## IDAPA 18 – IDAHO DEPARTMENT OF INSURANCE

### Market Oversight

### 18.04.13 – Rules Governing Small Employer Health Insurance Availability Act Plan Design

**Who does this rule apply to**?
*This rule applies to carriers that provide benefit plans to eligible individuals and health benefit plans sold to eligible individuals.*

**What is the purpose of this rule**?
*The purpose of this rule promotes broader spreading of risk in the individual marketplace.*

**What is the legal authority for the agency to promulgate this rule**?
*This rule implements the following statutes passed by the Idaho Legislature:*

Insurance -
- 41-02, et seq., Idaho Code – The Department of Insurance
- 41-52, Idaho Code – Individual Health Insurance Availability Act
- 41-55, et seq., Idaho Code – Idaho Individual High Risk Reinsurance Pool

**Who do I contact for more information on this rule**?

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## 18.04.13 – The Individual Health Insurance Availability Act

**000. LEGAL AUTHORITY.**
Title 41, Chapters 2, 52, and 55, Idaho Code. (7-1-21)T

**001. TITLE AND SCOPE.**

**01. Title**. IDAPA 18.04.13, "The Individual Health Insurance Availability Act." (7-1-21)T

**02. Scope**. The Act and this chapter are intended to promote broader spreading of risk in the individual marketplace. The Act and chapter 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 chapter. (7-1-21)T

**002. INCORPORATION BY REFERENCE.**
The Outline of Coverage for Individual Major Medical Expense Coverage is incorporated by reference into this chapter from the April 1999 version of the National Association of Insurance Commissioners Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Act. (7-1-21)T

**003. -- 009. (RESERVED)**

**010. DEFINITIONS.**
As used in this chapter: (7-1-21)T

**01. Geographic Area**. Geographic areas are limited to six (6) designated areas, with no area being smaller than a county. (7-1-21)T

**02. 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. (7-1-21)T

**03. 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. (7-1-21)T

**04. 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(10), 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. (7-1-21)T

**011. POLICY DEFINITIONS.**
An insurance policy subject to this chapter will not apply definitions more restrictive than the following: (7-1-21)T

**01. Accident**. "Accident," "accidental injury," and "accidental" is to employ "result" language and does not include words that establish an accidental means test or use words such as "external, violent, visible wounds" or similar words of description or characterization. (7-1-21)T

**a.** "Injury" or "injuries" means accidental bodily injury sustained by the insured person that is the direct cause of the condition for which benefits are provided, independent of disease or bodily infirmity or any other cause, and that occurs while the insurance is in force. (7-1-21)T

**b.** It may exclude injuries for which benefits are provided: (7-1-21)T

i. Under workers' compensation, employers' liability, or similar law; or (7-1-21)T

ii. Under a motor vehicle no-fault plan, unless the motor vehicle no-fault plan provides for coordination of benefits; or (7-1-21)T

iii. For injuries occurring while the insured person is engaged in any activity pertaining to a trade, business, employment or occupation for wage or profit. (7-1-21)T

**02. Convalescent Nursing Home**. Includes "extended care facility," or "skilled nursing facility." Is to be defined in relation to its status, facility and available services. (7-1-21)T

**a.** Such home or facility is to: (7-1-21)T

i. Be operated pursuant to law; (7-1-21)T

ii. Be approved for payment of Medicare benefits or be qualified to receive approval for payment of Medicare benefits, if so requested; (7-1-21)T

iii. Be primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a duly licensed physician; (7-1-21)T

iv. Provide continuous twenty-four (24) hours per day nursing service by or under the supervision of a registered nurse; and (7-1-21)T

v. Maintain a daily medical record of each patient. (7-1-21)T

**b.** Such home or facility definition may exclude: (7-1-21)T

i. A home, facility or part of a home or facility used primarily for rest; (7-1-21)T

ii. A home or facility for the aged or for the care of drug addicts or alcoholics; or (7-1-21)T

iii. A home or facility primarily used for the care and treatment of mental or nervous disorders, or for custodial or educational care. (7-1-21)T

**03. Home Health Care Agency**. An agency approved under Medicare, or that is licensed to provide home health care under applicable state law. (7-1-21)T

**04. Hospice**. A facility licensed, certified or registered in accordance with state law that provides a formal program of care that is: (7-1-21)T

**a.** For terminally ill patients whose life expectancy is less than six (6) months; (7-1-21)T

**b.** Provided on an inpatient or outpatient basis; and (7-1-21)T

**c.** Directed by a physician. (7-1-21)T

**05. Hospital**. Is defined in relation to its status, facilities and available services or to reflect its accreditation by the Joint Commission on Accreditation of Healthcare Organizations, Accreditation of Rehabilitation Facilities or by Medicare. (7-1-21)T

**a.** The term “hospital” may: (7-1-21)T

i. Be an institution licensed to operate as a hospital pursuant to law; (7-1-21)T

ii. Be primarily and continuously engaged in providing or operating, either on its premises or in facilities available to the hospital on a prearranged basis and under the supervision of a staff of licensed physicians, medical, diagnostic and major surgical facilities for the medical care and treatment of sick or injured persons on an inpatient basis for which a charge is made; and (7-1-21)T

iii. Provide twenty-four (24) hour nursing service by or under the supervision of registered nurses. (7-1-21)T

**b.** The term “hospital” may exclude, unless the facility otherwise meets the requirements: (7-1-21)T

i. Convalescent homes or, convalescent, rest, or nursing facilities; (7-1-21)T

ii. Facilities affording primarily the care and treatment of mental or nervous disorders, or for custodial educational, or rehabilitative care; (7-1-21)T

iii. Facilities for the aged, drug addicts, or alcoholics; or (7-1-21)T

iv. A military or veterans' hospital, a soldiers' home or a hospital contracted for or operated by any national government or government agency for the treatment of members or ex-members of the armed forces, except for services rendered on an emergency basis where a legal liability for the patient exists for charges made to the individual for the services. (7-1-21)T

**06. Mental or Nervous Disorders**. Neurosis, psychoneurosis, psychosis, or mental or emotional disease or disorder of any kind. (7-1-21)T

**07. Pre-existing Condition**. (7-1-21)T

**a.** A condition or disease that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care or treatment during the six (6) months immediately preceding the effective date of coverage; (7-1-21)T

**b.** A condition or disease for which medical advice, diagnosis, care or treatment was recommended or received during the six (6) months immediately preceding the effective date of coverage; or (7-1-21)T

**c.** A pregnancy existing on the effective date of coverage. (7-1-21)T

**08. Sickness or Illness**. A sickness or disease of an insured person that first manifests itself after the effective date of insurance and while the insurance is in force. It may be further modified to exclude sickness or disease for which benefits are provided under a worker's compensation, occupational disease, employers' liability or similar law. (7-1-21)T

**09. Total Disability**. An individual not engaged in any employment or occupation for which the individual is or becomes qualified by reason of education, training or experience, and is not in fact engaged in any employment or occupation for wage or profit. (7-1-21)T

**a.** It may be defined in relation to the inability of the person to perform duties but will not be based solely upon an individual's inability to: (7-1-21)T

i. Perform “any occupation whatsoever,” “any occupational duty,” or “any and every duty of his occupation”; or (7-1-21)T

ii. Engage in a training or rehabilitation program. (7-1-21)T

**b.** An insurer may require the complete inability of the person to perform all of the substantial and material duties of his or her regular occupation or words of similar import. An insurer may require care by a provider other than the insured or a member of the insured's immediate family. (7-1-21)T

**012. ASSESSMENTS.**
The Board, prior to March 1st of each year, determines and files with the Director an estimate of the assessments needed to fund the losses incurred by the Idaho Small Employer and Individual Health Reinsurance Program. The March 1, 2001 assessment anticipated by Section 41-4711, Idaho Code, will consist of the amounts needed to cover the claims cost of the individual policies issued on or before June 30, 2000. This interim assessment is based on the assessment formula set forth in Section 41-4711(12)(c), Idaho Code. Initial or interim assessments paid, on behalf of the Idaho Individual High Risk Reinsurance Pool, will be credited to each carrier’s account when the amounts needed to fund losses and pay program expenses are known. (7-1-21)T

**013. -- 027. (RESERVED)**

**028. TRANSITION FOR ASSUMPTIONS OF BUSINESS FROM ANOTHER CARRIER.**

**01. Conditions for Transfer or Assumption of Entire Insurance Obligation**. An individual carrier will not transfer or assume the entire insurance obligation and/or risk of a health benefit plan covering an individual in this state unless: (7-1-21)T

**a.** The transaction received any necessary approval of the insurance supervisory official of the state of domicile of the assuming carrier; (7-1-21)T

**b.** The transaction received any necessary approval of the insurance supervisory official of the state of domicile of the ceding carrier; and, (7-1-21)T

**c.** The transaction meets the other requirements of this Section. (7-1-21)T

**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 makes 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 chapter. The Director will 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. (7-1-21)T

**03. Filing Requirements**. The filing for Subsection 028.02 will: (7-1-21)T

**a.** Describe the health benefit plan (including any eligibility requirements) of the ceding carrier from which the health benefit plans will be ceded; (7-1-21)T

**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 will describe the business of the assuming carrier into which the health benefit plans will be incorporated; (7-1-21)T

**c.** Describe whether the health benefit plans being assumed are currently available for purchase by eligible individuals; (7-1-21)T

**d.** Describe the potential effect of the assumption, if any, on the benefits provided by the health benefit plans to be assumed; (7-1-21)T

**e.** Describe the potential effect of the assumption, if any, on the premiums for the health benefit plans to be assumed; (7-1-21)T

**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 (7-1-21)T

**g.** Include any other information prescribed by the Director. (7-1-21)T

**04. Informational Filings in Other States**. An individual carrier prescribed to make a filing under Subsection 028.02 will 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 will be made concurrently with the filing made under Subsection 028.02 and will include at least the information specified in Subsection 028.03 for the individual health benefit plans in that state. (7-1-21)T

**05. Considerations in the Transfer and Assumption of the Entire Insurance Obligation**. An individual carrier will 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: (7-1-21)T

**a.** The carrier has provided notice to the Director at least sixty (60) days prior to the date of the

proposed assumption. The notice contains the information specified in Subsection 028.03 for the health benefit plans covering eligible individuals in this state. (7-1-21)T

**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 makes 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. (7-1-21)T

**c.** An assuming carrier seeking suspension of the application of Section 41-5206(1)(a), Idaho Code, will not complete the assumption of health benefit plans covering eligible individuals in this state unless the Director grants the suspension requested pursuant to Paragraph 028.05.b. (7-1-21)T

**d.** Unless a different period is approved by the Director, a suspension of the application of Section 41-5206(1)(a), Idaho Code, with respect to assumed one (1) or more health benefit plans, is for no more than fifteen (15) months and, with respect to each individual, lasts 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). (7-1-21)T

**06. Exceptions to Ceding or Assumption of Business**. Except as provided in Subsection 028.02, an individual carrier will 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. (7-1-21)T

**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: (7-1-21)T

**a.** One (1) 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 includes each health benefit plan with the exception of those health benefit plans for which an eligible individual has rejected the proposed cession; or (7-1-21)T

**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. (7-1-21)T

**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. (7-1-21)T

**09. Restrictions to Apply Eligibility Requirements by Assuming Carrier**. An assuming carrier will 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. (7-1-21)T

**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 is made within sixty (60) days from assumption of the health benefit plan and clearly states the justification for a longer transition period. (7-1-21)T

**11. Additional Information**. Nothing in this Section or in the Act is intended to: (7-1-21)T

**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; (7-1-21)T

**b.** Authorize a carrier not admitted to transact the business of insurance in this state to offer or insure health benefit plans in this state; or (7-1-21)T

**c.** Reduce or diminish the protections related to an assumption reinsurance transaction provided in

Section 41-511, Idaho Code, or provided by law. (7-1-21)T

**029. -- 035. (RESERVED)**

**036. RESTRICTIONS RELATING TO PREMIUM RATES.**
The following provisions are applicable for all individual health benefit plans. (7-1-21)T

**01. Rate Manual**. An individual carrier develops a rate manual for all individual business. Base premium rates and new business premium rates charged to eligible individuals by the individual carrier are computed solely from the applicable rate manual developed pursuant to this Section. To the extent that a portion of the premium rates charged by an individual carrier is based on the carrier's discretion, the manual specifies the criteria and factors considered by the carrier in exercising such discretion. (7-1-21)T

**02. Requirements for Adjustments to Rating Method**. An individual carrier will not modify the rating method used in the rate manual for its individual business until the change has been approved as provided in this Section. 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 chapter. (7-1-21)T

**03. Information 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 makes a filing with the Director at least thirty (30) days prior to the proposed date of the change. The filing contains at least the following information: (7-1-21)T

**a.** The reasons the change in rating method is being requested; (7-1-21)T

**b.** A complete description of each of the proposed modifications to the rating method; (7-1-21)T

**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); (7-1-21)T

**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 (7-1-21)T

**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. (7-1-21)T

**04. Change in Rating Method**. For the purpose of this Section a change in rating method means: (7-1-21)T

**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 will not use case characteristics other than age, individual tobacco use, geography or gender without prior approval of the Director); (7-1-21)T

**b.** A change in the method of allocating expenses among health benefit plans; or (7-1-21)T

**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%). (7-1-21)T

**d.** For the purpose of this Subsection, a change in a rating factor means 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 considers the cumulative effect of all such changes in applying the ten percent (10%) test. (7-1-21)T

**05. Rate Manual to Specify Case Characteristics and Rate Factors**. The rate manual developed

pursuant to Subsection 036.01 specifies the case characteristics and rate factors to be applied by the individual carrier in establishing premium rates for the health benefit plans. (7-1-21)T

**06. Prior Approval of Case Characteristics**. An individual carrier will not use case characteristics other than those specified in Section 41-5206(1)(f), Idaho Code, without the prior approval of the Director. An individual carrier seeking such an approval makes a filing with the Director for a change in rating method under Subsection 036.02. (7-1-21)T

**07. Uniform Application of Case Characteristics**. An individual carrier uses the same case characteristics in establishing premium rates for each health benefit plan and applies them in the same manner in establishing premium rates for each such health benefit plan. Case characteristics are applied without regard to the risk characteristics of an eligible individual. (7-1-21)T

**08. Base Premium Rates and Any Difference in New Business Rate**. The rate manual developed pursuant to Subsection 036.01 clearly illustrates 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 illustrates the difference. (7-1-21)T

**09. Reasonable and Objective Rate Differences**. Differences among base premium rates for health benefit plans are based solely on the reasonable and objective differences in the design and benefits of the health benefit plans and cannot be based in any way on the actual or expected health status or claims experience of the eligible individual or groups that choose or are expected to choose a particular health benefit plan. An individual carrier applies 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. (7-1-21)T

**10. Two-Step Process**. The rate manual developed pursuant to Subsection 036.01 provides for premium rates to be developed in a two (2) step process. In the first step, a base premium rate is 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. (7-1-21)T

**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 will not include a separate application fee, underwriting fee, or any other separate fee or charge. (7-1-21)T

**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 are included in determining compliance with the Act and this chapter. (7-1-21)T

**13. Uniform Allocation of Administration Expenses**. The rate manual developed pursuant to Subsection 036.01 describes the method of allocating administrative expenses to the health benefit plans for which the manual was developed. (7-1-21)T

**14. Rate Manual to be Maintained for a Period of Six Years**. Each rate manual developed pursuant to Subsection 036.01 is maintained by the carrier for a period of six (6) years. Updates and changes to the manual are maintained with the manual. (7-1-21)T

**15. Guidelines Issued by Director**. The rate manual and rating practices of an individual carrier comply with any guidelines issued by the Director. (7-1-21)T

**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 are applied as follows: (7-1-21)T

**a.** An individual carrier revises its rate manual each rating period to reflect changes in base premium

rates and changes in new business premium rates. (7-1-21)T

**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 is the change in the base premium rate for the purposes of Sections 41-5206(1)(b)(i) and 41-5206(1)(d)(i), Idaho Code. (7-1-21)T

**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 is considered a health benefit plan into which the individual carrier is no longer enrolling new eligible individuals for the purposes of Section 41-5206(1)(b)(i), Idaho Code. (7-1-21)T

**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 makes 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 is made within thirty (30) days of the beginning of the rating period. (7-1-21)T

**e.** An individual carrier keeps 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. (7-1-21)T

**17. Change in Premium Rate**. Except as provided in Subsection 036.18, a change in premium rate for an eligible individual produces a revised premium rate that is no more than the following: (7-1-21)T

**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: (7-1-21)T

**b.** One (1) plus the sum of: (7-1-21)T

i. The risk load applicable to the eligible individual during the previous rating period; and (7-1-21)T

ii. Fifteen percent (15%) (prorated for periods of less than one (1) year). (7-1-21)T

**18. Plans 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 will 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 Paragraphs 036.18.a. and 036.18.b.; (7-1-21)T

**a.** One (1) plus the lesser of: (7-1-21)T

i. The change in the base rate; or (7-1-21)T

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. (7-1-21)T

**b.** One (1) plus the sum of: (7-1-21)T

i. The risk load applicable to the Individual during the previous rating period; and (7-1-21)T

ii. Fifteen percent (15%) (prorated for periods of less than one (1) year). (7-1-21)T

**19. Limitations on Revised Premium Rate**. Notwithstanding the provisions of Subsections 036.17 and 036.18, a change in premium rate for an Individual will not produce a revised premium rate that would exceed the limitations on rates provided in Section 41-5206, Idaho Code. (7-1-21)T

**037. -- 045. (RESERVED)**

**046. REQUIREMENT TO INSURE INDIVIDUALS.**

**01. Offer of Coverage**. An individual carrier that offers coverage to an individual will offer to provide coverage to each eligible individual and to each eligible dependent of an eligible individual. (7-1-21)T

**02. Risk Characteristics**. Individuals are 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. (7-1-21)T

**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 is the same risk load charged to the Individual immediately prior to acceptance of the new entrant into the health benefit plan. (7-1-21)T

**04. Rescission**. When material application misstatements are found, rescission action by the carrier may be taken at the carrier's option. When rescission action is taken, premiums are refunded less any claims which had been paid prior to the date the rescission was initiated. At the carrier's option, the carrier may seek to recover any amounts of claims paid in excess of premiums paid. The applicable contract or coverage is considered null and void. (7-1-21)T

**05. Coverage Rescinded for Fraud or Misrepresentation**. Any individual whose coverage is subsequently rescinded for fraud or misrepresentation will not be an "eligible individual" for a period of twelve (12) months from the effective date of the termination of the individual coverage and cannot be deemed to have "qualifying previous coverage" under Title 41, Chapter 22, 47, 52, or 55, Idaho Code; provided such limitations are not in conflict with the Health Insurance Portability and Accountability Act of 1996. (7-1-21)T

**06. Certification of Creditable Coverage**. (7-1-21)T

**a.** Individual carriers will provide written certification of creditable coverage to individuals in accordance with this Subsection. (7-1-21)T

**b.** The certification of creditable coverage is provided: (7-1-21)T

i. At the time an individual ceases to be covered under the health benefit plan or otherwise becomes covered under a COBRA continuation provision; (7-1-21)T

ii. In the case of an individual who becomes covered under a COBRA continuation provision, at the time the individual ceases to be covered under that provision; and (7-1-21)T

iii. Such certification is automatically provided by the individual carrier or at the time a request is made on behalf of an individual if the request is made not later than twenty-four (24) months after the date of cessation of coverage described in Paragraphs 046.06.b.i. and 046.06.b.ii., whichever is later. (7-1-21)T

**c.** The certificate of creditable coverage contains: (7-1-21)T

i. Written certification of the period of creditable coverage of the individual under the health benefit plan; and (7-1-21)T

ii. The waiting period, if any, and if applicable, affiliation period imposed with respect to the individual for any coverage under the health benefit plan. (7-1-21)T

**047. -- 054. (RESERVED)**

**055. APPLICATION TO REENTER STATE.**

**01. Restrictions on Offering Individual Health Insurance**. An individual carrier that has been banned from writing coverage for individuals in this state pursuant to Section 41-5207(2), Idaho Code, will 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. (7-1-21)T

**02. Geographic Service Areas**. In the case of an individual carrier doing business in an established geographic service area of the state, if the individual carrier elects to non-renew a health benefit plan under Section 41-5207(3), Idaho Code, the individual carrier is banned from offering health benefit plans to individuals in that service area for a period of five (5) years. (7-1-21)T

**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) is considered qualifying previous coverage or qualifying existing coverage for the purposes of Sections 41-5203(20), and 41-5208(3), Idaho Code, an individual carrier interprets the Act no less favorably to an insured individual than the following: (7-1-21)T

**a.** An individual carrier ascertains 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. (7-1-21)T

**061. -- 066. (RESERVED)**

**067. RESTRICTIVE RIDERS.**
Except as permitted in Section 41-5208(3), Idaho Code, an individual carrier will 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.
(7-1-21)T

**068. -- 074. (RESERVED)**

**075. RULES RELATED TO FAIR MARKETING.**

**01. Individual Carrier to Actively Market**. An individual carrier actively markets each of its health benefit plans to individuals in this state. (7-1-21)T

**02. Offer**. An individual carrier offers all health benefit plans to any individual that applies for or makes an inquiry regarding health insurance coverage from the individual carrier. The offer may be provided directly to the individual or delivered through a producer. The offer is in writing and includes at least the following information: (7-1-21)T

**a.** A general description of the benefits contained in the all actively marketed health benefit plans; and (7-1-21)T

**b.** Information describing how the individual may enroll in the plans. (7-1-21)T

**04. Timeliness of Price Quote**. An individual carrier provides 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 notifies 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. (7-1-21)T

**05. Restrictions as to Application Process**. An individual carrier will not apply more stringent or

detailed requirements related to the application process for the mandated health benefit plans than are applied for other health benefit plans offered by the carrier. (7-1-21)T

**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 is in writing and maintained in the individual carrier's office. This written denial states 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 is accompanied by a written explanation of the availability of any mandated health benefit plans from the individual carrier. The explanation includes at least the following: (7-1-21)T

**a.** A general description of the benefits contained in each such plan; (7-1-21)T

**b.** A price quote for each such plan; and (7-1-21)T

**c.** Information describing how the individual may enroll in such plans. (7-1-21)T

**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. (7-1-21)T

**07. Premium Rate Charged**. The price quote prescribed under Paragraph 075.06.b. is for the lowest premium rate charged under the rating system for a health benefit plan for which the individual is eligible. (7-1-21)T

**08. Toll-Free Telephone Service**. An individual carrier establishes and maintains a toll-free telephone service to provide information to individuals regarding the availability of individual health benefit plans in this state. The service provides 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 reasonably designed to assist the caller to locate an authorized producer or to apply for coverage. (7-1-21)T

**09. No Requirement to Qualify for Other Insurance Product**. An individual carrier will 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. (7-1-21)T

**10. Plans Subject to Requirements**. Carriers offering individual health benefit plans in this state are responsible for determining whether the plans are subject to the requirements of the Act and this chapter. (7-1-21)T

**11. Annual Filing Requirement**. An individual carrier files 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: (7-1-21)T

**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); (7-1-21)T

**b.** The number of individuals that were covered under each mandated health benefit plan in the previous calendar year (separated as to newly issued plans and renewals). (7-1-21)T

**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; (7-1-21)T

**d.** The number of individual health benefit plans that were voluntarily not renewed by Individuals in the previous calendar year; (7-1-21)T

**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 (7-1-21)T

**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. (7-1-21)T

**12. Total Number of Residents**. All carriers 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 reinsurance by way of excess loss and stop loss plans. (7-1-21)T

**13. Filing Date**. The information described in Subsections 075.11 and 075.12 is filed no later than March 15, each year. (7-1-21)T

**14. Specific Data**. For purposes of this section, health benefit plan information includes policies or certificates of insurance for specific disease, hospital confinement indemnity, reinsurance by way of excess loss, and stop loss coverages. (7-1-21)T

**076. -- 080. (RESERVED)**

**081. BANNED POLICY PROVISIONS.**

**01. Probationary or Waiting Period**. Except as provided in Subsection 081.02 for a pre-existing condition, a policy cannot contain provisions establishing a probationary or waiting period during which no coverage is provided under the policy. (7-1-21)T

**02. Pre-existing Conditions**. A policy will not deny, exclude or limit benefits for covered expenses incurred more than twelve (12) months following the effective date of the coverage due to a pre-existing condition. (7-1-21)T

**a.** A policy waives any time period applicable to a pre-existing condition exclusion or limitation period with respect to particular services for the period of time an individual was previously covered by qualifying previous coverage to the extent such previous coverage provided benefits with respect to such services, provided that the qualifying previous coverage was continuous to a date not more than sixty-three (63) days prior to the effective date of the new coverage. (7-1-21)T

**b.** A carrier will not modify a policy with respect to an individual or dependent through riders, endorsements, or otherwise, to restrict or exclude coverage for specifically named pre-existing conditions otherwise covered by the policy. (7-1-21)T

**03. Exclusions**. A policy cannot limit or exclude coverage by type of illness, accident, treatment or medical condition, except that a policy may include one or more of the following limitations or exclusions: (7-1-21)T

**a.** Pre-existing conditions, except for congenital anomalies of a covered dependent child; (7-1-21)T

**b.** Mental or nervous disorders, alcoholism and drug addiction; (7-1-21)T

**c.** Pregnancy, except for complications of pregnancy; (7-1-21)T

**d.** Illness, treatment or medical condition arising out of: (7-1-21)T

i. War or act of war (whether declared or undeclared); participation in a felony, riot or insurrections; service in the armed forces or units auxiliary to it; (7-1-21)T

ii. Suicide (sane or insane), attempted suicide or intentionally self-inflicted injury; and (7-1-21)T

iii. Professional aviation for wage or profit; (7-1-21)T

**e.** Cosmetic surgery, except that "cosmetic surgery" cannot include reconstructive surgery when the service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part; reconstructive surgery because of congenital disease or anomaly of a covered dependent child; or involuntary complications related to a cosmetic procedure; (7-1-21)T

**f.** Foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet; (7-1-21)T

**g.** Care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion, or subluxation in the human body for purposes of removing nerve interference and the effects of it, where the interference is the result of or related to distortion, misalignment or subluxation of, or in the vertebral column; (7-1-21)T

**h.** Benefits in excess of Medicare eligible expense, if enrolled in Medicare or other governmental program (except Medicaid), or benefits provided under a state or federal worker's compensation law, employers liability or occupational disease law, or motor vehicle no-fault law unless the motor vehicle no-fault plan provides for coordination of benefits; services performed by a member of the covered person's immediate family; and services for which no charge is normally made in the absence of insurance; (7-1-21)T

**i.** Dental care or treatment; (7-1-21)T

**j.** Eye glasses and the examination for the prescription or fitting of them; (7-1-21)T

**k.** Rest cures, custodial care, transportation, and routine physical examinations; (7-1-21)T

**l.** Territorial limitations; (7-1-21)T

**m.** Hearing aids, auditory osseointegrated (bone conduction) devices, cochlear implants and examination for or fitting of them, except for congenital or acquired hearing loss that without intervention may result in cognitive or speech development deficits of a covered dependent child, covering not less than one (1) device every thirty-six (36) months per ear with loss and not less than forty-five (45) language/speech therapy visits during the first twelve (12) months after delivery of the covered device; (7-1-21)T

**n.** Missed or cancelled appointments; completion of claim forms or records copying; failure to vacate a room on or before the facility's established discharge hour; educational and training services except as provided by the policy; over the counter medical supplies, consumable or disposable supplies, including but not limited to elastic stockings, ace bandages, gauze, alcohol swabs or dressings; (7-1-21)T

**o.** Treatment, services or supplies not prescribed by or upon the direction of a licensed provider, acting within the scope of his or her license; (7-1-21)T

**p.** Services rendered prior to the effective date of coverage or after termination of coverage, except as provided by an extension of benefits provision; and (7-1-21)T

**q.** The reversal of an elective sterilization procedure, including but not limited to vasovasostomy or salpingoplasty. (7-1-21)T

## 082. GENERAL MINIMUM STANDARDS.

An insurance policy subject to this chapter cannot be offered, delivered or issued for delivery, continued or renewed in this state unless it meets the following minimum standards. (7-1-21)T

**01. Outline of Coverage**. An insurer will deliver an outline of coverage to an applicant or enrollee with the sale, which complies with the model outline of coverage established by the National Association of Insurance Commissioners ("NAIC"), incorporated herein in Section 002. (7-1-21)T

**a.** If an outline of coverage was delivered at the time of application or enrollment and the policy is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy will accompany the policy when it is delivered and contain the following statement in no less than twelve (12) point type, immediately above the company name: "NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon (application) (enrollment), and the coverage originally applied for has not been issued." (7-1-21)T

**b.** In any case where the prescribed outline of coverage is inappropriate for the coverage provided by the policy, an alternate outline of coverage is to be submitted to the Director for prior written approval. (7-1-21)T

**02. Coverage of Dependents**. A policy will consider as an eligible dependent a child who is chiefly dependent on the insured for support and maintenance and who is incapable of self-sustaining employment due to intellectual disability or physical disability on the date that the child's coverage would otherwise terminate under the policy due to the attainment of a specified age for children. The policy may require that within thirty-one (31) days of such date the company receives due proof of the incapacity in order for the insured to elect to continue the policy in force with respect to the child, or that a separate converted policy be issued at the option of the insured or policyholder. (7-1-21)T

**03. Limitation on Termination of Coverage of Dependent**. A policy cannot provide for termination of coverage of a covered dependent solely because of the occurrence of an event specified for termination of coverage of the insured, other than nonpayment of premium. In addition, the policy will provide that in the event of the insured's death, the spouse or dependent of the insured, if covered under the policy, will become the insured. (7-1-21)T

**04. Continuous Loss Extension**. Termination of the policy will be without prejudice to a continuous loss that commenced while the policy was in force. Such extension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. (7-1-21)T

**05. Pregnancy Benefit Extension**. In the event the insurer cancels or refuses to renew, policies providing pregnancy benefits will provide for an extension of benefits as to pregnancy commencing while the policy is in force and for which benefits would have been payable had the policy remained in force. (7-1-21)T

**06. Expenses of Live Donor**. A policy providing coverage for the recipient in a transplant operation also provides reimbursement of any medical expenses of a live donor to the extent that benefits remain and are available under the recipient's policy or certificate, after benefits for the recipient's own expenses have been paid. (7-1-21)T

**07. Fractures or Dislocations.** A policy providing coverage for fractures or dislocations will not provide benefits only for "full or complete" fractures or dislocations. (7-1-21)T

**08. Coinsurance**. Except for out-of-network benefits offered as part of a managed care plan, a coinsurance percentage will not exceed fifty percent (50%) of covered charges. A coinsurance percentage for out-of-network benefits offered as part of a managed care plan will not exceed sixty percent (60%) of covered charges. (7-1-21)T

**083. -- 100. (RESERVED)**

**101. DISCLOSURE PROVISIONS.**

**01. Requisite Provisions.** Each policy will include a renewal, continuation or nonrenewal provision. The language or specification of the provision will be consistent with the type of contract to be issued. The provision will be appropriately captioned, will appear on the first page of the policy, and will clearly state the duration, where limited, of renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed. (7-1-21)T

**02. Added Riders or Endorsements**. Riders or endorsements added to a policy after date of issue or at reinstatement or renewal that reduce or eliminate benefits or coverage in the policy require signed acceptance by the policyholder. After date of policy issue, any rider or endorsement that increases benefits or coverage with a concomitant increase in premium during the policy term will be agreed to in writing and signed by the policyholder, except if the increased benefits or coverage is prescribed by law. (7-1-21)T

**03. Separate Additional Premium**. Where a separate additional premium is charged for benefits

provided in connection with riders or endorsements, the premium charge is set forth in the policy. (7-1-21)T

**04. Requisite Definition of Terms.** A policy that provides for the payment of benefits based on standards described as "usual and customary," "reasonable and customary," or words of similar import will include a definition of the terms and an explanation of the terms in its accompanying outline of coverage. (7-1-21)T

**05. Pre-existing Conditions Limitations**. If a policy contains any limitations with respect to pre-existing conditions, the limitations will appear as a separate paragraph of the policy and be labeled as "Pre-existing Condition Limitations." (7-1-21)T

**06. Requisite Notice**. All policies will have a notice prominently printed on the first page of the policy stating in substance that the policyholder has the right to return the policy within ten (10) days of its delivery and have the premium refunded if, after examination of the policy, the policyholder holder is not satisfied for any reason. (7-1-21)T

**102. -- 999. (RESERVED)**

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