Table of Contents

18.01.72 - RULE TO IMPLEMENT THE INDIVIDUAL HEALTH INSURANCE AVAILABILITY ACT

IDAPA 18
TITLE 01
CHAPTER 72

18.01.72 - RULE TO IMPLEMENT THE INDIVIDUAL HEALTH INSURANCE AVAILABILITY ACT

000. LEGAL AUTHORITY.
This rule is promulgated and adopted pursuant to the authority vested in the Director under chapters 2, 47 and 52, title 41, Idaho Code. (7-1-98)

001. TITLE AND SCOPE.

01. Title. This Rule shall be cited in full as Idaho Department of Insurance Rules, IDAPA 18.01.72, "Rule to Implement the Individual Health Insurance Availability Act". (7-1-98)

02. Scope. The Act and this Rule are intended to promote broader spreading of risk in the individual marketplace. The Act and Rule are intended to regulate all health benefit plans sold to eligible individuals. Carriers that provide health benefit plans to eligible individuals are intended to be subject to all of the provisions of the Act and this Rule. (7-1-98)

002. WRITTEN INTERPRETATIONS.
In accordance with Section 67-5201(19)(b)(iv), Idaho Code, this agency may have written statements which pertain to the interpretation of the rules of the chapter, or to the documentation of compliance with the rules of this chapter. These documents will be available for public inspection and copying at cost in the main office and each regional or district office of this agency. (7-1-98)

003. ADMINISTRATIVE APPEALS.
All contested cases shall be governed by the provisions of IDAPA 04.11.01, Idaho Rules of Administrative Procedure of the Office of the Attorney General. (7-1-98)

004. DEFINITIONS.
As used in this Rule: (7-1-98)

01. Carrier. Carrier means any entity operating under a current Certificate of Authority issued from the Department of Insurance to do the business of disability insurance in this state. Further definition is found under Section 41-5201(7). (7-1-98)

02. Case Characteristics. Case Characteristics are limited to age, individual tobacco use, geography and gender. An individual carrier must apply the use of such case characteristics on a uniform basis. Further definition is found under Section 41-5201(8), Idaho Code, and in IDAPA 18.01.69.015. (7-1-98)

03. Geographic Area. Geographic areas are limited to six (6) designated areas, with no area being smaller than a county. (7-1-98)

04. Risk Characteristic. Risk Characteristic means the health status, claims experience, duration of coverage, or any similar characteristic related to the health status or claims experience of an individual. Such characteristics can include family composition. (7-1-98)

05. Risk Load. Risk Load means the percentage above the applicable base premium rate that is charged by an individual carrier to the rates of the eligible individual, to reflect the risk characteristics of the eligible individual. (7-1-98)

06. Idaho Resident. Idaho resident means a person who is able to provide satisfactory proof of having resided in Idaho, as their place of domicile for a continuous six (6) month period, for purposes of being an eligible individual pursuant to Section 41-5203(14), Idaho Code. The six (6) month residency requirements would be waived for eligible individuals based on the Health Insurance Portability and Accountability Act of 1996. (7-1-98)

005. -- 010. (RESERVED).

011. ASSESSMENTS.

01. Initial Assessment. The Board shall determine the initial capital cost of the program and shall make an initial assessment of each carrier in equal amount to fund the initial costs of the program. (7-1-98)

02. Annual Assessment To Fund Losses. The Board shall, prior to March 1st of each year determine and file with the Director an estimate of the assessments needed to fund the losses incurred by the program in the previous calendar year. This interim assessment shall be based on the assessment formula set forth in Section 41-4711(12)(c), Idaho Code. Initial or interim assessments paid will be credited to each carrier's account when the amounts needed to fund losses and pay program expenses are known. (7-1-98)

012. -- 014. (RESERVED).

015. APPLICABILITY.
Idaho Code Section 41-5204. (7-1-98)

016. -- 027. (RESERVED).

028. TRANSITION FOR ASSUMPTIONS OF BUSINESS FROM ANOTHER CARRIER.

01. Conditions For Transfer or Assumption of Entire Insurance Obligation. An individual carrier shall not transfer or assume the entire insurance obligation and/or risk of a health benefit plan covering an individual in this state unless: (7-1-98)

a. The transaction received any necessary approval of the insurance supervisory official of the state of domicile of the assuming carrier; (7-1-98)

b. The transaction received any necessary approval of the insurance supervisory official of the state of domicile of the ceding carrier; and, (7-1-98)

c. The transaction otherwise meets the requirements of Section 028. (7-1-98)

02. Time Frame for Filing Plan to Assume or Cede Entire Insurance Obligation. A carrier domiciled in this state that proposes to assume or cede the entire insurance obligation and/or risk of one or more individual health benefit plans from another carrier shall make a filing for approval with the Director at least sixty (60) days prior to the date of the proposed assumption. The Director may approve the transaction if the Director 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 Director shall not approve the transaction until at least thirty (30) days after the date of the filing; except that, if the ceding carrier is in hazardous financial condition, the Director may approve the transaction as soon as the Director deems reasonable after the filing. (7-1-98)

03. Filing Requirements. The filing required under Subsection 028.02.shall: (7-1-98)

a. Describe the health benefit plan (including any eligibility requirements) of the ceding carrier from which the health benefit plans will be ceded; (7-1-98)

b. Describe whether the assuming carrier will maintain the assumed health benefit plans (pursuant to Subsection 028.08 or will incorporate them into existing business (pursuant to Subsection 028.09). If the assumed health benefit plans will be incorporated into existing business, the filing shall describe the business of the assuming carrier into which the health benefit plans will be incorporated; (7-1-98)

c. Describe whether the health benefit plans being assumed are currently available for purchase by eligible individuals; (7-1-98)

d. Describe the potential effect of the assumption, if any, on the benefits provided by the health benefit

plans to be assumed; (7-1-98)

e. Describe the potential effect of the assumption, if any, on the premiums for the health benefit plans to be assumed; (7-1-98)

f. Describe any other potential material effects of the assumption on the coverage provided to the eligible individuals covered by the health benefit plans to be assumed; and (7-1-98)

g. Include any other information required by the Director. (7-1-98)

04. Requirements for Informational Filings in Each State in Which There Are Individual Health Benefit Plans. An individual carrier required to make a filing under Subsection 028.02 shall also make an informational filing with the Insurance Supervisory Official of each state in which there are individual 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 028.02 and shall include at least the information specified in Subsection 028.03 for the individual health benefit plans in that state. (7-1-98)

05. Other Provisions and Conditions to Be Considered in the Transfer and Assumption of the Entire Insurance Obligation. An individual carrier shall not transfer or assume the entire insurance obligation and/or risk of a health benefit plan covering an eligible individual in this state unless it complies with the following provisions: (7-1-98)

a. The carrier has provided notice to the Director at least sixty (60) days prior to the date of the proposed assumption. The notice shall contain the information specified in Subsection 028.03 for the health benefit plans covering eligible individuals in this state. (7-1-98)

b. If the assumption of a health benefit plan would result in the assuming individual carrier being out of compliance with the limitations related to premium rates contained in Section 41-5206(1)(a), Idaho Code, the assuming carrier shall make a filing with the Director pursuant to Section 41-5206(2), Idaho Code, seeking suspension of the application of Section 41-5206(1)(a), Idaho Code. (7-1-98)

c. An assuming carrier seeking suspension of the application of Section 41-5206(1)(a), Idaho Code, shall not complete the assumption of health benefit plans covering eligible individuals in this state unless the Director grants the suspension requested pursuant to Subsection 028.05.b. (7-1-98)

d. Unless a different period is approved by the Director, a suspension of the application of Section 41-5206(1)(a), Idaho Code, shall, with respect to assumed one (1) or more health benefit plans, be for no more than fifteen (15) months and, with respect to each individual, shall last only until the anniversary date of such individual's coverage (except that the period with respect to an individual may be extended beyond such individual first anniversary date for a period of up to twelve (12) months if the anniversary date occurs within three (3) months of the date of assumption of the health benefit plan). (7-1-98)

06. Exceptions to Ceding or Assumption of Business. Except as provided in Subsection 028.02, an individual carrier shall not cede or assume the entire insurance obligation or risk for an individual health benefit plan unless the transaction includes the ceding to the assuming carrier of all business within Idaho which includes such health benefit plan. (7-1-98)

07. Requirements for Ceding Less Than Entire Business. An Individual carrier may cede less than an entire health benefit plan to an assuming carrier if: (7-1-98)

a. One or more eligible individuals in the health benefit plan have exercised their right under contract 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 with the exception of those health benefit plans for which an eligible individual has rejected the proposed cession; or (7-1-98)

b. After a written request from the transferring carrier, the Director determines that the transfer of less than all health benefit plans is in the best interests of the eligible individuals insured. (7-1-98)

08. Separate Health Benefit Plans. Except as provided in Subsection 028.09, an individual carrier that assumes one (1) or more health benefit plans from another carrier may maintain such health benefit plans as a separate health benefit plan. (7-1-98)

09. Restrictions to Apply Eligibility Requirements by Assuming Carrier. An assuming carrier may not apply eligibility requirements, with respect to an assumed health benefit plan (or with respect to any health benefit plan subsequently offered to an eligible individual 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. (7-1-98)

10. Request for Extension of the Transition Period. The Director may approve a longer period of transition upon application of an individual carrier. The application shall be made within sixty (60) days after the date of assumption of the health benefit plan and shall clearly state the justification for a longer transition period. (7-1-98)

11. Additional Information. Nothing in Section 028 or in the Act is intended to: (7-1-98)

a. Reduce or diminish any legal or contractual obligation or requirement, including any obligation provided in Section 41-511, Idaho Code, of the ceding or assuming carrier related to the transaction; (7-1-98)

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 (7-1-98)

c. Reduce or diminish the protections related to an assumption reinsurance transaction provided in Section 41-511, Idaho Code, or otherwise provided by law. (7-1-98)

029. -- 035. (RESERVED).

036. RESTRICTIONS RELATING TO PREMIUM RATES.

01. Rate Manual. An individual carrier shall develop a rate manual for all individual business. Base premium rates and new business premium rates charged to eligible individuals by the individual 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 an individual carrier is based on the carrier's discretion, the manual shall specify the criteria and factors considered by the carrier in exercising such discretion. (7-1-98)

02. Requirements for Adjustments to Rating Method. An individual carrier shall not modify the rating method used in the rate manual for its individual business until the change has been approved as provided in this paragraph. The Director may approve a change to a rating method if the Director finds that the change is reasonable, actuarially appropriate, and consistent with the purposes of the Act and this Rule. (7-1-98)

03. Information Required for Review of Modification of Rating Method. A carrier may modify the rating method for its individual business only with prior approval of the Director. A carrier requesting to change the rating method for its individual business shall make a filing with the Director at least thirty (30) days prior to the proposed date of the change. The filing shall contain at least the following information: (7-1-98)

a. The reasons the change in rating method is being requested; (7-1-98)

b. A complete description of each of the proposed modifications to the rating method; (7-1-98)

c. A description of how the change in rating method would affect the premium rates currently charged to eligible individuals in the health benefit plan, including an estimate from a qualified actuary of the number of individuals (and a description of the types of individuals) whose premium rates may change by more than ten percent (10%) due to the proposed change in rating method (not generally including increases in premium rates applicable to all individuals in a health benefit plan); (7-1-98)

d. 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 (7-1-98)

e. A certification from a qualified actuary that the proposed change in rating method would not produce premium rates for eligible individuals that would be in violation of Section 41-5206, Idaho Code. (7-1-98)

04. Change in Rating Method. For the purpose of Section 036 a change in rating method shall mean: (7-1-98)

a. A change in the number of case characteristics used by an individual carrier to determine premium rates for health benefit plans in its individual business (an individual carrier shall not use case characteristics other than age, individual tobacco use, geography or gender without prior approval of the Director); (7-1-98)

b. A change in the method of allocating expenses among health benefit plans; or, (7-1-98)

c. A change in a rating factor with respect to any case characteristic if the change would produce a change in premium for any individual that exceeds ten percent (10%). (7-1-98)

d. For the purpose of Subsection 036.04, a change in a rating factor shall mean the cumulative change with respect to such factor considered over a twelve (12) month period. If an individual carrier changes rating factors with respect to more than one case characteristic in a twelve (12) month period, the carrier shall consider the cumulative effect of all such changes in applying the ten percent (10%) test. (7-1-98)

05. Rate Manual to Specify Case Characteristics and Rate Factors to Be Applied. The rate manual developed pursuant to Subsection 036.01 shall specify the case characteristics and rate factors to be applied by the individual carrier in establishing premium rates for the health benefit plans. (7-1-98)

06. Case Characteristics Other Than Age, Individual Tobacco Use, Geography and Gender - Must Have Prior Approval of Director. An individual carrier may not use case characteristics other than those specified in Section 41-5206(1)(g), Idaho Code, without the prior approval of the Director. An individual carrier seeking such an approval shall make a filing with the Director for a change in rating method under Subsection 036.02. (7-1-98)

07. Case Characteristics Shall Be Applied in a Uniform Manner. An individual carrier shall use the same case characteristics in establishing premium rates for each health benefit plan 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 eligible individual. (7-1-98)

08. Rate Manual Must Clearly Illustrate Relationship Among Base Premium Rate and Any Difference in New Business Rate. The rate manual developed pursuant to Subsection 036.01 shall clearly illustrate the relationship among the base premium rates charged for each health benefit plan. 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. (7-1-98)

09. Differences in Premium Rates Must Reflect Reasonable and Objective Differences. 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 shall not be based in any way on the actual or expected health status or claims experience of the eligible individual groups that choose or are expected to choose a particular health benefit plan. An individual carrier shall apply case characteristics and rate factors within its health benefit plans in a manner that assures that premium differences among health benefit plans for identical individuals vary only due to reasonable and objective differences in the design and benefits of the health benefit plans and are not due to the actual or expected health status or claims experience of the individuals that choose or are expected to choose a particular health benefit plan. (7-1-98)

10. Premium Rates to Be Developed in Two (2) Step Process. The rate manual developed pursuant to Subsection 036.01 shall provide for premium rates to be developed in a two (2) step process. In the first step, a base premium rate shall be developed for the eligible individual without regard to any risk characteristics. In the second step, the resulting base premium rate may be adjusted by a risk load, subject to the provisions of Section 41-5206, Idaho Code, to reflect the risk characteristics of the individual. (7-1-98)

11. Exception to Application Fee, Underwriter Fee or Other Fees. Except as provided in Subsection 036.12., a premium charged to an individual for a health benefit plan shall not include a separate application fee, underwriting fee, or any other separate fee or charge. (7-1-98)

12. Uniform Application of Fees. A carrier may charge a separate fee with respect to a health benefit plan provided the fee is applied in a uniform manner to all health benefit plans. All such fees are premium and shall be included in determining compliance with the Act and this rule. (7-1-98)

13. Uniform Allocation of Administration Expenses. An individual carrier shall allocate administrative expenses to the basic, standard, and catastrophic health benefit plans on no less favorable of a basis than expenses are allocated to other health benefit plans. The rate manual developed pursuant to Subsection 036.01 shall describe the method of allocating administrative expenses to the health benefit plans for which the manual was developed. (7-1-98)

14. Rate Manual to Be Maintained for a Period of Six (6) Years. Each rate manual developed pursuant to Subsection 036.01 shall be maintained by the carrier for a period of six (6) years. Updates and changes to the manual shall be maintained with the manual. (7-1-98)

15. Rate Manual and Practices Must Comply with Guidelines Issued by Director. The rate manual and rating practices of an individual carrier shall comply with any guidelines issued by the Director. (7-1-98)

16. Application of Restrictions Related to Changes in Premium Rates. The restrictions related to changes in premium rates are set forth in Section 41-5206(1)(b), Idaho Code, and shall be applied as follows: (7-1-98)

a. An individual carrier shall revise its rate manual each rating period to reflect changes in base premium rates and changes in new business premium rates. (7-1-98)

b. 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 Sections 41-5206(1)(b)(ii) and 41-5206(1)(d)(i), Idaho Code. (7-1-98)

c. 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 individual carrier is no longer enrolling new eligible individuals for the purposes of Sections 41-5206(1)(b) and (d), Idaho Code. (7-1-98)

d. 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 by more than twenty percent (20%), the carrier shall make a filing with the Director 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 within thirty (30) days of the beginning of the rating period. (7-1-98)

e. An individual carrier shall keep on file for a period of at least six (6) 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. (7-1-98)

17. Change in Premium Rate. Except as provided in Subsections 036.18 and 036.19, a change in premium rate for an eligible individual shall produce a revised premium rate that is no more than the following: (7-1-98)

a. The base premium rate for the eligible individual, given its present composition, (as shown in the rate manual as revised for the rating period), multiplied by: (7-1-98)

b. One (1) plus the sum of: (7-1-98)

i. The risk load applicable to the eligible individual during the previous rating period; and (7-1-98)

ii. Fifteen percent (15%) (prorated for periods of less than one (1) year). (7-1-98)

18. Rating Restrictions on Plans Where Carrier Is No Longer Enrolling New Business. In the case of a health benefit plan into which an Individual carrier is no longer enrolling new Individuals, a change in premium rate for an Individual shall produce a revised premium rate that is no more than the base premium rate for the Individual (given its present composition and as shown in the rate manual in effect for the Individual at the beginning of the previous rating period), multiplied by Subsection 136.18.a. and 036.18.b. below; (7-1-98)

a. One (1) plus the lesser of: (7-1-98)

i. The change in the base rate; or (7-1-98)

ii. The percentage change in the new business premium for the most similar health benefit plan into which the Individual carrier is enrolling new Individuals. (7-1-98)

b. One (1) plus the sum of: (7-1-98)

i. The risk load applicable to the Individual during the previous rating period; and (7-1-98)

ii. Fifteen percent (15%) (prorated for periods of less than one (1) year). (7-1-98)

19. Plans Written Prior to January 1, 1995. In the case of a health benefit plan described in Section 41-5206(1)(d), Idaho Code, if the current premium rate for the health benefit plan exceeds the ranges set forth in Section 41-5206, Idaho Code, the formula set forth in Subsections 036.17 and 036.18 will be applied as if the fifteen percent (15%) adjustment provided in Subsections 036.17.b.ii. and 036.18.c.ii. were a zero percent (0%) adjustment. (7-1-98)

20. Limitations on Revised Premium Rate. Notwithstanding the provisions of Subsections 036.17 and 036.18, a change in premium rate for an Individual shall not produce a revised premium rate that would exceed the limitations on rates provided in Section 41-5206, Idaho Code. (7-1-98)

037. -- 045. (RESERVED).

046. REQUIREMENT TO INSURE INDIVIDUALS.

01. Offer of Coverage. An individual carrier that offers coverage to an individual shall offer to provide coverage to each eligible individual and to each eligible dependent of an eligible individual. (7-1-98)

02. No Restrictions or Limitations on Coverage Related To Risk Characteristics. Individuals shall be accepted for coverage by the individual carrier without any restrictions or limitations on coverage related to the risk characteristics of the Individual or their dependents, except that a carrier may exclude or limit coverage for pre-existing medical conditions, consistent with the provisions provided in Section 41-5208(3), Idaho Code. (7-1-98)

03. Risk Load. An individual carrier may assess a risk load to the premium rate associated with a new entrant, consistent with the requirements of Section 41-5206, Idaho Code. The risk load shall be the same risk load charged to the Individual immediately prior to acceptance of the new entrant into the health benefit plan. (7-1-98)

04. Rescission. When material application misstatements are found, rescission action by the carrier shall be taken at the carrier's option. When rescission action is taken, premiums must be refunded less any claims which had been paid prior to the date the rescission was initiated. At the carrier's option, the carrier shall seek to recover any amounts of claims paid in excess of premiums paid. The applicable contract or coverage shall be considered null and void. (7-1-98)

05. Coverage Rescinded for Fraud or Misrepresentation. Any individual whose coverage is subsequently rescinded for fraud or misrepresentation shall not be deemed to be an "eligible individual" for a period of twelve (12) months from the effective date of the termination of the individual coverage and shall not be deemed to

have "qualifying previous coverage" under chapter 47 or 52, title 41, Idaho Code; provided such limitations cannot be in conflict with the Health Insurance Portability and Accountability Act of 1996. (7-1-98)

047. -- 054. (RESERVED).

055. APPLICATION TO REENTER STATE.

01. Restrictions on Offering Individual Health Insurance. An individual carrier that has been prohibited from writing coverage for individuals in this state pursuant to Section 41-5207(2), Idaho Code, may not resume offering health benefit plans to individuals in this state until the carrier has made a petition to the Director to be reinstated as an individual carrier and the petition has been approved by the Director. In reviewing a petition, the Director may ask for such information and assurances as the Director finds reasonable and appropriate. (7-1-98)

02. Restrictions Based on Geographic Service Area. In the case of an individual carrier doing business in only one established geographic service area of the state, if the individual carrier elects to non renew a health benefit plan under Section 41-5207(1)(d), Idaho Code, the individual carrier shall be prohibited from offering health benefit plans to individuals in that service area for a period of five (5) years. (7-1-98)

056. -- 059. (RESERVED).

060. QUALIFYING PREVIOUS AND QUALIFYING EXISTING COVERAGES.

01. Previous Coverage or Existing Coverage. In determining whether a health benefit plan or other health benefit arrangement (whether public or private) shall be considered qualifying previous coverage or qualifying existing coverage for the purposes of Sections 41-5203(21), 41-5208(3)(b) and 41-5208(3)(c), Idaho Code, an individual carrier shall interpret the Act no less favorably to an insured individual than the following: (7-1-98)

a. A health benefit plan, certificate or other health benefit arrangement shall be considered employer-based if an employer sponsors the plan or arrangement or makes a contribution to the plan or arrangement; and (7-1-98)

b. A health benefit plan, certificate or other benefit arrangement shall be considered to provide benefits similar to or exceeding the benefits provided under the basic health benefit plan if the policy, certificate or other benefit arrangement provides benefits that: (7-1-98)

i. Have an actuarial value that is not substantially less than the actuarial value of the basic health benefit plan; or (7-1-98)

ii. Provides coverage for hospitalization and physician services that is substantially similar to or exceeds the coverage for such services in the basic health benefit plan. (7-1-98)

c. In making a determination under Subsection 060.01.b., an individual carrier shall evaluate the previous or existing policy, certificate or other benefit arrangement taken as a whole and shall not base its decision solely on the fact that one portion of the previous or existing policy, certificate or benefit arrangement provides less coverage than the comparable portion of the basic health benefit plan. (7-1-98)

02. Particular Service. For the purposes of Section 41-5208(3)(b), Idaho Code, an individual will be considered to have qualifying previous coverage with respect to a particular service if the previous policy, certificate or other benefit arrangement covering such individual met the definition of qualifying previous coverage contained in Section 41-5203(21), Idaho Code, and provided any benefit with respect to the service. (7-1-98)

03. Source of Previous or Existing Coverage. An individual carrier shall ascertain the source of previous or existing coverage of each eligible individual and each dependent of an eligible individual at the time such individual or dependent initially enrolls into the health benefit plan provided by the individual carrier. The individual carrier shall have the responsibility to contact the source of such previous or existing coverage to resolve any questions about the benefits or limitations related to such previous or existing coverage. (7-1-98)

061. -- 066. (RESERVED).

067. RESTRICTIVE RIDERS.

01. Restrictive Riders. A restrictive rider, endorsement or other provision that would violate the provisions of Section 41-5208(3)(c), Idaho Code, and that was in force on the effective date of this rule may not remain in force beyond the first anniversary date of the health benefit plan subject to the restrictive provision that follows the effective date of this rule. An individual carrier shall provide written notice to those individuals whose coverage will be changed pursuant to this subsection at least thirty (30) days prior to the required change to the health benefit plan. (7-1-98)

02. Basic, Standard, and Catastrophic Plans. Except as permitted in Section 41-5208(3)(a), Idaho Code, an individual carrier shall not modify or restrict a basic, standard, or catastrophic health benefit plan in any manner for the purposes of restricting or excluding coverage or benefits for specific diseases, medical conditions or services otherwise covered by the plan. (7-1-98)

03. Other Health Benefit Plans. Except as permitted in Section 41-5208(3), Idaho Code, an individual carrier shall not modify or restrict any health benefit plan with respect to any eligible individual or dependent of an eligible individual, through riders, endorsements or otherwise, for the purpose of restricting or excluding the coverage or benefits provided to such individual or dependent for specific diseases, medical conditions or services otherwise covered by the plan. (7-1-98)

068. -- 074. (RESERVED).

075. RULES RELATED TO FAIR MARKETING.

01. Individual Carrier Shall Actively Market. An individual carrier shall actively market each of its health benefit plans to individuals in this state. An individual carrier may not suspend the marketing or issuance of the basic, standard, or catastrophic health benefit plans unless the carrier has good cause and has received the prior approval of the Director. (7-1-98)

02. Marketing Basic, Standard, and Catastrophic Plans. In marketing the basic and standard health benefit plans to individuals, an individual carrier shall use at least the same sources and methods of distribution that it uses to market other health benefit plans to individuals. Any producer authorized by an individual carrier to market health benefit plans to Individuals in the state shall also be authorized to market the basic, standard, and catastrophic health benefit plans. (7-1-98)

03. Offer Must Be in Writing. An individual carrier shall offer at least the basic and standard health benefit plans to any individual that applies for or makes an inquiry regarding health insurance coverage from the individual carrier. The offer shall be in writing and shall include at least the following information: (7-1-98)

a. A general description of the benefits contained in the basic, standard, and catastrophic health benefit plans and any other health benefit plan being offered to the individual; and (7-1-98)

b. Information describing how the individual may enroll in the plans. (7-1-98)

c. The offer may be provided directly to the individual or delivered through a producer. (7-1-98)

04. Timeliness of Price Quote. An individual carrier shall provide a price quote to an individual (directly or through an authorized producer) within fifteen (15) working days of receiving a request for a quote and such information as is necessary to provide the quote. An individual carrier shall notify an individual (directly or through an authorized producer) within ten (10) working days of receiving a request for a price quote of any additional information needed by the individual carrier to provide the quote. (7-1-98)

05. Restrictions As to Application Process. An individual carrier may not apply more stringent or detailed requirements related to the application process for the basic, standard, and catastrophic health benefit plans than are applied for other health benefit plans offered by the carrier. (7-1-98)

06. Denial of Coverage. If an individual carrier denies coverage under a health benefit plan to an individual on the basis of a risk characteristic, the denial shall be in writing and shall be maintained in the individual carrier's office. This written denial shall state with specificity the risk characteristic(s) of the individual that made it ineligible for the health benefit plan it requested (for example, health status). The denial shall be accompanied by a written explanation of the availability of the basic, standard, and catastrophic health benefit plans from the individual carrier. The explanation shall include at least the following: (7-1-98)

a. A general description of the benefits contained in each such plan; (7-1-98)

b. A price quote for each such plan; and (7-1-98)

c. Information describing how the individual may enroll in such plans. (7-1-98)

d. The written information described in this paragraph may be provided within the time periods provided in Subsection 075.04 directly to the individual or delivered through an authorized producer. (7-1-98)

07. Lowest Priced Basic, Standard, and Catastrophic Plan. The price quote required under Subsection 075.06.b. shall be for the lowest-priced basic, standard, and catastrophic health benefit plan for which the individual is eligible. (7-1-98)

08. Toll-Free Telephone Service. An individual carrier shall establish and maintain a toll-free telephone service to provide information to individuals regarding the availability of individual health benefit plans in this state. The service shall provide information to callers on how to apply for coverage from the carrier. The information may include the names and phone numbers of producers located geographically proximate to the caller or such other information that is reasonably designed to assist the caller to locate an authorized producer or to otherwise apply for coverage. (7-1-98)

09. No Requirement to Qualify for Other Insurance Product. An individual carrier may not require, as a condition to the offer of sale of a health benefit plan to an individual, that the individual purchase or qualify for any other insurance product or service. (7-1-98)

10. Plans Subject to Requirement of the Act and This Rule. Carriers offering individual health benefit plans in this state shall be responsible for determining whether the plans are subject to the requirements of the Act and this Rule. Carriers shall elicit the following information from applicants for such plans at the time of application: (7-1-98)

a. Whether or not any portion of the premium will be paid by or on behalf of an Individual, either directly or through wage adjustments or other means of reimbursement; and (7-1-98)

b. Whether or not the prospective policyholder, certificate holder or any prospective insured individual intends to treat the health benefit plans as part of a plan or program under Section 162 (other than Section 162(1)), Section 125 or Section 106, Internal Revenue Code. (7-1-98)

11. Failure to Comply. If an individual carrier fails to comply with Subsection 075.11, the individual carrier shall be deemed to be on notice of any information that could reasonably have been attained if the individual carrier had complied with Subsection 075.11. (7-1-98)

12. Annual Filing Requirement. An individual carrier shall file annually the following information with the Director related to health benefit plans issued by the individual carrier to individuals in this state on forms prescribed by the Director: (7-1-98)

a. The number of individuals that were covered under health benefit plans in the previous calendar year (separated as to newly issued plans and renewals); (7-1-98)

b. The number of individuals that were covered under the basic, standard, and catastrophic health benefit plan in the previous calendar year (separated as to newly issued plans and renewals). (7-1-98)

c. The number of individual health benefit plans in force in each county (or by five (5) digit zip code) of the state as of December 31 of the previous calendar year; (7-1-98)

d. The number of individual health benefit plans that were voluntarily not renewed by Individuals in the previous calendar year; (7-1-98)

e. The number of individual health benefit plans that were terminated or non renewed (for reasons other than nonpayment of premium) by the carrier in the previous calendar year; and (7-1-98)

f. The number of health benefit plans that were issued to residents that were uninsured for at least the sixty-three (63) days prior to issue. (7-1-98)

13. Total Number of Residents. All carriers shall file annually with the Director, on forms prescribed by the Director, the total number of residents, including spouses and dependents, covered during the previous calendar year under all health benefit plans issued in this state. This includes residents covered under stop loss plans. (7-1-98)

14. Filing Date. The information described in Sections 075.12 and 075.13 shall be filed no later than March 15, each year. (7-1-98)

15. Specific Data. For purposes of this section, health benefit plan information shall include policies or certificates of insurance for specific disease, hospital confinement indemnity and stop loss coverages. (7-1-98)

076. -- 080. (RESERVED).

081. STATUS OF CARRIERS AS INDIVIDUAL CARRIERS.

01. Market Status. Each carrier providing health benefit plans in this state shall make a filing to the Director if it intends to continue or discontinue to operate as an individual carrier in this state under the terms of this Rule. (7-1-98)

02. Restrictions as to the Offering of Insurance. Subject to Subsection 081.03, a carrier shall not offer health benefit plans to individuals, or continue to provide coverage under health benefit plans previously issued to individuals in this state, unless the filing provided pursuant to Subsection 081.01 indicates that the carrier intends to operate as a individual carrier in this state. (7-1-98)

03. Specific Compliance Requirements. If the filing made pursuant Subsection 081.01 indicates that a carrier does not intend to operate as a individual carrier in this state, the carrier may continue to provide coverage under health benefit plans previously issued to individuals in this state only if the carrier complies with the following provisions: (7-1-98)

a. The carrier complies with the requirements of the Act (other than Sections 41-5209, 41-5210, and 41-4711, Idaho Code) with respect to each of the health benefit plans previously issued to individuals by the carrier. (7-1-98)

b. The carrier provides coverage to each new dependent to a health benefit plan previously issued to an individual by the carrier. The provisions of the Act (other than Sections 41-5209, 41-5210, and 41-4711, Idaho Code) and this Rule shall apply to the coverage issued to such new dependents. (7-1-98)

c. The carrier complies with the requirements of Section 067 of this Rule as they apply to individuals whose coverage has been terminated by the carrier and to individuals whose coverage has been limited or restricted by the carrier. (7-1-98)

04. Not Eligible for Reinsurance Program. A carrier that continues to provide coverage pursuant to this subsection shall not be eligible to participate in the reinsurance program established under Section 41-4711, Idaho Code. (7-1-98)

05. Precluded from Operating in Idaho. If the filing made pursuant Subsection 081.01 indicates that a carrier does not intend to operate as a individual carrier in this state, the carrier shall be precluded from operating as an individual carrier in this state (except as provided for in Subsections 081.03.a. through 081.13.c.) for a period of five (5) years from the date of the filing. Upon a written request from such a carrier, the Director may reduce the period provided for in the previous sentence if the Director finds that permitting the carrier to operate as an individual carrier would be in the best interests of the individuals in the state. (7-1-98)

082. -- 999. (RESERVED).