

IDAHO ADMINISTRATIVE BULLETIN

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Preface

The Idaho Administrative Bulletin is published once each month by the Department of Administration, Office of the Administrative Rules Coordinator, pursuant to Section 67-5203, Idaho Code. The Bulletin is a monthly compilation of all administrative rule-making documents in Idaho. The Bulletin publishes the official rulemaking notices and administrative rule text of state agency rulemakings and other official documents as necessary.

State agencies are required to provide public notice of rulemaking activity and invite public input. The public receives notice of rulemaking activity through the Idaho Administrative Bulletin and the Legal Notice published monthly in local newspapers. The Legal Notice provides reasonable opportunity for public input, either oral or written, which may be presented to the agency within the time and manner specified in the Rulemaking Notice published in the Bulletin. After the comment period closes, the agency considers fully all information submitted in regard to the rule. Comment periods are not provided in temporary or final rule-making activities.

CITATION TO THE IDAHO ADMINISTRATIVE BULLETIN

The Bulletin is cited by year and issue number. For example, Bulletin 05-1 refers to the first Bulletin issued in calendar year 2005; Bulletin 06-1 refers to the first Bulletin issued in calendar year 2006. Volume numbers, which proceed from 1 to 12 in a given year, correspond to the months of publication, i.e.; Volume No. 05-1 refers to January 2005; Volume No. 05-2 refers to February 2005; and so forth. Example: The Bulletin published in January of 2006 is cited as Volume 06-1. The December 2005 Bulletin is cited as Volume 05-12.

RELATIONSHIP TO THE IDAHO ADMINISTRATIVE CODE

*The Idaho Administrative Code is published once a year and is a compilation or supplemental compilation of all final and enforceable administrative rules in effect in Idaho. In an effort to provide the reader with current, enforceable rules, temporary rules are also published in the Administrative Code. Temporary rules and final rules that have been approved by the legislature during the legislative session, and published in the monthly Idaho Administrative Bulletin, supplement the Administrative Code. Negotiated, proposed, and pending rules are **not** printed in the Administrative Code and are published only in the Bulletin.*

*To determine if a particular rule remains in effect, or to determine if a change has occurred, the reader should refer to the **Cumulative Rulemaking Index of Idaho Administrative Rules**, printed in each Bulletin.*

TYPES OF RULEMAKINGS PUBLISHED IN THE ADMINISTRATIVE BULLETIN

The state of Idaho administrative rulemaking process, governed by the Administrative Procedure Act, Title 67, Chapter 52, Idaho Code, comprises five distinct activities: negotiated, proposed, temporary, pending and final rulemaking. Not all rulemakings involve all five. At a minimum, a rulemaking includes proposed, pending and final rulemaking. Many rules are adopted as temporary rules when they meet the required statutory criteria and agencies often engage in negotiated rulemaking at the beginning of the process to facilitate consensus building in controversial or complex rulemakings. In the majority of cases, the process begins with proposed rulemaking and ends with the final rulemaking. The following is a brief explanation of each type of administrative rule.

NEGOTIATED RULEMAKING

Negotiated rulemaking is a process in which all interested parties and the agency seek consensus on the content of a rule. Agencies are encouraged, and in some cases required, to engage in this rulemaking activity whenever it is feasible to do so. Publication of a "Notice of Intent to Promulgate" a rule in the Administrative Bulletin by the agency is optional. This process should result in the formulation of a proposed and/or temporary rule.

PROPOSED RULEMAKING

A proposed rulemaking is an action by an agency wherein the agency is proposing to amend or repeal an existing rule or to adopt a new rule. Prior to the adoption, amendment, or repeal of a rule, the agency must publish a "Notice of Proposed Rulemaking" in the Bulletin. This notice must include:

- a) the specific statutory authority (from Idaho Code) for the rulemaking including a citation to a specific federal statute or regulation if that is the basis of authority or requirement for the rulemaking;*
- b) a statement in nontechnical language of the substance of the proposed rule, including a specific description of any fee or charge imposed or increased;*
- c) the text of the proposed rule prepared in legislative format;*
- d) the location, date, and time of any public hearings the agency intends to hold on the proposed rule;*
- e) the manner in which persons may make written comments on the proposed rule, including the name and address of a person in the agency to whom comments on the proposal may be sent;*
- f) the manner in which persons may request an opportunity for an oral presentation as provided in Section 67-5222, Idaho Code; and*
- g) the deadline for public (written) comments on the proposed rule.*

As stated, the text of the proposed rule must be published in the Bulletin. After meeting the statutory rulemaking criteria for a proposed rule, the agency may proceed to the pending rule stage. A proposed rule does not have an assigned effective date unless published in conjunction with a temporary rule. An agency may vacate a proposed rulemaking if it decides not to proceed further with the promulgation process.

TEMPORARY RULEMAKING

Temporary rules may be adopted only when the governor finds that it is necessary for:

- a) protection of the public health, safety, or welfare; or*
- b) compliance with deadlines in amendments to governing law or federal programs; or*
- c) conferring a benefit;*

If a rulemaking meets any one or all of the above requirements, a rule may become effective before it has been submitted to the legislature for review and the agency may proceed and adopt a temporary rule. However, a temporary rule that imposes a fee or charge may be adopted only if the Governor finds that the fee or charge is necessary to avoid an immediate danger which justifies the imposition of the fee or charge.

A temporary rule expires at the conclusion of the next succeeding regular legislative session unless the rule is approved, amended, or modified by concurrent resolution or when the rule has been replaced by a final rule.

State law required that the text of both a proposed rule and a temporary rule be published in the Administrative Bulletin. In cases where the text of the temporary rule is the same as the proposed rule, the rulemaking can be done concurrently as a proposed/temporary rule. Combining the rulemaking allows for a single publication of the text.

An agency may, at any time, rescind a temporary rule that has been adopted and is in effect. If the temporary rule is being replaced by a new temporary rule or if it has been published concurrently with a proposed rulemaking that is being vacated, the agency, in most instances, should rescind the temporary rule.

PENDING RULEMAKING

A pending rule is a rule that has been adopted by an agency under regular rulemaking procedures and remains subject to legislative review before it become a final, enforceable rule.

When a pending rule is published in the Bulletin, the agency is required to include certain information in the "Notice of Pending Rulemaking". This includes:

- a) a statement giving the reasons for adopting the rule;*
- b) a statement of any change between the text of the proposed rule and the pending rule with an explanation of the reasons for any changes;*
- c) the date the pending rule will become final and effective;*
- d) an identification of any portion of the rule imposing or increasing a fee or charge.*

Agencies are required to republish the text of the rule when substantive changes have been made to the proposed rule. An agency may adopt a pending rule that varies in content from that which was originally proposed if the subject matter of the rule remains the same, the pending rule change is a logical outgrowth of the proposed rule, and the original notice was written so as to assure that members of the public were reasonably notified of the subject. It is not always necessary to republish all the text of the pending rule. With the permission of the Rules Coordinator, only the Section(s) that have changed from the proposed text are republished. If no changes have been made to the previously published text, it is not required to republish the text again and only the "Notice of Pending Rulemaking" is published.

FINAL RULEMAKING

A final rule is a rule that has been adopted by an agency under the regular rulemaking procedures and is in effect and enforceable.

No pending rule adopted by an agency will become final and effective until it has been submitted to the legislature for review. Where the legislature finds that an agency has violated the legislative intent of the statute under which the rule was made, a concurrent resolution may be adopted to reject the rulemaking or any part thereof. A "Notice of Final Rule" must be published in the Bulletin for any rule that is rejected, amended, or modified by the legislature showing the changes made. A rule that has been reviewed by the legislature and has not been rejected, amended or modified will become final with no further legislative action. No rule shall become final and effective before the conclusion of the regular or special legislative session at which the rule was submitted for review. However, a rule that is final and effective may be applied retroactively, as provided in the rule.

AVAILABILITY OF THE ADMINISTRATIVE CODE AND BULLETIN

The Idaho Administrative Code and all monthly Bulletins are available for viewing and use by the public in all 44 county law libraries, state university and college and community college libraries, the state law library, the state library, the Public Libraries in Boise, Pocatello, Idaho Falls, Twin Falls, Lewiston and East Bonner County Library.

SUBSCRIPTIONS AND DISTRIBUTION

For subscription information and costs of publications, please contact the Department of Administration, Office of the Administrative Rules Coordinator, 650 W. State Street, Room 100, Boise, Idaho 83720-00306, telephone (208) 332-1820.

The Idaho Administrative Bulletin is an official monthly publication of the State of Idaho. Yearly subscriptions or individual copies are available for purchase.

The Idaho Administrative Code, is an annual compilation or supplemental compilation of all final and enforceable temporary administrative rules and includes tables of contents, reference guides, and a subject index.

Individual Rule Chapters and Individual Rule Making Dockets, are specific portions of the Bulletin and Administrative Code produced on demand.

Internet Access - The Administrative Code and Administrative Bulletin are available on the Internet at the following address: <http://adm.idaho.gov/adminrules/>

HOW TO USE THE IDAHO ADMINISTRATIVE BULLETIN

Rulemaking documents produced by state agencies and published in the *Idaho Administrative Bulletin* are organized by a numbering system. Each state agency has a two-digit identification code number known as the "IDAPA" number. (The "IDAPA" Codes are listed in the alphabetical/numerical index at the end of this Preface.) Within each agency there are divisions or departments to which a two-digit "TITLE" number is assigned. There are "CHAPTER" numbers assigned within the Title and the rule text is divided among major sections with a number of subsections. An example IDAPA number is as follows:

IDAPA 38.07.01.200.02.c.ii.

"IDAPA" refers to Administrative Rules in general that are subject to the Administrative Procedures Act and are required by this act to be published in the Idaho Administrative Code and the Idaho Administrative Bulletin.

"IDAPA 38" refers to the Idaho Department of Administration

"05." refers to Title 05, which is the Department of Administrations's Division of Purchasing

"01." refers to Chapter 01 of Title 05, "Rules of the Division of Purchasing"

"200." refers to Major Section 200, "Content of the Invitation to Bid"

"02." refers to Subsection 200.02.

"c." refers to Subsection 200.02.c.

"ii." refers to Subsection 200.02.c.ii.

DOCKET NUMBERING SYSTEM

Internally, the Bulletin is organized sequentially using a rule docketing system. All rulemaking actions (documents) are assigned a "DOCKET NUMBER." The "Docket Number" is a series of numbers separated by a hyphen "-", (38-0501-0501). The docket numbers are published sequentially by IDAPA designation (e.g. the two-digit agency code). The following example is a breakdown of a typical rule docket:

"DOCKET NO. 38-0501-0501"

"38-" denotes the agency's IDAPA number; in this case the Department of Administration.

"0501-" refers to the **TITLE AND CHAPTER** numbers of the agency rule being promulgated; in this case the Division of Purchasing (TITLE 05), Rules of the Division of Purchasing (Chapter 01).

"0501" denotes the year and sequential order of the docket received during the year; in this case the first rule-making action in calendar year 2005.

Within each Docket, only the affected sections of chapters are printed. (see **Sections Affected Index** in each Bulletin for a listing of these.) The individual sections affected are printed in the Bulletin sequentially (e.g. Section "200" appears before Section "345" and so on). Whenever the sequence of the numbering is broken the following statement will appear:

(BREAK IN CONTINUITY OF SECTIONS)

**INTERNAL AND EXTERNAL CITATIONS TO ADMINISTRATIVE
RULES IN THE CODE AND BULLETIN**

When making a citation to another Section or Subsection of a rule that is part of the same rule, a typical internal citation may appear as follows:

"...as found in Section 201 of this rule." OR "...in accordance with Subsection 201.06.c. of this rule."

The citation may also include the IDAPA, Title, or Chapter number, as follows"

"...in accordance with IDAPA 38.05.01.201..."

"38" denotes the IDAPA number of the agency.

"05" denotes the TITLE number of the rule.

"01" denotes the Chapter number of the rule.

"201" denotes the main Section number of the rule to which the citation refers.

Citations made within a rule to a different rule chapter (external citation) should also include the name of the Department and the name of the rule chapter being referenced, as well as the IDAPA, Title, and Chapter numbers. The following is a typical example of an external citation to another rule chapter:

"...as outlined in the Rules of the Department of Administration, IDAPA 38.04.04, "Rules Governing Capitol Mall Parking."

BULLETIN PUBLICATION SCHEDULE FOR CALENDAR YEAR 2006

Vol. No.	Monthly Issue of Bulletin	Closing Date for Agency Filing	Publication Date	21-day Comment Period End Date
06-1	January 2006	*November 19, 2005	January 4, 2006	January 25, 2006
06-2	February 2006	January 5, 2006	February 1, 2006	February 22, 2006
06-3	March 2006	February 3, 2006	March 1, 2006	March 22, 2006
06-4	April 2006	March 3, 2006	April 5, 2006	April 26, 2006
06-5	May 2006	March 31, 2006	May 3, 2006	May 24, 2006
06-6	June 2006	May 5, 2006	June 7, 2006	June 28, 2006
06-7	July 2006	June 2, 2006	July 5, 2006	July 26, 2006
06-8	August 2006	June 30, 2006	August 2, 2006	August 23, 2006
06-9	September 2006	August 4, 2006	September 6, 2006	September 27, 2006
06-10	October 2006	**August 23, 2006	October 4, 2006	October 25, 2006
06-11	November 2006	October 6, 2006	November 1, 2006	November 22, 2006
06-12	December 2006	November 3, 2006	December 6, 2006	December 27, 2006

BULLETIN PUBLICATION SCHEDULE FOR CALENDAR YEAR 2007

Vol. No.	Monthly Issue of Bulletin	Closing Date for Agency Filing	Publication Date	21-day Comment Period End Date
07-1	January 2007	*November 15, 2006	January 3, 2007	January 24, 2007
07-2	February 2007	January 5, 2007	February 7, 2007	February 28, 2007
07-3	March 2007	February 2, 2007	March 7, 2007	March 28, 2007
07-4	April 2007	March 2, 2007	April 4, 2007	April 26, 2007
07-5	May 2007	April 6, 2007	May 2, 2007	May 24, 2007
07-6	June 2007	May 4, 2007	June 6, 2007	June 28, 2007
07-7	July 2007	June 1, 2007	July 4, 2007	July 26, 2007
07-8	August 2007	June 29, 2007	August 1, 2007	August 23, 2007
07-9	September 2007	August 3, 2007	September 5, 2007	September 27, 2007
07-10	October 2007	**August 22, 2007	October 3, 2007	October 25, 2007
07-11	November 2007	October 5, 2007	November 7, 2007	November 22, 2007
07-12	December 2007	November 2, 2007	December 5, 2007	December 27, 2006

****Last day to submit proposed rulemaking before moratorium begins and last day to submit pending rules to be reviewed by the legislature.***

*****Last day to submit proposed rules in order to complete rulemaking for review by legislature.***

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THE OFFICE OF THE GOVERNOR

**EXECUTIVE DEPARTMENT
STATE OF IDAHO
BOISE**

EXECUTIVE ORDER NO. 2006-29

**EXPANDING MEMBERSHIP IN THE CRIMINAL JUSTICE COMMISSION
FOR OVERSIGHT OF THE STATE'S CRIMINAL JUSTICE SYSTEM
REPEALING AND REPLACING EXECUTIVE ORDER 2005-17**

WHEREAS, it is in the best interests of the citizens of the State of Idaho that government promote efficiency and effectiveness of the criminal justice system and, where possible, encourage dialogue among the respective branches of government to achieve this effectiveness and efficiency; and

WHEREAS, combating crime and protecting citizens from criminal depredation is of vital concern to government; and

WHEREAS, communication and cooperation among the various facets of the community of criminal justice professionals is of utmost importance in promoting efficiency and effectiveness; and

WHEREAS, providing policy makers and criminal justice decision makers with accurate information results in better decisions, which improves public safety and results in the efficient use of public resources; and

WHEREAS, the continued growth of the State's adult incarcerated offender population necessitates more in-depth analysis of the State's criminal justice system; and

WHEREAS, the manufacturing, trafficking and abuse of methamphetamine is a critical issue that plagues communities across the state and is a drain on state and local resources; and

WHEREAS, we need to be increasingly vigilant in the adoption of a zero tolerance policy against emerging gang activity in Idaho;

WHEREAS, Idaho's current criminal justice efforts and initiatives require clear strategic planning and increased coordination;

NOW, THEREFORE, I, JAMES E. RISCH, Governor of the State of Idaho, by the authority vested in me by the Constitution and laws of the State of Idaho, do hereby establish the Idaho Criminal Justice Commission.

1. *The Idaho Criminal Justice Commission ("Commission") shall consist of 25 members. The Commission members representing the judiciary will serve in a non-voting, advisory capacity. The Commission's membership shall be as follows:*
 - a. *A representative from the Governor's Office;*
 - b. *The Attorney General or his or her designee;*
 - c. *The Chair and Ranking Minority member of the Senate Judiciary and Rules Committee;*
 - d. *The Chair and Ranking Minority member of the House Judiciary, Rules and Administration Committee;*
 - e. *The Chief Justice of the Idaho State Supreme Court*
 - f. *The Director of the Idaho Department of Correction;*
 - g. *The Director of the Idaho State Police;*
 - h. *The Director of the Idaho Department of Juvenile Corrections;*
 - i. *The Idaho Drug Czar;*
 - j. *A representative from the Idaho Department of Education;*
 - k. *The Executive Director of the Idaho Commission of Pardons and Parole;*
 - l. *The Director of the Idaho Department of Health and Welfare;*
 - m. *Four (4) representatives of the judiciary as designated by the Chief Justice, including a Supreme Court Justice, Court of Appeals Judge, District Judge and Magistrate Judge;*
 - n. *One (1) representative from the Idaho Prosecuting Attorneys Association;*

This Executive Order repeals and replaces Executive Order 2005-17. This Executive Order shall cease to be effective four years after its entry into force.



IN WITNESS WHEREOF, I have hereunto set my hand and caused to be affixed the Great Seal of the State of Idaho at the Capitol in Boise on this 29th day of September in the year of our Lord two thousand and six, and of the Independence of the United States of America the two hundred thirty-first and of the Statehood of Idaho the one hundred seventeenth.

JAMES E. RISCH
GOVERNOR

BEN YSURSA
SECRETARY OF STATE

THE OFFICE OF THE GOVERNOR

**EXECUTIVE DEPARTMENT
STATE OF IDAHO
BOISE**

EXECUTIVE ORDER NO. 2006-30

ESTABLISHING THE GOVERNOR'S TASK FORCE FOR CHILDREN AT RISK

WHEREAS, Idaho's children are our most valuable and most vulnerable resource; and

WHEREAS, crimes of abuse and neglect can psychologically and physically harm innocent children for life, depriving them of the opportunity to live happy and productive lives; and

WHEREAS, abuse and neglect of children have been recognized to be multi-generational problems; and

WHEREAS, thousands of incidents of child abuse and neglect occur each year in Idaho; and

WHEREAS, the system that responds to reports of child abuse and neglect requires more effective and efficient statewide coordination and consistent monitoring in order to better protect children; and

WHEREAS, in order to protect all children, those who commit crimes against children need to be held accountable for their actions; and

WHEREAS, the child victims of abuse, neglect, and domestic violence must receive immediate and adequate protection from continued maltreatment; and

WHEREAS, it is the responsibility of all Idahoans to provide a community system of support and protection for these children; and

WHEREAS, the protection of children from abuse and neglect is in the best interest of all Idahoans;

NOW, THEREFORE, I, JAMES E. RISCH, Governor of the State of Idaho, by the authority vested in me by the Constitution and laws of the State of Idaho, do hereby order the continuance of the Governor's Task Force for Children at Risk.

The Task Force's responsibilities are:

- 1. To review existing systems and procedures and encourage improvements in the investigative, administrative, and judicial handling of cases of child abuse and neglect, particularly child sexual abuse to limit the trauma to the child victim;*
- 2. To evaluate, propose, and encourage cooperation between persons and agencies involved in cases of child abuse and domestic violence evaluations;*
- 3. To investigate and recommend optimum models of prevention, evaluation and treatment of victims and offenders;*
- 4. To establish procedures for reviewing child fatalities and substantial or severe injuries where the circumstances of the death or injury suggest the possibility of child abuse; and*
- 5. To study, propose, and encourage means to establish a highly professional, stable work force devoted to working with child abuse cases and issues.*

The Task Force shall be composed of up to 16 members appointed by the Governor. The membership shall include, but will not be limited to, the following with consideration of cultural and geographical representation:

- A Judge (Handling civil and criminal cases)*
- A Prosecuting Attorney*
- At least one representative of the Division of Family and Community Services of the Department of Health and Welfare*

- *A law enforcement representative with experience in child abuse cases*
- *A representative of the Department of Correction's*
- *Department of Probation and Parole*
- *A juvenile correction or probation worker*
- *A defense attorney*
- *A pediatrician*
- *A mental health professional specializing in therapy for abused children*
- *A parent or parent group representative*
- *An individual experienced in working with children with disabilities*
- *A Court Appointed Special Advocate (CASA) representative*
- *A child advocate Attorney for children*

The members of the Task Force shall serve at the pleasure of the Governor for a four-year term. Reappointment is at the discretion of the Governor. Members of the Task Force shall elect their chair from among their members.

The Department of Health and Welfare shall be the lead agency, providing support for the Task Force, and shall maintain office staff to carry out the activities directed by the Task Force, as funding is available.



IN WITNESS WHEREOF, I have hereunto set my hand and caused to be affixed the Great Seal of the State of Idaho at the Capitol in Boise on this 28th day of August in the year of our Lord two thousand and six, and of the independence of the United States of America the two hundred thirty-first and of the Statehood of Idaho the one hundred seventeenth.

JAMES E. RISCH
GOVERNOR

BEN YSURSA
SECRETARY OF STATE

THE OFFICE OF THE GOVERNOR

**EXECUTIVE DEPARTMENT
STATE OF IDAHO
BOISE**

EXECUTIVE ORDER NO. 2006-31

**RENEWING THE CERTIFIED PUBLIC MANAGER PROGRAM REPEALING
AND REPLACING EXECUTIVE ORDER NO. 2005-04**

WHEREAS, the State of Idaho recognizes the value of investing in its human resources; and

WHEREAS, the government agencies of Idaho have identified the critical need for management development initiatives and to support and provide for successful workforce planning; and

WHEREAS, management development should be viewed as an integral tool to improve productivity and service delivery to the citizens of Idaho; and

WHEREAS, Idaho government agencies will benefit from the application of a comprehensive set of management principles and best practices; and

WHEREAS, the State of Idaho's leadership has placed a priority on the use of management knowledge and skills; and

WHEREAS, the Division of Human Resources and the Center for Public Policy and Administration at Boise State University will develop and use a nationally recognized management development curriculum; and

WHEREAS, the Certified Public Manager program is an accepted standard and has proven its value in a significant number of states;

NOW, THEREFORE, I, JAMES E. RISCH, Governor of the State of Idaho by the authority vested in me under the Constitution and laws of this State do hereby renew the:

CERTIFIED PUBLIC MANAGER PROGRAM

as a preferred management development program for the State of Idaho and, thereby, actively encourage the participation of state agencies in the development of government managers to enhance the quality and productivity of services delivered to the citizens of Idaho.

This Executive Order shall cease to be effective four years after its entry into force.



IN WITNESS WHEREOF, I have hereunto set my hand and caused to be affixed the Great Seal of the State of Idaho at the Capitol in Boise on this 6th day of September in the year of our Lord two thousand and six, and of the independence of the United States of America the two hundred thirty-first and of the Statehood of Idaho the one hundred seventeenth.

JAMES E. RISCH
GOVERNOR

BEN YSURSA
SECRETARY OF STATE

THE OFFICE OF THE GOVERNOR

**EXECUTIVE DEPARTMENT
STATE OF IDAHO
BOISE**

EXECUTIVE ORDER NO. 2006-32

**AUTHORIZING THE IDAHO DEPARTMENT OF FISH AND GAME AND THE DEPARTMENT
OF AGRICULTURE TO DEAL WITH DOMESTIC ELK THAT HAVE ESCAPED
FROM REX RAMMEL'S CONANT CREEK FACILITY**

WHEREAS, the State is responsible for preserving, protecting, perpetuating and managing the wild elk herds of Idaho; and

WHEREAS, there is imminent threat to the health of wild elk herds of the State of Idaho and surrounding States from domestic elk that have escaped from Rex Rammel's Conant Creek Facility (Conant Creek Facility); and

WHEREAS, there is an imminent threat to public health and safety of the citizens of Idaho as well as neighboring states due to the escape of domestic elk from the Conant Creek Facility; and

WHEREAS, there is also an imminent threat of damage to public and private property from the domestic elk that have escaped from the Conant Creek Facility; and

WHEREAS, the owner of the private elk ranch, Conant Creek Facility, delayed notification to the State that his domestic elk had escaped; and

WHEREAS, any domestic elk that have escaped from the Conant Creek Facility have escaped the control of the owner for more than seven (7) days;

NOW, THEREFORE, I, JAMES E. RISCH, Governor of the State of Idaho, by authority vested in me under the Constitution and laws of the State of Idaho do hereby order:

- 1. That as a result of the facts and circumstances described above, the Idaho Department of Fish and Game and the Idaho Department of Agriculture immediately identify and shoot on site, any domestic elk that have escaped from the Conant Creek Facility; and*
- 2. The Idaho Department of Fish and Game and the Idaho Department of Agriculture shall exercise all statutory authority necessary to take, as defined under title 36, section 202(i) and control as authorized under title 25, section 3705A and title 36, section 104 of the Idaho Code, any domestic elk that have escaped from the Conant Creek Facility; and*
- 3. The Idaho Fish and Game Commission shall promulgate an emergency rule or proclamation:*
 - a. That allows licensed hunters to identify and shoot on site any domestic elk that have escaped from the Conant Creek Facility and possess the carcass of the animal taken; and*
 - b. That allows private property owners to identify and immediately kill any domestic elk on their private property that have escaped from the Conant Creek Facility and possess the carcass of the animal taken; and*
 - c. That places no limit on the number of escaped domestic elk from the Conant Creek Facility that can be taken by any private property owner on their property or licensed hunter; and*
 - d. Requires anyone who takes a domestic elk that has escaped from the Conant Creek Facility to notify the Idaho Department of Fish and Game within three business days of the taking and provide the identification number of the elk to the Department; and*
 - e. Requests, but does not require, any individual who takes a domestic elk that has escaped from the Conant Creek Facility provide a brain, blood and tissue sample to the Idaho Department of Fish and Game.*

4. Pursuant to title 25, section 3705A of the Idaho Code no licensed hunter, state agency, state employee, nor the State shall be liable for the taking, possessing or consuming of any domestic elk that have escaped from the Conant Creek Facility; and
5. No private landowner shall be liable for the taking, possessing, or consuming any domestic elk on their property that have escaped from the Conant Creek Facility pursuant to the emergency rule promulgated.



IN WITNESS WHEREOF, I have hereunto set my hand and caused to be affixed the Great Seal of the State of Idaho at the Capitol in Boise on this 7th day of September in the year of our Lord two thousand and six and of the Independence of the United States of America the two hundred thirty-first and of the Statehood of Idaho the one hundred seventeenth.

JAMES E. RISCH
GOVERNOR

BEN YSURSA
SECRETARY OF STATE

THE OFFICE OF THE GOVERNOR

**EXECUTIVE DEPARTMENT
STATE OF IDAHO
BOISE**

EXECUTIVE ORDER NO. 2006-33

CREATING THE GOVERNOR'S ROADLESS RULE TASK FORCE

WHEREAS, Idaho's 275 inventoried roadless areas comprise approximately 9.3 million acres in 12 national forests across Idaho; and

WHEREAS, Idaho has more inventoried roadless acres than any other state outside of Alaska; and

WHEREAS, Idaho's inventoried roadless areas represent habitat for protected species such as gray wolves and several species of anadromous fish; and

WHEREAS, inventoried roadless areas in Idaho provide excellent recreational opportunities for hunters, fishermen and outdoors enthusiasts, as well as a significant source for drinking and irrigation water throughout the Northwest; and

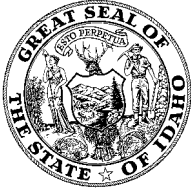
WHEREAS, tribes, industry groups, environmental organizations, local communities, and Idaho counties were invited to participate by providing input during the period prior to drafting the Governor's petition on management recommendations for inventoried roadless areas; and

WHEREAS, county commissioners led the effort to gather public input and present recommendations from local communities, tribes, industry groups and environmental organizations to the Governor;

NOW, THEREFORE, I, JAMES E. RISCH, Governor of the State of Idaho, by the authority vested in me under the Constitution and laws of the State of Idaho do hereby order the following:

- 1) *The creation of the Governor's Roadless Rule Task Force (Task Force).*
 - A. *Membership on the Task Force shall be appointed by and serve at the pleasure of the Governor through calendar year 2009 and shall include:*
 - i. *Staff from the Office of the Governor and other State agencies as determined by the Governor;*
 - ii. *No less than three (3) commissioners from Idaho counties with inventoried roadless areas representing a geographical diversity across the State.*
 - B. *The Chair of the Task Force shall be appointed by the Governor from the membership of the Task Force and serve at the pleasure of the Governor.*
 - C. *From the membership of the Task Force, the Governor shall appoint a Special Assistant to the Chair to help coordinate the Committee's efforts with the U.S. Forest Service in drafting the federal rule, serving as a liaison between the Task Force and the U.S. Forest Service, and any other duty as directed by the Governor or Chair.*
- 2) *The Task Force shall:*
 - A. *Work with the Department of Agriculture and U.S. Forest Service in drafting the roadless rule for Idaho.*
 - B. *Ensure that the spirit and letter of the Governor's petition is achieved in the draft and final federal rule.*

- C. *Review the proposed rule and coordinate State comments in response to the draft federal rule.*



IN WITNESS WHEREOF, I have hereunto set my hand and caused to be affixed the Great Seal of the State of Idaho at the Capitol in Boise on this 20th day of September in the year of our Lord two thousand and six and of the Independence of the United States of America the two hundred thirty-first and of the Statehood of Idaho the one hundred seventeenth.

JAMES E. RISCH
GOVERNOR

BEN YSURSA
SECRETARY OF STATE

THE OFFICE OF THE GOVERNOR

**EXECUTIVE DEPARTMENT
STATE OF IDAHO
BOISE**

EXECUTIVE ORDER NO. 2006-34

THE GOVERNOR'S ROADLESS RULE IMPLEMENTATION COMMISSION

WHEREAS, Idaho's 275 inventoried roadless areas comprise approximately 9.3 million acres in 12 national forests across Idaho; and

WHEREAS, Idaho has more inventoried roadless acres than any other state in the coterminous forty-eight; and

WHEREAS, Idaho's inventoried roadless areas not only represent pristine habitat for protected species such as gray wolves and several species of anadromous fish; but also comprise a significant boon to Idaho's economy; and

WHEREAS, roadless areas in Idaho provide excellent recreational opportunities for hunters, fishermen and outdoors enthusiasts, as well as a significant source for drinking and irrigation water throughout the Northwest; and

WHEREAS, Idaho counties, communities, and interested parties were invited to participate, in a process outlined by the Governor; by providing input during the drafting of management recommendations for inventoried roadless areas; and

WHEREAS, county commissioners led the effort to gather public input and present recommendations from local communities and interested parties to the Governor;

NOW, THEREFORE, I, JAMES E. RISCH, Governor of the State of Idaho, by the authority vested in me under the Constitution and laws of the State of Idaho do hereby order the following:

- 1) The creation of the Governor's Roadless Rule Advisory Commission (Commission).*
 - A. The members of the Commission shall be appointed by and serve at the pleasure of the Governor through calendar year 2010. At which time the Commission may be reestablished for another term as the Governor deems necessary.*
 - i. The Commission shall be composed of as many members as the Governor deems necessary and sufficient. The Office of the Governor will staff this entity.*
 - ii. The Commission shall consist of no less than three (3) Commissioners from Idaho counties with inventoried roadless areas representing the geographical diversity of the State.*
 - iii. Committee members shall be selected based upon:*
 - 1. Their knowledge of Idaho inventoried roadless areas (IRA) and roadless area management.*
 - 2. Their knowledge and expertise in the potential conflicts between IRA management and human activities.*
 - 3. Their knowledge and expertise in the interests that may be affected by IRA management.*
 - 4. Their knowledge and expertise in other fields that may prove useful to the Committee.*

- B) *The Chair shall be appointed by the Governor from Governor's Office staff or the membership of the Committee.*
- 2) *The Committee shall:*
 - A) *In partnership with the U.S. Forest Service, Department of Agriculture and the Tribes of Idaho ensure the implementation of the Inventoried Roadless Area Management Rule for Idaho.*



IN WITNESS WHEREOF, I have hereunto set my hand and caused to be affixed the Great Seal of the State of Idaho at the Capitol in Boise on this 20th day of September in the year of our Lord two thousand and six and of the Independence of the United States of America the two hundred thirty-first and of the Statehood of Idaho the one hundred seventeenth.

JAMES E. RISCH
Governor

BEN YSURSA
Secretary of State

IDAPA 02 - DEPARTMENT OF AGRICULTURE

02.02.14 - RULES FOR WEIGHTS AND MEASURES

DOCKET NO. 02-0214-0601

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2007 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 71-111, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

This change will incorporate by reference the 2006 edition of the National Institute of Standards and Technology Handbook 44; Specifications, Tolerances, and Other Technical Requirements for Weighing and Measuring Devices.

The pending rule is being adopted as proposed. The complete text of the proposed rule was published in the August 2, 2006 Idaho Administrative Bulletin, Vol. 06-8, pages 19 and 20. No comments were received in regards to the proposed rule.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars (\$10,000) during the fiscal year: N/A

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Tom Schafer, Section Manager at 332-8690.

DATED this 25th day of September, 2006.

Patrick A. Takasugi, Director
Idaho State Department of Agriculture
P.O. Box 790
Boise, Idaho 83701
Phone (208) 332-8503
FAX (208) 334-2170

DOCKET NO. 02-0214-0601 - ADOPTION OF PENDING RULE

There are no substantive changes from the proposed rule text.

The complete text of the proposed rule was published in the Idaho Administrative Bulletin, Volume 06-8, August 2, 2006, pages 19 and 20.

This rule has been adopted as a pending rule by the Agency and is now pending review and approval by the 2007 Idaho State Legislature as a final rule.

IDAPA 02 - DEPARTMENT OF AGRICULTURE

02.02.14 - RULES FOR WEIGHTS AND MEASURES

DOCKET NO. 02-0214-0602

NOTICE OF INTENT TO PROMULGATE RULES - NEGOTIATED RULEMAKING

AUTHORITY: In compliance with Section 67-5220(1) and 67-5220(2), Idaho Code, notice is hereby given that this agency intends to promulgate rules and desires public comment prior to initiating formal rulemaking procedures. The action is negotiated rulemaking authorized pursuant to Sections 71-111 and 71-241, Idaho Code.

MEETING SCHEDULE: Public meetings on the negotiated rulemaking will be held as follows:

**Thursday, November 9th 2006,
7:00 to 9:00 p.m.
Nampa Civic Center
311 Third Street South, Nampa, ID 83651**

**Friday, November 10th 2006
10:00 a.m. to 12 p.m.
Idaho State Department of Agriculture
Meeting rooms Lower 1 & 2
2270 Old Penitentiary Rd.
Boise, ID 83712**

AND

**Tuesday, November 14, 2006
3:00 to 5:00 p.m.
Idaho Commerce and Labor
1221 West Ironwood Drive Suite 200
Coeur d'Alene, Idaho 83814**

**Tuesday, November 14, 2006
10:00a.m. to 12:00 p.m.
Idaho Department of Agriculture, FF&V
1120 Lincoln Road
Idaho Falls, Idaho 83402**

METHOD OF PARTICIPATION: Persons wishing to participate in the negotiated rulemaking can do so by the following:

1. Attend a negotiated rulemaking meeting and participate in the negotiation process, or;
2. Provide written recommendations at a negotiated rulemaking meeting, or;
3. Submit written recommendations and comments to the address below.

DESCRIPTIVE SUMMARY: The following is a statement in nontechnical language of the substance and purpose of the intended negotiated rulemaking and the principle issues involved: The change to the rule would exempt ethanol or ethyl alcohol blended fuels from the oxygenate pump labeling requirements.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS, OBTAINING COPIES: For assistance on technical questions concerning this negotiated rulemaking or to obtain a copy of the preliminary draft of the text of the proposed rule, contact Tom Schafer, Section Manager at 332-8690.

Anyone may submit written comments regarding this negotiated rulemaking. All written comments must be directed to the undersigned and must be delivered on or before November 22, 2006.

DATED this 25th day of September, 2006.

Patrick A. Takasugi, Director
Idaho State Department of Agriculture
2270 Old Penitentiary Road
P.O. Box 790
Boise, Idaho 83701
Phone: (208) 332-8503
FAX: (208) 334-2170

**IDAPA 10 - BOARD OF PROFESSIONAL ENGINEERS
AND PROFESSIONAL LAND SURVEYORS**

10.01.01 - RULES OF PROCEDURE

DOCKET NO. 10-0101-0601

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2007 Idaho State Legislature for final adoption. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 54-1208, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

The pending rule is being adopted as proposed. The original text of the proposed rule was published in the September 6, 2006 Idaho Administrative Bulletin, Volume 06-9, pages 65 through 69.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact David L. Curtis, P.E., Executive Director, at (208) 373-7210.

DATED this 2nd day of October, 2006.

David L. Curtis, P.E., Executive Director
Idaho Board of Registration of Professional Engineers and Professional Land Surveyors
5535 W. Overland Road
Boise, Idaho 83705-2728
Phone (208) 373-7210/Fax 373-7213

DOCKET NO. 10-0101-0601 - ADOPTION OF PENDING RULE

There are no substantive changes from the proposed rule text.

The complete text of the proposed rule was published in the Idaho Administrative Bulletin, Volume 06-9, September 6, 2006, pages 65 through 69.

This rule has been adopted as a pending rule by the Agency and is now pending review and approval by the 2007 Idaho State Legislature as a final rule.

IDAPA 11 - IDAHO STATE POLICE

11.04.01 - RULES GOVERNING HORSE RACING

DOCKET NO. 11-0401-0603

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2007 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended, or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5221(1) Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 54-2506 Idaho Code.

DESCRIPTIVE SUMMARY: The following is concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

The pending rule is being adopted as proposed. The complete text of the proposed rules was published in the September 6, 2006, Idaho Administrative Bulletin, Vol. 06-09, page 73 and 74.

FEE SUMMARY: The following a specific description of the fee or charge imposed or increased: N/A

FISCAL IMPACT: There is no impact to the general fund.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Eugene O. Baker, telephone 208-884-7080.

DATED this 5th day of October, 2006.

Eugene O. Baker
Executive Director
Idaho State Racing Commission
PO Box 700
Meridian, ID 83680-0700
208-884-7080
208-884-7090 Fax

DOCKET NO. 11-0401-0603 - PENDING RULE

There are no substantive changes from the proposed rule text.

The complete text of the proposed rule was published in the Idaho Administrative Bulletin, Volume 05-9, September 6, 2006, pages 73 and 74.

This rule has been adopted as a pending rule by the Agency and is now pending review and approval by the 2007 Idaho State Legislature as a final rule.

IDAPA 11 - IDAHO STATE POLICE

11.04.01 - RULES GOVERNING HORSE RACING

DOCKET NO. 11-0401-0604

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2007 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended, or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5221(1) Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 54-2506 Idaho Code.

DESCRIPTIVE SUMMARY: The following is concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

The pending rule is being adopted as proposed. The complete text of the proposed rules was published in the September 6, 2006, Idaho Administrative Bulletin, Vol. 06-09, page 75.

FEE SUMMARY: The following a specific description of the fee or charge imposed or increased: N/A

FISCAL IMPACT: There is no impact to the general fund.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Eugene O. Baker, telephone 208-884-7080.

DATED this 5th day of October, 2006.

Eugene O. Baker
Executive Director
Idaho State Racing Commission
PO Box 700
Meridian, ID 83680-0700
208-884-7080
208-884-7090 Fax

DOCKET NO. 11-0401-0604 - PENDING RULE

There are no substantive changes from the proposed rule text.

The complete text of the proposed rule was published in the Idaho Administrative Bulletin, Volume 05-9, September 6, 2006, page 75.

This rule has been adopted as a pending rule by the Agency and is now pending review and approval by the 2007 Idaho State Legislature as a final rule.

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.05 - RULES GOVERNING ELIGIBILITY FOR AID TO THE AGED, BLIND AND DISABLED (AABD)

DOCKET NO. 16-0305-0602

NOTICE OF RULEMAKING - PENDING RULE AND AMENDMENT TO TEMPORARY RULE

EFFECTIVE DATE: The effective dates of the amendments to the temporary rules are January 1, 2006, February 8, 2006 and July 1, 2006. This pending rule has been adopted by the agency and is now pending review by the 2007 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended, or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended, or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224 and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a pending rule and amended a temporary rule. The action is authorized pursuant to Section 56-202(b), Idaho Code, and the federal Deficit Reduction Act (DRA) of 2005.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and amending the temporary rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

The text of the pending rule has been amended in accordance with Section 67-5227, Idaho Code, and is being republished following this notice. Rather than keep the temporary rule in place while the pending rule awaits legislative approval, the Department amended the temporary rule with the same revisions which have been made to the pending rule. Only the sections that have changes from the proposed text are printed in this bulletin. The original text of the proposed rule was published in the July 5, 2006 Idaho Administrative Bulletin, Vol. 06-7, pages 45 through 58.

The amendments to these rules are the result of comments received from the Centers for Medicare and Medicaid Services on the DRA of 2005, and comments received during the comment period. The following are specific changes made to the temporary and proposed rules:

- 1) Section 105 - amended U.S. citizenship and identity documentation requirements for what can be accepted as proof for these requirements.
- 2) Section 238 - amended the home equity exclusion amount for a participant in long-term care from \$500,000 to \$750,000.
- 3) Section 247 - amended to clarify that one (1) year is twelve (12) consecutive months.
- 4) Section 831 - amended to clarify that the asset transfer amount was the outstanding balance due on the date of the Medicaid application.
- 5) Section 835 - amended to clarify that restricted coverage continues until the fair market value at the time of the transfer for all assets is received.
- 6) Section 836 - added to clarify requirements regarding multiple penalty periods.
- 7) Section 838 - amended to clarify the conditions under which an annuity is considered to be an asset transfer.

FISCAL IMPACT: The following is a specific description, if applicable, of any fiscal impact on the state general fund greater than ten thousand dollars (\$10,000) during the fiscal year.

There is no anticipated fiscal impact to the state general fund.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule and the amendment to temporary rule, contact Peggy Cook at (208) 334-5969.

DATED this 28th day of September, 2006.

Sherri Kovach
Program Supervisor
DHW – Administrative Procedures Section
450 West State Street - 10th Floor
P.O. Box 83720
Boise, Idaho 83720-0036
(208) 334-5564 phone; (208) 334-6558 fax
kovachs@idhw.state.id.us e-mail

DOCKET NO. 16-0305-0602 - ADOPTION OF PENDING RULE

There are substantive changes from the proposed rule text.

Only those sections that have changed from the original proposed text are printed in this Bulletin following this notice.

The text of the proposed rule was published in the Idaho Administrative Bulletin, Volume 06-7, July 5, 2006, pages 45 through 58.

This rule has been adopted as a pending rule by the Agency and is now pending review and approval by the 2007 Idaho State Legislature as a final rule.

THE FOLLOWING IS THE AMENDED TEXT FOR DOCKET 16-0305-0602

105. ~~IDENTITY AND PROOF OF~~ U.S. CITIZENSHIP AND IDENTITY DOCUMENTATION REQUIREMENTS.

To be eligible for Medicaid, an individual must provide documentation of ~~identity and either~~ U.S. citizenship ~~or qualified non-citizenship, and identity~~ unless he has otherwise met the requirements under Subsection 105.04~~8~~ of this rule. ~~The following are acceptable forms of documentation:~~ The individual must provide the Department with the most reliable document that is available. Documents must be originals or copies certified by the issuing agency. Copies of originals or notarized copies cannot be accepted. The Department will accept original documents in person, by mail, or through a guardian or authorized representative. ~~(7-1-06)F(7-1-06)T~~

01. Documents Accepted as Primary Level Proof of Both ~~Identity and~~ U.S. Citizenship and Identity. The following documents ~~may be~~ are accepted as the primary level of proof of both U.S. citizenship and identity: ~~(7-1-06)F(7-1-06)T~~

- a. A U.S. passport; (7-1-06)T
- b. A Certificate of Naturalization, DHS Forms N-550 or N-570; or ~~(7-1-06)F(7-1-06)T~~
- c. A Certificate of U.S. Citizenship, DHS Forms N-560 or N-561; ~~or~~ ~~(7-1-06)F(7-1-06)T~~
- ~~d. A driver's license if the state issuing the license requires proof of citizenship before the license is issued.~~ ~~(7-1-06)F~~

02. Documents Accepted as Secondary Level Proof of U.S. Citizenship but Not Identity. The

following documents ~~may be~~ are accepted as proof of U.S. citizenship ~~only if the proof in Subsection 105.01 is not available.~~ These documents are not proof of identity and must be used in combination with a least one (1) document listed in Subsections 105.035 or 105.06 of this rule to establish both citizenship and identity.

~~(7-1-06)F(7-1-06)T~~

- a.** A U.S. birth certificate; that shows the individual was born in one (1) of the following:
~~(7-1-06)F(7-1-06)T~~
- i.** United States fifty (50) states; (7-1-06)T
- ii.** District of Columbia; (7-1-06)T
- iii.** Puerto Rico, on or after January 13, 1941; (7-1-06)T
- iv.** Guam, on or after April 10, 1899; (7-1-06)T
- v.** U.S. Virgin Islands, on or after January 17, 1917. (7-1-06)T
- vi.** American Samoa; (7-1-06)T
- vii.** Swain's Island; or (7-1-06)T
- viii.** Northern Mariana Islands, after November 4, 1986; (7-1-06)T
- b.** A certification of report of birth issued by the Department of State, Forms DS-1350 or FS-545;
(7-1-06)T
- bc.** A report of birth abroad of a U.S. Citizen, Form ~~FS-545 or DS-1350~~240; ~~(7-1-06)F(7-1-06)T~~
- cd.** A U.S. Citizen I.D. card, DHS Form I-197; (7-1-06)T
- d.** *A hospital record of birth issued at the time of birth in one (1) of the fifty (50) states, the District of Columbia, Puerto Rico (on or after January 13, 1941), Guam (on or after April 10, 1899), the U.S. Virgin Islands (on or after January 17, 1917), American Samoa, Swain's Island, or the Northern Mariana Islands. If the person was born to foreign diplomats residing in one (1) of the preceding jurisdictions of the U.S., he is not a citizen of the United States;*
~~(7-1-06)F~~
- e.** *A religious record of birth recorded in the United States or its territories within three (3) months of birth which indicates a U.S. place of birth. This document must show either the date of birth or the individual's age at the time the record was made;*
~~(7-1-06)F~~
- fe.** A Northern Mariana Identification Card ~~issued by the Immigration and Naturalization Service (INS) to a collectively naturalized citizen of the United States who was born in the Northern Mariana Islands before November 3, 1986,~~ Form I-873;
~~(7-1-06)F(7-1-06)T~~
- gf.** An American Indian Card issued by the Department of Homeland Security with the classification code "KIC," Form I-873;
~~(7-1-06)F(7-1-06)T~~
- h.** *Information from a primary source such as the State Data Exchange (SDX) or birth confirmations from Vital Statistics;* or
~~(7-1-06)F~~
- i.** *An affidavit made by a blood relative of the individual and who has personal knowledge of the events establishing the individual's claim of citizenship. For example, the date and place of the individual's birth in the United States.*
~~(7-1-06)F~~
- g.** A final adoption decree showing the child's name and U.S. place of birth; (7-1-06)T

- h.** Evidence of U.S. Civil Service employment before June 1, 1976; or (7-1-06)T
- i.** An official U.S. Military record showing a U.S. place of birth. (7-1-06)T

03. Documents Accepted as Third Level Proof of U.S. Citizenship but Not Identity. The following documents are accepted as proof of U.S. citizenship if a primary or secondary level of proof is not available. These documents are not proof of identity and must be used in combination with a least one (1) document listed in Subsections 105.05 or 105.06 of this rule to establish both citizenship and identity. (7-1-06)T

- a.** A written hospital record on hospital letterhead established at the time of the person's birth that was created five (5) years before the initial application date that indicates a U.S. place of birth; or (7-1-06)T
- b.** Life, health, or other insurance record that was created at least five (5) years before the initial application date and that indicates a U.S. place of birth. (7-1-06)T

04. Documents Accepted as Fourth Level Proof of U.S. Citizenship but Not Identity. The following documents are accepted as proof of U.S. citizenship only if documents in Subsections 105.01 through 105.03 of this rule do not exist and cannot be obtained for a person who claims U.S. citizenship. These documents are not proof of identity and must be used in combination with a least one (1) document listed in Subsections 105.05 or 105.06 of this rule to establish both citizenship and identity. (7-1-06)T

- a.** Federal or state census record that shows the individual has U.S. citizenship or a U.S. place of birth; (7-1-06)T
- b.** One (1) of the following documents that shows a U.S. place of birth and was created at least five (5) years before the application for Medicaid; (7-1-06)T
 - i.** Seneca Indian tribal census record; (7-1-06)T
 - ii.** Bureau of Indian Affairs tribal census records of the Navajo Indians; (7-1-06)T
 - iii.** U.S. State Vital Statistics official notification of birth registration; (7-1-06)T
 - iv.** An amended U.S. public birth record that is amended more than five (5) years after the person's birth; (7-1-06)T
 - v.** Statement signed by the physician or midwife who was in attendance at the time of birth; (7-1-06)T
 - vi.** Medical (clinic, doctor, or hospital) record; (7-1-06)T
 - vii.** Institutional admission papers from a nursing facility, skilled care facility or other institution; or (7-1-06)T
- c.** A written declaration, signed and dated, which states, "I declare under penalty of perjury that the foregoing is true and correct." A declaration is accepted if no other documentation is available and complies with the following; (7-1-06)T
 - i.** Declarations must be made by two (2) persons who have personal knowledge of the events establishing the individual's claim of U.S. citizenship; (7-1-06)T
 - ii.** One (1) of the persons making a declaration cannot be related to the individual claiming U.S. citizenship; (7-1-06)T
 - iii.** Neither of the two (2) persons making the declaration can be an applicant or recipient of Medicaid; (7-1-06)T
 - iv.** The persons making the declaration must provide proof of their own U.S. citizenship and identity;

and (7-1-06)T

v. The persons making the declaration must provide an explanation as to why documentation for the individual does not exist or cannot be obtained. (7-1-06)T

vi. A declaration must be obtained from the individual applying for Medicaid, a guardian, or representative that explains why the documentation does not exist or cannot be obtained. (7-1-06)T

035. Documents Accepted for Proof of Identity but Not Citizenship. The following documents ~~may~~ be accepted as proof of identity. They are not proof of citizenship and must be used in combination with at least one (1) document listed in Subsection 105.02~~1~~ through 105.04 of this rule to establish both citizenship and identity.

~~(7-1-06)T~~(7-1-06)T

a. A ~~current~~ state-issued driver's license bearing the individual's picture or other identifying information such as name, age, gender, race, height, weight, or eye color; ~~(7-1-06)T~~(7-1-06)T

b. A federal, state, or local government-issued identity card ~~issued to a non-driver bearing the individual's picture for which the state required proof of identity as a condition of issuing the identity document; or with the same identifying information that is included on driver's licenses as described in Subsection 105.05.a of this rule;~~ ~~(7-1-06)T~~(7-1-06)T

c. ~~Any other document the state finds that establishes the true identity of the individual.~~ School identification card with a photograph of the individual; ~~(7-1-06)T~~(7-1-06)T

d. U.S. Military card or draft record; (7-1-06)T

e. Military dependent's identification card; (7-1-06)T

f. U. S. Coast Guard Merchant Mariner card; (7-1-06)T

g. Certificate of Degree of Indian blood; or (7-1-06)T

h. Native American Indian or Alaska Native Tribal document with a photograph or other personal identifying information relating to the individual. (7-1-06)T

06. Identity Rules for Children. The following documentation of identity for children under sixteen (16) may be used: (7-1-06)T

a. School records may be used to establish identity. Such records also include nursery or daycare records. (7-1-06)T

b. A written declaration, signed and dated, which states, "I declare under penalty of perjury that the foregoing is true and correct," if documents listed in Subsection 105.02 of this rule are not available. A declaration may be used if it meets the following conditions: (7-1-06)T

i. It states the date and place of the child's birth; and (7-1-06)T

ii. It is signed by a parent or guardian. (7-1-06)T

c. A declaration cannot be used for identity if a declaration for citizenship documentation was provided for the child. (7-1-06)T

07. Eligibility for Applicants and Medicaid Participants Who Do Not Provide Citizenship and Identity Documentation. (7-1-06)T

a. Eligibility will be denied to any applicant who does not provide proof of citizenship and identity documentation; (7-1-06)T

b. Any Medicaid participant, who does not provide proof of citizenship and identity documentation at a scheduled renewal and who is making a good faith effort to obtain documentation, will not be terminated from Medicaid for lack of documentation unless the participant: (7-1-06)T

i. Does not meet other eligibility criteria required in this chapter of rules; or (7-1-06)T

ii. Refuses to obtain the documentation. (7-1-06)T

~~048.~~ **048. Individuals Considered as Meeting the U.S. Citizenship and Identity Documentation Requirements.** The following individuals are considered to have met the U.S. citizenship and identity documentation requirements, regardless of whether documentation required in Subsections 105.01 through 105.07 of this rule is provided: (~~7-1-06~~)T(7-1-06)T

~~a.~~ *Children receiving Title IV-E foster care assistance;* (7-1-06)T

~~b.a.~~ SSI ~~or RSDI~~ recipients; and (~~7-1-06~~)T(7-1-06)T

~~e.b.~~ Individuals determined by the SSA to be entitled to or are receiving Medicare recipients. (~~7-1-06~~)T(7-1-06)T

09. Title IV-E Foster Care Child. The Department will not deny or delay Medicaid for a child receiving Title IV-E Foster Care assistance pending citizenship and identity documentation. (7-1-06)T

10. Assistance in Obtaining Documentation. The Department will assist individuals who are mentally or physically incapacitated and who lack a representative to assist them in obtaining such documentation. (7-1-06)T

11. Provide Documentation of Citizenship and Identity One Time. When an individual has provided citizenship and identity documents, changes in eligibility will not require an individual to provide such documentation again unless later verification of the documents provided raises a question of the individual's citizenship or identity. (7-1-06)T

(BREAK IN CONTINUITY OF SECTIONS)

238. HOME AS RESOURCE.

An individual's home is property he owns, and serves as his principal place of residence. His principal place of residence is the place he considers his principal home. If the individual is absent from his home, it is still his principal place of residence if he intends to return. (1-1-06)T

01. AABD Cash, and Medicaid With the Exception of Long-Term Care. For AABD Cash and Medicaid with the exception of long-term care, the value of an individual's home is an excluded resource. (1-1-06)T

02. Long-Term Care Services. For long-term care services, when the value of a participant's equity in the home is ~~five~~ seven hundred ~~fifty~~ thousand dollars (\$~~50~~75,000) or less, the home is excluded as a resource. When the equity value exceeds ~~five~~ seven hundred ~~fifty~~ thousand dollars (\$~~50~~75,000), the individual is ineligible for long-term care services. The equity value, regardless of the amount, is an excluded resource when one (1) of the following applies: (~~1-1-06~~)T(1-1-06)T

a. The spouse of the individual lives in the home; or (1-1-06)T

b. The individual's child, who is under age twenty-one (21), or is blind, or meets the disability requirements for AABD cash, lives in the home. (1-1-06)T

(BREAK IN CONTINUITY OF SECTIONS)

247. LIFE ESTATE INTEREST IN ANOTHER'S HOME.

The purchase of a life estate interest in another individual's home is a resource unless the purchaser resides in the home for a period of at least ~~one (1) year~~ twelve (12) consecutive months after the date of purchase.

~~(2-8-06)T~~(2-8-06)T

(BREAK IN CONTINUITY OF SECTIONS)

831. ASSET TRANSFER RESULTING IN PENALTY.

Starting August 11, 1993, the participant is subject to a penalty if he transfers his income or resources for less than fair market value. The asset transfer penalty applies to Medicaid services received October 1, 1993 and later. Excluded resources, other than the home and associated property, are not subject to the asset transfer penalty. Asset transfers subject to penalty under these rules may be voided and set aside by court action as provided in Section 56-218, Idaho Code. The asset transfer penalty applies to a Medicaid participant in long-term care or HCBS. A participant in long-term care is a patient in a nursing facility or a patient in a medical institution, requiring and receiving the level of care provided in a nursing facility. (2-8-06)T

01. Rebuttable Presumption. Unless a transfer meets the requirements of Section 841 of these rules, it is presumed that the transfer was made for the purpose of qualifying for Medicaid. The asset transfer penalty is applied unless the participant shows that the asset transfer would not have affected his eligibility for Medicaid or the transfer was made for another purpose than qualifying for Medicaid. (4-11-06)

02. Contract for Services Provided by a Relative. A contract for personal services to be furnished to the participant by a relative is presumed to be made for the purpose of qualifying for Medicaid. The asset transfer penalty applies unless the participant shows that: (3-15-02)

a. A written contract for personal services was signed before services were delivered. The contract must require that payment be made after services are rendered. The contract must be dated and the signatures notarized. Either party must be able to terminate the contract; and (3-15-02)

b. The contract must be signed by the participant or a legally authorized representative through a power of attorney, legal guardianship or conservatorship. A representative who signs the contract must not be the provider of the personal care services under the contract; and (3-15-02)

c. Compensation for services rendered must be comparable to rates paid in the open market. (3-15-02)

03. Transfer of Income or Resources. Transfer of income or resources includes reducing or eliminating the participant's ownership or control of the asset. (4-5-00)

04. Transfer of Income or Resources by a Spouse. A transfer by the participant's spouse of either spouse's income or resources, before eligibility is established, subjects the participant to the asset transfer penalty. After the participant's eligibility is established, a transfer by the spouse of the spouse's own income or resources does not subject the participant to the asset transfer penalty. (4-5-00)

05. Transfer of Certain Notes and Loans. Funds used to purchase a promissory note, loan, or mortgage are considered a transferred asset which subjects the participant to a period of ineligibility. The amount of the asset transfer of such note, loan or mortgage is the outstanding balance due on the date of the Medicaid application, unless the note, loan or mortgage meets the following: ~~(2-8-06)T~~(2-8-06)T

a. Has a repayment term that is actuarially sound; (2-8-06)T

- b. Provides for payments to be made in equal amounts during the term of the loan with no deferral and no balloon payments ~~made~~; and ~~(2-8-06)T~~(2-8-06)T
- c. Prohibits the cancellation of the balance upon the death of the lender. (2-8-06)T

(BREAK IN CONTINUITY OF SECTIONS)

835. APPLYING THE PENALTY PERIOD OF RESTRICTED COVERAGE.

Restricted coverage continues until the participant or spouse recovers all the assets, receives fair market value at the time of the transfer for all of the assets, or the period of restricted coverage ends. The penalty continues whether or not the participant is in long-term care. The penalty period for asset transfers is applied as follows:

~~(2-8-06)T~~(2-8-06)T

01. Penalty Period for Transfer Prior to February 8, 2006. For assets transferred prior to February 8, 2006, there is no penalty if the amount transferred is less than the cost of one (1) month's care. The penalty period begins running the month the transfer took place. The month the transfer took place is counted as one (1) of the penalty months. A penalty period is computed for each transfer. A penalty period must expire before the next begins. Each partial month before the end of consecutive penalty periods is a penalty month. A partial month at the end of consecutive penalty periods is dropped. (2-8-06)T

02. Penalty Period for Transfers On or After February 8, 2006. For assets transferred on or after February 8, 2006, the penalty period begins running the first day of the month after the month the transfer took place, or the date the individual would have been eligible for long-term care services, if not for the transfer, whichever date is later in time. The value of all asset transfers made during the look-back period is accumulated for the purpose of calculating the penalty. If an additional transfer is discovered after the penalty has been served, a new penalty period begins the month following timely notice of closure of benefits. When a penalty period ends after the first day of the month, eligibility for long-term care services begins the day after the penalty period ends. (2-8-06)T

836. ~~(RESERVED)~~ MULTIPLE PENALTY PERIODS APPLIED CONSECUTIVELY.

A penalty period is computed for each transfer. One (1) penalty period must expire before the next begins.

(2-8-06)T

(BREAK IN CONTINUITY OF SECTIONS)

838. ANNUITY AS ASSET TRANSFER.

Except as provided in this rule, when assets are used to purchase an annuity during the look-back period, it is an asset transfer presumed to be made for the purpose of qualifying for Medicaid. To rebut this presumption, the participant must provide proof that clearly establishes the annuity was not purchased to make the participant eligible for Medicaid or avoid recovery from the estate following death. In addition, the participant must show the annuity will be paid out in the participant's expected life, is irrevocable, earns interest at a reasonable rate of return, and names the state as the remainder beneficiary as described in Subsections 838.02 through 838.04 of these rules, unless the annuity is permitted under Section 838.05.

~~(2-8-06)T~~(2-8-06)T

01. Revocable Annuity. The surrender amount of a revocable annuity is a countable resource.

(2-8-06)T

02. Irrevocable Annuity. An irrevocable annuity is an annuity that under no circumstance can be sold or traded for value, including the sale of the stream of income from the annuity. The purchase price of an irrevocable annuity is treated as an asset transfer if it does not provide fair market value to the participant. The sixty (60) month look-back period applies. The irrevocable annuity provides fair market value to the participant if it passes all of the following tests, unless the requirements of Subsections 838.02.a., 838.02.b., 838.03 and 838.04 of these rules are met.

~~(2-8-06)F(2-8-06)T~~

a. **Irrevocable Annuity Life Expectancy Test.** The participant's life expectancy, as shown in the following table, must equal or exceed the term of the annuity. Using Table 838.02.a. compare the face value of the annuity to the participant's life expectancy at the purchase time. The annuity meets the life expectancy test if the participant's life expectancy equals or exceeds the term of the annuity. If the exact age is not in the Table, use the next lower age.

TABLE 838.02.a. - LIFE EXPECTANCY TABLE					
Age	Years of Life Remaining Male	Years of Life Remaining Female	Age	Years of Life Remaining Male	Years of Life Remaining Female
0	73.26	79.26	74	10.12	12.74
10	64.03	69.93	75	9.58	12.09
20	54.41	60.13	76	9.06	11.46
30	45.14	50.43	77	8.56	10.85
40	35.94	40.86	78	8.07	10.25
50	27.13	31.61	79	7.61	9.67
60	19.07	22.99	80	7.16	9.11
61	18.33	22.18	81	6.72	8.57
62	17.60	21.38	82	6.31	8.04
63	16.89	20.60	83	5.92	7.54
64	16.19	19.82	84	5.55	7.05
65	15.52	19.06	85	5.20	6.59
66	14.86	18.31	86	4.86	6.15
67	14.23	17.58	87	4.55	5.74
68	13.61	16.85	88	4.26	5.34
69	13.00	16.14	89	3.98	4.97
70	12.41	15.44	90	3.73	4.63
71	11.82	14.75	95	2.71	3.26
72	11.24	14.06	100	2.05	2.39
73	10.67	13.40	110	1.14	1.22

~~(2-8-06)F(2-8-06)T~~

b. **Annual Interest and Insurer Rating Test.** The annuity must produce annual interest of at least five percent (5%). A variable rate annuity meets the interest rate test if the average yearly rate for the most recent five (5) year period is five percent (5%) or more. To rebut the five percent (5%) interest test, the participant must show that single premium annuities were not offered by insurers when the annuity was purchased and it would not be practical to exchange the annuity for one with a higher interest rate. The insurer must be rated excellent or superior by an insurance rating firm.

(2-8-06)T

e. *Third Party Beneficiary Test. Effective February 8, 2006, the annuity must name the State of Idaho,*

~~Medicaid Estate Recovery, as follows:~~

~~(2-8-06)T~~

03. State Named as Beneficiary. The purchase of an annuity is treated as an asset transfer unless the State of Idaho, Medicaid Estate Recovery is named as: (2-8-06)T

a. The remainder beneficiary in the first position for at least the total amount of medical assistance paid on behalf of the annuitant under this title; or (2-8-06)T

b. The remainder beneficiary in the second position after the community spouse or minor or disabled child and is named in the first position if the community spouse or a representative of the minor or disabled child disposes of any remainder for less than fair market value. (2-8-06)T

04. Equal Payment Test. The annuity must provide for payments in equal amounts during the term of the annuity with no deferral and no balloon payments made. (2-8-06)T

05. Permitted Annuity. The purchase of an annuity is not treated as an asset transfer if the annuity meets any of the descriptions in Sections 408(b), or 408(q), Internal Revenue Code; or is purchased with proceeds from an account or trust described in Sections 408(a), 408(c), or 408(p), Internal Revenue Code, or is a simplified employee pension as described in Section 408(k), Internal Revenue Code, or is a Roth IRA described in Section 408A, Internal Revenue Code. (2-8-06)T

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.05 - RULES GOVERNING ELIGIBILITY FOR AID TO THE AGED, BLIND AND DISABLED (AABD)

DOCKET NO. 16-0305-0605

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2007 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended, or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended, or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 56-202(b), Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

The text of the pending rule has been amended in accordance with Section 67-5227, Idaho Code. Only those sections that have changes that differ from the proposed text are printed in this bulletin. The complete text of the proposed rule was published in the July 5, 2006, Idaho Administrative Bulletin, Vol. 06-7, pages 59 through 62.

The amendments to these rules are the result of comments received during the comment period. The following are specific changes made to the proposed rules:

- 1) Section 005 - added definitions for long-term care, Title XIX, Title XXI, and amended definitions for annuity and Medical Assistance Rules.
- 2) Section 737 - added a reference to the CFR for clarification of an excluded home.
- 3) Section 871 - added a reference to the CFR for clarification when a home and adjoining property loses its exclusion for eligibility purposes.

FISCAL IMPACT: The following is a specific description, if applicable, of any fiscal impact on the state general fund greater than ten thousand dollars (\$10,000) during the fiscal year.

There is no anticipated fiscal impact to the state general fund.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Peggy Cook at (208) 334-5969.

DATED this 28th day of September, 2006.

Sherri Kovach
Program Supervisor
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DOCKET NO. 16-0305-0605 - ADOPTION OF PENDING RULE

There are substantive changes from the proposed rule text.

Only those sections that have changed from the original proposed text are printed in this Bulletin following this notice.

The complete text of the proposed rule was published in the Idaho Administrative Bulletin, Volume 06-7, July 5, 2006, pages 59 through 62.

This rule has been adopted as a pending rule by the Agency and is now pending review and approval by the 2007 Idaho State Legislature as a final rule.

THE FOLLOWING IS THE AMENDED TEXT FOR DOCKET 16-0305-0605

Subsections 005.03, 005.04, 005.12, 005.14, 005.19, and 005.20

005. DEFINITIONS.

These definitions apply to IDAPA 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind and Disabled (AABD)": (7-1-99)

01. AABD Cash. An EBT payment to a participant, a participant's guardian, or a holder of a limited power of attorney for EBT payments. (5-3-03)

02. Applicant. A person applying for public assistance from the Department, and whose application is not fully processed. (7-1-99)

03. Annuity. A right to receive periodic payments, either for life, a term of years, or other interval of time, whether or not the initial payment or investment has been annuitized. It includes contracts for single payments where the single payment represents an initial payment or investment together with increases or deductions for interest or fees rather than an actuarially-based payment from an insurance pool. ()

04. Asset. Includes all income and resources of the individual and the individual's spouse, including any income or resources which the individual or such individual's spouse is entitled to, but does not receive because of action by: ()

a. The individual or such individual's spouse; ()

b. A person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or such individual's spouse; or ()

c. A person, including any court or administrative body, acting at the direction or upon the request of the individual or such individual's spouse. ()

035. Asset Transfer for Sole Benefit. An asset transfer is considered to be for the sole benefit of a spouse, blind or disabled child, or disabled individual if the transfer is arranged in such a way that no individual or entity except the spouse, blind or disabled child, or disabled individual can benefit from the assets transferred in any way, whether at the time of transfer or at any time in the future. (5-3-03)

~~046.~~ **Child.** A child is under age eighteen (18), or under twenty-one (21) and attending school, college, university, or vocational or technical training designed to prepare him for gainful employment. A child is not married. A child is not the head of a household. (7-1-99)

~~057.~~ **Department.** The Department of Health and Welfare. (7-1-99)

~~068.~~ **Direct Deposit.** The electronic deposit of a participant's AABD cash to the participant's personal account with a financial institution. (7-1-99)

~~079.~~ **Electronic Benefits Transfer (EBT).** A method of issuing AABD cash to a participant, a participant's guardian or a holder of a limited power of attorney for EBT payments for a participant. EBT rules are in IDAPA 16.03.20, "Rules Governing Electronic Payments of Public Assistance, Food Stamps and Child Support". (7-1-99)

~~0910.~~ **Essential Person.** A person of the participant's choice whose presence in the household is essential to the participant's well-being. The essential person provides the services a participant needs to live at home. (5-3-03)

~~0911.~~ **Fair Market Value.** The fair market value of an asset is the price for which the asset can be reasonably expected to sell on the open market, in the geographic area involved. (5-3-03)

~~12.~~ **Long-Term Care.** Long-term care services are services provided to an institutionalized individual as defined in 42 U.S.C. 1396(c)(1)(c). ()

~~103.~~ **Medicaid.** The Federally-funded program for medical care (Title XIX, Social Security Act). (5-3-03)

~~144.~~ **Medical Assistance Rules.** Idaho Department of Health and Welfare Rules, IDAPA 16.03.09, "~~Rules Governing the Medical Assistance Program~~ Medicaid Basic Plan Benefits," and IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." (7-1-99)()

~~125.~~ **Medicaid for Families With Children Rules.** Idaho Department of Health and Welfare Rules, IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children". (7-1-99)

~~136.~~ **Participant.** An individual applying for or receiving assistance. (7-1-99)

~~147.~~ **Sole Beneficiary.** The only beneficiary of a trust, including a beneficiary during the grantor's life, a beneficiary with a future interest, and a beneficiary by the grantor's will. (7-1-99)

~~158.~~ **TAFI Rules.** Idaho Department of Health and Welfare Rules, IDAPA 16.03.08, "Rules Governing Temporary Assistance for Families in Idaho". (7-1-99)

~~19.~~ **Title XIX.** Title XIX of the Social Security Act, known as Medicaid, is a medical benefits program jointly financed by the federal and state governments and administered by the states. This program pays for medical assistance for certain individuals and families with low income and limited resources. ()

~~20.~~ **Title XXI.** Title XXI of the Social Security Act, known as the State Children's Health Insurance Program (SCHIP). This is a program that primarily pays for medical assistance for low-income children. ()

~~1621.~~ **Working Day.** A calendar day when regular office hours are observed by the state of Idaho. (7-1-99)

(BREAK IN CONTINUITY OF SECTIONS)

Subsection 737.03

737. RESOURCES EXCLUDED FROM ASSESSMENT.

Resources excluded in determining AABD cash are excluded in determining the couple's total combined FSI resources except: *There is no limit on the total value of household goods and personal effects and one (1) automobile is excluded regardless of its value. Any additional automobiles are countable resources in the amount of their equity value.* (7-1-99)(____)

01. Resources For Sale. Excess resources offered for sale, are not excluded from the couple's total combined resources for the FSI resource assessment. (7-1-99)(____)

02. Jointly Owned Real Property. Jointly owned real property that is not the principal residence of the participant, is not excluded, if the community spouse is the joint owner. (7-1-99)(____)

03. Excluded Home. *As defined in 42 U.S.C. 1396r-5(c)(5)*, an excluded home placed in trust retains its exclusion for purposes of the resource assessment. (____)

(BREAK IN CONTINUITY OF SECTIONS)

Section 871 and Subsection 871.01.d.

871. TREATMENT OF TRUSTS.

These trust treatment rules apply to all Medicaid participants. These rules apply to trusts established with the participant's assets on August 11, 1993 or later, and to amounts placed in trusts funded on or after August 11, 1993 or later. ~~This~~ Section 871 of these rules does not apply to an irrevocable trust if the participant meets the undue hardship exemption in Subsection 841.11 of these rules. Assets transferred to a trust are subject to the asset transfer penalty. Section 871 of these rules does not apply to a trust created with assets other than those of the individual, including a trust established by a will. (4-11-06)(____)

01. Revocable Trust. Revocable trusts are treated as listed in Subsections 871.01.a. through 871.01.d. of these rules. A revocable burial trust is not a trust for the purposes of Subsection 871.01 of these rules. (4-11-06)

a. The body (corpus) of a revocable trust is a resource. (7-1-99)

b. Payments from the trust to or for the participant are income. (7-1-99)

c. Any other payments from the trust are an asset transfer, triggering an asset transfer penalty period. (7-1-99)

d. As defined in 42 U.S.C. 1396p(e)(5), the home and adjoining property loses its exclusion for eligibility purposes when transferred to a revocable trust, unless the participant or spouse is the sole beneficiary of the trust. The home is excluded again if removed from the trust. The exclusion restarts the ~~next~~ month following the month the home was removed from the trust. (7-1-99)(____)

02. Irrevocable Trust. Irrevocable trusts are treated as listed in Subsections 871.02.a. through 871.02.g. of these rules. (4-11-06)

a. The part of the body of an irrevocable trust, from which corpus or income payments could be made to or for the participant, is a resource. (7-1-99)

b. Payments made to or for the participant are income. (7-1-99)

c. Payments from the trust for any other reason are asset transfers, triggering the asset transfer penalty. (7-1-99)

d. Any part of the trust from which payment cannot be made to, or for the benefit of, the participant under any circumstances, is an asset transfer. (7-1-99)

e. The effective date of the transfer is the date the trust was established, or the date payments to the participant were foreclosed. (7-1-99)

f. The value of the trust, for calculating the transfer penalty, includes any payments made from that portion of the trust after the date the trust was established or payments were foreclosed. (7-1-99)

g. An irrevocable burial trust is not subject to treatment under Subsection 871.02 of these rules, unless funds in the trust can be paid for a purpose other than the participant's funeral and related expenses. The trust can provide that funds not needed for the participant's funeral expenses are available to reimburse Medicaid, or to go to the participant's estate. (4-11-06)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.05 - RULES GOVERNING ELIGIBILITY FOR AID TO THE AGED, BLIND AND DISABLED (AABD)

DOCKET NO. 16-0305-0607

NOTICE OF RULEMAKING - TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is October 1, 2006.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule, and proposed rulemaking procedures have been initiated. The action is authorized pursuant to Sections 56-202, and 56-250 through 56-257.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than November 15, 2006.

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is the required finding and concise statement of its supporting reasons for adopting a temporary rule and a non-technical explanation of the substance and purpose of the proposed rulemaking:

The current Traumatic Brain Injury (TBI) Waiver expired on September 30, 2006. The Department needs to provide TBI Waiver participants a service plan that is effective on October 1, 2006. The coverage for TBI participants has been moved to the A&D Waiver Services coverage found in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." The A&D Waiver has similar eligibility criteria for the level of care and services, and will provide TBI Waiver participants continued coverage without disruption. The eligibility criteria for the TBI Waiver is being deleted in this rulemaking. The A&D eligibility section was revised and now includes participants aged sixty-five (65) and older. This age group has been eligible and is included in the IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits" rule; however, it needed to be added to this rule also. Also, effected sections of this rule have been updated by deleting the reference to IDAPA 16.03.09, "Rules Governing the Medical Assistance Program" and replacing it with the new IDAPA 16.03.10 "Medicaid Enhanced Plan Benefits."

TEMPORARY RULE JUSTIFICATION: Pursuant to Section(s) 67-5226(1)(c), Idaho Code, the Governor has found that temporary adoption of the rule is being done to confer a benefit to current Traumatic Brain Injury (TBI) Waiver participants.

FEE SUMMARY: There is no fee or charge being imposed or increased in this docket.

FISCAL IMPACT: The following is a specific description, if applicable, of any fiscal impact on the state general fund greater than ten thousand dollars (\$10,000) during the fiscal year.

There is no fiscal impact to the state General Fund due to this rulemaking.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because changes to rule are being made to benefit TBI Waiver participants.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Peggy Cook at (208) 334-5969.

Anyone may submit written comments regarding the proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before Wednesday, November 22, 2006.

DATED this 20th day of September, 2006.

Sherri Kovach
Program Supervisor
DHW - Administrative Procedures Section
450 West State Street - 10th Floor
P.O. Box 83720, Boise, Idaho 83720-0036
(208) 334-5564 phone; (208) 334-6558 fax
kovachs@idhw.state.id.us e-mail

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0305-0607

721. LONG-TERM CARE RESIDENT AND MEDICAID.

A resident of a long-term care facility must meet the AABD eligibility criteria to be eligible for Medicaid. A long-term care facility is a nursing facility, or an intermediate care facility for the mentally retarded. The need for long-term care is determined using IDAPA 16.03.0910, "~~Rules Governing the Medical Assistance Program Medicaid Enhanced Plan Benefits.~~" ~~(3-20-04)~~(10-1-06)T

01. Resources of Resident. The resident's resource limit is two thousand dollars (\$2,000). Resources of a married person in long-term care are computed using Federal Spousal Impoverishment rules. Under the SSI method, spouses can use the three thousand dollar (\$3,000) couple resource limit if more advantageous. The couple must have lived in the nursing home, in the same room, for six (6) months. (3-20-04)

02. Medicaid Income Limit of Long-Term Care Resident Thirty Days or More. The monthly income limit for a long-term care facility resident is three (3) times the Federal SSI benefit for a single person. To qualify for this income limit the participant must be, or be likely to remain, in long-term care at least thirty (30) consecutive days. (3-20-04)

03. Medicaid Income Limit of Long-Term Care Resident Less Than Thirty Days. The monthly income limit, for the resident of a long-term care facility for less than thirty (30) consecutive days, is the AABD income limit for the participant's living situation before long-term care. Living situations before long-term care do not include hospital stays. (7-1-99)

04. Income Not Counted. The income listed in Subsections 721.04.a. through 721.04.e. of these rules is not counted to compute Medicaid eligibility for a long-term care facility resident. This income is counted in determining participation in the cost of long-term care. (3-20-04)

a. Income excluded or disregarded, in determining eligibility for AABD cash, is not counted. (3-20-04)

b. The September 1972 RSDI increase is not counted. (3-20-04)

c. Any VA Aid and Attendance allowance, including any increment which is the result of a VA Unusual Medical Expense allowance, is not counted. These allowances are not counted for patient liability, unless the veteran lives in a state operated veterans' home. (3-20-04)

d. RSDI benefit increases, from cost-of-living adjustments (COLA) after April 1977, are not counted if they made the participant lose SSI or AABD cash. The COLA increases after SSI or AABD cash stopped are not counted. (3-20-04)

e. Income paid into an income trust exempt from counting for Medicaid eligibility under Subsection 872.02 of these rules is used for patient liability. Income paid to the trust and not used for patient liability, is subject to the asset transfer penalty. (3-20-04)

(BREAK IN CONTINUITY OF SECTIONS)

785. CERTAIN DISABLED CHILDREN.

A disabled child, not eligible for Medicaid outside a medical institution, is eligible for Medicaid if he meets the conditions in Subsections 785.01 through 785.07 of these rules. (3-15-02)

- 01. Age.** Is under nineteen (19) years old. (7-1-99)
- 02. AABD Criteria.** Meets the AABD blindness or disability criteria. (7-1-99)
- 03. AABD Resource Limit.** Meets the AABD single person resource limit. (7-1-99)
- 04. Income Limit.** Has monthly income not exceeding three (3) times the Federal SSI benefit payable monthly to a single person. (7-1-99)
- 05. Eligible for Long Term Care.** Meets the medical conditions for long-term care in IDAPA 16.03.0910, "~~Rules Governing the Medical Assistance Program,~~" Subsection 160.09 Medicaid Enhanced Plan Benefits." ~~(7-1-99)~~(10-1-06)T
- 06. Appropriate Care.** Is appropriately cared for outside a medical institution, under a physician's plan of care. (7-1-99)
- 07. Cost of Care.** Can be cared for cost effectively outside a medical institution. The estimated cost of caring for the child must not exceed the cost of the child's care in a hospital, nursing facility, or ICF-MR. (3-15-02)

(BREAK IN CONTINUITY OF SECTIONS)

787. HOME AND COMMUNITY BASED SERVICES (HCBS).

An aged, blind or disabled participant, who is not income eligible for SSI or AABD cash, in his own home or community setting, is eligible for Medicaid if he meets the conditions in Subsections 787.01 through 787.07 of these rules, and meets all requirements in one (1) of the waiver Sections 788 through 794 of these rules. ~~(3-20-04)~~(10-1-06)T

- 01. Resource Limit.** Meets the AABD single person resource limit. (3-20-04)
- 02. Income Limit.** Income of the participant must not exceed three (3) times the Federal SSI monthly benefit for a single person. A married participant living at home with his spouse who is not an HCBS participant, may choose between the SSI, CP, and FSI methods. If his spouse is also an HCBS participant or lives in a nursing home, the couple may choose between the SSI and CP methods. (3-20-04)
- 03. Maintained in the Community.** The applicant must be able to be maintained safely and effectively in his own home or in the community with the waiver services. (3-20-04)
- 04. Cost of Care.** The cost of the participant's care must be determined to be cost effective as provided in IDAPA 16.03.0910, "~~Rules Governing the Medical Assistance Program~~" Medicaid Enhanced Plan Benefits." ~~(3-20-04)~~(10-1-06)T
- 05. Waiver Services Needed.** The participant must need and receive, or be likely to need and receive, waiver services for thirty (30) consecutive days. The participant is ineligible when there is a break in need for, or receipt of, waiver services for thirty (30) consecutive days. (3-20-04)

06. Effective Date. Waiver services are effective the first day the participant is likely to need and receive waiver services. Medicaid begins the first day of the month in which the first day of approved waiver services are received. (3-20-04)

07. Annual Limit. The Department limits the number of participants approved for waiver services each year. A participant who applies for waiver services after the annual limit is reached, must be denied waiver services. (3-20-04)

788. AGED AND DISABLED (A&D) WAIVER.

~~To be eligible, the participant must be disabled or at least eighteen (18) years of age and less than sixty-five (65) years of age and need nursing facility level of care as provided in IDAPA 16.03.09 "Rules Governing the Medical Assistance Program".~~ In order to be eligible for the Aged and Disabled (A&D) Waiver, the participant must:
~~(3-20-04)~~(10-1-06)T

01. Age Eighteen Through Sixty-Four. Be eighteen (18) through sixty-four (64) years old and meet both the disability criteria, as provided in Subsection 156 of these rules, and need nursing facility level of care as provided in IDAPA 16.03.10 "Medicaid Enhanced Plan Benefits"; or (10-1-06)T

02. Age Sixty-Five or Older. Be age sixty-five (65) or older and need nursing facility level of care as provided in IDAPA 16.03.10 "Medicaid Enhanced Plan Benefits." (10-1-06)T

789. DEVELOPMENTALLY DISABLED (DD) WAIVER.

To be eligible, the participant must be at least eighteen (18) years of age and need the level of care provided by an intermediate care facility for the mentally retarded (ICF/MR) under IDAPA 16.03.09 "~~Rules Governing the Medical Assistance Program~~ Medicaid Enhanced Plan Benefits." ~~(3-20-04)~~(10-1-06)T

~~**790. TRAUMATIC BRAIN INJURY (TBI) WAIVER.**~~

~~To be eligible, the participant must have sustained a traumatic brain injury on or after his twenty-second birthday and need nursing facility level of care as provided in IDAPA 16.03.09 "Rules Governing the Medical Assistance Program".~~ (3-20-04)

~~**791. IDAHO STATE SCHOOL AND HOSPITAL (ISSH) WAIVER.**~~

~~To be eligible, the participant must be at least fifteen (15) years of age but less than nineteen (19) years of age and is currently at or would be placed at the Idaho State School and Hospital (ISSH) if not for waiver services. (3-20-04)~~

~~**792. -- 798. (RESERVED).**~~

(BREAK IN CONTINUITY OF SECTIONS)

802. WOMAN DIAGNOSED WITH BREAST OR CERVICAL CANCER.

A woman not otherwise eligible for Medicaid and meeting the conditions in Subsections 802.01 through 802.06 of this rule is eligible for Medicaid for the duration of her cancer treatment. Medicaid income and resource limits do not apply to this coverage group. (5-3-03)

01. Diagnosis. The participant is diagnosed with breast or cervical cancer through the Centers for Disease Control and Prevention's National Breast and Cervical Cancer Early detection Program. (3-15-02)

02. Age. The participant is under age sixty-five (65). (3-15-02)

03. Creditable Health Insurance. The participant is uninsured or, if insured, the plan does not cover her type of cancer. (3-15-02)

04. Non-Financial Eligibility. The participant meets the Medicaid non-financial eligibility requirements in Sections 100 through 108 and Sections 166 and 167 of these rules. (3-15-02)

05. Medical Support Cooperation. The participant meets the medical support cooperation requirement in Sections 702 through 706 of these rules. (3-15-02)

06. Group Health Plan Enrollment. The participant meets the requirement to enroll in available cost-effective employer group health insurance. (3-15-02)

07. Presumptive Eligibility. The Department can presume the participant is eligible for Medicaid, before a formal Medicaid eligibility determination is made. A clinic authorized to screen for breast or cervical cancer by the National Breast and Cervical Cancer Early Detection Program makes the presumptive eligibility determination. The clinic tells the participant how to complete the formal Medicaid determination process. The Medicaid notice and hearing rights do not apply to presumptive eligibility. No overpayment occurs if the formal Medicaid determination finds the participant is not eligible. (5-3-03)

08. End of Treatment. The Division of Medicaid determines the end of treatment date according to IDAPA 16.03.0910, "~~Rules Governing the Medical Assistance Program,~~" Section 013 Medicaid Enhanced Plan Benefits. (~~5-3-03~~)(10-1-06)T

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.10 - MEDICAID ENHANCED PLAN BENEFITS

DOCKET NO. 16-0310-0603

NOTICE OF RULEMAKING - TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective dates of the temporary rules are October 1, 2006.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule, and proposed rulemaking procedures have been initiated. The action is authorized pursuant to Sections 56-202(b), and 56-250 through 56-257, Idaho Code.

PUBLIC HEARING SCHEDULE: A public hearing concerning this rulemaking will be held as follows:

Wednesday, November 8, 2006 - 2:00 p.m.
DHW - Region IV Office
1720 Westgate Dr., Suite D, Room 119
Boise, Idaho

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

The current Traumatic Brain Injury (TBI) Waiver expires on September 30, 2006. In order to not disrupt services for the TBI Waiver participants, the Department is moving the coverage for TBI participants under the rules for Aged and Disabled (A&D) Waiver services. The A&D Waiver has similar eligibility criteria for the level of care and services that are currently provided to TBI Waiver participants.

The sections of rules outlining the TBI Waiver Services are being deleted. Services that were covered in the TBI Waiver services for habilitation, supported employment, behavior consultation, and crisis management will be provided under the Aged and Disabled Waiver Services rules. These changes will assure continuity of care for those participants who have been served under the former TBI Waiver. Minor changes have also been made to the rules for consistency and clarification.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section 67-5226(1)(c), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate for the following reasons:

These rule amendments confer a benefit to eligible Medicaid participants in Idaho.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: N/A

FISCAL IMPACT: The following is a specific description, if applicable, of any fiscal impact on the state general fund greater than ten thousand dollars (\$10,000) during the fiscal year. N/A

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because the rule changes confer a benefit.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Chris Baylis at (208) 364-1891.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before Wednesday, November 22, 2006.

DATED this 28th day of September, 2006.

Sherri Kovach, Program Supervisor
DHW – Administrative Procedures Section
450 West State Street - 10th Floor
P.O. Box 83720, Boise, Idaho 83720-0036
(208) 334-5564 phone; (208) 332-7347 fax
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THE FOLLOWING IS THE TEXT FOR DOCKET 16-0310-0603

075. ENHANCED PLAN BENEFITS - COVERED SERVICES.

Individuals who are eligible for the Medicaid Enhanced Plan Benefits are eligible for all benefits covered under IDAPA 16.03.09, “Medicaid Basic Plan Benefits.” In addition to those benefits, individuals in the enhanced plan are eligible for the following enhanced benefits as provided for in this chapter of rules. (7-1-06)T

01. Enhanced Hospital Benefits. Organ transplants are provided under the Enhanced Hospital services as described in Sections 090 through 099 of these rules. (7-1-06)T

02. Enhanced Mental Health Benefits. Enhanced Mental Health services are provided under Sections 100 through 147 of these rules. (7-1-06)T

03. Enhanced Home Health Benefits. Private Duty Nursing services are provided under the Enhanced Home Health as described in Sections 200-219 of these rules. (7-1-06)T

04. Therapies. Physical, Speech, and Occupational Therapy Providers as described in Section 215 of these rules. (7-1-06)T

05. Long Term Care Services. The following services are provided under the Long Term Care Services. (7-1-06)T

a. Nursing Facility Services as described in Sections 220 through 299 of these rules. (7-1-06)T

b. Personal Care Services as described in Sections 300 through 319 of these rules. (7-1-06)T

c. A & D Waiver Services as described in Sections 320 through 335 of these rules. (7-1-06)T

~~**d.** *TBI Waiver Services as described in Sections 335 through 350 of these rules.* (7-1-06)T~~

06. Hospice. Hospice services as described in Sections 450 through 459 of these rules. (7-1-06)T

07. Developmental Disabilities Services. (7-1-06)T

a. Developmental Disability Standards as described in Sections 500 through 506 of these rules. (7-1-06)T

b. Behavioral Health Prior Authorization as described in Sections 507 through 520 of these rules. (7-1-06)T

c. ICF/MR as described in Sections 580 through 649 of these rules. (7-1-06)T

d. Developmental Disabilities Agencies as described in Sections 700 through 719 of these rules.

(7-1-06)T

08. Service Coordination Services. Service coordination as described in 720 through 779 of these rules. (7-1-06)T

09. Breast and Cervical Cancer Program. Breast and Cervical Cancer Program is described in Sections 780 through 800 of these rules. (7-1-06)T

(BREAK IN CONTINUITY OF SECTIONS)

326. AGED OR DISABLED WAIVER SERVICES - COVERAGE AND LIMITATIONS.

01. Adult Day Care. Adult day care is a supervised, structured day program, outside the home of the participant, that may offer one (1) or more of a variety of social, recreational, health activities, supervision for safety, and assistance with activities of daily living. (7-1-06)T

02. Adult Residential Care Services. Services are those that consist of a range of services provided in a congregate setting licensed in accordance with IDAPA 16.03.22, "Residential Care or Assisted Living Facilities in Idaho," that includes: (7-1-06)T

- a.** Medication management; (7-1-06)T
- b.** Assistance with activities of daily living; (7-1-06)T
- c.** Meals, including special diets; (7-1-06)T
- d.** Housekeeping; (7-1-06)T
- e.** Laundry; (7-1-06)T
- f.** Transportation; (7-1-06)T
- g.** Opportunities for socialization; (7-1-06)T
- h.** Recreation; and (7-1-06)T
- i.** Assistance with personal finances. (7-1-06)T
- j.** Administrative oversight must be provided for all services provided or available in this setting. (7-1-06)T

k. A written individual service plan must be negotiated between the participant or his legal representative, and a facility representative. (7-1-06)T

03. Assistive Technology. Assistive technology is any item, piece of equipment, or product system beyond the scope of the Medicaid State Plan, whether acquired off the shelf or customized, that is used to increase, maintain, or improve the functional capability of the participant. Assistive technology also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment. (7-1-06)T

04. Assisted Transportation. Individual assistance with non-medical transportation services, including escort to a person who has difficulties (physical or cognitive) using regular vehicular transportation. Such services are specified in the plan for services in order to enable waiver participants to gain access to waiver and other community services and resources. (7-1-06)T

a. Assisted transportation service is offered in addition to medical transportation required in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Sections 860 through 876, and will not replace it. (7-1-06)T

b. Whenever possible, family, neighbors, friends, or community agencies who can provide this service without charge or public transit providers will be utilized. (7-1-06)T

05. Attendant Care. Attendant care services are those services that involve personal and medically oriented tasks dealing with the functional needs of the participant. These services may include, ~~but are not limited to~~ personal care and medical tasks that can be done by unlicensed persons, or delegated to an unlicensed person by a licensed health care professional. Services may occur in the participant's home, community, work, school or recreational settings. ~~(7-1-06)T~~ (10-1-06)T

a. To utilize the services of a Personal Assistance Agency acting as a fiscal intermediary, the participant family, or legal representative must be able and willing to assume responsibility for the direction of the participant's care and for personnel activities such as provider selection and supervision. If the participant, family, or legal representative is unable or unwilling to assume such responsibility, then an agency employee must be utilized. (7-1-06)T

b. The Department may require supervision by a health care professional if the required care is so complex that such supervision is necessary for health and safety. (7-1-06)T

06. Chore Services. Chore services include the services provided in Subsection 326.06.a. and 326.06.b. of this rule: (7-1-06)T

a. Intermittent Assistance may include the following. (7-1-06)T

i. Yard maintenance; (7-1-06)T

ii. Minor home repair; (7-1-06)T

iii. Heavy housework; (7-1-06)T

iv. Sidewalk maintenance; and (7-1-06)T

v. Trash removal to assist the participant to remain in their home. (7-1-06)T

b. Chore activities may include the following: (7-1-06)T

i. Washing windows; (7-1-06)T

ii. Moving heavy furniture; (7-1-06)T

iii. Shoveling snow to provide safe access inside and outside the home; (7-1-06)T

iv. Chopping wood when wood is the participant's primary source of heat; and (7-1-06)T

v. Tacking down loose rugs and flooring. (7-1-06)T

c. These services are only available when neither the participant, nor anyone else in the household is capable of performing or financially providing for them, and where no other relative, caretaker, landlord, community volunteer, agency, or third party payer is willing to or is responsible for their provision. (7-1-06)T

d. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service. Chore services are limited to the services provided in a home rented or owned by the participant. (7-1-06)T

07. Adult Companion. In-home services to insure the safety and well-being of a person who cannot be left alone because of frail health, a tendency to wander, inability to respond to emergency situations, or other conditions that would require a person on-site. The service provider may provide voice cuing and occasional assistance with toileting, personal hygiene, dressing, and other activities of daily living. However, the major responsibility is to provide companionship and be there in case they are needed. (7-1-06)T

08. Consultation. Consultation services are services to a participant or family member. Services provided by a PAA to a participant or family member to increase their skills as an employer or manager of their own care. Such services are directed at achieving the highest level of independence and self reliance possible for the participant/family. Services to the provider are for the purpose of understanding the special needs of the participant and the role of the care giver. (7-1-06)T

09. Home Delivered Meals. Meals which are designed to promote adequate participant nutrition through the provision and home delivery of one (1) to two (2) meals per day. Home delivered meals are limited to participants who: (7-1-06)T

- a. Rent or own their own home; (7-1-06)T
- b. Are alone for significant parts of the day; (7-1-06)T
- c. Have no regular caretaker for extended periods of time; and (7-1-06)T
- d. Are unable to prepare a balanced meal. (7-1-06)T

10. Homemaker Services. Assistance to the participant with light housekeeping, laundry, assistance with essential errands, meal preparation, and other light housekeeping duties if there is no one else in the household capable of performing these tasks. (7-1-06)T

11. Home Modifications. Minor housing adaptations that are necessary to enable the participant to function with greater independence in the home, or without which, the participant would require institutionalization. Such adaptations may include: (7-1-06)T

a. The installation of ramps and lifts, widening of doorways, modification of bathroom facilities, or installation of electric and plumbing systems which are necessary to accommodate the medical equipment and supplies necessary for the welfare of the waiver participant, but will exclude those adaptations or improvements to the home which are not of direct medical or remedial benefit to the participant, such as carpeting, roof repair, or central air conditioning. (7-1-06)T

b. Permanent environmental modifications are limited to modifications to a home owned by the participant or the participant's family and the home is the participant's principal residence. (7-1-06)T

c. Portable or Non-Stationary Modifications. Portable or non-stationary modifications may be made when such modifications can follow the participant to his next place of residence or be returned to the Department. (7-1-06)T

12. Personal Emergency Response System. A system which may be provided to monitor waiver participant safety or provide access to emergency crisis intervention for emotional, medical, or environmental emergencies through the provision of communication connection systems. PERS are limited to participants who: (7-1-06)T

- a. Rent or own their home, or live with unpaid relatives; (7-1-06)T
- b. Are alone for significant parts of the day; (7-1-06)T
- c. Have no caretaker for extended periods of time; and (7-1-06)T
- d. Would otherwise require extensive routine supervision. (7-1-06)T

13. Psychiatric Consultation. Psychiatric Consultation is direct consultation and clinical evaluation of participants, who are currently experiencing or may be expected to experience a psychological, behavioral, or emotional crisis. This service may provide training to the direct service provider or participant's family related to the needs of a participant. These services also provide emergency intervention involving the direct support of the participant in crisis. (7-1-06)T

14. Respite Care. Occasional breaks from care giving responsibilities to non-paid care givers. The care giver or participant is responsible for selecting, training, and directing the provider. While receiving respite care services, the waiver participant cannot receive other waiver services which are duplicative in nature. Respite care services provided under this waiver will not include room and board payments. (7-1-06)T

15. Service Coordination. Service coordination includes all of the activities contained in Section 727 of these rules. Such services are designed to foster independence of the participant, and will be time limited. (7-1-06)T

a. All services will be provided in accordance with an individual service plan. All services will be incorporated into the Individual Service plan and authorized by the RMS. (7-1-06)T

b. The service coordinator must notify the RMS, the Personal Assistance Agency, as well as the medical professionals involved with the participant of any significant change in the participant's situation or condition. (7-1-06)T

16. Skilled Nursing Services. Intermittent or continuous oversight, training, or skilled care which is within the scope of the Nurse Practice Act and as such care must be provided by a licensed registered nurse, or licensed practical nurse under the supervision of a registered nurse, licensed to practice in Idaho. These services are not appropriate if they are less cost effective than a Home Health visit. Nursing services may include but are not limited to: (7-1-06)T

a. The insertion and maintenance of nasogastric tubes and the monitoring or installation of feeding material; (7-1-06)T

b. The maintenance of volume ventilators including associated tracheotomy care, tracheotomy, and oral pharyngeal suctioning. (7-1-06)T

c. Maintenance and monitoring of IV fluids or nutritional supplements which are to be administered on a continuous or daily basis; (7-1-06)T

d. Injections; (7-1-06)T

e. Blood glucose monitoring; and (7-1-06)T

f. Blood pressure monitoring. (7-1-06)T

17. Habilitation. Habilitation services consist of an integrated array of individually-tailored services and supports furnished to eligible participants. These services and supports are designed to assist the participants to reside successfully in their own homes, with their families, or in alternate family homes. (10-1-06)T

a. Residential habilitation services assist the individual to acquire, retain, or improve his ability to reside as independently as possible in the community or maintain family unity. Habilitation services include training in one (1) or more of the following areas: (10-1-06)T

i. Self-direction consists of identifying and responding to dangerous or threatening situations, making decisions and choices affecting the individual's life, and initiating changes in living arrangements or life activities; (10-1-06)T

ii. Money management consists of training or assistance in handling personal finances, making

purchases, and meeting personal financial obligations; (10-1-06)T

iii. Daily living skills consist of training in accomplishing routine housekeeping tasks, meal preparation, dressing, personal hygiene, self administration of medications, and other areas of daily living including proper use of adaptive and assistive devices, appliances, as well as following home safety, first aid, and emergency procedures; (10-1-06)T

iv. Socialization consists of training or assistance in participation in general community activities and establishing relationships with peers with an emphasis on connecting the participant to his community. Socialization training associated with participation in community activities includes assisting the participant to identify activities of interest, working out arrangements to participate in such activities, and identifying specific training activities necessary to assist the participant to continue to participate in such activities on an on-going basis. Socialization training does not include participation in nontherapeutic activities that are merely diversional or recreational in nature; (10-1-06)T

v. Mobility consists of training or assistance aimed at enhancing movement within the person's living arrangement, mastering the use of adaptive aids and equipment, accessing and using public transportation, independent travel, or movement within the community; or (10-1-06)T

vi. Behavior shaping and management consist of training and assistance in appropriate expressions of emotions or desires, assertiveness, acquisition of socially appropriate behaviors, or extension of therapeutic services that consist of reinforcing physical, occupational, speech, and other therapeutic programs. (10-1-06)T

b. Day rehabilitation consists of assistance with acquisition, retention, or improvement in self-help, socialization, and adaptive skills that take place in a non-residential setting, separate from the home or facility in which the participant resides. Services will normally be furnished four (4) or more hours per day on a regularly scheduled basis, for one (1) or more days per week, unless provided as an adjunct to other day activities included in a participant's plan of care. Day rehabilitation services will focus on enabling the participant to attain or maintain his or her maximum functional level and will be coordinated with any physical, occupational, or speech therapies listed in the plan of care. In addition, day rehabilitation services may serve to reinforce skills or lessons taught in school, therapy, or other settings. (10-1-06)T

18. Supported Employment. Supported employment consists of competitive work in integrated work settings for individuals with the most severe disabilities for whom competitive employment has not traditionally occurred, or for whom competitive employment has been interrupted or intermittent as a result of a severe disability. Because of the nature and severity of their disability, these individuals need intensive supported employment services or extended services in order to perform such work. (10-1-06)T

a. Supported employment services rendered under this waiver are not available under a program funded by either the Rehabilitation Act of 1973, as amended, or the Individuals with Disabilities Education Act (IDEA). Documentation must be maintained by RMS in the file of each individual receiving this service verifying that the service is not otherwise available or funded under the Rehabilitation Act of 1973, as amended, or the IDEA. (10-1-06)T

b. Federal Financial Participation (FFP) can not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following: incentive payments made to an employer of waiver participants to encourage or subsidize the employer's participation in a supported employment programs, payments that are passed through to beneficiaries of supported employment programs, or payments for vocational training that is not directly related to a waiver participant's supported employment program. (10-1-06)T

19. Behavior Consultation or Crisis Management. Behavior consultation or crisis management consists of services that provide direct consultation and clinical evaluation of participants who are currently experiencing, or are expected to experience, a psychological, behavioral, or emotional crisis. This service may provide training and staff development related to the needs of a participant. These services also include emergency back-up that provides direct support and services to a participant in crisis. (10-1-06)T

(BREAK IN CONTINUITY OF SECTIONS)

328. AGED OR DISABLED WAIVER SERVICES - PROCEDURAL REQUIREMENTS.

01. Role of the Regional Medicaid Services. The RMS will provide for the administration of the UAI, and the development of the initial individual service plan. This will be done either by RMS staff or a contractor. The RMS will review and approve all individual service plans, and ~~the~~ will authorize Medicaid payment by type, scope, and amount. ~~(7-1-06)T~~(7-1-06)T

a. Services which are not in the individual service plan approved by the RMS are not eligible for Medicaid payment. (7-1-06)T

b. Services in excess of those in the approved individual service plan are not eligible for Medicaid payment. (7-1-06)T

c. The earliest date that services may be approved by the RMS for Medicaid payment is the date that the participant's individual service plan is signed by the participant or his designee. (7-1-06)T

02. Pre-Authorization Requirements. All waiver services must be pre-authorized by the Department. Authorization will be based on the information from: (7-1-06)T

a. The UAI; (7-1-06)T

b. The individual service plan developed by the Department or its contractor; and (7-1-06)T

c. Any other medical information which verifies the need for nursing facility services in the absence of the waiver services. (7-1-06)T

03. UAI Administration. The UAI will be administered, and the initial individual service plan developed, by the RMS or its contractor. (7-1-06)T

04. ~~Service Delivered Following a Written~~ Individual Service Plan. All waiver services must be authorized by the RMS in the Region where the participant will be residing and services provided based on a written individual service plan. ~~(7-1-06)T~~(10-1-06)T

a. The initial individual service plan is developed by the RMS or its contractor, based on the UAI, in conjunction with: (7-1-06)T

i. The waiver participant (with efforts made by the RMS to maximize the participant's involvement in the planning process by providing him with information and education regarding his rights); ~~and~~ ~~(7-1-06)T~~(10-1-06)T

ii. The guardian, when appropriate; ~~and~~ ~~(7-1-06)T~~(10-1-06)T

iii. The supervising nurse or case manager, when appropriate; and (7-1-06)T

iv. Others identified by the waiver participant. (7-1-06)T

b. The individual service plan must include the following: (7-1-06)T

i. The specific type, amount, frequency, and duration of Medicaid reimbursed waiver services to be provided; ~~and~~ ~~(7-1-06)T~~(10-1-06)T

ii. Supports and service needs that are to be met by the participant's family, friends, neighbors, volunteers, church, and other community services; ~~and~~ ~~(7-1-06)T~~(10-1-06)T

- iii. The providers of waiver services when known; ~~and~~ ~~(7-1-06)T~~ (10-1-06)T
- iv. Documentation that the participant has been given a choice between waiver services and institutional placement; and (7-1-06)T
- v. The signature of the participant or his legal representative, agreeing to the plan. (7-1-06)T
- c. The individual service plan must be revised and updated at least annually, based upon treatment results or a change in the participant's needs. (7-1-06)T
- d. All services reimbursed under the Aged or Disabled Waiver must be authorized by the RMS prior to the payment of services. (7-1-06)T
- e. The individual service plan, which includes all waiver services, is monitored by the Personal Assistance Agency, participant, family, and the RMS or its contractor. (7-1-06)T
- 05. Service Delivered Following a Written Plan of Care.** All services that are provided must be based on a written plan of care. (10-1-06)T
- a. The plan of care is developed by the plan of care team which includes: (10-1-06)T
- i. The waiver participant with efforts made to maximize his participation on the team by providing him with information and education regarding his rights; (10-1-06)T
- ii. The Department's administrative case manager; (10-1-06)T
- iii. The guardian when appropriate; (10-1-06)T
- iv. Service provider identified by the participant or guardian; and (10-1-06)T
- v. May include others identified by the waiver participant. (10-1-06)T
- b. The plan of care must be based on an assessment process approved by the Department. (10-1-06)T
- c. The plan of care must include the following: (10-1-06)T
- i. The specific types, amounts, frequency and duration of Medicaid reimbursed waiver services to be provided; (10-1-06)T
- ii. Supports and service needs that are to be met by the participant's family, friends and other community services; (10-1-06)T
- iii. The providers of waiver services; (10-1-06)T
- iv. Goals to be addressed within the plan year; (10-1-06)T
- v. Activities to promote progress, maintain functional skills, or delay or prevent regression; and (10-1-06)T
- vi. The signature of the participant or his legal representative. (10-1-06)T
- d. The plan must be revised and updated by the plan of care team based upon treatment results or a change in the participant's needs. A new plan must be developed and approved annually. (10-1-06)T
- e. The Department's case manager monitors the plan of care and all waiver services. (10-1-06)T
- f. The plan of care may be adjusted during the year with an addendum to the plan. These adjustments

must be based on changes in a participant's need or demonstrated outcomes. Additional assessments or information may be clinically necessary. Adjustment of the plan of care is subject to prior authorization by the Department.

(10-1-06)T

056. Provider Records. Records will be maintained on each waiver participant. (7-1-06)T

a. Each service provider must document each visit made or service provided to the participant, and will record at a minimum the following information: (7-1-06)T

i. Date and time of visit; (7-1-06)T

ii. Services provided during the visit; (7-1-06)T

iii. Provider observation of the participant's response to the service, if appropriate to the service provided, including any changes in the participant's condition; and (7-1-06)T

iv. Length of visit, including time in and time out, if appropriate to the service provided. Unless the RMS or its contractor determines that the participant is unable to do so, the service delivery will be verified by the participant as evidenced by their signature on the service record. (7-1-06)T

b. The provider is required to keep the original service delivery record. A copy of the service delivery record will be maintained in the participant's living arrangement unless authorized to be kept elsewhere by the RMS. Failure to maintain documentation according to these rules will result in the recoupment of funds paid for undocumented services. (7-1-06)T

c. The individual service plan initiated by the RMS or its contractor must specify which waiver services are required by the participant. The plan will contain all elements required by Subsection 328.04.a of these rules and a copy of the most current individual service plan will be maintained in the participant's home and will be available to all service providers and the Department. A copy of the current individual service plan and UAI will be available from the RMS to each individual service provider with a release of information signed by the participant or legal representative. (7-1-06)T

067. Provider Responsibility for Notification. The service provider is responsible to notify the RMS, physician or authorized provider, or case manager, and family if applicable, when any significant changes in the participant's condition are noted during service delivery. Such notification will be documented in the service record. (7-1-06)T

078. Records Retention. Personal Assistance Agencies, and other providers are responsible to retain their records for five (5) years following the date of service. (7-1-06)T

089. Requirements for an Fiscal Intermediary (FI). Participants of PCS will have one (1) year from the date which services begin in their geographic region to obtain the services of an FI and become an employee in fact or to use the services of an agency. Provider qualifications are in accordance with Section 329 of these rules. (7-1-06)T

329. AGED OR DISABLED WAIVER SERVICES - PROVIDER QUALIFICATIONS AND DUTIES.

Each provider must have a signed provider agreement with the Department for each of the services it provides. (7-1-06)T

01. Employment Status. Unless otherwise specified by the Department, each individual service provider must be an employee of record or fact of an agency. The Department may enter into provider agreements with individuals in situations ~~where in which~~ no agency exists, or no fiscal intermediary is willing to provide services. Such agreements will be reviewed annually to verify whether coverage by an agency or fiscal intermediary is still not available. ~~(7-1-06)T~~(10-1-06)T

02. Personal Assistance Agency That Provides Fiscal Intermediary Services. A personal assistance agency that focuses on fostering participant independence and personal control of services delivered. The core tasks

are: (7-1-06)T

- a. To directly assure compliance with legal requirements related to employment of waiver service providers; (7-1-06)T
- b. To offer supportive services to enable participants or families consumers to perform the required employer tasks themselves; (7-1-06)T
- c. To bill the Medicaid program for services approved and authorized by the Department; (7-1-06)T
- d. To collect any participant participation due; (7-1-06)T
- e. To pay personal assistants and other waiver service providers for service; (7-1-06)T
- f. To perform all necessary withholding as required by state and federal labor and tax laws, rules and regulations; (7-1-06)T
- g. To offer a full range of services and perform all services contained in a written agreement between the participant and the provider; (7-1-06)T
- h. Make referrals for PCS eligible participant for service coordination when a need for such services is identified; and (7-1-06)T
- i. Obtain such criminal background checks and health screens on new and existing employees of record and fact as required. (7-1-06)T

03. Provider Qualifications. All providers of homemaker, respite care, adult day health, transportation, chore companion, attendant adult residential care, home delivered meals, and behavior consultants must meet, either by formal training or demonstrated competency, the training requirements contained in the provider training matrix and the standards for direct care staff and allowable tasks or activities in the Department's approved Aged and Disabled waiver as approved by CMS. (7-1-06)T

- a. A waiver provider can not be a relative of any participant to whom the provider is supplying services. (7-1-06)T
- b. For the purposes of Section 329 of these rules, a relative is defined as a spouse or parent of a minor child. (7-1-06)T

04. Specialized Medical Equipment Provider Qualifications. Providers of specialized medical equipment and supplies must be enrolled in the Medicaid program as participating medical vendor providers. (7-1-06)T

05. Nursing Service Provider Qualifications. Nursing Service Providers must be licensed as an R.N. or L.P.N. in Idaho or be practicing on a federal reservation and be licensed in another state. (7-1-06)T

06. Psychiatric Consultation Provider Qualifications. Psychiatric Consultation Providers must have: (7-1-06)T

- a. A master's degree in a behavioral science; (7-1-06)T
- b. Be licensed in accordance with state law and regulations; or (7-1-06)T
- c. Have a bachelor's degree and work for an agency with direct supervision from a licensed or Ph.D. psychologist and have one (1) year's experience in treating severe behavior problems. (7-1-06)T

07. Service Coordination. Service coordinators and service coordination agencies must meet the requirements specified in Section 729 of these rules unless specifically modified by another section of these rules.

(7-1-06)T

08. Consultation Services. Services must be provided through a Personal Assistance Agency by a person who has demonstrated skills in training participants/family members in hiring, firing, training, and supervising their own care providers. (7-1-06)T

09. Adult Residential Care Providers. Adult Residential Care providers will meet all applicable state laws and regulations. In addition, the provider must ensure that adequate staff are is provided to meet the needs of the participants accepted for admission. (7-1-06)T

10. Home Delivered Meals. Providers must be a public agency or private business and must be capable of: (7-1-06)T

a. Supervising the direct service; (7-1-06)T

b. Providing assurance that each meal meets one-third (1/3) of the recommended daily allowance, as defined by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences; (7-1-06)T

c. Delivering the meals in accordance with the plan for care, in a sanitary manner and at the correct temperature for the specific type of food; (7-1-06)T

d. Maintaining documentation that the meals served are made from the highest USDA grade for each specific food served; and (7-1-06)T

e. Being inspected and licensed as a food establishment by the district health department. (7-1-06)T

11. Personal Emergency Response Systems. Providers must demonstrate that the devices installed in waiver participant's homes meet Federal Communications Standards, Underwriter's Laboratory Standards, or equivalent standards. (7-1-06)T

12. Adult Day Care. Facilities ~~which~~ that provide adult day care must be maintained in safe and sanitary manner. ~~(7-1-06)T~~ (10-1-06)T

a. Facilities will provide the necessary space and staff to meet the needs of the participants accepted by the provider. Supervision must be provided by the facility as necessary, to assure the safety and comfort of participants served. (7-1-06)T

b. Providers ~~accepting~~ who accept participants into their homes for services must maintain the homes in a safe and sanitary manner. Supervision must be provided by the provider as necessary to assure the safety and comfort of participants served. ~~(7-1-06)T~~ (10-1-06)T

13. Assistive Technology. All items must meet applicable standards of manufacture, design and installation. The equipment must be the most cost effective to meet the participant's need. (7-1-06)T

14. Assisted Transportation Services. See Subsection 329.03 of this rule for provider qualifications. (7-1-06)T

15. Attendant Care. See Subsection 329.03 of this rule for provider qualifications. (7-1-06)T

16. Homemaker Services. The homemaker must be an employee of record or fact of an agency. (7-1-06)T

17. Home Modifications. All services must be provided in accordance with applicable state or local building codes and meet state or local building, plumbing, and electrical requirements for certification. (7-1-06)T

18. Residential Habilitation Provider Qualifications. Providers of residential habilitation services

- must meet the following requirements: (10-1-06)T
- a. Direct service staff must meet the following minimum qualifications: (10-1-06)T
 - i. Be at least eighteen (18) years of age: (10-1-06)T
 - ii. Be a high school graduate or have a GED or demonstrate the ability to provide services according to a plan of care: (10-1-06)T
 - iii. Have current CPR and First Aid certifications: (10-1-06)T
 - iv. Be free from communicable diseases: (10-1-06)T
 - v. Satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Rules Governing Mandatory Criminal History Checks:": (10-1-06)T
 - vi. Participate in an orientation program, including the purpose and philosophy of services, service rules, policies and procedures, proper conduct in relating to waiver participants, and handling of confidential and emergency situations that involve the waiver participant, provided by the agency prior to performing services; and (10-1-06)T
 - vii. Have appropriate certification or licensure if required to perform tasks which require certification or licensure. Direct service staff must also have taken a traumatic brain injury training course approved by the Department. (10-1-06)T
 - b. The provider agency is responsible for providing direct service staff with a traumatic brain injury training course approved by the Department, and training specific to the needs of the participant. Skill training may be provided by a Program Coordinator who has demonstrated experience in writing skill training programs, if no agency is available in their geographic area as outlined in Subsection 329.18.c. of this rule. Additional training requirements may also include: (10-1-06)T
 - i. Instructional technology: (10-1-06)T
 - ii. Behavior technology: (10-1-06)T
 - iii. Feeding: (10-1-06)T
 - iv. Communication or sign language: (10-1-06)T
 - v. Mobility: (10-1-06)T
 - vi. Assistance with medications, training in assistance with medications must be provided by a licensed nurse: (10-1-06)T
 - vii. Activities of daily living: (10-1-06)T
 - viii. Body mechanics and lifting techniques: (10-1-06)T
 - ix. Housekeeping techniques and maintenance of a clean, safe, and healthy environment. (10-1-06)T
 - c. Residential habilitation providers who are unable to be employed by an agency because one is not available in their geographic area, must receive program development, implementation and oversight of service delivery services by a program coordinator who has a valid service coordination provider agreement with the Department and who has taken a traumatic brain injury training course approved by the Department. (10-1-06)T
 - d. When residential habilitation services are provided in the provider's home, the provider must be certified by the Department as a certified family home and meet the requirements in IDAPA 16.03.19, "Rules

Governing Certified Family Homes.” Non-compliance with the certification process is cause for termination of the provider agreement or contract. (10-1-06)T

19. Day Rehabilitation Provider Qualifications. Providers of day rehabilitation services must have a minimum of two (2) years of experience working directly with persons with a traumatic brain injury, must provide documentation of standard licensing specific to their discipline, and must have taken a traumatic brain injury course approved by the Department. (10-1-06)T

20. Supported Employment Service Providers. Supported employment services must be provided by an agency capable of supervising the direct service and be accredited by the Commission on Accreditation of Rehabilitation Facilities; or other comparable standards; or meet State requirements to be a State-approved provider, and have taken a traumatic brain injury training course approved by the Department. (10-1-06)T

21. Behavior Consultation or Crisis Management Service Providers. Behavior consultation or crisis management providers must meet the following: (10-1-06)T

a. Have a Master's Degree in a behavioral science such as social work, psychology, psychosocial rehabilitation counseling, psychiatric nursing, or a closely related course of study; (10-1-06)T

b. Be a licensed pharmacist; or (10-1-06)T

c. Work for a provider agency capable of supervising the direct service or work under the direct supervision of a licensed psychologist or Ph.D., with training and experience in treating severe behavior problems and training and experience in applied behavior analysis; and (10-1-06)T

d. Take a traumatic brain injury training course approved by the Department. (10-1-06)T

e. Emergency back-up providers must also meet the minimum provider qualifications under residential habilitation services. (10-1-06)T

(BREAK IN CONTINUITY OF SECTIONS)

~~335. TRAUMATIC BRAIN INJURY (TBI) WAIVER SERVICES:~~

~~Pursuant to 42 CFR Section 435.217, it is the intention of the Department to provide waiver services to eligible participants in order to prevent unnecessary institutional placement, to provide for the greatest degree of independence possible, to enhance the quality of life, to encourage individual choice, and to achieve and maintain community integration. For a participant to be eligible, the Department must find that the participant requires services due to a traumatic brain injury which impairs their mental or physical function or independence, be capable of being maintained safely and effectively in a non-institutional setting and would, in the absence of such services, require the level of care provided in a nursing facility under Sections 222 and 226 of these rules.~~ (7-1-06)T

~~336. (RESERVED):~~

~~337. TBI WAIVER SERVICES – ELIGIBILITY:~~

~~Persons who are Medicaid eligible, whose injury to the brain occurred on or after the age of twenty-two (22) and have been diagnosed with a traumatically acquired non-degenerative, structural brain injury resulting in residual deficits and disability who require the level of care provided in a nursing facility.~~ (7-1-06)T

01. Diagnostic Criteria. In order to qualify for the waiver under this rule the person must have a diagnosis listed in the International Classification of Diseases – Clinical Modification Medicode (ICD-CM). The diagnosis must be within one (1) of the classification codes listed in the table below:

TABLE 337

Classification Code Number	Classification Description
348.1	Anoxic brain damage
434	Intra cerebral hemorrhage
800-800.9	Fracture of a vault of the skull
801-801.99	Fracture of the base of the skull
803-803.99	Other skull fractures
804-804.99	Multiple fractures involving the skull, face, and other bones
850-850.9	Concussion
851-851.9	Cerebral laceration and contusion
852-852.99	Subarachnoid, subdural, and extradural hemorrhage following injury
853-853.99	Other unspecified Intra cerebral hemorrhage following injury
854-854.99	Intracranial injury of other and unspecified nature
905-907.0	Late effects of skull and face fractures plus late effects of intracranial injury without fractures

(7-1-06)T

~~338. TBI WAIVER SERVICES – ELIGIBILITY DETERMINATION.~~

~~The Regional Medicaid Services determines whether the participant meets the NH level of care required for waiver eligibility. The self reliance specialist determines whether the participant meets the other medical assistance eligibility requirements as described in IDAPA 16.03.05, “Rules Governing Eligibility for the Aged, Blind, and Disabled (AABD),” Section 787. In addition, waiver participants must meet the following requirements: (7-1-06)T~~

~~**01. Requirements for Determining Participant Eligibility.** The Regional Medicaid Services must determine that: (7-1-06)T~~

~~**a.** The participant would qualify for nursing facility level of care as set forth in Sections 222 and 226 of these rules if the waiver services listed in Section 340 of these rules were not made available; (7-1-06)T~~

~~**b.** The participant could be safely and effectively maintained in the requested or chosen community residence with appropriate waiver services. This determination must be made by the Department's Case Manager, with input from the Plan of Care team; and prior to any denial of services on this basis, be determined by the Department's Case manager that services to correct the concerns of the team are not available; and (7-1-06)T~~

~~**c.** The average daily cost of waiver services and other medical services to the participant would not exceed the average daily cost to Medicaid of nursing facility care and other medical costs. Individual participants whose cost of services exceeds this average may be approved on a case by case basis that assures that the average per capita expenditures under the waiver do not exceed one hundred percent (100%) of the average per capita expenditures for nursing facility care under the State plan that would have been made in that fiscal year had the waiver not been granted. This approval will be made by a team identified by the Administrators of the Divisions of Medicaid and Family and Community Services. (7-1-06)T~~

~~**d.** Following the approval by the Regional Medicaid Services for services under the waiver, the participants must receive and continue to receive a waiver service as described in these rules. A participant who does not use a waiver service for thirty (30) consecutive days will be terminated from the waiver program. (7-1-06)T~~

~~**02. Admission to a Nursing Facility.** A participant who is determined by the Regional Medicaid Services to be eligible for services under the Home and Community Based Services Waiver for adults with a traumatic brain injury may elect to not utilize waiver services but may choose admission to a nursing facility.~~

(7-1-06)F

~~03. **Self-Reliance Specialist.** The participant's self-reliance specialist will process the application in accordance with IDAPA 16.03.05, "Rules Governing Eligibility for the Aged, Blind, and Disabled (AABD)," as if the application was for admission to a nursing facility except that the self-reliance specialist will forward potentially eligible applications immediately to the Regional Medicaid Services for review. The Medicaid application process cited above conforms to all statutory and regulatory requirements relating to the Medicaid application process.~~

(7-1-06)F

~~04. **Redetermination Process. Case Redetermination.**~~

(7-1-06)F

~~a. Financial redetermination will be conducted pursuant to IDAPA 16.03.05, "Rules Governing Eligibility for the Aged, Blind, and Disabled (AABD)." Medical redetermination will be made at least annually by the Regional Medicaid Services, or sooner at the request of the participant, the self-reliance specialist, provider agency or physician. The sections cited implement and are in accordance with Idaho's approved State Plan with the exception of deeming of income provisions.~~

(7-1-06)F

~~b. The redetermination process will assess the following factors:~~

(7-1-06)F

~~i. The participant's continued need for waiver services; and~~

(7-1-06)F

~~ii. Discharge from the waiver services program.~~

(7-1-06)F

~~339. **HOME AND COMMUNITY-BASED WAIVER PARTICIPANT LIMITATIONS.**~~

~~The number of Medicaid participants to receive waiver services under the home and community-based waiver for participants with a traumatic brain injury will be limited to the projected number of users contained in the Department's approved waiver. Individuals who apply for waiver services after the waiver maximum has been reached will be placed on a waiting list and will have their applications processed after September 30th of each new waiver year. The earliest effective date of waiver service delivery for these participants will be October 1st of each new waiver year.~~

(7-1-06)F

~~340. **TBI WAIVER SERVICES – COVERAGE AND LIMITATIONS.**~~

~~Services that may be provided under the waiver consist of residential habilitation, chore, respite care, supported employment, transportation, environmental accessibility adaptations, specialized medical equipment and supplies, personal emergency response system, day rehabilitation, home-delivered meals, behavior consultation/ crisis management, and skilled nursing services. Also included are extended state plan services including administrative case management, physical therapy, occupational therapy, speech therapy, personal care services.~~

(7-1-06)F

~~01. **Residential Habilitation.** Services consist of an integrated array of individually-tailored services and supports furnished to eligible participants designed to assist them to reside successfully in their own homes, with their families, or alternate family homes. The services and supports that may be furnished are listed in Subsections 340.02 and 340.03 of these rules.~~

(7-1-06)F

~~02. **Habilitation Services.** Services consist of assisting the individual to acquire, retain or improve his ability to reside as independently as possible in the community or maintain family unity. Habilitation services include training in one (1) or more of the following areas:~~

(7-1-06)F

~~a. **Self-Direction.** Self-direction consists of the identification of and response to dangerous or threatening situations, making decisions and choices affecting the individual's life, and initiating changes in living arrangements or life activities;~~

(7-1-06)F

~~b. **Money Management.** Money management consists of training or assistance in handling personal finances, making purchases, and meeting personal financial obligations;~~

(7-1-06)F

~~c. **Daily Living Skills.** Daily living skills consists of training in accomplishing routine housekeeping tasks, meal preparation, dressing, personal hygiene, self-administration of medications, and other areas of daily living including proper use of adaptive and assistive devices, appliances, home safety, first aid, and emergency~~

procedures;

(7-1-06)F

~~d. Socialization. Socialization consists of training or assistance in participation in general community activities and establishing relationships with peers with an emphasis on connecting the participant to his community. Socialization training associated with participation in community activities includes assisting the participant to identify activities of interest, working out arrangements to participate in such activities and identifying specific training activities necessary to assist the participant to continue to participate in such activities on an on-going basis. Socialization training does not include participation in nontherapeutic activities which are merely diversional or recreational in nature.~~

(7-1-06)F

~~e. Mobility. Mobility consists of training or assistance aimed at enhancing movement within the person's living arrangement, mastering the use of adaptive aids and equipment, accessing and using public transportation, independent travel, or movement within the community;~~ or

(7-1-06)F

~~f. Behavior Shaping and Management. Behavior shaping and management consists of training and assistance in appropriate expressions of emotions or desires, assertiveness, acquisition of socially appropriate behaviors; or extension of therapeutic services, which consist of reinforcing physical, occupational, speech and other therapeutic programs.~~

(7-1-06)F

~~03. Personal Assistance Services. Services consist of assisting the individual in daily living activities, household tasks, and such other routine activities as the participant or the participant's primary caregiver(s) are unable to accomplish on his own behalf.~~

(7-1-06)F

~~04. Personal Assistance Services Skills Training. Skills training consists of teaching waiver participants, family members, alternative family caregiver, or a participant's roommate or neighbor to perform activities with greater independence and to carry out or reinforce habilitation training. Services are focused on training and are not designed to provide substitute task performance. Skill training is provided to encourage and accelerate development in independent daily living skills, self direction, money management, socialization, mobility and other therapeutic programs.~~

(7-1-06)F

~~05. Chore Services. Services consist of heavy household maintenance and minor home repairs necessary to maintain the functional use of the home and to provide a clean, sanitary and safe environment. Chore activities include washing windows; moving heavy furniture and shoveling snow to provide safe access inside and outside the home; chopping wood when wood is the participant's primary source of heat; and tacking down loose rugs and flooring. These services are only available when neither the participant, nor anyone else in the household is capable of performing or financially providing for them, and where no other relative, caretaker, landlord, community volunteer/agency or third party payer is capable of or responsible for their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service. Chore services are limited to the services provided in a home rented or owned by the participant.~~

(7-1-06)F

~~06. Respite Care Services. Services consist of those services provided, on a short term basis, in the home of either the waiver participant or respite provider, to relieve the person's family or other primary caregiver(s) from daily stress and care demands. While receiving respite care services, the waiver participant cannot receive other waiver services which are duplicative in nature. Respite care services provided under this waiver will not include room and board payments. Respite care services are limited to participants who reside with non-paid caregivers.~~

(7-1-06)F

~~07. Supported Employment. Supported employment consists of competitive work in integrated work settings for individuals with the most severe disabilities for whom competitive employment has not traditionally occurred; or for whom competitive employment has been interrupted or intermittent as a result of a severe disability; and who, because of the nature and severity of their disability, need intensive supported employment services or extended services in order to perform such work.~~

(7-1-06)F

~~08. Exclusions From Supported Employment.~~

(7-1-06)F

~~a. Supported Employment Services. Supported employment services rendered under the waiver are not available under a program funded by either the Rehabilitation Act of 1973, as amended, or the Individuals with~~

~~Disabilities Education Act (IDEA). Documentation will be maintained in the file of each individual receiving this service verifying that the service is not otherwise available/funded under the Rehabilitation Act of 1973 as amended, or IDEA. (7-1-06)T~~

~~**b.** Federal Financial Participation (FFP). FFP will not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following: incentive payments made to an employer of waiver participants to encourage or subsidize employers' participation in a supported employment program; payments that are passed through to beneficiaries of supported employment programs; or payments for vocational training that is not directly related to a waiver participant's supported employment program. (7-1-06)T~~

~~**09.** **Transportation Services.** Services consist of services offered in order to enable waiver participants to gain access to waiver and other community services and resources required by the Plan of Care. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services offered under the State plan, defined at 42 CFR 440.170(a), and will not replace them. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge or public transit providers will be utilized. (7-1-06)T~~

~~**10.** **Environmental Accessibility Adaptations.** Adaptations consist of interior or exterior physical adaptations to the home, required by the waiver participant's support plan, which are necessary to ensure the health, welfare, safety of the individual, or which enable the individual to function with greater independence in the home and without which, the waiver participant would require institutionalization. Such adaptations may include the installation of ramps and lifts, widening of doorways, modification of bathroom facilities, or installation of electric and plumbing systems which are necessary to accommodate the medical equipment and supplies necessary for the welfare of the waiver participant, but will exclude those adaptations or improvements to the home which are not of direct medical or remedial benefit to the participant, such as carpeting, roof repair, or central air conditioning. All services must be provided in accordance with applicable State or local building codes. Permanent environmental modifications are limited to modifications to a home rented or owned by the participant or the participant's family when the home is the participant's principal residence. Portable or non-stationary modifications may be made when such modifications can follow the participant to his next place of residence or be returned to the Department. (7-1-06)T~~

~~**11.** **Specialized Medical Equipment and Supplies.** Specialized medical equipment and supplies consist of devices, controls, or appliances, specified in the Plan of Care which enable participants to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. They also include items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State Plan. Items reimbursed with waiver funds will be in addition to any medical equipment and supplies furnished under the State Plan and will exclude those items which are not of direct medical or remedial benefit to the participant. All items must meet applicable standards of manufacture, design and installation. (7-1-06)T~~

~~**12.** **Personal Emergency Response Systems (PERS).** PERS may be provided to monitor waiver participant safety and provide access to emergency crisis intervention for emotional, medical or environmental emergencies through the provision of communication connection systems. PERS are limited to participants who rent or own their home, who are alone for significant parts of the day, have no regular caretaker for extended periods of time and who would otherwise require extensive routine supervision. (7-1-06)T~~

~~**13.** **Home Delivered Meals.** Home delivered meals consist of meals designed to promote adequate waiver participant nutrition through the provision and home delivery of one (1) to two (2) meals per day. Home delivered meals are limited to participants who rent or own their own home, who are alone for significant parts of the day, and who have no regular caretaker for extended periods of time. (7-1-06)T~~

~~**14.** **Extended State Plan Services.** Extended State Plan services under the waiver consist of physical therapy services; occupational therapy services; and speech, hearing and language services. These services are to be available through the waiver when the need for such services exceeds the therapy limitations under the State Plan. Under the waiver, therapy services will include: (7-1-06)T~~

~~**a.** Services provided in the waiver participant's residence, day rehabilitation site, or supported~~

~~employment site. (7-1-06)F~~

~~b. Consultation with other service providers and family members; (7-1-06)F~~

~~e. Participation on the participant's Plan of Care team. (7-1-06)F~~

~~15. **Skilled Nursing Services.** Services consist of intermittent or continuous oversight and skilled care in a non-congregate setting, which is within the scope of the Nurse Practice Act and as such must be provided by a licensed registered nurse or licensed practical nurse under the supervision of a registered nurse, licensed to practice in Idaho. These services are appropriate if they are available and more cost effective than a Home Health visit. Nursing services may include but are not limited to the insertion and maintenance of nasogastric tubes and the monitoring or installation of feeding material, the maintenance of volume ventilators including associated tracheotomy care, tracheotomy and oral pharyngeal suctioning, maintenance and monitoring of IV fluids or nutritional supplements which are to be administered on a continuous or daily basis, injections, blood glucose monitoring, and blood pressure monitoring. (7-1-06)F~~

~~16. **Personal Care Services.** Services consist of assistance due to a medical condition which impairs physical or mental function and which maintains a participant safely and effectively in his own home or residence. Services include but are not limited to bathing, care of the hair, assistance with clothing, basic skin care, bladder and bowel requirements, medication management, food nutrition and diet activities, active treatment training programs, and non-nasogastric gastrostomy tube feedings. (7-1-06)F~~

~~17. **Behavior Consultation or Crisis Management.** Behavior consultation or crisis management consist of services which provide direct consultation and clinical evaluation of participants who are currently experiencing or may be expected to experience, a psychological, behavioral, or emotional crisis. This service may provide training and staff development related to the needs of a participant. These services also provide emergency back-up involving the direct support of the participant in crisis. (7-1-06)F~~

~~18. **Day Rehabilitation.** Day rehabilitation consists of assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills which take place in a non-residential setting, separate from the home or facility in which the participant resides. Services will normally be furnished four (4) or more hours per day on a regularly scheduled basis, for one (1) or more days per week unless provided as an adjunct to other day activities included in a participant's Plan of Care. Day rehabilitation services will focus on enabling the participant to attain or maintain his or her maximum functional level and will be coordinated with any physical, occupational, or speech therapies listed in the Plan of Care. In addition, day rehabilitation services may serve to reinforce skills or lessons taught in school, therapy, or other settings. (7-1-06)F~~

~~19. **Place of Service Delivery.** Waiver services for participants with a traumatic brain injury may be provided in the participant's personal residence, certified family home, waiver facilities, day rehabilitation/supported employment program or community. The following living situations are specifically excluded as a personal residence for the purpose of these rules: (7-1-06)F~~

~~a. Excluded as a Personal Residence. (7-1-06)F~~

~~i. Licensed Skilled, or Intermediate Care Facilities, Certified Nursing Facility (NF) or hospital; and (7-1-06)F~~

~~ii. Licensed Intermediate Care Facility for the Mentally Retarded (ICF/MR); and (7-1-06)F~~

~~iii. Residential Care or Assisted Living Facility. (7-1-06)F~~

~~b. **Additional Service Limitations.** Additional limitations to specific services are listed under that service definition. (7-1-06)F~~

~~341. **TBI WAIVER SERVICES PROCEDURAL REQUIREMENTS.**~~

~~01. **Service Delivered Following a Written Plan of Care.** All waiver services must be authorized by the~~

~~Regional Medicaid Services in the region where the participant will be residing and provided based on a written Plan of Care. (7-1-06)F~~

~~**a.** Development of the Plan of Care. The Plan of Care is developed by the Plan of Care team which includes: (7-1-06)F~~

~~*i.* The Waiver Participant. Efforts must be made to maximize the participant's participation on the team by providing him with information and education regarding his rights; and (7-1-06)F~~

~~*ii.* The Department's administrative case manager; and (7-1-06)F~~

~~*iii.* The guardian when appropriate; and (7-1-06)F~~

~~*iv.* May include others identified by the waiver participant. (7-1-06)F~~

~~**b.** Assessment Process Approved by the Department. The Plan of Care must be based on an assessment process approved by the Department. (7-1-06)F~~

~~**c.** Included in the Plan of Care. The Plan of Care must include the following: (7-1-06)F~~

~~*i.* The specific types, amounts, frequency and duration of Medicaid reimbursed waiver services to be provided; and (7-1-06)F~~

~~*ii.* Supports and service needs that are to be met by the participant's family, friends and other community services; and (7-1-06)F~~

~~*iii.* The providers of waiver services when known; and (7-1-06)F~~

~~*iv.* Documentation that the participant has been given a choice between waiver services and institutional placement; and (7-1-06)F~~

~~*v.* The signature of the participant or his legal representative and the case manager. (7-1-06)F~~

~~*vi.* The plan must be revised and updated by the Plan of Care team based upon treatment results or a change in the participant's needs. A new plan must be developed and approved annually. (7-1-06)F~~

~~**d.** Authorization of Services. All services reimbursed under the Home and Community Based Waiver for participants with a traumatic brain injury must be authorized prior to the payment of services by the Regional Medicaid Services. (7-1-06)F~~

~~**e.** Service Supervision. The Plan of Care which includes all waiver services is monitored by the Department's case manager. (7-1-06)F~~

~~**02.** **Provider Records.** Three (3) types of record information will be maintained on all participants receiving waiver services: (7-1-06)F~~

~~**a.** Service Provider Information. Direct Service Provider Information which includes written documentation of each visit made or service provided to the participant, and will record at a minimum the following information: (7-1-06)F~~

~~*i.* Date and time of visit; and (7-1-06)F~~

~~*ii.* Services provided during the visit; and (7-1-06)F~~

~~*iii.* A statement of the participant's response to the service, if appropriate to the service provided, including any changes in the participant's condition; and (7-1-06)F~~

~~iv. Length of visit, including time in and time out, if appropriate to the service provided. Unless the participant is determined by the Case manager to be unable to do so, the delivery will be verified by the participant as evidenced by their signature on the service record. (7-1-06)F~~

~~v. A copy of the above information will be maintained in the participant's home unless authorized to be kept elsewhere by the Regional Medicaid Services. Failure to maintain documentation according to these rules will result in the recoupment of funds paid for undocumented services. (7-1-06)F~~

~~b. Plan of Care. The Plan of Care which is initiated by the Regional Medicaid Services and developed by the case manager and the Plan of Care team must specify which waiver services are required by the participant. The plan will contain all elements required by Subsection 341.01 of these rules and a copy of the most current Plan of Care will be maintained in the participant's home and will be available to all service providers and the Department. (7-1-06)F~~

~~c. Verification of Services Provided. In addition to the Plan of Care, at least monthly the case manager will verify in writing that the services provided were consistent with the Plan of Care. Any changes in the plan will be documented and include the signature of the case manager and when possible, the participant. (7-1-06)F~~

~~03. Records Maintenance. In order to provide continuity of services, when a participant is transferred among service providers, or when a participant changes case managers, all of the foregoing participant records will be delivered to and held by the Regional Medicaid Services until a replacement service provider or case manager assumes the case. When a participant leaves the waiver services program, the records will be retained by the Regional Medicaid Services as part of the participant's closed case record. Provider agencies will be responsible to retain their participant's records for three (3) years following the date of service. (7-1-06)F~~

~~04. Provider Responsibility for Notification. It is the responsibility of the service provider to notify the case manager when any significant changes in the participant's condition are noted during service delivery. Such notification will be documented in the service record. (7-1-06)F~~

~~**342. TBI WAIVER SERVICES—PROVIDER QUALIFICATIONS AND DUTIES.**~~

~~All providers of waiver services must have a valid provider agreement or performance contract with the Department. Performance under this agreement or contract will be monitored by the Regional Medicaid Services in each region. (7-1-06)F~~

~~**01. Residential Habilitation Service Providers.** Providers of residential habilitation services must meet the following requirements: (7-1-06)F~~

~~a. Direct service staff must meet the following minimum qualifications: be at least eighteen (18) years of age; be a high school graduate or have a GED or demonstrate the ability to provide services according to a Plan of Care; have current CPR and First Aid certifications; be free from communicable diseases; pass a criminal background check (when residential habilitation services are provided in a certified family home, all adults living in the home must pass a criminal background check); participate in an orientation program, including the purpose and philosophy of services, service rules, policies and procedures, proper conduct in relating to waiver participants, and handling of confidential and emergency situations that involve the waiver participant, provided by the agency prior to performing services; and have appropriate certification or licensure if required to perform tasks which require certification or licensure. Direct service staff must also have taken a traumatic brain injury training course approved by the Department. (7-1-06)F~~

~~b. The provider agency will be responsible for providing direct service staff with a traumatic brain injury training course approved by the Department, and training specific to the needs of the participant. Skill training may be provided by a Program Coordinator, if no agency is available in their geographic area as outlined in Subsection 342.01.e of these rules, who has demonstrated experience in writing skill training programs. Additional training requirements may also include: instructional technology; behavior technology; feeding; communication/sign language; mobility; assistance with medications (training in assistance with medications must be provided by a licensed nurse); activities of daily living; body mechanics and lifting techniques; housekeeping techniques and maintenance of a clean, safe, and healthy environment. (7-1-06)F~~

~~e. Residential habilitation providers who are unable to be employed by an agency because one is not available in their geographic area, must receive program development, implementation and oversight of service delivery services by a Program Coordinator who has a valid service coordination provider agreement with the Department and who has taken a traumatic brain injury training course approved by the Department. (7-1-06)F~~

~~d. When residential habilitation services are provided in the provider's home, the agency must meet the environmental sanitation standards; fire and life safety standards; and building, construction and physical home standards for certification as a certified family home. Non-compliance with the above standards will be cause for termination of the provider's provider agreement/contract. (7-1-06)F~~

~~02. **Chore Service Providers.** Providers of chore services must meet the following minimum qualifications: (7-1-06)F~~

~~a. Be skilled in the type of service to be provided; and (7-1-06)F~~

~~b. Demonstrate the ability to provide services according to a Plan of Care (7-1-06)F~~

~~03. **Respite Care Service Providers.** Providers of respite care services must meet the following minimum qualifications: (7-1-06)F~~

~~a. Meet the qualifications prescribed for the type of services to be rendered, for instance. Residential habilitation providers must be an employee of an agency selected by the waiver participant or the family or guardian; (7-1-06)F~~

~~b. Have received care giving instructions in the needs of the person who will be provided the service; (7-1-06)F~~

~~c. Demonstrate the ability to provide services according to a Plan of Care; (7-1-06)F~~

~~d. Have good communication and interpersonal skills and the ability to deal effectively, assertively and cooperatively with a variety of people; (7-1-06)F~~

~~e. Be willing to accept training and supervision by a provider agency or the primary caregiver of services; (7-1-06)F~~

~~f. Be free of communicable diseases; and (7-1-06)F~~

~~g. Have successfully completed a traumatic brain injury training course approved by the Department. (7-1-06)F~~

~~04. **Supported Employment Service Providers.** Supported Employment services must be provided by an agency capable of supervising the direct service and be accredited by the Commission on Accreditation of Rehabilitation Facilities; or other comparable standards; or meet State requirements to be a State approved provider; and have taken a traumatic brain injury training course approved by the Department. (7-1-06)F~~

~~05. **Transportation Service Providers.** Transportation service providers must: (7-1-06)F~~

~~a. Possess a valid driver's license; and (7-1-06)F~~

~~b. Possess valid vehicle insurance. (7-1-06)F~~

~~06. **Environmental Modifications Service Providers.** Environmental Modifications services must: (7-1-06)F~~

~~a. Be done under a permit, if required; and (7-1-06)F~~

~~b. Demonstrate that all modifications, improvements, or repairs are made in accordance with local~~

~~and state housing and building codes. (7-1-06)F~~

~~**07. Specialized Medical Equipment and Supplies.** Specialized Medical Equipment and Supplies purchased under this service must: (7-1-06)F~~

~~**a.** Meet Underwriter's Laboratory, FDA, or Federal Communication Commission standards where applicable; and (7-1-06)F~~

~~**b.** Be obtained or provided by authorized dealers of the specific product where applicable. For instance, medical supply businesses or organizations that specialize in the design of the equipment. (7-1-06)F~~

~~**08. Personal Emergency Response Systems.** Personal Emergency Response Systems must demonstrate that the devices installed in waiver participants' homes meet Federal Communications Standards or Underwriter's Laboratory standards or equivalent standards. (7-1-06)F~~

~~**09. Home-Delivered Meal Services.** Home-Delivered Meals under this section may only be provided by an agency capable of supervising the direct service and must: (7-1-06)F~~

~~**a.** Provide assurances that each meal meets one third (1/3) of the Recommended Dietary Allowance as defined by the Food and Nutrition Board of National Research Council or meet physician ordered individualized therapeutic diet requirement; (7-1-06)F~~

~~**b.** Maintain Registered Dietitian documented review and approval of menus, menu cycles and any changes or substitutes; (7-1-06)F~~

~~**c.** Must provide assurances that the meals are delivered on time and demonstrate the ability to deliver meals at a minimum of three (3) days per week; (7-1-06)F~~

~~**d.** Maintain documentation reflecting the meals delivered are nutritionally balanced and made from the highest U.S.D.A. Grade for each specific food served; (7-1-06)F~~

~~**e.** Provide documentation of current driver's license for each driver; and (7-1-06)F~~

~~**f.** Must be inspected and licensed as a food establishment by the District Health Department. (7-1-06)F~~

~~**10. Extended State Plan Service Providers.** All therapy services, with the exception of physical therapy, must be provided by a provider agency capable of supervising the direct service. Providers of services must meet the provider qualifications listed in the State Plan and have taken a traumatic brain injury training course approved by the Department. (7-1-06)F~~

~~**11. Nursing Service Providers.** Nursing Service Providers must provide documentation of current Idaho licensure as a RN or LPN in good standing and have taken a traumatic brain injury training course approved by the Department. (7-1-06)F~~

~~**12. Behavior Consultation or Crisis Management Service Providers.** Behavior Consultation or Crisis Management Providers must meet the following: (7-1-06)F~~

~~**a.** Have a Master's Degree in a behavioral science such as social work, psychology, psychosocial rehabilitation counseling, psychiatric nursing, or a closely related course of study; or (7-1-06)F~~

~~**b.** Be a licensed pharmacist; or (7-1-06)F~~

~~**c.** Work for a provider agency capable of supervising the direct service or work under the direct supervision of a licensed psychologist or Ph.D., with training and experience in treating severe behavior problems and training and experience in applied behavior analysis; and (7-1-06)F~~

- ~~d. Take a traumatic brain injury training course approved by the Department. (7-1-06)F~~
- ~~e. Emergency back-up providers must also meet the minimum provider qualifications under Residential Habilitation services. (7-1-06)F~~

~~13. **Day Rehabilitation Providers.** Day Rehabilitation Providers must have a minimum of two (2) years of experience working directly with persons with a traumatic brain injury, must provide documentation of standard licensing specific to their discipline, and must have taken a traumatic brain injury course approved by the Department. (7-1-06)F~~

~~14. **Personal Care Service Providers.** Personal Care Service providers must meet the requirements outlined in Section 305 of these rules for PCS Provider Qualifications. Providers must take a traumatic brain injury training course approved by the Department. (7-1-06)F~~

~~343. **TBI WAIVER SERVICES – PAYMENT METHODOLOGY.** The following outlines the criteria used in reimbursing providers for waiver services. (7-1-06)F~~

~~01. **Fee for Services.** Waiver service providers will be paid on a fee for service basis based on the type of service provided as established by the Department. (7-1-06)F~~

~~02. **Provider Claims.** Provider claims for payment will be submitted on claim forms provided or approved by the Department. Billing instructions will be provided by the Department. (7-1-06)F~~

~~03. **Calculation of Fees.** The fees calculated for waiver services include both services and mileage. No separate charges for mileage will be paid by the Department for provider transportation to and from the participant's home or other service delivery location when the participant is not being provided transportation. (7-1-06)F~~

34435. -- 449. (RESERVED).

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE
16.05.06 - CRIMINAL HISTORY AND BACKGROUND CHECKS
NOTICE OF PUBLIC MEETING - INFORMATIONAL AND TRAINING MEETINGS

INFORMATIONAL NOTICE: Notice is hereby given that this agency intends to hold public meetings to provide training and to present rule changes for the IDAPA 16.05.06 "Mandatory Criminal History Checks." These informational public meetings are in response to legislation passed by the 2006 Legislature.

MEETING SCHEDULE: Public meetings will be held as follows:

Monday, December 4, 2006
2:00 p.m.
Dept. of Health & Welfare
1720 Westgate,
Suite D, Rm 119
Boise, ID 83704

Tuesday, December 5, 2006
2:00 p.m.
Dept. of Health & Welfare
3402 Franklin Rd.
E. Grand Teton/West Sawtooth Rm.
Caldwell, ID 83605

Wednesday, December 6, 2006
2:00 p.m.
Red Lion Inn
621 21st Street
Port 1 & 2, Conf. Rm.
Lewiston, ID 83501

Thursday, December 7, 2006
2:00 p.m.
Dept. of Health & Welfare
1120 Ironwood Drive
Lower Level-Large Conf. Rm.
Coeur d'Alene, ID 83814

Tuesday, December 12, 2006
2:00 p.m.
Dept. of Health & Welfare
601 Pole Line road
Conf. Rms. A, B, C & D
Twin Falls, ID 83301

Wednesday, December 13, 2006
2:00 p.m.
Ameritel Inn
1140 Bench Road
Pebble Creek Rm.
Pocatello, ID 83201

Thursday, December 14, 2006
2:00 p.m.
Dept. of Health & Welfare
2475 Leslie Ave., Conference Rm.
Idaho Falls, ID 83402

METHOD OF PARTICIPATION: Persons wishing to participate in the public meetings:

1. Attend the public meeting for training and presentation of rule changes.
2. Provide oral or written recommendations at the meeting.

DESCRIPTIVE SUMMARY: The following is a statement in nontechnical language of the substance and purpose of the public meetings:

In order to protect vulnerable adults and children in Idaho, the Department conducts criminal history and background checks on individuals who provide direct care or services to them. The 2006 Legislature passed SB 1327, Section 1004A, Idaho Code, further defining the authority to conduct criminal history and background checks. Department rule changes will take effect January 1, 2007. The Department is implementing major changes to the criminal history application system that will impact all applicants and their employers. Training on these changes will be given during these public meetings and it is important to attend and learn the changes to the criminal history system with regards to the on-line registration for employers and the application process for Department criminal history checks.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning these meetings contact Mond Warren at (208) 334-5997. All written comments should be directed to Mond Warren, P.O. Box 83720, Boise, ID 83720-0036.

DATED this 13th day of October, 2006.

Sherri Kovach - Program Supervisor
DHW - Administrative Procedures Section
450 West State Street - 10th Floor
Boise, Idaho 83720-0036

P.O. Box 83720
(208) 334-5564 phone; (208) 332-7347 fax
kovachs@idhw.state.id.us e-mail

IDAPA 18 - IDAHO DEPARTMENT OF INSURANCE

18.01.24 - ADVERTISEMENT OF DISABILITY (ACCIDENT AND SICKNESS) INSURANCE

DOCKET NO. 18-0124-0601

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2007 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Sections 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 41-211, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

In the proposed rule a new Subsection k. was added to Section 013 under Subsection 01. Based upon public comment, the new proposed text in Section 013.01.k. of the rule that would prohibit marketing devices designed to create undue fear or anxiety in the minds of consumers is being removed. This text has been removed from this pending rule but is not being reprinted in this Bulletin. No other changes have been made to this pending rule and the remainder of the proposed text is being adopted as originally proposed. The original text of the proposed rule was published in the August 2, 2006 Idaho Administrative Bulletin, Vol. 06-8, pages 12 through 17.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars (\$10,000) during the fiscal year: No fiscal impact.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Martha Hopper at (208) 334-4315.

DATED this 2nd day of October, 2006.

Shad Priest, Acting Director
Idaho Department of Insurance
700 West State St., 3rd Floor, Boise, Idaho 83720-0043
Phone: (208) 334-4250 / Fax: (208) 334-4398

DOCKET NO. 18-0124-0601 - ADOPTION OF PENDING RULE

There are substantive changes from the proposed rule text.

Only those sections that have changed from the original proposed text are printed in this Bulletin following this notice.

The text of the proposed rule was published in the Idaho Administrative Bulletin, Volume 06-8, August 2, 2006, pages 12 through 17.

This rule has been adopted as a pending rule by the Agency and is now pending review and approval by the 2007 Idaho State Legislature as a final rule.

IDAPA 18 - IDAHO DEPARTMENT OF INSURANCE

18.01.34 - CERTIFICATE OF LIABILITY INSURANCE FOR MOTOR VEHICLES

DOCKET NO. 18-0134-0601

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2007 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Sections 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 41-211, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

The pending rule is being adopted as proposed. The complete text of the proposed rule was published in the July 5th, 2006 Idaho Administrative Bulletin, Vol. 06-7, pages 63 through 68.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars (\$10,000) during the fiscal year: No fiscal impact.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Gina McBride at (208) 334-4250.

DATED this 2nd day of October, 2006.

Shad Priest, Acting Director
Idaho Department of Insurance
700 West State St., 3rd Floor
Boise, Idaho 83720-0043
Phone: (208) 334-4250
Fax: (208) 334-4398

DOCKET NO. 18-0134-0601 - ADOPTION OF PENDING RULE

There are no substantive changes from the proposed rule text.

The complete text of the proposed rule was published in the Idaho Administrative Bulletin, Volume 06-7, July 5, 2006, pages 63 through 68.

This rule has been adopted as a pending rule by the Agency and is now pending review and approval by the 2007 Idaho State Legislature as a final rule.

IDAPA 18 - IDAHO DEPARTMENT OF INSURANCE

18.01.44 - SCHEDULE OF FEES, LICENSES AND MISCELLANEOUS CHARGES

DOCKET NO. 18-0144-0601

NOTICE OF RULEMAKING - ADOPTION OF PENDING FEE RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2007 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Sections 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 41-211, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

The pending rule is being adopted as proposed. The complete text of the proposed rule was published in the August 2, 2006 Idaho Administrative Bulletin, Vol. 06-8, pages 18 through 20.

FEE SUMMARY: Pursuant to Section 67-5226(2), the Governor has found that the fee or charge being imposed or increased is justified and necessary to avoid immediate danger and the fee is described herein:

The rule reduces an existing fee.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars (\$10,000) during the fiscal year: No fiscal impact.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Gina McBride at (208) 334-4250.

DATED this 5th day of October, 2006.

Shad Priest, Acting Director
Idaho Department of Insurance
700 West State St., 3rd Floor
Boise, Idaho 83720-0043
Phone: (208) 334-4250
Fax: (208) 334-4398

DOCKET NO. 18-0144-0601 - ADOPTION OF PENDING RULE

There are no substantive changes from the proposed rule text.

The complete text of the proposed rule was published in the Idaho Administrative Bulletin, Volume 06-8, August 2, 2006, pages 18 through 20.

This rule has been adopted as a pending rule by the Agency and is now pending review and approval by the 2007 Idaho State Legislature as a final rule.

IDAPA 18 - IDAHO DEPARTMENT OF INSURANCE

18.01.56 - REBATES AND ILLEGAL INDUCEMENTS TO OBTAINING TITLE INSURANCE BUSINESS

DOCKET NO. 18-0156-0601

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2007 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Sections 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 41-211, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

The pending rule is being adopted as proposed. The complete text of the proposed rule was published in the August 2, 2006 Idaho Administrative Bulletin, Vol. 06-8, pages 21 through 27.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars (\$10,000) during the fiscal year: No fiscal impact.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Dale Freeman at (208) 334-4250.

DATED this 2nd day of October, 2006

Shad Priest, Acting Director
Idaho Department of Insurance
700 West State St., 3rd Floor
Boise, Idaho 83720-0043
Phone: (208) 334-4250
Fax: (208) 334-4398

DOCKET NO. 18-0156-0601 - ADOPTION OF PENDING RULE

There are no substantive changes from the proposed rule text.

The complete text of the proposed rule was published in the Idaho Administrative Bulletin, Volume 06-8, August 2, 2006, pages 21 through 27.

This rule has been adopted as a pending rule by the Agency and is now pending review and approval by the 2007 Idaho State Legislature as a final rule.

IDAPA 18 - DEPARTMENT OF INSURANCE

18.01.60 - LONG-TERM CARE INSURANCE MINIMUM STANDARDS

DOCKET NO. 18-0160-0601

NOTICE OF RULEMAKING - TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is November 1, 2007.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule, and proposed rulemaking procedures have been initiated. The action is authorized pursuant to Sections 41-211 and 56-1305, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than November 22, 2006. The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is the required finding and concise statement of its supporting reasons for adopting a temporary rule and a nontechnical explanation of the substance and purpose of the proposed rulemaking:

The rule is being amended to implement the Long Term Care Partnership Program provided for at Chapter 13, Title 56, Idaho Code. Chapter 13 became effective upon repeal of restrictions to asset protection contained in the omnibus budget reconciliation act of 1993. The restrictions were repealed by the passage of the federal Deficit Reduction Act of 2005. The proposed changes incorporate the latest changes to the model Long Term Care Minimum Standards Rule adopted by the National Association of Insurance Commissioners and are intended to make Idaho's rule consistent with the standards most likely to be adopted by other states.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section(s) 67-5226(1)(b), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate for the following reasons: Compliance with changes to governing law.

FEE SUMMARY: Pursuant to Section 67-5226(2), the Governor has found that the fee or charge being imposed or increased is justified and necessary to avoid immediate danger and the fee is described herein: The rule does not impose a fee.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars (\$10,000) during the fiscal year resulting from this rulemaking: No fiscal impact.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because the changes made by this rulemaking were needed to implement the Long Term Care Partnership Program, Chapter 13, Title 56, Idaho Code.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Joan Krosch, 208-334-4300.

Anyone may submit written comments regarding the proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before November 22, 2006.

DATED this 6th day of October, 2006.

Shad Priest, Acting Director
Idaho Department of Insurance
700 West State Street, 3rd Floor
Boise, Idaho 83720-0043
Phone: (208) 334-4250 / Fax: (208) 334-4398

THE FOLLOWING IS THE TEXT OF DOCKET NO. 18-0160-0601

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.~~ (4-5-00)(11-1-06)T

003. ADMINISTRATIVE APPEALS.

~~There is no appeal to the Attorney General from application of this Rule. All such appeals must be instituted by written demand for a hearing before the Director of Insurance, Section 41-232, Idaho Code. Further appeal from the Director's decision can be taken to district court, pursuant to Section 67-5270, Idaho Code. All administrative appeals shall be governed by Chapter 2, Title 41, Idaho Code, and the Idaho Administrative Procedure Act, Title 67, Chapter 52, Idaho Code, and IDAPA 04.11.01, "Idaho Rules of Administrative Procedure of the Attorney General." Sections 000 through 099, General Provisions.~~ (4-5-00)(11-1-06)T

004. OFFICE -- OFFICE HOURS -- MAILING ADDRESS, STREET ADDRESS AND WEB SITE.

01. Office Hours. The Department of Insurance is open from 8 a.m. to 5pm. Except Saturday, Sunday and legal holidays. (11-1-06)T

02. Mailing Address. The department's mailing address is: Idaho Department of Insurance, P.O. Box 83720, Boise, ID 83720-0043. (11-1-06)T

03. Street Address. The principal place of business is 700 West State Street, 3rd Floor, Boise, Idaho 83720-0043. (11-1-06)T

04. Web Site Address. The department's web address is <http://www.doi.idaho.gov>. (11-1-06)T

005. PUBLIC RECORDS ACT COMPLIANCE.

Any records associated with these rules are subject to the provision of the Idaho Public Records Act, Title 9, Chapter 3, Idaho Code. (11-1-06)T

006. -- 009. (RESERVED).

00410. DEFINITIONS.

For the purpose of this rule, no long-term care insurance policy delivered or issued for delivery in this state shall use the terms set forth below, unless the terms are defined in the policy. In relation to the Qualified Long-Term Care plans, such definitions must satisfy definitions as amended by the U.S. Treasury Department and the following requirements: (4-5-00)

01. Activities of Daily Living. At least bathing, continence, dressing, eating, toileting, and transferring. (4-5-00)

02. Acute Condition. The individual is medically unstable. Such an individual requires frequent monitoring by medical professionals, such as physicians and registered nurses, in order to maintain his health status. (4-5-00)

03. Adult Day Care. A program for six (6) or more individuals, of social and health-related services provided during the day in a community group setting for the purpose of supporting frail, impaired elderly or other disabled adults who can benefit from care in a group setting outside the home. (4-5-00)

04. Bathing. Washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower. (4-5-00)

05. Cognitive Impairment. A deficiency in a person's short or long-term memory, orientation as to person, place and time, deductive or abstract reasoning, or judgment as it relates to safety awareness. (4-5-00)

06. Contenance. The ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag). (4-5-00)

07. Dressing. Putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs. (4-5-00)

08. Eating. Feeding oneself by getting food into the body from a receptacle (such as a plate, cup, or table) or by a feeding tube or intravenously. (4-5-00)

09. Exceptional Increase. Means only those increases filed by an insurer as exceptional for which the director determines the need for the premium rate increase is justified due to changes in Idaho laws or rules applicable to long-term care coverage, or due to increased and unexpected utilization that affects the majority of insurers of similar products. (3-30-01)

a. Except as provided in Section 0205, Premium Rate Schedule Increases, exceptional increases are subject to the same requirements as other premium rate schedule increases. ~~(3-30-01)~~(11-1-06)T

b. The director may request a review by an independent actuary or a professional actuarial body of the basis for a request that an increase be considered an exceptional increase. (3-30-01)

c. The director, in determining that the necessary basis for an exceptional increase exists, shall also determine any potential offsets to higher claims costs. (3-30-01)

10. Hands-On Assistance. Physical assistance (minimal, moderate, or maximal) without which the individual would not be able to perform the activity of daily living. (4-5-00)

11. Home Health Care Services. Medical and non-medical services, provided to ill, disabled, or infirm persons in their residences. Such services may include homemaker services, assistance with activities of daily living, and respite care services. (4-5-00)

12. Incidental. As used in Subsection 0205.10, the value of the long-term care benefits provided is less than ten percent (10%) of the total value of the benefits provided over the life of the policy. These values shall be measured as of the date of issue. ~~(3-30-01)~~(11-1-06)T

13. Medicare. "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended," or "Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof," or words of similar import. (4-5-00)

14. Mental or Nervous Disorder. Shall not be defined to include more than neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder. (4-5-00)

15. Personal Care. The provision of hands-on services to assist an individual with activities of daily living. (4-5-00)

16. Qualified Actuary. Means a member in good standing of the American Academy of Actuaries. (3-30-01)

17. Similar Policy Forms. Means all of the long-term care insurance policies and certificates issued by an insurer in the same long-term care benefit classification as the policy form being considered. Certificates of groups that meet the definition in Section 41-4603(4)(a), Idaho Code, are not considered similar to certificates or policies otherwise issued as long-term care insurance, but are similar to other comparable certificates with the same long-term

care benefit classifications. For purposes of determining similar policy forms, long-term care benefit classifications are defined as follows: (3-30-01)

- a. Institutional long-term care benefits only; (3-30-01)
- b. Non-institutional long-term care benefits only; or (3-30-01)
- c. Comprehensive long-term care benefits. (3-30-01)

18. Skilled Nursing Care, ~~Intermediate Care~~, Personal Care, Home Care, Specialized Care, Assisted Living Care and Other Services. Skilled Nursing Care, Personal Care, Home Care, Specialized Care, Assisted Living Care and other services shall be defined in relation to the level of skill required, the nature of the care and the setting in which care must be delivered. ~~(4-5-00)~~(11-1-06)T

19. Toileting. Getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene. (4-5-00)

20. Transferring. Moving into or out of a bed, chair, or wheelchair. (4-5-00)

21. All Providers of Services. All providers of services including but not limited to Skilled Nursing Facility, Extended Care Facility, ~~Intermediate Care Facility~~, Convalescent Nursing Home, Personal Care Facility, Specialized Care Providers, Assisted Living Facility, and Home Care Agency. Such services shall be defined in relation to the services and facilities required to be available and the licensure, certification, registration or degree status of those providing or supervising the services. When the definition may requires that the provider be appropriately licensed, or certified or registered, it shall also state what requirements a provider must meet in lieu of licensure, certification or registration when the state in which the service is to be furnished does not require a provider of these services to be licensed, certified or registered, or when the state licenses, certifies or registers the provider of services under another name. ~~(4-5-00)~~(11-1-06)T

00511. POLICY PRACTICES AND PROVISIONS.

01. Renewability. The terms “guaranteed renewable” and “noncancellable” shall not be used in any individual long-term care insurance policy without further explanatory language in accordance with the disclosure requirements of Section ~~009~~14 of this rule. ~~(4-5-00)~~(11-1-06)T

a. A policy issued to an individual shall not contain renewal provisions other than “guaranteed renewable” or “noncancellable.” (4-5-00)

b. The term “guaranteed renewable” may be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums and when the insurer has no unilateral right to make any change in any provision of the policy or rider while the insurance is in force, and cannot decline to renew, except that rates may be revised by the insurer on a class basis. (4-5-00)

c. The term “noncancellable” may be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums during which period the insurer has no right to unilaterally make any change in any provision of the insurance or in the premium rate. (4-5-00)

d. The term “level premium” may only be used when the insurer does not have the right to change the premium for a specified period for the life of the policy. (3-30-01)

e. In addition to the other requirements of Subsection ~~005~~11.01, a qualified long-term care insurance contract shall be guaranteed renewable, within the meaning of Section 7702B(b)(1)(C) of the Internal Revenue Code of 1986 as amended. ~~(4-5-00)~~(11-1-06)T

02. Limitations and Exclusions. A policy may not be delivered or issued for delivery in this state as long-term care insurance if the policy limits or excludes coverage by type of illness, treatment, medical condition or accident, except as follows: (4-5-00)

- a. Preexisting conditions or diseases; (4-5-00)
- b. Mental or nervous disorders; however, this shall not permit exclusion or limitation of benefits on the basis of Alzheimer's Disease; (4-5-00)
- c. Alcoholism and drug addiction; (4-5-00)
- d. Illness, treatment, or medical condition arising out of: (4-5-00)
- i. War or act of war (whether declared or undeclared); (4-5-00)
- ii. Participation in a felony, riot, or insurrection; (4-5-00)
- iii. Service in the armed forces or units auxiliary thereto; (4-5-00)
- iv. Suicide (sane or insane), attempted suicide, or intentionally self-inflicted injury; or (4-5-00)
- v. Aviation (this exclusion applies only to non-fare-paying passengers). (4-5-00)
- e. Treatment provided in a government facility (unless otherwise required by law), services for which benefits are available under Medicare or other governmental program (except Medicaid), any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law, services provided by a member of the covered person's immediate family, and services for which no charge is normally made in the absence of insurance; (4-5-00)
- f. Expenses for services or items available or paid under another long-term care insurance or health insurance policy; or (4-5-00)
- g. In the case of a qualified long-term care insurance contract, expenses for services or items to the extent that the expenses are reimbursable under Title XVIII of the Social Security Act or would be so reimbursable but for the application of a deductible or coinsurance amount. (4-5-00)
- h. Subsection 00511.02 is not intended to prohibit exclusions and limitations by type of provider or territorial limitations. However, no long term care issuer may deny a claim because services are provided in a state other than the state of policy issue under the following conditions: ~~(4-5-00)~~(11-1-06)T
- i. When the state other than the state of policy issue does not have the provider licensing, certification or registration required in the policy, but where the provider satisfies the policy requirements outlined for providers in lieu of licensure, certification or registration; or (11-1-06)T
- ii. When the state other than the state of policy issue licenses, certifies or registers the provider under another name. For purposes of this Subsection 011.02.h, "state of policy issue" means the state in which the individual policy or certificate was originally issued. (11-1-06)T
- iii. Subsection 011.02 is not intended to prohibit territorial limitations. (11-1-06)T
- 03. Extension of Benefits.** Termination of long-term care insurance shall be without prejudice to any benefits payable for institutionalization if the institutionalization began while the long-term care insurance was in force and continues without interruption after termination. The extension of benefits beyond the period the long-term care insurance was in force may be limited to the duration of the benefit period, if any, or to payment of the maximum benefits and may be subject to any policy waiting period, and all other applicable provisions of the policy. (4-5-00)
- 04. Continuation or Conversion.** (4-5-00)
- a. Group long-term care insurance issued in this state on or after the effective date of Section 00511 shall provide covered individuals with a basis for continuation or conversion of coverage. ~~(4-5-00)~~(11-1-06)T

b. For the purposes of Section ~~00511~~, “a basis for continuation of coverage” means a policy provision that maintains coverage under the existing group policy when the coverage would otherwise terminate and which is subject only to the continued timely payment of premium when due. Group policies that restrict provision of benefits and services to, or contain incentives to use certain providers or facilities, may provide continuation benefits that are substantially equivalent to the benefits of the existing group policy. The director shall make a determination as to the substantial equivalency of benefits, and in doing so, shall take into consideration the differences between managed care and non-managed care plans, including, but not limited to, provider system arrangements, service availability, benefit levels and administrative complexity. ~~(4-5-00)~~(11-1-06)T

c. For the purposes of Section ~~00511~~, “a basis for conversion of coverage” means a policy provision that an individual whose coverage under the group policy would otherwise terminate or has been terminated for any reason, including discontinuance of the group policy in its entirety or with respect to an insured class, and who has been continuously insured under the group policy (and any group policy which it replaced) for at least six (6) months immediately prior to termination, shall be entitled to the issuance of a converted policy by the insurer under whose group policy he or she is covered, without evidence of insurability. ~~(4-5-00)~~(11-1-06)T

d. For the purposes of Section ~~00511~~, “converted policy” means an individual policy of long-term care insurance providing benefits identical to or benefits determined by the director to be substantially equivalent to or in excess of those provided under the group policy from which conversion is made. Where the group policy from which conversion is made restricts provision of benefits and services to, or contains incentives to use certain providers or facilities, the director, in making a determination as to the substantial equivalency of benefits, shall take into consideration the differences between managed care and non-managed care plans, including, but not limited to, provider system arrangements, service availability, benefit levels and administrative complexity. ~~(4-5-00)~~(11-1-06)T

e. Written application for the converted policy shall be made and the first premium due, if any, shall be paid as directed by the insurer not later than thirty-one (31) days after termination of coverage under the group policy. The converted policy shall be issued effective on the day following the termination of coverage under the group policy and shall be renewable annually. (4-5-00)

f. Unless the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured’s age at inception of coverage under the group policy from which conversion is made. Where the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured’s age at inception of coverage under the group policy replaced. (4-5-00)

g. Continuation of coverage or issuance of a converted policy shall be mandatory, except where: (4-5-00)

i. Termination of group coverage resulted from an individual’s failure to make any required payment of premium or contribution when due; or (4-5-00)

ii. The terminating coverage is replaced not later than thirty-one (31) days after termination, by group coverage effective on the day following the termination of coverage: (4-5-00)

(1) Providing benefits identical to or benefits determined by the director to be substantially equivalent to or in excess of those provided by the terminating coverage; and (4-5-00)

(2) The premium for which is calculated in a manner consistent with the requirements of Subsection ~~005-06~~ 011.04.f. ~~(4-5-00)~~(11-1-06)T

h. Notwithstanding any other provision of Section ~~00511~~, a converted policy issued to an individual who at the time of conversion is covered by another long-term care insurance policy that provides benefits on the basis of incurred expenses, may contain a provision that results in a reduction of benefits payable if the benefits provided under the additional coverage, together with the full benefits provided by the converted policy, would result in payment of more than one hundred percent (100%) of incurred expenses. The provision shall only be included in the converted policy if the converted policy also provides for a premium decrease or refund which reflects the reduction in benefits payable. ~~(4-5-00)~~(11-1-06)T

i. The converted policy may provide that the benefits payable under the converted policy, together with the benefits payable under the group policy from which conversion is made, shall not exceed those that would have been payable had the individual's coverage under the group policy remained in force and effect. (4-5-00)

j. Notwithstanding any other provision of Section ~~00511~~, an insured individual whose eligibility for group long-term care coverage is based upon his relationship to another person shall be entitled to continuation of coverage under the group policy upon termination of the qualifying relationship by death or dissolution of marriage. ~~(4-5-00)~~(11-1-06)T

k. For the purposes of Section ~~00511~~ a "managed-care plan" is a health care or assisted living arrangement designed to coordinate patient care or control costs through utilization review, case management or use of specific provider networks. ~~(4-5-00)~~(11-1-06)T

05. Discontinuance and Replacement. If a group long-term care policy is replaced by another group long-term care policy issued to the same policyholder, the succeeding insurer shall offer coverage to all persons covered under the previous group policy on its date of termination. Coverage provided or offered to individuals by the insurer and premiums charged to persons under the new group policy: (4-5-00)

a. Shall not result in an exclusion for preexisting conditions that would have been covered under the group policy being replaced; and (4-5-00)

b. Shall not vary or otherwise depend on the individual's health or disability status, claim experience or use of long-term care services. (4-5-00)

06. Premium Changes. (4-5-00)

a. The premium charged to an insured shall not increase due to either: (4-5-00)

i. The increasing age of the insured at ages beyond sixty-five (65); or (4-5-00)

ii. The duration the insured has been covered under the policy. (4-5-00)

b. The purchase of additional coverage shall not be considered a premium rate increase, but for purposes of the calculation required under Section ~~02532~~, the portion of the premium attributable to the additional coverage shall be added to and considered part of the initial annual premium. ~~(3-30-01)~~(11-1-06)T

c. A reduction in benefits shall not be considered a premium change, but for purpose of the calculation required under Section ~~02532~~, the initial annual premium shall be based on the reduced benefits. ~~(3-30-01)~~(11-1-06)T

07. Electronic Enrollment for Group Policies. (4-5-00)

a. In the case of a group defined in Section 41-4603(4)(a), Idaho Code, any requirement that a signature of an insured be obtained by an ~~agent~~ producer or insurer shall be deemed satisfied if: ~~(4-5-00)~~(11-1-06)T

i. The consent is obtained by telephonic or electronic enrollment by the group policyholder or insurer. A verification of enrollment information shall be provided to the enrollee; (4-5-00)

ii. The telephonic or electronic enrollment provides necessary and reasonable safeguards to assure the accuracy, retention, and prompt retrieval of records; and (4-5-00)

iii. The telephonic or electronic enrollment provides necessary and reasonable safeguards to assure that the confidentiality of individually identifiable information, "privileged information," is maintained. (4-5-00)

b. The insurer shall make available, upon request of the director, records that will demonstrate the insurer's ability to confirm enrollment and coverage amounts. (4-5-00)

00612. INCORPORATION OF DOCUMENTS BY REFERENCE.

01. Forms. An insurer shall use the forms published on the Department of Insurance *Internet Website* www.doi.state.id.us, select the link, "Consumer Assistance," Homepage <http://www.doi.idaho.gov>, select consumer or company services link and go to Attachments to Idaho Rule, IDAPA 18.01.60 "Long-Term Care Insurance Minimum Standards," to comply with the disclosure requirements of Subsection 00914.10.a. and Subsection 00914.10.b., which forms are incorporated herein by this reference. ~~(3-30-01)~~(11-1-06)T

02. NAIC Model Regulation for Long-Term Care Insurance Minimum Standards Appendices B, C, and D. Copies Of NAIC Model Regulation For Long-Term Care Insurance Minimum Standards Appendices B, C, and D can be found at the Idaho Department of Insurance Home page, www.doi.state.id.us, select SHIBA (Senior Health Insurance Benefits Advisors) under the Consumer Assistance link, which appendices are hereby incorporated by reference. To obtain a hard copy of the required illustrations based on the NAIC Model Regulation, contact SHIBA at the Idaho Department of Insurance (208) 334-4250. ~~(3-30-01)~~

007. (RESERVED).

00813. UNINTENTIONAL LAPSE.

01. Notice Before Lapse or Termination. Each insurer offering long-term care insurance shall, as a protection against unintentional lapse, comply with the following: (4-5-00)

a. No individual long-term care policy or certificate shall be issued until the insurer has received from the applicant either a written designation of at least one (1) person, in addition to the applicant, who is to receive notice of lapse or termination of the policy or certificate for nonpayment of premium, or a written waiver dated and signed by the applicant electing not to designate additional persons to receive notice. The applicant has the right to designate at least one (1) person who is to receive the notice of termination, in addition to the insured. Designation shall not constitute acceptance of any liability on the third party for services provided to the insured. The form used for the written designation must provide space clearly designated for listing at least one (1) person. The designation shall include each person's full name and home address. In the case of an applicant who elects not to designate an additional person, the waiver shall state: "Protection against unintended lapse. I understand that I have the right to designate at least one (1) person other than myself to receive notice of lapse or termination of this long-term care insurance policy for nonpayment of premium. I understand that notice will not be given until thirty (30) days after a premium is due and unpaid. I elect NOT to designate a person to receive this notice." The insurer shall notify the insured of the right to change this written designation, no less often than once every two (2) years. (4-5-00)

b. When the policyholder or certificate holder pays premium for a long-term care insurance policy or certificate through a payroll or pension deduction plan, the requirements contained in Subsection 00813.01.a. need not be met until sixty (60) days after the policyholder or certificate holder is no longer on such a payment plan. The application or enrollment form for such policies or certificates shall clearly indicate the payment plan selected by the applicant. ~~(4-5-00)~~(11-1-06)T

c. Lapse or termination for nonpayment of premium. No individual long-term care policy or certificate shall lapse or be terminated for nonpayment of premium unless the insurer, at least thirty (30) days before the effective date of the lapse or termination, has given notice to the insured and to those persons designated pursuant to Subsection 00813.01.a., at the address provided by the insured for purposes of receiving notice of lapse or termination. Notice shall be given by first class United States mail, postage prepaid; and notice may not be given until thirty (30) days after a premium is due and unpaid. Notice shall be deemed to have been given as of five (5) days after the date of mailing. ~~(4-5-00)~~(11-1-06)T

02. Reinstatement. In addition to the requirement in Subsection 00813.01, a long-term care insurance policy or certificate shall include a provision that provides for reinstatement of coverage, in the event of lapse if the insurer is provided proof that the policyholder or certificate holder was cognitively impaired or had a loss of functional capacity before the grace period contained in the policy expired. This option shall be available to the insured if requested within five (5) months after termination and shall allow for the collection of past due premium, where appropriate. The standard of proof of cognitive impairment or loss of functional capacity shall not be more

stringent than the benefit eligibility criteria on cognitive impairment or the loss of functional capacity contained in the policy and certificate. ~~(4-5-00)~~(11-1-06)T

00914. REQUIRED DISCLOSURE PROVISIONS.

01. Renewability. Individual long-term care insurance policies shall contain a renewability provision. (3-30-01)

a. The provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state that the coverage is guaranteed renewable or noncancellable. This provision shall not apply to policies that do not contain a renewability provision, and under which the right to nonrenew is reserved solely to the policyholder. (3-30-01)

b. A long-term care insurance policy or certificate, other than one where the insurer does not have the right to change the premium, shall include a statement that the premium rates may change. (3-30-01)

02. Riders and Endorsements. Except for riders or endorsements by which the insurer effectuates a request made in writing by the insured under an individual long-term care insurance policy, all riders or endorsements added to an individual long-term care insurance policy after date of issue or at reinstatement or renewal that reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the individual insured. After the date of policy issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to in writing signed by the insured, except if the increased benefits or coverage are required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy, rider or endorsement. (4-5-00)

03. Payment of Benefits. A long-term care insurance policy that provides for the payment of benefits based on standards described as "usual and customary," "reasonable and customary," or words of similar import shall include a definition of these terms and an explanation of the terms in its accompanying outline of coverage. (4-5-00)

04. Limitations. If a long-term care insurance policy or certificate contains any limitations with respect to preexisting conditions, the limitations shall appear as a separate paragraph of the policy or certificate and shall be labeled as "Preexisting Condition Limitations." (4-5-00)

05. Other Limitations or Conditions on Eligibility for Benefits. A long-term care insurance policy or certificate containing any limitations or conditions for eligibility other than those prohibited in ~~this rule~~ Section 41-4605(4)(b)(i), Idaho Code, shall set forth a description of the limitations or conditions, including any required number of days of confinement, in a separate paragraph of the policy or certificate and shall label such paragraph "Limitations or Conditions on Eligibility for Benefits." ~~(4-5-00)~~(11-1-06)T

06. Disclosure of Tax Consequences. With regard to life insurance policies that provide an accelerated benefit for long-term care, a disclosure statement is required at the time of application for the policy or rider and at the time the accelerated benefit payment request is submitted that receipt of these accelerated benefits may be taxable, and that assistance should be sought from a personal tax advisor. The disclosure statement shall be prominently displayed on the first page of the policy or rider and any other related documents. Subsection ~~00914.06~~ shall not apply to qualified long-term care insurance contracts. ~~(4-5-00)~~(11-1-06)T

07. Benefit Triggers. Activities of daily living and cognitive impairment shall be used to measure an insured's need for long-term care and shall be described in the policy or certificate in a separate paragraph and shall be labeled "Eligibility for the Payment of Benefits." Any additional benefit triggers shall also be explained. If these triggers differ for different benefits, explanation of the trigger shall accompany each benefit description. If an attending physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this too shall be specified. (4-5-00)

08. Qualified Contracts. A qualified long-term care insurance contract shall include a disclosure statement in the policy and in the outline of coverage as contained in Section ~~02735~~ that the policy is intended to be a qualified long-term care insurance contract under Section 7702B (b) of the Internal Revenue Code of 1986, as

amended.

~~(4-5-00)~~(11-1-06)T

09. Non-Qualified Contracts. A non-qualified long-term care insurance contract shall include a disclosure statement in the policy and in the outline of coverage as contained in Section ~~02735~~ that the policy is not intended to be a qualified long-term care insurance contract. ~~(4-5-00)~~(11-1-06)T

10. Required Disclosure of Rating Practices to Consumers. (3-30-01)

a. Subsection ~~00914.10~~ shall apply as follows: ~~(3-30-01)~~(11-1-06)T

i. Except as provided in Subsection ~~00914.10.a.ii.~~, Subsection ~~00914.10~~ applies to any long-term care policy or certificate issued in this state on or after July 1, 2001. ~~(3-30-01)~~(11-1-06)T

ii. For certificates issued on or after the effective date of this amended rule under a group long-term care insurance policy as defined in Section 41-4603(4)(a), Idaho Code, which policy was in force at the time this amended rule became effective, the provisions of Subsection ~~00914.10~~ shall apply on the policy anniversary following January 1, 2002. ~~(3-30-01)~~(11-1-06)T

b. Other than policies for which no applicable premium rate or rate schedule increases can be made, insurers shall provide all of the information listed in Subsection ~~00914.10.b.~~ to the applicant at the time of application or enrollment, unless the method of application does not allow for delivery at that time. In such a case, an insurer shall provide all information listed in Subsection ~~00914.10.b.~~ to the applicant no later than at the time of delivery of the policy or certificate. ~~(3-30-01)~~(11-1-06)T

i. A statement that the policy may be subject to rate increases in the future; (3-30-01)

ii. An explanation of potential future premium rate revisions, and the policyholder's or certificateholder's option in the event of a premium rate revision; (3-30-01)

iii. The premium rate or rate schedules applicable to the applicant that will be in effect until a request is made for an increase; and (3-30-01)

iv. A general explanation for applying premium rate or rate schedule adjustments that shall include, a description of when premium rate or rate schedule adjustments will be effective (e.g., next anniversary date, next billing date, etc.); and the right to a revised premium rate or rate schedule as provided in Subsection ~~00914.10.b.ii.~~, if the premium rate or rate schedule is changed. ~~(3-30-01)~~(11-1-06)T

c. Information regarding each premium rate increase on this policy form or similar forms over the past ten (10) years for this state or any other state that, at a minimum, identifies: (3-30-01)

i. The policy forms for which premium rates have been increased; (3-30-01)

ii. The calendar years when the form was available for purchase; and (3-30-01)

iii. The amount or percent of each increase. The percentage may be expressed as a percentage of the premium rate prior to the increase, and may also be expressed as minimum and maximum percentages if the rate increase is variable by rating characteristics. (3-30-01)

d. The insurer may, in a fair manner, provide additional explanatory information related to the rate increases. (3-30-01)

e. An insurer shall have the right to exclude from the disclosure premium rate increases that only apply to blocks of business acquired from other nonaffiliated insurers or the long-term care policies acquired from other nonaffiliated insurers when those increases occurred prior to acquisition. (3-30-01)

f. If an acquiring insurer files for a rate increase on a long-term care policy form acquired from nonaffiliated insurers or a block of policy forms acquired from nonaffiliated insurers on or before the later of the

effective date of Subsection ~~009~~14.10 or the end of a twenty-four (24) month period following the acquisition of the block of policies, the acquiring insurer may exclude that rate increase from the disclosure. However, the nonaffiliated selling company shall include the disclosure of that rate increase in accordance with Subsection ~~009~~14.10.c.

~~(3-30-01)~~(11-1-06)T

g. If the acquiring insurer in Subsection ~~009~~14.10.f. above files for a subsequent rate increase, even within the twenty-four (24) month period, on the same policy form acquired from nonaffiliated insurers or block of policy forms acquired from nonaffiliated insurers referenced in Subsection ~~009~~14.10.f., the acquiring insurer must make all disclosures required by Subsection ~~009~~14.10.c., including disclosure of the earlier rate increase referenced in Subsection ~~009~~14.10.f.

~~(3-30-01)~~(11-1-06)T

h. An applicant shall sign an acknowledgement at the time of application, unless the method of application does not allow for signature at that time, that the insurer made the disclosure required under Subsections ~~009-10-a~~ 014.10.b. and ~~009-10-b~~ 014.10.c. If because of the method of application the applicant cannot sign an acknowledgement at the time of application, the applicant shall sign no later than at the time of delivery of the policy or certificate.

~~(3-30-01)~~(11-1-06)T

i. An insurer shall use the forms ~~published on the Department of Insurance Internet Website www.doi.state.id.us and select the link, "Consumer Assistance," in Appendices B and F~~ to comply with the disclosure requirements of Subsection ~~009-10-a~~ 014.10.b. and Subsection ~~009-10-b~~ 014.10.h. The company forms are published on the Department of Insurance Homepage <http://www.doi.idaho.gov>, select consumer or company services link and go to Attachments to Idaho Rule, IDAPA 18.01.60 "Long-Term Care Minimum Standards."

~~(3-30-01)~~(11-1-06)T

j. An insurer shall provide notice of an upcoming premium rate schedule increase to all policyholders or certificateholders, if applicable, at least thirty (30) days prior to the implementation of the premium rate schedule increase by the insurer. The notice shall include the information required by Subsection ~~009~~14.10.b., when the increase is implemented.

~~(3-30-01)~~(11-1-06)T

0145. PROHIBITION AGAINST POST-CLAIMS UNDERWRITING.

01. Health Conditions. All applications for long-term care insurance policies or certificates except those that are guaranteed issue shall contain clear and unambiguous questions designed to ascertain the health condition of the applicant. (4-5-00)

02. Medication. If an application for long-term care insurance contains a question that asks whether the applicant has had medication prescribed by a physician, it must also ask the applicant to list the medication that has been prescribed. If the medications listed in the application were known by the insurer, or should have been known at the time of application, to be directly related to a medical condition for which coverage would otherwise be denied, then the policy or certificate shall not be rescinded for that condition. (4-5-00)

03. Non-Guaranteed Issue. Except for policies or certificates which are guaranteed issue: (4-5-00)

a. The following language shall be set out conspicuously and in close conjunction with the applicant's signature block on an application for a long-term care insurance policy or certificate: *Caution: If your answers on this application are incorrect or untrue, (company) has the right to deny benefits or rescind your policy.* (4-5-00)

b. The following language, or language substantially similar to the following, shall be set out conspicuously on the long-term care insurance policy or certificate at the time of delivery: *Caution: The issuance of this long-term care insurance (policy) (certificate) is based upon your responses to the questions on your application. A copy of your (application) (enrollment form) (is enclosed) (was retained by you when you applied). If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address: (insert address)* (4-5-00)

c. Prior to issuance of a long-term care policy or certificate to an applicant age eighty (80) or older, the insurer shall obtain one (1) of the following: (4-5-00)

- i. A report of a physical examination; (4-5-00)
- ii. An assessment of functional capacity; (4-5-00)
- iii. An attending physician's statement; or (4-5-00)
- iv. Copies of medical records. (4-5-00)

04. Delivery of Application or Enrollment and Form. A copy of the completed application or enrollment form (whichever is applicable) shall be delivered to the insured no later than at the time of delivery of the policy or certificate unless it was retained by the applicant at the time of application. (4-5-00)

05. Record of Rescissions. Every insurer or other entity selling or issuing long-term care insurance benefits shall maintain a record of all policy or certificate rescissions, both state and countrywide, except those that the insured voluntarily effectuated and shall annually furnish this information to the insurance director in the format prescribed by the National Association of Insurance Commissioners in Appendix A. The notice required in Subsection 0105.05 shall be provided in substantially the following format based on the NAIC Model Regulation ~~which includes Appendixes A, B, C, and D, and all other outlines of coverage and specific plan designs. For Website, go to Idaho Department of Insurance Home page, www.doi.state.id.us, select SHIBA (Senior Health Insurance Benefits Advisors) under Consumer Assistance link, see attachments to the NAIC Model Regulation implementing the Long-Term Care Insurance Minimum Standards. To obtain a copy of the required illustrations based on the NAIC Model Regulation, contact SHIBA at the Idaho Department of Insurance (208) 334-4250. The forms are published on the Department of Insurance Homepage <http://www.doi.idaho.gov>, select consumer or company services link and go to Attachments to Idaho Rule, IDAPA 18.01.60 "Long-Term Care Minimum Standards."~~ (4-5-00)(11-1-06)T

0146. MINIMUM STANDARDS FOR HOME HEALTH AND COMMUNITY CARE BENEFITS IN LONG-TERM CARE INSURANCE POLICIES.

01. Limitations or Exclusions. A long-term care insurance policy or certificate shall not, if it provides benefits for home health care or community care services, limit or exclude benefits: (4-5-00)

- a. By requiring that the insured or claimant would need care in a skilled nursing facility if home health care services were not provided; (4-5-00)
- b. By requiring that the insured or claimant first or simultaneously receive nursing or therapeutic services, or both, in a home, community, or institutional setting before home health care services are covered; (4-5-00)
- c. By limiting eligible services to services provided by registered nurses or licensed practical nurses; (4-5-00)
- d. By requiring that a nurse or therapist provide services covered by the policy that can be provided by a home health aide, or other licensed or certified home care worker acting within the scope of his or her licensure or certification; (4-5-00)
- e. By excluding coverage for personal care services provided by a home health aide; (4-5-00)
- f. By requiring that the provision of home health care services be at a level of certification or licensure greater than that required by the eligible service; (4-5-00)
- g. By requiring that the insured or claimant have an acute condition before home health care services are covered; (4-5-00)
- h. By limiting benefits to services provided by Medicare-certified agencies or providers; or (4-5-00)
- i. By excluding coverage for adult day care services. (4-5-00)

02. Coverage Equivalency. A long-term care insurance policy or certificate, if it provides for home health or community care services, shall provide total home health or community care coverage that is a dollar amount equivalent to at least one-half (1/2) of one (1) year's coverage available for nursing home benefits under the policy or certificate, at the time covered home health or community care services are being received. This requirement shall not apply to policies or certificates issued to residents of continuing care retirement communities. (4-5-00)

03. Maximum Coverage. Home health care coverage may be applied to the non-home health care benefits provided in the policy or certificate when determining maximum coverage under the terms of the policy or certificate. (4-5-00)

0127. REQUIREMENT TO OFFER INFLATION PROTECTION.

01. Inflation Protection Offer. No insurer may offer a long-term care insurance policy unless the insurer also offers to the policyholder in addition to any other inflation protection the option to purchase a policy that provides for benefit levels to increase with benefit maximums or reasonable durations which are meaningful to account for reasonably anticipated increases in the costs of long-term care services covered by the policy. Insurers must offer to each policyholder, at the time of purchase, the option to purchase a policy with an inflation protection feature no less favorable than one (1) of the following: (4-5-00)

a. Increases benefit levels annually in a manner so that the increases are compounded annually at a rate not less than five percent (5%); (4-5-00)

b. Guarantees the insured individual the right to periodically increase benefit levels without providing evidence of insurability or health status as long as the option for the previous period has not been declined. The amount of the additional benefit shall be no less than the difference between the existing policy benefit and that benefit compounded annually at a rate of at least five percent (5%) for the period beginning with the purchase of the existing benefit and extending until the year in which the offer is made; or (4-5-00)

c. Covers a specified percentage of actual or reasonable charges and does not include a maximum specified indemnity amount or limit. (4-5-00)

d. With respect to inflation protection for a Partnership policy only: (11-1-06)T

i. If the policy is sold to an individual who has not attained age sixty-one (61) as of the date of purchase, the policy must provide compound annual inflation protection; (11-1-06)T

ii. If the policy is sold to an individual who has attained age sixty-one (61) but has not attained age 76 as of the date of purchase, the policy must provide some level of inflation protection; and (11-1-06)T

iii. If the policy is sold to an individual who has attained age seventy-six (76) as of the date of purchase, the policy may (but is not required to) provide some level of inflation protection. (11-1-06)T

02. Group Offer. Where the policy is issued to a group, the required offer in Subsection 0127.01 shall be made to the group policyholder; except, if the policy is issued to a group defined in Section 41-4603(4)(d), Idaho Code, other than to a continuing care retirement community, the offering shall be made to each proposed certificate holder. ~~(4-5-00)~~(11-1-06)T

03. Requirements for Life Insurance Policies. The offer in Subsection 0127.01 above shall not be required of life insurance policies or riders containing accelerated long-term care benefits. ~~(4-5-00)~~(11-1-06)T

04. Outline of Coverage. Insurers shall include the following information in or with the outline of coverage: (4-5-00)

a. A graphic comparison of the benefit levels of a policy that increases benefits over the policy period with a policy that does not increase benefits. The graphic comparison shall show benefit levels over at least a twenty

(20) year period. (4-5-00)

b. Any expected premium increases or additional premiums to pay for automatic or optional benefit increases. (4-5-00)

c. An insurer may use a reasonable hypothetical, or a graphic demonstration, for the purposes of this disclosure. (4-5-00)

05. Continuation of Inflation Protection. Inflation protection benefit increases under a policy which contains these benefits shall continue without regard to an insured's age, claim status or claim history, or the length of time the person has been insured under the policy. (4-5-00)

06. Premium Disclosures. An offer of inflation protection that provides for automatic benefit increases shall include an offer of a premium which the insurer expects to remain constant. The offer shall disclose in a conspicuous manner that the premium may change in the future unless the premium is guaranteed to remain constant. (4-5-00)

07. Rejection of Offer. Inflation protection as provided in Subsection 0127.01 shall be included in a long-term care insurance policy unless an insurer obtains a rejection of inflation protection signed by the policyholder as required in Subsection 0127.07. The rejection may be either in the application or on a separate form. The rejection shall be considered a part of the application and shall state: I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of this policy with and without inflation protection. Specifically, I have reviewed Plans _____, and I reject inflation protection (signature line: _____). ~~(4-5-00)~~(11-1-06)T

0138. REQUIREMENTS FOR APPLICATION FORMS AND REPLACEMENT COVERAGE.

01. Application Forms. Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant has another long-term care insurance policy or certificate in force or whether a long-term care policy or certificate is intended to replace any other accident and sickness or long-term care policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and ~~agent producer~~, except where the coverage is sold without an ~~agent producer~~, containing the questions may be used. With regard to a replacement policy issued to a group defined by Section 41-4603(a), Idaho Code, the following questions may be modified only to the extent necessary to elicit information about health or long-term care insurance policies other than the group policy being replaced, provided that the certificate holder has been notified of the replacement. ~~(4-5-00)~~(11-1-06)T

a. Do you have another long-term care insurance policy or certificate in force (including insurance, Fraternal Benefit Societies, Managed Care Organization) or other similar organizations? (4-5-00)

b. Did you have another long-term care insurance policy or certificate in force during the last twelve (12) months? (4-5-00)

i. If so, with which company? (4-5-00)

ii. If that policy lapsed, when did it lapse? (4-5-00)

c. Are you covered by Medicaid? (4-5-00)

d. Do you intend to replace any of your medical or health insurance coverage with this policy (certificate)? (4-5-00)

02. Other Policy Disclosures. ~~Agents~~ Producers shall list any other health insurance policies they have sold to the applicant. ~~(4-5-00)~~(11-1-06)T

a. List policies sold that are still in force. (4-5-00)

b. List policies sold in the past five (5) years that are no longer in force. (4-5-00)

03. Solicitations Other Than Direct Response. Upon determining that a sale will involve replacement, an insurer, other than an insurer using direct response solicitation methods, or its agent producer shall furnish the applicant, prior to issuance or delivery of the individual long-term care insurance policy, a notice regarding replacement of accident and sickness or long-term care coverage. One (1) copy of the notice shall be retained by the applicant and an additional copy signed by the applicant shall be retained by the insurer. The required notice shall be in a form based on the NAIC Model Regulation, ~~which form can be obtained from the Idaho Department of Insurance Home page, www.doi.state.id.us, select SHIBA (Senior Health Insurance Benefits Advisors) under Consumer Assistance link, see attachments to the NAIC Model Regulation implementing the Long-Term Care Insurance Minimum Standards. To obtain a copy of the required illustrations based on the NAIC Model Regulation, contact SHIBA at the Idaho Department of Insurance (208) 334-4250. Attachment I, NOTICE TO APPLICANT REGARDING REPLACEMENT OF INDIVIDUAL ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE, is published on the Department of Insurance Homepage <http://www.doi.idaho.gov> select consumer or company services link and go to Attachments to Idaho Rule, IDAPA 18.01.60 “Long-Term Care Minimum Standards.”~~ (4-5-00)(11-1-06)T

04. Direct Response Solicitations. Insurers using direct response solicitation methods shall deliver a notice regarding replacement of accident and sickness or long-term care coverage to the applicant upon issuance of the policy. The required notice shall be in a form based on the NAIC Model Regulation, ~~which form can be obtained from the Idaho Department of Insurance Home page, www.doi.state.id.us, select SHIBA (Senior Health Insurance Benefits Advisors) under Consumer Assistance link, see attachments to the NAIC Model Regulation implementing the Long-Term Care Insurance Minimum Standards. To obtain a copy of the required illustrations based on the NAIC Model Regulation, contact SHIBA at the Idaho Department of Insurance (208) 334-4250. Attachment II, NOTICE TO APPLICANT REGARDING REPLACEMENT OF INDIVIDUAL ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE, is published on the Department of Insurance Homepage <http://www.doi.idaho.gov> select consumer or company services link and go to Attachments to Idaho Rule, IDAPA 18.01.60 “Long-Term Care Minimum Standards.”~~ (4-5-00)(11-1-06)T

05. Notice of Replacement. Where replacement is intended, the replacing insurer shall notify, in writing, the existing insurer of the proposed replacement. The existing policy shall be identified by the insurer, name of the insured and policy number or address including zip code. Notice shall be made within five (5) working days from the date the application is received by the insurer or the date the policy is issued, whichever is sooner. (4-5-00)

06. Life Insurance Policy Replacement. Life insurance policies that accelerate benefits for long-term care shall ~~be deemed to require compliance~~ comply with Section 01~~38~~ if the policy being replaced is a long-term care insurance policy. If the policy being replaced is a life insurance policy, the insurer shall comply with the replacement requirements of IDAPA 18.01.41, “Replacement of Life Insurance and Annuities.” If a life insurance policy that accelerates benefits for long-term care is replaced by another such policy, the replacing insurer shall comply with both the long-term care and the life insurance replacement requirements. (4-5-00)(11-1-06)T

01~~42~~. REPORTING REQUIREMENTS.

01. Maintenance of Agent Producer Records. Every insurer shall maintain records for each agent producer of that agent’s producer’s amount of replacement sales as a percent of the agent’s producer’s total annual sales and the amount of lapses of long-term care insurance policies sold by the agent producer as a percent of the agent’s producer’s total annual sales. Appendix G, which is published on the Department of Insurance Homepage <http://www.doi.idaho.gov> select consumer or company services link and go to Attachments to Idaho Rule, IDAPA 18.01.60 “Long-Term Care Minimum Standards.” (4-5-00)(11-1-06)T

02. Agents Producers Experiencing Lapses and Replacements. Every insurer shall report annually by June 30 the ten percent (10%) of its agents producer’s with the greatest percentages of lapses and replacements as measured by Subsection 01~~42~~.01. (4-5-00)(11-1-06)T

03. Purpose of Reports. Reported replacement and lapse rates do not alone constitute a violation of insurance laws or necessarily imply wrongdoing. The reports are for the purpose of reviewing more closely agent producer activities regarding the sale of long-term care insurance. (4-5-00)(11-1-06)T

04. Lapsed Policies. Every insurer shall report annually by June 30 the number of lapsed policies as a percent of its total annual sales and as a percent of its total number of policies in force as of the end of the preceding calendar year. (4-5-00)

05. Replacement Policies. Every insurer shall report annually by June 30 the number of replacement policies sold as a percent of its total annual sales and as a percent of its total number of policies in force as of the preceding calendar year. (4-5-00)

06. Claims Denied. Every insurer shall report annually by June 30, for qualified long-term care insurance contracts, the number of claims denied for each class of business, expressed as a percentage of claims denied, other than claims denied for failure to meet the waiting period or because of an applicable preexisting condition. See Appendix E, which is published on the Department of Insurance Homepage <http://www.doi.idaho.gov> select consumer or company services link and go to Attachments to Idaho Rule, IDAPA 18.01.60 "Long-Term Care Minimum Standards." (~~4-5-00~~)(11-1-06)T

07. Policies and Reports. For purposes of Section 01~~49~~, "policy" shall mean only long-term care insurance and "report" means on a statewide basis. (~~4-5-00~~)(11-1-06)T

a. Policy means only long-term care insurance; (4-5-00)

b. Claim means any request for payment of benefits under a policy regardless of whether the benefit claimed is covered under the policy or any terms or conditions of the policy have been met; (4-5-00)

c. Denied means the insurer refused to pay a claim for any reason; and (4-5-00)

d. Report means on a statewide basis. (4-5-00)

08. Filing. Reports required under Section 01~~49~~ shall be filed with the Director. (~~4-5-00~~)(11-1-06)T

~~01520.~~ LICENSING.

No ~~agent or broker~~ producer is authorized to sell, solicit, or negotiate with respect to long-term care insurance except as authorized by Title 41, Chapter 10, ~~Licensing Requirements And Procedures~~ Producer Licensing. (~~3-30-01~~)(11-1-06)T

~~01621.~~ DISCRETIONARY POWERS OF DIRECTOR.

The director may upon written request and after an administrative hearing, issue an order to modify or suspend a specific provision or provisions of this rule with respect to a specific long-term care insurance policy or certificate upon a written finding that: (4-5-00)

01. General Requirement. The modification or suspension would be in the best interest of the insureds; the purposes to be achieved could not be effectively or efficiently achieved without the modification or suspension; and the modification or suspension is necessary to the development of an innovative and reasonable approach for insuring long-term care; or (4-5-00)

02. Residential Care Community. The policy or certificate is to be issued to residents of a life care or continuing care retirement community or some other residential community for the elderly and the modification or suspension is reasonably related to the special needs or nature of such a community; or (4-5-00)

03. Other Insurance Products. The modification or suspension is necessary to permit long-term care insurance to be sold as part of, or in conjunction with, another insurance product. (4-5-00)

~~01722.~~ RESERVE STANDARDS.

01. Acceleration of Benefits Under Life Policies. When long-term care benefits are provided through the acceleration of benefits under group or individual life policies or riders to such policies, policy reserves for the benefits shall be determined in accordance with Section 41-612, Idaho Code, Standard Valuation Law – Life

Insurance. Claim reserves shall also be established in the case when the policy or rider is in claim status. (4-5-00)

02. Decrement Models. Reserves for policies and riders subject to ~~Subsection 017-01~~ 022 should be based on the multiple decrement model utilizing all relevant decrements except for voluntary termination rates. Single decrement approximations are acceptable if the calculation produces essentially similar reserves, if the reserve is clearly more conservative, or if the reserve is immaterial. The calculations may take into account the reduction in life insurance benefits due to the payment of long-term care benefits. However, in no event shall the reserves for the long-term care benefit and the life insurance benefit be less than the reserves for the life insurance benefit assuming no long-term care benefit. ~~(4-5-00)~~(11-1-06)T

03. Considerations Impacting Projected Claim Costs. Any applicable valuation morbidity table shall be certified as appropriate as a statutory valuation table by a member of the American Academy of Actuaries. In the development and calculation of reserves for policies and riders subject to ~~Subsection 017-01~~ 022, due regard shall be given to the applicable policy provisions, marketing methods, administrative procedures and all other considerations which have an impact on projected claim costs, including, but not limited to, the following: ~~(4-5-00)~~(11-1-06)T

- a. Definition of insured events; (4-5-00)
- b. Covered long-term care facilities; (4-5-00)
- c. Existence of home convalescence care coverage; (4-5-00)
- d. Definition of facilities; (4-5-00)
- e. Existence or absence of barriers to eligibility; (4-5-00)
- f. Premium waiver provision; (4-5-00)
- g. Renewability; (4-5-00)
- h. Ability to raise premiums; (4-5-00)
- i. Marketing method; (4-5-00)
- j. Underwriting procedures; (4-5-00)
- k. Claims adjustment procedures; (4-5-00)
- l. Waiting period; (4-5-00)
- m. Maximum benefit; (4-5-00)
- n. Availability of eligible facilities; (4-5-00)
- o. Margins in claim costs; (4-5-00)
- p. Optional nature of benefit; (4-5-00)
- q. Delay in eligibility for benefit; (4-5-00)
- r. Inflation protection provisions; and (4-5-00)
- s. Guaranteed insurability option. (4-5-00)

04. Benefits Not Covered in ~~Subsection 017-01~~ 022. When long-term care benefits are provided other than as in Subsection ~~017-01~~ 022.01 above, reserves shall be determined in accordance with Section 41-608, Idaho Code,

“Reserve for Disability Insurance.”

~~(4-5-00)~~(11-1-06)T

01823. LOSS RATIO.

Section 01823 shall apply to all (group and individual) long-term care insurance policies or certificates except those covered under Sections 01924 and 0205 of this ~~rule~~ chapter. ~~(3-30-01)~~(11-1-06)T

01. Expected Loss Ratios. Benefits under long-term care insurance policies shall be deemed reasonable in relation to premiums provided the expected loss ratio is at least sixty percent (60%), calculated in a manner which provides for adequate reserving of the long-term care insurance risk. In evaluating the expected loss ratio, due consideration shall be given to all relevant factors, including: (4-5-00)

- a. Statistical credibility of incurred claims experience and earned premiums; (4-5-00)
- b. The period for which rates are computed to provide coverage; (4-5-00)
- c. Experienced and projected trends; (4-5-00)
- d. Concentration of experience within early policy duration; (4-5-00)
- e. Expected claim fluctuation; (4-5-00)
- f. Experience refunds, adjustments or dividends; (4-5-00)
- g. Renewability features; (4-5-00)
- h. All appropriate expense factors; (4-5-00)
- i. Interest; (4-5-00)
- j. Experimental nature of the coverage; (4-5-00)
- k. Policy reserves; (4-5-00)
- l. Mix of business by risk classification; and (4-5-00)
- m. Product features such as long elimination periods, high deductibles and high maximum limits. (4-5-00)

02. Policies That Accelerate Benefits. Subsection 01823.01 shall not apply to life insurance policies that accelerate benefits for long-term care. A life insurance policy that funds long-term care benefits entirely by accelerating the death benefit is considered to provide reasonable benefits in relation to premiums paid, if the policy complies with all of the following provisions: ~~(4-5-00)~~(11-1-06)T

a. The interest credited internally to determine cash value accumulations, including long-term care, if any, are guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy; (4-5-00)

b. The portion of the policy that provides life insurance benefits meets the nonforfeiture requirements of Section 41-1927, Idaho Code, Standard Nonforfeiture Law – Life Insurance. (4-5-00)

c. The policy meets the disclosure requirements of Sections 41-4605(9), 41-4605(10), and 41-4605(11), Idaho Code. (4-5-00)

i. Any policy illustration that meets the applicable requirements of the NAIC Life Insurance Illustrations Model Regulation. (11-1-06)T

d. An actuarial memorandum is filed with the insurance department that includes: (4-5-00)

- i. A description of the basis on which the long-term care rates were determined; (4-5-00)
- ii. A description of the basis for the reserves; (4-5-00)
- iii. A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance; (4-5-00)
- iv. A description and a table of each actuarial assumption used. For expenses, an insurer must include percent of premium dollars per policy and dollars per unit of benefits, if any; (4-5-00)
- v. A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives; (4-5-00)
- vi. The estimated average annual premium per policy and the average issue age; (4-5-00)
- vii. A statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used and, if used, the statement shall include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and (4-5-00)
- viii. A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values and reserves on the underlying life insurance policy, both for active lives and those in long-term care claim status. (4-5-00)

04924. FILING REQUIREMENT.

Prior to an insurer or similar organization offering group long-term care insurance to a resident of this state pursuant to Section 41-4604, Idaho Code, Extraterritorial Jurisdiction – Group Long-Term Care Insurance, it shall file with the director evidence that the group policy or certificate thereunder has been approved by a state having statutory or regulatory long-term care insurance requirements substantially similar to those adopted in this state. (4-5-00)

- 01. Initial Filing Requirements.** (3-30-01)
- a. Subsection 04924.01 applies to any long-term care policy issued in this state on or after July 1, 2001. ~~(3-30-01)~~(11-1-06)T
- b. An insurer will provide the information listed in Subsection 04924.01 to the director thirty (30) days prior to making the long-term care insurance form available for sale. ~~(3-30-01)~~(11-1-06)T
- c. A copy of the disclosure documents required in Section 00914. ~~(3-30-01)~~(11-1-06)T
- d. An actuarial certification consisting of at least the following: (3-30-01)
 - i. A statement that the initial premium rate schedule is sufficient to cover anticipated costs under moderately adverse experience and that the premium rate schedule is reasonably expected to be sustainable over the life of the form with no future premium increases anticipated; (3-30-01)
 - ii. A statement that the policy design and coverage provided have been reviewed and taken into consideration; (3-30-01)
 - iii. A statement that the underwriting and claims adjudication processes have been reviewed and taken into consideration. (3-30-01)
- e. A complete description of the basis for contract reserves that are anticipated to be held under the form, to include: (3-30-01)

- i. Sufficient detail or sample calculations provided so as to have a complete depiction of the reserve amounts to be held; (3-30-01)
- ii. A statement that the assumptions used for reserves contain reasonable margins for adverse experience; (3-30-01)
- iii. A statement that the net valuation premium for renewal years does not increase (except for attained-age rating where permitted; and (3-30-01)
- iv. A statement that the difference between the gross premium and the net valuation premium for renewal years is sufficient to cover expected renewal expenses; or if such a statement cannot be made, a complete description of the situations where this does not occur; (3-30-01)
- v. An aggregate distribution of anticipated issues may be used as long as the underlying gross premiums maintain a reasonably consistent relationship; (3-30-01)
- vi. If the gross premiums for certain age groups appear to be inconsistent with this requirement, the director may request a demonstration under Subsection ~~07924.02~~ based on a standard age distribution; and ~~(3-30-01)~~(11-1-06)T
- vii. A statement that the premium rate schedule is not less than the premium rate schedule for existing similar policy forms also available from the insurer except for reasonable differences attributable to benefits; or, (3-30-01)
- viii. A comparison of the premium schedules for similar policy forms that are currently available from the insurer with an explanation of the differences. (3-30-01)

02. Actuarial Demonstration. The director may request an actuarial demonstration that benefits are reasonable in relation to premiums. The actuarial demonstration shall include either premium and claim experience on similar policy forms, adjusted for any premium or benefit differences, relevant and credible data from other studies, or both. (3-30-01)

a. In the event the director requests additional information under this provision, the period referred to in Subsection ~~07924.01.b.~~ of this section does not include the period of time during which the insurer is preparing the requested information. ~~(3-30-01)~~(11-1-06)T

~~0205.~~ PREMIUM RATE SCHEDULE INCREASES.

01. Premium Rate Increases. This Section ~~0205~~ shall apply as follows: ~~(3-30-01)~~(11-1-06)T

a. Except as provided in Subsection ~~0205.01.b.~~, this section applies to any long-term care policy or certificate issued in this state on or after July 1, 2001. ~~(3-30-01)~~(11-1-06)T

b. For certificates issued on or after the effective date of this amended rule under a group long-term care insurance policy as defined in Section 41-4603 (4)(a), Idaho Code, which policy was in force at the time this amended rule became effective, the provisions of this section shall apply on the policy anniversary following January 1, 2002. (3-30-01)

c. An insurer shall provide notice of a pending premium rate schedule increase, including an exceptional increase, to the director at least thirty (30) days prior to the notice to the policyholders and shall include: (3-30-01)

i. Information required by Section ~~00914.~~ ~~(3-30-01)~~(11-1-06)T

d. Certification by a qualified actuary that: (3-30-01)

i. If the requested premium rate schedule increase is implemented and the underlying assumptions,

which reflect moderately adverse conditions, are realized, no further premium rate schedule increases are anticipated; and (3-30-01)

- ii. The premium rate filing is in compliance with the provisions of this Section 0205. ~~(3-30-01)~~(11-1-06)T

02. Actuarial Memorandum. An actuarial memorandum justifying the rate schedule change request that includes: (3-30-01)

a. Lifetime projections of earned premiums and incurred claims based on the filed premium rate schedule increase; and the method of assumptions used in determining the projected values, including reflection of any assumptions that deviate from those used for pricing other forms currently available for sale: (3-30-01)

i. Annual values for the past five (5) years preceding and the three (3) years following the valuation date shall be provided separately; (3-30-01)

ii. The projections shall include the development of the lifetime loss ratio, unless the rate of increase is an exceptional increase; (3-30-01)

iii. The projections shall demonstrate compliance with Subsection 0205.03, and ~~(3-30-01)~~(11-1-06)T

iv. For exceptional increases; (3-30-01)

(1) The projected experience should be limited to the increases in claims expenses attributable to the approved reasons for the exceptional increase; and (3-30-01)

(2) In the event the director determines as provided in Subsection ~~004.09.b.~~ 010.09.c. that offsets may exist, the insurer shall use appropriate net projected experience. ~~(3-30-01)~~(11-1-06)T

b. Disclosure of how reserves have been incorporated in this rate increase will trigger contingent benefit upon lapse. (3-30-01)

c. Disclosure of the analysis performed to determine why a rate adjustment is necessary, which pricing assumptions were not realized and why, and what other actions taken by the company have been relied on by the actuary. (3-30-01)

d. A statement that policy design, underwriting and claims adjudication practices have been taken into consideration; and in the event that it is necessary to maintain consistent premium rates for new certificates and certificates receiving a rate increase, the insurer will need to file composite rates reflecting projections of new certificates. (3-30-01)

e. A statement that renewal premium rate schedules are not greater than new business premium rate schedules except for differences attributable to benefits, unless sufficient justification is provided to the director; and sufficient information for review of the premium rate schedule increase by the director. (3-30-01)

03. Premium Rate Schedule Increases. All premium rate schedule increases shall be determined in accordance with the following requirements: (3-30-01)

a. Exceptional increases shall provide that seventy percent (70%) of the present value of projected additional premiums from the exceptional increase will be returned to policyholders in benefits. (3-30-01)

b. Premium rate schedule increases shall be calculated such that the sum of the accumulated value of incurred claims, without the inclusion of active life reserves, and the present value of future projected incurred claims, without the inclusion of active life reserves, will not be less than the sum of the following: (3-30-01)

i. The accumulated value of the initial earned premium times fifty eight percent (58%); (3-30-01)

- ii. Eighty-five percent (85%) of the accumulated value of prior premium rate schedule increases on an earned basis; (3-30-01)
- iii. The present value of future projected initial earned premiums times fifty-eight percent (58%); and (3-30-01)
- iv. Eighty-five percent (85%) of the present value of future projected premiums not in Subsection 0205.03.b.iii. on an earned basis. ~~(3-30-01)~~(11-1-06)T
- c. In the event that a policy form has both exceptional and other increases, the values in Subsections 0205.03.b.ii. and 0205.03.b.iv., will also include seventy percent (70%) for exceptional rate increase amounts. ~~(3-30-01)~~(11-1-06)T
- d. All present and accumulated values used to determine rate increases shall use the maximum valuation interest rate for contract reserves as specified in IDAPA 18.01.68, "Minimum Reserve Standards For Individual And Group Health Insurance Contracts," Appendix A, IIA. The actuary shall disclose as part of the actuarial memorandum the use of any appropriate averages. (3-30-01)

04. Projections Filed for Review. For each rate increase that is implemented, the insurer shall file for review by the director updated projections, as defined in Subsection 0205.02.a., annually for the following three (3) years and include a comparison of actual results to projected values. The director may extend the period to greater than three (3) years if actual results are not consistent with projected values from prior projections. For group insurance policies that meet the conditions in Subsection ~~0205.04~~ 025.13, the projections required by this Subsection 0205.04 shall be provided to the policyholder in lieu of filing with the director. ~~(3-30-01)~~(11-1-06)T

05. Revised Premium Rate. If any premium rate in the revised premium rate schedule is greater than 200 percent (200%) of the comparable rate in the initial premium schedule, lifetime projections, as defined in Subsection 0205.02.a., shall be filed for review by the director every five (5) years following the end of the required period in Subsection 0205.04. For group insurance policies that meet the conditions in Subsection 0205.13, the projections required by Subsection 0205.05 shall be provided to the policyholder in lieu of filing with the director. ~~(3-30-01)~~(11-1-06)T

06. Actual and Projected Experience. If the director has determined that the actual experience following a rate increase does not adequately match the projected experience and that the current projections under moderately adverse conditions demonstrate that incurred claims will not exceed proportions of the premium specified in Subsection 0205.03, the director may require the insurer to implement any of the following: ~~(3-30-01)~~(11-1-06)T

- a. Premium rate schedule adjustments; or (3-30-01)
 - i. Other measures to reduce the difference between the projected and actual experience. (3-30-01)
- b. In determining whether the actual experience adequately matches the projected experience, consideration should be given to Subsection 0205.02.d. and 025.02.e., if applicable. ~~(3-30-01)~~(11-1-06)T

07. Contingent Benefit upon Lapse. If the majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse, the insurer shall file: (3-30-01)

- a. A plan, subject to director approval, for improved administration or claims processing designed to eliminate the potential for further deterioration of the policy form requiring further premium rate schedule increases, or both, or to demonstrate that appropriate administration and claims processing have been implemented or are in effect. If the director should determine that such appropriate administration and claims processing functions have not been addressed, provisions of Subsection 025.08 may be applied; and ~~(3-30-01)~~(11-1-06)T
- b. The original anticipated lifetime loss ratio, and the premium rate schedule increase that would have been calculated according to Subsection 0205.03 had the greater of the original anticipated lifetime loss ratio or fifty-eight percent (58%) been used in the calculations described in Subsections 0205.03.b.i. and 0205.03.b.iii. ~~(3-30-01)~~(11-1-06)T

08. Additional Rate Increase Filings. For a rate increase filing that meets the following criteria, the director shall review, for all policies included in the filing, the projected lapse rates and past lapse rates during the twelve (12) months following each increase to determine if significant adverse lapse has occurred or is anticipated: (3-30-01)

- a. The rate increase is not the first rate increase requested for the specific policy form or forms; (3-30-01)
- b. The rate increase is not an exceptional increase; and (3-30-01)
- c. The majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse. (3-30-01)

d. In the event significant adverse lapse has occurred, is anticipated in the filing or is evidenced in the actual results as presented in the updated projections provided by the insurer following the requested rate increase, the director may determine that a rate spiral exists. Following the determination that a rate spiral exists, the director may require the insurer to offer, without underwriting, to all in force insureds subject to the rate increase option to replace existing coverage with one or more reasonably comparable products being offered by the insurer or its affiliates. The offer shall; (3-30-01)

- i. Be subject to the approval of the director; (3-30-01)
- ii. Be based on actuarially sound principles, but not be based on attained age; and (3-30-01)
- iii. Provide that the maximum benefits under any new policy accepted by an insured shall be reduced by comparable benefits already paid under the existing policy. (3-30-01)

e. The insurer shall maintain the experience of all the replacement insureds separate from the experience of insureds originally issued the policy forms. In the event of a request for a rate increase on the policy form, the rate increase shall be limited to the lesser of: (3-30-01)

- i. The maximum rate increase determined based on the combined experience; and (3-30-01)
- ii. The maximum rate increase determined based only on the experience of the insureds originally issued the form plus ten percent (10%). (3-30-01)

09. Persistent Practice of Inadequate Rate Filings. If the director determines that the insurer has exhibited a persistent practice of filing inadequate initial premium rates for long-term care insurance, the director may, in addition to the provisions of Subsection 0205.08 of this section, prohibit the insurer from either of the following: ~~(3-30-01)~~(11-1-06)T

- a. Filing and marketing comparable coverage for a period of up to five (5) years; or (3-30-01)
- b. Offering all other similar coverages and limiting marketing of new applications to the products subject to recent premium rate schedule increases. (3-30-01)

10. Exceptions. Subsections 0205.01 and 0205.09 shall not apply to policies for which the long-term care benefits provided by the policy are incidental, as defined in Subsection 00410.12, if the policy complies with all of the following provisions: ~~(3-30-01)~~(11-1-06)T

a. The interest credited internally to determine cash value accumulations, including long-term care, if any, are guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy; (3-30-01)

b. The portion of the policy that provides insurance benefits other than long-term care coverage meets the nonforfeiture requirements as applicable in any of the following: (3-30-01)

- i. Section 41-1927, Idaho Code, Standard Nonforfeiture Law-Life Insurance; (3-30-01)
- ii. Section 41-1927A, Idaho Code, Standard Nonforfeiture Law for Individual Deferred Annuities; (3-30-01)
- iii. IDAPA 18.01.16, Subsection 018.02, "Variable Contracts." (3-30-01)

11. Exceptions for Disclosure and Performance Standards. The policy meets the disclosure requirements of Sections 41-4605(9), 41-4605(10) and 41-4605(11), Idaho Code, pertaining to the Disclosure and Performance Standards for Long-term Care Coverage. (3-30-01)

12. Exception If Actuarial Memorandum Filed Which Includes Defined Information. An actuarial memorandum is filed with the Department of Insurance that includes: (3-30-01)

- a. A description of the basis on which the long-term care rates were determined; (3-30-01)
- b. A description of the basis for the reserves; (3-30-01)
- c. A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance; (3-30-01)
- d. A description and a table of each actuarial assumption used. For expenses, an insurer must include percent of premium dollars per policy and dollars per unit of benefits, if any; (3-30-01)
- e. A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives; (3-30-01)
- f. The estimated average annual premium per policy and the average issue age; (3-30-01)
- g. A statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used and, if used, the statement shall include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and (3-30-01)
- h. A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values and reserves on the underlying insurance policy, both for active lives and those in long-term care claims status. (3-30-01)

13. Exceptions for Association Plans, Premium Rate Schedule Increases Subsections 0205.06 and 0205.08 shall not apply to group insurance policies as defined in Section 41-4603(4)(a), Idaho Code, where:

~~(3-30-01)~~(11-1-06)T

- a. The policies insure two hundred fifty (250) or more persons and the policyholder has five thousand (5,000) or more eligible employees of a single employer; or (3-30-01)
- b. The policyholder, and not the certificateholders, pay a material portion of the premium, which shall not be less than twenty percent (20%) of the total premium for the group in the calendar year prior to the year a rate increase is filed. (3-30-01)

0246. FILING REQUIREMENTS FOR ADVERTISING.

01. Filing and Retention. Every Insurer, Fraternal Benefit Society, Managed Care Organization, or other similar organization providing long-term care insurance or benefits in this state shall provide a copy of any long-term care insurance advertisement intended for use in this state whether through written, radio, or television medium to the Director of Insurance of this state for review and approval by the Director. In addition, all

advertisements shall be retained by the insurer or other entity for at least five (5) years from the date the advertisement was first used; or until the filing of the next regular report of examination of the insurer, whichever is the longer period of time. (4-5-00)

02. Exemptions. The director may exempt from these requirements any advertising form or material when, in the director's opinion, this requirement may not be reasonably applied. (4-5-00)

0227. STANDARDS FOR MARKETING AND PRODUCER TRAINING.

01. General Provisions. Every Insurer, Fraternal Benefit Society, Managed Care Organization or other similar organization marketing long-term care insurance coverage in this state, directly or through its ~~agents~~ producers, shall: (4-5-00)(11-1-06)T

a. Establish marketing procedures and ~~agent~~ producer training requirements to assure that any marketing activities, including any comparison of policies by its ~~agents~~ producers will be fair and accurate. (3-30-01)(11-1-06)T

b. Establish marketing procedures to assure excessive insurance is not sold or issued. (4-5-00)

c. Display prominently by type, stamp or other appropriate means, on the first page of the outline of coverage and policy the following: "Notice to buyer: This policy may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations." (4-5-00)

d. Provide copies of the disclosure forms required in Subsection 009.10. (3-30-01)

e. Provide an explanation of contingent benefit upon lapse as provided for in Subsection 02532.04.b. and if applicable, the additional contingent benefit upon lapse provided to policies with fixed or limited premium paying period in Subsection 032.04.c. (3-30-01)(11-1-06)T

f. Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for long-term care insurance already has accident and sickness or long-term care insurance and the types and amounts of any such insurance, except that in the case of qualified long-term care insurance contracts, an inquiry into whether a prospective applicant or enrollee for long-term care insurance has accident and sickness insurance is not required. (4-5-00)

g. Establish auditable procedures for verifying compliance with Subsection 0227.01. (3-30-01)(11-1-06)T

h. At solicitation, provide written notice to the prospective policyholder and certificate holder that Senior Health Insurance Benefits Advisors/SHIBA the program is available and the name, address and telephone number of the program. (3-30-01)

i. For long-term care insurance policies and certificates, use the terms "noncancellable" or "level premium" only when the policy or certificate conforms to Subsection 00511.01.c. of this ~~rule~~ chapter. (4-5-00)(11-1-06)T

02. Prohibited Practices. In addition to the practices prohibited in Chapter 13, Title 41, Idaho Code, Trade Practices and Frauds, the following acts and practices are prohibited: (3-30-01)

a. Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on or convert any insurance policy, or to take out a policy of insurance with another insurer. (4-5-00)

b. High Pressure Tactics. Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to

purchase or recommend the purchase of insurance. (4-5-00)

c. Cold Lead Advertising. Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance ~~agent~~ producer or insurance company. ~~(4-5-00)~~(11-1-06)T

d. Misrepresentation. Misrepresenting a material fact in selling or offering to sell a long-term care insurance policy. (4-5-00)

03. Associations. With respect to the obligations set forth in Subsection 0227.03, the primary responsibility of an association, as defined in Section 41-4603(4)(b), Idaho Code, when endorsing or selling long-term care insurance shall be to educate its members concerning long-term care issues in general so that its members can make informed decisions. Associations shall provide objective information regarding long-term care insurance policies or certificates endorsed or sold by such associations to ensure that members of such associations receive a balanced and complete explanation of the features in the policies or certificates that are being endorsed or sold. ~~Subsection 022.03 shall not apply to qualified long-term care insurance contracts.~~ ~~(3-30-01)~~(11-1-06)T

a. The insurer shall file with the insurance department the following material: (4-5-00)

i. The policy and certificate; (4-5-00)

ii. A corresponding outline of coverage; and (4-5-00)

iii. All advertisements to be utilized. (4-5-00)

b. The association shall disclose in any long-term care insurance solicitation: (4-5-00)

i. The specific nature and amount of the compensation arrangements (including all fees, commissions, administrative fees and other forms of financial support) that the association receives from endorsement or sale of the policy or certificate to its members; and (4-5-00)

ii. A brief description of the process under which the policies and the insurer issuing the policies were selected. (4-5-00)

c. If the association and the insurer have interlocking directorates or trustee arrangements, the association shall disclose that fact to its members. (4-5-00)

d. The board of directors of associations selling or endorsing long-term care insurance policies or certificates shall review and approve the insurance policies as well as the compensation arrangements made with the insurer. (4-5-00)

e. The association shall also: (4-5-00)

i. At the time of the association's decision to endorse, engage the services of a person with expertise in long-term care insurance not affiliated with the insurer to conduct an examination of the policies, including its benefits, features, and rates, and update the examination thereafter in the event of material change; (4-5-00)

ii. Actively monitor the marketing efforts of the insurer and its ~~agents~~ producers; and ~~(4-5-00)~~(11-1-06)T

iii. Review and approve all marketing materials or other insurance communications used to promote sales or sent to members regarding the policies or certificates. (4-5-00)

iv. Subsections 0227.03.e.i. ~~and~~ through 0227.03.e.iii. shall not apply to qualified long-term care insurance contracts. ~~(3-30-01)~~(11-1-06)T

f. No group long-term care insurance policy or certificate may be issued to an association unless the

insurer files with the state insurance department the information required in Section 0227. ~~(3-30-07)~~(11-1-06)T

g. The insurer shall not issue a long-term care policy or certificate to an association or continue to market such a policy or certificate unless the insurer certifies annually that the association has complied with the requirements set forth in Section 0227. ~~(3-30-07)~~(11-1-06)T

h. Failure to comply with the filing and certification requirements of Section 0227 constitutes an unfair trade practice in violation of Chapter 13, Title 241, Idaho Code, Trade Practices and Frauds. ~~(3-30-07)~~(11-1-06)T

04. Producer Training Requirements. An individual may not sell, solicit or negotiate long-term care insurance unless the individual is licensed as an insurance producer for life and disability (accident and health insurance) and has completed a one-time training course by or before November 1, 2007, and ongoing training every twenty-four (24) months thereafter. The training shall meet the requirements set forth in this Subsection 027.04. Such training requirements may be approved as continuing education course under IDAPA 18.01.53 "Continuing Education." (11-1-06)T

a. The one-time training required by this section shall be no less than eight (8) hours and the ongoing training required by this Subsection 027.04 shall be no less than four (4) hours. (11-1-06)T

b. The training required under Subsection 027.04.a. shall consist of topics related to long-term care insurance, long-term care services and qualified state long-term care insurance partnership program, including, but not limited to: (11-1-06)T

i. State and federal regulations and requirements and the relationship between qualified state long-term care insurance partnership programs and other public and private coverage of long-term care services, including Medicaid; (11-1-06)T

ii. Available long-term care services and providers; (11-1-06)T

iii. Changes or improvements in long-term care services or providers; (11-1-06)T

iv. Alternatives to the purchase of private long-term care insurance; (11-1-06)T

v. The effect of inflation on benefits and the importance of inflation protection; and (11-1-06)T

vi. Consumer suitability standards and guidelines. (11-1-06)T

c. The training required by Subsection 027.04. shall not include any sales or marketing information, materials, or training, other than those required by state and federal law. (11-1-06)T

d. Insurers subject to this rule shall obtain verification that a producer receives training required by Subsection 027.04 before a producer is permitted to sell, solicit or negotiate the insurer's long-term care insurance products, maintain records subject to the state's record retention requirements, and make that verification available to the director upon request. An insurer shall maintain records with respect to the training of its producers concerning the distribution of its long-term care Partnership policies that will allow the Department of Insurance to provide assurance to the Division of Medicaid that the producers have received the training as required by Subsection 027.04 and that producers have demonstrated an understanding of the Partnership policies and their relationship to public and private coverage of long term care including Medicaid in this state. These records shall be maintained in accordance with the state's record retention requirements and shall be made available to the director upon request. (11-1-06)T

e. The satisfaction of these training requirements in any state shall be deemed to satisfy the training requirements of this state. (11-1-06)T

0238. SUITABILITY.

01. Life Insurance Policies That Accelerate Benefits. Section 0238 shall not apply to life insurance

policies that accelerate benefits for long-term care.

~~(3-30-01)~~(11-1-06)T

02. General Provisions. Every Insurer, Fraternal Benefit Society, Managed Care Organization or other similar organization marketing long-term care insurance (the “issuer”) shall: (4-5-00)

a. Develop and use suitability standards to determine whether the purchase or replacement of long-term care insurance is appropriate for the needs of the applicant; (4-5-00)

b. Train its ~~agents~~ producers in the use of its suitability standards; and ~~(4-5-00)~~(11-1-06)T

c. Maintain a copy of its suitability standards and make them available for inspection upon request by the director. (4-5-00)

03. Determination of Standards. To determine whether the applicant meets the standards developed by the issuer; (4-5-00)

a. The ~~agent~~ producer and issuer shall develop procedures that take the following into consideration: ~~(4-5-00)~~(11-1-06)T

i. The ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage; (4-5-00)

ii. The applicant’s goals or needs with respect to long-term care and the advantages and disadvantages of insurance to meet these goals or needs; and (4-5-00)

iii. The values, benefits, and costs of the applicant’s existing insurance, if any, when compared to the values, benefits and costs of the recommended purchase or replacement. (4-5-00)

b. The issuer and an ~~agent~~ producer, if involved, shall make reasonable efforts to obtain the information set out in Subsection 02~~38~~.03~~a~~. The efforts shall include presentation to the applicant, at or prior to application, the “Long-Term Care Insurance Personal Worksheet.” The personal worksheet used by the issuer shall contain, at a minimum, the information in the format contained in the NAIC Model Regulations in Appendix B, in not less than twelve (12) point type. The issuer may request the applicant to provide additional information to comply with its suitability standards. A copy of the issuer’s personal worksheet shall be filed with the director. ~~(3-30-01)~~(11-1-06)T

i. Copies of NAIC Model Regulations for Long-Term Care Insurance Minimum Standards Appendixes B, C, and D can be found at the Idaho Department of Insurance Homepage, ~~www.doi.state.id.us~~, *select SHIBA (Senior Health Insurance Benefits Advisors) under Consumer Assistance link, see attachments to the NAIC Model Regulation implementing the Long-Term Care Insurance Minimum Standards. To obtain a copy of the required illustrations based on the NAIC Model Regulation, contact SHIBA at the Idaho Department of Insurance (208) 334-4250. <http://www.doi.idaho.gov> select consumer or company services link and go to Attachments to Idaho Rule, IDAPA 18.01.60 “Long-Term Care Minimum Standards.”* ~~(4-5-00)~~(11-1-06)T

c. A completed personal worksheet shall be returned to the issuer prior to the issuer’s consideration of the applicant for coverage, except the personal worksheet need not be returned for sales of employer group long-term care insurance to employees and their spouses. (4-5-00)

d. The sale or dissemination outside the company or agency by the issuer or ~~agent~~ producer of information obtained through the personal worksheet in the NAIC Model Regulations, Appendix B is prohibited. ~~(4-5-00)~~(11-1-06)T

04. Appropriateness. The issuer shall use the suitability standards it has developed pursuant to Section 02~~38~~ in determining whether issuing long-term care insurance coverage to an applicant is appropriate. ~~(3-30-01)~~(11-1-06)T

05. Use of Standards. ~~Agents~~ Producers shall use the suitability standards developed by the issuer in

marketing long-term care insurance.

~~(4-5-00)~~(11-1-06)T

06. Disclosure Form. At the same time as the personal worksheet is provided to the applicant, the disclosure form entitled "Things You Should Know Before You Buy Long-Term Care Insurance" shall be provided. The form shall be in the format contained in the NAIC Model Regulations, Appendix C, in not less than twelve (12) point type. (4-5-00)

07. Rejection and Alternatives. If the issuer determines that the applicant does not meet its financial suitability standards, or if the applicant has declined to provide the information, the issuer may reject the application. In the alternative, the issuer shall send the applicant a letter similar to the NAIC Model Regulations, Appendix D. However, if the applicant has declined to provide financial information, the issuer may use some other method to verify the applicant's intent. Either the applicant's returned letter or a record of the alternative method of verification shall be made part of the applicant's file. (4-5-00)

08. Reporting. The issuer shall report annually to the director the total number of applications received from residents of this state, the number of those who declined to provide information on the personal worksheet, the number of applicants who did not meet the suitability standards, and the number of those who chose to confirm after receiving a suitability letter. (4-5-00)

0249. PROHIBITION AGAINST PREEXISTING CONDITIONS AND PROBATIONARY PERIODS IN REPLACEMENT POLICIES OR CERTIFICATES.

If a long-term care insurance policy or certificate replaces another long-term care policy or certificate, the replacing insurer shall waive any time periods applicable to preexisting conditions and probationary periods in the new long-term care policy for similar benefits to the extent that similar exclusions have been satisfied under the original policy. (4-5-00)

030. AVAILABILITY OF NEW SERVICES OR PROVIDERS.

01. Notification to Policyholder. An insurer shall notify the policyholder of the availability of a new long-term care policy that provides coverage for new long-term care services or providers material in nature and not previously available through the insurer to the general public. The notice shall be provided within twelve (12) months of the date the new policy is made available for sale in this state. (11-1-06)T

02. Exceptions to Notification Requirements. Notwithstanding Subsection 030.01, notification is not required for any policy issued prior to the effective date of this Section 030. or to any policyholder who is currently eligible for benefits, within an elimination period or on claim, or who previously has been in claim status, or who would not be eligible to apply for coverage due to issue age limitations under the new policy. The insurer may require that policyholders meet all eligibility requirements, including underwriting and payment of the required premium to add such new services or providers. (11-1-06)T

03. New Coverage. The insurer shall make the new coverage available in one of the following ways: (11-1-06)T

a. By adding a rider to the existing policy and charging a separate premium for the new rider based on the insured's attained age; (11-1-06)T

b. By exchanging the existing policy or certificate for one with an issue age based on the present age of the insured and recognizing past insured status by granting premium credits toward the premiums for the new policy or certificate. The premium credits shall be based on premiums paid or reserves held for the prior policy or certificate. (11-1-06)T

c. By exchanging the existing policy or certificate for a new policy or certificate in which consideration for past insured status shall be recognized by setting the premium for the new policy or certificate at the issue age of the policy or certificate being exchanged. The cost of the new policy or certificate may recognize the difference in reserves between the new policy or certificate and the original policy or certificate; or (11-1-06)T

d. By an alternative program developed by the insurer that meets the intent of Section 030 if the

program is filed with and approved by the Director. (11-1-06)T

04. Proprietary Policy. An insurer is not required to notify policyholders of a new proprietary policy created and filed for use in a limited distribution channel. For purposes of this Subsection 030.04, "limited distribution channel" means through a discrete entity, such as a financial institution or brokerage, for which specialized products are available that are not available for sale to the general public. Policyholders that purchased such a proprietary policy shall be notified when a new long-term care policy that provides coverage for new long-term care services or providers material in nature is made available to that limited distribution channel. (11-1-06)T

05. Exchanges and Not Replacements. Policies issued pursuant to this Section 030, shall be considered exchanges and not replacements. These exchanges shall not be subject to Section 018, and Section 028, and the reporting requirements of Section 019.01, through 019.05, of this Chapter. (11-1-06)T

06. Employer Sponsored Plan. Where the policy is offered through an employer, labor organization, professional, trade or occupational association, the required notification in Subsection 030.01 shall be made to the offering entity. However, if the policy is issued to a group defined in Section 41-4603 (04) (d), Idaho Code, Long Term Care Insurance Act, the notification shall be made to each certificateholder. (11-1-06)T

07. Nothing Shall Prohibit an Insurer From Offering Coverage. Nothing in this Section 030, shall prohibit an insurer from offering any policy, rider, certificate or coverage change to any policyholder or certificateholder. However, upon request any policyholder may apply for currently available coverage that includes the new services or providers. The insurer may require that policyholders meet eligibility requirements, including underwriting and payment of the required premium to add such new services or providers. (11-1-06)T

08. Not Applicable to Life Insurance Policies. This Section 030 does not apply to life insurance policies or riders containing accelerated long-term care benefits. (11-1-06)T

031. RIGHT TO REDUCE COVERAGE AND LOWER PREMIUMS.

01. Reduction of Coverage. Every long-term care insurance policy and certificate shall include a provision that allows the policyholder or certificateholder to reduce coverage and lower the policy or certificate premium in at least one of the following ways: (11-1-06)T

- a.** Reducing the maximum benefit; or (11-1-06)T
- b.** Reducing the daily, weekly or monthly benefit amount. (11-1-06)T
- c.** The insurer may also offer other reduction options that are consistent with the policy or certificate design or the carrier's administrative processes. (11-1-06)T

02. Implementing a Reduction in Coverage. The provision shall include a description of the ways in which coverage may be reduced and the process for requesting and implementing a reduction in coverage. (11-1-06)T

03. Determination of Premium for Reduced Coverage. The age to determine the premium for the reduced coverage shall be based on the age used to determine the premiums for the coverage currently in force. (11-1-06)T

04. Limitations for the Reduction of Coverage. The insurer may limit any reduction in coverage to plans or options available for that policy form and to those for which benefits will be available after consideration of claims paid or payable. (11-1-06)T

05. Notification in Regard to the Possible Lapse of Policy. If a policy or certificate is about to lapse, the insurer shall provide a written reminder to the policyholder or certificateholder of his or her right to reduce coverage and premiums in the notice required by Subsection 013.01.c. of this rule. (11-1-06)T

06. Not Applicable to Life Insurance Policies or Riders Containing Accelerated Benefits. This

Section 031 does not apply to life insurance policies or riders containing accelerated long-term care benefits.

(11-1-06)T

07. Compliance Requirements. The requirements of this Section 031 shall apply to any long-term care policy issued in this state on or after November 1, 2007. Compliance with this Section 031 may be accomplished by policy replacement, exchange or by adding the required provision via amendment or endorsement to the policy.

(11-1-06)T

02532. NONFORFEITURE BENEFIT REQUIREMENT.

01. Life Insurance Policies That Accelerate Benefits. Section 02532 does not apply to life insurance policies or riders containing accelerated long-term care benefits. ~~(3-30-01)~~(11-1-06)T

02. Nonforfeiture Benefits. To comply with the requirement to offer a nonforfeiture benefit pursuant to the provisions of Section 41-4607, Idaho Code, every Insurer, Fraternal Benefit Society, Managed Care Organization, or other similar organization marketing long-term care insurance coverage in this state shall satisfy the following: (4-5-00)

a. A policy or certificate offered with nonforfeiture benefits shall have coverage elements, eligibility, benefit triggers and benefit length that are the same as coverage to be issued without nonforfeiture benefits. The nonforfeiture benefit included in the offer shall be the benefit described in Subsection ~~025-04d~~ 032.04.e. ~~(3-30-01)~~(11-1-06)T

b. The offer shall be in writing if the nonforfeiture benefit is not otherwise described in the Outline of Coverage or other materials given to the prospective policyholder. (4-5-00)

03. Contingent Benefit. If the offer required to be made under Section 41-4607, Idaho Code, is rejected, the insurer shall provide the contingent benefit upon lapse described in Section 02532. Even if this offer is accepted for a policy with a fixed or limited premium paying period, the contingent benefit on lapse in Subsection 032.04.b.i. shall still apply. ~~(3-30-01)~~(11-1-06)T

04. Rejection of Offer. After rejection of the offer required under Section 41-4607, Idaho Code, as it pertains to nonforfeiture benefits, for individual and group policies without nonforfeiture benefits issued after the effective date of Section 02532, the insurer shall provide a contingent benefit upon lapse. ~~(3-30-01)~~(11-1-06)T

a. In the event a group policyholder elects to make the nonforfeiture benefit an option to the certificate holder, a certificate shall provide either the nonforfeiture benefit or the contingent benefit upon lapse. (4-5-00)

b. ~~The~~ A contingent benefit on lapse shall be triggered every time an insurer increases the premium rates to a level which results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth within Subsection 02532.04 based on the insured's issue age, and the policy or certificate lapses within one hundred twenty (120) days of the due date of the premium so increased. Unless otherwise required, policyholders shall be notified at least thirty (30) days prior to the due date of the premium reflecting the rate increase.

Table: Issue Age - Percent Increase Over Initial Premium

Issue Age	Percent Increase Over Initial Premium	Issue Age	Percent Increase Over Initial Premium
29 and under	200%	72	36%
30-34	190%	73	34%
35-39	170%	74	32%
40-44	150%	75	30%
45-49	130%	76	28%
50-54	110%	77	26%
55-59	90%	78	24%
60	70%	79	22%
61	66%	80	20%
62	62%	81	19%
63	58%	82	18%
64	54%	83	17%
65	50%	84	16%
66	48%	85	15%
67	46%	86	14%
68	44%	87	13%
69	42%	88	12%
70	40%	89	11%
71	38%	90 and over	10%

~~(3-30-01)~~(11-1-06)T

i. A contingent benefit on lapse shall also be triggered for policies with a fixed or limited premium paying period every time an insurer increases the premium rates to a level that results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial premium set forth below based on the insured's issue age, the policy or certificate lapses within one hundred twenty (120) days of the due date of the premium so increased, and the ratio in Subsection 032.04.d.ii. is forty percent (40%) or more. Unless otherwise required, policyholders shall be notified at least thirty (30) days prior to the due date of the premium reflecting the rate increase.

Triggers For A Substantial Premium Increase

Issue Age	Percent Increase Over Initial Premium
<u>Under 65</u>	<u>50%</u>
<u>65-80</u>	<u>30%</u>
<u>Over 80</u>	<u>10%</u>

This provision shall be in addition to the contingent benefit provided by Subsection 032.04.b. above and where both are triggered, the benefit provided shall be at the option of the insured.

(11-1-06)T

c. On or before the effective date of a substantial premium increase as defined in Subsection ~~02532.04.b.~~, the insurer shall: ~~(3-30-01)~~(11-1-06)T

i. Offer to reduce policy benefits provided by the current coverage without the requirement of additional underwriting so that required premium payments are not increased; (4-5-00)

ii. Offer to convert the coverage to a paid-up status with a shortened benefit period in accordance with the terms of Subsection ~~025.04.d.~~ 032.04.e. This option may be elected at any time during the one hundred twenty (120) day period referenced in Subsection ~~02532.04.b.~~; and ~~(3-30-01)~~(11-1-06)T

iii. Notify the policyholder or certificate holder that a default or lapse at any time during the one hundred twenty (120) day period referenced in Subsection ~~02532.04.b.~~ shall be deemed to be the election of the offer to convert in Subsection ~~02532.04.c.ii.~~ unless the automatic option in Subsection 032.04.d.iii. applies. ~~(3-30-01)~~(11-1-06)T

d. On or before the effective date of a substantial premium increase as defined in Subsection 032.04.b.i., the insurer shall: (11-1-06)T

i. Offer to reduce policy benefits provided by the current coverage without the requirement of additional underwriting so that required premium payments are not increased; (11-1-06)T

ii. Offer to convert the coverage to a paid-up status where the amount payable for each benefit is ninety percent (90%) of the amount payable in effect immediately prior to lapse times the ratio of the number of completed months of paid premiums divided by the number of months in the premium paying period. This option may be elected at any time during the one hundred twenty (120) day period referenced in Subsection 032.04.b.i.; and (11-1-06)T

iii. Notify the policyholder or certificateholder that a default or lapse at any time during the one hundred twenty (120) day period referenced in Subsection 032.04.b.i. shall be deemed to be the election of the offer to convert in Subsection 032.04.d.ii. above if the ratio is forty percent (40%) or more. (11-1-06)T

de. Benefits continued as nonforfeiture benefits, including contingent benefits upon lapse, in accordance with Subsection 032.04.b. but not Subsection 032.04.b.i. are described in Subsection ~~025.04.d.~~ 032.04.e. ~~(3-30-01)~~(11-1-06)T

i. For purposes of this Subsection ~~025.04.d.~~ 032.04.e., attained age rating is defined as a schedule of premiums starting from the issue date which increases age at least one percent (1%) per year prior to age fifty (50), and at least three percent (3%) per year beyond age fifty (50); ~~(3-30-01)~~(11-1-06)T

ii. For purposes of Subsection ~~025.04.d.~~ 032.04.e., the nonforfeiture benefit shall be of a shortened benefit period providing paid-up long-term care insurance coverage after lapse. The same benefits (amounts and frequency in effect at the time of lapse but not increased thereafter) will be payable for a qualifying claim, but the lifetime maximum dollars or days of benefits shall be determined as specified in Subsection ~~025.04.d.iii.~~ 032.04.e.iii.; ~~(3-30-01)~~(11-1-06)T

iii. The standard nonforfeiture credit will be equal to one hundred percent (100%) of the sum of all premiums paid, including the premiums paid prior to any changes in benefits. The insurer may offer additional shortened benefit period options, as long as the benefits for each duration equal or exceed the standard nonforfeiture credit for that duration. However, the minimum nonforfeiture credit shall not be less than thirty (30) times the daily nursing home benefit at the time of lapse. In either event, the calculation of the nonforfeiture credit is subject to the limitation of Subsection ~~025.04.e.~~ 032.04.f.; ~~(3-30-01)~~(11-1-06)T

iv. The nonforfeiture benefit shall begin not later than the end of the third year following the policy or certificate issue date. The contingent benefit upon lapse shall be effective during the first three (3) years as well as thereafter. (3-30-01)

v. Notwithstanding Subsection ~~025.04.d.iv.~~ 032.04.e.iv. for a policy or certificate with attained age rating, the nonforfeiture benefit shall begin on the earlier of: ~~(3-30-01)~~(11-1-06)T

(1) The end of the tenth year following the policy or certificate issue date; or (4-5-00)

(2) The end of the second year following the date the policy or certificate is no longer subject to attained age rating. (4-5-00)

vi. Nonforfeiture credits may be used for all care and services qualifying for benefits under the terms of the policy or certificate, up to the limits specified in the policy or certificate. (4-5-00)

ef. All benefits paid by the insurer while the policy or certificate is in premium paying status and in the paid-up status will not exceed the maximum benefits which would be payable if the policy or certificate had remained in premium paying status. (4-5-00)

fg. There shall be no difference in the minimum nonforfeiture benefits as required under Section ~~025.32~~ for group and individual policies. ~~(3-30-01)~~(11-1-06)T

~~**g.** The requirements set forth in Section 025 shall become effective twelve (12) months after adoption of this provision and shall apply as follows: (3-30-01)~~

~~**i.** Except as provided in Subsection 025.04.g.ii., the provisions of Section 025 apply to any long-term care policy issued in this state on or after the effective date of this rule. (3-30-01)~~

~~**ih.** For certificates issued on or after the effective date of this Section ~~025.32~~, under a group long-term care insurance policy as defined in Section 41-4603(4)(a), Idaho Code, which policy was in force at the time this rule became effective, the provisions of Section ~~025.32~~ shall not apply. (3-30-01)(11-1-06)T~~

i. The last sentence Subsection 032.03 and Subsections 032.04.b. and Subsections 032.04.d. shall apply to any long-term care insurance policy defined in Section 41-4603(4)(a), Idaho Code one year after adoption. (11-1-06)T

~~**ji.** Premiums charged for a policy or certificate containing nonforfeiture benefits or a contingent benefit on lapse shall be subject to the loss ratio requirements of Section ~~048.23~~ or Section 025, whichever is applicable, treating the policy as a whole. (4-5-00)(11-1-06)T~~

~~**jj.** To determine whether contingent nonforfeiture upon lapse provisions are triggered under Subsection ~~025.32~~.04.b. or ~~032.04.b.i.~~, a replacing insurer that purchased or otherwise assumed a block or blocks of long-term care insurance policies from another insurer shall calculate the percentage increase based on the initial annual premium paid by the insured when the policy was first purchased from the original insurer. (3-30-01)(11-1-06)T~~

~~**jk.** A nonforfeiture benefits for qualified long-term care insurance contracts that are level premium contracts shall be offered that meets the following requirements: (4-5-00)(11-1-06)T~~

~~i. The nonforfeiture provision shall be appropriately captioned; (4-5-00)~~

~~ii. The nonforfeiture provision shall provide a benefit available in the event of a default on the payment of any premiums and shall state that the amount of the benefit may be adjusted subsequent to being initially granted only as necessary to reflect changes in claims, persistency and interest as reflected in rates for premium paying contracts approved by the Secretary of the Treasury filed for review with the Director for the same contract form; and (4-5-00)(11-1-06)T~~

~~iii. The nonforfeiture provision shall provide at least one (1) of the following: (4-5-00)~~

~~(1) Reduced paid-up insurance; (4-5-00)~~

- (2) Extended term insurance; (4-5-00)
- (3) Shortened benefit period; or (4-5-00)
- (4) Other similar offerings approved by the Director. (4-5-00)

02633. STANDARDS FOR BENEFIT TRIGGERS.

01. Conditions of Benefits Payment. A long-term care insurance policy shall condition the payment of benefits on a determination of the insured's ability to perform activities of daily living and on cognitive impairment. Eligibility for the payment of benefits shall not be more restrictive than requiring either a deficiency in the ability to perform not more than three (3) of the activities of daily living or the presence of cognitive impairment. (4-5-00)

02. Activities of Daily Living. Insurers may use activities of daily living to trigger covered benefits in addition to those contained in Subsection 02633.02 as long as they are defined in the policy. Activities of daily living shall include at least the following as defined in Section 00410 and in the policy. ~~(3-30-01)~~(11-1-06)T

- a. Bathing; (4-5-00)
- b. Continence; (4-5-00)
- c. Dressing; (4-5-00)
- d. Eating; (4-5-00)
- e. Toileting; and (4-5-00)
- f. Transferring. (4-5-00)

03. Additional Provisions. An insurer may use additional provisions for the determination of when benefits are payable under a policy or certificate; however the provisions shall not restrict, and are not in lieu of, the requirements contained in Subsections 02633.01 and 02633.02. ~~(3-30-01)~~(11-1-06)T

04. Determinations of Deficiency. For purposes of Section 02633 the determination of a deficiency shall not be more restrictive than: ~~(3-30-01)~~(11-1-06)T

- a. Requiring the hands-on assistance of another person to perform the prescribed activities of daily living; or (4-5-00)
- b. If the deficiency is due to the presence of a cognitive impairment, supervision or verbal cueing by another person is needed in order to protect the insured or others. (4-5-00)

05. Assessments. Assessments of activities of daily living and cognitive impairment shall be performed by licensed or certified professionals, such as physicians, nurses or social workers. (4-5-00)

06. Appeals. Long-term care insurance policies shall include a clear description of the process for appealing and resolving benefit determinations. (4-5-00)

07. Effective Date. The requirements set forth in Section 02633 shall be effective within twelve (12) months of the effective date of the rule and shall apply as follows: ~~(3-30-01)~~(11-1-06)T

- a. Except as provided in Subsection 02633.07.b. the provisions of Section 02633 apply to a long-term care policy issued in this state on or after the effective date of the rule. ~~(3-30-01)~~(11-1-06)T
- b. For certificates issued on or after the effective date of Section 02633, under a group long-term care insurance policy as defined in Section 41-4603(4)(a), Idaho Code, that was in force at the time this rule became

effective, the provisions of Section 02633 shall not apply.

~~(3-30-01)~~(11-1-06)T

02734. ADDITIONAL STANDARDS FOR BENEFIT TRIGGERS FOR QUALIFIED LONG-TERM CARE INSURANCE CONTRACTS.

01. Definitions. For purposes of Section 02734 the following definitions apply: ~~(3-30-01)~~(11-1-06)T

a. Qualified long-term care services means services that meet the requirements of Section 7702B~~(b)~~(1) of the Internal Revenue Code of 1986, as amended, as follows: necessary diagnostic, preventive, therapeutic, curative, treatment, mitigation, and rehabilitative services and maintenance or personal care services which are required by a chronically ill individual, and are provided pursuant to a plan of care prescribed by a licensed health care practitioner. ~~(4-5-00)~~(11-1-06)T

b. Chronically ill individual has the meaning prescribed for this term by Section 7702B(c)(2) of the Internal Revenue Code of 1986, as amended. Under this provision, a chronically ill individual means any individual who has been certified by a licensed health care practitioner as: (4-5-00)

i. Being unable to perform (without substantial assistance from another individual) at least two (2) activities of daily living for a period of at least ninety (90) days due to a loss of functional capacity; or (4-5-00)

ii. Requiring substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment. (4-5-00)

c. The term chronically ill individual shall not include an individual otherwise meeting these requirements unless within the preceding twelve (12) month period a licensed health care practitioner has certified that the individual meets these requirements. (4-5-00)

d. Licensed health care practitioner means a physician, as defined in Section 1861(r)(1) of the Social Security Act, and a registered professional nurse, licensed social worker, or other individual who meets requirements prescribed by the Secretary of the Treasury. (4-5-00)

e. Maintenance or personal care services means any care, the primary purpose of which is the provision of needed assistance with any of the disabilities, the existence of which leads to the conclusion that the individual is a chronically ill individual (including the protection from threats to health and safety due to severe cognitive impairment). (4-5-00)

02. The Chronically Ill. A qualified long-term care insurance contract shall pay for qualified long-term care services received by a chronically ill individual provided pursuant to a plan of care prescribed by a licensed health care practitioner. (4-5-00)

03. Payments and Conditions. A qualified long-term care insurance contract shall condition the payment of benefits on a determination of the insured's inability to perform activities of daily living for an expected period of at least ninety (90) days due to a loss of functional capacity; or to severe cognitive impairment, ~~as described in Subsection 027.06.b. (and as described under regulations or other guidance developed by the Secretary of the Treasury). An insured will be considered to have met a condition of payment if, within the preceding twelve (12) month period, a licensed health care practitioner has certified that the insured has met the requirements and the provider has prescribed the qualified long-term care insurance services pursuant to a plan of care.~~

~~(3-30-01)~~(11-1-06)T

04. Certifications by Professionals. Certifications regarding activities of daily living and cognitive impairment required pursuant to Subsection 02734.03 shall be performed by licensed or certified professionals, such as physicians, registered professional nurses, licensed social workers, or other individuals who meet requirements prescribed by the Secretary of the Treasury. ~~(3-30-01)~~(11-1-06)T

05. Certifications by Carrier. Certification required pursuant to Subsection 02734.03 may be performed by a licensed health care professional at the direction of the carrier as is reasonably necessary with respect to a specific claim, except that when a licensed health care practitioner has certified that an insured is unable to

perform activities of daily living for an expected period of at least ninety (90) days due to a loss of functional capacity and the insured is in claim status, the certification may not be rescinded and additional certifications may not be performed until after the expiration of the ninety (90) day period. ~~(3-30-01)~~(11-1-06)T

~~06. Standards. For the purposes of Section 027, determinations of functional capacity and severe cognitive impairment shall be based on the following standards:~~ ~~(3-30-01)~~

~~a. For loss of functional capacity, requiring the substantial assistance of another person to perform the prescribed activities of daily living; or~~ ~~(4-5-00)~~

~~b. For severe cognitive impairment, requiring substantial supervision by another person to protect the insured from threats to health and safety.~~ ~~(4-5-00)~~

~~076. Appeals.~~ Qualified long-term care contracts shall include a clear description of the process for appealing and resolving benefit determinations. ~~(4-5-00)~~

~~02835. STANDARD FORMAT OUTLINE OF COVERAGE.~~

Section ~~02835~~ of the rule implements, interprets and makes specific, the provisions of Section 41-4605(7)(a), Idaho Code, in prescribing a standard format and the content of an outline of coverage. ~~(3-30-01)~~(11-1-06)T

~~01. Format.~~ The outline of coverage shall be a freestanding document, using no smaller than ten (10) point type. Text that is capitalized or underscored in the standard format outline of coverage may be emphasized by other means that provide prominence equivalent to the capitalization or underscoring. ~~(4-5-00)~~

~~02. Content.~~ The outline of coverage shall contain no material of an advertising nature. ~~(4-5-00)~~

~~03. Standard Form.~~ Use of the text and sequence of text of the standard format outline of coverage is mandatory, unless otherwise specifically indicated. Format for the outline of coverage ~~may be found on the Idaho Department of Insurance Home Page website, www.doi.state.id.us, select SHIBA (Senior Health Insurance Benefits Advisors) under Consumer Assistance link, see attachments to the NAIC Model Regulation implementing the Long-Term Care Insurance Minimum Standards.~~ is published on the Department of Insurance Homepage <http://www.doi.idaho.gov> select consumer or company services link and go to Attachments to Idaho Rule, IDAPA 18.01.60 "Long-Term Care Minimum Standards." ~~(4-5-00)~~(11-1-06)T

~~02936. REQUIREMENT TO DELIVER SHOPPER'S GUIDE.~~

~~01. Approved Format.~~ A long-term care insurance shopper's guide in the format developed by the National Association of Insurance Commissioners, or a guide developed or approved by the director, shall be provided to all prospective applicants of a long-term care insurance policy or certificate. ~~(4-5-00)~~

~~a.~~ In the case of ~~agent~~ producer solicitations, ~~an agent~~ producer must deliver the shopper's guide prior to the presentation of an application or enrollment form. ~~(4-5-00)~~(11-1-06)T

~~b.~~ In the case of direct response solicitations, the shopper's guide must be presented in conjunction with any application or enrollment form. ~~(4-5-00)~~

~~02. Exceptions.~~ Life insurance policies or riders containing accelerated long-term care benefits are not required to furnish the above-referenced guide, but shall furnish the policy summary required under Section 41-4605(9), Idaho Code, Disclosure and Performance Standards for Long-Term Care Insurance. ~~(4-5-00)~~

~~0307. PENALTIES.~~

In addition to any other penalties provided by the laws of this state any insurer and any ~~agent~~ producer found to have violated any requirement of this state relating to the marketing of such insurance or of IDAPA 18.01.60, "Long-Term Care Insurance Minimum Standards," shall be subject to an administrative penalty of up to three (3) times the amount of any commissions paid for each policy involved in the violation or up to ten thousand dollars (\$10,000), whichever is greater. ~~(3-30-01)~~(11-1-06)T

~~0318. -- 999. (RESERVED).~~

IDAPA 18 - IDAHO DEPARTMENT OF INSURANCE
18.01.68 - MINIMUM RESERVE STANDARDS FOR INDIVIDUAL
AND GROUP HEALTH INSURANCE

DOCKET NO. 18-0168-0601

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2007 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Sections 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 41-211, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

The pending rule is being adopted as proposed. The complete text of the proposed rule was published in the August 2, 2006 Idaho Administrative Bulletin, Vol. 06-8, pages 28 through 39.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars (\$10,000) during the fiscal year: No fiscal impact.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Martha Hopper at (208) 334-4315.

DATED this 2nd day of October, 2006.

Shad Priest, Acting Director
Idaho Department of Insurance
700 West State St., 3rd Floor
Boise, Idaho 83720-0043
Phone: (208) 334-4250
Fax: (208) 334-4398

DOCKET NO. 18-0168-0601 - ADOPTION OF PENDING RULE

There are no substantive changes from the proposed rule text.

The complete text of the proposed rule was published in the Idaho Administrative Bulletin, Volume 06-8, August 2, 2006, pages 28 through 39.

This rule has been adopted as a pending rule by the Agency and is now pending review and approval by the 2007 Idaho State Legislature as a final rule.

IDAPA 18 - IDAHO DEPARTMENT OF INSURANCE

18.01.74 - COORDINATION OF BENEFITS

DOCKET NO. 18-0174-0601

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2007 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Sections 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 41-211, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

The pending rule is being adopted as proposed. The complete text of the proposed rule was published in the September 6, 2006 Idaho Administrative Bulletin, Vol. 06-9, pages 96 through 107.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars (\$10,000) during the fiscal year: No fiscal impact.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Joan Krosch at (208) 334-4300.

DATED this 2nd day of October, 2006.

Shad Priest, Acting Director
Idaho Department of Insurance
700 West State St., 3rd Floor
Boise, Idaho 83720-0043
Phone: (208) 334-4250
Fax: (208) 334-4398

DOCKET NO. 18-0174-0601 - ADOPTION OF PENDING RULE

There are no substantive changes from the proposed rule text.

The complete text of the proposed rule was published in the Idaho Administrative Bulletin, Volume 06-9, September 6, 2006, pages 96 through 107.

This rule has been adopted as a pending rule by the Agency and is now pending review and approval by the 2007 Idaho State Legislature as a final rule.

IDAPA 18 - IDAHO DEPARTMENT OF INSURANCE
18.01.76 - PROPERTY CASUALTY ACTUARIAL OPINION RULE
DOCKET NO. 18-0176-0601
NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2007 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Sections 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 41-211, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

The pending rule is being adopted as proposed. The complete text of the proposed rule was published in the August 2, 2006 Idaho Administrative Bulletin, Vol. 06-8, pages 40 through 43.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars (\$10,000) during the fiscal year: No fiscal impact.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Martha Hopper at (208) 334-4315.

DATED this 2nd day of October, 2006.

Shad Priest, Acting Director
Idaho Department of Insurance
700 West State St., 3rd Floor
Boise, Idaho 83720-0043
Phone: (208) 334-4250
Fax: (208) 334-4398

DOCKET NO. 18-0176-0601 - ADOPTION OF PENDING RULE

There are no substantive changes from the proposed rule text.

The complete text of the proposed rule was published in the Idaho Administrative Bulletin, Volume 06-8, August 2, 2006, pages 40 through 43.

This rule has been adopted as a pending rule by the Agency and is now pending review and approval by the 2007 Idaho State Legislature as a final rule.

IDAPA 18 - IDAHO DEPARTMENT OF INSURANCE

18.01.77 - ACTUARIAL OPINION AND MEMORANDUM RULE

DOCKET NO. 18-0177-0601

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2007 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Sections 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 41-211, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

The pending rule is being adopted as proposed. The complete text of the proposed rule was published in the August 2, 2006 Idaho Administrative Bulletin, Vol. 06-8, pages 44 through 65.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars (\$10,000) during the fiscal year: No fiscal impact.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Martha Hopper at (208) 334-4315.

DATED this 2nd day of October, 2006.

Shad Priest, Acting Director
Idaho Department of Insurance
700 West State St., 3rd Floor
Boise, Idaho 83720-0043
Phone: (208) 334-4250
Fax: (208) 334-4398

DOCKET NO. 18-0177-0601 - ADOPTION OF PENDING RULE

There are no substantive changes from the proposed rule text.

The complete text of the proposed rule was published in the Idaho Administrative Bulletin, Volume 06-8, August 2, 2006, pages 44 through 65.

This rule has been adopted as a pending rule by the Agency and is now pending review and approval by the 2007 Idaho State Legislature as a final rule.

IDAPA 20 - DEPARTMENT OF LANDS

20.03.14 - RULES GOVERNING GRAZING LEASES AND CROPLAND LEASES

DOCKET NO. 20-0314-0601 (FEE RULE)

NOTICE OF RULEMAKING - ADOPTION OF PENDING FEE RULE AND AMENDMENT TO TEMPORARY RULE

EFFECTIVE DATE: The effective date of the revised temporary rule is September 13, 2006. This pending rule has been adopted by the agency and is now pending review by the 2007 Idaho State Legislature for final approval. Pursuant to Section 67-5224(5)(c), Idaho Code, this pending rule will not become final and effective until it has been approved, amended, or modified by concurrent resolution of the legislature because of the fee being imposed or increased through this rulemaking. The rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Sections 67-5224 and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a pending and temporary rule. The action is authorized pursuant to Section(s) 58-104(6) and 58-105, Idaho Code.

DESCRIPTIVE SUMMARY: The following is the required finding and concise statement of its supporting reasons for adopting a temporary rule and a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for any change.

Currently, the Department of Lands makes valuations of lessee-owned rangeland improvements on State grazing leases. However, there is no process for filing objections and resolving conflicts over the valuations made by the department. Both the temporary and proposed rules will establish a process and timetable that provides structure and certainty in how objections are resolved.

Changes to the temporary and proposed rules are based on public comments received by the department. These changes will allow applicants more time to submit an objection to the department's valuations, and for the department to respond to the applicants with the results of the independent third party review.

The text of the pending rule has been amended in accordance with Section 67-5227, Idaho Code. Only those sections that have changes that differ from the proposed text are printed in this bulletin. The original text of the proposed rule was published in the August 2, 2006 Idaho Administrative Bulletin, Vol. 06-8, pages 66 through 68.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section(s) 67-5226(1)(c), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate for the following reason(s):

It confers a benefit by protecting the endowment trust from the costs, delayed lease payments, and reduced revenues associated with resolving objections to department valuations of lessee owned rangeland improvements on State grazing leases. Those costs are a threat to the constitutional mandate to maximize financial returns to the endowments.

FEE SUMMARY: Pursuant to Section 67-5226(2), the Governor has found that the fee or charge being imposed or increased is justified and necessary to avoid immediate danger. This fee or charge is being imposed pursuant to Section 58-127, Idaho Code. The following is a specific description of the fee or charge imposed or increased:

Objectors must submit a fee of \$2,500 or 10% of the State's total valuation, whichever is greater.

Pursuant to Section 67-5224(5)(c), Idaho Code, this pending rule will not become final and effective until it has been approved, amended, or modified by concurrent resolution of the legislature because of the fee being imposed or increased through this rulemaking.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars (\$10,000) during the fiscal year: N/A

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending

rule or temporary rule, contact George Bacon or Tracy Behrens at (208) 334-0200.

DATED this 12th day of September, 2006.

George B. Bacon
Assistant Director, Lands, Minerals & Range
Idaho Department of Lands
954 West Jefferson Street
P.O. Box 83720
Boise, Idaho, 83720-0050
Phone: (208) 334-0200
Fax: (208) 334-3698

DOCKET NO. 20-0314-0601 - ADOPTION OF PENDING RULE

There are substantive changes from the proposed rule text.

Only those sections that have changed from the original proposed text are printed in this Bulletin following this notice.

The text of the proposed rule was published in the Idaho Administrative Bulletin, Volume 06-8, August 2, 2006, pages 66 through 68.

This rule has been adopted as a pending rule by the Agency and is now pending review and approval by the 2007 Idaho State Legislature as a final rule.

THE FOLLOWING IS THE AMENDED TEXT OF DOCKET NO. 20-0314-0601

Subsections 102.01, 102.02, 102.04, and 102.06

102. VALUATION OF IMPROVEMENTS.

Credited improvements will be valued on the basis of replacement cost, including lessee provided labor, equipment and materials, less depreciation based on loss of utility. Improvements cannot be appraised higher than current market value, regardless of lessee's cost. Any improvement amortization or cost limitations identified by the Department will be considered in determining a final value. (6-15-06)T

01. Applicant Review of Department Improvement Credit Valuation. All applicants for a conflicted lease will be provided a copy of the Department's improvement credit valuation for review and a notice of objection form. Any applicant objecting to the appraisal will have ~~fourteen~~ twenty-one (~~14~~21) days from the date of the valuation mailing to submit the notice of objection form to the Department. If no objections are received during the ~~fourteen~~ twenty-one (~~14~~21) day review period, the lease auction will be scheduled and will proceed using the Departments improvement credit valuation. (~~6-15-06~~)T(9-13-06)T

02. Failure to File a Timely Notice of Objection. Failure to submit a notice of objection within the specified ~~fourteen~~ twenty-one (1421) day period will preclude any applicant from further administrative remedies and the auction will proceed using the Department's improvement credit valuation. ~~(6-15-06)~~(9-13-06)T

04. Selection of an Independent Third Party. The applicants will have ~~fourteen~~ twenty-one (1421) days from the date of the Department's notification of an objection to select by mutual agreement, one individual from the list of certified appraisers to serve as an independent third party. If the applicants cannot agree on an independent third party within the ~~fourteen~~ twenty-one (1421) day time period, the Department will randomly select one individual from the list to serve as the independent third party. ~~(6-15-06)~~(9-13-06)T

06. Notification of Final Improvement Value. Within ~~three~~ five (35) days of receiving the independent third party's final determination of improvement credit value, the Department will mail to each applicant an auction notice which shall reference the independent third party's determined value of improvements. The determination by the independent third party of the improvement value will be deemed final, and the appraised value of improvements will not be allowed as a basis for appeal of the auction. ~~(6-15-06)~~(9-13-06)T

IDAPA 21 - DIVISION OF VETERANS SERVICES

21.01.05 - RULES GOVERNING MEDICAL TRANSPORTATION PAYMENT FOR WHEELCHAIR CONFINED VETERANS

DOCKET NO. 21-0105-0601

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2007 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 65-202, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

The pending rule is being adopted as proposed. The complete text of the proposed rule was published in the September 6, 2006 Idaho Administrative Bulletin, Vol. 06-9, pages 112 through 113.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars (\$10,000) during the fiscal year: N/A

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact David Brasuell, Administrator, (208) 334-3513.

DATED this 28th day of September 2006.

David Brasuell, Administrator
Division of Veterans Services
320 Collins Rd.
Boise ID 83702
Phone: (208) 334-3513
Fax: (208) 334-2627

DOCKET NO. 21-0105-0601 - ADOPTION OF PENDING RULE

There are no substantive changes from the proposed rule text.

The complete text of the proposed rule was published in the Idaho Administrative Bulletin, Volume 06-9, September 6, 2006, pages 112 and 113.

This rule has been adopted as a pending rule by the Agency and is now pending review and approval by the 2007 Idaho State Legislature as a final rule.

IDAPA 23 - BOARD OF NURSING

23.01.01 - RULES OF THE IDAHO BOARD OF NURSING

DOCKET NO. 23-0101-0601

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2007 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 54-1404, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

The pending rule is being adopted as proposed. The complete text of the proposed rule was published in the September 6, 2006 Idaho Administrative Bulletin, Vol. 06-9, pages 114 through 145.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars (\$10,000) during the fiscal year: N/A

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Sandra Evans, Executive Director, (208) 334-3110.

DATED this 28th day of September 2006.

Sandra Evans, MAEd., R.N., Executive Director
Idaho Board of Nursing
280 N. 8th St., Ste. 210
P. O. Box 83720
Boise, Idaho 83720-0061
Phone: (208) 334-3110; Fax: (208) 334-3262

DOCKET NO. 23-0101-0601 - ADOPTION OF PENDING RULE

There are no substantive changes from the proposed rule text.

The complete text of the proposed rule was published in the Idaho Administrative Bulletin, Volume 06-9, September 6, 2006, pages 114 through 145.

This rule has been adopted as a pending rule by the Agency and is now pending review and approval by the 2007 Idaho State Legislature as a final rule.

IDAPA 24 - BUREAU OF OCCUPATIONAL LICENSES

24.15.01 - RULES OF THE IDAHO LICENSING BOARD OF PROFESSIONAL COUNSELORS AND MARRIAGE AND FAMILY THERAPISTS

DOCKET NO. 24-1501-0602 (FEE RULE)

NOTICE OF RULEMAKING - PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section(s) 54-3404, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than November 15, 2006.

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

Increase the fee for renewal of licenses for Counselors and Marriage and Family Therapists from \$60 to \$100.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased:

By increasing the fee for renewal of licenses from \$60 to \$100 the change could have a positive impact of \$54,040 per year on the dedicated funds of the Board.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars (\$10,000) during the fiscal year resulting from this rulemaking: N/A

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because the change is necessary to balance the Boards budget.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Cherie Simpson at (208) 334-3233.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before November 22, 2006.

DATED this 26th day of September, 2006.

Rayola Jacobsen
Bureau Chief
Bureau of Occupational Licenses
1109 Main St., STE 220
Boise, ID 83702
(208) 334-3233
(208)334-3945 fax

THE FOLLOWING IS THE TEXT OF DOCKET NO. 24-1501-0602

250. FEES (RULE 250).

- 01. Application Fee.** Application fee: (7-1-97)
- a.** Professional Counselor -- seventy-five dollars (\$75). (3-13-02)
 - b.** Clinical Professional Counselor -- seventy-five dollars (\$75). (3-13-02)
 - c.** Marriage and Family Therapist -- seventy-five dollars (\$75). (3-13-02)
 - d.** Intern Registration -- twenty-five dollars (\$25). (4-2-03)
- 02. Professional Counselor and Marriage and Family Therapist Examination or Reexamination Fee.** The Professional Counselor and Marriage and Family Therapist license examination or reexamination fee shall be the fee as set by the provider of the approved examination plus an administration fee of twenty-five dollars (\$25). (3-30-06)
- 03. Original License Fee.** Original license fee for Professional Counselor or Clinical Professional Counselor or Marriage and Family Therapist -- seventy-five dollars (\$75). (4-6-05)
- 04. Annual Renewal Fee.** Annual license renewal fee for Professional Counselor, Clinical Professional Counselor, or Marriage and Family Therapist -- ~~sixty~~ one hundred dollars (\$100). (~~4-6-05~~)()
- 05. Fees are Non-Refundable.** All fees are non-refundable. (7-1-93)

IDAPA 35 - IDAHO STATE TAX COMMISSION

35.01.03 - PROPERTY TAX ADMINISTRATIVE RULES

DOCKET NO. 35-0103-0602

**NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE
AND AMENDMENT TO TEMPORARY RULE**

EFFECTIVE DATE: The effective date of the amendment to temporary rule is January 1, 2006. The pending rule has been adopted by the agency and is now pending review by the 2007 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Sections 67-5224 and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a pending rule and is also adopting this rule as a temporary rule. The action is authorized pursuant to Section(s) 67-5226(2) Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and temporary rule.

The text of the pending rule has been amended in accordance with Section 67-5227, Idaho Code. Only those sections that have changes that differ from the proposed text are printed in this bulletin. The original text of the proposed rule was published in the July 5, 2006 Idaho Administrative Bulletin, Vol. 06-7, pages 82 through 84.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section(s) 67-5226(1)(2), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate for the following reason(s): A temporary/proposed rule change is needed for Rule 317 due to the enactment of the homeowner's exemption changes in House Bill 421, effective January 1, 2006.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars (\$10,000) during the fiscal year: No fiscal impact to state government.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule or temporary rule, contact Alan Dornfest (208) 334-7500.

DATED this 3rd day of October, 2006.

Alan Dornfest
Tax Policy Supervisor
State Tax Commission
P.O. Box 36
Boise, ID 83722-0410
(208) 334-7500

DOCKET NO. 35-0103-0602 - ADOPTION OF PENDING RULE

There are substantive changes from the proposed rule text.

Only those sections that have changed from the original proposed text are printed in this Bulletin following this notice.

The text of the proposed rule was published in the Idaho Administrative Bulletin, Volume 06-7, July 5, 2006, pages 82 through 84.

This rule has been adopted as a pending rule by the Agency and is now pending review and approval by the 2007 Idaho State Legislature as a final rule.

THE FOLLOWING IS THE AMENDED TEXT OF DOCKET NO. 35-0103-0602

Subsection 317.06

317. OCCUPANCY TAX ON NEWLY CONSTRUCTED IMPROVEMENTS ON REAL PROPERTY (RULE 317).
Section 63-317, Idaho Code. (5-3-03)

06. Allocation to Urban Renewal Agencies. Occupancy tax revenue shall be allocated to any applicable ~~school district and~~ urban renewal agency. ~~The revenue distribution to any applicable school district must be satisfied prior to the distribution to the urban renewal agency. Only the occupancy tax revenue from properties within the revenue allocation area shall be distributed in this manner. School districts shall be allocated an amount of occupancy tax equal to four tenths of one percent (0.4%) of the prorated value of property subject to occupancy tax, provided that such property is located within the school district and within the revenue allocation area of an urban renewal agency.~~

~~(1-1-06)~~(1-1-06)T

IDAPA 35 - IDAHO STATE TAX COMMISSION

35.01.03 - PROPERTY TAX ADMINISTRATIVE RULES

DOCKET NO. 35-0103-0603

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: The pending rule has been adopted by the agency and is now pending review by the 2007 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Sections 67-5224 and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a pending rule and is also adopting this rule as a temporary rule. The action is authorized pursuant to Section(s) 67-5226(2) Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule. The pending rule is being adopted as proposed. The original text of the proposed rule was published in the July 5, 2006 Idaho Administrative Bulletin, Vol. 06-7, pages 85 through 87.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section(s) 67-5226(1)(2), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate for the following reason(s): A temporary/proposed rule change is needed for Rule 700 due to the enactment of the property tax reduction (circuit breaker) changes in House Bill 422, effective January 1, 2006, and the homeowner's exemption changes in House Bill 421, effective January 1, 2006.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars (\$10,000) during the fiscal year: This change to Rule 700 only implements the laws (House Bill 422 and House Bill 421) and has no fiscal impact to state government beyond that caused by these laws.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule or temporary rule, contact Alan Dornfest (208) 334-7500.

DATED this 3rd day of October, 2006.

Alan Dornfest
Tax Policy Supervisor
State Tax Commission
P.O. Box 36
Boise, ID 83722-0410
(208) 334-7500

DOCKET NO. 35-0103-0603 - ADOPTION OF PENDING RULE

There are no substantive changes from the proposed rule text.

The complete text of the proposed rule was published in the Idaho Administrative Bulletin, Volume 06-7, July 5, 2006, pages 88 through 90.

This rule has been adopted as a pending rule by the Agency and is now pending review and approval by the 2007 Idaho State Legislature as a final rule.

IDAPA 35 - IDAHO STATE TAX COMMISSION

35.01.03 - PROPERTY TAX ADMINISTRATIVE RULES

DOCKET NO. 35-0103-0604

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: The pending rule has been adopted by the agency and is now pending review by the 2007 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Sections 67-5224 and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a pending rule and is also adopting this rule as a temporary rule. The action is authorized pursuant to Section(s) 67-5226(2) Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule. The pending rule is being adopted as proposed. The original text of the proposed rule was published in the July 5, 2006 Idaho Administrative Bulletin, Vol. 06-7, pages 88 through 90.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section(s) 67-5226(1)(2), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate for the following reason(s): A temporary/proposed rule change is needed for Rule 802 due to the repeal of the exemption under Section 63-602FF, Idaho Code, by House Bill 676, effective January 1, 2006.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars (\$10,000) during the fiscal year: No fiscal impact to state government; however, taxing districts could be able to increase property tax funded budgets because of increases on the new construction rolls.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule or temporary rule, contact Alan Dornfest (208) 334-7500.

DATED this 3rd day of October, 2006.

Alan Dornfest
Tax Policy Supervisor
State Tax Commission
P.O. Box 36
Boise, ID 83722-0410
(208) 334-7500

DOCKET NO. 35-0103-0603 - ADOPTION OF PENDING RULE

There are no substantive changes from the proposed rule text.

The complete text of the proposed rule was published in the Idaho Administrative Bulletin, Volume 06-7, July 5, 2006, pages 88 through 90.

This rule has been adopted as a pending rule by the Agency and is now pending review and approval by the 2007 Idaho State Legislature as a final rule.

IDAPA 35 - IDAHO STATE TAX COMMISSION

35.01.03 - PROPERTY TAX ADMINISTRATIVE RULES

DOCKET NO. 35-0103-0605

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: The pending rule has been adopted by the agency and is now pending review by the 2007 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Sections 67-5224 and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a pending rule and is also adopting this rule as a temporary rule. The action is authorized pursuant to Section(s) 67-5226(2) Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule.

The pending rule is being adopted as proposed. The original text of the proposed rule was published in the July 5, 2006 Idaho Administrative Bulletin, Vol. 06-7, pages 91 through 94.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section(s) 67-5226(1)(2), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate for the following reason(s): A temporary/proposed rule change is needed for Rule 989 due to the enactment of the date for payment of the recapture tax in House Bill 443, effective January 1, 2006.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars (\$10,000) during the fiscal year: No fiscal impact to state government.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule or temporary rule, contact Alan Dornfest (208) 334-7500.

DATED this 3rd day of October, 2006.

Alan Dornfest
Tax Policy Supervisor
State Tax Commission
P.O. Box 36
Boise, ID 83722-0410
(208) 334-7500

DOCKET NO. 35-0103-0605 - ADOPTION OF PENDING RULE

There are no substantive changes from the proposed rule text.

The complete text of the proposed rule was published in the Idaho Administrative Bulletin, Volume 06-7, July 5, 2006, pages 91 through 94.

This rule has been adopted as a pending rule by the Agency and is now pending review and approval by the 2007 Idaho State Legislature as a final rule.

IDAPA 35 - IDAHO STATE TAX COMMISSION

35.01.03 - PROPERTY TAX ADMINISTRATIVE RULES

DOCKET NO. 35-0103-0606

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: The pending rule has been adopted by the agency and is now pending review by the 2007 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Sections 67-5224 and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a pending rule and is also adopting this rule as a temporary rule. The action is authorized pursuant to Section(s) 67-5226(2) Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule.

The pending rule is being adopted as proposed. The original text of the proposed rule was published in the September 6, 2006 Idaho Administrative Bulletin, Vol. 06-9, pages 151 through 153.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section(s) 67-5226(1)(2), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate for the following reason(s): Temporary rule 609 is needed to be in compliance with governing state law. The temporary rule implements the provisions of House Bill 421 that became law July 1, 2006. The rule outlines the procedures to index the homeowner's exemption each year and updates examples for consistency with this legislation.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars (\$10,000) during the fiscal year: No fiscal impact to state government.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule or temporary rule, contact Alan Dornfest (208) 334-7500.

DATED this 3rd day of October, 2006.

Alan Dornfest
Tax Policy Supervisor
State Tax Commission
P.O. Box 36, Boise, ID 83722-0410
(208) 334-7500

DOCKET NO. 35-0103-0606 - PENDING RULE

There are no substantive changes from the proposed rule text.

The complete text of the proposed rule was published in the Idaho Administrative Bulletin, Volume 05-9, September 6, 2006, pages 151 through 153.

This rule has been adopted as a pending rule by the Agency and is now pending review and approval by the 2007 Idaho State Legislature as a final rule.

IDAPA 35 - IDAHO STATE TAX COMMISSION

35.01.03 - PROPERTY TAX ADMINISTRATIVE RULES

DOCKET NO. 35-0103-0607

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: These rules have been adopted by the agency and are now pending review by the 2007 Idaho State Legislature for final approval. The pending rules become final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section(s) 63-105 and 63-105A, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

The text of the pending rule has been amended in accordance with Section 67-5227, Idaho Code. Only those sections that have changes that differ from the proposed text are printed in this bulletin. The complete text of the proposed rules were published in the September 6, 2006 Idaho Administrative Bulletin, Vol. 06-9, pages 154 through 200.

Subsection 803.01.g., which is the only change made to Rule 803, is being removed from the pending rule. As a result Rule 803 will remain unchanged and returned to the original codified language. Because Rule 803 is being removed and reverted back to the codified text, Rule 803 is not being republished in this Bulletin. The remainder of this docket is being adopted as originally proposed with no additional changes.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars (\$10,000) during the fiscal year: N/A

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Alan Dornfest (208) 334-7500.

DATED this 11th day of October, 2006.

Alan Dornfest
Tax Policy Supervisor
State Tax Commission
P.O. Box 36, Boise, ID 83722-0410
(208) 334-7500

DOCKET NO. 35-0103-0606 - PENDING RULE

There are no substantive changes from the proposed rule text.

The complete text of the proposed rule was published in the Idaho Administrative Bulletin, Volume 05-9, September 6, 2006, pages 154 through 200.

This rule has been adopted as a pending rule by the Agency and is now pending review and approval by the 2007 Idaho State Legislature as a final rule.

IDAPA 35 - IDAHO STATE TAX COMMISSION
35.01.05 - IDAHO MOTOR FUELS TAX ADMINISTRATIVE RULES
DOCKET NO. 35-0105-0601
NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2007 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section(s) 63-105, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

Pursuant to Section 67-5228, Idaho Code, typographical, transcriptional, and/or clerical corrections have been made to the rule and are being published with this Notice of Rulemaking as part of the pending rule.

The text of pending rule has been amended in accordance with Section 67-5227, Idaho Code. Only those sections that have changes that differ from the proposed text are printed in this bulletin. The original text of the proposed rule was published in the August 2, 2006 Idaho Administrative Bulletin, Vol. 06-8, pages 81 through 90.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars (\$10,000) during the fiscal year: N/A

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Randy Nilson at (208) 334-7530.

DATED this September 5, 2006.

Randy Nilson
Tax Policy Specialist
Idaho State Tax Commission
800 Park Bl., Plaza IV
P.O. Box 36, Boise, ID 83722-0410

DOCKET NO. 35-0105-0601 - ADOPTION OF PENDING RULE

There are substantive changes from the proposed rule text.

Only those sections that have changed from the original proposed text are printed in this Bulletin following this notice.

The complete text of the proposed rule was published in the Idaho Administrative Bulletin, Volume 06-8, August 2, 2006, pages 81 through 90.

This rule has been adopted as a pending rule by the Agency and is now pending review and approval by the 2007 Idaho State Legislature as a final rule.

THE FOLLOWING IS THE AMENDED TEXT OF DOCKET NO. 35-0105-0601

Subsection 270.06.b.

270. REFUND CLAIMS -- DOCUMENTATION (RULE 270).

06. Records Required for Motor Fuels Tax Refunds. Each claimant shall maintain records that are sufficient to prove the accuracy of the fuels tax refund claim. Such records shall include all motor fuels receipts, the gallons of tax-paid fuel used in each type of equipment, both taxable and nontaxable, and other uses. The records must show the date of receipt or disbursements and identify the equipment into which the tax-paid fuel is dispensed. Failure of the claimant to maintain the required records and to provide them for examination is a waiver of all rights to the refund. The following rules shall govern records maintained to support claims for refund. (4-11-06)

b. Use of Fuel from Multiple Storage Tanks. When separate bulk storage tanks are maintained for both exempt and taxable uses, the seller must mark the invoices at the time of delivery, identifying the storage tanks into which the fuel was delivered. Detailed withdrawal records will only be required if fuel is ~~used~~ purchased by persons who operate motor vehicles that are licensed under IFTA or by persons who operate non-IFTA motor vehicles who claim refunds for nontaxable uses of motor fuels in motor vehicles granted in Rule 290 and Rule 292 of these rules. All fuel invoices must be retained as required by Subsection 270.03 of this rule. Exempt fuel may not be used in motor vehicles ~~licensed~~ registered or required to be ~~licensed~~ registered. (3-20-04)(____)

IDAPA 41 - PUBLIC HEALTH DISTRICT #1

41.01.01 - RULES OF PUBLIC HEALTH DISTRICT #1

DOCKET NO. 41-0101-0601

NOTICE OF PUBLIC HEARING

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has scheduled a public hearing and extended the period of public comment. The action is authorized pursuant to Section 39-416, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be held as follows:

**November 6, 2006
5:30 p.m. to 7:00 p.m.
Kellogg Middle School Library
800 Bunker Ave. Kellogg, ID 83837**

**November 8, 2006
5:30 p.m. to 7:00 p.m.
Panhandle Health District Office
8500 N. Atlas Road, Hayden, ID 83835**

Written comment will be received until the close of the November 8, 2006 hearing at the hearing site. Written comment may otherwise be submitted for receipt up to the close of business (5:00 p.m.) on November 8, 2006 to Dale Peck, Panhandle Health District, 8500 N. Atlas Road, Hayden, ID 83835.

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The summary of this action is found in Idaho Administrative Bulletin Vol. 06-10, dated October 4, 2006, pages 539 through 563.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this rulemaking or the hearing schedule, contact Jerry Cobb (Shoshone County/Bunker Hill), 114 West Riverside, Kellogg, ID (208) 783-0707 or Dale Peck, (all other changes) 8500 N. Atlas Road, Hayden, ID 83835; (208) 415-5210.

DATED this 10th day of October, 2006.

Jeanne Bock, Director
Panhandle Health District
8500 N. Atlas Road
Hayden, ID 83835
Phone: (208) 415-5100
Fax (208)415-5106

IDAPA 58 - DEPARTMENT OF ENVIRONMENTAL QUALITY

DOCKET NO. 58-0000-0606

NOTICE OF FINAL DECISION ON THE AMERICAN FALLS TMDL

AUTHORITY: In compliance with Section 39-3611, Idaho Code, notice is hereby given that this agency has issued a final decision on the American Falls Total Maximum Daily Load (TMDL).

DESCRIPTIVE SUMMARY: The Department of Environmental Quality (DEQ) hereby gives notice of the final decision on the American Falls TMDL. The final decision may be appealed to the Board of Environmental Quality by initiating a contested case in accordance with Sections 39-107(5), 67-5240 et seq., Idaho Code, and IDAPA 58.01.23, "Rules of Administrative Procedure Before the Board of Environmental Quality." The petition initiating a contested case must be filed with the undersigned hearing coordinator within thirty-five (35) days of the publication date of this notice in the Idaho Administrative Bulletin.

The area covered by the American Falls TMDL (Hydrologic Unit Code 17040206) addresses seventeen (17) assessment units (AUs) on Idaho's 2002 Section 303(d) list as being impaired by one or more pollutants; five (5) non-listed AUs and two (2) additional waterbodies with no assigned AU. Eight (8) of the AUs in the American Falls subbasin include tribal waters. DEQ has submitted this TMDL to the U.S. Environmental Protection Agency for approval under the Clean Water Act.

AVAILABILITY OF THE TMDL: Electronic copy of the TMDL can be obtained at http://www.deq.idaho.gov/water/data_reports/surface_water/tmdls/american_falls/american_falls.cfm or by contacting Marti Bridges, TMDL Program Manager, 208-373-0382, marti.bridges@deq.idaho.gov.

Dated this 25th day of September, 2006.

Paula J. Wilson
Hearing Coordinator
Department of Environmental Quality
1410 N. Hilton
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(208)373-0418/Fax No. (208)373-0481
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IDAPA 58 - DEPARTMENT OF ENVIRONMENTAL QUALITY

DOCKET NO. 58-0000-0607

NOTICE OF FINAL DECISION ON THE KOOTENAI RIVER/MOYIE RIVER SUBBASIN TMDLS

AUTHORITY: In compliance with Section 39-3611, Idaho Code, notice is hereby given that this agency has issued a final decision on the Kootenai River/Moyie River Total Maximum Daily Load (TMDL).

DESCRIPTIVE SUMMARY: The Department of Environmental Quality (DEQ) hereby gives notice of the final decision on the Kootenai River/Moyie River Subbasin TMDLs. The final decision may be appealed to the Board of Environmental Quality by initiating a contested case in accordance with Sections 39-107(5), 67-5240 et seq., Idaho Code, and IDAPA 58.01.23, "Rules of Administrative Procedure Before the Board of Environmental Quality". The petition initiating a contested case must be filed with the undersigned hearing coordinator within thirty-five (35) days of the publication date of this notice in the Idaho Administrative Bulletin.

The area covered by the Kootenai River/Moyie River Subbasin TMDLs (Hydrologic Unit Codes 17010104 and 17010105) addresses fifteen (15) assessment units on Idaho's 2002 Section 303(d) list. The fifteen (15) assessment units (AUs) contain thirteen (13) TMDLs. In addition eight (8) assessment unit pollutant combinations are recommended for listing changes. DEQ has submitted this HUC TMDL to the U.S. Environmental Protection Agency for approval under the Clean Water Act.

AVAILABILITY OF THE TMDL: Electronic copy of the TMDL can be obtained at http://www.deq.idaho.gov/water/data_reports/surface_water/tmdls/kootenai_moyie_rivers/kootenai_moyie_rivers.cfm or by contacting Marti Bridges, TMDL Program Manager, 208-373-0382, Marti.Bridges@deq.idaho.gov.

Dated this 10th day of October, 2006.

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LEGAL NOTICE

Summary of Proposed Rulemakings

PUBLIC NOTICE OF INTENT TO PROPOSE OR PROMULGATE NEW OR CHANGED AGENCY RULES

The following agencies of the state of Idaho have published the complete text and all related, pertinent information concerning their intent to change or make the following rules in the new issue of the state Administrative Bulletin.

*The written comment deadline is November 22, 2006, unless otherwise listed.
Temp & Prop indicates the rule is both temporary and proposed.
** Indicates that a public hearing has been scheduled.*

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE PO Box 83720, Boise, ID 83720-0036

16-0305-0607, Rules Governing Eligibility for Aid to the Aged, Blind and Disabled. (Temp & Prop) Removes the Traumatic Brain Injury (TBI) Waiver from the rule and places it in IDAPA 16.03.10 and deletes references to IDAPA 16.03.09.

*****16-0310-0603, Medicaid Enhanced Plan Benefits.*** (Temp & Prop) Services that were covered in the TBI Waiver services for habilitation, supported employment, behavior consultation, and crisis management will be provided under the Aged and Disabled Waiver Services rules in this chapter.

*****16-0506-0601, Criminal History and Background Checks.*** Notice of Public Meetings - informational and training meetings are being held on this docket. See Bulletin for dates, times and places.

IDAPA 18 - DEPARTMENT OF INSURANCE PO Box 83720, Boise, ID 83720-0043

18-0160-0601, Long-Term Care Insurance Minimum Standards. (Temp & Prop) Implements the Long Term Care Partnership Program and incorporate the latest changes to the model Long Term Care Minimum Standards Rule adopted by the National Association of Insurance Commissioners and are intended to make Idaho's rule consistent with the standards most likely to be adopted by other states.

IDAPA 24 - BUREAU OF OCCUPATIONAL LICENSES 1109 Main St., Suite 220, Boise, ID 83702

24-1501-0602, Rules of the Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists. Increases license renewal fee for Counselors and Marriage and Family Therapists to \$100.

IDAPA 41 - PUBLIC HEALTH DISTRICT #1 8500 N. Atlas Rd, Hayden, ID 83835

*****41-0101-0601, Rules of Public Health District #1.*** Notice of Public Hearing. See Bulletin for dates, times and places.

Please refer to the Idaho Administrative Bulletin Volume 06-11, November 1, 2006, for notices and text of all rulemakings, public hearing schedules, Governor's executive orders, and agency contact information.

Issues of the Idaho Administrative Bulletin can be viewed at the county law libraries or online.

To view the Bulletin or Code, or for information on purchasing the Bulletin and other rules publications, visit our website at www.adm.idaho.gov/adminrules/ or call (208) 332-1820 or write the Dept. of Administration, Office of Administrative Rules, 650 W. State St., Room 100, Boise, ID 83720-0306. Visa and MasterCard accepted for most purchases.

CUMULATIVE RULEMAKING INDEX OF IDAHO ADMINISTRATIVE RULES

**FOR THE ABOVE LINK TO WORK YOU HAVE
TO BE CONNECTED TO THE INTERNET**

**This index tracks the history of all agency rulemakings from 1993 to the present.
It includes all rulemaking activities on each chapter of rules
and includes negotiated, temporary, proposed, pending
and final rules, public hearing notices
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