

Effective 5/13/2014

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 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;
 - (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 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; 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 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) 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 290, 2014 General Session

Amended by Chapter 300, 2014 General Session