

IDAHO ADMINISTRATIVE BULLETIN

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October 1, 1997

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IDAPA 01 - IDAHO STATE BOARD OF ACCOUNTANCY
01.01.01 - RULES GOVERNING THE IDAHO BOARD OF ACCOUNTANCY

DOCKET NO. 01-0101-9701

NOTICE OF PROPOSED RULES

AUTHORITY: In compliance with Section 67-5220(1), Idaho Code, notice is hereby given that this agency proposed rule-making. The action is authorized pursuant to Section 54-204(1), Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rule-making will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 15, 1997.

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 rule-making:

Educational requirements to sit for the Uniform Certified Public Accountant examination become more stringent on 7/1/2000 by existing rule. However, the rules do not allow for "grandfather" rights of candidates who qualify for the exam prior to that date. This rule change creates a grandfather provision for exam candidates who have met the educational requirements and are accepted to sit for the CPA exam prior to 7/1/2000. These individuals will be able to continue sitting for the exam without having to comply with the new educational standards.

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

There is no fee or charge imposed by this rule change.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rule-making was not conducted because the change was not considered controversial.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Barbara R. Porter at (208) 334-2490.

Anyone may submit written comments regarding this proposed rule-making. All written comments must be directed to the undersigned and must be delivered on or before October 22, 1997.

DATED this 14th day of August, 1997

Barbara R. Porter, Executive Director
Idaho State Board of Accountancy
1109 Main Street, Owyhee Plaza Ste 470
PO Box 83720
Boise ID 83720-0002
(208) 334-2490 Phone
(208) 334-2615 Fax

TEXT OF DOCKET NO. 01-0101-9701

115. QUALIFICATIONS OF CANDIDATES FOR CERTIFIED PUBLIC ACCOUNTANT EXAMINATION AFTER JULY 1, 2000 (Rule 115).

01. Semester Hours. Each applicant must have at least one hundred fifty (150) semester hours (or two hundred twenty-five (225) quarter hours) of college education including a baccalaureate or higher degree conferred by a college or university acceptable to the Board. The total educational program must include an accounting concentration or equivalent. Any applicant who is accepted for the May 2000 CPA exam or prior, but does not pass the entire exam, may continue to take the exam after July 1, 2000, without having to fulfill any additional educational requirements. (7-1-2000)(7-1-2000)

02. Accreditation. The Board shall recognize any college or university accredited by the Northwest Association of Schools and Colleges (NASC) or any other regional accrediting association having the equivalent standards, or any independent senior college in Idaho certified by the State Department of Education for teacher training, and accounting and business programs accredited by the American Assembly of Collegiate Schools of Business (AACSB) or any other accrediting agency having equivalent standards. (7-1-2000)

03. Education Requirement. An applicant shall be deemed to have met the education requirement if, as part of the one hundred fifty (150) semester hours of education, the applicant has met any one of the following four (4) conditions: (7-1-2000)

a. Earned a graduate degree with a concentration in accounting from a program that is accredited in accounting by an accrediting agency approved by the Board. (7-1-2000)

b. Earned a graduate degree from a program that is accredited in business by an accrediting agency approved by the Board and completed at least twenty-four (24) semester hours in accounting at the undergraduate or fifteen (15) semester hours at the graduate level, or an equivalent combination thereof, including at least one (1) course each in the subjects of financial accounting, auditing, taxation, and management accounting. (7-1-2000)

c. Earned a baccalaureate degree from a program that is accredited in business by an accrediting agency approved by the board and completed twenty-four (24) semester hours in accounting at the undergraduate or graduate level including at least one course each in the subjects of financial accounting, auditing, taxation, and management accounting; and completed at least twenty-four (24) semester hours in business courses (other than accounting courses) at the undergraduate or graduate level. (7-1-2000)

d. Earned a baccalaureate or higher degree and completed at least twenty-four (24) semester hours in accounting at the upper division or graduate level at an institution approved by the Board and including at least one (1) course each in the subjects of financial accounting, auditing, taxation, and management accounting; and completed at least twenty-four (24) semester hours in business courses (other than accounting courses) at the undergraduate or graduate level. (7-1-2000)

IDAPA 02 - DEPARTMENT OF AGRICULTURE
02.03.03 - RULES GOVERNING PESTICIDE USE AND APPLICATION
DOCKET NO. 02-0303-9701

NOTICE OF TEMPORARY AND PROPOSED RULES

EFFECTIVE DATE: These temporary rules are effective September 1, 1997.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted temporary rules, and proposed regular rule-making procedures have been initiated. The action is authorized pursuant to Section 22-3421, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rule-making will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 15, 1997.

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 recertification period for professional applicators and dealers shall be concurrent with the licensing period. Dealers shall earn two (2) credits during each recertification period, or may recertify by passing a recertification examination with a score of seventy percent (70%) or higher. Licensed dealers may make pesticide use recommendations in certified categories. The amendment will establish an expiration date and recertification process for mixer/loader licenses. The amendments will also provide for the composting of alfalfa and clover seed screenings, and will modify wind restrictions, low-flying requirements, and associated aerial application regulations to address FAA concerns and National Drift Task Force recommendations. Pesticide recordkeeping requirements will be updated. The required professional applicator insurance information shall be submitted on a form approved by the Director. Financial responsibility requirements will be modified to reflect increases in coverage limits, to delete the deductible limit requirement, and to delete language regarding waiver of coverage and address exceptions.

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

The rule is necessary to protect the public health, safety, or welfare.

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

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Robert S. Hays, Ronda Hirnyck or Beth Williams at (208) 332-8605.

Anyone may submit written comments regarding this temporary and proposed rule-making. All written comments must be directed to the undersigned and must be delivered on or before October 22, 1997.

DATED this 20th day of August, 1997.

Mike Everett, Deputy Director
Idaho State Department of Agriculture
2270 Old Penitentiary Road
Boise, Idaho 83712
(208) 332-8500
(208) 334-4623 FAX

TEXT OF DOCKET NO. 02-0303-9701

000. LEGAL AUTHORITY.

This chapter is adopted under the legal authority of Sections ~~22-3402(6)~~ and 22-3421, Idaho Code.

(3-20-97)(9-1-97)T

(BREAK IN CONTINUITY OF SECTIONS)

005. FINDINGS.

These rules are promulgated pursuant to Section 57-5226, Idaho Code, ~~in compliance with the deadlines in the governing law, Title 22, Chapter 34, Idaho Code. The rule changes are necessitated by the passage of H.B. 453 and H.B. 454 in February 1996. The rules confer a benefit by combining chemigator licensing with pesticide applicator licensing, simplifying the recertification record keeping and providing a uniform two year license and recertification period for all licenses. The rules confer a benefit and address public health, safety, and welfare by establishing and clarifying license periods and recertification requirements of professional and private pesticide applicators, mixer-loaders, and dealers; expanding the authority of licensed dealers to allow pesticide use recommendations; allowing composting of alfalfa and clover seed screenings; modifying wind restrictions; clarifying aerial application over-flight requirements; combining pesticide application recordkeeping and notification requirements from the Idaho Pesticide Law, the 1990 U.S.D.A. Farm Bill, and the Federal Workers Protection Standard. Additionally, financial responsibility requirements have been modified to reflect current industry standards and recommendations recommended by the Bureau of Risk Management, Department of Administration.~~

(3-20-97)(9-1-97)T

(BREAK IN CONTINUITY OF SECTIONS)

050. PRIVATE APPLICATOR LICENSING.

01. Private Applicator's License. Applicants who wish to obtain a private applicator's license shall (3-20-97)
 - a. Fill out an application prescribed by the Department. (3-20-97)
 - b. Take an examination based on the Environmental Protection Agency (EPA) core manual and score a minimum of seventy percent (70%). The examination procedure shall be the same as for professional applicators (Subsection 100.03), except private applicators shall not be assessed an examination fee. (3-20-97)
 - c. Private applicators shall be certified and licensed in one or both of the following categories: (3-20-97)
 - i. Restricted Use Pesticide (RU). For persons who use or supervise the use of restricted use pesticides to produce agricultural commodities or forest crops on land they or their employer(s) own(s) or operate(s). (3-20-97)
 - ii. Chemigation (CH). For persons who apply chemicals through irrigation systems on land they or their employer(s) own(s) or operate(s). (3-20-97)
 - d. Non-reading applicators may be certified to purchase and apply a single restricted use pesticide when they have demonstrated their competence in the safe and proper use of such pesticide to the Director or other designated agent. (3-20-97)
02. Recertification. In order for a private applicator's license to be renewed, the license holder must complete the recertification provisions of this section. Beginning July 1, 1996, licenses belonging to private applicators with last names beginning with A through L, inclusive, shall expire on the last day of the month listed on

the chart in Subsection 050.02.a. in every odd-numbered years, and licenses belonging to private applicators with last names beginning with M through Z, inclusive, shall expire on the last day of the month listed on the chart in Subsection 050.02.a., in every even-numbered years. The recertification period shall be concurrent with the licensing period. Those persons who are currently licensed as a private applicator or chemigator on June 30, 1996, shall be reissued a private applicator license with the appropriate categories. Those persons who are currently licensed as a private applicator or chemigator on June 30, 1996, shall be grandfathered into the licensing schedule at Subsection 050.02.a. Any person with less than thirteen (13) months in the initial licensing period shall not be required to obtain recertification credits for the initial period. Upon issuance of the replacement license, the previous license shall be null and void. Any private applicator license without an expiration date shall be null and void on December 31, 1996. Recertification and relicensing may be accomplished by complying with either Subsection 050.02.b. or 050.02.c.

~~(3-20-97)~~(9-1-97)T

a. Licensing Schedule.

Last Name		Month to License
Odd Year	Even Year	
A-D	M-P	MARCH
E-H	Q-T	JULY
I-L	U-Z	OCTOBER

(3-20-97)

b. A person shall accumulate recertification credits by attending Department-accredited pesticide instruction seminars. (3-20-97)

i. A minimum of two (2) credits shall be earned during each recertification period. (3-20-97)

ii. Guidelines for obtaining recertification credits shall be the same as for professional applicators, as described in Subsections 100.04.a.ii. through 100.04.a.v. Any credits accumulated beyond the required two (2) in a recertification period may not be carried over to the next recertification period. (3-20-97)

iii. Upon earning the recertification credits as described above, a person shall be considered by the Department to be recertified and eligible for license renewal for the next licensing period. (3-20-97)

c. A person shall pass the Department's private applicator recertification examination(s) for all categories in which the person intends to license with a minimum score of seventy percent (70%). (3-20-97)

i. Recertification examinations may be taken by a person beginning the thirteenth (13th) month of the license period. (3-20-97)

ii. The examination procedures as outlined in Subsection 100.03 shall be followed, except that an examination fee shall not be assessed. (3-20-97)

iii. Upon passing the recertification examinations, a person shall be considered by the Department to be recertified and eligible for license renewal for the next licensing period. (3-20-97)

(BREAK IN CONTINUITY OF SECTIONS)

100. LICENSING PROFESSIONAL APPLICATORS, ~~AND~~ PESTICIDE DEALERS AND MIXER-LOADERS.

01. Demonstration of Competence. (3-20-97)
- a. Professional applicators shall not recommend the application or make an application of any pesticide for any purpose, unless they have demonstrated competence for that purpose, which competence must be demonstrated by passing Department examinations and becoming licensed in the appropriate categories listed in Subsection 100.02. (3-20-97)
- b. An applicant shall demonstrate competency in the following areas: (3-20-97)
- i. Labels and labeling, including terminology, instructions, format, warnings and symbols. (3-20-97)
- ii. Safety factors and procedures, including protective clothing and equipment, first aid, toxicity, symptoms of poisoning, storage, handling, transportation and disposal. (3-20-97)
- iii. Laws, rules, and regulations governing pesticides. (3-20-97)
- iv. Environmental considerations, including the effect of climate and physical or geographical factors on pesticides, and the effects of pesticides on the environment, and the animals and plants living in it. (3-20-97)
- v. Mixing and loading, including interpretation of labels, safety precautions, compatibility of mixtures, and protection of the environment. (3-20-97)
- vi. Methods of use or application, including types of equipment, calibration, application techniques, and prevention of drift and other types of pesticide migration. (3-20-97)
- vii. Pests to be controlled, including identification, damage characteristics, biology and habitat. (3-20-97)
- viii. Types of pesticides, including formulations, mode of action, toxicity, persistence, and hazards of use. (3-20-97)
- ix. Chemigation practices involving the application of chemicals through irrigation systems. (3-20-97)
02. Certification. A person shall be certified by passing Department examinations with a minimum of seventy percent (70%) in the categories of pesticides they apply. (3-20-97)
- a. Professional applicators shall be certified and licensed in one or more of the following categories: (3-20-97)
- i. Law and Safety (LS). This shall include general knowledge of pesticides including proper use and disposal, product characteristics, first aid, labeling, and laws. Certification in this category is required when certifying in Subsections 100.02.a.ii. through 100.02.a.ix. (3-20-97)
- ii. Agriculture. For persons doing field crop applications. Agriculture Herbicide (AH). Certification in this category shall also certify a person to make herbicide applications in rights-of-way, forests, and rangelands. Agriculture Insecticide/Fungicide (AI). Certification in this category shall also certify a person to make insecticide/fungicide applications in rights-of-way, forests, and rangelands. Soil Fumigation (SF). (3-20-97)
- iii. Forest Environment (FE). For U.S. Forest Service and Bureau of Land Management personnel, contractors, and private industry personnel who control pests in forests and on rangelands. (3-20-97)
- iv. Right-of-Way Herbicide (RW). For railroads, highway departments and others, for roadside weed control, soil sterilant herbicides, and weed control on public lands (non-crop). Certification in the Agricultural Herbicide category shall exempt the applicant from the need to certify in this category. (3-20-97)

- v. Public Health Pest (PH). For abatement districts and others controlling mosquitoes and other public health pests. (3-20-97)
- vi. Livestock Pest Control (LP). For persons treating livestock pests. (3-20-97)
- vii. Ornamental Herbicide (OH). For persons doing outside urban or residential herbicide applications, with the exception of soil sterilant applications (see Subsection 100.02.a.iv.). Ornamental Insecticide/Fungicide (OI). For persons doing outside urban or residential insecticide and fungicide applications, including exterior applications to residential, urban or commercial buildings, excluding structural destroying pests (see Subsection 100.02.a.ix). (3-20-97)
- viii. General Pest Control Operations (GP). For persons controlling pests in and around residential, commercial, or other buildings, excluding structural destroying pests. (3-20-97)
- ix. Structural Destroying Pest (SP). For persons involved in the control of pests which destroy wooden structures, such as bridges, houses, offices, and warehouses. (3-20-97)
- x. General Vertebrate Control (GV). For Animal Damage Control personnel of the United States Department of Agriculture-Animal and Plant Health Inspection Service, for controlling vertebrates such as rodents, predators, and birds. (3-20-97)
- xi. Rodent Control (RC). For rodent districts and others, for the control of field rodents. Certification in the General Pest Control category shall exempt the applicant from the need to certify in this category. (3-20-97)
- xii. Aquatic Weed Control (AW). For irrigation districts, canal companies and others, for weed control on aquatic sites. (3-20-97)
- xiii. Seed Treatment (ST). For persons doing treatments to protect seeds used for plant reproduction. (3-20-97)
- xiv. Commodity Pest Control (CP). For persons controlling pests in stored commodities. (3-20-97)
- xv. Potato Cellar Pest Control (PC). For persons who apply sprout inhibitors in potato cellars. (3-20-97)
- xvi. Wood Preservative (WP). For persons who apply wood preservatives. (3-20-97)
- xvii. Pest Control Consultant-Statewide (SW). For persons who make recommendations or supply technical advice concerning the use of any pesticide for agricultural purposes. (3-20-97)
- xviii. Demonstration and Research (DR). For persons who apply or supervise the use of restricted use pesticides at no charge to demonstrate the action of the pesticide or conduct research with restricted use pesticides. A person shall be eligible to license in this category by passing the Pest Control Consultant examination. (3-20-97)
- xix. Chemigation (CH). For persons who apply chemicals through an irrigation system, excluding Aquatic Weed Control applicators (see Subsection 100.02.xii.). (3-20-97)
- b. Pesticide Dealers shall be certified and licensed in any category listed in Subsection 100.02 that pertains to the types of restricted use pesticides sold or distributed. A dealer may make recommendations in the certified pesticide category(ies). (~~3-20-97~~)(9-1-97)T
- c. Persons with an active license category on June 30, 1996, shall retain said category under the rules which became effective on July 1, 1996, until the expiration of the certification period or suspension of the license by the Department. (9-1-97)T
- ed. Mixer-Loaders. No person shall act as a mixer-loader for a professional applicator without first

obtaining a mixer-loader license issued by the Department. Professional and private applicators are exempt from this requirement. (3-20-97)

- i. An applicant must be at least eighteen (18) years of age. (3-20-97)
- ii. An applicant must be employed by a licensed professional applicator. (3-20-97)
- iii. Before obtaining a license, an applicant shall receive Department-approved training in areas relevant to the pesticide mixing and loading operation. Such training shall include instruction on the interpretation of pesticide labels, safety precautions, first aid, compatibility of mixtures, and protection of the environment. (3-20-97)
- iv. In lieu of training, an applicant may become certified by passing the Department's mixer-loader examination with a minimum score of seventy percent (70%). (3-20-97)
- v. Application for a mixer-loader license shall be on a form prescribed by the Department. If the training option (Subsection 100.02.ed.iii.) is selected, the application form must include the signatures of both the applicant and the professional applicator verifying that the applicant received the required mixer-loader training. If the examination option is selected, the application form must include the name and professional applicator license number of the employer. (~~3-20-97~~)(9-1-97)T

03. Department Examination Procedures. (3-20-97)

- a. Examinations shall be administered by a designated agent. (3-20-97)
- b. To pass a Department examination, ~~Professional applicators,~~ mixer-loaders, and pesticide dealers shall obtain a score of seventy percent (70%) or higher. (~~3-20-97~~)(9-1-97)T
- c. Payment of examination fees shall be received by the Idaho Department of Agriculture before examination results may be released. (3-20-97)
- d. A minimum waiting period shall be required before an applicant may retake an examination: (3-20-97)
 - i. One (1) week shall be required for the first failure. (3-20-97)
 - ii. Two (2) weeks shall be required for the second failure. (3-20-97)
 - iii. Thirty (30) days shall be required for the third or subsequent failures. (3-20-97)

04. Licensing Periods and Recertification. Professional applicators shall be required to comply with certain recertification requirements. Professional applicator, mixer-loader, and dealer licenses shall be renewed by satisfying the recertification provisions of this section. Beginning July 1, 1996, licenses belonging to professional applicators with last names beginning with A through L, inclusive, shall expire on the last day of the year in every odd-numbered year, and licenses belonging to professional applicators with last names beginning with M through Z, inclusive, shall expire on the last day of the year in every even-numbered year. Effective January 1, 1998, licenses belonging to mixer-loaders with last names beginning with A through L, inclusive, shall expire on the last day of the year in every odd-numbered year, and licenses belonging to mixer-loaders with last names beginning M through Z, inclusive, shall expire on the last day of the year in every even-numbered year. Any person professional applicator or mixer-loader with less than thirteen (13) months in the licensing period shall not be required to obtain recertification credits during the initial licensing period. The recertification period for professional applicators and mixer-loaders shall be concurrent with their two (2) year licensing period. The recertification period for dealers shall be concurrent with their one (1) year licensing period. Recertification requirements may be accomplished by complying with either Subsection 100.04.a. or 100.04.b. (~~3-20-97~~)(9-1-97)T

- a. A person shall accumulate recertification credits by attending Department-accredited pesticide instruction seminars. (3-20-97)

i. A minimum of five (5) credits shall be earned by a professional applicator during each recertification period. A minimum of two (2) credits shall be earned by a mixer-loader or dealer during each recertification period. ~~(3-20-97)~~(9-1-97)T

ii. A completed request for accreditation of a seminar shall be received by the Department not less than thirty (30) days prior to the scheduled seminar. Such a request shall be submitted on a form prescribed by the Department. Under exceptional circumstances, as described in writing by the person requesting accreditation, the thirty (30) day requirement may be waived. (3-20-97)

iii. Credit will be given only for those parts of seminars that deal with pesticide subjects as listed in Subsection 100.01.b. No credit will be given for training given to persons to prepare them for initial certification. (3-20-97)

iv. The number of credits assigned in advance for a seminar, or a part of a seminar, shall be tentative, and may be revised by the Department if it is later found that the training does not comply with Subsection 100.04.a.iii. (3-20-97)

v. A recertification credit shall be based upon one (1) credit for each one hundred fifty (150) minute period of instruction, as described in Subsection 100.04.a.iii. (3-20-97)

vi. Verification of attendance at a seminar shall be accomplished by validating the attendee's pesticide license, using a stamp, sticker, or other method approved by the Department. A designated agent shall ensure that such attendance records are properly completed. Verification of attendance must be submitted with the license renewal application. (3-20-97)

vii. If a person has accumulated more than five (5) credits during the recertification period, the excess credits may not be carried over to the next recertification period. (3-20-97)

viii. Upon earning the recertification credits as described above, a person shall be considered by the Department to be recertified for the next recertification period corresponding with the next issuance of a license. (3-20-97)

b. A person shall pass the Department's recertification examinations for all categories in which a person intends to license. (3-20-97)

i. Recertification examinations may be taken by a ~~person~~ professional applicator or mixer-loader beginning the thirteenth (13th) month of the recertification period. Recertification examinations may be taken by a dealer beginning the ninth (9th) month of the recertification period. ~~(3-20-97)~~(9-1-97)T

ii. The examination procedures ~~at~~ as outlined in Subsection 100.03 shall be followed. ~~(3-20-97)~~(9-1-97)T

iii. In addition to examinations for categories listed under Subsection 100.02.a.ii. through 100.02.a.viii., a person must also pass a Law and Safety recertification examination. (3-20-97)

iv. Recertification shall not be achieved by passing an entry-level examination. (3-20-97)

v. Upon passing the recertification examination(s), a person shall be considered by the Department to be recertified for the next recertification period. (3-20-97)

c. Any person who fails to accumulate the required recertification credits prior to the expiration date of their license shall be required to pass the appropriate recertification examination(s) before being licensed. (3-20-97)

05. Licensed Professional Applicator. Only a licensed professional applicator shall operate or supervise the operation of commercial application equipment by being present during the time of operation. (3-20-97)

(BREAK IN CONTINUITY OF SECTIONS)

150. RECORDS REQUIREMENTS.

01. Applicator Records. Professional applicators shall maintain the following pesticide application records for three (3) years, ready to be inspected, duplicated, or submitted when requested by the Director. The records shall be maintained in a location designated by the professional applicator. (3-20-97)

02. Record Contents. Such records shall contain: (3-20-97)

a. The name and address of the owner or operator of each property treated; and (3-20-97)

b. The specific crop, animal, or property treated; and (3-20-97)

c. ~~The trade name or brand name of the pesticide applied; and~~ The location by the address, general legal description (township, range, and section) or latitude/longitude of the specific crop, animal, or property treated; and ~~(3-20-97)(9-1-97)T~~

d. ~~The dilution applied or rate of application; and~~ The size or amount of specific crop, animal, or property treated; and ~~(3-20-97)(9-1-97)T~~

e. The trade name or brand name of the pesticide applied; and (9-1-97)T

ef. The total amount of pesticide ~~(active ingredient)~~ applied; and ~~(3-20-97)(9-1-97)T~~

g. The dilution applied or rate of application; and (9-1-97)T

h. The EPA registration number of the pesticide applied; and (9-1-97)T

fi. The date of application; and (3-20-97)

g. ~~The full name of the professional applicator applying the pesticide. NOTE – in addition to the above records requirements, records of aerial applicators shall contain:~~ (3-20-97)

ij. The time of day when the pesticide is applied; and (3-20-97)

ii. The approximate wind velocity; and (3-20-97)

iii. ~~The approximate wind direction; and~~ and ~~(3-20-97)(9-1-97)T~~

m. The full name of the person recommending the pesticide application; and (9-1-97)T

n. The full name of the professional applicator applying the pesticide; and (9-1-97)T

o. The license number of the professional applicator applying the pesticide; and (9-1-97)T

p. Worker protection information exchange, prior to pesticide application, shall be documented by: (9-1-97)T

i. Date of contact; and (9-1-97)T

ii. Time of contact; and (9-1-97)T

iii. Name of grower or operator contacted. (9-1-97)T

(BREAK IN CONTINUITY OF SECTIONS)

250. FINANCIAL RESPONSIBILITY.

01. Proof of Financial Ability. A professional applicator's license will not be issued by the Department until an applicant submits written proof of financial responsibility by any of the following methods: (3-20-97)

a. Liability insurance with an insurance company licensed to do business in Idaho and documented on either a standard insurance "ACORD" form or on a form approved by the Director; or ~~(3-20-97)~~(9-1-97)T

b. A bond that is approved by the Director; or (3-20-97)

c. A cash certificate of deposit in escrow with a bank or trust company; or (3-20-97)

d. An annuity; or (3-20-97)

e. An irrevocable letter of credit. (3-20-97)

f. Any certificate of deposit, annuity, or irrevocable letter of credit must be payable to the Director as trustee and shall remain on file with the Department until it is released, canceled or discharged by the Director. Any certificate of deposit, annuity, or irrevocable letter of credit must maintain a cash value equal to the requirements of Subsection 250.02, less any penalty for early withdrawal. Accrued interest upon a certificate of deposit or annuity shall be payable to the purchaser of the certificate or annuity. (3-20-97)

g. Under the provisions of this chapter, an irrevocable letter of credit shall not be acceptable unless it is issued by a national bank in Idaho or by an Idaho state-chartered bank insured by the federal deposit insurance corporation. Under the provisions of this chapter, an annuity shall not be accepted by the Department unless it is issued by an insurance company, bank or other financial institution found acceptable by the Director. (3-20-97)

02. Minimum Coverage Required. (3-20-97)

a. Professional applicators. (3-20-97)

i. ~~Bodily injury—twenty five thousand dollars (\$25,000) per person/fifty thousand dollars (\$50,000) per occurrence~~ Bodily injury/property damage - A combined single limit (CSL) of three hundred thousand dollars (\$300,000) is required per occurrence. ~~(3-20-97)~~(9-1-97)T

ii. ~~Property damage—fifty thousand dollars (\$50,000) per occurrence.~~ All new professional applicator licenses issued on or after September 1, 1997, shall require the updated coverage limits as specified in Subsection 250.02.a.i. ~~(3-20-97)~~(9-1-97)T

iii. ~~Maximum deductible—five thousand dollars (\$5,000)~~ In order to maintain an existing professional applicator license the updated coverage limits shall be effective on or before September 1, 1998. ~~(3-20-97)~~(9-1-97)T

03. ~~Exceptions~~ Exclusions. Any ~~exceptions not covered~~ exclusions to coverage by such insurance policy, bond, or cash deposit shall be listed. ~~(3-20-97)~~(9-1-97)T

04. Cancellation or Reduction. The Department shall be notified by the surety in writing ~~at least ten (10) within fifteen (15) days prior to a notice of~~ after cancellation or reduction of the financial coverage. ~~(3-20-97)~~(9-1-97)T

05. ~~Chemical Injury.~~ Chemical Injury. ~~These financial requirements do not include, nor are they meant to include, any chemical injury to the immediate property being treated.~~ (3-20-97)

065. Coverage Waived. Subsection 250.02.a.ii. as it pertains to property damage in the amount of "fifty thousand dollars (\$50,000) per occurrence" may be waived on a case-by-case basis by the Director when it can be demonstrated by the applicant that there is not a need for this type of coverage. In addition, any applicator may apply, on a form prescribed by the Director, for an exemption to Subsection 250.01 if that professional applicator will not be making applications of pesticides or will only be making applications for the purpose of demonstration or research. Coverage waivers which have been issued prior to September 1, 1997, shall remain in effect until the first license expiration date subsequent to September 1, 1997. (3-20-97)(9-1-97)T

(BREAK IN CONTINUITY OF SECTIONS)

310. LOW-FLYING PROHIBITIONS.

01. Low-Flying Prohibitions. Aircraft pilots during spray operations are prohibited from turning or low-flying: (3-20-97)

a. ~~Over cities, towns and densely populated areas unless authorized by the city or town in question pursuant to an agreement in writing for pesticide applications~~ Over cities, towns, schools, hospitals and densely populated areas unless the pilot obtains an agreement in writing for pesticide applications from the authorized agent for the city, town, school, hospital, or densely populated area in question; or (3-20-97)(9-1-97)T

b. ~~Directly over an occupied structure such as a residence, a school in session, or a hospital except by permission of the person(s) whose occupied structure is involved without prior notification by some effective means such as daily newspapers, radio, television, telephone, or door-to-door notice.~~ (3-20-97)(9-1-97)T

02. Restriction. The low-flying restrictions listed in Subsection 310.01 shall only pertain to persons other than those persons whose property is to be treated. (3-20-97)

(BREAK IN CONTINUITY OF SECTIONS)

320. WIND VELOCITY RESTRICTIONS.

01. ~~Restrictions. No aircraft pilot person shall apply any pesticide with an aircraft in sustained wind conditions exceeding seven (7) ten (10) miles per hour or in wind conditions exceeding product label directions.~~ (3-20-97)(9-1-97)T

02. ~~Exceptions. Application of pesticides by injection or by impregnated dry fertilizer granules may be made to target areas in winds exceeding ten (10) miles per hour.~~ (9-1-97)T

03. ~~Approval for Use of Other Application. Techniques~~ Other pesticide application techniques or methods may be approved by the Director or his agent on a case-by-case basis. (9-1-97)T

321. CHANGE OF ~~OWNERSHIP~~ LICENSE STATUS.

01. Change Notification. Any person who is licensed by this act shall immediately notify the Director, in writing, of any change of status of any person or agent so named, or of any change in the business name, organization, or any other information shown in the licensing application. (3-20-97)

02. Transferable. Licenses are not transferable, and in case of a change of business ownership, a new application and fee are required. No fee is required for a change of business name. (3-20-97)

(BREAK IN CONTINUITY OF SECTIONS)

550. PHENOXY HERBICIDE RESTRICTIONS.

01. High Volatile Ester Restrictions. No aircraft pilot shall apply high volatile ester formulations of 2,4-D: (3-20-97)

a. In Latah, Nez Perce, and Clearwater Counties in Idaho; or (3-20-97)

b. Within five (5) miles of a susceptible crop or hazard area in any other county in Idaho. (3-20-97)

c. Waiver of the restriction in Subsections 550.01.a. and 550.01.b. may be issued on a project-by-project basis by the Director. (3-20-97)

02. Low Volatile Ester Restrictions. No aircraft pilot shall apply low volatile ester formulations of 2,4-D; MCPA and MCPB: (3-20-97)

a. In Latah, Nez Perce, and Clearwater Counties in Idaho during the period between May 1 and October 15, or (3-20-97)

b. Within one (1) mile of a hazard area in any other county in Idaho. (3-20-97)

c. Waiver of the restriction in Subsection 550.02.a. may be issued on a project-by-project basis by the Director. (3-20-97)

03. Hazard Area. Aircraft pilots shall maintain the following spray distances from hazard areas when applying amine or acid formulations of 2,4-D; MCPA; MCPB; and Dicamba:

Mean Sustained Wind Velocity	Downwind	Upwind
0-3 MPH	1/2 mile	600 feet
4-7 MPH	1 mile	200 feet
Over 7 8-10 MPH	Do not apply 1 mile	Do not apply 50 feet
<u>Over 10 MPH</u>	<u>Do not apply</u>	<u>Do not apply</u>

~~(3-20-97)~~(9-1-97)T

04. Airflow and Temperature Inversion Indicators. A continuous smoke column or other device satisfactory to the Director shall be employed to indicate to the pilot of any aircraft the direction and velocity of the airflow, and indicate a temperature inversion by layering of smoke, at the time and place of application when applying any formulation of 2,4-D; MCPA; MCPB and Dicamba. (3-20-97)

05. Other Spraying Equipment. If any aerial applicator wishes to use spraying equipment other than the equipment specified, such equipment must be approved by the Director prior to use. (3-20-97)

(BREAK IN CONTINUITY OF SECTIONS)

800. PESTICIDE USE ON ALFALFA SEED AND CLOVER SEED.

01. Nonfood and Nonfeed Site Conditions. For purposes of pesticide registration, all alfalfa seed and

clover seed crop fields are considered nonfood and nonfeed sites for pesticide use and the following conditions shall be met: (3-20-97)

a. No portion of the seed alfalfa or seed clover plant, including but not limited to seed screenings, green chop, hay, chaff, combine tailings, pellets, meal, whole seed and cracked seed, may be grazed, used, or distributed for food or feed purposes. (3-20-97)

b. The seed conditioner shall keep records of individual growers' alfalfa and clover seed dirt weight and clean weight for three (3) years and shall furnish the records to the Director forthwith upon request. (3-20-97)

c. All seed screenings shall be disposed of at a controlled dump site, incinerator, or other equivalent disposal site or by a procedure approved by the Director. (~~3-20-97~~)(9-1-97)T

d. The seed conditioner shall keep seed screening disposal records for three (3) years from the date of disposal and shall furnish the records to the Director forthwith, upon request. Disposal records shall consist of documentation from the disposal site and shall show the total weight of disposed screenings and the date of disposal. (3-20-97)

e. All alfalfa or clover seed grown or conditioned in this state shall bear a tag or container label which forbids the use of the seed for human consumption or animal feed. (3-20-97)

f. No alfalfa or clover seed grown or conditioned in this state shall be distributed for human consumption or animal feed. (3-20-97)

g. All portions of the seed alfalfa or seed clover plant, including but not limited to seed screenings, pellets, meal, whole seed and cracked seed may be composted. All composted material may be applied to agricultural crop land as approved by the Director. (9-1-97)T

02. Exemption. Alfalfa seed grown for human consumption shall be exempt from the requirements of Subsection 800.01 provided: (3-20-97)

a. All pesticides used are labeled for use on alfalfa, and have established residue tolerances which allow food or feed use; and (3-20-97)

b. All producers maintain for three (3) years complete records of all pesticides applied as specified in Pesticide Use and Application Rules Subsection 150.02. These records shall be ready to be inspected, duplicated, or submitted when requested by the Director. (3-20-97)

IDAPA 02 - DEPARTMENT OF AGRICULTURE

02.04.14 - RULES GOVERNING DAIRY WASTE

DOCKET NO. 02-0414-9701

NOTICE OF TEMPORARY AND PROPOSED RULES

EFFECTIVE DATE: These temporary rules are effective September 1, 1997.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted temporary rules, and proposed regular rule-making procedures have been initiated. The action is authorized pursuant to Title 37, Chapter 4, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearings concerning this rule-making will be held as follows:

**Monday, November 17 and Tuesday, November 18, 1997 at 7:00 pm (MST)
At the College of Southern Idaho in the Shields Building, Rooms 117 and 118
315 Falls Avenue, Twin Falls, 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 amendment will adopt by reference the 1997 amended version of the 1993 Idaho Waste Management Guidelines for Confined Feeding Operations and amend definitions for non-compliance, discharge violations, and livestock.

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

The rule is necessary to protect the public health, safety, or welfare.

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

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Marv Patten at (208) 332-8550.

Anyone may submit written comments regarding this temporary and proposed rule-making. All written comments must be directed to the undersigned and must be delivered on or before October 22, 1997.

DATED this 20th day of August, 1997.

Mike Everett, Deputy Director
Idaho State Department of Agriculture
2270 Old Penitentiary Road
Boise, Idaho 83712
(208) 332-8500
(208) 334-4623 FAX

TEXT OF DOCKET NO. 02-0414-9701

004. DEFINITIONS.

The following definitions shall apply in the interpretation and enforcement of this chapter:

(3-20-97)

01. Dairy Farm. A place or premise where one (1) or more milking cows, sheep or goats are kept, and from which all or a portion of the milk produced thereon is delivered, sold or offered for sale. (3-20-97)
02. Department. The Idaho Department of Agriculture. (3-20-97)
03. Director. The Director of the Idaho Department of Agriculture. (3-20-97)
04. Discharge Violation. A practice or facility condition which has caused an unauthorized release of dairy livestock waste into surface, or ground water, or beyond the dairy farm's property boundaries or beyond the property boundary of any facility operated by the producer. Contract manure haulers, producers and other persons who haul livestock waste beyond the producer's property boundaries are responsible for releases of livestock waste between the property boundaries of the producer and the property boundaries at the point of application. ~~(3-20-97)~~(9-1-97)T
05. Farm Certification. A permit issued by the Department allowing the sale of manufacture grade milk. (3-20-97)
06. Fieldman. An individual qualified and approved by the Department to perform dairy farm inspections. (3-20-97)
07. Idaho Waste Management Guidelines for Confined Feeding Operations. A 1993 publication as amended in 1997 by the Idaho Department of Health and Welfare, Division of Environmental Quality which is hereby incorporated by reference. Copies of the guidelines are available at the Idaho Department of Agriculture, 2270 Old Penitentiary Road, Boise, Idaho 83712 and through the Department of Administration, Office of the Rules Coordinator, located at 650 West State Street, Boise, Idaho 83720. ~~(3-20-97)~~(9-1-97)T
08. Inspector. A qualified, trained person employed by the Department to perform dairy farm inspections. (3-20-97)
09. Livestock. For the purposes of these rules the term livestock shall include bovidae, suidae, equidae and other animals that are kept on or contiguous to a dairy farm and are owned or controlled by a dairy farm. (9-1-97)T
10. Livestock Waste. Manure that may also contain bedding, spilled feed, water or soil. It also includes wastes not particularly associated with manure, such as milking center or washing wastes, milk or other debris. (9-1-97)T
- ~~09~~11. Manufacture Grade Milk. Milk produced for processing into dairy products for human consumption but not subject to Grade A requirements. (3-20-97)
102. Memorandum Of Understanding. The Idaho Dairy Pollution Prevention Initiative Memorandum of Understanding between the Environmental Protection Agency, Division of Environmental Quality, Idaho Department of Agriculture and the Idaho Dairymen's Association. The memorandum is hereby incorporated by reference and copies of the memorandum are available at the Idaho Department of Agriculture, 2270 Old Penitentiary Road, Boise, Idaho 83712 and through the Department of Administration, Office of the Rules Coordinator, located at 650 West State Street, Boise, Idaho 83720. (3-20-97)
113. Non-Compliance. A practice or facility condition which will likely cause a discharge violation if left uncorrected. ~~(3-20-97)~~(9-1-97)T
124. Permit. A permit issued by the Department allowing the sale of Grade A milk. (3-20-97)
135. Person. Any individual, partnership, association, corporation, or any organized group of persons whether incorporated or not. (3-20-97)
146. Producer. The person who exercises control over the production of milk delivered to a plant, and who receives payment for this product. (3-20-97)

IDAPA 07 - DIVISION OF BUILDING SAFETY
07.02.06 - RULES CONCERNING THE UNIFORM PLUMBING CODE
DOCKET NO. 07-0206-9701
NOTICE OF PROPOSED RULES

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has proposed rule-making. The action is authorized pursuant to Section 54-2605(1), Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rule-making will be held as follows:

Public hearing(s) concerning this rule-making will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 15, 1997.

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 at the address below.

DESCRIPTIVE SUMMARY: The following is a statement in nontechnical language of the substance of the proposed rule:

To allow the plumbing industry to use the current addition of the Uniform Plumbing Code and amend the Code to be less restrictive in some areas.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning this proposed rule, contact Joe Meyer, Bureau Chief, Division of Building Safety, 277 N. 6th Street, Suite 101, P.O. Box 83720, Boise, Idaho 83720-0068, (208) 334-3442.

Anyone may submit written comments regarding this rule. All written comments and data concerning the proposed rules must be directed to the undersigned and must be postmarked or delivered on or before October 22, 1997.

DATED this 20th day of August, 1997.

Connie J Mumm
Division of Building Safety
277 N. 6th, Suite 101
P.O. Box 83720
Boise, ID 83720-4801
(208) 334-3442/fax (208) 334-2683

TEXT OF DOCKET NO. 07-0206-9701

011. ADOPTION OF ~~1994~~ 1997 UNIFORM PLUMBING CODE.

The ~~1994~~ 1997 Uniform Plumbing Code, including Appendix "E" and the installation standards for polybutylene hot and cold water distribution tubing systems, is adopted with the following amendments. (12-29-91)()

- | | | |
|-----|--|------------|
| 01. | Part 1. Administration. Delete the fee schedule (Table A). | (12-29-91) |
| 02. | <u>Section 412.2.1. Delete.</u> | () |
| 03. | <u>Section 412.4. Delete.</u> | () |
| 04. | <u>Section 413. Delete.</u> | () |

05. Section 420.0. Pressure balance or thermostatic mixing valves are not required for high flow (over eight (8) g.p.m.) tub only filler valves or high flow (over eight (8) g.p.m.) tub filler valves with hand shower sets attached. The one hundred twenty (120) degree maximum mixed water setting is limited to gang showers only.()

06. Table 4-1. Delete. ()

07. Section 604.1. Listed PE (polyethylene) water service piping may be installed within a building (above ground and below ground) with one joint. (Brass insert adaptor with two (2) strap-type all stainless steel bands over pipe.) ()

08. Section 609.10. Water hammer. Does not apply to residential construction. ()

09. Table 6-4. Change fixture unit loading value for bathtub or combination bath/shower, clotheswashers, domestic, and whirlpool bath or combination bath/shower to two (2) fixture units. ()

10. Table 6-5. Add: Branch pipes up to twenty (20) feet developed length (from main to outlet or fixture) may supply maximum of four (4) fixture units for one-half (1/2) inch size and maximum sixteen (16) fixture units for three-quarter (3/4) inch nominal size. ()

0211. Section ~~403~~ 703.1 - Underground Drainage Piping. No portion of the drainage system installed underground or below a basement or cellar shall be less than two (2) inches in diameter. (~~12-16-82~~)()

12. Section 704.2. Double sanitary tees may be used for back to back or side by side fixture trap arms without increasing the barrel size. ()

013. Section ~~406A~~ 707.4 Cleanouts. A full-sized accessible cleanout shall be installed at the base or above floor level in each vertical waste or soil stack. A full-size cleanout extending to or above finished grade line shall be installed at the junction of the building drain and the building sewer. (ref.: Section ~~407a~~ 719.1) Cleanouts shall be installed at fifty (50) foot intervals in horizontal drain lines two (2) inches IPS or smaller. (~~12-16-82~~)()

014. Section ~~404a~~ 604.1 - Materials. Portion relating to polybutylene pipe is amended to provide that such materials may be used for hot and cold water distribution systems within a building, or cold water distribution systems outside of a building. Crosslinked Polyethylene (PEX) Tubing manufactured to ASTM - F876/F877 and tested, approved, and listed to ANSI/NSF 14 and 61, for potable water, and Crosslinked Polyethylene, Aluminum, Crosslinked Polyethylene (PEX/AL/PEX) along with Polyethylene, Aluminum, Polyethylene (PE/AL/PE) manufactured to ASTM - F1281/F1282 and tested, approved, and listed to the ANSI/NSF 61, for potable water, along with all applicable installation standards. (~~7-1-97~~)()

015. Table ~~4-3~~ 7-3. Maximum unit loading and maximum length of drainage and vent piping. (EXCEPTION) The building drain and building sewer is not less than four (4) inches IPS extending from its connection with the city or private sewer system and shall run full size to inside the foundation or building lines (ref: Section ~~405~~ 717). Change fixture unit loading value for bathtub or combination bath/shower, clotheswashers, domestic, and whirlpool bath or combination bath/shower to two (2) fixture units. Change trap arm for whirlpool bath or combination bath/shower to one and a half (1 1/2) inches. (~~12-16-82~~)()

16. Table 7-5. Change fixture unit loading value for one and a half (1 1/2) inch horizontal drainage to two (2) fixture units. ()

0617. Section ~~613~~ 908. Exception - Vertical Wet Venting. A horizontal wet vent may be created provided it is created in a vertical position and all other requirements of Section ~~613~~ 908 are met. (~~8-25-88~~)()

0718. Section ~~419(b)~~ 722.2. Every cesspool, septic tank and seepage pit which has been abandoned or has been discontinued otherwise from further use or to which no waste or soil pipe from a plumbing fixture is connected, shall have the sewage removed therefrom and be completely filled with earth, sand, gravel, concrete or other approved material, if required by the Administrative Authority. (~~8-25-88~~)()

0819. Section ~~119(e)~~ 722.5. Where disposal facilities are abandoned consequent to connecting any premises with the public sewer, the permittee making the connection shall fill all abandoned facilities if required by the Administrative Authority within 30 days from the time of connecting to the public sewer. (8-25-88)()

0920. Section ~~608(e)~~ 807.4. ~~No~~ A domestic dishwashing machine in a non-residential installation shall be directly connected to a drainage system or food waste disposer without the use of an approved dishwasher airgap fitting on the discharge side of the dishwashing machine. Listed airgaps shall be installed with the flood level (FL) marking at or above the flood level of the sink or drainboard, whichever is higher. for residential use may be installed without the use of an airgap if the drain hose is looped to the bottom side of the counter top and secured properly. (8-25-88)()

21. Section 1002.3. Trap arms less than three (3) inches in diameter may not exceed one hundred thirty five (135) degrees without the use of a cleanout. ()

22. Chapter 13. Delete. ()

IDAPA 07 - DIVISION OF BUILDING SAFETY
07.02.06 - RULES CONCERNING THE UNIFORM PLUMBING CODE
DOCKET NO. 07-0206-9702
NOTICE OF PROPOSED RULES

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has proposed rule-making. The action is authorized pursuant to Section 54-2605(1), Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rule-making will be held as follows:

Public hearing(s) concerning this rule-making will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 15, 1997.

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 at the address below.

DESCRIPTIVE SUMMARY: The following is a statement in nontechnical language of the substance of the proposed rule:

To provide an alternate method of venting plumbing fixtures in addition to that which is in the Uniform Plumbing Code.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning this proposed rule, contact Joe Meyer, Bureau Chief, Division of Building Safety, 277 N. 6th Street, Suite 101, P.O. Box 83720, Boise, Idaho 83720-0068, (208) 334-3442.

Anyone may submit written comments regarding this rule. All written comments and data concerning the proposed rules must be directed to the undersigned and must be postmarked or delivered on or before October 22, 1997.

DATED this 20th day of August, 1997.

Connie J Mumm
Division of Building Safety
277 N. 6th, Suite 101
P.O. Box 83720
Boise, ID 83720-4801
(208) 334-3442/fax (208) 334-2683

TEXT OF DOCKET NO. 07-0206-9702

012. PLUMBING SYSTEMS.

In addition to the venting requirements in Chapter Nine of the 1997 Uniform Plumbing Code, the following venting system has been adopted for use. Air admittance valves that conform to both ANSI/ASSE 1051 and ASSE 1050 have been adopted for use in plumbing systems in the State of Idaho when installed according to the manufacturer installation standards with the limitation of no more than twenty four (24) drainage fixture units per vent. ()

0123. -- 999. (RESERVED).

IDAPA 09 - IDAHO DEPARTMENT OF LABOR
09.01.06 - RULES OF THE APPEALS BUREAU
DOCKET NO. 09-0106-9701
NOTICE OF PENDING RULE

EFFECTIVE DATE: These rules have been adopted by the agency and are now pending review by the 1998 Idaho State Legislature for final adoption. The pending rule becomes final and effective on July 1, 1998, 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 72-1333(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 pending rules clarify that all appeals within the Department are governed solely by the Department's rules of appeals procedure and by the Employment Security Law or by the applicable federal law governing the program; and adds filing by fax machine to the existing filing methods of mailing and personal delivery of appeals.

The pending rules are being adopted as proposed. No comments were received on the proposed rules, and there are no substantive amendments from the proposed rule text. The original text of the proposed rules was published August 6, 1997, in the Idaho Administrative Bulletin, Volume 97-8, pages 19 and 20.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Joseph Karpach, Jr., Appeals Bureau Chief, Idaho Department of Labor, at (208) 334-6268.

Dated this 14th day of August, 1997.

Roger B. Madsen, Director
Idaho Department of Labor
317 Main Street
Boise, ID 83735
Fax # (208) 334-6430

IDAPA 09
TITLE 01
Chapter 06

RULES OF THE APPEALS BUREAU

**There are no substantive changes
from the proposed rule text.**

**The original text was published in the Idaho Administrative Bulletin,
Volume 97-8, August 6, 1997, pages 19 and 20.**

**This rule has been adopted as Final by the Agency and is now pending review
by the 1998 Idaho State Legislature for final adoption.**

IDAPA 09 - IDAHO DEPARTMENT OF LABOR
09.01.30 - RULES OF UNEMPLOYMENT INSURANCE BENEFIT CLAIMS

DOCKET NO. 09-0130-9701

NOTICE OF PENDING RULE

EFFECTIVE DATE: These rules have been adopted by the agency and are now pending review by the 1998 Idaho State Legislature for final adoption. The pending rule becomes final and effective on July 1, 1998, 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 72-1333(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 pending rules clarify that a claims examiner may transfer any request for redetermination to the Appeals Bureau, and changes the provision for filing requests for redetermination by fax. Also, the pending rules provide that a claim may be canceled at any time, provided the claimant did not misrepresent or fail to report a material fact in making the claim and has repaid any benefits received, unless the benefits received will be offset from a new claim the claimant is filing. A typographical correction is being made to the rule in Section 061. The word "state" was misspelled "tate" and is being corrected.

The pending rules are being adopted as proposed. No comments were received on the proposed rules, and there are no substantive amendments from the proposed rule text. The original text of the proposed rule was published August 6, 1997, in the Idaho Administrative Bulletin, Volume 97-8, pages 21 and 22.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Jean Hull, Benefits Bureau Chief, Idaho Department of Labor, at (208) 334-6317.

Dated this 14th day of August, 1997.

Roger B. Madsen, Director
Idaho Department of Labor
317 Main Street
Boise, ID 83735
Fax # (208) 334-6430

IDAPA 09
TITLE 01
Chapter 30

RULES OF UNEMPLOYMENT INSURANCE BENEFIT CLAIMS

**There are no substantive changes
from the proposed rule text.**

**The original text was published in the Idaho Administrative Bulletin,
Volume 97-8, August 6, 1997, pages 21 and 22.**

**This rule has been adopted as Final by the Agency and is now pending review by the
1998 Idaho State Legislature for final adoption.**

IDAPA 09 - IDAHO DEPARTMENT OF LABOR
09.01.40 - RULES OF THE JOB TRAINING PARTNERSHIP ACT
DOCKET NO. 09-0140-9701
NOTICE OF PENDING RULE

EFFECTIVE DATE: These rules have been adopted by the agency and are now pending review by the 1998 Idaho State Legislature for final adoption. The pending rule becomes final and effective on July 1, 1998, 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 72-1333(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 current rule defining one category of "dislocated worker" for eligibility under Title III of the Job Training Partnership Act is too vague. By amending the definition and making it more specific, the Department will ensure that the criteria is interpreted as required by the Act.

The pending rules are being adopted as proposed. No comments were received on the proposed rules, and there are no substantive amendments from the proposed rule text. The original text of the proposed rule was published August 6, 1997, in the Idaho Administrative Bulletin, Volume 97-8, pages 23 and 24.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Kay Vaughan, Workforce Systems, Idaho Department of Labor, at (208) 334-6138.

Dated this 14th day of August, 1997.

Roger B. Madsen, Director
Idaho Department of Labor
317 Main Street
Boise, ID 83735
Fax # (208) 334-6430

IDAPA 09
TITLE 01
Chapter 40

RULES OF THE JOB TRAINING PARTNERSHIP ACT

**There are no substantive changes
from the proposed rule text.**

**The original text was published in the Idaho Administrative Bulletin,
Volume 97-8, August 6, 1997, pages 23 and 24.**

**This rule has been adopted as Final by the Agency and is now pending review by the
1998 Idaho State Legislature for final adoption.**

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE
16.03.03 - RULES GOVERNING CHILD SUPPORT SERVICES

DOCKET NO. 16-0303-9703

NOTICE OF PUBLIC HEARING

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has scheduled a public hearing at the request of 36 people, and has extended the period of public comment to the close of business, October 10, 1997. The action is authorized pursuant to Section(s) 56-202 and 56-203a, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be held as follows:

October 10, 1997, at 9:00 a.m., in the J.R. Williams Bldg., East Conference Room, 700 West State Street, 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: This rule deals with defining eligibility requirements for Temporary Assistance for Families in Idaho (TAFI), Medicaid, Food Stamps and Child Support Services; outlines how any support payments received will be allocated, including support payments received in Title IV-E Foster Care cases; states Child Support Services' fees and cost reimbursement; outlines the circumstances for termination of services; defines procedures for review and modification of orders; implements the federally required form for income withholding; procedure for reporting arrears to credit reporting agencies; good cause determination in license suspension proceedings; and rescission of voluntary acknowledgments. The complete notice of this action is found in Idaho Administrative Bulletin Volume No. 97-8, dated August 6, 1997, pages 170 through 180.

Anyone may submit written comments regarding this proposed rule-making. All written comments must be directed to the undersigned and must be delivered on or before October 10, 1997.

DATED this 1st day of October, 1997.

SHERRI KOVACH
Administrative Procedures Coordinator
DHW - Division of Legal Services
450 West State Street, 10th Floor
P.O. Box 83720
Boise, Idaho 83720-0036
(208) 334-5564 phone, (208) 334-5548 fax

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE
16.03.04 - RULES GOVERNING FOOD STAMP PROGRAM IN IDAHO
DOCKET NO. 16-0304-9703

NOTICE OF PENDING RULE AND AMENDMENT TO TEMPORARY RULE

EFFECTIVE DATE: The amendments to the temporary rule are effective July 1, 1997. These rules have been adopted by the agency and are now pending review by the 1998 Idaho State Legislature for final adoption. The pending rule becomes final and effective on July 1, 1998, 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(s) 56-202(b) and 39-106(l), Idaho Code.

DESCRIPTIVE SUMMARY: The proposed rules have been amended in response to public comment and to make typographical, transcriptional, and clerical corrections to the rules, and are being amended pursuant to Section 67-5227, Idaho Code.

Only the sections that have changes are printed in this bulletin. The original text of the proposed rules was published in the July 2, 1997 Administrative Bulletin, Volume 97-7, pages 118 through 149.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Patti Campbell at (208) 334-5819.

DATED this 1st day of October, 1997.

Sherri Kovach
Administrative Procedures Coordinator
DHW - Legal Services Division
450 West State Street - 10th Floor
P.O. Box 83720
Boise, Idaho 83720-0036
(208) 334-5564 phone; (208) 334-5548 fax

IDAPA 16
TITLE 03
Chapter 04

RULES GOVERNING FOOD STAMP PROGRAM IN IDAHO

**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 original text was published in the
Idaho Administrative Bulletin, Volume 97-7, July 2, 1997,
pages 118 through 149.**

**This rule has been adopted as Final by the Agency
and is now pending review by the
1998 Idaho State Legislature
for final adoption.**

TEXT OF DOCKET NO. 16-0304-9703

203. SOCIAL SECURITY NUMBER (SSN) REQUIREMENT.

Before certification, households must provide the Department the SSN, or proof of application for SSN, for each household member. If a household member has more than one (1) SSN, he must provide all of his SSNs. (7-1-97)T

01. Religious Objection. Households declaring a valid religious objection to getting or providing an SSN may get Food Stamps, if otherwise eligible. Document the valid reason for the SSN objection. Tell the household SSNs may be assigned to household members without their cooperation. Tell the household other sources may be used to get SSN data. (6-1-94)

02. Apply for SSN. If a household member does not have an SSN, he must apply for an SSN. After the member files the SSN application, he may get Food Stamps while the SSN is assigned. If a household member is unable to provide his SSN, he must apply for a duplicate SSN card. If a household member does not know if he has an SSN, he must apply for an SSN. If a household member has a questionable SSN he must apply for an SSN. SSN application process and proof is listed below: (7-1-97)

a. Application for SSN or duplicate SSN card. For the household member with a SS card, the Department must tell the household an SS-5 Application for SSN must be filed at an SSA office, give the household an HW 0446 Social Security Number Referral form tell the household proof of age, identity, and citizenship must be provided to the SSA. (6-1-94)

b. Proof of SSN application. The household must prove it applied for an SSN by giving one (1) of three (3) forms to the Department: A completed HW 0446 Social Security Number Referral, signed and dated by SSA, a completed SSA-5028 Evidence of Application for Account Number Card, signed and dated by SSA, a completed SSA-2853 Message From Social Security, signed and dated by a hospital representative. The acquired SSN card is proof of application. (6-1-94)

03. Proof of Application for an SSN for a Newborn. A newborn may participate when the household cannot provide proof of application for an SSN for the newborn. Proof of application for an SSN for that child must be provided at the next recertification or six (6) months after the month the child was born, whichever is later. If the household does not provide proof, treat the child as a disqualified household member the month following the month the household failed to provide the proof. (7-1-97)T

04. Expedited Services SSN Requirements. Households getting expedited services must furnish an SSN or apply for an SSN for each person before the ~~first~~ second full month of Food Stamp participation. If the application date is the first day of the month and proof is delayed, the household is assigned a normal certification period. For a household applying on the first day of the month, if the SSN or application for SSN is not provided for a household member during the first month, the person is treated as an excluded household member beginning the second month. A newborn may participate when the household cannot provide proof of application for an SSN for the

newborn. Proof of application for an SSN for that child must be provided at the next recertification or six (6) months after the month the child was born, whichever is later. ~~(7-1-97)~~(7-1-97)T

05. Refusal or Failure to Provide SSN. Refusal or failure, without good cause, to provide an SSN will end benefits of the person without an SSN. Refusal or failure, without good cause, to apply for an SSN, will end benefits of the person without an SSN. The person is not eligible until an SSN is provided or application is made. The disqualified person's income and resources must be counted in the Food Stamp budget. Explain these penalties to the household. If benefits are reduced or ended, because one (1) or more persons fail to meet the SSN requirement, send a Notice of Decision. The notice includes the name of the disqualified household member, the reason and the new household benefit. The notice tells the household the actions they must take to get Food Stamps for the disqualified member. (6-1-94)

06. Good Cause for Not Applying for SSN. If a member can show good cause why an SSN application was not completed, within the application month, the member can participate for an additional month. Good Cause is described below: (6-1-94)

a. Good cause exists if the HW 0446 or other documents show the household submitted form SS-5 to the SSA, but the SS-5 was not processed in a timely manner by the SSA. Once the SS-5 has been filed and accepted by the SSA, the member can be eligible until the SS-5 is processed. (6-1-94)

b. Good cause exists if documents or collateral data show the household applied for, or made every effort to apply for, an SSN. (6-1-94)

c. Good cause does not include household-caused delays due to illness, lack of transportation, or temporary absences. (6-1-94)

07. Person Unable to Get Proof for SSA. If the person is unable to get the proof required by SSA for an SSN, the Department will help the person get proof. (6-1-94)

08. Good Cause Extension. If the person cannot get an SSN in the application month, and good cause exists, a one (1) month extension must be granted to allow the person to get Food Stamps until the SSN is received. (6-1-94)

09. SSN Proof Required. Verify all SSNs, or application for SSNs, for each household member. SSNs are proved through Numident. (6-1-94)

10. SSN Not Proved Due to Numident Discrepancy. If there is a Numident discrepancy take the action listed below: (6-1-94)

a. Notify household. Notify the household, in writing, they must submit a corrected SS-5 and supporting data to SSA within ten (10) calendar days. Notify the household Food Stamps will end if the Department does not have proof the SS-5 was submitted to SSA within ten (10) calendar days. (6-1-94)

b. Evaluate good cause. Determine good cause for refusal to cooperate if a household claims it cannot submit the SS-5 and supporting data to SSA. If the supporting data has been destroyed good cause may exist. (6-1-94)

c. End benefits. Close the case after timely notice if the household refuses to cooperate. Refusal to cooperate means the household fails or refuses to submit the SS-5 and required proof to SSA, without good cause. (6-1-94)

(BREAK IN CONTINUITY OF SECTIONS)

576. CERTIFICATION PERIODS.

A certification period must be assigned for each household. Households must be assigned the longest certification period possible based on expected household circumstances. At the end of each certification period, entitlement to Food Stamps ends. Further eligibility starts only upon recertification based upon a newly completed application, an interview and verification. Benefits cannot be continued beyond the end of a certification period without a new determination of eligibility. (6-1-94)

01. First Month of Certification. The first month the household is eligible is the first month in the certification period for initial applicants. Upon recertification, a new certification period begins. (6-1-94)

02. Elderly or Disabled Households. Households consisting entirely of elderly or disabled members, whose income is stable, must be certified for up to twelve (12) months. (6-1-94)

03. Farmworker Households. Annual certification periods will be assigned to farmworkers who receive their annual salaries on a scheduled monthly basis. The income must not change as the amount of work changes. (6-1-94)

04. Self-Employed For At Least One (1) Year. Self-employed households, working as self-employed for at least one (1) year, will be certified up to twelve (12) months. Income must be readily predictable and household circumstances must not be likely to change. (6-1-94)

05. Self-Employed For Less Than One (1) Year. Households, self-employed less than one (1) year, will be certified up to six (6) months. Households self-employed for less than one (1) year are assigned a certification period to bring the household into the annual cycle. (6-1-94)

06. Financial and Medical Assistance Households. Households in which all members receive AABD, AABD-related Medicaid, or SSI or Medicaid will be assigned certification periods coinciding with the other program review. To align the Food Stamp certification with the redetermination date for the AABD, AABD-related Medicaid or SSI program, the household's Food Stamp certification can be shortened or extended when the AABD, AABD-related Medicaid, or SSI application is initially approved. The Food Stamp certification period for these households may be extended up to twelve (12) months. The household must be notified of changes in the length of the certification period. ~~(7-1-97)~~(7-1-97)T

07. Households Eligible for a Child Support Deduction. Households eligible for a child support deduction with no record of regular child support or arrearage payments will be certified up to three (3) months. Households eligible for a child support deduction with a record of regular child support or arrearage payments will be certified for up to six (6) months. These requirements do not apply to households assigned certification periods under Subsections 576.02, 576.04, 576.05, and 576.06. (5-1-97)T

08. Households Granted Separate Household Status. Households consisting of a parent and that parent's children who have been granted separate household status will be assigned a certification period up to six (6) months. Financial and medical assistance households granted separate household status must be assigned certification periods up to six (6) months. (9-1-94)

09. Stable Households. Households with stable income or work records, except self-employed and farmworker households, are certified for up to six (6) months. The household should expect no major changes in income, deductions, or household composition. (6-1-94)

10. Stable Homeless Households. Households in which all members are homeless, whose living arrangements reflect a stable living situation must be certified for up to six (6) months. Stable living situations include living with another household. Living in transitional housing is not a stable living situation. (6-1-94)

11. Unstable Households. Households will be certified for one (1) or two (2) months, when the household cannot predict its future circumstances, or when frequent changes in income or household status is expected. Households must be certified for the period the household can predict its circumstances, household status, and household income. Migrant and seasonal farmworkers, whose income is subject to large fluctuations during the work season will be certified for one (1) to two (2) months. The income fluctuation may be due to uncertainty of

continuous employment, or due to bad weather, or other circumstances. (6-1-94)

12. Residents of Alcohol and Drug Abuse Centers. Residents of alcohol and drug abuse centers may be certified for periods of one (1) to six (6) months depending on the length of the treatment or rehabilitation program. (6-1-94)

13. Certifications After the Fifteenth (15th) of the Month. Households eligible for a certification period of three (3) or fewer months must have their certification period increased by one (1) month if the application is approved after the fifteenth (15th) day of the application month and the household's circumstances warrant the longer period. (6-1-94)

(BREAK IN CONTINUITY OF SECTIONS)

793. NARCOTIC ADDICT AND ALCOHOLIC TREATMENT CENTERS.

Narcotic addicts and their children residing in a treatment center may qualify for Food Stamps. Alcoholics and their children residing in a treatment center may qualify for Food Stamps. Food Stamp rules for residents in a drug addiction or alcohol treatment and rehabilitation program lasting at least thirty (30) days are listed below: (9-1-94)

01. Center Provides Certification List. Each month, each center must give the Field Office a list of current client residents. The list's accuracy must be certified in writing by the center manager or designee. The Department must conduct random on-site visits to assure list accuracy. (6-1-94)

02. Resident and Nonresident Clients. Eligible narcotic addicts or alcoholics must be certified as one (1) person households. Eligible narcotic addicts with children or alcoholics with children residing in a center must be certified as one (1) household. Clients not residing at the treatment center are certified under normal procedures. (9-1-94)

03. Food Stamp Basis. Eligibility and Food Stamp amounts must be based on income and resources. (6-1-94)

04. Work Registration. Resident clients are exempt from work registration. (6-1-94)

05. Expedited Processing. When the application needs expedited processing, Food Stamps must be received by the ~~fifth~~ seventh calendar day after the application date. (~~6-1-94~~)(7-1-97)T

06. Normal Processing. If processing under normal procedures, the Department must verify circumstances before determining eligibility. Changes and recertifications are processed using the standards for all other households. Resident clients have the same rights to adverse action notices, fair hearings and lost Food Stamps as all other households. (6-1-94)

07. Center Misusing Food Stamps. The Department must promptly notify FCS if it believes a center is misusing coupons. The Department must not take action before FCS takes action against the center. (7-1-97)T

(BREAK IN CONTINUITY OF SECTIONS)

867. FOOD STAMP INFORMATION REQUIREMENTS.

Federal regulations and procedures in FCS notices and policy memos must be available for examination by the public. State plans of operation must be available for examination by the public. Examination may take place during office hours at Department headquarters. Handbooks must be available for examination upon request at each Field Office. The Department must provide information about Food Stamps through mass media, posters, fliers, pamphlets and face-to-face contacts. Minimum requirements are listed below: (7-1-97)T

01. Rights and Responsibilities. Households must be informed of Food Stamp program rights and responsibilities. (6-1-94)

~~02. Nutrition Information. Posters and pamphlets with information about foods with large amounts of protein, minerals and vitamins must be available to clients. Menus making use of these foods must be available to clients. Information about the relationship between health and diet must be available to clients. (6-1-94)~~

~~03. Expanded Food and Nutrition Education Program. Households should be encouraged to take part in the Expanded Food and Nutrition Education Program (EFNEP). When practical, EFNEP personnel must be allowed into Field Offices to distribute information and speak with Food Stamp recipients. (6-1-94)~~

~~04. Other Food Programs. Posters, pamphlets and fliers must be available to clients to explain the Special Supplemental Food Program for Women, Infants, and Children (WIC), and where available, the Commodity Supplemental Food Program. (6-1-94)~~

05. Bilingual Information. All program information must be available in Spanish. Spanish information must say the program is available without regard to race, color, sex, age, handicap, religious creed, national origin or political belief. (6-1-94)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE
16.03.05 - RULES GOVERNING AID TO THE AGED, BLIND AND DISABLED
DOCKET NO. 16-0305-9702

NOTICE OF PENDING RULE AND AMENDMENT TO TEMPORARY RULE

EFFECTIVE DATE: The amendments to the temporary rule are effective August 22, 1996. These rules have been adopted by the agency and are now pending review by the 1998 Idaho State Legislature for final adoption. The pending rule becomes final and effective on July 1, 1998, 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(s) 39-106(l) and 56-202(b), Idaho Code.

DESCRIPTIVE SUMMARY: The proposed rules have been amended in response to public comment and to make typographical, transcriptional, and clerical corrections to the rules, and are being amended pursuant to Section 67-5227, Idaho Code.

Only the sections that have changes are printed in this bulletin. The original text of the proposed rules was published in the July 2, 1997 Administrative Bulletin, Volume 97-7, pages 150 through 179.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Patti Campbell at (208) 334-5819.

DATED this 1st day of October, 1997.

Sherri Kovach
Administrative Procedures Coordinator
DHW - Legal Services Division
450 West State Street - 10th Floor
P.O. Box 83720
Boise, Idaho 83720-0036
(208) 334-5564 phone; (208) 334-5548 fax

IDAPA 16
TITLE 03
Chapter 05

RULES GOVERNING AID TO THE AGED, BLIND, AND DISABLED (AABD)

**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 original text was published in the
Idaho Administrative Bulletin, Volume 97-7, July 2, 1997,
pages 150 through 179.

This rule has been adopted as Final by the Agency
and is now pending review by the
1998 Idaho State Legislature
for final adoption.

TEXT OF DOCKET NO. 16-0305-9702

605. CITIZENSHIP AND LEGAL NON-CITIZEN REQUIREMENT.

The participant must be a citizen or national of the U.S. or an eligible legal non-citizen. (8-22-96)T

01. Eligible Legal Non-Citizens Before August 22, 1996. Eligible legal non-citizens are persons lawfully admitted to the U.S. for permanent residence. Eligible legal non-citizens are also persons lawfully living in the U.S. under color of law. The person can get Medicaid without time limits. (8-22-96)T

02. Eligible Legal Non-Citizens August 22, 1996 and Later. The participant must be a citizen of the U.S. or legal non-citizen. Nationals of American Samoa or Swain's Island are the equivalent of U.S. citizens. Only legal non-citizens listed in Subsections 605.03.a. through 605.03.g. are legal non-citizens. The participant must provide proof of citizenship or proof of legal non-citizen status. The participant must sign a declaration, under penalty of perjury, attesting to citizenship or legal non-citizen status. The parent or legal guardian must sign for a child or a participant with a legal guardian. ~~(8-22-96)T~~(8-22-96)T

03. Definitions for Legal Non-Citizen Requirement. (8-22-96)T

a. A permanent resident is a person admitted to the U.S. for permanent residence. (8-22-96)T

b. A refugee is a person admitted under 207 of the INA. (8-22-96)T

c. An asylee is a person granted asylum under 208 of the INA (8-22-96)T

d. A deportee is a person with deportation withheld under 243 of the INA. (8-22-96)T

e. A conditional entrant is a person granted conditional entry under 302(a)(7) of the INA. (8-22-96)T

f. A battered immigrant is an immigrant meeting certain INS entry conditions. (8-22-96)T

04. Legal Non-Citizen Requirements and Limitations. Legal non-citizens, who are otherwise eligible, are subject to the requirements and limitations in Subsections 605.04.a. through 605.04.f. (8-22-96)T

a. Permanent residents entering the U.S. August 22, 1996 or later, and having forty (40) quarters of ~~Social Security coverage~~ work, can get Medicaid without time limits after they live in the U.S. for five (5) years. ~~(8-22-96)T~~(8-22-96)T

b. Regardless of entry date, honorably discharged veterans, whose discharge reason is not alienage, can get Medicaid without time limits. This includes the veteran's spouse and unmarried dependent children. (8-22-96)T

c. Regardless of entry date, active duty members of the U.S. Armed Forces who are not on active duty for training only can get AABD without time limits. This includes the participant's spouse and unmarried dependent children. (8-22-96)T

d. Regardless of entry date, refugees can get Medicaid for five (5) years from their entry date. (8-22-96)T

e. Regardless of entry date, asylees can get Medicaid for five (5) years from the date asylum is granted. (8-22-96)T

f. Regardless of entry date, individuals whose deportation is withheld can get Medicaid for five (5) years from the date deportation is withheld. (8-22-96)T

05. Verifying Legal Non-Citizen Status. A participant's legal non-citizen status must be verified through the INS automated Alien Status Verification Index (ASVI). If INS reports the participant's status cannot be verified through ASVI, secondary proof is required before AABD can be based on legal non-citizen status. (8-22-96)T

(BREAK IN CONTINUITY OF SECTIONS)

633. EXTENDED (POSTPARTUM) MEDICAID FOR PREGNANT WOMEN.

A woman receiving Medicaid while pregnant continues to be eligible through the last day of the month in which the sixty (60) day post partum period ends. The sixty (60) day post partum period starts the last day of pregnancy. The last day of pregnancy is the day the child is born, the pregnant woman miscarries the fetus, or undergoes an induced abortion. The woman must meet Medicaid eligibility requirements during the sixty (60) day coverage period. Only pregnancy and postpartum services available under Idaho's Medicaid State Plan and those included in Idaho Department of Health and Welfare Rules, IDAPA 16.03.09, "Rules Governing Medical Assistance" are covered. Timely notice of termination must be mailed ten (10) days before the end of the coverage period, and can be mailed as early as the last day of pregnancy. An ineligible legal non-citizen or an illegal non-citizen with a pregnancy-related emergency medical condition is not eligible. Applications for Extended Medicaid made during the month the child is born, but after the child's birthdate, must not be approved for Extended Medicaid. ~~(8-22-96)T~~(8-22-96)T

**IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE
16.03.09 - RULES GOVERNING MEDICAL ASSISTANCE**

DOCKET NO. 16-0309-9707

NOTICE OF PENDING RULE

EFFECTIVE DATE: These rules have been adopted by the agency and are now pending review by the 1998 Idaho State Legislature for final adoption. The pending rule becomes final and effective on July 1, 1998, 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) 56-202 and 56-203, Idaho Code.

DESCRIPTIVE SUMMARY: The pending rules are being adopted as proposed. The original text of the proposed rules was published in the July 2, 1997 Administrative Bulletin, Volume 97-7, pages 180 through 184.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Lloyd Forbes at (208) 334-5795.

DATED this 3rd day in September, 1997.

Sherri Kovach
Administrative Procedures Coordinator
DHW - Legal Services Division
450 West State Street - 10th Floor
P.O. Box 83720
Boise, Idaho 83720-0036
(208) 334-5564 phone; (208) 334-5548 fax

**IDAPA 16
TITLE 03
Chapter 09**

RULES GOVERNING MEDICAL ASSISTANCE

**There are no substantive changes
from the proposed rule text.**

**The original text was published in the Idaho
Administrative Bulletin, Volume 97-7, July 2, 1997,
pages 180 through 184.**

**This rule has been adopted as Final by the Agency
and is now pending review by the
1998 Idaho State Legislature for final adoption.**

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE
16.03.09 - RULES GOVERNING MEDICAL ASSISTANCE
DOCKET NO. 16-0309-9710
NOTICE OF CORRECTION TO RULE-MAKING NOTICE

CORRECTION: The following docket is being reprinted to correct errors published in the September 3, 1997, Administrative Bulletin, Volume 97-9 on pages 139 through 140. The Notice of Temporary and Proposed Rulemaking contained an incorrect temporary effective date, and incorrect comment deadline date and an incorrect public hearing request date. The text of the rule also contained an incorrect effective date of the rule.

AUTHORITY: In compliance with Section 67-5228, Idaho Code, notice is hereby given that this agency, with the consent of the Administrative Rules Coordinator, is correcting a transcription error and is republishing this notice as it should have been published. This action is authorized pursuant to Section 67-5228, Idaho Code. The following is the notice in its corrected form.

NOTICE OF TEMPORARY AND PROPOSED RULE
DOCKET NO. 16-0309-9710

EFFECTIVE DATE: These temporary rules are effective July 1, 1997.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted temporary rules, and proposed regular rulemaking procedures have been initiated. The action is authorized pursuant to Section(s) 56-202(b), 56-203(g), and 56-203, Idaho Code.

PUBLIC HEARING SCHEDULE: Pursuant to Section 67-5222(2), Idaho Code, 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 September 17, 1997.

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: These rules expand Medicaid coverage to allow screening mammographies to be allowed for women at least forty years of age once per calendar year. Covered mammographies must be performed with certified or certifiable mammography equipment and staff.

TEMPORARY RULE JUSTIFICATION: Temporary rules have been adopted in accordance with Section 67-5226, Idaho Code and are necessary in order to confer a benefit.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary or proposed rule, contact Robbie Charlton at (208) 334-5795.

Anyone can submit written comments regarding this rule. All written comments and data concerning the rule must be directed to the undersigned and must be postmarked on or before September 24, 1997.

DATED this 3rd day of September, 1997.

Sherri Kovach, Administrative Procedures Coordinator
DHW - Division of Legal Services
450 W. State St, 10th Floor
P.O. Box 83720, Boise, ID 83720-0036
(208) 334-5564, (208) 334-5548 fax

TEXT OF DOCKET NO. 16-0309-9710

110. LABORATORY AND RADIOLOGY SERVICES.

01. Qualifications. Laboratories in a physician's office or a physician's group practice association, except when physicians personally perform their own patients' laboratory tests, must be certified by the Idaho Bureau of Laboratories and be eligible for Medicare certification for participation. All other Idaho laboratories must fulfill these requirements. (2-15-86)

02. Payment Procedures. Payment for laboratory tests can only be made to the actual provider of that service. An exception to the preceding is made in the case of an independent laboratory that can bill for a reference laboratory. A physician is not an independent laboratory. (2-15-86)

a. The payment level for clinical diagnostic laboratory tests performed by or personally supervised by a physician will be at a rate established by the Department that is no higher than Medicare's fee schedule. The payment level for other laboratory tests will be a rate established by the Department. (2-15-86)

b. The payment level for clinical diagnostic laboratory tests performed by an independent laboratory will be at a rate established by the Department that is no higher than Medicare's fee schedule. The payment level for other laboratory tests will be at a rate established by the Department. (2-15-86)

c. The payment level for clinical diagnostic laboratory tests performed by a hospital laboratory for anyone who is not an inpatient will be at a rate established by the Department that is no higher than Medicare's fee schedule as described in Section 085. The payment level for other laboratory tests will be at a rate established by the Department. (12-31-91)

d. Collection fees for specimens drawn by vein puncture or catheterization are payable only to the physician or laboratory who draws the specimen. (2-15-86)

03. Mammography Services. Idaho Medicaid will cover screening or diagnostic mammographies performed with certified or certifiable mammography equipment and staff. (7-1-97)T

a. Screening mammographies will be limited to one (1) per calendar year for women who are forty (40) or more years of age. No physician's referral or orders are required except for clients enrolled in Healthy Connections. (7-1-97)T

b. Diagnostic mammographies will be covered when a physician orders the procedure for a patient of any age who is at high risk. (7-1-97)T

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE
16.03.09 - RULES GOVERNING MEDICAL ASSISTANCE
DOCKET NO. 16-0309-9711

NOTICE OF TEMPORARY AND PROPOSED RULES

EFFECTIVE DATE: These temporary rules are effective July 1, 1997.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted temporary rules, and proposed regular rulemaking procedures have been initiated. The action is authorized pursuant to Section(s) 56-202 (b) and 56-203 (g), Idaho Code.

PUBLIC HEARING SCHEDULE: Pursuant to Section 67-5222(2), Idaho Code, 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 October 15, 1997.

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: These rule changes delete the requirement for Indian Health providers to bill dental services on the dental form and be paid on the fee-schedule. Effective July 1, 1997, they will be required to bill dental services on the HCFA 1500 claim form at the per visit amount specific to the facility. This change is being made at the request of the Indian tribes of Idaho.

TEMPORARY RULE JUSTIFICATION: Temporary rules have been adopted in accordance with Section 67-5226, Idaho Code and are necessary in order to comply with Idaho Code Section(s) 56-202 (b) and 56-203 (g), and in order to protect the public health, safety, and welfare.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary or proposed rule, contact Robbie Charlton at (208) 334-5924.

Anyone can submit written comments regarding this rule. All written comments and data concerning the rule must be directed to the undersigned and must be postmarked on or before October 22, 1997.

DATED this 1st day of October, 1997.

Sherri Kovach
Administrative Procedures Coordinator
DHW - Division of Legal Services
450 West State Street, 10th Floor
P.O. Box 83720
Boise, Idaho 83720-0036
(208) 334-5564 phone, (208) 334-5548 fax

TEXT OF DOCKET NO. 16-0309-9711

130. INDIAN HEALTH SERVICE CLINICS.

01. Care and Services Provided. Payment will be available to Indian Health Service (IHS) clinics for any service provided within the conditions of the scope of care and services described in Sections 050 through 155.
(12-31-91)

02. Payment Procedures. (7-1-93)
- a. Payment for services other than prescribed drugs and dental services will be made on a per visit basis at a rate not exceeding the out-patient visit rate established by the Federal Office of Management and Budget as published annually in the Federal Register. ~~(11-10-81)~~(7-1-97)T
- b. Payment for prescribed drugs will be available as described in Section 126. (12-31-91)
- c. The allowed dispensing fee used to compute maximum payment for each prescription will be the midpoint dispensing fee of the range of fees in effect at the date of service unless a higher fee is justified by a pharmacy cost of operations report on file with the Department. (11-10-81)
- ~~d. Payment for dental services will be made on a fee for service basis as described in Subsections 100.03 through 100.05. (12-31-91)~~
- ed. The provisions of Section 030, "Third Party Liability," are not applicable to Indian health service clinics. (12-31-91)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE
16.04.03 - RULES GOVERNING FEES FOR MENTAL HEALTH CENTER SERVICES

DOCKET NO. 16-0403-9701

NOTICE OF PROPOSED RULES

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has proposed rulemaking. The action is authorized pursuant to Section(s) 39-119, 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 October 15, 1997.

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 statement in nontechnical language of the substance of the proposed rules:

The program proposes to charge the insurance company the full charge and then apply the sliding scale fee to the client after the insurance company has paid the amount they are obligated for under the client's policy.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning these proposed rules, contact Roy Sargeant at (208) 334-5528.

Anyone can submit written comments regarding these rules. All written comments and data concerning the rule must be directed to the undersigned and delivered on or before October 22, 1997.

DATED this 1st day of October, 1997.

Sherri Kovach
Administrative Procedures Coordinator
DHW - Legal Services Division
450 West State Street - 10th Floor
P.O. Box 83720
Boise, Idaho 83720-0036
(208) 334-5564 phone; (208) 334-5548 fax

TEXT OF DOCKET NO. 16-0403-9701

100. FEE DETERMINATION.

The service recipient, parent or guardian must make application for Mental Health Program services and complete a "Fee Determination Form" (HW-0733) prior to delivery of services. The fee determination process includes the following procedures: (1-1-94)

01. Charges. An amount will be charged based on family size, income assets and allowable deductions, exclusive of third-party liable sources, but in no case will the amount charged for care services as specified in the table of charges exceed the cost of the services. (5-1-82)

02. Equity. To achieve equity in determining amounts to be charged, a "Discount Schedule" (HW-0734) will be employed. The "Discount Schedule" takes into consideration income, family size, and average expenditures by family size, and is shown in the TABLE in Subsection 100.03. (12-31-91)

03. Discount Schedule - TABLE. Incomes below the five percent (5%) level are to be charged the zero percent (0%) minimum rate.

TABLE 100A
Poverty Guidelines per the Federal Register as of February 12, 1992
Standard Fee Percentage Schedule (Sliding Fee Scale)

Number of Persons in Household									
1	2	3	4	5	6	7	8	9+	Client%
\$26,406	\$36,862	\$45,045	\$54,364	\$63,684	\$73,004	\$82,323	\$91,943	\$100,963	100%
\$25,244	\$35,241	\$43,064	\$51,974	\$60,883	\$69,793	\$78,703	\$87,613	\$96,522	95%
\$24,088	\$33,627	\$41,091	\$49,593	\$58,095	\$66,597	\$75,098	\$83,600	\$92,102	90%
\$22,941	\$32,025	\$39,135	\$47,232	\$55,328	\$63,425	\$71,522	\$79,619	\$87,719	85%
\$21,849	\$30,500	\$37,271	\$44,982	\$52,964	\$60,405	\$68,116	\$75,828	\$83,539	80%
\$20,808	\$29,048	\$35,496	\$42,840	\$50,185	\$57,529	\$64,873	\$72,217	\$79,561	75%
\$19,798	\$27,638	\$33,774	\$40,762	\$47,749	\$54,737	\$61,725	\$68,712	\$75,700	70%
\$18,802	\$26,247	\$32,074	\$38,710	\$35,346	\$51,982	\$58,618	\$65,254	\$71,890	65%
\$17,805	\$24,855	\$30,373	\$36,657	\$42,941	\$49,225	\$55,509	\$61,794	\$68,078	60%
\$16,813	\$23,471	\$28,681	\$34,615	\$40,549	\$46,483	\$52,417	\$58,351	\$64,285	55%
\$15,817	\$22,080	\$26,981	\$32,563	\$38,146	\$43,728	\$49,310	\$54,893	\$60,475	50%
\$14,823	\$20,693	\$25,287	\$30,519	\$35,750	\$40,982	\$46,214	\$51,446	\$56,678	45%
\$13,841	\$19,321	\$23,611	\$28,495	\$33,380	\$38,265	\$43,150	\$48,035	\$52,920	40%
\$12,851	\$17,940	\$21,923	\$26,458	\$30,994	\$35,530	\$40,065	\$44,601	\$49,137	35%
\$11,866	\$16,565	\$20,242	\$24,430	\$28,619	\$32,807	\$36,995	\$41,183	\$45,371	30%
\$10,876	\$15,183	\$18,554	\$22,393	\$26,231	\$30,070	\$33,909	\$37,748	\$41,586	25%
\$9,888	\$13,803	\$16,867	\$20,357	\$23,847	\$27,337	\$30,826	\$34,316	\$37,806	20%
\$8,900	\$12,424	\$15,182	\$18,323	\$21,464	\$24,605	\$27,746	\$30,888	\$34,029	15%
\$7,911	\$11,044	\$13,495	\$16,287	\$19,079	\$21,871	\$24,664	\$27,456	\$30,248	10%
\$6,970	\$9,730	\$11,890	\$14,350	\$16,810	\$19,270	\$21,730	\$24,190	\$26,650	5%

Clients with income below the Department's minimum level may have their fee established at zero (0) when properly authorized. (7-1-93)

04. Forms. To achieve simplicity of operation, two (2) basic documents are used to determine ability to pay -- a "Fee Determination Form" and a "Discount Schedule." (5-1-82)

a. The "Fee Determination Form," when properly completed, contains the economic factors -- income/allowable deductions/size of family -- necessary to determine the charge by easy referral to the "Discount Schedule." (5-1-82)

b. The "Discount Schedule" reflects variations in the cost of living by family size and adjusted gross income. (5-1-82)

05. Review of Fees. A review of ability determinations will be made: (5-1-82)
- a. On petition of the person receiving services; or (1-1-94)
 - b. If circumstances are known to have changed; or (5-1-82)
 - c. Annually for the purpose of updating the determinations to current conditions which may or may not have changed during the previous year. (5-1-82)
06. Allowable Deductions from Income. The only allowable deductions from income are for expenses projected to occur during the annual charge period: (5-1-82)
- a. Court-ordered obligations paid annually; and (5-1-82)
 - b. Annual child care expenses necessary to availability for employment; and (5-1-82)
 - c. Annual dependent support payments for children not included in dependents for calculating percent of fee; and (5-1-82)
 - d. Annual medical expenses (1-1-94)
07. Adjustments to Established Fee. Adjustments, such as a waiver or reduction of fees, may only be made upon signature authorization of the Director. Clinical criteria based on the following guidelines may be used as a basis for adjustment: (12-31-91)
- a. There is reasonable expectation that without receiving the service, the mentally ill person would severely regress and require more intensive and costly care or institutionalization; and (5-1-82)
 - b. Adjustments to other agencies or organizational units may be negotiated and established by contract with the Department. (12-31-91)
08. Established Fee. The maximum fee charged for Community Mental Health Center services shall be that established by the Department of Health and Welfare. (12-31-91)
09. Charges for Community Mental Health Center Services. (1-1-94)
- a. Diagnostic: (1-1-94)
 - i. Psychiatric Examination - sixty-three dollars per hour (\$63/hr); (1-1-94)
 - ii. Psychosocial Examination - fifty-seven dollars per hour (\$57/hr); (1-1-94)
 - iii. Psychological Testing - fifty-seven dollars per hour (\$57/hr); (1-1-94)
 - iv. Medical - fifty-seven dollars per hour (\$57/hr). (1-1-94)
 - b. Treatment Service: (1-1-94)
 - i. Individual Therapy - fifty-seven dollars per hour (\$57/hr); (1-1-94)
 - ii. Family/Couple Therapy - fifty-seven dollars per hour (\$57/hr); (1-1-94)
 - iii. Group Therapy - twenty-one dollars per hour (\$21/hr); (1-1-94)
 - iv. Inpatient Service - fifty-seven dollars per hour (\$57/hr); (1-1-94)
 - v. Emergency Service - fifty-seven dollars per hour (\$57/hr). (1-1-94)

- c. Medical Service: (1-1-94)
- i. Chemotherapy Visit - twenty-eight dollars per visit (\$28/visit); (1-1-94)
- ii. Blood Drawing - ten dollars per occurrence (\$10/occurrence); (1-1-94)
- iii. Nursing Service - thirteen dollars per visit (\$13/visit); (1-1-94)
- iv. Injections - eight dollars (\$8) plus cost of medication. (1-1-94)
- d. Collateral Contact (Interview with collaterals - service recipient seen or not seen)* - sixty-three dollars per hour (\$63/hr). (1-1-94)
- e. Community Support Service (Day Treatment/Partial Care) - fourteen dollars per hour (\$14/hr). (1-1-94)
- f. Other Nonclient Specific (Consultation/Education) - sixty-three dollars per hour (\$63/hr). (1-1-94)
- g. Transportation - twenty-five cents per mile (\$.25/mile). (1-1-94)

* This activity includes those instances in which collaterals having primary treatment relationship to the client are interviewed regarding a client with the client included or intentionally excluded. This category does not include case management and other agency collaterals or service coordination activities. (1-1-94)

10. Obligation to Pay Difference Between Insurance and Mental Health Charges. If the person responsible for payment has insurance coverage, then the private insurance obligation will be one hundred percent (100%) of the amount contained in the policy, but not to exceed the Mental Health Charge. If the insurance company pays less than the Mental Health charge, then the participant will be responsible to pay towards the difference between what the insurance paid and the original Mental Health charge based upon their ability to pay as determined by the sliding fee schedule. ()

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE
16.04.06 - RULES GOVERNING FEES FOR ADULT AND CHILD DEVELOPMENT CENTERS
DOCKET NO. 16-0406-9701
NOTICE OF PROPOSED RULES

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has proposed rulemaking. The action is authorized pursuant to Section(s) 39-119, 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 October 15, 1997.

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 statement in nontechnical language of the substance of the proposed rules:

The Developmental Disabilities Program currently charges clients with insurance at a sliding fee scale before billing the insurance company, which results in diminished collections for services. The program proposes to charge the insurance company the full charge and then apply the sliding fee scale to the client after the insurance company has paid the amount they are obligated for under the client's policy.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning these proposed rules, contact Paul Swatsenbarg at (208) 334-5512.

Anyone can submit written comments regarding these rules. All written comments and data concerning the rule must be directed to the undersigned and delivered on or before October 22, 1997.

DATED this 1st day of October, 1997.

Sherri Kovach
Administrative Procedures Coordinator
DHW - Legal Services Division
450 West State Street - 10th Floor
P.O. Box 83720
Boise, Idaho 83720-0036
(208) 334-5564 phone; (208) 334-5548 fax

TEXT OF DOCKET NO. 16-0406-9701

100. FEE DETERMINATION.

The parent(s) or guardian must make application for Adult and Child Development Center services and complete a "Fee Determination Form" (HW-0733) prior to delivery of services. The fee determination process includes the following procedures: (5-1-82)

01. Ability to Pay. Charges are organized into a discount schedule based upon the number of dependents and income. (5-1-82)

a. Ability determination will be made on the first visit, if possible, utilizing a fee determination form. (5-1-82)

- b. Redetermination of ability will be made: (5-1-82)
 - i. At least annually; or (5-1-82)
 - ii. Upon request of the person receiving services; or (9-20-91)
 - iii. At any time changes occur in family size, income, allowable deductions. (9-20-91)
 - c. Information regarding third-party payors and other resources including, but not limited to, Medicaid, Medicare, or insurance, must be identified and developed in order to determine fully the responsible party's ability to pay and to maximize reimbursement for the cost of service provided. (9-20-91)
 - d. A follow-up system will be established and maintained by the Adult and Child Development Center to obtain required information not available at the time of the initial financial interview. (5-1-82)
 - e. Persons with a developmental disability receiving services may be required to produce necessary supporting documentation. (9-20-91)
02. Time of Payment. Normally charges for services will be due upon delivery of the service unless other arrangements are made, such as for monthly billing. (5-1-82)
03. Charges. An amount will be charged based on family size, resources, income assets and allowable deductions, exclusive of third-party liable sources, but in no case will the amount charged exceed the cost of the services. (9-20-91)
04. Equity. To achieve equity in determining amounts to be charged, a "Discount Schedule" will be employed. The "Discount Schedule" takes into consideration income, family size, and average expenditures by family size, and is shown in the TABLE in Subsection 100.05. (1-7-94)
05. Discount Schedule - TABLE. Incomes below the five percent (5%) level are to be charged zero percent (0%) minimum rate.

TABLE 100.05
Poverty Guidelines per the Federal Register as of February 12, 1993
Standard Fee Percentage Schedule (Sliding Fee Scale)

Number of Persons in Household									
1	2	3	4	5	6	7	8	9+	Client%
\$26,406	\$36,862	\$45,045	\$54,364	\$63,684	\$73,004	\$82,323	\$91,943	\$100,963	100%
\$25,244	\$35,241	\$43,064	\$51,974	\$60,883	\$69,793	\$78,703	\$87,613	\$96,522	95%
\$24,088	\$33,627	\$41,091	\$49,593	\$58,095	\$66,597	\$75,098	\$83,600	\$92,102	90%
\$22,941	\$32,025	\$39,135	\$47,232	\$55,328	\$63,425	\$71,522	\$79,619	\$87,719	85%
\$21,849	\$30,500	\$37,271	\$44,982	\$52,964	\$60,405	\$68,116	\$75,828	\$83,539	80%
\$20,808	\$29,048	\$35,469	\$42,840	\$50,185	\$57,529	\$64,873	\$72,217	\$79,561	75%
\$19,798	\$27,638	\$33,774	\$40,762	\$47,749	\$54,737	\$61,725	\$68,712	\$75,700	70%
\$18,082	\$26,247	\$32,074	\$38,710	\$35,346	\$51,982	\$58,618	\$65,254	\$71,890	65%
\$17,805	\$24,855	\$30,373	\$36,657	\$42,941	\$49,225	\$55,509	\$61,794	\$68,078	60%
\$16,813	\$23,471	\$28,681	\$34,615	\$40,549	\$46,483	\$52,417	\$58,351	\$64,285	55%

Number of Persons in Household									
1	2	3	4	5	6	7	8	9+	Client%
\$15,817	\$22,080	\$26,981	\$32,563	\$38,146	\$43,728	\$49,310	\$54,893	\$60,475	50%
\$14,823	\$20,693	\$25,287	\$30,519	\$35,750	\$40,982	\$46,214	\$51,446	\$56,678	45%
\$13,841	\$19,321	\$23,611	\$28,495	\$33,380	\$38,265	\$43,150	\$48,035	\$52,920	40%
\$12,851	\$17,940	\$21,923	\$26,458	\$30,994	\$35,530	\$40,065	\$44,601	\$49,137	35%
\$11,866	\$16,565	\$20,242	\$24,430	\$28,619	\$32,807	\$36,995	\$41,183	\$45,371	30%
\$10,876	\$15,183	\$18,554	\$22,393	\$26,231	\$30,070	\$33,909	\$37,748	\$41,568	25%
\$9,888	\$13,803	\$16,867	\$20,357	\$23,847	\$27,337	\$30,826	\$34,316	\$37,806	20%
\$8,900	\$12,424	\$15,182	\$18,323	\$21,464	\$24,605	\$27,746	\$30,888	\$34,029	15%
\$7,911	\$11,044	\$13,495	\$16,287	\$19,079	\$21,871	\$24,664	\$27,456	\$30,248	10%
\$6,970	\$9,730	\$11,890	\$14,350	\$16,810	\$19,271	\$21,730	\$24,190	\$26,650	5%

(9-20-91)

06. Determination of Ability to Pay. To achieve simplicity of operation, two (2) basic documents are used to determine ability to pay -- a "Fee Determination Form" and a "Discount Schedule." (5-1-82)

a. The "Fee Determination Form," when properly completed, contains the economic factors -- income/allowabledeductions/sizeoffamily --necessarytodeterminethechargebyeasyreferraltothe"DiscountSchedule." (5-1-82)

b. The "Discount Schedule" reflects variations in the cost of living by family size and adjusted gross income. (5-1-82)

07. Review of Fees. A review of ability determinations will be made: (5-1-82)

a. On petition of the person with a developmental disability receiving services; or (9-20-91)

b. If circumstances are known to have changed; or (5-1-82)

c. Annually for the purpose of updating the determinations to current conditions which may or may not have changed during the previous year. (5-1-82)

08. Allowable Deductions from Income. The only allowable deductions from income are for expenses projected to occur during the annual charge period: (5-1-82)

a. Court-ordered obligations paid annually; and (5-1-82)

b. Annual child care expenses necessary to availability for employment; and (5-1-82)

c. Annual dependent support payments for children not included in dependents for calculating percent of fee; and (5-1-82)

d. Annual medical expenses; and (1-7-94)

e. Transportation expenses of twenty-six cents (\$.26) per mile or the prevailing rate approved by the State Board of Examiners multiplied by the estimate of annual miles of transportation to the Center provided by parent(s) or guardian(s); and (9-20-91)

f. Annual extraordinary rehabilitative expenses; and (9-20-91)

g. Annual state and federal income tax payments, including FICA taxes. (5-1-82)

09. Established Fee. The maximum hourly fee or flat fee charged for Adult and Child Development Center services shall be that established by the Department of Health and Welfare. It is anticipated that the fees will be reviewed at least every two (2) years and adjusted for inflationary increases. The current charges are set out in the TABLE in Subsection 100.10. The fees for services based on Medicaid reimbursement may vary according to inflationary increases. Fees will be reviewed and adjusted as the Medicaid rates vary. Current information regarding services and fee charges can be obtained from regional Adults and Child Development Centers. (1-7-94)

10. Hourly Charges for Adult and Child Development Center Services - TABLE. (1-7-94)

a. Medical. (1-7-94)

b. Psychological: seventy-nine dollars (\$79). (1-7-94)

i. Individual: sixty-three dollars (\$63). (1-7-94)

ii. Family: sixty-three dollars (\$63). (1-7-94)

iii. Group: twenty-four dollars (\$24). (1-7-94)

iv. Evaluation: sixty-three dollars (\$63). (1-7-94)

c. Social Work: (1-7-94)

i. Individual: sixty-three dollars (\$63). (1-7-94)

ii. Family: sixty-three dollars (\$63). (1-7-94)

iii. Group: twenty-four dollars (\$24). (1-7-94)

iv. Evaluation: sixty-three dollars (\$63). (1-7-94)

d. Speech/Audiology: (1-7-94)

i. Individual: forty-seven dollars (\$47). (1-7-94)

ii. Family: forty-seven dollars (\$47). (1-7-94)

iii. Group: thirteen dollars (\$13). (1-7-94)

iv. Evaluation: forty-seven dollars (\$47). (1-7-94)

e. Physical Therapy: (1-7-94)

i. Individual: forty-seven dollars (\$47). (1-7-94)

ii. Group: ten dollars (\$10). (1-7-94)

iii. Evaluation: forty-seven dollars (\$47). (1-7-94)

f. Occupational Therapy: (1-7-94)

i. Individual: thirty-two dollars (\$32). (1-7-94)

- ii. Group: ten dollars (\$10). (1-7-94)
- iii. Evaluation: thirty-two dollars (\$32). (1-7-94)
- g. Developmental/Behavioral: (1-7-94)
- i. Individual: twenty-four dollars (\$24). (1-7-94)
- ii. Group: fourteen dollars (\$14). (1-7-94)
- iii. Evaluation: twenty-four dollars (\$24). (1-7-94)
- h. Therapeutic Recreation: (1-7-94)
- i. Individual: sixteen dollars (\$16). (1-7-94)
- ii. Group: nine dollars (\$9). (1-7-94)
- iii. Evaluation: sixteen dollars (\$16). (1-7-94)
- i. Personal Care Service: (1-7-94)
- i. Case Management Ongoing-PCS: forty-five dollars (\$45). (1-7-94)
- ii. Case Management- Development Individual Community Services Plan (one-time flat fee only):
two hundred and seventy dollars (\$270). (1-7-94)
- iii. QMRP Plan Development and/or Evaluation (flat fee): seventy-two dollars (\$72). (1-7-94)
- iv. QMRP Visit: twenty-six dollars (\$26). (1-7-94)
- j. Deaf Interpretation: (1-7-94)
- i. Non-Certified: eight dollars (\$8). (1-7-94)
- ii. Partially Certified: ten dollars (\$10). (1-7-94)
- iii. Certified: twelve dollars (\$12). (1-7-94)
- k. Transportation (or the prevailing rate approved by the State Board of Examiners): twenty-six cents
(\$0.26) per mile. (1-7-94)
- l. Collateral Contact (Interview with collaterals - service recipient seen or not seen): * sixty-three
dollars (\$63). (1-7-94)

* This activity includes those instances in which collaterals having primary treatment relationship to the person receiving service are interviewed regarding him with him included or intentionally excluded. This category does not include case management and other agency collaterals or service coordination activities. (9-20-91)

11. Adjustments to Established Fee. Adjustments such as a waiver or reduction of fees may be made by authorization of the Director of the Department of Health and Welfare or his designee. Adjustments must be evidenced by written documents demonstrating the reasons or justifications for the adjustment. (9-20-91)

12. Waiver Under Public Law 99-457. If a child has an approved individualized education plan or an individualized family service plan under the rules and regulations of Public Law 99-457, the persons receiving services and families will not be charged fees for evaluations and services covered by those educational plans.

However, if the child becomes ineligible under this law, a redetermination of services and parent fee obligations will be necessary. (9-20-91)

13. Obligation to Pay A/CDC Charges. The responsible person is liable for one hundred percent (100%) of the A/CDC charge and will be billed based upon their ability to pay as determined by the sliding fee schedule. However, when the participant has insurance coverage, the private insurance obligation will be one hundred percent (100%) of the A/CDC charge, but not to exceed any maximums established in the insurance policy. Any balance remaining after payment by any available insurance, will be billed to the responsible party based upon their ability to pay as determined by the sliding fee schedule. ()

**IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE
16.04.15 - RULES GOVERNING HOMEMAKER SERVICES**

DOCKET NO. 16-0415-9701

NOTICE OF PROPOSED RULES

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has proposed rulemaking. The action is authorized pursuant to Section(s) 39-119, 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 October 15, 1997.

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 statement in nontechnical language of the substance of the proposed rules:

Authority for this program is no longer with the Department of Health and Welfare, but with another agency. Department of Health and Welfare rules governing Homemaker Services must be repealed.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning these proposed rules, contact Roseanne Hardin at (208) 334-5700.

Anyone can submit written comments regarding these rules. All written comments and data concerning the rule must be directed to the undersigned and delivered on or before October 22, 1997.

DATED this 1st day of October, 1997.

Sherri Kovach
Administrative Procedures Coordinator
DHW - Legal Services Division
450 West State Street - 10th Floor
P.O. Box 83720
Boise, Idaho 83720-0036
(208) 334-5564 phone; (208) 334-5548 fax

THIS RULE IS REPEALED IN ITS ENTIRETY

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE
16.06.07 - RULES GOVERNING JUVENILE JUSTICE SERVICES
DOCKET NO. 16-0607-9701
NOTICE OF PROPOSED RULES

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has proposed rulemaking. The action is authorized pursuant to Section(s) 39-105(l), 39-106(l)(a), 56-202(b) and 56-204A, 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 October 15, 1997.

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 statement in nontechnical language of the substance of the proposed rules:

Authority for this program is no longer with the Department of Health and Welfare. Department of Health and Welfare rules governing Juvenile Justice Services must be repealed.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning these proposed rules, contact Roseanne Hardin at (208) 334-5680.

Anyone can submit written comments regarding these rules. All written comments and data concerning the rule must be directed to the undersigned and delivered on or before October 22, 1997.

DATED this 1st day of October, 1997.

Sherri Kovach
Administrative Procedures Coordinator
DHW - Legal Services Division
450 West State Street - 10th Floor
P.O. Box 83720
Boise, Idaho 83720-0036
(208) 334-5564 phone; (208) 334-5548 fax

THIS RULE IS REPEALED IN ITS ENTIRETY

IDAPA 17 - INDUSTRIAL COMMISSION
17.02.02 - SCOPE, COVERAGE, LIABILITY
DOCKET NO. 17-0202-9701

NOTICE OF PENDING RULE AND AMENDMENT TO TEMPORARY RULE

EFFECTIVE DATE: These rules have been adopted by the agency and are now pending review by the 1997 Idaho State Legislature for final adoption. The pending rule becomes final and effective upon adjournment of the legislature, 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(s) 72-508, 72-212, 72-213, and 72-214, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and amending the existing 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.

This rule sets forth the procedure and form by which certain members of a sole proprietor's family not dwelling in his household may exempt themselves from workers' compensation coverage under Section 72-212(5), Idaho Code, and provides a mechanism for revocation of the exemption. The IC53 form has been revised to make the title more specific and to clarify the language. The references to the IC53 form in rule 011.01 and 011.02.b. have been amended to conform with the changes in the form. Additional text which inadvertently was omitted in the first published version of the rule has been inserted in Rule 011.02.h.

The proposed rules have been amended in response to public comment and to make typographical, transcriptional, and clerical corrections to the rules, and are being amended pursuant to Section 67-5227, Idaho Code. Rather than keep the temporary rules in place while the pending rules await legislative approval, the Industrial Commission amended the temporary rules with the same revisions which have been made to the proposed rules.

Only the sections that have changes are printed in this bulletin. The original text of the proposed rules was published in the Idaho Administrative Bulletin, Volume 97-6, dated June 4, 1997, pages 132 through 135.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Christi Simon, Employer Compliance Manager, Industrial Commission, (208)334-6000.

DATED this 19th day of April 1997.

Patricia S. Ramey, Commission Secretary
Industrial Commission
317 Main Street
P. O. Box 83720
Boise, Idaho 83720-0041

IDAPA 17
TITLE 02
Chapter 02

SCOPE, COVERAGE, LIABILITY

**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 original text was published in the
Idaho Administrative Bulletin, Volume 97-6, June 4, 1997,
pages 132 through 135.**

**This rule has been adopted as Final by the Agency
and is now pending review by the
1998 Idaho State Legislature
for final adoption.**

TEXT OF DOCKET NO. 17-0202-9701

**011. RULES GOVERNING PROCEDURE FOR FILING ELECTION FOR EXEMPTION OR
REVOCAION OF EXEMPTION.**

01. Authority. Pursuant to Section 72-212, Idaho Code, the Industrial Commission hereby promulgates a rule, including a form designated as IC53 ~~Employee's Election for Exemption or Revocation of Exemption Declaration Under Idaho Code Section 72-212(5)~~ (Appendix A), to establish a procedure by which a family member employee of a sole proprietorship who is related to the sole proprietor employer within the first degree of consanguinity, and who is not residing in the household of the sole proprietor employer, may elect exemption from workers' compensation insurance coverage. It also sets forth the manner in which employees may revoke a previous exemption. ~~(7-1-97)T~~(7-1-97)T

02. Filing Requirements. (7-1-97)T

a. Each person who elects to exempt himself/herself from coverage under Section 72-212(5) of the Idaho Workers' Compensation Law must file a written declaration of such exemption with the Industrial Commission. (7-1-97)T

b. The validity of the election is subject to approval by the Commission. The Commission reserves the right to require verification of all information submitted ~~in on the election for exemption~~ IC53 form (Appendix A). Fraud or misrepresentation in the information provided will void the election. ~~(7-1-97)T~~(7-1-97)T

c. In order to revoke an election for exemption, a revocation of exemption form must be filed with the Industrial Commission. (7-1-97)T

d. The form for filing an election for exemption or revocation of exemption shall be an IC53 ~~Employee's Election for Exemption or Revocation of Exemption~~ Declaration Under Idaho Code Section 72-215(5) (Appendix A). The form shall be submitted to the Commission on eight and one half by eleven inch (8 1/2" x 11") paper in a format substantially the same as that shown in Appendix A. The form is designated as either an election for exemption or revocation of exemption by checking the appropriate ~~box~~ declaration at the bottom of the form.

~~(7-1-97)F(7-1-97)T~~

e. The IC53 ~~Election for Exemption and Revocation of Exemption~~ Declaration Under Idaho Code Section 72-212(5) form must be signed by both the employee and the employer. An original and one (1) copy of the IC53 ~~Election for Exemption and Revocation of Exemption~~ form shall be filed with the Commission. Upon approval by the Commission, the copy will be returned to the employee filing for an exemption or revocation of an exemption.

~~(7-1-97)F(7-1-97)T~~

f. If the employer is insured, it is the responsibility of the employer to file a copy of the IC53 ~~Election for Exemption or Revocation of Exemption~~ form with the employer's insurance company.

~~(7-1-97)F(7-1-97)T~~

g. The effective date of the exemption or revocation of exemption shall be the date the properly completed form is received by the Commission.

~~(7-1-97)T~~

h. The exemption shall remain in effect until ~~Aa~~ revocation of exemption is filed with the Commission, or, termination of employment with the designated employer, or, upon the death of the employee, whichever occurs first.

~~(7-1-97)F(7-1-97)T~~

By my signature I certify that the foregoing is true and correct, to the best of my knowledge.

Signature of Employee: _____ Date: _____

Signature of Employer: _____ Date: _____

IDAPA 17 - INDUSTRIAL COMMISSION
17.02.03 - SECURITY FOR COMPENSATION
DOCKET NO. 17-0203-9701
NOTICE OF PENDING RULE

EFFECTIVE DATE: These rules have been adopted by the agency and are now pending review by the 1998 Idaho State Legislature for final adoption. The pending rule becomes final and effective upon adjournment of the legislature, 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. The action is authorized pursuant to Section(s) 72-508, 72-324, 72-327, and 72-328, 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 any change.

The pending rules are being adopted as proposed. The original text of the proposed rules was published in the Idaho Administrative Bulletin, Volume 97-7, dated July 2, 1997, pages 185 through 188.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Gary W. Stivers, Executive Director, Industrial Commission, at the address and telephone number listed below.

DATED this 19th day of April 1997.

Patricia S. Ramey, Commission Secretary
Industrial Commission
317 Main Street
P. O. Box 83720
Boise, Idaho 83720-0041

IDAPA 17
TITLE 02
Chapter 03

SECURITY FOR COMPENSATION

**There are no substantive changes
from the proposed rule text.**

**The original text was published in the Idaho Administrative Bulletin,
Volume 97-7, July 2, 1997, pages 185 through 188.**

**This rule has been adopted as Final by the Agency and is now pending review
by the 1998 Idaho State Legislature for final adoption.**

IDAPA 17 - INDUSTRIAL COMMISSION
17.02.03 - SECURITY FOR COMPENSATION
DOCKET NO. 17-0203-9702
NOTICE OF PUBLIC HEARING

AUTHORITY: In compliance with Section 67-5220(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(s) 72-508, 72-301, 72-302, 72-304, and 72-311, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing concerning this rule-making will be held as follows:

Tuesday, October 7, 1997, at 2:00 p.m.
In the Industrial Commission Offices
317 Main Street, 1st floor west, 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 summary of this action is found in Idaho Administrative Bulletin Volume 97-7, dated July 2, 1997, pages 189 through 197.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Executive Director Gary W. Stivers, Industrial Commission, at the address or phone number below.

Anyone may submit written comments regarding this proposed rule-making. All written comments must be directed to the undersigned and must be delivered on or before October 7, 1997.

DATED this 19th day of April 1997.

Patricia S. Ramey, Commission Secretary
Industrial Commission
317 Main Street
P. O. Box 83720
Boise, Idaho 83720-0041

IDAPA 17 - INDUSTRIAL COMMISSION
17.02.04 - WORKERS COMPENSATION LAW - BENEFITS
DOCKET NO. 17-0204-9402

NOTICE OF CORRECTION TO FINAL RULE

CORRECTION: The following notice is being printed to correct an error made by the Office of Administrative Rules. The final rule was never updated to the Idaho Administrative Code. The original final notice and rule were published in the March 1, 1995, Administrative Bulletin, Volume 95-3 on pages 106 through 111. The original docket is being republished following this notice.

AUTHORITY: In compliance with Section 67-5228, Idaho Code, notice is hereby given that this agency, with the consent of the Administrative Rules Coordinator, is correcting a transcription error. This action is authorized pursuant to Section 67-5228, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise statement of the correction being made:

Docket No. 17-0204-9402 was published as a final rule in the March 1, 1995 Administrative Bulletin, Volume 95-3. The final text of this rule was inadvertently not updated and not included in the Idaho Administrative Code. The docket is being republished following this notice and has already been updated to the current Idaho Administrative Code.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this correction, contact Karen L. Gustafson at (208) 334-3579.

DATED this 1st day of October, 1997.

Karen L. Gustafson
Office of the Administrative Rules Coordinator
Department of Administrative
PO Box 83720, Boise, ID 83720-0011

TEXT OF DOCKET NO. 17-0204-9402

~~322. MEDICAL REPORT FORMS.~~

~~01. Seven (7) Days to Submit Report. Any physician or other practitioner providing any evaluation, examination and/or treatment to any person claiming to have suffered a job-related injury SHALL submit a written report to the Industrial Commission, 317 Main Street, P. O. Box 83720, Boise, ID 83720-0041, within seven (7) days following each evaluation, examination and/or treatment. (11-17-78)~~

~~02. Report Form and Content. The Written report required by this rule shall be in substantially the following form and submitted on eight and one half by eleven inch (8 1/2" x 11") paper:~~

~~**IC Form 2 - INDUSTRIAL COMMISSION**
P. O. Box 83720 Boise, Idaho 83720-0041
Surety:~~

~~**WORKERS' COMPENSATION MEDICAL SERVICES REPORT**~~

322. SUBMISSION OF MEDICAL REPORTS TO THE INDUSTRIAL COMMISSION.

01. Authority and Definitions. Pursuant to Sections 72-432 , 75-508, 72-602 and 72-207, Idaho Code, the Industrial Commission of the State of Idaho promulgates this rule governing the procedure for submission of medical reports to the Industrial Commission. This procedure applies to all open workers' compensation claims where medical services are provided on or after the effective date and which have not denied by the Payor. The following definitions shall be applicable to this Rule. (2-20-95)

a. "Commission" means the Idaho Industrial Commission. (2-20-95)

b. "Medical Only Claim" means the injured worker will not suffer a disability lasting more than five (5) calendar days as a result of a job-related injury or occupational disease. (2-20-95)

c. "Rehabilitation Division" means the Rehabilitation Division of the Industrial Commission and includes its field offices. (2-20-95)

d. "Time loss claim" means the injured worker will suffer, or has suffered, a disability that lasts more than five (5) calendar days as a result of a job-related injury or occupational disease, or the injured worker requires, or required, in-patient treatment as a result of such injury or disease. (2-20-95)

e. "Impairment rated claim" means those claims in which the provider establishes an impairment rating for the injured worker. (2-20-95)

f. "Medical report" includes without limitation, all bills, chart notes, surgical records, testing results, treatment records, hospital records, prescriptions, and medication records. (2-20-95)

g. "Employer" is defined in Idaho Code Section 72-402(11) and includes agents of employers such as attorneys, sureties, and adjusters. (2-20-95)

h. "Provider" means anyone who provides medical services as defined in Idaho Code Section 72-102(16). (2-20-95)

i. "ISIF" means the Industrial Special Indemnity Fund, which is commonly referred to as the Second Injury Fund. (2-20-95)

j. "Payor" means the entity that is responsible for making payment to the Provider for services rendered to treat an industrially injured patient and includes self-insured employers, sureties, adjusters and their agents. (2-20-95)

k. "Claimant" means the patient who sought treatment for an industrial accident or occupational disease and includes agents such as attorneys. (2-20-95)

02. Procedure for Submitting Medical Reports. (2-20-95)

a. In all cases in which a particular injury or occupational disease results in a workers' compensation claim, the Provider shall submit written medical reports for each medical visit to the Payor. Payers and Providers may contract with one another to identify specific records that will be provided in support of billings. The Provider shall also submit the same written medical reports to the Claimant upon request. These reports shall be submitted within fourteen (14) days following each evaluation, examination and/or treatment. The first copy of any such reports shall be provided to the Payor and the Claimant at no charge. If duplicate copies of reports already provided are requested by either the Payor or the Claimant, the Provider may charge the requesting party a reasonable charge to provide the additional reports. Whenever possible, billing information shall be coded using the Current Procedural Terminology (CPT). In the case of hospitals, reports shall include a Uniform Billing (UB) Form 92. In the case of physicians and other providers supplying outpatient services, this reporting requirement shall include a Health Care Financing Administration (HCFA) Form 1500. (2-20-95)

b. If an injury or occupational disease results in a claim, the Employer/Surety/Adjuster or Provider

shall submit written reports to the Commission upon request. Such request either may be in writing or telephonic. If a claim is referred to the Rehabilitation Division, medical reports shall be furnished by the Payor or Provider directly to the office that request such reports. The Payor or Provider shall consider this an on-going request until notice is received that the reports are no longer required. (2-20-95)

c. If the injury or occupational disease results in a time-loss claim, the Payor shall submit copies of medical records containing information regarding the beginning and ending of disability, releases to work whether light duty or regular duty, impairment ratings, physical restrictions, Notices of Change of Status or Summaries of Payments shall be supported with medical reports when they are submitted to the Commission. Other medical reports shall be submitted to the Commission only upon request. (2-20-95)

d. ISIF shall receive all copies of medical reports, without charge, from either the Claimant or the Payor, depending upon who seeks to join it as a party to a workers' compensation claim. (2-20-95)

e. If the Commission requests medical reports from the Payor or Provider, the information shall be provided within a reasonable time period without charge. If information is received for which the Commission has no need, the information may be discarded or destroyed. (2-20-95)

03. Report Form and Content. The medical reports required by this regulation shall be submitted on eight and one half inch by eleven inch (8 1/2" by 11") paper. Upon approval of the Commission, medical reports may be submitted in electronic or other machine-readable form usable to all parties. (2-20-95)

04. Timely Response Requirement. When the Commission requests a medical report from a Payor or Provider for use in monitoring a workers' compensation claim, the Payor or Provider shall provide the requested information promptly. The Commission request may be either in writing or telephonic. (2-20-95)

05. Forfeiture of Payment. If a provider fails to give records to the Payor or Claimant, the Payor or Claimant may petition the Commission for an order requiring the Provider to provide the requested information. The petition shall set forth the Petitioner's efforts to obtain the information, the responses to those efforts, and why the Petitioner believes that the Provider has the information. In response to the petition, the Commission may enter an Order requiring the Provider to furnish the requested records or demonstrate that the records are not available. If a Provider fails to provide records when ordered by the Commission, the Commission may enter an Order of Forfeiture. In the event such an Order is entered, the Provider will forfeit its right to payment from both the Payor and Claimant, until such time as the records are provided. (2-20-95)

IDAPA 17 - INDUSTRIAL COMMISSION

17.10.01 - SAFETY AND HEALTH RULES FOR PLACES OF PUBLIC EMPLOYMENT

DOCKET NO. 17-1001-9701

NOTICE OF PENDING RULE

EFFECTIVE DATE: These rules have been adopted by the agency and are now pending review by the 1998 Idaho State Legislature for final adoption. The pending rule becomes final and effective upon adjournment of the legislature, 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. The action is authorized pursuant to Section(s) 72-508, 72-720, 72-721, 72-722, and 72-723, 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 any change.

The pending rules are being adopted as proposed. The original text of the proposed rules was published in the Idaho Administrative Bulletin, Volume 97-7, dated July 2, 1997, pages 198 through 200.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Mike Poulin, Division of Building Safety, Industrial Safety Section, (208) 334-3950.

DATED this 19th day of April 1997.

Patricia S. Ramey, Commission Secretary
Industrial Commission
317 Main Street
P. O. Box 83720
Boise, Idaho 83720-0041

**IDAPA 17
TITLE 10
Chapter 01**

SAFETY AND HEALTH RULES FOR PLACES OF PUBLIC EMPLOYMENT

**There are no substantive changes
from the proposed rule text.**

**The original text was published in the Idaho Administrative Bulletin,
Volume 97-7, July 2, 1997, pages 198 through 200.**

**This rule has been adopted as Final by the Agency and is now pending review
by the 1998 Idaho State Legislature for final adoption.**

IDAPA 18 - IDAHO DEPARTMENT OF INSURANCE
18.01.26 - HEALTH MAINTENANCE ORGANIZATIONS
DOCKET NO. 18-0126-9701
NOTICE OF TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The repeal of these rules are effective January 1, 1998.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted temporary rules, and proposed regular rule-making procedures have been initiated. These rules are proposed pursuant to the authority vested in the Director of the Department of Insurance under Title 41, Chapter 2, 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 on or before October 15, 1997. 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 address below.

DESCRIPTIVE SUMMARY: The following is a statement in nontechnical language of the substance of the proposed rule:

The rule is being repealed in its entirety and will be replaced with a new rule pertaining to managed care organizations.

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

To be in compliance with deadlines in amendments to governing law or federal programs.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning these temporary and proposed rules, contact James M. Alcorn at (208) 334-4202.

Anyone may submit written comments regarding these rules. All written comments and data concerning the rule must be directed to the undersigned and must be received on or before October 22, 1997.

Dated this 20th day of August, 1997.

James M. Alcorn, Director
Idaho Department of Insurance
700 West State Street - 3rd Floor
P.O. Box 83720
Boise, ID 83720-0043
Telephone No. (208) 334-4250

THIS RULE IS REPEALED IN ITS ENTIRETY

IDAPA 18 - IDAHO DEPARTMENT OF INSURANCE

18.01.26 - MANAGED CARE ORGANIZATIONS

DOCKET NO. 18-0126-9702

NOTICE OF TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The repeal of these rules are effective January 1, 1998.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted temporary rules, and proposed regular rule-making procedures have been initiated. These rules are proposed pursuant to the authority vested in the Director of the Department of Insurance under Title 41, Chapter 2, 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 on or before October 15, 1997. 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 address below.

DESCRIPTIVE SUMMARY: The following is a statement in nontechnical language of the substance of the temporary and proposed rule:

The temporary and proposed rule sets forth financial solvency requirements for managed care organizations and establishes procedures for provider billings. The rule reflects changes to Chapter 39, Title 41, Idaho Code, made by SB 1150, 1997. It will replace the existing Rule 26 pertaining to HMOs.

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

To be in compliance with deadlines in amendments to governing law or federal programs.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning these temporary and proposed rules, contact James M. Alcorn at (208) 334-4202.

Anyone may submit written comments regarding these rules. All written comments and data concerning the rule must be directed to the undersigned and must be received on or before October 22, 1997.

Dated this 20th day of August, 1997.

James M. Alcorn, Director
Idaho Department of Insurance
700 West State Street - 3rd Floor
P.O. Box 83720
Boise, ID 83720-0043
Telephone No. (208) 334-4250

TEXT OF DOCKET NO 18-0126-9702

**IDAPA 18
TITLE 01
Chapter 26**

18.01.26 - MANAGED CARE REFORM ACT

000. LEGAL AUTHORITY.

This rule is promulgated and adopted pursuant to the authority vested in the Director under Chapter 39, Title 41, Idaho Code. (1-1-98)T

001. TITLE AND SCOPE.

01. Title. This rule shall be cited in full as Idaho Department of Insurance Rules, IDAPA 18, Title 01, Chapter 26, rule to implement the Managed Care Reform Act. (1-1-98)T

02. Scope. The Act and this Rule are intended to define procedures to be followed in establishing and operating a Managed Care Organization; to define how certain of the powers of the Managed Care Organization shall be exercised; to define certain required reserves or liabilities; to establish requirements of certain reports and general disclosures to be furnished to the Director; and to establish rules pertaining to an organized system of health care providers, or those providers who willingly accept referrals through the managed care organization. (1-1-98)T

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 at this agency. (1-1-98)T

003. ADMINISTRATIVE APPEALS.

All contested cases shall be governed by the provisions of IDAPA 04.01.01, Idaho Rules of Administrative Procedure of the Office of the Attorney General. (1-1-98)T

004. DEFINITIONS.

01. The Act. All terms defined in the Act which are used in this rule shall have the same meaning as used in the Act. (1-1-98)T

02. Balance Billing. An organized system of health care providers and providers who accept referrals from the Managed Care Organization are prohibited from balance billing individuals. Balance billing refers to the practice whereby a provider bills an individual covered under the benefit plan for the difference between the amount the provider normally charges for a service and the amount the plan, policy, or contract recognizes as the allowable charge or negotiated price for the service delivered. (1-1-98)T

03. Director. The term, Director, as referred to in this rule, shall mean the Director of the Department of Insurance, State of Idaho. NOTE: Senate Bill No. 1294, effective July 1, 1974, created the position of Director of the Department of Insurance to be the chief executive officer of that department and to assume the duties of the previous Commissioner of Insurance. (1-1-98)T

04. MCO. Managed Care Organizations shall be abbreviated to MCO in this rule. (1-1-98)T

05. MCO Provider. MCO provider means any provider owned, managed, employed by, or under contract with an MCO to provide health care services to MCO members. An MCO provider includes a physician, hospital, or other person licensed or otherwise authorized to furnish health care services. (1-1-98)T

005. -- 010. (RESERVED)

011. APPLICATION FOR CERTIFICATE OF AUTHORITY.

01. Certificate of Authority Required. Any person offering a managed care plan on a predetermined and prepaid basis is transacting the business of insurance and must be authorized under a Certificate of Authority issued by the Director of Insurance. (1-1-98)T

02. Availability of Forms. Application forms will be furnished by the Director on the request of the MCO.

(1-1-98)T

03. Application Requirements. The application for a Certificate of Authority will include the additional affidavits, statements, and other information as enumerated in Idaho Code, Sections 41-319, 41-3904, 41-3905, and 41-3906. After receiving these completed documents, the Director has the authority to request any supplemental information he deems necessary before final approval or disapproval is given. (1-1-98)T

04. Capital Surplus and Deposit Requirements. In accordance with Idaho Code, Sections 41-3905(8) and 41-3905(9), a managed care organization having a valid Idaho certificate of authority to transact insurance as a health maintenance organization on or before July 1, 1997, or a managed care organization issued a certificate of authority after July 1, 1997, may be allowed by the Director of the Department of Insurance a period of up to three years to comply with the capital, surplus, and deposit requirements of Idaho Code, Sections 41-313 and 41-316 or 41-316A. (1-1-98)T

a. The Director has established the following minimum increases in capital fund requirements as per Idaho Code, Section 41-3905(8), based on the number of enrolled members:

Enrolled Members	Capital Funds
0-100	200,000
101-200	400,000
201-300	600,000
301-400	800,000
401-500	1,000,000
501-750	1,500,000
750-1,000	2,000,000

(1-1-98)T

b. In no event shall the organization's capital funds be less than the following:

One year after the organization becomes subject to Title 41, Chapter 39, as amended effective July 1, 1997:	\$1,000,000
Two years after the date the organization becomes subject to Title 41, Chapter 39, as amended effective July 1, 1997:	\$1,500,000
Three years after the date the organization becomes subject to Title 41, chapter 39, as amended effective July 1, 1997:	\$2,000,000

(1-1-98)T

c. Immediately upon becoming subject to Title 41, Chapter 39, as amended effective July 1, 1997, the managed care organization's minimum statutory deposit requirements shall be calculated as fifty percent (50%) of the amount of the organization's Capital funds as calculated above up to a maximum of one million dollars (\$1,000,000), but shall not be less than two hundred thousand dollars (\$200,000). The amount of the deposit so held by the Department shall be adjusted based on the organization's December 31st and June 30th financial statement filings each year. In no event will the minimum required statutory deposit amount be reduced. Upon notification by the department of the necessary increase in the deposit amount, the organization will have no more than thirty (30) days to come into compliance with the required amount. Failure to increase the deposit as required will subject the organization to suspension or revocation of its certificate of authority pursuant to Idaho Code, Section 41-326.

(1-1-98)T

012. SOLICITATION PRIOR TO ISSUANCE OF CERTIFICATE OF AUTHORITY.

01. Permission for Solicitation Required. In accordance with Section 4, paragraph (2) of the Act, a proposed MCO, after filing its application for a Certificate of Authority, may request permission from the Director to inform potential enrollees concerning its proposed managed care services. (1-1-98)T

02. Solicitation Materials. Before contacting potential enrollees or subscribers, the proposed MCO shall submit its request for permission to the Director in writing, with copies of brochures, advertising or solicitation materials, sales talks or any other procedures or methods to be used. (1-1-98)T

03. Methods of Solicitation. Advertising and solicitation materials used by a proposed MCO must meet the following minimum requirements: (1-1-98)T

- a. The prospective enrollee shall clearly be advised that: (1-1-98)T
 - i. The proposed MCO is not as yet authorized to offer health care services in this state; (1-1-98)T
 - ii. Coverage for health care services is not being provided at the time of the solicitation; (1-1-98)T
 - iii. The solicitation is not a guarantee that any services will be provided at a future date. (1-1-98)T
- b. The format and content of any material offered shall be in conformity with the MCO Act. Such material shall contain but not be limited to the following information: (1-1-98)T
 - i. Complete description of the proposed MCO services and other benefits to which the enrollee would be entitled; (1-1-98)T
 - ii. The location of all facilities, the hours of operation, and the services which would be provided in each facility; (1-1-98)T
 - iii. The predetermined periodic rate of payment for the proposed services; (1-1-98)T
 - iv. All exclusions and limitations on the proposed services, including any copayment feature, and all restrictions relating to pre-existing conditions. (1-1-98)T
- c. No person shall solicit enrollment or inform prospective enrollees concerning proposed MCO services unless compensated solely as a salaried employee of the proposed MCO. (1-1-98)T

013. ANNUAL DISCLOSURE, FILING WITH DIRECTOR.

The annual disclosure material required to be filed with the Director pursuant to Idaho Code, Section 41-3914(3), shall be filed with the reports to the Director on or before March 1 each year. (1-1-98)T

014. ANNUAL REPORT TO THE DIRECTOR.

In accordance with Idaho Code, Sections 41-3910 and 41-335, every managed care organization shall annually on or before the first day of March, file with the Director a full and true statement of its financial condition, transactions and affairs as of the preceding December 31. Unless otherwise required by the Director, the statement is to be prepared in accordance with the annual statement instructions and the accounting practices and procedures manual adopted by the National Association of Insurance Commissioners (NAIC) and is to be submitted on the NAIC annual convention blank form. The managed care organization shall also file its annual audited financial report in accordance with IDAPA 18.01.62. (1-1-98)T

015. PERSONNEL AND FACILITIES LISTING REQUIRED.

01. Current Listing Required. The MCO shall at all times keep a current list of all personnel, providers and facilities employed, retained or under contract to furnish health care services to enrollees. This list shall be available to the Director at his request. (1-1-98)T

02. Allowable Expense - No Balance Billing. No MCO provider or other provider accepting a referral from an MCO, who treats or provides services to an individual covered by the MCO, shall charge to or collect from any member or other beneficiary any amount in excess of that amount of compensation determined or allowed for a particular service by the MCO or by the administrator for the MCO. Nothing in this section shall be construed to prevent the collection of any copayments, coinsurance, or deductibles allowed for in the plan design. (1-1-98)T

03. Procedures for Basic Care and Referrals. The MCO shall provide basic health care to enrollees through an organized system of health care providers. In plans in which referrals to specialty physicians and ancillary services are required, the MCO provider or the MCO shall initiate the referrals. The MCO shall inform its providers of their responsibility to provide written referrals and any specific procedures that must be followed in providing referrals, including prohibition of balance billing. (1-1-98)T

04. Health Care Services to Be Accessible. The MCO, either directly or through its organized system of health care providers, shall arrange for covered health care services, including referrals to providers within the organized system of health care providers and noncontracting providers, to be accessible to enrollees on a timely basis in accordance with medically appropriate guidelines consistent with generally accepted practice parameters. (1-1-98)T

05. Out of Network Services. In the case of provider care which is delivered outside of the organized system of health care providers or defined referral system, the MCO must alert those covered under health benefit plans to the fact that providers which are not MCO providers, or have not accepted written referrals, may balance bill the customer for amounts above the MCO's maximum allowance. Consumers should be encouraged to discuss the issue with their providers (1-1-98)T

016. SEVERABILITY CLAUSE.

If any provision of this rule, or the application thereof to any person or circumstance, is held invalid, the remainder of the rule, or the applicability of such provision to other persons or circumstances, shall not be affected thereby. (1-1-98)T

017. -- 999. (RESERVED).

IDAPA 18 - IDAHO DEPARTMENT OF INSURANCE

18.01.53 - CONTINUING EDUCATION

DOCKET NO. 18-0153-9701

NOTICE OF PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has proposed rule making. These rules are proposed pursuant to the authority vested in the Director of the Department of Insurance under Title 41, Chapter 2, 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 October 15, 1997. 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 address below.

DESCRIPTIVE SUMMARY: The following is a statement in nontechnical language of the substance of the proposed rule:

Amends the existing rule to change the term limits for members of the Continuing Education Committee, and modifies the continuing education requirements for insurance agents to reflect changes to existing law made by HB 16aa, 1997.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning these proposed rules, contact James M. Alcorn at (208) 334-4202.

Anyone may submit written comments regarding these rules. All written comments and data concerning the rule must be directed to the undersigned and must be received on or before October 22, 1997.

Dated this 28th day of August, 1997.

James M. Alcorn, Director
Idaho Department of Insurance
700 West State Street - 3rd Floor
P.O. Box 83720
Boise, ID 83720-0043
Telephone No. (208) 334-4250

TEXT OF DOCKET NO. 18-0153-9701

001. TITLE AND SCOPE.

The purpose of this rule is to help protect the public by maintaining high standards of professional competence in the insurance industry; to maintain and improve the insurance skills and knowledge of agents, brokers, ~~solicitors~~, and consultants licensed by the Department of Insurance by prescribing a minimum education in approved subjects that a licensee must periodically complete, procedures and standards for the approval of such education, and a procedure for establishing that continuing education requirements have been met. (7-1-93)(____)

(BREAK IN CONTINUITY OF SECTIONS)

011. APPLICABILITY.

01. Applicability to Certain Insurance Professionals. This rule applies to all resident agents, brokers, ~~solicitors~~, consultants, and limited agents licensed by the Department of Insurance except employees or owners of travel agencies if the employee's or owner's license allows the sale of travel or trip insurance to customers booking travel plans with the travel agency, or to a limited agent whose qualification license covers credit life insurance or credit disability insurance pursuant to Chapter 23, Title 41, Idaho Code, or to one (1) person named in the license or registered with the Director as to the license of persons regulated or licensed by the Department of Finance pursuant to Chapter 46, Title 28, Idaho Code, national or state chartered banks, federal or state chartered savings and loan associations, or federal or state chartered credit unions dealing with insurance licensed pursuant to section 41-1045(1)(b),(c) and (d), Idaho Code (limited agent's license). (7-1-93)(____)

02. High Standards for Programs. The Department of Insurance anticipates and expects that licensees will maintain high standards of professionalism in selecting quality education programs to fulfill the continuing education requirements set forth herein. (7-1-93)

012. BASIC REQUIREMENTS.

01. Proof of Completion. As a condition for the continuation of a license, a licensee must furnish the Director of the Department of Insurance ("Director"), on or before the licensing renewal date, proof of satisfactory completion of approved subjects or courses having at least forty (40) hours of continuing education credit during each two (2) year licensing period. (7-1-93)

02. Relicensing Procedures After Voluntary Termination of License. An insurance agent who voluntarily terminates his/her license can apply to be relicensed without testing if the application is received by the Department within twelve (12) months after the termination and if the continuing education requirements were completed during the licensing period prior to voluntary termination. Non-resident insurance agents who were former resident agents and who wish to obtain a resident license once again, will be subject to the continuing education requirements on a pro-rata basis. For example: If an agent resided in Idaho for nine (9) months, that agent's continuing education requirement would be fifteen (15) credit hours should the agent return to Idaho and request to be relicensed. (7-1-93)

03. Carry Over of Credits ~~Prohibited~~. Upon renewal of a license, up to but no more than twenty (20) continuing education credit hours, in excess of the credit hours number required to renew the license, may be carried over or applied to any subsequent credited to the next consecutive licensing period. However, the licensee should submit only the required number of hours and indicate dates of completion. It is the responsibility of the licensee to keep track of earned credit hours and documentation to verify proof of completion. (7-1-93)(____)

04. Completion within Two (2) Years. Each course to be applied toward satisfaction of the continuing education requirement must have been completed within the two (2) year period immediately preceding renewal of the license ~~and may not have been used previously in the same renewal period~~, except carryover credits as defined in Subsection 012.03 or as allowed in Idaho Code Section 41-1077(h). Courses may not have been duplicated in the same renewal period. The date of completion for a self-study course is the date of successful completion of exam. (7-1-93)(____)

(BREAK IN CONTINUITY OF SECTIONS)

014. CONTINUING EDUCATION ADVISORY COMMITTEE.

01. Continuing Education Advisory Committee. An eleven (11) member Continuing Education Advisory Committee, comprised of representatives from each segment of the insurance industry, shall be appointed by the Director, ~~to perform the following duties: The committee shall be appointed as follows:~~ (7-1-93)(____)

- a. Five (5) of the members to serve a term of two (2) years and six (6) of the members to serve a term

of three (3) years. ()

b. Subsequent committee members shall serve a term of three (3) years. ()

c. Members may succeed themselves if: ()

i. Renominated by the industry and approved by the Director; or ()

ii. Reappointed by the Director. ()

02. Duties of the Advisory Committee. The advisory committee shall perform the following duties at the discretion of the Director: ()

a. Approve or disapprove programs as per the standards of this rule; (7-1-93)

b. Assign the number of continuing education hours to be awarded to programs that are approved; (7-1-93)

c. Consider applications for exceptions and extensions as permitted under Section 013 of this rule; and (7-1-93)

d. Consider other related matters as the Director may assign. (7-1-93)

023. Quorum. Those present at any meeting of the Continuing Education Advisory Committee shall be deemed to be a quorum for purposes of acting to perform the duties of the Committee pursuant to this rule. Matters before the Continuing Education Advisory Committee may be decided by a majority of those members present. In the event of a tie vote, the Chairman shall vote to break the tie. (7-1-93)

034. Decisions or Rulings. Decisions or rulings of the Continuing Education Advisory Committee in its performance of the duties set forth herein shall have the effect of decisions or rulings of the Director of the Department of Insurance. Such decisions are, however, in the discretion of the Director, subject to his review and approval or rejection. (7-1-93)

(BREAK IN CONTINUITY OF SECTIONS)

016. PROGRAMS WHICH QUALIFY.

01. Requirements of Acceptable Program. A specific program will qualify as an acceptable continuing education program if it is a formal program of learning which contributes directly to the professional competence of a licensee. It will be left to each individual licensee to determine the course of study to be pursued. All programs must meet the standards outlined in Section 018. (7-1-93)

02. Subjects Which Qualify. (7-1-93)

a. The following general subjects are acceptable as long as they contribute to the knowledge and professional competence of an individual licensee as an agent, broker, ~~solicitor~~, or consultant, and demonstrate a direct and specific application to insurance; and relate to the area or areas of expertise covered by the license or licenses held by the licensee. (7-1-93)()

i. Insurance, annuities, and risk management. (7-1-93)

ii. Insurance laws and rules. (7-1-93)

iii. Mathematics, statistics, and probability. (7-1-93)

- iv. Economics. (7-1-93)
- v. Business law. (7-1-93)
- vi. Finance. (7-1-93)
- vii. Taxes. (7-1-93)
- viii. Business environment, management, or organization. (7-1-93)
- ix. Securities. ()

b. Areas other than those listed above may be acceptable if the licensee can demonstrate that they contribute to professional competence and otherwise meet the standards set forth in this rule. The responsibility for substantiating that a particular program meets the requirements of this rule rests solely upon the licensee. (7-1-93)

017. PROGRAMS WHICH DO NOT QUALIFY.

- 01. Any Course Used to Prepare for Taking an Insurance Licensing Examination. (7-1-93)
- 02. Committee Service of Professional Organizations. (7-1-93)
- 03. Computer Science Courses. (7-1-93)
- 04. Motivation, Psychology, or Selling Skills Courses. (7-1-93)
- ~~05. Securities, Other than Variable Annuities. (7-1-93)~~
- 06. Reviews, Quizzes and/or Examinations. (7-1-93)
- ~~07. Any Program Not in Accordance with This Rule. (7-1-93)~~

IDAPA 18 - IDAHO DEPARTMENT OF INSURANCE
18.01.62 - ANNUAL AUDITED FINANCIAL REPORTS
DOCKET NO. 18-0162-9701
NOTICE OF PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has proposed rule making. These rules are proposed pursuant to the authority vested in the Director of the Department of Insurance under Title 41, Chapter 2, 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 October 15, 1997. 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 address below.

DESCRIPTIVE SUMMARY: The following is a statement in nontechnical language of the substance of the proposed rule:

Changes the deadline for insurers to file annual audited financial reports with the Department of Insurance from June 30 to June 1. The purpose of the change is to make Idaho's filing deadline consistent with that of other states.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning these proposed rules, contact James M. Alcorn at (208) 334-4202.

Anyone may submit written comments regarding these rules. All written comments and data concerning the rule must be directed to the undersigned and must be received on or before October 22, 1997.

Dated this 20 day of August, 1997.

James M. Alcorn, Director
Idaho Department of Insurance
700 West State Street - 3rd Floor
P.O. Box 83720
Boise, ID 83720-0043
Telephone No. (208) 334-4202

TEXT OF DOCKET NO. 18-0162-9701

011. FILING AND EXTENSIONS FOR FILING OF ANNUAL AUDITED FINANCIAL REPORTS.

All insurers shall have an annual audit by an independent certified public accountant and shall file an audited financial report with the director on or before ~~June 30~~ June 1 for the year ended December 31 immediately preceding. The Director may require an insurer to file an audited financial report earlier than ~~June 30~~ June 1 with ninety (90) days advance notice to the insurer. Extensions of the ~~June 30~~ June 1 filing date may be granted by the director for thirty (30) day periods upon showing by the insurer and its independent certified public accountant the reasons for requesting such extension and determination by the director of good cause for an extension. The request for extension must be submitted in writing not less than ten (10) days prior to the due date in sufficient detail to permit the director to make an informed decision with respect to the requested extension. (7-1-93)()

IDAPA 18 - IDAHO DEPARTMENT OF INSURANCE
18.01.69 - RULE TO IMPLEMENT THE SMALL EMPLOYER
HEALTH INSURANCE AVAILABILITY ACT

DOCKET NO. 18-0169-9701

NOTICE OF PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has proposed rule making. These rules are proposed pursuant to the authority vested in the Director of the Department of Insurance under Title 41, Chapter 2, 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 October 15, 1997. 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 address below.

DESCRIPTIVE SUMMARY: The following is a statement in nontechnical language of the substance of the proposed rule:

Amends the existing rule to conform to 1997 changes to Chapter 47, Title 41, Idaho Code. Changes include the addition of tobacco and geography as case characteristics, allowing up to six geographic areas for case characteristic purposes and requiring that geographic areas be no smaller than a county, changing from 49 to 50 the maximum number of employees to remain within the definition of a small employer, adding references to a catastrophic health plan, and eliminating language concerning rescission of health plans.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning these proposed rules, contact James M. Alcorn at (208) 334-4202.

Anyone may submit written comments regarding these rules. All written comments and data concerning the rule must be directed to the undersigned and must be received on or before October 22, 1997.

Dated this 28th day of August, 1997.

James M. Alcorn, Director
Idaho Department of Insurance
700 West State Street - 3rd Floor
P.O. Box 83720
Boise, ID 83720-0043
Telephone No. (208) 334-4250

TEXT OF DOCKET NO. 18-0169-9701

002. WRITTEN INTERPRETATIONS.

In accordance with Section 67-5201(4619)(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. (1-25-95)()

(BREAK IN CONTINUITY OF SECTIONS)

004. DEFINITIONS.

As used in this Rule: (1-25-95)

01. Associate Member. Associate Member of an employee organization means any individual who participates in an employee benefit plan (as defined in 29 U.S.C. Section 1002(1)) that is a multi-employer plan (as defined in 29 U.S.C. Section 1002(37A)), other than the following: (1-25-95)

a. An individual (or the beneficiary of such individual) who is employed by a participating employer within a bargaining unit covered by at least one (1) of the collective bargaining agreements under or pursuant to which the employee benefit plan is established or maintained; or (1-25-95)

b. An individual who is a present or former employee (or a beneficiary of such employee) of the sponsoring employee organization, of an employer who is or was a party to at least one of the collective bargaining agreements under or pursuant to which the employee benefit plan is established or maintained, or of the employee benefit plan (or of a related plan). (1-25-95)

02. Carrier. Carrier means any entity operating under a current Certificate of Authority issued from the Department of Insurance to do the business of disability insurance in this state. (1-25-95)

03. Case Characteristics. Case Characteristics are limited to age, individual tobacco use, geography, and gender. A Small Employer Carrier must apply the use of such case characteristics on a uniform basis within a class of business. Further definition is found under Section 41-4703(8), Idaho Code, and in Section 015 of this rule. (1-25-95)()

04. Geographic Area. Geographic areas are limited to no more than six (6) designated areas, with no area being smaller than a county. ()

045. New Entrant. New Entrant means an eligible employee, or the dependent of an eligible employee, who becomes part of an employer group after the initial period for enrollment in a health benefit plan. (1-25-95)

056. Risk Characteristic. Risk Characteristic means the health status, claims experience, duration of coverage, or any similar characteristic related to the health status or claims experience of a small employer group or of any member of a small employer group. Such characteristics can include family composition, group size, industry and geographic location. (1-25-95)()

067. Risk Load. Risk Load means the percentage above the applicable base premium rate that is charged by a small employer carrier to the rates of the small employer group, to reflect the risk characteristics of the small employer group. (1-25-95)

(BREAK IN CONTINUITY OF SECTIONS)

015. APPLICABILITY.

01. Applicability. Except as provided in Subsection 015.02 and Section 091, this rule shall apply to any health benefit plan, whether provided on a group or individual basis, which: (1-25-95)

a. Meets one or more of the conditions set forth in Sections 41-4704(1) through 41-4704(4), Idaho Code; (1-25-95)

b. Provides coverage to two (2) or more eligible employees of a small employer located in this state, without regard to whether the policy or certificate was issued in this state; and, (1-25-95)

- c. Is in effect on or after the effective date of the Act. (1-25-95)
02. Exceptions. The provisions of this Rule shall not apply to an individual health benefit plan delivered or issued for delivery prior to 4/1/94. (1-25-95)
03. Individual Health Benefit Plans Subject to Provisions of The Act and This Rule. A carrier that provides individual health benefit plans to two (2) or more of the eligible employees of a small employer shall be considered a small employer carrier and shall be subject to the provisions of the Act and this Rule with respect to such policies if the small employer contributes directly or indirectly to the premiums for the policies and the carrier is aware of such contribution. Agents and brokers are prohibited, at risk of losing their license, from arranging individual health benefit plans which they know to be supported financially by an employer. (1-25-95)
04. Provisions that Would Subject Individual Health Plans to The Act and This Rule. In the case of a carrier that provides individual health benefit plans to two (2) or more eligible employees of a small employer, the small employer shall be considered to be an eligible small employer as defined in Section 41-4708(1)(c), Idaho Code, and the small employer carrier shall be subject to Section 41-4708(1)(b), Idaho Code, relating to guaranteed issue of coverage, if: (1-25-95)
- a. The small employer has at least two (2) eligible employees; (1-25-95)
- b. The small employer contributes as defined in Section 41-4704, Idaho Code; and, (1-25-95)
- c. The carrier is aware of the contribution by the employer. (1-25-95)
05. Group Policy or Trust Arrangement. The provisions of the Act and this Rule shall apply to a health benefit plan provided to a small employer or to the eligible employees of a small employer without regard to whether the health benefit plan is offered under or provided through a group policy or trust arrangement of any size sponsored by an association or discretionary group. (1-25-95)
06. Deduction Under Section 162(1), Internal Revenue Code. An individual health benefit plan shall not be subject to the provisions of the Act and this Rule solely because the policyholder elects a deduction under Section 162(1), Internal Revenue Code. (1-25-95)
07. Subsequent Employment of More Than ~~Forty-nine (49)~~ Fifty (50) Eligible Employees. If a small employer is issued a health benefit plan under the terms of the Act, the provisions of the Act and this Rule shall continue to apply to the health benefit plan in the case that the small employer subsequently employs more than ~~Forty-nine (49)~~ Fifty (50) eligible employees. A carrier providing coverage to such an employer shall, within sixty (60) days of becoming aware that the employer has more than ~~Forty-nine (49)~~ Fifty (50) eligible employees but no later than the anniversary date of the employer's health benefit plan, notify the employer that the protections provided under the Act and this Rule shall cease to apply to the employer if such employer fails to renew its current health benefit plan or elects to enroll in a different health benefit plan. (~~1-25-95~~)(____)
08. Employer Subsequently Becomes a Small Employer. If a health benefit plan is issued to an employer that is not a small employer as defined in the Act, but subsequently the employer becomes a small employer (due to the loss or change of work status of one or more employees), the terms of the Act shall not apply to the health benefit plan. The carrier providing a health benefit plan to such an employer shall not become a small employer carrier under the terms of the Act solely because the carrier continues to provide coverage under the health benefit plan to the employer. (1-25-95)
09. Time Period for Notification of Options to Employer. A carrier providing coverage to an employer described in Subsection 015.08 shall, within sixty (60) days of becoming aware that the employer has ~~Forty-nine (49)~~ Fifty (50) or fewer eligible employees, notify the employer of the options and protections available to the employer under the Act, including the employer's option to purchase a small employer health benefit plan from any small employer carrier. (~~1-25-95~~)(____)
10. Employees in More Than One (1) State. If a small employer has employees in more than one (1) state, the provisions of the Act and this Rule shall apply to a health benefit plan issued to the small employer if:

(1-25-95)

- a. The majority of eligible employees of such small employer are employed in this state; or (1-25-95)
- b. If no state contains a majority of the eligible employees of the small employer, the primary business location of the small employer is in this state. (1-25-95)

11. Laws of This State or Another State. In determining whether the laws of this state or another state apply to a health benefit plan issued to a small employer described in Subsection 015.10, the provisions of the paragraph shall be applied as of the date the health benefit plan was issued to the small employer for the period that the health benefit plan remains in effect. (1-25-95)

12. Health Benefit Plan Subject to The Act and This Rule. If a health benefit plan is subject to the Act and this Rule, the provisions of the Act and this Rule shall apply to all individuals covered under the health benefit plan, whether they reside in this state or in another state. (1-25-95)

13. When Is a Small Employer Carrier Not Subject to The Act and This Rule. A carrier that is not operating as a small employer carrier in this state shall not become subject to the provisions of the Act and this Rule solely because a small employer that was issued a health benefit plan in another state by that carrier moves to this state. (1-25-95)

(BREAK IN CONTINUITY OF SECTIONS)

036. RESTRICTIONS RELATING TO PREMIUM RATES.

01. Separate Rate Manual for Each Class of Business. A small employer carrier shall develop a separate rate manual for each class of business. Base premium rates and new business premium rates charged to small employers by the small employer carrier shall be computed solely from the applicable rate manual developed pursuant to this subsection. To the extent that a portion of the premium rates charged by a small employer carrier is based on the carrier's discretion, the manual shall specify the criteria and factors considered by the carrier in exercising such discretion. (1-25-95)

02. Requirements for Adjustments to Rating Method. A small employer carrier shall not modify the rating method used in the rate manual for a class of business until the change has been approved as provided in this subsection. The Director may approve a change to a rating method if the Director finds that the change is reasonable, actuarially appropriate, and consistent with the purposes of the Act and this Rule. (1-25-95)

03. Information Required for Review of Modification of Rating Method. A carrier may modify the rating method for a class of business only with prior approval of the Director. A carrier requesting to change the rating method for a class of business shall make a filing with the Director at least thirty (30) days prior to the proposed date of the change. The filing shall contain at least the following information: (1-25-95)

- a. The reasons the change in rating method is being requested; (1-25-95)
- b. A complete description of each of the proposed modifications to the rating method; (1-25-95)
- c. A description of how the change in rating method would affect the premium rates currently charged to small employers in the class of business, including an estimate from a qualified actuary of the number of groups or individuals (and a description of the types of groups or individuals) whose premium rates may change by more than ten percent (10%) due to the proposed change in rating method (not generally including increases in premium rates applicable to all small employers in a health benefit plan); (1-25-95)
- d. A certification from a qualified actuary that the new rating method would be based on objective and credible data and would be actuarially sound and appropriate; and (1-25-95)

e. A certification from a qualified actuary that the proposed change in rating method would not produce premium rates for small employers that would be in violation of Section 41-4706, Idaho Code. (1-25-95)

04. Change in Rating Method. For the purpose of Section 036 a change in rating method shall mean: (1-25-95)

a. A change in the number of case characteristics used by a small employer carrier to determine premium rates for health benefit plans in a class of business (a small employer should not use case characteristics other than age, individual tobacco use, geography or gender without prior approval of the Director); ~~(1-25-95)~~()

b. A change in the manner or procedures by which insureds are assigned into categories for the purpose of applying a case characteristic to determine premium rates for health benefit plans in a class of business; (1-25-95)

c. A change in the method of allocating expenses among health benefit plans in a class of business; or (1-25-95)

d. A change in a rating factor with respect to any case characteristic if the change would produce a change in premium for any small employer that exceeds ten percent (10%). (1-25-95)

e. For the purpose of Subsection 036.04, a change in a rating factor shall mean the cumulative change with respect to such factor considered over a twelve (12) month period. If a small employer carrier changes rating factors with respect to more than one case characteristic in a twelve (12) month period, the carrier shall consider the cumulative effect of all such changes in applying the ten percent (10%) test. (1-25-95)

05. Rate Manual to Specify Case Characteristics and Rate Factors to Be Applied. The rate manual developed pursuant to Subsection 036.01 shall specify the case characteristics and rate factors to be applied by the small employer carrier in establishing premium rates for the class of business. (1-25-95)

06. Case Characteristics Other Than Age, Individual Tobacco Use, Geography and Gender - Must Have Prior Approval of Director. A small employer carrier may not use case characteristics other than those specified in Section 41-4706(1)(I), Idaho Code, without the prior approval of the Director. A small employer carrier seeking such an approval shall make a filing with the Director for a change in rating method under Subsection 036.02. ~~(1-25-95)~~()

07. Case Characteristics Shall Be Applied in a Uniform Manner. A small employer carrier shall use the same case characteristics in establishing premium rates for each health benefit plan in a class of business and shall apply them in the same manner in establishing premium rates for each such health benefit plan. Case characteristics shall be applied without regard to the risk characteristics of a small employer. (1-25-95)

08. Rate Manual Must Clearly Illustrate Relationship Among Base Premium Rate and Any Difference in New Business Rate. The rate manual developed pursuant to Subsection 036.01 shall clearly illustrate the relationship among the base premium rates charged for each health benefit plan in the class of business. If the new business premium rate is different than the base premium rate for a health benefit plan, the rate manual shall illustrate the difference. (1-25-95)

09. Differences in Premium Rates Must Reflect Reasonable and Objective Differences. Differences among base premium rates for health benefit plans shall be based solely on the reasonable and objective differences in the design and benefits of the health benefit plans and shall not be based in any way on the actual or expected health status or claims experience of the small employer groups that choose or are expected to choose a particular health benefit plan. A small employer carrier shall apply case characteristics and rate factors within a class of business in a manner that assures that premium differences among health benefit plans for identical small employer groups vary only due to reasonable and objective differences in the design and benefits of the health benefit plans and are not due to the actual or expected health status or claims experience of the small employer groups that choose or are expected to choose a particular health benefit plan. (1-25-95)

10. Premium Rates to Be Developed in Two (2) Step Process. The rate manual developed pursuant to Subsection 036.01 shall provide for premium rates to be developed in a two step process. In the first step, a base premium rate shall be developed for the small employer group without regard to any risk characteristics of the group. In the second step, the resulting base premium rate may be adjusted by a risk load, subject to the provisions of Section 41-4706, Idaho Code, to reflect the risk characteristics of the group. (1-25-95)

11. Exception to Application Fee, Underwriter Fee, or Other Fees. Except as provided in Subsection 036.12, a premium charged to a small employer for a health benefit plan shall not include a separate application fee, underwriting fee, or any other separate fee or charge. (1-25-95)

12. Uniform Application of Fees. A carrier may charge a separate fee with respect to a health benefit plan provided the fee is applied in a uniform manner to every health benefit plan in a class of business. All such fees are premium and shall be included in determining compliance with the Act and these Rules. (1-25-95)

13. Uniform Allocation of Administration Expenses. A small employer carrier shall allocate administrative expenses to the basic, ~~and standard, and catastrophic~~ health benefit plans on no less favorable of a basis than expenses are allocated to other health benefit plans in the class of business. The rate manual developed pursuant to Subsection 036.01 shall describe the method of allocating administrative expenses to the health benefit plans in the class of business for which the manual was developed. (~~1-25-95~~)()

14. Rate Manual To Be Maintained for a Period of Six (6) Years. Each rate manual developed pursuant to Subsection 015.01 shall be maintained by the carrier for a period of six (6) years. Updates and changes to the manual shall be maintained with the manual. (1-25-95)

15. Rate Manual and Practices Must Comply with Guidelines Issued by Director. The rate manual and rating practices of a small employer carrier shall comply with any guidelines issued by the Director. (1-25-95)

16. Application of Restrictions Related to Changes in Premium Rates. The restrictions related to changes in premium rates are set forth in Section 41-4706(1)(c), Idaho Code, and shall be applied as follows: (1-25-95)

a. A small employer carrier shall revise its rate manual each rating period to reflect changes in base premium rates and changes in new business premium rates. (1-25-95)

b. If, for any health benefit plan with respect to any rating period, the percentage change in the new business premium rate is less than or the same as the percentage change in the base premium rate, the change in the new business premium rate shall be deemed to be the change in the base premium rate for the purposes of Sections 41-4706(1)(c)(ii) and 41-4706(1)(f)(i), Idaho Code. (1-25-95)

c. If, for any health benefit plan with respect to any rating period, the percentage change in the new business premium rate exceeds the percentage change in the base premium rate, the health benefit plan shall be considered a health benefit plan into which the small employer carrier is no longer enrolling new small employers for the purposes of Sections 41-4706(1)(c) and (f), Idaho Code. (1-25-95)

d. If, for any rating period, the change in the new business premium rate for a health benefit plan differs from the change in the new business premium rate for any other health benefit plan in the same class of business by more than twenty percent (20%), the carrier shall make a filing with the Director containing a complete explanation of how the respective changes in new business premium rates were established and the reason for the difference. The filing shall be made within thirty (30) days of the beginning of the rating period. (1-25-95)

e. A small employer carrier shall keep on file for a period of at least six (6) years the calculations used to determine the change in base premium rates and new business premium rates for each health benefit plan for each rating period. (1-25-95)

17. Change In Premium Rate. Except as provided in Subsections 036.18 and 036.19, a change in premium rate for a small employer shall produce a revised premium rate that is no more than the following:(1-25-95)

- a. The base premium rate for the small employer, given its present composition, (as shown in the rate manual as revised for the rating period), multiplied by; (1-25-95)
- b. One (1) plus the sum of: (1-25-95)
- i. The risk load applicable to the small employer during the previous rating period; and (1-25-95)
- ii. Fifteen percent (15%) (prorated for periods of less than one (1) year). (1-25-95)
18. **Rating Restrictions on Plans Where Carrier Is No Longer Enrolling New Business.** In the case of a health benefit plan into which a small employer carrier is no longer enrolling new small employers, a change in premium rate for a small employer shall produce a revised premium rate that is no more than the base premium rate for the small employer (given its present composition and as shown in the rate manual in effect for the small employer at the beginning of the previous rating period), multiplied by Subsections 036.18.a. and 036.18.b. below; (1-25-95)
- a. One (1) plus the lesser of: (1-25-95)
- i. The change in the base rate; or (1-25-95)
- ii. The percentage change in the new business premium for the most similar health benefit plan into which the small employer carrier is enrolling new small employers. (1-25-95)
- b. One (1) plus the sum of: (1-25-95)
- i. The risk load applicable to the small employer during the previous rating period; and (1-25-95)
- ii. Fifteen percent (15%) (prorated for periods of less than one (1) year). (1-25-95)
19. **Plans Written Prior to January 1, 1994.** In the case of a health benefit plan described in Section 41-4706(1)(f), Idaho Code, if the current premium rate for the health benefit plan exceeds the ranges set forth in Section 41-4706, Idaho Code, the formulae set forth in Subsections 036.17 and 036.18 will be applied as if the fifteen (15%) adjustment provided in Subsections 036.17.b.ii. and 036.18.c.ii. were a zero percent (0%) adjustment. (1-25-95)
20. **Limitations on Revised Premium Rate.** Notwithstanding the provisions of Subsections 036.17 and 036.18, a change in premium rate for a small employer shall not produce a revised premium rate that would exceed the limitations on rates provided in Section 41-4706(1)(b), Idaho Code. (1-25-95)
21. **Waiver Request for a Taft-Hartley Trust.** A representative of a Taft-Hartley trust (including a carrier upon the written request of such a trust) may file a written request with the Director for the waiver of application of the provisions of Section 41-4706(1), Idaho Code, with respect to such trust. (1-25-95)
22. **Provisions for Which Trust Is Seeking Waiver.** A request made under Subsection 036.21 shall identify the provisions for which the trust is seeking the waiver and shall describe, with respect to each provision, the extent to which application of such provision would: (1-25-95)
- a. Adversely affect the participants and beneficiaries of the trust; and (1-25-95)
- b. Require modifications to one (1) or more of the collective bargaining agreements under or pursuant to which the trust was or is established or maintained. (1-25-95)
23. **Waiver Shall Not Apply to Individual or Associate Member.** A waiver granted under this provision shall not apply to an individual who participates in the trust because the individual is an associate member of an employee organization or the beneficiary of such an individual. (1-25-95)

(BREAK IN CONTINUITY OF SECTIONS)

046. REQUIREMENT TO INSURE ENTIRE GROUPS.

01. Offer of Coverage. A small employer carrier that offers coverage to a small employer shall offer to provide coverage to each eligible employee and to each dependent of an eligible employee. Except as provided in Subsection 046.02, the small employer carrier shall provide the same health benefit plan to each such employee and dependent. (1-25-95)

02. Choice of Health Benefit Plans. A small employer carrier may offer the employees of a small employer the option of choosing among one or more health benefit plans, provided that each eligible employee may choose any of the offered plans. Except as provided in Section 41-4708(3), Idaho Code, (with respect to exclusions for pre-existing conditions), the choice among benefit plans may not be limited, restricted or conditioned based upon the risk characteristics of the eligible employees or their dependents. (1-25-95)

03. Participation Requirement. The small employer carrier may impose reasonable minimum participation requirements for issuance of coverage to small employers, subject to prior approval from the Director. (1-25-95)

04. Employer Census and Supporting Documentation. A small employer carrier shall require each small employer that applies for coverage, as part of the application process, to prepare or provide an employer census of eligible employees as defined in Sections 41-4703(12) and (14), Idaho Code. The small employer carrier shall require the small employer to provide appropriate supporting documentation (such as the W-2 Summary Wage and Tax Form) or a certification of information by a Small Employer as to the current census information. (1-25-95)

05. Waiver for Documentation of Coverage. A small employer carrier shall secure a waiver with respect to each eligible employee and each dependent of such an eligible employee who declines an offer of coverage under a health benefit plan provided to a small employer. The waiver shall be signed by the eligible employee (on behalf of such employee or the dependent of such employee) and shall certify that the individual who declined coverage was informed of the availability of coverage under the health benefit plan. The waiver form shall require that the reason for declining coverage be stated on the form and shall include a written warning of the penalties imposed on late enrollees. Waivers shall be maintained by the small employer carrier for a period of six (6) years. (1-25-95)

06. Refusal to Provide Information. A small employer carrier shall not issue coverage to a small employer that refuses to provide the list required under Subsection 046.01 or a waiver required under Subsection 046.05, except for the following: (1-25-95)

a. The excluded individual has coverage under a health benefit plan or other health benefit arrangement that provides benefits similar to or exceeding benefits provided under the basic health benefit plan. (1-25-95)

07. Small Employer Carrier Shall Not Issue Coverage. A small employer carrier shall not issue coverage to a small employer if the carrier, or an agent for such carrier, has reason to believe that the small employer has induced or pressured an eligible employee (or dependent of an eligible employee) to decline coverage due to the individual's risk characteristics. (1-25-95)

08. Agent Notification to Small Employer Carrier. An agent shall notify a small employer carrier, prior to submitting an application for coverage with the carrier on behalf of a small employer, of any circumstances that would indicate that the small employer has induced or pressured an eligible employee (or dependent of an eligible employee) to decline coverage due to the individual's risk characteristics. (1-25-95)

09. New Entrants. New entrants to a small employer group shall be offered an opportunity to enroll in the health benefit plan currently held by such group based upon the provisions of Section 41-4708(3)(b), Idaho Code. A new entrant that does not exercise the opportunity to enroll in the health benefit plan within the period provided by the small employer carrier may be treated as a late enrollee by the carrier, provided that the period provided to enroll in the health benefit plan extends at least thirty (30) days after the date the new entrant is notified of his or her

opportunity to enroll. The period of continuous coverage shall not include any waiting period for the effective date of the new coverage applied by the employer or the carrier to all new enrollees under the Employee Benefit Plan. If a small employer carrier has offered more than one health benefit plan to a small employer group pursuant to Subsection 046.02, the new entrant shall be offered the same choice of health benefit plans as the other members of the group. (1-25-95)

10. **Small Employer Carrier Shall Not Apply Waiting Period or Similar Limitation.** A small employer carrier shall not apply a waiting period, elimination period or other similar limitation of coverage (other than an exclusion for pre-existing medical conditions consistent with Section 41-4708(3)(b), Idaho Code. This provision does not preclude application of any waiting periods applicable to all new enrollees under the health benefit plan. (1-25-95)

11. **No Restrictions or Limitations on Coverage Related to Risk Characteristics.** New entrants to a group shall be accepted for coverage by the small employer carrier without any restrictions or limitations on coverage related to the risk characteristics of the employees or their dependents, except that a carrier may exclude or limit coverage for pre-existing medical conditions, consistent with the provisions provided in Section 41-4708(3), Idaho Code. (1-25-95)

12. **Risk Load.** A small employer carrier may assess a risk load to the premium rate associated with a new entrant, consistent with the requirements of Section 41-4706, Idaho Code. The risk load shall be the same risk load charged to the small employer group immediately prior to acceptance of the new entrant into the group. (1-25-95)

13. **Open Enrollment.** In the case of an eligible employee (or dependent of an eligible employee) who, prior to the effective date of Section 41-4708, Idaho Code, was excluded from coverage or denied coverage by a small employer carrier in the process of providing a health benefit plan to an eligible small employer (as defined in Section 41-4708(1)(c), Idaho Code, the small employer carrier shall provide an opportunity for the eligible employee (or dependent of such eligible employee) to enroll in the health benefit plan currently held by the small employer. (1-25-95)

14. **Statement that Coverage Was Not Offered.** A small employer carrier may require an individual who requests enrollment under this subsection to sign a statement indicating that such individual sought coverage under the group contract (other than as a late enrollee) and that the coverage was not offered to the individual. (1-25-95)

15. **Opportunity to Enroll.** The opportunity to enroll shall meet the following requirements: (1-25-95)

- a. The opportunity to enroll shall begin October 1st, 1994 and shall last for a period of at least thirty (30) days. (1-25-95)
- b. Eligible employees and dependents of eligible employees who are provided an opportunity to enroll pursuant to this subsection shall be treated as new entrants. Premium rates related to such individuals shall be set in accordance with Subsection 046.15.c. (1-25-95)

- c. The terms of coverage offered to an individual described in Subsection 046.13 may exclude or limit, coverage for pre-existing medical conditions if the health benefit plan currently held by the small employer contains such an exclusion or limitation, provided that the exclusion or limitation shall be reduced by the number of days between the date the individual was excluded or denied or limited coverage and the date coverage is provided to the individual pursuant to this subsection. (1-25-95)

- d. A small employer carrier shall provide written notice at least forty-five (45) days prior to the opportunity to enroll provided in Subsection 046.13 to each small employer insured under a health benefit plan offered by such carrier. The notice shall clearly describe the rights granted under this subsection to employees and dependents who were previously excluded from or allowed through a rider or limited benefits or denied coverage and the process for enrollment of such individuals in the employer's health benefit plan. (1-25-95)

16. **Rescission.** When material application misstatements are found, rescission action by the carrier shall be taken at the carrier's option. When rescission action is taken, premiums must be refunded less any claims

which had been paid prior to the date the rescission was initiated. At the carrier's option, the carrier shall seek to recover any amounts of claims paid in excess of premiums paid. The applicable contract or coverage shall be considered null and void. (1-25-95)

a. Employer Misstatements - Rescissions taken against the coverage of an entire small employer (including employees and dependents) shall be limited to circumstances under which the application misstatements have been made by the small employer in his or her capacity as an employer. (1-25-95)

~~b. Employee Misstatements - Whenever possible, rescission actions shall be limited to the coverages derived through a single employee. (1-25-95)~~

~~e. Any individual who was not a late enrollee at the time of his enrollment with a small employer group and whose coverage is subsequently rescinded shall be allowed to re-enroll as of a current date in such plan or arrangement subject to any pre-existing condition or other provisions applicable to new enrollees without previous coverage. On and after the effective date of such individual's re-enrollment, the small employer carrier may modify the premium rates charged to the small employer for future rating periods, to the level determined by the carrier as applicable under the carrier's established rating practices had full, accurate and timely underwriting information been supplied when the individual initially enrolled in the plan. (1-25-95)~~

(BREAK IN CONTINUITY OF SECTIONS)

067. RESTRICTIVE RIDERS.

01. Restrictive Riders. A restrictive rider, endorsement or other provision that would violate the provisions of Section 41-4708(3)(e)(ii), Idaho Code, and that was in force on the effective date of this rule may not remain in force beyond the first anniversary date of the health benefit plan subject to the restrictive provision that follows the effective date of this rule. A small employer carrier shall provide written notice to those small employers whose coverage will be changed pursuant to this subsection at least thirty (30) days prior to the required change to the health benefit plan. (1-25-95)

02. ~~Basic, and Standard, and Catastrophic~~ Plans. Except as permitted in Section 41-4708(3), Idaho Code, a small employer carrier shall not modify or restrict a basic, ~~or standard, or catastrophic~~ health benefit plan in any manner for the purposes of restricting or excluding coverage or benefits for specific diseases, medical conditions or services otherwise covered by the plan. (1-25-95)(____)

03. Other Health Benefit Plans. Except as permitted in Section 41-4708(3), Idaho Code, a small employer carrier shall not modify or restrict any health benefit plan with respect to any eligible employee or dependent of an eligible employee, through riders, endorsements or otherwise, for the purpose of restricting or excluding the coverage or benefits provided to such employee or dependent for specific diseases, medical conditions or services otherwise covered by the plan. (1-25-95)

(BREAK IN CONTINUITY OF SECTIONS)

075. RULES RELATED TO FAIR MARKETING.

01. Small Employer Carrier Shall Actively Market. A small employer carrier shall actively market each of its health benefit plans to small employers in this state. A small employer carrier may not suspend the marketing or issuance of the basic, ~~and standard, or catastrophic~~ health benefit plans unless the carrier has good cause and has received the prior approval of the Director. (1-25-95)(____)

02. Marketing ~~Basic, and Standard, or Catastrophic~~ Plans. In marketing the basic, ~~and standard, or catastrophic~~ health benefit plans to small employers, a small employer carrier shall use at least the same sources and

methods of distribution that it uses to market other health benefit plans to small employers. Any producer authorized by a small employer carrier to market health benefit plans to small employers in the state shall also be authorized to market the basic, ~~and~~ standard, or catastrophic health benefit plans. (1-25-95)(____)

03. Offer Must Be in Writing. A small employer carrier shall offer at least the basic, ~~and~~ standard, or catastrophic health benefit plans to any small employer that applies for or makes an inquiry regarding health insurance coverage from the small employer carrier. The offer shall be in writing and shall include at least the following information: (1-25-95)(____)

a. A general description of the benefits contained in the basic, ~~and~~ standard, or catastrophic health benefit plans and any other health benefit plan being offered to the small employer, and (1-25-95)(____)

b. Information describing how the small employer may enroll in the plans. The offer may be provided directly to the small employer or delivered through a producer. (1-25-95)

04. Timeliness Of Price Quote. A small employer carrier shall provide a price quote to a small employer (directly or through an authorized producer) within ten (10) working days of receiving a request for a quote and such information as is necessary to provide the quote. A small employer carrier shall notify a small employer (directly or through an authorized producer) within five (5) working days of receiving a request for a price quote of any additional information needed by the small employer carrier to provide the quote. (1-25-95)

05. Restrictions as to Application Process. A small employer carrier may not apply more stringent or detailed requirements related to the application process for the basic, ~~and~~ standard, or catastrophic health benefit plans than are applied for other health benefit plans offered by the carrier. (1-25-95)(____)

06. Denial of Coverage. If a small employer carrier denies coverage under a health benefit plan to a small employer on the basis of a risk characteristic, the denial shall be in writing and shall be maintained in the small employer carrier's office. This written denial shall state with specificity the risk characteristic(s) of the small employer group that made it ineligible for the health benefit plan it requested (for example, health status, industry, group size, etc.). The denial shall be accompanied by a written explanation of the availability of the basic, ~~and~~ standard, or catastrophic health benefit plans from the small employer carrier. The explanation shall include at least the following: (1-25-95)(____)

a. A general description of the benefits contained in each such plan; (1-25-95)

b. A price quote for each such plan; and (1-25-95)

c. Information describing how the small employer may enroll in such plans. The written information described in this paragraph may be provided within the time periods provided in Subsection 075.04 directly to the small employer or delivered through an authorized producer. (1-25-95)

07. Lowest Priced Basic, ~~and~~ Standard, or Catastrophic Plan. The price quote required under Subsection 075.06.b. shall be for the lowest-priced basic, ~~and~~ standard, or catastrophic health benefit plan for which the small employer is eligible. (1-25-95)(____)

08. Toll-Free Telephone Service. A small employer carrier shall establish and maintain a toll-free telephone service to provide information to small employers regarding the availability of small employer health benefit plans in this state. The service shall provide information to callers on how to apply for coverage from the carrier. The information may include the names and phone numbers of producers located geographically proximate to the caller or such other information that is reasonably designed to assist the caller to locate an authorized producer or to otherwise apply for coverage. (1-25-95)

09. Restrictions as to Contribution to Association. The small group carrier shall not require a small employer to join or contribute to any association or group as a condition of being accepted for coverage by the small employer carrier, except that, if membership in an association or other group is a requirement for accepting a small employer into a particular health benefit plan, a small employer carrier may apply such requirement, subject to the requirements of Section 41-4708(1)(b)(ii), Idaho Code. (1-25-95)

10. No Requirement to Qualify for Other Insurance Product. A small employer carrier may not require, as a condition to the offer of sale of a health benefit plan to a small employer, that the small employer purchase or qualify for any other insurance product or service. (1-25-95)

11. Plans Subject to Requirement of The Act and This Rule. Carriers offering individual and group health benefit plans in this state shall be responsible for determining whether the plans are subject to the requirements of the Act and this Rule. Carriers shall elicit the following information from applicants for such plans at the time of application: (1-25-95)

a. Whether or not any portion of the premium will be paid by or on behalf of a small employer, either directly or through wage adjustments or other means of reimbursement; and (1-25-95)

b. Whether or not the prospective policyholder, certificate holder or any prospective insured individual intends to treat the health benefit plans as part of plan or program under Section 162 (other than Section 162(1)), Section 125 or Section 106, Internal Revenue Code. (1-25-95)

12. Failure to Comply. If a small employer carrier fails to comply with Subsection 075.11, the small employer carrier shall be deemed to be on notice of any information that could reasonably have been attained if the small employer carrier had complied with Subsection 075.11. (1-25-95)

13. Annual Filing Requirement. A small employer carrier shall file annually the following information with the Director related to health benefit plans issued by the small employer carrier to small employers in this state on forms prescribed by the Director: (1-25-95)

a. The number of small employers that were covered under health benefit plans in the previous calendar year (separated as to newly issued plans and renewals); (1-25-95)

b. The number of small employers that were covered under the basic, ~~health benefit plan and the standard, or catastrophic~~ health benefit plan in the previous calendar year (separated as to newly issued plans and renewals). (1-25-95)()

c. The number of small employer health benefit plans in force in each county (or by five digit zip code) of the state as of December 31 of the previous calendar year; (1-25-95)

d. The number of small employer health benefit plans that were voluntarily not renewed by small employers in the previous calendar year; (1-25-95)

e. The number of small employer health benefit plans that were terminated or non renewed (for reasons other than nonpayment of premium) by the carrier in the previous calendar year; and (1-25-95)

f. The number of health benefit plans that were issued to residents that were uninsured for at least ~~the one (1) month~~ sixty-three (63) days prior to issue. (1-25-95)()

14. Total Number of Residents. All carriers shall file annually with the Director, on forms prescribed by the Director, the total number of residents, including spouses and dependents, covered during the previous calendar year under all health benefit plans issued in this state. This includes residents covered under stop loss plans. (1-25-95)

15. Filing Date. The information described in Subsections 075.13 and 075.14 shall be filed no later than March 15, each year. (1-25-95)

16. Specific Data. For purposes of this section, health benefit plan information shall include policies or certificates of insurance for specific disease, hospital confinement indemnity and stop loss coverages. (1-25-95)

IDAPA 18 - IDAHO DEPARTMENT OF INSURANCE
18.01.70 - RULE TO IMPLEMENT THE SMALL EMPLOYER HEALTH
INSURANCE AVAILABILITY ACT PLAN DESIGN

DOCKET NO. 18-0170-9701

NOTICE OF PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has proposed rule making. These rules are proposed pursuant to the authority vested in the Director of the Department of Insurance under Title 41, Chapter 2, 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 October 15, 1997. 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 address below.

DESCRIPTIVE SUMMARY: The following is a statement in nontechnical language of the substance of the proposed rule:

The existing rule is being amended to provide for a small employer catastrophic health insurance plan in accordance with Idaho Code Section 41-4718.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning these proposed rules, contact James M. Alcorn at (208) 334-4202.

Anyone may submit written comments regarding these rules. All written comments and data concerning the rule must be directed to the undersigned and must be received on or before October 22, 1997.

Dated this 20 day of August, 1997.

James M. Alcorn, Director
Idaho Department of Insurance
700 West State Street - 3rd Floor
P.O. Box 83720
Boise, ID 83720-0043
Telephone No. (208) 334-4250

TEXT OF DOCKET NO. 18-0170-9701

002. WRITTEN INTERPRETATIONS.

In accordance with Section 67-5201(162)(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. (1-25-95)(_____)

(BREAK IN CONTINUITY OF SECTIONS)

004. DEFINITIONS.

As used in this Rule:

(1-25-95)

01. Benefit Percentage. Benefit percentage is the percentage of the cost of a health care service paid by

the insurer under a health insurance plan as defined in the schedule of benefits. (1-25-95)

02. Calendar Year. Calendar year is a period of one (1) year which starts on January 1st and ends on December 31st. (1-25-95)

03. Coinsurance. Coinsurance is a percentage of the cost of a health care service, paid by the patient under a health insurance plan, as defined in the schedule of benefits. (1-25-95)

04. Copayment. Copayment is a specified charge that must be paid each time care is received of a particular type or in a designated setting. The instances in which a copayment will be required are specified in the schedule of benefits. (1-25-95)

05. Expense. Expense means the expense incurred for a covered service or supply. A physician or other licensed practitioner has to order or prescribe the service or supply. Expense is considered incurred on the date the service or supply is received. Expense does not include any charge: (1-25-95)

a. For a service or supply which is not medically necessary; or (1-25-95)

b. Which is in excess of reasonable and customary charge for a service or supply. (1-25-95)

06. Medical Emergency. Medical emergency means a severe onset of a condition which: (1-25-95)

a. Results in symptoms which occur suddenly and unexpectedly; and (1-25-95)

b. Requires immediate physician's care to prevent death or serious impairment of the insured person's health; or (1-25-95)

c. Poses a serious threat to the patient or to others. (1-25-95)

07. Medically Necessary Service or Supply. Medically necessary service or supply means one which is ordered by a physician and which the small employer carrier or a qualified party or entity selected by us determines is: (1-25-95)

a. Provided for the diagnosis or direct treatment of an injury or sickness; (1-25-95)

b. Appropriate and consistent with the symptoms and findings of diagnosis and treatment of the insured persons injury or sickness; (1-25-95)

c. Is not considered experimental or investigative; (1-25-95)

d. Provided in accord with generally accepted medical practice; (1-25-95)

e. The most appropriate supply or level of service which can be provided on a cost effective basis (including, but not limited to, in-patient vs. out-patient care, electric vs. manual wheelchair, surgical vs. medical or other types of care.) The fact that the insured person's physician prescribes services or supplies does not automatically mean such service or supply are medically necessary and covered by the policy. (1-25-95)

08. Out-of-pocket Expense. Out-of-pocket expense is the medical expense that an insured must pay, which includes deductibles and coinsurance but not copayment, as defined in the schedule of benefits. (1-25-95)

09. Physician. Physician means any of the following licensees duly licensed by the state of Idaho to practice in any of the following categories of health care professions; (1-25-95)

a. Chiropractor; (1-25-95)

b. Dentist; (1-25-95)

- c. Optometrist; (1-25-95)
- d. Pharmacist; (1-25-95)
- e. Physician and surgeon, of either medicine and surgery or of osteopathic medicine and surgery; and (1-25-95)
- f. Podiatrist; and (1-25-95)
- g. Any other licensed practitioner who is acting within the scope of that license and who performs a service which is payable under the policy when performed by any of the above health care practitioners. A physician does not include a person who lives with the insured or is part of insureds family (spouse, child, brother, sister, or parent of insured or insureds spouse). (1-25-95)

10. Pre-Existing Condition. A health benefit plan shall not deny, exclude or limit benefits for a covered individual for covered expenses incurred more than twelve (12) months following the effective date of the individual's coverage due to a pre-existing condition. (1-25-95)

- a. A health benefit plan shall not define a pre-existing condition more restrictively than: (1-25-95)
 - i. ~~A condition, whether physical or mental, regardless of the cause of the condition, for which that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care or treatment was recommended or received~~ during the six (6) months immediately preceding the effective date of coverage; ~~(1-25-95)()~~
 - ii. ~~A condition for which medical advice, diagnosis, care or treatment was recommended or received during the six (6) months immediately preceding the effective date of coverage; or~~ (1-25-95)
 - iii. ~~A pregnancy existing on the effective date of coverage.~~ (1-25-95)
- b. Genetic information shall not be considered as a condition described in Subsection 010.10 in the absence of a diagnosis of the condition related to such information. ()

~~bc.~~ A health benefit plan shall waive any time period applicable to a pre-existing condition exclusion or limitation period with respect to particular services for the period of time an individual was previously covered by qualifying previous coverage that provided benefits with respect to such services, provided that the qualifying previous coverage was continuous to a date not more than ~~thirty (30)~~ sixty-three (63) days prior to the effective date of the new coverage. This provision does not preclude application of any waiting period applicable to all new enrollees under the health benefit plan. ~~(1-25-95)()~~

~~ed.~~ A health benefit plan may exclude coverage for late enrollees for the greater of twelve (12) months or for a twelve (12) months pre-existing condition exclusion; provided that if both a period of exclusion from coverage and a pre-existing condition exclusion are applicable to a late enrollee, the combined period shall not exceed twelve (12) months from the date the individual enrolls for coverage under the health benefit plan. (1-25-95)

11. Restricted Network Provision. Restricted network provision means any provision of a health benefit plan that conditions the payment of benefits, in whole or in part, on the use of health care providers that have entered into a contractual arrangement with the carrier pursuant to Chapter 34, Title 41, Idaho Code, ~~Hospital and Professional Service Corporations~~, and Chapter 39, Title 41, Idaho Code, ~~Health Maintenance Organizations~~, to provide health care services to covered individuals. ~~(1-25-95)()~~

(BREAK IN CONTINUITY OF SECTIONS)

015. COORDINATION OF BENEFITS.

Coordination of benefits shall be utilized on the small employer basic, ~~and standard, and catastrophic~~ plan based upon the current NAIC birthday rule so long as such Coordination of Benefits would not be in conflict with Chapter 22, Title 41, Idaho Code. This provision will expire upon final adoption of the NAIC Coordination of Benefits model rule or upon order Director. (1-25-95)()

016. LIMITATIONS AND EXCLUSIONS.

01. Services Not Medically Necessary, Excluded. Any service not medically necessary or appropriate unless specifically included within the coverage provisions. (1-25-95)

02. No Coverage. Custodial, convalescent or intermediate level care or rest cures. (1-25-95)

03. Experimental or Investigational. Services which are experimental or investigational. (1-25-95)

04. Workers' Compensation, Medicare, Champus. Services eligible for coverage by Workers' Compensation, Medicare or CHAMPUS. (1-25-95)

05. No Charges. Services for which no charges are made or for which no charges would be made in the absence of insurance or for which the insured has no legal obligation to pay. (1-25-95)

06. No Medical Diagnosis. Services ~~(including surgery), self-help and training programs for weight control, nutrition, smoking cessation, etc., as well as prescription drugs used in conjunction with such programs and services; for weight control, nutrition, and smoking cessation, including self-help and training programs as well as prescription drugs, used in conjunction with such programs and services.~~ (1-25-95)()

07. Cosmetic Surgery. Cosmetic surgery and services, except for treatment for non-congenital injury or surgery. Mastectomy reconstruction is covered if within two (2) years of mastectomy. (1-25-95)

08. Artificial Insemination, Infertility, Sexual Dysfunction. Artificial insemination and infertility treatment. Treatment of sexual dysfunction not related to organic disease. (1-25-95)

09. Induced Infertility. Services for reversal of elective, surgically or pharmaceutically induced infertility. (1-25-95)

10. Vision. Vision therapy, tests, glasses, contact lenses and other vision aids. Radial keratotomy, myopic keratomileusis and any surgery involving corneal tissue to alter or correct myopia, hyperopia or stigmatic error. Vision tests and glasses will be covered for children under the age of twelve (12), except in catastrophic health benefit plans. (1-25-95)()

11. Limitation Foot Care. For treatment of weak, strained, or flat feet, including orthopedic shoes or other supportive devices, or for cutting, removal, or ~~treatment~~ treatment of corns, calluses, or nails other than corrective surgery, or for metabolic or peripheral vascular disease. (1-25-95)()

12. Spinal Manipulation. Chiropractic services will be subject to one thousand dollar (\$1,000) per year limit, subject to the policy deductible and co-insurance. (1-25-95)

13. Dental, Orthodontic Services. ~~Dental and orthodontic services, except those needed for treatment of a medical condition or injury or as specifically allowed in the policy for children under the age of twelve (12).~~ (1-25-95)()

a. For Basic and Standard plans: Dental and orthodontic services, except those needed for treatment of a medical condition or injury or as specifically allowed in the policy for children under the age of twelve (12). ()

b. For Catastrophic plans: Dental care or treatment, except for injury sustained while insured under this policy, or as a result of nondental disease covered by the policy. ()

14. Hearing Tests. Hearing tests without illness being suspect. (1-25-95)
15. Hearing Aids, Supplies. Hearing aids and supplies, tinnitus maskers, cochlear implants and exams for the prescription or fitting of hearing aids. (1-25-95)
16. Speech Tests. Speech tests and therapy except as specifically allowed in the policy for children under the age of twelve (12). (1-25-95)
17. Private Room Accommodation Charges. Private room accommodation charges in excess of the institution's most common semi-private room charge except when prescribed as medically necessary. (1-25-95)
18. Services Performed by a Member of the Insureds Family. Services performed by a member of the insured's family or of the insured's spouse's family. Family includes parents or grandparents of the insured or spouse and any descendants of such parents or grandparents. (1-25-95)
19. No Coverage Prior to Effective Date of Coverage. Care incurred before the effective date of the person's coverage. (1-25-95)
20. Covered Injury or Disease. Immunizations and medical exams and tests of any kind not related to treatment of covered injury or disease, except as specifically stated in the policy. (1-25-95)
21. Act of War or Armed Conflict. Injury or sickness caused by war or armed international conflict. (1-25-95)
22. ~~Operation and Treatment, Sexual Change, Sex Change Operations and Treatment in connection with transsexualism.~~ (1-25-95)
23. Counseling. Marriage and family and child counseling except as specifically allowed in the policy. (1-25-95)
24. Acupuncture. ~~Acupuncture except when used as anesthesia during a covered surgical procedure.~~ (1-25-95)()
 - a. For Basic and Standard plans: Acupuncture except when used as anesthesia during a covered surgical procedure. ()
 - b. For Catastrophic plans: Acupuncture. ()
25. Private Duty Nursing. Private duty nursing except as specifically allowed in the policy. (1-25-95)
26. Employer Maintained Medical or Dental Care. Services received from a medical or dental department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group. (1-25-95)
27. ~~Termination. Incurred after the date of termination of the insured's coverage, except as allowed by any extension of benefits provision in the policy. Services incurred after the date of termination of a covered person's coverage except as allowed by the extension of benefits provision of the policy, if any.~~ (1-25-95)()
28. Personal Convenience Items. Expenses for personal hygiene and convenience items such as air conditioners, humidifiers, and physical fitness equipment. (1-25-95)
29. Failure to Keep a Scheduled Visit. Charges for failure to keep a scheduled visit, charges for completion of any form, and charges for medical information. (1-25-95)
30. Screening Examinations. Charges for screening examinations except as otherwise provided in the policy. (1-25-95)

31. No Allowance. Charges for wigs or cranial prostheses, hair analysis, hair loss and baldness.
 (1-25-95)
32. Pre-existing Conditions. Pre-existing conditions, except as provided specifically in the policy.
 (1-25-95)

(BREAK IN CONTINUITY OF SECTIONS)

APPENDIX A
HMO MANAGED CARE STANDARD BENEFIT PLAN

Schedule of Benefits

ALL BENEFIT AREAS	
Calendar Year Benefit Maximum	\$100,000
Benefit Area A	
Preventive Services	
Copayment:	
-Adults	\$15
-Children	\$0
Benefit Percentage	\$100%
Coinsurance Percentage	\$0%
Annual Benefit Maximum*	\$500
Vision Annual Benefit Sub-cap*	\$75
Benefit Area B1	
Primary Maternity Services	
Initial Visit Copayment	\$15
Benefit Percentage	100%
Coinsurance Percentage	0%
Benefit Area B2	
Other Maternity	
Copayment (per admission)	\$500
Benefit Percentage	80%
Coinsurance Percentage	20%
Benefit Area C	
Inpatient Services	
Copayment (per admission)	\$500
Benefit Percentage	80%

ALL BENEFIT AREAS	
Coinsurance Percentage	20%
Benefit Area D	
Outpatient Services	
Copayment	
1. Emergency Room+	\$100
2. Outpatient Surgery	\$200
3. Office Visits and Other Outpatient Services	\$20
+\$100 network provider; \$200 non-designated provider	
Benefit Area E	
Transportation & Medical Equipment	
Emergency Ambulance Service	
Annual Benefit Maximum*	\$750
Copayment	\$100
Benefit Percentage	0%
Coinsurance Percentage	0%
Durable Medical Equipment	
Annual Benefit Maximum*	\$15,000
Copayment	\$0
Benefit Percentage	80%
Coinsurance Percentage	20%
Benefit Area F	
Psychiatric and Substance Abuse	
Annual Benefit Maximum (Inpatient and Outpatient)*	\$5,000
Outpatient	
Sub-cap	\$1,500
Copayment	\$0
Benefit percentage	50%
Coinsurance percentage	50%
Inpatient	
Copayment	\$500
Benefit percentage	80%
Coinsurance percentage	20%
Benefit Area G	
Pharmacy Benefits	

ALL BENEFIT AREAS	
Copayment per Prescription	\$10
Benefit Percentage	100%**
Coinsurance	0%**
Out-of-Pocket Expense Limit	
Individual	\$5,000
Family	\$10,000

(Applicable to Benefit Areas "B2", "C", "D", "E" and "F")

*Maximum benefit payable during any twelve (12) month period.

** One hundred percent (100%) of the cost of the generic substitute (when available) is paid. The insured must pay the difference between the cost of a brand name drug and the generic substitute if a brand name drug is selected when a generic is available. If a generic substitute is not available, one hundred percent (100%) of the cost of the brand name drug after the copayment is payable.

(BREAK IN CONTINUITY OF SECTIONS)

APPENDIX C
HMO MANAGED CARE BASIC BENEFIT PLAN

Schedule of Benefits

ALL BENEFIT AREAS	
Calendar Year Benefit Maximum	\$25,000
Benefit Area A	
Preventive Services	
Copayment:	
-Adults	\$15
-Children	\$0
Benefit Percentage	100%
Coinsurance Percentage	0%
Annual Benefit Maximum*	\$500
Vision Annual Benefit Sub-cap*	\$75
Benefit Area B1	
Primary Maternity Services	
Initial Visit Copayment	\$15
Benefit Percentage	100%
Coinsurance Percentage.	0%

ALL BENEFIT AREAS	
Benefit Area B2	
Other Maternity	
Copayment (per admission)	\$1,000
Benefit Percentage	50%
Coinsurance Percentage	50%
Benefit Area C	
Inpatient Services	
Copayment (per admission)	\$1,000
Benefit Percentage	50%
Coinsurance Percentage	50%
Benefit Area D	
Outpatient Services	
Copayment	
1. Emergency Room+	\$100
2. Outpatient Surgery	\$400
3. Office Visits and Other Outpatient Services	\$30
+\$100 network provider; \$200 non-designated provider	
Benefit Area E	
Transportation & Medical Equipment	
Emergency Ambulance Service	
Annual Benefit Maximum*	\$750
Copayment	\$200
Benefit Percentage	100%
Coinsurance Percentage	0%
Durable Medical Equipment	
Annual Benefit Maximum*	\$15,000
Copayment	\$0
Benefit Percentage	50%
Coinsurance Percentage	50%
Benefit Area F	
Psychiatric and Substance Abuse	
Annual Benefit Maximum (Outpatient)*	\$1,500
Copayment	\$0
Benefit percentage	50%

ALL BENEFIT AREAS	
Coinsurance percentage	50%
Benefit Area G	
Pharmacy Benefits	
Copayment per Prescription	\$10
Benefit Percentage	100%**
Coinsurance	0%**
Out-of-Pocket Expense Limit	
Individual	\$5,000
Family	\$10,000

(Applicable to Benefit Areas "B2", "C", "D", "E")

*Maximum benefit payable during any twelve (12) month period.

**One hundred percent (100%) of the cost of the generic substitute (when available) is paid. The insured must pay the difference between the cost of a brand name drug and the generic substitute if a brand name drug is selected when a generic is available. If a generic substitute is not available, one hundred percent (100%) of the cost of the brand name drug after the copayment is payable.

APPENDIX E
MANAGED CARE CATASTROPHIC BENEFIT PLAN

Schedule of Benefits

<u>ALL BENEFIT AREAS</u>	
<u>Calendar Year Benefit Maximum</u>	<u>\$200,000</u>
<u>Calendar Year Out-of-Pocket Limits</u>	
<u>For Copayments and Coinsurance:</u>	
-per person	<u>\$12,000</u>
- per family	<u>\$24,000</u>
<u>The per person Benefit maximum applies when family coverage is purchased.</u>	
<u>Copayments - Only as stated for specific Benefit Areas</u>	
<u>Coinsurance - Only as stated for specific Benefit Areas</u>	
<u>Benefit Area A</u>	
<u>Preventive Services</u>	
<u>Copayment</u>	
- Adults	<u>\$20</u>
- Children	<u>\$-0-</u>
<u>Annual Benefit Maximum</u>	<u>\$250</u>
<u>Benefit Area B</u>	
<u>Maternity</u>	

<u>ALL BENEFIT AREAS</u>	
<u>Outpatient Maternity Copayment per Visit</u>	<u>\$20</u>
<u>Outpatient Maternity Out-Of-Pocket Expense Limit (per pregnancy) (fully paid thereafter)</u>	<u>\$240</u>
<u>Inpatient Maternity Copayment per Day per pregnancy</u>	<u>\$500</u>
<u>Inpatient Maternity Out-Of-Pocket Expense Limit (per pregnancy) (fully paid thereafter)</u>	<u>\$1,000</u>
<u>Benefit Area C</u>	
<u>General Inpatient Services</u>	
<u>Copayment per Day (not to exceed 5 days per admission)</u>	<u>\$500</u>
<u>-Out-of-Pocket Expense Limit per Admission</u>	<u>\$2,500</u>
<u>Benefit Area D</u>	
<u>General Outpatient Services</u>	
<u>Copayment per Office Visit</u>	<u>\$20</u>
<u>Copayment for Laboratory and Radiology (X-ray)</u>	<u>\$-0-</u>
<u>Benefit Area E</u>	
<u>Transportation and Medical Equipment</u>	
<u>Ambulance</u>	
<u>-Coinsurance per Trip</u>	<u>50%</u>
<u>-Annual Benefit Sub-maximum</u>	<u>\$750</u>
<u>Durable Medical Equipment</u>	
<u>-Coinsurance</u>	<u>50%</u>
<u>-Annual Benefit Sub-maximum</u>	<u>\$10,000</u>
<u>Benefit Area F</u>	
<u>Psychiatric and Substance Abuse</u>	
<u>Outpatient Services</u> (not including drugs are covered under Area G)	
<u>-Copayment per Visit</u>	<u>\$50</u>
<u>-Annual number of Covered Visits</u>	<u>10</u>
<u>Inpatient Services</u> (including drugs)	
<u>-Copayment per Day</u>	<u>\$400</u>
<u>-Annual maximum number of Covered Days</u>	<u>10</u>
<u>Benefit Area G</u>	
<u>Drugs and Pharmaceuticals</u>	
<u>Coinsurance for each prescription, for up to a 30-day supply (formularies permitted - subjects unlisted drugs to managed care plan approval)</u>	<u>50%</u>

APPENDIX F
CATASTROPHIC BENEFIT PLAN

Schedule of Benefits

<u>ALL BENEFIT AREAS</u>	
<u>Calendar Year Individual Benefit Maximum</u>	\$200,000
<u>Calendar Year Deductible</u>	
- <u>Individual</u>	<u>\$2,000 or \$5,000</u>
- <u>Family</u>	<u>\$4,000 or \$10,000</u>
<u>Benefit Percentage</u>	<u>50%</u>
<u>Coinsurance Percentage</u>	<u>50%</u>
<u>Calendar Year Out-of-Pocket Expense Limit</u>	
- <u>Individual</u>	<u>\$10,000 for \$2,000 deductible</u> <u>\$13,000 for \$5,000 deductible</u>
- <u>Family</u>	<u>\$20,000 for \$4,000 deductible</u> <u>\$26,000 for \$10,000 deductible</u>

Change to Higher Deductible - Charges previously applied to deductible amount for the same year are applied to the new deductible amount. New covered charges are applied to the new deductible amount. Change to lower deductible is not permitted. Charges applied to the deductible amount are not carried over to the next calendar year.

<u>Benefit Area A</u>	
<u>Preventive Services</u>	
<u>Annual Benefit Maximum*</u>	\$500
<u>Vision Annual Benefit Sub-cap*</u>	\$75
<u>Benefit Areas B2, C, D, E, F</u>	
<u>Emergency Ambulance Service</u>	
<u>Annual Benefit Maximum*</u>	\$750
<u>Durable Medical Equipment</u>	
<u>Annual Benefit Maximum*</u>	\$15,000
<u>Psychiatric and Substance Abuse Services</u>	
<u>Annual Benefit Maximum*</u>	\$5,000
<u>Benefit Area G</u>	
<u>Pharmacy Benefits</u>	
<u>Copayment per Prescription</u>	\$10
<u>Benefit Percentage</u>	100%**
<u>Coinsurance</u>	0%**

* Maximum benefit payable during any twelve (12) month period.

** 100% of the cost of the generic substitute (when available) is paid. The insured must pay the difference between the cost of a brand name drug and the generic substitute if a brand name drug is selected when a generic is available. If a generic substitute is not available, 100% of the cost of the brand name drug after the copayment is payable.

IDAPA 18 - IDAHO DEPARTMENT OF INSURANCE

18.01.72 - RULE TO IMPLEMENT THE INDIVIDUAL HEALTH INSURANCE AVAILABILITY ACT

DOCKET NO. 18-0172-9401

NOTICE OF PENDING RULE

EFFECTIVE DATE: These rules have been adopted by the agency and are now pending review by the 1998 Idaho State Legislature for final adoption. The pending rule becomes final and effective July 1, 1998, 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. This 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 rules and a statement of any change between the text of the proposed rules and text of the pending rules with an explanation of the reasons for the change.

The rule makes permanent the temporary rules implementing The Individual Health Insurance Availability Act, Chapter 52, Title 41, Idaho Code. The proposed rules have been amended pursuant to Section 67-5227, Idaho Code, to conform to 1997 changes to Chapter 52, Title 41, Idaho Code, and to make clerical corrections. These changes include the addition of tobacco and geography as case characteristics, allowing up to six geographic areas for case characteristic purposes, requiring that geographic areas be no smaller than a county, adding references to a catastrophic health plan, and eliminating language concerning rotation of carriers.

Only the sections that have changes are printed in this bulletin. The original text of the proposed rules was published in the Idaho Administrative Bulletin, Volume 94-12, December 7, 1994, pages 362 through 381.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the pending rules, contact James Alcorn at (208) 334-4202.

Dated this 2nd day of September, 1997.

James M. Alcorn, Director
Idaho Department of Insurance
700 West State Street - 3rd Floor
P.O. Box 83720
Boise, ID 83720-0043
Telephone No. (208) 334-4250
Fax: (208) 334-4398

There are substantive changes from the proposed rule text.

Only those Sections that have changed from the original proposed text are being reprinted in this Bulletin following this notice.

The complete original text was published in the Idaho Administrative Bulletin, Volume 94-12, December 7, 1994, pages 382 through 390.

This rule has been adopted as Final by the Agency and is now pending review by the 1998 Idaho State Legislature for final adoption.

TEXT OF DOCKET NO. 18-0172-9401

002. WRITTEN INTERPRETATIONS.

In accordance with Section 67-5201(4619)(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. (1-1-95)T()

(BREAK IN CONTINUITY OF SECTIONS)

004. DEFINITIONS.

As used in this Rule: (1-1-95)T

01. Carrier. Carrier means any entity operating under a current Certificate of Authority issued from the Department of Insurance to do the business of disability insurance in this state. Further definition is found under Section 41-5201(7). (1-1-95)T

02. Case Characteristics. Case Characteristics are limited to age, individual tobacco use, geography and gender. An individual carrier must apply the use of such case characteristics on a uniform basis. Further definition is found under Section 41-5201(8), Idaho Code, and in IDAPA 18.01.69.015. (1-1-95)T()

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

034. Risk Characteristic. Risk Characteristic means the health status, claims experience, duration of coverage, or any similar characteristic related to the health status or claims experience of an individual. Such characteristics can include family composition and geographic location. (1-1-95)T()

045. Risk Load. Risk Load means the percentage above the applicable base premium rate that is charged by an individual carrier to the rates of the eligible individual, to reflect the risk characteristics of the eligible individual. (1-1-95)T

056. Idaho Resident. Idaho resident means a person who is able to provide satisfactory proof of having resided in Idaho, as their place of domicile for a continuous six (6) month period, for purposes of being an eligible individual pursuant to Section 41-5203(13), Idaho Code. The six (6) month residency requirements would be waived for eligible individuals based on the Health Insurance Portability and Accountability Act of 1996. (1-1-95)T()

(BREAK IN CONTINUITY OF SECTIONS)

036. RESTRICTIONS RELATING TO PREMIUM RATES.

01. Rate Manual. An individual carrier shall develop a rate manual for all individual business. Base premium rates and new business premium rates charged to eligible individuals by the individual carrier shall be computed solely from the applicable rate manual developed pursuant to this subsection. To the extent that a portion of the premium rates charged by an individual carrier is based on the carrier's discretion, the manual shall specify the criteria and factors considered by the carrier in exercising such discretion. (1-1-95)T

02. Requirements for Adjustments to Rating Method. An individual carrier shall not modify the rating method used in the rate manual for its individual business until the change has been approved as provided in this

paragraph. The Director may approve a change to a rating method if the Director finds that the change is reasonable, actuarially appropriate, and consistent with the purposes of the Act and this Rule. (1-1-95)T

03. Information Required for Review of Modification of Rating Method. A carrier may modify the rating method for its individual business only with prior approval of the Director. A carrier requesting to change the rating method for its individual business shall make a filing with the Director at least thirty (30) days prior to the proposed date of the change. The filing shall contain at least the following information: (1-1-95)T

a. The reasons the change in rating method is being requested; (1-1-95)T

b. A complete description of each of the proposed modifications to the rating method; (1-1-95)T

c. A description of how the change in rating method would affect the premium rates currently charged to eligible individuals in the health benefit plan, including an estimate from a qualified actuary of the number of individuals (and a description of the types of individuals) whose premium rates may change by more than ten percent (10%) due to the proposed change in rating method (not generally including increases in premium rates applicable to all individuals in a health benefit plan); (1-1-95)T

d. A certification from a qualified actuary that the new rating method would be based on objective and credible data and would be actuarially sound and appropriate; and (1-1-95)T

e. A certification from a qualified actuary that the proposed change in rating method would not produce premium rates for eligible individuals that would be in violation of Section 41-5206, Idaho Code. (1-1-95)T

04. Change in Rating Method. For the purpose of Section 036 a change in rating method shall mean: (1-1-95)T

a. A change in the number of case characteristics used by an individual carrier to determine premium rates for health benefit plans in its individual business (an individual carrier shall not use case characteristics other than age, individual tobacco use, geography or gender without prior approval of the Director); ~~(1-1-95)T()~~

b. A change in the method of allocating expenses among health benefit plans; or, (1-1-95)T

c. A change in a rating factor with respect to any case characteristic if the change would produce a change in premium for any individual that exceeds ten percent (10%). (1-1-95)T

d. For the purpose of Subsection 036.04, a change in a rating factor shall mean the cumulative change with respect to such factor considered over a twelve (12) month period. If an individual carrier changes rating factors with respect to more than one case characteristic in a twelve (12) month period, the carrier shall consider the cumulative effect of all such changes in applying the ten percent (10%) test. (1-1-95)T

05. Rate Manual to Specify Case Characteristics and Rate Factors to Be Applied. The rate manual developed pursuant to Subsection 036.01 shall specify the case characteristics and rate factors to be applied by the individual carrier in establishing premium rates for the health benefit plans. (1-1-95)T

06. Case Characteristics Other Than Age, Individual Tobacco Use, Geography and Gender - Must Have Prior Approval of Director. An individual carrier may not use case characteristics other than those specified in Section 41-5206(1)(g), Idaho Code, without the prior approval of the Director. An individual carrier seeking such an approval shall make a filing with the Director for a change in rating method under Subsection 036.02. ~~(1-1-95)T()~~

07. Case Characteristics Shall Be Applied in a Uniform Manner. An individual carrier shall use the same case characteristics in establishing premium rates for each health benefit plan and shall apply them in the same manner in establishing premium rates for each such health benefit plan. Case characteristics shall be applied without regard to the risk characteristics of an eligible individual. (1-1-95)T

08. Rate Manual Must Clearly Illustrate Relationship Among Base Premium Rate and Any Difference in New Business Rate. The rate manual developed pursuant to Subsection 036.01 shall clearly illustrate the

relationship among the base premium rates charged for each health benefit plan. If the new business premium rate is different than the base premium rate for a health benefit plan, the rate manual shall illustrate the difference. (1-1-95)T

09. Differences in Premium Rates Must Reflect Reasonable and Objective Differences. Differences among base premium rates for health benefit plans shall be based solely on the reasonable and objective differences in the design and benefits of the health benefit plans and shall not be based in any way on the actual or expected health status or claims experience of the eligible individual groups that choose or are expected to choose a particular health benefit plan. An individual carrier shall apply case characteristics and rate factors within its health benefit plans in a manner that assures that premium differences among health benefit plans for identical individuals vary only due to reasonable and objective differences in the design and benefits of the health benefit plans and are not due to the actual or expected health status or claims experience of the individuals that choose or are expected to choose a particular health benefit plan. (1-1-95)T

10. Premium Rates to Be Developed in Two (2) Step Process. The rate manual developed pursuant to Subsection 036.01 shall provide for premium rates to be developed in a two (2) step process. In the first step, a base premium rate shall be developed for the eligible individual without regard to any risk characteristics. In the second step, the resulting base premium rate may be adjusted by a risk load, subject to the provisions of Section 41-5206, Idaho Code, to reflect the risk characteristics of the individual. (1-1-95)T

11. Exception to Application Fee, Underwriter Fee or Other Fees. Except as provided in Subsection 036.12, a premium charged to an individual for a health benefit plan shall not include a separate application fee, underwriting fee, or any other separate fee or charge. (1-1-95)T

12. Uniform Application of Fees. A carrier may charge a separate fee with respect to a health benefit plan provided the fee is applied in a uniform manner to all health benefit plans. All such fees are premium and shall be included in determining compliance with the Act and this rule. (1-1-95)T

13. Uniform Allocation of Administration Expenses. An individual carrier shall allocate administrative expenses to the basic, ~~and standard, and catastrophic~~ health benefit plans on no less favorable of a basis than expenses are allocated to other health benefit plans. The rate manual developed pursuant to Subsection 036.01 shall describe the method of allocating administrative expenses to the health benefit plans for which the manual was developed. ~~(1-1-95)T()~~

14. Rate Manual to Be Maintained for a Period of Six (6) Years. Each rate manual developed pursuant to Subsection 036.01 shall be maintained by the carrier for a period of six (6) years. Updates and changes to the manual shall be maintained with the manual. (1-1-95)T

15. Rate Manual and Practices Must Comply with Guidelines Issued by Director. The rate manual and rating practices of an individual carrier shall comply with any guidelines issued by the Director. (1-1-95)T

16. Application of Restrictions Related to Changes in Premium Rates. The restrictions related to changes in premium rates are set forth in Section 41-5206(1)(b), Idaho Code, and shall be applied as follows: (1-1-95)T

a. An individual carrier shall revise its rate manual each rating period to reflect changes in base premium rates and changes in new business premium rates. (1-1-95)T

b. If, for any health benefit plan with respect to any rating period, the percentage change in the new business premium rate is less than or the same as the percentage change in the base premium rate, the change in the new business premium rate shall be deemed to be the change in the base premium rate for the purposes of Sections 41-5206(1)(b)(ii) and 41-5206(1)(d)(i), Idaho Code. (1-1-95)T

c. If for any health benefit plan with respect to any rating period, the percentage change in the new business premium rate exceeds the percentage change in the base premium rate, the health benefit plan shall be considered a health benefit plan into which the individual carrier is no longer enrolling new eligible individuals for the purposes of Sections 41-5206(1)(b) and (d), Idaho Code. (1-1-95)T

d. If, for any rating period, the change in the new business premium rate for a health benefit plan differs from the change in the new business premium rate for any other health benefit plan by more than twenty percent (20%), the carrier shall make a filing with the Director containing a complete explanation of how the respective changes in new business premium rates were established and the reason for the difference. The filing shall be made within thirty (30) days of the beginning of the rating period. (1-1-95)T

e. An individual carrier shall keep on file for a period of at least six (6) years the calculations used to determine the change in base premium rates and new business premium rates for each health benefit plan for each rating period. (1-1-95)T

17. Change in Premium Rate. Except as provided in Subsections 036.18 and 036.19, a change in premium rate for an eligible individual shall produce a revised premium rate that is no more than the following: (1-1-95)T

a. The base premium rate for the eligible individual, given its present composition, (as shown in the rate manual as revised for the rating period), multiplied by: (1-1-95)T

b. One (1) plus the sum of: (1-1-95)T

i. The risk load applicable to the eligible individual during the previous rating period; and (1-1-95)T

ii. Fifteen percent (15%) (prorated for periods of less than one (1) year). (1-1-95)T

18. Rating Restrictions on Plans Where Carrier Is No Longer Enrolling New Business. In the case of a health benefit plan into which an Individual carrier is no longer enrolling new Individuals, a change in premium rate for an Individual shall produce a revised premium rate that is no more than the base premium rate for the Individual (given its present composition and as shown in the rate manual in effect for the Individual at the beginning of the previous rating period), multiplied by Subsection 136.18.a. and 036.18.b. below; (1-1-95)T

a. One (1) plus the lesser of: (1-1-95)T

i. The change in the base rate; or (1-1-95)T

ii. The percentage change in the new business premium for the most similar health benefit plan into which the Individual carrier is enrolling new Individuals. (1-1-95)T

b. One (1) plus the sum of: (1-1-95)T

i. The risk load applicable to the Individual during the previous rating period; and (1-1-95)T

ii. Fifteen percent (15%) (prorated for periods of less than one (1) year). (1-1-95)T

19. Plans Written Prior to January 1, 1995. In the case of a health benefit plan described in Section 41-5206(1)(d), Idaho Code, if the current premium rate for the health benefit plan exceeds the ranges set forth in Section 41-5206, Idaho Code, the formulae set forth in Subsections 036.17 and 036.18 will be applied as if the fifteen percent (15%) adjustment provided in Subsections 036.17.b.ii. and 036.18.c.ii. were a zero percent (0%) adjustment. (1-1-95)T

20. Limitations on Revised Premium Rate. Notwithstanding the provisions of Subsections 036.17 and 036.18, a change in premium rate for an Individual shall not produce a revised premium rate that would exceed the limitations on rates provided in Section 41-5206, Idaho Code. (1-1-95)T

(BREAK IN CONTINUITY OF SECTIONS)

046. REQUIREMENT TO INSURE INDIVIDUALS.

01. Offer of Coverage. An individual carrier that offers coverage to an individual shall offer to provide coverage to each eligible individual and to each eligible dependent of an eligible individual. (1-1-95)T

02. No Restrictions or Limitations on Coverage Related To Risk Characteristics. Individuals shall be accepted for coverage by the individual carrier without any restrictions or limitations on coverage related to the risk characteristics of the Individual or their dependents, except that a carrier may exclude or limit coverage for pre-existing medical conditions, consistent with the provisions provided in Section 41-5208(3), Idaho Code. (1-1-95)T

03. Risk Load. An individual carrier may assess a risk load to the premium rate associated with a new entrant, consistent with the requirements of Section 41-5206, Idaho Code. The risk load shall be the same risk load charged to the Individual immediately prior to acceptance of the new entrant into the health benefit plan. (1-1-95)T

04. Rescission. When material application misstatements are found, rescission action by the carrier shall be taken at the carrier's option. When rescission action is taken, premiums must be refunded less any claims which had been paid prior to the date the rescission was initiated. At the carrier's option, the carrier shall seek to recover any amounts of claims paid in excess of premiums paid. The applicable contract or coverage shall be considered null and void. (1-1-95)T

05. Coverage Rescinded for Fraud or Misrepresentation. Any individual whose coverage is subsequently rescinded for fraud or misrepresentation shall not be deemed to be an "eligible individual" for a period of twelve (12) months from the effective date of the termination of the individual coverage and shall not be deemed to have "qualifying previous coverage" under chapter 47 or 52, title 41, Idaho Code; provided such limitations cannot be in conflict with the Health Insurance Portability and Accountability Act of 1996. (1-1-95)T()

047. - 0504. (RESERVED).

~~051. ROTATION OF CARRIERS.~~

~~As of January 1, 1995 individual carriers are to provide enrollments to all persons in the first thirty (30) days of the calendar year. Thereafter, individual carriers shall participate in an orderly rotation in which all individual carriers shall provide enrollments to all persons, however, beginning July 1, 1995, individual carriers may decline enrollments for not more than one (1) calendar month provided that a written request is filed with the Director and approved. The Director shall approve such requests unless approval together with any prior approved requests would exceed the total number of individual carriers in Idaho divided by twelve (12) plus one (1).~~ (1-1-95)T

~~052. -- 054. (RESERVED).~~

(BREAK IN CONTINUITY OF SECTIONS)

067. RESTRICTIVE RIDERS.

01. Restrictive Riders. A restrictive rider, endorsement or other provision that would violate the provisions of Section 41-5208(3)(c), Idaho Code, and that was in force on the effective date of this rule may not remain in force beyond the first anniversary date of the health benefit plan subject to the restrictive provision that follows the effective date of this rule. An individual carrier shall provide written notice to those individuals whose coverage will be changed pursuant to this subsection at least thirty (30) days prior to the required change to the health benefit plan. (1-1-95)T

02. Basic, and Standard, and Catastrophic Plans. Except as permitted in Section 41-5208(3)(a), Idaho Code, an individual carrier shall not modify or restrict a basic, or standard, or catastrophic health benefit plan in any manner for the purposes of restricting or excluding coverage or benefits for specific diseases, medical conditions or services otherwise covered by the plan. (1-1-95)T()

03. Other Health Benefit Plans. Except as permitted in Section 41-5208(3), Idaho Code, an individual carrier shall not modify or restrict any health benefit plan with respect to any eligible individual or dependent of an eligible individual, through riders, endorsements or otherwise, for the purpose of restricting or excluding the coverage or benefits provided to such individual or dependent for specific diseases, medical conditions or services otherwise covered by the plan. (1-1-95)T

(BREAK IN CONTINUITY OF SECTIONS)

075. RULES RELATED TO FAIR MARKETING.

01. Individual Carrier Shall Actively Market. An individual carrier shall actively market each of its health benefit plans to individuals in this state. An individual carrier may not suspend the marketing or issuance of the basic, ~~and standard, or catastrophic~~ health benefit plans unless the carrier has good cause and has received the prior approval of the Director. (1-1-95)T()

02. Marketing Basic, ~~and Standard, and Catastrophic~~ Plans. In marketing the basic and standard health benefit plans to individuals, an individual carrier shall use at least the same sources and methods of distribution that it uses to market other health benefit plans to individuals. Any producer authorized by an individual carrier to market health benefit plans to Individuals in the state shall also be authorized to market the basic, ~~and standard, and catastrophic~~ health benefit plans. (1-1-95)T()

03. Offer Must Be in Writing. An individual carrier shall offer at least the basic and standard health benefit plans to any individual that applies for or makes an inquiry regarding health insurance coverage from the individual carrier. The offer shall be in writing and shall include at least the following information: (1-1-95)T

a. A general description of the benefits contained in the basic, ~~and standard, and catastrophic~~ health benefit plans and any other health benefit plan being offered to the individual; and (1-1-95)T()

b. Information describing how the individual may enroll in the plans. (1-1-95)T

c. The offer may be provided directly to the individual or delivered through a producer. (1-1-95)T

04. Timeliness of Price Quote. An individual carrier shall provide a price quote to an individual (directly or through an authorized producer) within fifteen (15) working days of receiving a request for a quote and such information as is necessary to provide the quote. An individual carrier shall notify an individual (directly or through an authorized producer) within ten (10) working days of receiving a request for a price quote of any additional information needed by the individual carrier to provide the quote. (1-1-95)T

05. Restrictions As to Application Process. An individual carrier may not apply more stringent or detailed requirements related to the application process for the basic, ~~and standard, and catastrophic~~ health benefit plans than are applied for other health benefit plans offered by the carrier. (1-1-95)T()

06. Denial of Coverage. If an individual carrier denies coverage under a health benefit plan to an individual on the basis of a risk characteristic, the denial shall be in writing and shall be maintained in the individual carrier's office. This written denial shall state with specificity the risk characteristic(s) of the individual that made it ineligible for the health benefit plan it requested (for example, health status). The denial shall be accompanied by a written explanation of the availability of the basic, ~~and standard, and catastrophic~~ health benefit plans from the individual carrier. The explanation shall include at least the following: (1-1-95)T()

a. A general description of the benefits contained in each such plan; (1-1-95)T

b. A price quote for each such plan; and (1-1-95)T

c. Information describing how the individual may enroll in such plans. (1-1-95)T

d. The written information described in this paragraph may be provided within the time periods provided in Subsection 075.04 directly to the individual or delivered through an authorized producer. (1-1-95)T

07. Lowest Priced Basic, ~~and Standard, and Catastrophic~~ Plan. The price quote required under Subsection 075.06.b. shall be for the lowest-priced basic, ~~and standard, and catastrophic~~ health benefit plan for which the individual is eligible. ~~(1-1-95)T(____)~~

08. Toll-Free Telephone Service. An individual carrier shall establish and maintain a toll-free telephone service to provide information to individuals regarding the availability of individual health benefit plans in this state. The service shall provide information to callers on how to apply for coverage from the carrier. The information may include the names and phone numbers of producers located geographically proximate to the caller or such other information that is reasonably designed to assist the caller to locate an authorized producer or to otherwise apply for coverage. (1-1-95)T

09. No Requirement to Qualify for Other Insurance Product. An individual carrier may not require, as a condition to the offer of sale of a health benefit plan to an individual, that the individual purchase or qualify for any other insurance product or service. (1-1-95)T

10. Plans Subject to Requirement of the Act and This Rule. Carriers offering individual health benefit plans in this state shall be responsible for determining whether the plans are subject to the requirements of the Act and this Rule. Carriers shall elicit the following information from applicants for such plans at the time of application: (1-1-95)T

a. Whether or not any portion of the premium will be paid by or on behalf of an Individual, either directly or through wage adjustments or other means of reimbursement; and (1-1-95)T

b. Whether or not the prospective policyholder, certificate holder or any prospective insured individual intends to treat the health benefit plans as part of a plan or program under Section 162 (other than Section 162(1)), Section 125 or Section 106, Internal Revenue Code. (1-1-95)T

11. Failure to Comply. If an individual carrier fails to comply with Subsection 075.11, the individual carrier shall be deemed to be on notice of any information that could reasonably have been attained if the individual carrier had complied with Subsection 075.11. (1-1-95)T

12. Annual Filing Requirement. An individual carrier shall file annually the following information with the Director related to health benefit plans issued by the individual carrier to individuals in this state on forms prescribed by the Director: (1-1-95)T

a. The number of individuals that were covered under health benefit plans in the previous calendar year (separated as to newly issued plans and renewals); (1-1-95)T

b. The number of individuals that were covered under the basic, ~~health benefit plan and the standard, and catastrophic~~ health benefit plan in the previous calendar year (separated as to newly issued plans and renewals). ~~(1-1-95)T(____)~~

c. The number of individual health benefit plans in force in each county (or by five digit zip code) of the state as of December 31 of the previous calendar year; (1-1-95)T

d. The number of individual health benefit plans that were voluntarily not renewed by Individuals in the previous calendar year; (1-1-95)T

e. The number of individual health benefit plans that were terminated or non renewed (for reasons other than nonpayment of premium) by the carrier in the previous calendar year; and (1-1-95)T

f. The number of health benefit plans that were issued to residents that were uninsured for at least the ~~one (1) month~~ sixty-three (63) days prior to issue. ~~(1-1-95)T(____)~~

13. Total Number of Residents. All carriers shall file annually with the Director, on forms prescribed by the Director, the total number of residents, including spouses and dependents, covered during the previous calendar year under all health benefit plans issued in this state. This includes residents covered under stop loss plans. (1-1-95)T

14. Filing Date. The information described in Sections 075.12 and 075.13 shall be filed no later than March 15, each year. (1-1-95)T

15. Specific Data. For purposes of this section, health benefit plan information shall include policies or certificates of insurance for specific disease, hospital confinement indemnity and stop loss coverages. (1-1-95)T

IDAPA 18 - IDAHO DEPARTMENT OF INSURANCE
18.01.73 - RULE TO IMPLEMENT THE INDIVIDUAL HEALTH
INSURANCE AVAILABILITY ACT PLAN DESIGN

DOCKET NO. 18-0173-9701

NOTICE OF PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has proposed rule making. These rules are proposed pursuant to the authority vested in the Director of the Department of Insurance under Title 41, Chapter 2, 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 October 15, 1997. 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 address below.

DESCRIPTIVE SUMMARY: The following is a statement in nontechnical language of the substance of the proposed rule:

The existing rule is being amended to provide for an individual catastrophic health insurance plan in accordance with Idaho Code Section 41-5213.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning these proposed rules, contact James M. Alcorn at (208) 334-4202.

Anyone may submit written comments regarding these rules. All written comments and data concerning the rule must be directed to the undersigned and must be received on or before October 22, 1997.

Dated this 20 day of August, 1997.

James M. Alcorn, Director
Idaho Department of Insurance
700 West State Street - 3rd Floor
P.O. Box 83720
Boise, ID 83720-0043
Telephone No. (208) 334-4250

TEXT OF DOCKET NO. 18-0173-9701

002. WRITTEN INTERPRETATIONS.

In accordance with section 67-5201(169)(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. ~~(6-30-95)~~()

(BREAK IN CONTINUITY OF SECTIONS)

010. COORDINATION OF BENEFITS.

Coordination of Benefits shall be utilized on the Individual basic, ~~and~~ standard, and catastrophic plans based upon the

current NAIC birthday rule so long as such Coordination of Benefits would not be in conflict with Chapter 22, Title 41, Idaho Code. This provision will expire upon final adoption of the NAIC Coordination of Benefits model rule or upon order of the Director. (6-30-95)()

011. LIMITATIONS AND EXCLUSIONS.

01. Not Medically Necessary. Any service not medically necessary or appropriate unless specifically included within the coverage provisions. (6-30-95)

02. Custodial, Convalescent, Intermediate. Custodial, convalescent or intermediate level care or rest cures. (6-30-95)

03. Experimental, Investigational. Services which are experimental or investigational. (6-30-95)

04. Workers Compensation, Medicare or CHAMPUS. Services eligible for coverage by Workers' Compensation, Medicare or CHAMPUS. (6-30-95)

05. No Charges, No Legal Obligation to Pay. Services for which no charges are made or for which no charges would be made in the absence of insurance or for which the insured has no legal obligation to pay. (6-30-95)

06. ~~Self-Help and Training Programs. Services (including surgery), self-help and training programs for weight control, nutrition, smoking cessation, etc., as well as prescription drugs used in conjunction with such programs and services. No Medical Diagnosis. Services for weight control, nutrition, and smoking cessation, including self-help and training programs, as well as prescription drugs used in conjunction with such programs and services.~~ (6-30-95)()

07. Cosmetic Surgery. Cosmetic surgery and services, except for treatment for non-congenital injury or surgery. Mastectomy reconstruction is covered if within two (2) years of mastectomy. (6-30-95)

08. Artificial Insemination and Infertility Treatment. Artificial insemination and infertility treatment. Treatment of sexual dysfunction not related to organic disease. (6-30-95)

09. Reversal of Elective Infertility. Services for reversal of elective, surgically or pharmaceutical induced infertility. (6-30-95)

10. Vision Therapy. Vision therapy, tests, glasses, contact lenses and other vision aids. Radial keratotomy, myopic keratomileusis and any surgery involving corneal tissue to alter or correct myopia, hyperopia or stigmatic error. (6-30-95)

11. Weak, Strained, or Flat Feet. For treatment of weak, strained, or flat feet, including orthopedic shoes or other supportive devices, or for cutting, removal, or treatment of corns, calluses, or nails other than corrective surgery, or for metabolic or peripheral vascular disease. (6-30-95)

12. Spinal Manipulation. Chiropractic services will be subject to one thousand Dollars (\$1,000) per year limit, subject to the policy deductible and co-insurance. (6-30-95)

13. Dental and Orthodontic Services. ~~Dental and orthodontic services, except those needed for treatment of a medical condition or injury or as specifically allowed in the policy for children under the age of twelve (12).~~ (6-30-95)()

a. For Basic and Standard plans: Dental and orthodontic services, except those needed for treatment of a medical condition or injury or as specifically allowed in the policy for children under the age of twelve (12). ()

b. For Catastrophic plans: Dental care of treatment, except for injury sustained while insured under this policy, or on a result of nondental disease covered by the policy. ()

14. Hearing Tests. Hearing tests without illness being suspect. (6-30-95)
15. Hearing Aids. Hearing aids and supplies, tinnitus maskers, cochlear implants and exams for the prescription or fitting of hearing aids. (6-30-95)
16. Excludes. Speech tests and therapy. (6-30-95)
17. Private Room. Private room accommodation charges in excess of the institution's most common semi-private room charge except when prescribed as medically necessary. (6-30-95)
18. Services Performed by a Member of Family. Services performed by a member of the insured's family or of the insured's spouse's family. Family includes parents or grandparents of the insured or spouse and any descendants of such parents or grandparents. (6-30-95)
19. Prior to Effective Date. Care incurred before the effective date of the person's coverage. (6-30-95)
20. Immunizations and Medical Exams and Tests. Immunizations and medical exams and tests of any kind not related to treatment of covered injury or disease, except as specifically stated in the policy. (6-30-95)
21. Injury or Sickness. Injury or sickness caused by war or armed international conflict. (6-30-95)
22. Sex Change Operations. Sex change operations and treatment in connection with transsexualism. (6-30-95)
23. Marriage and Family Counseling. Marriage and family and child counseling except as specifically allowed in the policy. (6-30-95)
24. Acupuncture. ~~Acupuncture except when used as anesthesia during a covered surgical procedure.~~ (6-30-95)()
 - a. For Basic and Standard plans: Acupuncture except when used as anesthesia during a covered surgical procedure. ()
 - b. For Catastrophic plans: Acupuncture. ()
25. Private Duty Nursing. Private duty nursing except as specifically allowed in the policy. (6-30-95)
26. Medical Services Received from Employer, Labor Union Association. Services received from a medical or dental department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group. (6-30-95)
27. ~~After the Date of Termination. I~~ Services incurred after the date of termination of the insured's a covered person's coverage, except as allowed by extension of benefits provision in the policy, if any. (6-30-95)()
28. Personal Hygiene and Convenience Items. Expenses for personal hygiene and convenience items such as air conditioners, humidifiers, and physical fitness equipment. (6-30-95)
29. Failure to Keep a Scheduled Visit. Charges for failure to keep a scheduled visit, charges for completion of any form, and charges for medical information. (6-30-95)
30. Screening Examinations. Charges for screening examinations except as otherwise provided in the policy. (6-30-95)
31. Wigs or Hair Loss. Charges for wigs or cranial prostheses, hair analysis, hair loss and baldness. (6-30-95)
32. Pre-Existing Conditions. Pre-existing conditions, except as provided specifically in the policy.

(6-30-95)

(BREAK IN CONTINUITY OF SECTIONS)

ATTACHMENT A
STANDARD BENEFIT PLAN

Schedule of Benefits

ALL BENEFIT AREAS	
Calendar Year Benefit Maximum	\$100,000
Benefit Area A	
Preventive Services	
Copayment:	
-Adults	\$15
-Children	\$0
Benefit Percentage	100%
Coinsurance Percentage	0%
Annual Benefit Maximum	\$250
Benefit Areas B1, C, D, E, F,G	
Calendar Year Deductible	
-Individual	\$1,000
-Family	\$2,000
-Maternity (additional deductible)	\$1,000
Benefit Percentage	80%
Coinsurance Percentage	20%
Out-of-Pocket Expense Limit	
-Individual	\$5,000
-Family	\$10,000
Emergency Ambulance Service	
Annual Benefit Maximum	\$750
Durable Medical Equipment	
Annual Benefit Maximum	\$15,000
Psychiatric and Substance Abuse Services	
Annual Benefit Maximum	
Maximum benefit payable during calendar year	\$5,000
<u>Benefit Area G</u>	
<u>Drugs and Pharmaceuticals</u>	
<u>Coinsurance - for each prescription for up to a 30-day supply</u>	<u>80%</u>
<u>-(formularies permitted)</u>	

ATTACHMENT B
BASIC BENEFIT PLAN

Schedule of Benefits

ALL BENEFIT AREAS	
Calendar Year Benefit Maximum	\$25,000
Benefit Area A	
Preventive Services	
Copayment:	
-Adults	\$15
-Children under Age 12	\$0
Benefit Percentage	100%
Coinsurance Percentage	0%
Annual Benefit Maximum	\$250
Benefit Areas B, C, D, E, F, G	
Calendar Year Deductible	
- Individual	\$2,500
- Family	\$5,000
Benefit Percentage	50%
Coinsurance Percentage	50%
Out-of-Pocket Expense Limit	
- Individual	\$5,000
- Family	\$10,000
Emergency Ambulance Service	
Annual Benefit Maximum	\$750
Durable Medical Equipment	
Annual Benefit Maximum	\$15,000
Psychiatric and Substance Abuse Services	
Annual Benefit Maximum - Outpatient	
Maximum benefit payable during calendar year	\$2,500
<u>Benefit Area G</u>	
<u>Drugs and Pharmaceuticals</u>	
<u>-Coinsurance - for each prescription, for up to a 30-day supply</u>	<u>50%</u>
<u>-(formularies permitted)</u>	

ATTACHMENT C

MANAGED CARE CATASTROPHIC PLAN DESIGN

<u>ALL BENEFIT AREAS</u>	
<u>Calendar Year Benefit Maximum</u>	<u>\$200,000</u>
<u>Calendar Year Out-of-Pocket Expense Limits</u>	
(For Copayments and Coinsurance:)	
<u>-per person</u>	<u>\$12,000</u>
<u>-per family</u>	<u>\$24,000</u>
The per person Benefit Maximum applies when family coverage is purchased. <u>Copayments - Only as stated for specific Benefit Areas</u> <u>Coinsurance - Only as stated for specific Benefit Areas</u>	
<u>Benefit Area A -</u>	
<u>Preventive Services</u>	
<u>Copayment - per visit:</u>	
<u>-Adults</u>	<u>\$20</u>
<u>-Children</u>	<u>\$0</u>
<u>Preventive Services Annual Benefit Maximum</u>	<u>\$250</u>
<u>Benefit Area B</u>	
<u>Maternity</u>	
<u>-Outpatient Maternity Copayment per Visit</u>	<u>\$20</u>
<u>-Outpatient Maternity Out-of-Pocket Expense Limit</u> <u>(per pregnancy) (fully paid thereafter)</u>	<u>\$240</u>
<u>-Inpatient Maternity Copayment per Day per Pregnancy</u>	<u>\$500</u>
<u>-Inpatient Maternity Out-of-Pocket Expense Limit</u> <u>(per pregnancy) (fully paid thereafter)</u>	<u>\$1,000</u>
<u>Benefit Area C</u>	
<u>General Inpatient Services</u>	
<u>Copayment per Day (not to exceed 5 days per admission)</u>	<u>\$500</u>
<u>-Out-of-Pocket Expense Limit per Admission</u>	<u>\$2,500</u>
<u>Benefit Area D</u>	
<u>General Outpatient Services</u>	
<u>Copayment per Office Visit</u>	<u>\$20</u>
<u>Copayment for Laboratory and Radiology (x-ray)</u>	<u>\$0</u>
<u>Benefit Area E</u>	
<u>Transportation and Medical Equipment</u>	

<u>ALL BENEFIT AREAS</u>	
<u>Ambulance</u>	
-Coinsurance per Trip	<u>50%</u>
-Annual Benefit Sub-maximum	<u>\$750</u>
<u>Durable Medical Equipment</u>	
-Coinsurance	<u>50%</u>
-Annual Benefit Sub-maximum	<u>\$10,000</u>
<u>Benefit Area F</u>	
<u>Psychiatric and Substance Abuse</u>	
<u>Outpatient Services (not including drugs which are covered under Area G)</u>	
-Copayment per Visit	<u>\$50</u>
-Annual number of Covered Visits	<u>10</u>
<u>Inpatient Services (including drugs)</u>	
-Copayment per Day	<u>\$400</u>
-Annual maximum number of Covered Days	<u>10</u>
<u>Benefit Area G</u>	
<u>Drugs and Pharmaceuticals</u>	
-Coinsurance - for each prescription, for up to a 30-day supply	<u>50%</u>
-(formularies permitted)	

ATTACHMENT D

CATASTROPHIC BENEFIT PLAN
Schedule of Benefits

<u>ALL BENEFIT AREAS</u>	
<u>Calendar Year Individual Benefit Maximum</u>	<u>\$200,000</u>
<u>Calendar Year Deductible</u>	
-Individual	<u>\$2,000 or \$5,000</u>
-Family	<u>\$4,000 or \$10,000</u>
<u>Benefit Percentage</u>	<u>50%</u>
<u>Coinsurance Percentages</u>	<u>50%</u>
<u>Calendar Year Out-of-Pocket Expense Limit</u>	
-Individual	<u>\$10,000 for \$2,000 deductible</u> <u>\$13,000 for \$5,000 deductible</u>
-Family	<u>\$20,000 for \$4,000 deductible</u> <u>\$26,000 for \$10,000 deductible</u>

Change to Higher Deductible - Charges previously applied to deductible amount for the same year are applied to the new deductible amount. New covered charges are applied to the new deductible amount. Change to lower deductible is not permitted. Charges applied to the deductible amount are not carried over to the next calendar year.

<u>Benefit Area A</u>	
<u>Preventive Services</u> <u>Annual Benefit Maximum</u>	<u>\$250</u>
<u>Benefit Areas B1, C, D, E, F, G</u>	
<u>Emergency Ambulance Service</u> <u>Annual Benefit Maximum</u>	<u>\$750</u>
<u>Durable Medical Equipment</u> <u>Annual Benefit Maximum</u>	<u>\$15,000</u>
<u>Psychiatric and Substance Abuse Services</u> <u>Annual Benefit Maximum</u>	<u>\$5,000</u>
<u>Benefit Area G</u>	
<u>Pharmacy Benefits</u> <u>Coinsurance - for each prescription, for up to a 30 day supply</u> <u>(formularies permitted)</u>	<u>50%</u>

IDAPA 18 - IDAHO DEPARTMENT OF INSURANCE

18.01.74 - COORDINATION OF BENEFITS

DOCKET NO. 18-0174-9701

NOTICE OF PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has proposed rule making. These rules are proposed pursuant to the authority vested in the Director of the Department of Insurance under Title 41, Chapter 2, 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 October 15, 1997. 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 address below.

DESCRIPTIVE SUMMARY: The following is a statement in nontechnical language of the substance of the proposed rule:

Permits insurance plans to include provisions for coordination of benefits when coverage is provided for by more than one plan, establishes a uniform order of benefit determination, provides for transfer of information between plans, and imposes requirements for coordination of benefits provisions. This rule is required by Sections 41-2141 and 41-2216, Idaho Code, as amended by SB 1237, 1997.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning these proposed rules, contact James M. Alcorn at (208) 334-4202.

Anyone may submit written comments regarding these rules. All written comments and data concerning the rule must be directed to the undersigned and must be received on or before October 22, 1997.

Dated this 28th day of August, 1997.

James M. Alcorn, Director
Idaho Department of Insurance
700 West State Street - 3rd Floor
P.O. Box 83720
Boise, ID 83720-0043
Telephone No. (208) 334-4250

TEXT OF DOCKET NO. 18-0174-9701

**IDAPA 18
TITLE 01
Chapter 74**

COORDINATION OF BENEFITS

000. LEGAL AUTHORITY.

This rule is promulgated and adopted pursuant to the authority vested in the Director under chapters 2, 21, 22 and 34, title 41, Idaho Code. ()

001. TITLE AND SCOPE.

01. Title. This rule shall be cited in full as Idaho Department of Insurance Rules, IDAPA 18, Title 01, Chapter 74, "Coordination of Benefits." ()

02. Scope. The purpose of this rule is to permit, but not require, plans to include a coordination of benefits (COB) provision unless prohibited by federal law; establish a uniform order of benefit determination under which plans pay claims; provide authority for the orderly transfer of necessary information and funds between plans; reduce duplication of benefits by permitting a reduction of the benefits to be paid by plans that, pursuant to these rules, do not pay their benefits first; reduce claims payment delays; and require that COB provisions be consistent with this rule. ()

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 at this agency. ()

003. ADMINISTRATIVE APPEALS.

All contested cases shall be governed by the provisions of IDAPA 04.01.01, Model Rules of Procedure of the Office of the Attorney General. ()

004. DEFINITIONS.

As used in this rule, these words and terms have the following meanings, unless the context clearly indicates otherwise: ()

01. Allowable Expense. "Allowable expense" means a health care service or expense including deductibles, coinsurance or copayments, that is covered in full or in part by any of the plans covering the person, except as set forth below or where a statute requires a different definition. This means that an expense or service or a portion of an expense or service that is not covered by any of the plans is not an allowable expense. ()

a. The following are examples of expenses of services that are not an allowable expense: ()

i. If a covered person is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room (unless the patient's stay in the private hospital room is medically necessary in terms of generally accepted medical practice, or one of the plans routinely provides coverage for private hospital rooms) is not an allowable expense. ()

ii. If a person is covered by two (2) or more plans that compute their benefit payments on the basis of usual and customary fees, any amount in excess of the highest of the usual and customary fee for a specified benefit is not an allowable expense. ()

iii. If a person is covered by two (2) or more plans that provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees is not an allowable expense. ()

iv. If a person is covered by one plan that calculates its benefits or services on the basis of usual and customary fees and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangement shall be the allowable expense for all plans. ()

b. The definition of the "allowable expense" may exclude certain types of coverage or benefits such as dental care, vision care, prescription drug or hearing aids. A plan that limits the application of COB to certain coverages or benefits may limit the definition of Allowable Expenses in its contract to services or expenses that are similar to the services or expenses that it provides. When COB is restricted to specific coverages or benefits in a contract the definition of "Allowable Expense" shall include similar services or expenses to which COB applies. ()

c. When a plan provides benefits in the form of service, the reasonable cash value of each service will be considered as an allowable expense and a benefit paid. ()

d. The amount of the reduction may be excluded from allowable expense when a covered person's benefits are reduced under a primary plan: ()

i. Because the covered person does not comply with the plan provisions covering second surgical opinions or precertification of admissions or services. ()

ii. Because the covered person has a lower benefit because he or she did not use a preferred provider. ()

e. If the primary plan is a closed panel plan and the secondary plan is not a closed panel plan, the secondary plan shall pay or provide benefits as if it were primary when a covered person uses a nonpanel provider, except for emergency services or authorized referrals that are paid or provided by the primary plan. ()

02. Claim. "Claim" means a request that benefits of a plan be provided or paid. The benefits claimed may be in the form of: ()

a. Services (including supplies); ()

b. Payment for all or a portion of the expenses incurred; ()

c. A combination of Subsection 004.02.a. and 004.02.b.; or ()

d. An indemnification. ()

03. Claim Determination Period. "Claim determination period" means a period of not less than twelve consecutive months, over which allowable expenses shall be compared with total benefits payable in the absence of COB, to determine whether overinsurance exists and how much each plan will pay or provide. ()

a. The claim determination period is usually a calendar year, but a plan may use some other period of time that fits the coverage of the contract. A person is covered by a plan during a portion of a claim determination period if that person's coverage starts or ends during the claim determination period. ()

b. As each claim is submitted, each plan determines its liability and pays or provides benefits based upon allowable expenses incurred to that point in the claim determination period. That determination is subject to adjustment as later allowable expenses are incurred in the same claim determination period. ()

04. Closed Panel Plan. "Closed panel plan" means a health maintenance organization (HMO), preferred provider organization (PPO), exclusive provider organization (EPO), managed care plan, or other plan that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member. ()

05. Coordination of Benefits. "Coordination of benefits" means a provision establishing an order in which plans pay their claims, and permitting secondary plans to reduce their benefits so that the combined benefits of all plans do not exceed total allowable expenses. ()

06. Custodial Parent. "Custodial parent" means the parent awarded custody by a court decree. In the absence of a court decree, the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation is the custodial parent. ()

07. Hospital Indemnity Benefits. "Hospital indemnity benefits" means the benefits not related to expenses incurred. The term does not include reimbursement-type benefits even if they are designed or administered to give the insured the right to elect indemnity-type benefits at the time of claim. ()

08. Plan. "Plan" means a form of coverage with which coordination is allowed. The definition of plan in the contract must state the types of coverage that will be considered in applying the COB provision of that contract.

The right to include a type of coverage is limited by the rest of this definition. Separate parts of a plan for members of a group that are provided through alternative contracts that are intended to be part of a coordinated package of benefits are considered one plan and there is no COB among the separate parts of the plan. ()

- a. This rule uses the term “plan.” However, a contract may use “program” or some other term. ()
- b. Plan may include: ()
 - i. Group insurance contracts and group subscriber contracts; ()
 - ii. Uninsured group or group-type coverage arrangements: ()
 - iii. Group or group-type coverage through closed panel plans; ()
 - iv. Group-type contracts. Group-type contracts are contracts which are not available to the general public and can be obtained and maintained only because of membership in or connection with a particular organization or group, including franchise or blanket coverage. Individually underwritten and issued guaranteed renewable policies are not “group-type” even if purchased through payroll deduction at a premium savings to the insured since the insured would have the right to maintain or renew the policy independently of continued employment with the employer. ()
 - v. The amount by which group or group-type hospital indemnity benefits exceed two hundred dollars (\$200) per day. ()
 - vi. The medical care components of long-term care contracts, such as skilled nursing care. ()
 - vii. Medicare or other governmental benefits, except as provided in Subsection 004.08.c.vii. That part of the definition of plan may be limited to the hospital, medical and surgical benefits of the governmental program. ()
 - viii. Individual or family insurance contracts. ()
 - ix. Individual or family subscriber contracts. ()
 - x. Individual or family coverage through closed panel plans. ()
 - xi. Individual or family coverage under other prepayment, group practice and individual practice plans. ()
- c. Plan shall not include: ()
 - i. Group or group-type hospital indemnity benefits of two hundred dollars (\$200) per day or less. ()
 - ii. School accident-type coverages. These contracts cover students for accidents only, including athletic injuries, either on a twenty-four (24) hour basis or on a “to and from school” basis. ()
 - iii. Benefits provided in long-term care insurance policies for non-medical service; for example, personal care, adult daycare, homemaker services, assistance with activities of daily living, respite care, and custodial care or for contracts that pay as fixed daily benefit without regard to expenses incurred or the receipt of services. ()
 - iv. Medical benefits coverage in individual automobile “no fault” and traditional automobile “fault” type contracts. ()
 - v. Limited benefit health coverages, such as, but not limited to, accident only, specified disease, disability income, hospital indemnity, credit insurance benefits, dental insurance, vision insurance; coverages issued

to supplement liability insurance; and worker's compensation or similar insurance. ()

vi. Medicare supplement policies. ()

vii. A state plan under Medicaid. ()

viii. A governmental plan which, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan. ()

ix. Nonrenewable short-term coverages issued for a period of twelve (12) months or less. ()

09. Primary Plan. "Primary plan" means a plan whose benefits for a person's health care coverage must be determined without taking the existence of any other plan into consideration. A plan is a primary plan if either of the following is true: ()

a. The plan either has no order of benefit determination rules, or its rules differ from those permitted by this rule; ()

b. All plans that cover the person use the order of benefit determination required by this rule, and under those rules the plan determines its benefits first; ()

10. Secondary Plan. "Secondary plan" means a plan that is not a primary plan. If a person is covered by more than one secondary plan, the order of benefit determination of this rule decides the order in which secondary plans benefits are determined in relation to each other. Each secondary plan shall take into consideration the benefits of the primary plan or plans and the benefits of any other plan which, under this rule, has its benefits determined before those of the secondary plan. ()

11. This Plan. "This plan" means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one COB provision to certain of its benefits (such as dental benefits), coordinating only with similar benefits, and may apply another COB provision to coordinate with other benefits. ()

005. -- 010. (RESERVED).

011. COB CONTRACT PROVISION.

01. Limits on COB Provisions. A COB provision may not be used that permits a plan to reduce benefits on the basis that: ()

a. Another plan exists and the covered person did not enroll in that plan; ()

b. A person is or could have been covered under another plan, except with respect to Part B of Medicare; or ()

c. A person has elected an option under another plan providing a lower level of benefits than another option that could have been elected. ()

02. "Always Excess" or "Always Secondary." No plan may contain a provision that its benefits are "always excess" or "always secondary" except in accord with the order of benefit determination permitted by this rule. ()

03. Closed Panel Provider. Under the terms of a closed panel plan, benefits are not payable if the covered person does not use the services of a closed panel provider. In most instances, COB does not occur if a covered person is enrolled in two or more closed panel plans and obtains services from a provider in one of the closed panel plans because the other closed panel plan (the one whose providers were not used) has no liability. However, COB may occur during the claim determination period when the covered person receives emergency services that

would have been covered by both plans. ()

012. -- 015. (RESERVED).

016. RULES FOR COORDINATION OF BENEFITS.

01. Order of Benefit Payments. When a person is covered by two (2) or more plans, the rules for determining the order of benefit payments are as follows: ()

a. The primary plan must pay or provide its benefits as if the secondary plan or plans did not exist. ()

b. A plan that does not contain a coordination of benefits provision that is consistent with this rule is always primary. There are two (2) exceptions: ()

i. Coverage that is obtained by virtue of membership in a group and designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits. ()

ii. Individual plans as they shall always be secondary to group plans. ()

c. A plan may consider the benefits paid or provided by another plan only when it is secondary to that other plan. ()

02. Order of Benefit Determination. The first of the following rules that describes which plan pays its benefits before another plan is the rule that shall be applied. ()

a. A group plan shall always be primary to an individual plan. ()

b. Non-dependent or dependent: The plan that covers the person other than as a dependent, for example, as an employee, member, subscriber or retiree, is primary and the plan that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of the provisions of Title XVIII of the Social Security Act and implementing rules, Medicare is: ()

i. Secondary to the plan covering the person as a dependent; and ()

ii. Primary to the plan covering the person as other than a dependent (e.g. a retired employee), then the order of benefits is reversed so that the plan covering the person as an employee, member, subscriber or retiree, is secondary and the other plan is primary. ()

c. Child covered under more than one plan. ()

i. The primary plan is the plan of the parent whose birthday is earlier in the year if: ()

(1) The parents are married; ()

(2) The parents are not separated (whether or not they ever have been married); or ()

(3) A court decree awards joint custody without specifying that one parent has the responsibility to provide health care coverage. ()

ii. If both parents have the same birthday, the plan that covered either of the parents longer is primary. ()

iii. If the specific terms of a court decree state that one of the parents is responsible for the child's

health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with financial responsibility has no coverage for the child's health care services or expenses but that parent's spouse does, the spouse's plan is primary. This subparagraph shall not apply with respect to any claim determination period or plan year during which benefits are paid or provided before the entity has actual knowledge.
()

iv. If the parents are not married or are separated (whether or not they ever have been married) or are divorced and there is no court decree allocating responsibility for the child's health care services or expenses, the order of benefit determination among the plans of the parent and the parent's spouse (if any) is: ()

- (1) The plan of the custodial parent; ()
- (2) The plan of the spouse of the custodial parent; ()
- (3) The plan of the noncustodial parent; and then ()
- (4) The plan of the spouse of the noncustodial parent. ()

d. Active/inactive employee: The plan that covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) is primary. If the other plan does not have this rule; and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. Coverage provided an individual as a retired worker and as a dependent of that individual's spouse as an active worker will be determined under Subsection 016.01.b.
()

e. Continuation coverage: If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary and the continuation coverage is secondary. If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
()

f. Longer/shorter length of coverage: If none of the above rules determines the order of benefits, the plan that covered the person as an employee, member, subscriber or retiree for a longer period of time is primary.
()

i. To determine the length of time a person has been covered under a plan, two (2) plans shall be treated as one (1) if the person was eligible under the second within twenty-four (24) hours after the first ended.
()

ii. The start of a new plan does not include: ()

(1) A change in the amount of scope of a plan's benefits; ()

(2) A change in the entity that pays, provides or administers the plan's benefits; or ()

(3) A change from one type of plan to another (such as from a single employer plan to that of a multiple employer plan). ()

iii. The person's length of time covered under a plan is measured from the person's first date of coverage under that plan. If that date is not readily available for a group plan, the date the person first became a member of the group shall be used as the date from which to determine the length of time the person's coverage under the present plan has been in force. ()

g. If none of these rules determines the primary plan, the allowable expenses shall be shared equally between the plans. ()

017. -- 020. (RESERVED).

021. PROCEDURE TO BE FOLLOWED BY SECONDARY PLAN.

01. Individual Plan Reduction. Individual plans may reduce benefits in accordance with Section 022. ()
02. Secondary Plan Reduction. When a plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a claim determination period are not more than one hundred percent (100%) of total allowable expenses. As each claim is submitted, the secondary plan must: ()
- a. Determine its obligation pursuant to its contract. ()
 - b. Determine whether there are any unpaid allowable expenses during that claims determination period. ()
 - c. Pay up to one hundred percent (100%) of total allowable expenses incurred during the claim determination period. ()
03. Reduction of Secondary Plan Benefits. The benefits of the secondary plan shall be reduced when the sum of the benefits that would be payable for the allowable expenses under the secondary plan in the absence of this COB provision and the benefits that would be payable for the allowable expenses under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made, exceeds the allowable expenses in a claim determination period. In that case, the benefits of the secondary plan shall be reduced so that they and the benefits payable under the other plans do not total more than the allowable expenses. ()
- a. When the benefits of this plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of the plan. ()
 - b. The requirements of Subsection 021.02.a. do not apply if the plan provides only one (1) benefit, or may be altered to suit the coverage provided. ()

022. INDIVIDUAL PLANS.

Individual plans may provide for a reduction in covered benefits due to the existence of another plan by including language in the contract, policy or certificate that is consistent with this Rule ()

023. -- 025. (RESERVED).

026. MISCELLANEOUS PROVISIONS.

01. Benefits in the Form of Services. A secondary plan that provides benefits in the form of services may recover the reasonable cash value of the services from the primary plan, to the extent that benefits for the services are covered by the primary plan and have not already been paid or provided by the primary plan. Nothing in this provision shall be interpreted to require a plan to reimburse a covered person in cash for the value of services provided by a plan which provides benefits in the form of services. ()
02. Complying Plan Versus Noncomplying Plan. A plan with order of benefit determination rules that comply with this rule (complying plan) may coordinate its benefits with a plan that is "excess" or "always secondary" or that uses order of benefit determination rules that are inconsistent with those contained in this rule (noncomplying plan) on the following basis: ()
- a. If the complying plan is the primary plan, it shall pay or provide its benefits first; ()
 - b. If the complying plan is the secondary plan, it shall, nevertheless, pay or provide its benefits first, but the amount of the benefits payable shall be determined as if the complying plan were the secondary plan. In such a situation, the payment shall be the limit of the complying plan's liability; and ()
 - c. If the noncomplying plan does not provide the information needed by the complying plan to determine its benefits within a reasonable time after it is requested to do so, the complying plan shall assume that the

benefits of the noncomplying plan are identical to its own and shall pay its benefits accordingly. If, within two (2) years of payment, the complying plan receives information as the actual benefits of the noncomplying plan, it shall adjust payments accordingly. ()

i. If the noncomplying plan reduces its benefits so that the covered person receives less in benefits than he or she would have received had the complying plan paid or provided its benefits as the secondary plan and the noncomplying plan paid or provided its benefits as the primary plan, and governing state law allows the right of subrogation set forth below, then the complying plan shall advance to or on behalf of the covered person an amount equal to the difference. ()

ii. In no event shall the complying plan advance more than the complying plan would have paid had it been the primary plan less any amount it previously paid for the same expense or services. In consideration of the advance, the complying plan shall be subrogated to all rights of the covered person against the noncomplying plan. The advance by the complying plan shall also be without prejudice to any claim it may have against the noncomplying plan in the absence of such subrogation. ()

03. COB Versus Subrogation. The COB differs from subrogation. Provisions for one may be included in health care benefits contracts without compelling the inclusion or exclusion of the other. ()

04. Timely Payment of Benefits. If the plans cannot agree on the order of benefits within thirty (30) calendar days after the plans have received all of the information needed to pay the claim, the plans shall immediately pay the claim in equal shares and determine their relative liabilities following payment, except that no plan shall be required to pay more than it would have paid had it been primary. ()

027. -- 030. (RESERVED).

031. EFFECTIVE DATE; EXISTING CONTRACTS.

01. Effective Date of Rule. This rule is applicable to every plan that provides health care benefits and that is issued on or after the effective date of this rule, which is July 1, 1998. ()

02. Contract Compliance. A contract that provides health care benefits and that was issued before the effective date of this rule shall be brought into compliance with this rule by the later of: ()

a. The next anniversary date or renewal date of the plan; or ()

b. The expiration of any applicable collectively bargained contract pursuant to which it was written. ()

031. -- 999. (RESERVED).

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