.170:
(a) the state shall make the required payments:
(i) in accordance with Subsection (3); and
(ii) directly to the qualified health plan issuer in accordance with 45 C.F.R. 155.170;
(b) an issuer of a qualified health plan that receives a payment under the provisions of Subsection (1) and 45 C.F.R. 155.170 shall:
(i) reduce the premium charged to the individual on whose behalf the issuer will be paid under Subsection (1), in an amount equal to the amount of the payment under Subsection (1); or
(ii) notwithstanding Subsection 31A-23a-402.5(5), provide a premium rebate to an individual on whose behalf the issuer received a payment under Subsection (1), in an amount equal to the amount of the payment under Subsection (1); and
(c) a premium rebate made under this section is not a prohibited inducement under Section 31A-23a-402.5.

(3) A payment required under 45 C.F.R. 155.170(c) shall:
(a) unless otherwise required by PPACA, be based on a statewide average of the cost of the additional benefit for all issuers who are entitled to payment under the provisions of 45 C.F.R. 155.170; and
(b) be submitted to an issuer through a process established by the commissioner.
(4)
(a) As used in this Subsection (4), "account" means the State Mandated Insurer Payments Restricted Account created in Subsection (4)(b).
(b) There is created in the General Fund a restricted account known as the "State Mandated Insurer Payments Restricted Account."
(c) The account shall consist of:
(i) money appropriated to the account by the Legislature; and
(ii) interest earned on money in the account.
(d) Subject to appropriations from the Legislature, the commissioner shall administer the account for the sole benefit of a qualified health plan issuer who is eligible to receive payments under this section.
(e) An appropriation from the account is nonlapsing.
(5) The commissioner may adopt rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to:
(a) administer the provisions of this section and 45 C.F.R. 155.170; and
(b) establish or implement a process for submitting a payment to an issuer under Subsection (3)(b).

Amended by Chapter 194, 2023 General Session