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PREFACE

The Idaho Administrative Bulletin is an electronic-only, online monthly publication of the Office of the Administrative Rules Coordinator, Division of Financial Management, that is published pursuant to Section 67-5203, Idaho Code. The Bulletin is a compilation of all official rulemaking notices, official rule text, executive orders of the Governor, and all legislative documents affecting rules that are statutorily required to be published in the Bulletin. It may also include other rules-related documents an agency may want to make public through the Bulletin.

State agencies are required to provide public notice of all rulemaking actions and must invite public input. This is done through negotiated rulemaking procedures or after proposed rulemaking has been initiated. The public receives notice that an agency has initiated proposed rulemaking procedures through the Idaho Administrative Bulletin and a legal notice (Public Notice of Intent) that publishes in authorized newspapers throughout the state. The legal notice provides reasonable opportunity for the public to participate when a proposed rule publishes in the Bulletin. Interested parties may submit written comments to the agency or request public hearings of the agency, if none have been scheduled. Such submissions or requests must be presented to the agency within the time and manner specified in the individual “Notice of Rulemaking - Proposed Rule” for each proposed rule that is published in the Bulletin.

Once the comment period closes, the agency considers fully all comments and information submitted regarding the proposed rule. Changes may be made to the proposed rule at this stage of the rulemaking, but changes must be based on comments received and must be a “logical outgrowth” of the proposed rule. The agency may now adopt and publish the pending rule. A pending rule is “pending” legislative review for final approval. The pending rule is the agency’s final version of the rulemaking that will be forwarded to the legislature for review and final approval. Comment periods and public hearings are not provided for when the agency adopts a temporary or pending rule.

CITATION TO THE IDAHO ADMINISTRATIVE BULLETIN

The Bulletin is identified by the calendar year and issue number. For example, Bulletin 19-1 refers to the first Bulletin issued in calendar year 2019; Bulletin 20-1 refers to the first Bulletin issued in calendar year 2020. Volume numbers, which proceed from 1 to 12 in a given year, correspond to the months of publication, i.e.; Volume No. 19-1 refers to January 2019; Volume No. 20-2 refers to February 2020; and so forth. Example: The Bulletin published in January 2019 is cited as Volume 19-1. The December 2019 Bulletin is cited as Volume 19-12.

RELATIONSHIP TO THE IDAHO ADMINISTRATIVE CODE

The Idaho Administrative Code is an electronic-only, online compilation of all final and enforceable administrative rules of the state of Idaho that are of full force and effect. Any temporary rule that is adopted by an agency and is of force and effect is codified into the Administrative Code upon Bulletin publication. All pending rules that have been approved by the legislature during the legislative session as final rules and any temporary rules that are extended supplement the Administrative Code. These rules are codified into the Administrative Code upon becoming effective. Because proposed and pending rules are not enforceable, they are published in the Administrative Bulletin only and cannot be codified into the Administrative Code until approved as final.

To determine if a particular rule remains in effect or whether any amendments have been made to the rule, refer to the Cumulative Rulemaking Index. Link to it on the Administrative Rules homepage at adminrules.idaho.gov.

THE DIFFERENT RULES PUBLISHED IN THE ADMINISTRATIVE BULLETIN

Idaho’s administrative rulemaking process, governed by the Administrative Procedure Act, Title 67, Chapter 52, Idaho Code, comprises distinct rulemaking actions: negotiated, proposed, temporary, pending and final rulemaking. Not all rulemakings incorporate or require all of these actions. At a minimum, a rulemaking includes proposed, pending and final rulemaking. Many rules are adopted as temporary rules when they meet the required statutory criteria and agencies must, when feasible, engage in negotiated rulemaking at the beginning of the process to facilitate consensus building. In the majority of cases, the process begins with proposed rulemaking and ends with the final rulemaking. The following is a brief explanation of each type of rule.
1. NEGOTIATED RULEMAKING

Negotiated rulemaking is a process in which all interested persons and the agency seek consensus on the content of a rule through dialogue. Agencies are required to conduct negotiated rulemaking whenever it is feasible to do so. The agency files a “Notice of Intent to Promulgate – Negotiated Rulemaking” for publication in the Administrative Bulletin inviting interested persons to contact the agency if interested in discussing the agency’s intentions regarding the rule changes. This process is intended to result in the formulation of a proposed rule and the initiation of regular rulemaking procedures. One result, however, may also be that regular (proposed) rulemaking is not initiated and no further action is taken by the agency.

2. PROPOSED RULEMAKING

A proposed rulemaking is an action by an agency wherein the agency is proposing to amend or repeal an existing rule or to adopt a new rule. Prior to the adoption, amendment, or repeal of a rule, the agency must publish a “Notice of Rulemaking – Proposed Rule” in the Bulletin. This notice must include very specific information regarding the rulemaking including all relevant state or federal statutory authority occasioning the rulemaking, a non-technical description of the changes being made, any associated costs, guidance on how to participate through submission of written comments and requests for public hearings, and the text of the proposed rule in legislative format.

3. TEMPORARY RULEMAKING

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

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

If a rulemaking meets one or more of these criteria, and with the Governor’s approval, the agency may adopt and make a temporary rule effective prior to receiving legislative authorization and without allowing for any public input. The law allows an agency to make a temporary rule immediately effective upon adoption. A temporary rule expires at the conclusion of the next succeeding regular legislative session unless the rule is extended by concurrent resolution, is replaced by a final rule, or expires under its own terms.

4. PENDING RULEMAKING

A pending rule is a rule that has been adopted by an agency under regular rulemaking procedures and remains subject to legislative review before it becomes a final, enforceable rule. When a pending rule is published in the Bulletin, the agency is required to include certain information in the “Notice of Rulemaking – Pending Rule.” This includes a statement giving the reasons for adopting the rule, a statement regarding when the rule becomes effective, a description of how it differs from the proposed rule, and identification of any fees being imposed or changed.

Agencies are required to republish the text of the pending rule when substantive changes have been made to the proposed rule. An agency may adopt a pending rule that varies in content from that which was originally proposed if the subject matter of the rule remains the same, the pending rule change is a logical outgrowth of the proposed rule, and the original notice was written so as to assure that members of the public were reasonably notified of the subject. It is not always necessary to republish all the text of the pending rule.

5. FINAL RULEMAKING

A final rule is a rule that has been adopted by an agency under the regular rulemaking procedures and is of full force and effect.
HOW TO USE THE IDAHO ADMINISTRATIVE BULLETIN

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

**IDAPA 38.05.01.200.02.c.ii.**

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

“38.” refers to the Idaho Department of Administration

“05.” refers to Title 05, which is the Department of Administration’s Division of Purchasing

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

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

“02.” refers to Subsection 200.02.

“c.” refers to Subsection 200.02.c.

“ii.” refers to Subsection 200.02.c.ii.

DOCKET NUMBERING SYSTEM

Internally, the Bulletin is organized sequentially using a rule docketing system. Each rulemaking that is filed with the Coordinator is assigned a “DOCKET NUMBER.” The docket number is a series of numbers separated by a hyphen “-”, (38-0501-1401). Rulemaking dockets are published sequentially by IDAPA number (the two-digit agency code) in the Bulletin. The following example is a breakdown of a typical rule docket number:

**“DOCKET NO. 38-0501-1901”**

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

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

“1901” denotes the year and sequential order of the docket being published; in this case the numbers refer to the first rulemaking action published in calendar year 2019. A subsequent rulemaking on this same rule chapter in calendar year 2019 would be designated as “1902”. The docket number in this scenario would be 38-0501-1902.

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

**(BREAK IN CONTINUITY OF SECTIONS)**
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*Last day to submit a proposed rulemaking before moratorium begins AND last day to submit a pending rule to be reviewed by upcoming legislature.*

**Last day to submit a proposed rule to remain on course for rulemaking to be completed and submitted for review by upcoming legislature.*
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WHEREAS, Idaho law does not require Idahoans receive a COVID-19 vaccine, and it is a matter of personal choice; and

WHEREAS, some Idahoans are unable to receive a vaccine due to age, medical condition, religious objection, or philosophical objection; and

WHEREAS, some states are exploring and implementing various “vaccine passport” systems and mandates; and

WHEREAS, California has mandated that children receive a COVID-19 vaccine in order to access either public or private schools; and

WHEREAS, implementing “vaccine passport” requirements violates Idahoans’ medical privacy, impeded our economic recovery, encourages prejudice and discrimination, and causes division among our populace; and

WHEREAS, some entities within Idaho are ignoring these problems and still attempting to implement “vaccine passport” systems in violation of Executive Order No. 2021-04; and

WHEREAS, it is contrary to my core values as an Idahoan that any Idahoan should be forced, coerced, or threatened into receiving a vaccine; and

WHEREAS, I believe it is contrary to the principles of a free society for anyone to face prejudice or discrimination for their personal medical decisions; and

WHEREAS, pursuant to Article N, Section 5 of the Idaho constitution, the supreme executive power of the state is vested in the Governor of Idaho, who shall see that the laws are faithfully executed; and

WHEREAS, pursuant to Idaho Code 67-802, the Governor is authorized and empowered to implement and exercise his constitutional duties by issuing executive orders which shall have the force and effect of law when issued.

NOW, THEREFORE, I, Janice McGeachin, Acting Governor of the State of Idaho, by virtue of the authority vested in me by the Constitution of the United States, the Constitution of the State of Idaho, and the laws of the State of Idaho, do hereby proclaim and declare as follows:

1. No department, agency, board, commission, or other executive branch entity or official of the State of Idaho, including but not limited to the Idaho State Department of Education and all public schools, colleges, and universities shall:
   a. Require as a condition of accessing state services or facilities that an individual produce proof he or she has received a COVID-19 vaccine, produce proof he or she has tested negative for COVID-19, or reveal his or her COVID-19 vaccination status; or
   b. Require as a condition of continued or new employment that an individual produce proof he or she has received a COVID-19 vaccine, produce proof he or she has tested negative for COVID-19, or reveal his or her COVID-19 vaccination status; or
   c. Produce and issue a COVID-19 vaccine passport for the purpose of certifying that an individual has received a COVID-19 vaccine; or
d. Provide information of an individual's COVID-19 vaccine status to any person, company, or governmental entity for inclusion in a COVID-19 vaccine passport program.

2. All departments, agencies, boards, commissions, and other executive branch entities of the State of Idaho are directed to immediately take steps to rescind, alter, or suspend any administrative rules in conflict with this Executive Order.

3. This Executive Order does not, and shall not be construed to, prohibit, restrict, or otherwise limit:

   a. The right of an individual to access his or her own personal health information under state or federal law; or

   b. The normal operation of Idaho's existing Immunization Reminder Information System (IRIS).

4. This Executive Order is effective beginning at 2:00 pm on October 5, 2021.

IN WITNESS WHEREOF, I have hereunto set my hand and caused to be affixed the Great Seal of the State of Idaho in Boise on this 5th day of October in the year of our Lord two thousand twenty-one.

LAWERENCE DENNEY
SECRETARY OF STATE
October 7, 2021

TRANSMITTED VIA EMAIL

Mr. Brady Hall
General Counsel
Office of the Governor
Idaho State Capitol
Boise, ID 83720
Brady.Hall@gov.idaho.gov

Re: Meaning of “Absence from the State” in Article IV, Section 12 – Our File No. 21-74751

Dear Mr. Hall:

You have requested an analysis of whether the interpretation of article IV, section 12 of the Idaho Constitution expressed in a letter sent by Governor Little to Lieutenant Governor McGeachin on July 29, 2021 is correct. The Governor’s letter is based on his understanding that the phrase “absence from the state” in article IV, section 12 means physical absence combined with an inability to perform the duties of governor, which I refer to here as “effective absence.” The question is whether “absence from the state” means: (1) pure physical absence from the state of any distance or duration, or (2) effective absence.

As discussed further below, although this is a close question, the Governor’s interpretation is reasonable. A reviewing court could conclude that “absence from the state” as used in article IV, section 12 means effective absence based on the language of article IV, section 12 and language in other provisions of article IV; the law that was in effect at the time article IV, section 12 was adopted; the historical context; and the need to avoid absurd results. That said, this is a close question, as demonstrated by the fact that the states that have addressed similar language appear to be split as to whether “absence from the state” means effective or physical absence.

**BACKGROUND**

In the letter in question, Governor Little informed Lieutenant Governor McGeachin that he would be temporarily out of the state of Idaho on July 29, 2021 related to travel to attend an event. Governor Little wrote that his time outside of Idaho would be “brief and will not at all hinder my ability to perform any official duties as Idaho’s elected Governor.” The Governor
wrote, “I am not aware of any official business that will require your services in an acting Governor capacity. Thus, you are not authorized to act as Governor during my brief time out of state.” Governor Little continued, “[i]n the event my absence renders me unable to carry out the duties of the office, my staff will notify you immediately.”

Article IV, section 12 sets out the circumstances under which the powers, duties, and obligations of the governor devolve to the lieutenant governor. It provides in full:

In case of the failure to qualify, the impeachment, or conviction of treason, felony, or other infamous crime of the governor, or his death, removal from office, resignation, absence from the state, or inability to discharge the powers and duties of his office, the powers, duties and emoluments of the office for the residue of the term, or until the disability shall cease, shall devolve upon the lieutenant governor.

Idaho Const. art. IV, § 12. The Governor’s July 29, 2021 letter therefore interprets “absence from the state” in article IV, section 12 to mean effective absence.

ANALYSIS

A reviewing court could agree with the Governor’s interpretation and interpret “absence from the state” to mean effective absence. A court could reach this conclusion by first recognizing that the plain language of article IV, section 12 is ambiguous because: (1) related provisions in article IV do not provide complete clarity as to the intended meaning of “absence from the state;” (2) the dictionary definitions of the key terms “absence” and “disability” could support physical or effective absence interpretations; (3) the principles of statutory interpretation applied to the plain language of article IV, section 12 could support physical or effective absence interpretations; and (4) the relevant law that was in effect at the time article IV, section 12 was adopted demonstrates ambiguity as to the Framers’ intent. After finding the plain language ambiguous, a court could look to the comments made at the Constitutional Convention, the historical context of the provision, and the need to avoid absurd results to conclude that “absence from the state” means effective absence. As noted above, this is a close question, and courts in other states that have addressed similar language are split on effective absence versus physical absence interpretations.

A. It is possible, but unlikely, that the plain language of article IV, section 12 could be found to clearly express the intent that “absence from the state” means effective absence based on language in article IV.

“When interpreting constitutional provisions, the fundamental object is to ascertain the intent of the drafters by reading the words as written, employing their natural and ordinary meaning, and construing them to fulfill the intent of the drafters.” State v. Winkler, 167 Idaho 527, 531, 473 P.3d 796, 800 (2020) (quotation marks and citation omitted). “Where the constitutional provision is clear and unambiguous, the expressed intent of the drafters must be given effect.” Id. (quotation marks and citation omitted). “A constitutional provision is ambiguous where
reasonable minds might differ or be uncertain as to its meaning.” Id. (quotation marks and citation omitted).

The term “absence from the state” in article IV, section 12 of Idaho’s Constitution is not defined nor does it have an immediately apparent meaning in that section, as discussed further below. However, a reviewing court could look to related provisions in article IV to conclude that “absence from the state” has a clear meaning. See Winkler, 167 Idaho at 531, 473 P.3d at 800 (looking for any other language within the pertinent article that made the term “pardon” in the Idaho Constitution immediately clear to determine whether the term was ambiguous).

Article IV, section 14 could be read as providing the necessary clarification as to the meaning of “absence from the state.” Article IV, section 14 establishes both when president pro tempore becomes acting governor and when the speaker of the house assumes the position. It provides, in full:

In case of the failure to qualify in his office, death, resignation, absence from the state, impeachment, conviction of treason, felony or other infamous crime, or disqualification from any cause, of both governor and lieutenant governor, the duties of the governor shall devolve upon the president of the senate pro tempore, until such disqualification of either the governor or lieutenant governor be removed, or the vacancy filled; and if the president of the senate, for any of the above named causes, shall become incapable of performing the duties of governor, the same shall devolve upon the speaker of the house.

Idaho Const. art. IV, § 14 (emphasis added). The disqualifications stated in this provision are substantially the same as those stated in section 12, including the phrase “absence from the state.” Yet, section 14 provides additional information as to the phrase’s meaning with its conclusion as to when the duties devolve from the president of the senate to the speaker of the house. Under section 14, this devolution comes when the president of the senate “for any of the above named causes, shall become incapable of performing the duties of governor.” See id. In other words, section 14 arguably provides insight into the Framers’ intent with the enumerated causes in section 12: that they would be events that would render the governor incapable of performing the duties of governor. Given that the phrase “absence from the state” is a disqualifier in sections 12 and 14, it should be read consistently across the sections. Ratzlaf v. United States, 510 U.S. 135, 143, 114 S. Ct. 655, 660, 126 L. Ed. 2d 615 (1994). Thus, a court could conclude that the gloss provided in section 14 should be read to apply to section 12 to establish that “absence from the state” means effective absence.1

1 A term appearing in several places in a statutory text is generally read the same way each time it appears. See Estate of Cowart v. Nicklos Drilling Co., 505 U.S. 469, 479, 112 S. Ct. 2589, 2596, 120 L. Ed. 2d 379 (1992). It is essential to construe a single formulation here because otherwise Idaho could have one set of circumstances under which a lieutenant governor could assume the office of governor and a second set of slightly different circumstances under which the president pro tem or speaker assumes the role of governor if the lieutenant governor is unable to govern.
That said, the following contrary arguments could be made based on the language of section 14: (1) the Framers should be presumed to have intentionally not included this language in section 12 because it is not present in section 12, so section 12 should not be read in light of section 14; (2) the Framers could have intended to treat devolution to the speaker of the house differently from devolution to the lieutenant governor or the president of the senate pro tempore because the speaker of the house holds a different position; and (3) the Framers could have intended physical absence from the state to be a legal disqualification from performing the duties of governor. If a court were to agree with these arguments, it could conclude that section 14 does not clarify the plain language of section 12.2

Separately, a court could conclude that article IV, section 13 sheds necessary light on the meaning of the phrase “absence from the state” because section 13 treats “absence” as something different from the disqualifications stated in section 12. Article IV, section 13, which establishes the circumstances in which the president pro tempore becomes acting governor, states “[i]n case of the absence or disqualification of the lieutenant governor from any cause which applies to the governor, or when he shall hold the office of governor, then the president pro tempore of the senate shall perform the duties of the lieutenant governor until the vacancy is filled or the disability removed.” Because “absence” in this provision is treated as something different than the disqualifications stated in article IV, section 12, this could be read as suggesting that pure physical absence is something that is different from “absence from the state” under article IV, section 12.

However, again, there are flaws with this argument. The phrase in section 13 is “absence,” rather than “absence from the state.” A court could find this difference significant enough to trigger the canon of interpretation that the drafters are presumed to have intended different meanings when they used different words.

On the whole, any potential clarity provided by sections 13 and 14 for a plain language reading of “absence from the state” in section 12 could fail based on the contrary arguments identified above.

Separately, a court could conclude that article IV, section 5 provides the necessary clarity as to the meaning of “absence from the state” because it provides that “[t]he supreme executive power of the state is vested in the governor, who shall see that the laws are faithfully executed.” A court could conclude that interpreting “absence from the state” to mean that supreme executive power transfers to the lieutenant governor to potentially effect a different policy vision every time the governor momentarily leaves the state is inconsistent with plain meaning of article IV, section 5. In other words, a court could conclude that a physical absence interpretation defeats the governor’s supreme executive power and the lieutenant governor’s constitutional

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2 But as observed above, such a conclusion would be contrary to the generally accepted rules of statutory construction. If individuated interpretation were necessary, there would need to be a congruent compelling argument for such interpretation. In the preparation of this analysis, no such compelling reasoning could be identified.
subordination to the governor, particularly in light of the governor’s express direction that the lieutenant governor was not authorized to act in his absence.

That said, a court could find any potential clarity outweighed by the ambiguity inherent in the dictionary definitions of the relevant terms, in the overall construction of section 12, and in the law that was in effect at the time section 12 was drafted, as discussed below.

B. A reviewing court could find the plain language of article IV, section 12 ambiguous as to the meaning of “absence from the state.”

A court would likely look to the dictionary definitions of key terms, to principles of statutory interpretation, and to the law that was in effect at the time article IV, section 12 was adopted in order to understand what the Framers meant by “absence from the state.” A court could conclude that all three sources demonstrate that the plain language is ambiguous as to whether the Framers meant effective or physical absence.

1. The dictionary definitions of “absence” and “disability” could be found ambiguous.

In reviewing the plain language, the “Court begins with the dictionary definitions of disputed words or phrases contained in the [provision].” State v. Clark, 168 Idaho 503, 484 P.3d 187, 192 (2021). These words are given their plain, usual, and ordinary meaning, while construing the statute as a whole. State v. Hart, 135 Idaho 827, 829, 25 P.3d 850, 852 (2001). Pertinent to your question, article IV, section 12 provides that “the powers, duties and emoluments of the office [of governor] . . . devolve upon the lieutenant governor” “in case of the” governor’s “absence from the state” “for the residue of the term, or until the disability shall cease[.]” Thus, there are two key terms to be defined: “absence” and “disability.”

This is because the term “disability” arguably has some modifying effect on the meaning of the term “absence” as it is key to understanding when the devolution to the lieutenant governor on the grounds of “absence” ends (assuming the governor is not absent from the state for the remainder of his term). The lieutenant governor assumes the role of governor either (1) for the residue of the term or (2) until the disability shall cease. It seems fairly straightforward that the absence of the governor from the state would not result in the lieutenant governor assuming the office of governor for the “residue of the term,” thus “absence from the state” must pair with “until the disability shall cease.” In simplest terms, interpreting “absence from the state,” must necessarily include an interpretation of “until the disability shall cease.”

Looking at the definition of “absence” as it was understood at the time article IV, section 12 was adopted, the version of Webster’s Complete Dictionary of the English Language published in 1886 defined “absence” as (1) “[a] state of being absent or withdrawn from a place or from companionship”; (2) “[w]ant; destitution”; and (3) “inattention to things present; heedlessness.” Absence, WEBSTER’S COMPLETE DICTIONARY OF THE ENGLISH LANGUAGE (1886) (available at https://archive.org/details/websterscomplete00webs/page/n9/mode/2up).
The definition of “absence” has not changed much over time. Currently, Merriam-Webster offers three substantially similar definitions for “absence”: (1) “a state or condition in which something is expected, wanted, or looked for is not present or does not exist: a state or condition in which something is absent”; (2) “a failure to be present at a usual or expected place: the state of being absent” or “the period of time that one is absent”; or (3) “inattention to present surroundings or occurrences—usually used in the phrase absence of mind.” Absence, MERRIAM-WEBSTER.COM DICTIONARY, https://www.merriam-webster.com/dictionary/absence (last visited August 5, 2021).

Of all of these definitions, only one definition from each dictionary clearly applies to physical place. The other definitions of absence apply to something other than physical presence or non-presence, such as when absence refers to the non-presence of a less tangible concept, such as in the phrase “in the absence of reform [=without reform], progress will be slow,” which is offered by Merriam-Webster to explain its first definition. Id.

Here, the word “absence” in article IV, section 12 applies to “from the state.” But, having established that absence can have a meaning that encompasses more than the lack of physical presence, what does it mean for the governor to be absent from the state? Does absence mean solely a lack of physical presence in the state? Or does it mean that the governor is absent from the state when the state or condition of having a governor does not exist for the State, i.e., that he is physically absent and unable to discharge his duties because of his absence?

Turning to the definition of “disability,” it does not resolve this ambiguity. The relevant edition of Webster’s Complete Dictionary of the English Language defined “disability” as (1) “[s]tate of being disabled; deprivation of ability; want of competent physical or intellectual power, means, opportunity, and the like; incapacity; incompetency” or (2) “[w]ant of legal qualification; legal incapacity or incompetency.” Disability, WEBSTER’S COMPLETE DICTIONARY OF THE ENGLISH LANGUAGE (1886) (available at https://archive.org/details/websterscomplete00webs/page/n9/mode/2up).

Currently, Merriam-Webster provides three potentially relevant definitions for “disability”: (1) “a physical, mental, cognitive, or developmental condition that impairs, interferes with, or limits a person’s ability to engage in certain tasks or actions or participate in typical daily activities and interactions”; (2) “a disqualification, restriction or disadvantage”; and (3) “lack of legal qualification to do something.” Disability, MERRIAM-WEBSTER.COM DICTIONARY, https://www.merriam-webster.com/dictionary/disability (last visited August 5, 2021).

Again, there is ambiguity. Does disability mean inability to govern, meaning that the position of governor devolves to the lieutenant governor until the condition or restriction that has impaired the governor’s ability to perform his tasks as governor has ceased? In that case, it would suggest that “absence from the state” turns on both the governor’s physical absence and his inability to perform his duties as governor. Or does disability mean solely the cessation of the lack of legal qualification to act as governor, which could apply to physical or effective absence?
Looking outside of the confines of section 12, other provisions of article IV suggest that disability may have been intended to mean temporary disqualification, as opposed to a permanent disqualification for the remainder of the governor’s term. See Idaho Const. art. IV, § 13 ("In case of the absence or disqualification of the lieutenant governor from any cause which applies to the governor, or when he shall hold the office of governor, then the president pro tempore of the senate shall perform the duties of the lieutenant governor until the vacancy is filled or the disability removed." (Emphasis added.)); Idaho Const. art. IV, § 14 ("In case of . . . absence from the state, . . . or disqualification from any cause, of both governor and lieutenant governor, the duties of the governor shall devolve upon the president of the senate pro tempore, until such disqualification of either the governor or the lieutenant governor be removed, or the vacancy filled . . . . (Emphasis added.).) However, even understanding disability to mean temporary disqualification does not clear up the ambiguity as to the meaning of “absence from the state.” This interpretation of “disability” could be applicable to both physical absence and effective absence.

2. **Principles of statutory interpretation could be found ambiguous as to whether the Framers meant effective or physical absence.**

The command of plain language reading that one must give meaning to all the words in a provision could be understood to raise further ambiguity. Clark, 168 Idaho 503, 484 P.3d at 192 (plain language reading “includes giving effect to all the words and provisions of the statute so that none will be void, superfluous, or redundant.” (Quotation marks omitted.)). Article IV, section 12 uses a disjunctive to add the final clause “inability to discharge the powers and duties of his office” to the list of enumerated events that trigger devolution to the lieutenant governor, suggesting that the final clause may have been intended to set out a different cause for devolution.

Applying the principle of interpretation that every word and phrase must be given independent meaning, “inability to discharge the powers and duties of his office” could be read to have a different meaning than the preceding “failure to qualify,” “impeachment,” “conviction for treason, felony, or other infamous crime,” “death,” “removal from office, resignation,” and “absence from the state.” An effective absence interpretation could arguably violate this principle because “absence from the state” would not have independent meaning: events that trigger this exclusion would also fall within the exclusion “inability to discharge the powers and duties of office.” Thus, there would be no need to have the “absence from the state” exclusion at all. The principle of giving effect to all the words and provisions in a statute could therefore support interpreting “absence from the state” to mean physical absence.

That said, there is a flaw in the application of this principle to section 12 because it also applies to the other enumerated causes of devolution in section 12, such as death and removal from office. Yet, death and removal from office clearly would also render the governor unable to discharge the powers and duties of his office. But death is still enumerated separately from “inability to discharge the powers and duties of his office” in section 12.
Ultimately, although the enumerated causes of devolution have independent meaning, the Idaho Supreme Court requires that provisions be construed as a whole. Hart, 135 Idaho at 829, 25 P.3d at 852; Hoskins v. Howard, 132 Idaho 311, 315, 971 P.2d 1135, 1139 (1998). Another principle could be found better suited to understand what the Framers meant by “absence from the state.” The legal maxim of *noscitur a sociis* could be applied to understand “absence from the state” and the other enumerated disqualifications by reading them in context together and with the phrase “or inability to discharge the powers and duties of his office”. “The legal maxim *noscitur a sociis* . . . means ‘a word is known by the company it keeps.’” Chandler’s-Boise LLC, 162 Idaho at 453, 398 P.3d at 186 (citation omitted). Applying this principle here, the phrase “inability to discharge the powers and duties of his office” and the other enumerated causes, such as death and removal from office, wherein the governor is implicitly or explicitly unable to discharge his duties, provide necessary context to understand “absence from the state.” Based on the context of the other causes, “absence from the state” could be read as an absence that renders the governor unable to perform the duties of governor. Thus, based on the legal maxim *noscitur a sociis*, “absence from the state” could be understood to mean a circumstance where the governor is unable to discharge his duties as governor. This reading would support an effective absence interpretation.

3. The law that was in effect when the Constitution was drafted is unlikely to provide clarity as to whether the Framers meant effective or physical absence.

“[T]he law that was in effect when the Constitution was drafted” is another source one can apply to understand of the meaning of article IV, section 12. Nate v. Denney, 166 Idaho 801, 804, 464 P.3d 287, 290 (2017). In *Nate*, the Idaho Supreme Court compared the relevant provisions of the Organic Act of the Territory of Idaho against the relevant provision of the Idaho Constitution to understand its meaning. *Id.* at 804-08, 398 P.3d at 290-94. Relevant to article IV, section 12, section 3 of the Organic Act provided in pertinent part:

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3 In *Clark*, the Idaho Supreme Court repeated its prior precedent in describing this command as (1) a principle of statutory interpretation to be applied in determining whether the language of a provision is unambiguous and (2) as something different from the rules or canons of statutory construction, which may be applied only if the language is ambiguous. 168 Idaho at __, 484 P.3d at 192. However, there appears to be confusion as to whether other principles of statutory interpretation, such as the maxim *noscitur a sociis*, are canons of construction that are only applied to ambiguous text or whether they are principles of statutory interpretation that are applied to determine whether the text is ambiguous. For example, in *State v. Schulz*, which was quoted in *Clark* in support of the relevant discussion, the Court applied the maxim *noscitur a sociis* to a phrase that the Court described as “ambiguous” to conclude that the statute was unambiguous. 151 Idaho 863, 867, 264 P.3d 970, 974 (2011); see also Chandler’s-Boise LLC v. Idaho State Tax Comm’n, 162 Idaho 447, 452-53, 398 P.3d 180, 185-65 (2017) (looking to the maxim *noscitur a sociis* to support a plain language reading of a statute). In contrast, in *ABK, LLC v. Mid-Century Ins. Co.*, the Idaho Supreme Court refused to apply the doctrine of *noscitur a sociis* to a question of contract interpretation because it was a canon of construction “to be used to assist in contract interpretation only where an ambiguity exists.” 166 Idaho 92, 100, 454 P.3d 1175, 1184 (2019). For the purposes of this letter, I will assume that the Court will look to principles of statutory interpretation such as *noscitur a sociis* to understand the plain language of article IV, section 12 prior to concluding the provision is ambiguous based on its use of the doctrine in statutory interpretation cases.
§ 3. Secretary of territory--Term of office--Powers and duties.--.[In case of
the death, removal, resignation, or absence of the governor from the territory, the
secretary shall be, and he is hereby, authorized and required to execute and
perform all the powers and duties of the governor during such vacancy or
absence, or until another governor shall be duly appointed and qualified to fill
such vacancy.


Comparing section 3 of the Organic Act against Idaho’s Constitution, there is a notable
difference in the causes of devolution to the secretary under the Organic Act versus devolution to
the lieutenant governor under article IV, section 12. Under the Organic Act, only “death,
removal, resignation or absence of the governor from the territory” triggered devolution to the
causes for devolution: failure to qualify, impeachment, conviction of treason, felony, or other
infamous crime, or inability to discharge the duties of office. The addition of the final phrase in
section 12 could suggest that section 12 was only intended to articulate causes that render the
governor unable to perform the duties of his office under the principle of maxim noscitur a sociis, as discussed above. This argument is supported by the contrast with the
articulated causes of devolution in the Organic Act. This would support an effective absence
interpretation. However, a physical absence interpretation could also be supported by the
addition of inability to discharge the duties of office in section 12: the Framers could have
understood absence in the Organic Act and in section 12 to mean something other than inability
to discharge the duties of office and therefore added “inability to discharge the powers and duties
of office” to section 12.

It must also be noted that the triggers to terminate the devolution of the governor’s powers and
duties are different in the Organic Act versus article IV, section 12. Under section 3 of the
Organic Act, three of the causes would permanently cause devolution as they would cause a
“vacancy” that would need to be filled. Id. However, upon the governor’s “absence” there
would only be a temporary devolution, and the secretary would only be acting governor “during
such . . . absence.” Id. But the Framers used different language to terminate a temporary
devolution under section 12 on the grounds of absence. Under section 12, devolution on the
grounds of “absence from the state” terminates when “the disability shall cease.” Idaho Const.
art. IV, § 12.

It is notable that the Framers used different language to terminate devolution in the event of an
absence under the Idaho Constitution from what was used in the Organic Act. The Framers
could have continued to use “during such vacancy or absence” and added other language to
address the cessation of an inability to govern; instead, they chose to use “until the disability
shall cease.” This change in the language could be understood to mean that the Framers intended
“absence from the state” in section 12 to have a different meaning from the absence contained in
the Organic Act, one that encompassed the inability to govern. This reading would support an
effective absence interpretation. In the alternative, as discussed above, the Framers could have
understood “disability” as used in section 12 to mean legal disqualification and intended it to cover all of the temporary causes of devolution in section 12. This interpretation could support an effective or physical absence reading.

In light of the above, a court could conclude that ambiguity exists in the dictionary definitions of the terms, the possible plain language readings of section 12 using principles of statutory interpretation, and in light of the law at the time section 12 was adopted. Based on these linguistic uncertainties, it seems likely that a reviewing court would find the phrase “absence from the state” ambiguous.

C. **If article IV, section 12 is found ambiguous, statutory construction is required and could cause a court to conclude that “absence from the state” means effective absence.**

If a court found article IV, section 12 ambiguous as to the meaning of “absence from the state,” the court would look to the principles of statutory construction to ascertain the meaning of the disqualification. “[T]he ordinary rules of statutory construction” apply to interpreting constitutional provisions. *Moon v. Inv. Bd.*, 97 Idaho 595, 596, 548 P.2d 861, 862 (1976). “Where the language of a constitutional provision is ambiguous, the debates from the constitutional convention may be resorted to for the purpose of interpretation.” *Winkler*, 167 Idaho at 531, 473 P.3d at 800 (citation omitted). One should also look to the “context of the time in which” the provision was adopted. *Id.* (citation omitted).

1. **While at times contradictory, the debates from the constitutional convention and other provisions of the original constitution could be read to suggest that “absence from the state” was intended to mean effective absence.**

Article IV, section 12 of the Idaho Constitution was adopted at the 1889 constitutional convention. The only amendments offered were to insert the word “treason” and the word “other” between “or” and “infamous.” *1 Proceedings & Debates of the Const. Convention of Idaho 421* (I.W. Hart ed., 1912). These discussions are unenlightening for the purposes of this question. However, in the discussion of article IV, section 1, as to the number of executive officers proposed, Mr. Gray offered the following debate:

Mr. GRAY. I hardly see the force of the objection to the number of officers we have here. We considered that they are necessary. The lieutenant governor has been mentioned by the chairman of the committee. We have this benefit, that we would not have in the event we did not have that office: The likelihood is, if the governor holds his position, that all the duties he will have to perform is that of president of the senate; and that is the only pay he gets—is for that service, but in the event of the governor’s death, or **absence from his post**, then there is some sort of positive person to take his position; and we think it is a very important clause in it, when it costs the state nothing in the event that does not happen, to have the succession of the office provided for. We can easily see of how much
benefit it might be, supposing that we might suddenly lose the governor or for some reason he should be disqualified to perform his duties.

Id. at 414 (emphasis added).

Similarly, in the debate over an amendment to article IV, section 19 regarding compensation for the lieutenant governor while acting governor, Mr. Poe stated: “Now, this amendment is to the effect that if at any time the governor should be absent from the state and unable to perform the duties of governor, then by virtue of his office [the lieutenant governor] would act as governor.” 2 Proceedings & Debates of the Const. Convention of Idaho, 1324 (I.W. Hart ed., 1912) (emphasis added).

Thus, both Mr. Poe and Mr. Gray appear to have understood “absence from the state” to mean effective absence. In contrast, Mr. Heyburn indicated the opposite understanding, speaking of a salary for the lieutenant governor “if the governor is absent or unable to act and conduct his duties.” Id. at 1329 (emphasis added).

It must also be noted that the 1889 constitutional convention also adopted former article IV, section 19, which repeal was ratified at the general election on November 3, 1998. In pertinent part, the originally adopted provision stated: “Provided, however, the legislature may provide for the payment of actual and necessary expenses to the governor, lieutenant-governor, secretary of state, attorney general, and superintendent of public instruction, while traveling within the state in the performance of official duty.” Idaho Const. art. IV, § 19 (repealed). This provision could be read as indicating that the constitutional convention viewed the governor as only conducting official business while within the state, which would support a physical absence construction.5

That said, the same convention also adopted article V, section 27, which, as originally adopted, provided “the legislature may provide for the payment of actual and necessary expenses of the governor, secretary of state, attorney general, and superintendent of public instruction incurred while in the performance of official duty.” This provision, which does not include the “within the state” caveat of article IV, section 19, suggests that the convention did foresee the named officials leaving the state in the exercise of their official duties.

On the whole, while there is evidence in the constitutional convention debates that would support both the physical and the effective absence interpretations, a court could conclude that the majority of the delegates who issued comments bearing on this question understood that the lieutenant governor would only become acting governor upon the governor’s effective absence, which would support the effective absence interpretation.

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4 The committee later rejected this amendment based on the provision in article IV, section 12 stating that the emoluments of the governor pass to the lieutenant governor when he is acting governor. 2 Proceedings & Debates at 1324-29.

5 In 1994, the people ratified an amendment to this provision that removed the phrase “within the state”; thus, from 1994 until its repeal in 1998, article IV, section 19 stated, “the legislature may provide for the payment of actual and necessary expenses to these officers while traveling in the performance of official duty.”
2. A court could conclude that the historical context suggests that “absence from the state” was intended to mean effective absence.

The historical context in which article IV, section 12 was drafted must also be considered. Prior to the adoption of Idaho’s Constitution, Idaho was governed by territorial governors, who were resented and viewed as carpetbaggers. Donald Crowley and Florence Heffron, The Idaho State Constitution: A Reference Guide 4 (1994). At least one territorial governor never set foot in the territory. Id.

In addition, at the time of the constitutional convention, Idaho’s territorial railroads were the only method for significant travel, despite Idaho’s diverse and difficult geography. Dennis C. Colson, Idaho’s Constitution: The Tie That Binds 130-32 (1991). The convention delegates recognized the difficulty of traveling. 2 Proceedings & Debates at 1552 (discussing the possibility of having to travel by rail, on the back of a mule, or on snowshoes to get to court). Related to the difficulty of traveling in 1889, one can also assume that travel required more time and was associated with lengthier and more complete absences from the state than in the modern world. Contrary to the numerous methods of remote communication available today, telegram and physical mail was the order of the day. 2 Proceedings & Debates at 1693, 1811, 1929.

In light of this historical background, it could reasonably be inferred that the convention delegates understood that a governor’s “absence from the state” would necessarily prevent him from fulfilling his duties. Given the realities of travel and communication technologies in 1889, when the governor was absent from the state in 1889, the convention delegates could reasonably have understood that the governor was simply unable to fulfill his duties in the same way as when he was present in the state. But see State ex rel. Warmoth v. Graham, 26 La. Ann. 568, 569 (La. 1874) (“The mere absence, at Pass Christian, within a few hours’ run of the Capital, could not, by any possibility, affect the public interest.”). They therefore could have understood the governor’s absence from the state to mean effective absence.

3. Interpreting “absence from the state” as meaning effective absence could be found necessary to avoid absurdity.

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6 The Idaho Supreme Court has not viewed the past interpretations or practice of officials under a constitutional provision as controlling its interpretation of that provision. See Nate, 166 Idaho at 810-11, 464 P.3d at 296-97 (an over 50-year history of legislators routinely presenting bills to governors after adjournment, with no apparent objection from those governors, and an almost 39-year history of governors untimely vetoing laws without objection from legislators cannot change the constitutional requirements that bills be presented to the governor prior to adjournment sine die). Thus, it is unlikely that the court would give weight to a past practice of lieutenant governors acting as governor when the governor was temporarily out of the state nor is it likely that the court would give weight to Idaho Code section 67-805A(2), which provides that the lieutenant governor performs the duties of acting governor in the case of the governor’s “temporary absence from the state” “until the governor returns to the state.” This statute appears to suffer from the assumption that the governor is physically unable to perform his job duties while out of state.

7 It wasn’t until 1915 that the first coast-to-coast telephone call was completed.
Ultimately, a court could resolve any ambiguity as to the meaning of “absence from the state” by the need to construe the constitutional provision to avoid absurdity. Any construction of a constitutional provision that would render it absurd and defeat the intent of the drafters is to be avoided. See State ex rel. Idaho State Park Bd. v. City of Boise, 95 Idaho 380, 383, 509 P.2d 1301, 1304 (1973) (rejecting alternative constructions of the constitutional language as they “would be patently absurd and would defeat the constitutional intent as delineated by the proceedings and debates of the constitutional convention”); State v. McKie, 163 Idaho 675, 678, 417 P.3d 1001, 1004 (Ct. App. 2018), review denied (May 23, 2018) (“Constructions of an ambiguous statute that would lead to an absurd result are disfavored.”).

It would be absurd for the mere physical absence of the governor from the state to trigger the devolution of his duties to the lieutenant governor. Given the technologies available in this day and age, there is no impediment to the governor performing his duties remotely. Such a rule would require that the “movements of the [g]overnor should be watched, with the view that the [l]ieutenant [g]overnor or [p]resident pro tempore should slip into his seat, the moment he stepped across the borders of the State.” Warmoth, 26 La. Ann. at 570.

It would also mean that the governor could not act as governor outside of the state. But the Constitution vests “[t]he supreme executive power of the state” in the governor. Idaho Const. art. IV, § 5. Thus, under Idaho Code section 67-802(4), the governor “is the sole official organ of communication between the government of this state and the government of any other state or territory, or of the United States.” If the governor were unable to act as governor outside the state, he would be unable to carry out this function via in-person meetings and conferences with other governments. This would be an absurd result.

Further, an interpretation of “absence from the state” as meaning physical absence only would subject the state to whiplash policy changes when the lieutenant governor becomes acting governor. It is not unusual in Idaho politics for the voters to elect a governor from one political party and a lieutenant governor from the other party. Crowley, at 108. Thus, during a brief absence, the lieutenant governor could issue executive orders with different policy objectives. The people of Idaho could not be guaranteed the execution of the policy choices of the individual they elected solely because the quirks of Idaho’s geography, population centers, and airport locations, which cause the governor to have to temporarily travel out-of-state to execute his duties as Idaho’s governor.

These concerns led the Nevada Supreme Court to adopt the effective absence rule. Quoting a 1872 decision, the court wrote “to accept ‘strict’ absence forced one to ‘reflect upon the possible consequences of such a construction of the Constitution, upon the disgraceful tricks, strife, and exhibitions, which might be entailed upon the people of the State[,]’” Sawyer v. First Jud. Dist. Ct. in and for Ormsby County, 410 P.2d 748, 750 (Nev. 1966) (quoting People ex rel. Tennant v. Parker, 3 Neb. 409 (1872)). The court gave great weight to “the citizens’ . . . right to realize the unintruded policies of the individual they placed in that office.” Id. (emphasis added); see also State ex rel. Meyers v. Reeves, 78 P.2d 590, 512-13 (Wash. 1938) (Geraghty, J., concurring) (“Under present-day conditions, no good reason exists for a rule that would confine the
[governor to the limits of the state or permit him to cross the state line only at the risk of a
disruption of his policies.’]

On a related note, if “absence from the state” were interpreted to mean pure physical absence, the
governor’s staff would never quite know who their boss was when the governor was out of the
office. Staffers would have to constantly monitor the governor’s location to know whether they
should follow instructions given to them by the lieutenant governor or the governor. A staffer
could never be quite certain whether to follow the governor’s telephoned or emailed instructions
or the lieutenant governor’s contrary contemporaneous instruction when the governor was
traveling. The lieutenant governor could even fire the governor’s staff when the governor was
temporarily out of the state, even if he was just out of state for 30 minutes. Such outcomes
would be inconsistent with the lieutenant governor’s constitutional role as the governor’s
subordinate. See art. IV, § 5 (“The supreme executive power of the state is vested in the
governor, who shall see that the laws are faithfully executed.”).

Finally, a physical absence rule could lead to absurdity in terms of the compensation afforded to
the lieutenant governor while acting as governor. Article IV, section 12 states that the lieutenant
governor is entitled to the “emoluments” of the governor while acting as governor and Idaho
Code section 67-809(2) provides that the lieutenant governor will receive the difference between
the daily salaries of lieutenant governor and the governor in addition to the salary of the
lieutenant governor when acting as governor. If the lieutenant governor were acting governor
every time the governor was physically absent from the state, such as when the governor stopped
over in Spokane for a half hour in the process of traveling to a location in Idaho, there would be
absurdity in the lieutenant’s governor’s compensation.

Considering the debates at the constitutional convention, the historical context of when article
IV, section 12 was drafted, and the need to interpret “absence from the state” to avoid absurdity,
a court could conclude that the canons of construction compel the conclusion that “absence from
the state” means effective absence.

D. States with similar constitutional provisions are split as to whether “absence from the
state” means effective absence or pure physical absence.

It appears the states to have interpreted similar constitutional provisions that contain the phrase
“absence from the state” are split as to whether “absence from the state” means effective absence
or mere physical absence. Half of the states identified as having addressed this question.

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8 Or even video-conferenced instructions whereby the staffer and the governor could physically see one another on
a screen within a single room. Facetime, Zoom, WebEx, and others have made face-to-face access from virtually
anywhere a reality.

9 See, e.g., Ark. Const., amend. 6, § 4 (“In case of the impeachment of the Governor, or his removal from office,
death, inability to discharge the powers and duties of the said office, resignation or absence from the State, the
powers and duties of the office, shall devolve upon the Lieutenant Governor for the residue of the term, or until the
disability shall cease. But when the Governor shall, with the consent of the Legislature, be out of the State, in time
of war, at the head of a military force thereof, he shall continue commander-in-chief of all the military force of the
directly have concluded that “absence from the state” means effective absence. State ex rel. Ashcroft v. Blunt, 813 S.W.2d 849, 852-53 (Mo. 1991) (en banc) (reaffirming adoption of the rule that “the power of [g]overnor devolves upon the [l]ieutenant [g]overnor in the [g]overnor’s absence only when such absence effectively debilitates or prevents the [g]overnor from executing the duties of his office”); Sawyer, 410 P.2d at 749 (following the “overwhelming majority of states” that have concluded that absence means effective absence “i.e., an absence which is measured by the state’s need at a given moment for a particular act by the official then physically not present”); In re An Act Concerning Alcoholic Beverages, 31 A.2d 837, 840-41 (N.J. 1943) (holding that absence from the state means “an absence such as will injuriously affect the public interest and does not include a mere temporary absence” (quotation marks omitted)); Johnson v. Johnson, 3 N.W.2d 414, 415 (Neb. 1942) (“[M]ere temporary absence from the state for the performance of official duty or for recreation or for business of a personal nature not interfering with the interests of the public does not vacate the office of governor and instate the lieutenant governor therein with all the powers, duties and emoluments thereof.”); Warmoth, 26 La. Ann. at 569 (interpreting “absence from the state” to mean when the governor’s absence is “such as would injuriously affect the public interest”).

The other half of the states identified as having addressed this question directly have concluded that “absence from the state” means pure physical absence from the state, of any duration or distance. See Bratsenis v. Rice, 438 A.2d 789, 791 (Conn. 1981) (“We decline to conclude that absence implies anything other than physical absence.”)10; In re Governorship, 603 P.2d 1357, 1362 (Cal. 1979) (in bank) (concluding that “constitutional and legislative history, contemporaneous interpretation and historical practice, and considerations of public policy, namely the need for certainty in effectuating executive decisions, support the” interpretation that “absence from the state “must be given its literal, common meaning of physical nonpresence”);

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10 As demonstrated in footnote 8, Connecticut’s relevant constitutional provision had notably different language than Idaho’s, and had a far more apparent physical absence meaning.
Walls v. Hall, 154 S.W.2d 573, 577 (Ark. 1941) ("It is our view that ‘absence from the state’ ... means out of the state for any period of time."); Montgomery v. Cleveland, 98 So. 111, 114 (Miss. 1923) ("[W]henever the [g]overnor is beyond the confines of the state he is absent from the state, and he cannot perform the duties of his office during such absence, and the functions of the office are vested in the [l]ieutenant [g]overnor."); Ex parte Crump, 135 P. 428, 436 (Okla. Crim. App. 1913) ("[T]he plain intention of the framers of the Constitution and the people in adopting it was to provide that in [the governor’s] absence from the state for any purpose or for any period of time, however short, his constitutional functions shall devolve upon the [l]ieutenant [g]overnor as acting [g]overnor.").

Finally, one prominent legal treatise has concluded that absence means effective absence. See 38 Am. Jur. 2d, Governor § 12 ("Generally, the term ‘absence’ means effective absence from the state and that is an absence which is measured by the state’s need at any given moment for a particular act by the official then physically not present.").

CONCLUSION

In short, while this is a close legal question, as demonstrated by the split between the states that have addressed this question, a reviewing court could conclude that Governor Little’s interpretation of “absence from the state” in article IV, section 12 of Idaho’s Constitution as expressed in his July 29, 2021 letter is correct and that “absence from the state” means effective absence, not physical absence.

I hope you find this analysis helpful.

Sincerely,

BRIAN KANE
Chief Deputy
WHEREAS, on October 5, 2021, I traveled on official business to Texas to meet with several of my fellow Governors to inspect the southern border of the United States and propose specific strategies and solutions to alleviate the crisis and stem the flow of dangerous drugs from entering our respective states.

WHEREAS, prior to my departure from Idaho, I notified Lieutenant Governor Janice McGeachin of my official travels and that my temporary stay in Texas would not hinder my ability to perform any official duties as Idaho’s elected Governor. I further notified the Lieutenant Governor that no official business would require her services in an acting Governor capacity.

WHEREAS, on October 5, 2021, before I departed for Texas the Lieutenant Governor sought information on steps to deploy the National Guard to the border and expressed her intention to do so. Further, while I was enroute to Texas, the Lieutenant Governor issued Executive Order No. 2021-13, titled “Banning Vaccine Passports and Mandatory Testing.”

WHEREAS, the Lieutenant Governor’s actions were without legal authority. I did not direct or authorize the Lieutenant Governor to act in any manner pursuant to Idaho Code § 67-809(1). Nor does my temporary presence in Texas on official business impair my ability to represent the people of Idaho thus necessitating action by another executive to ensure the continuity of state government. The Founders of our Constitution did not permit, nor would they now sanction, a lieutenant governor’s actions to subvert or supplant the policies of an otherwise capable, qualified, and duly elected governor.

WHEREAS, that portion of Executive Order No. 2021-13 attempting to prohibit vaccine passports is a redundant and unwarranted use of executive powers. I previously banned COVID-19 vaccine passports on April 7, 2021, by way of Executive Order No. 2021-04, titled “Banning Vaccine Passports.”

WHEREAS, that portion of Executive Order No. 2021-13 that irresponsibly seeks to prohibit COVID-19 testing without exception is entirely without basis and will undoubtedly compromise the ability of the state to curb the spread of the deadly disease and protect Idahoans, including children, veterans and the elderly and infirm.

WHEREAS, Idaho Code § 67-802 authorizes the Governor to repeal any executive order by issuance of a new executive order; and

WHEREAS, it is necessary to repeal Executive Order No. 2021-13 in its entirety to reverse the misuse of executive authority, preserve the rule of law, protect Idahoans, and eliminate any confusion created by the Lieutenant Governor’s unlawful action.

NOW, THEREFORE, I, Brad Little, the duly elected and sworn Governor of the State of Idaho, by virtue of the authority vested in me by the Constitution of the United States, the Constitution of the State of Idaho, and the laws of the State of Idaho including, but not limited to, Idaho Code § 67-802, do here by proclaim and declare as follows:

1. Executive Order No. 2021-13 is repealed in its entirely, effective immediately.

2. The repeal of Executive Order No. 2021-13 shall apply retroactively to 2:00 p.m. on October 5, 2021.

3. Executive Order No. 2021-04 will remain in effect.
IN WITNESS WHEREOF, I have hereunto set my hand and caused to be affixed the Great Seal of the State of Idaho in Boise on this 6th day of October at 12:30 p.m. in the year of our Lord two thousand twenty-one.

BRAD LITTLE
GOVERNOR

LAWERENCE DENNEY
SECRETARY OF STATE
EFFECTIVE DATE: The effective date of the temporary rule is November 1, 2021.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule, and proposed rulemaking procedures have been initiated. The action is authorized pursuant to Section 22-1705, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than November 17, 2021.

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.

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

This rule conforms with the intent and requirements of House Bill 126, the Industrial Hemp Research and Development Act, which was passed by the Legislature and signed into law by the Governor.

H.B. 126 established the legislative intent for the Idaho to:

• Assume primary regulatory authority of industrial hemp as allowed by federal law;
• Allow production, processing, transportation, and research of industrial hemp in Idaho; and
• Require the director to submit a state plan to the secretary of agriculture as expeditiously as possible and, by a date certain, to allow the production of industrial hemp.

H.B. 126 provides direction for ISDA’s rulemaking:

• Production, processing, transportation, and research of industrial hemp are subject to the rules promulgated under Title 22, Chapter 17, Idaho Code, the state plan, and the 2018 Farm Bill and the rules promulgated.
• The department is authorized to promulgate rules establishing fees and penalties for violations associated with the provisions of this chapter.

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

Pertaining to subsection (b), the temporary rule brings the ISDA into compliance with House Bill 126, which directs the agency to assume regulatory authority as allowed by federal law and allows for the production, processing, transportation, and research of industrial hemp in Idaho. Further, this rule is required for submission of a state plan to the U.S. Secretary of Agriculture pursuant to the 2018 Farm Bill.

Pertaining to subsection (c), the temporary rule confers a benefit to those wishing to produce, process, transport, and research industrial hemp in Idaho. Without this rule in place, the ISDA would be unable to begin the application process for the 2022 calendar year, including for Idahoans who wish to begin planning the cultivation of hemp.

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

House Bill 126 authorizes the department to establish fees in rule in order to fund the program. The fees included are:
FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year:

It is anticipated that the fees outlined will result in a fiscal impact of $250,000 in revenue.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the June 2, 2021 Idaho Administrative Bulletin, Vol.21-6, Page 46.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into this rule:

- Domestic Hemp Production Program. 7 CFR Part 990.

The 2018 Farm Bill directed USDA to establish a national regulatory framework for hemp production in the United States. USDA published a final rule on January 19, 2021, that provides regulations for the production of hemp in the United States and is effective on March 22, 2021. The final rule builds on the interim final rule published October 31, 2019, that established the U.S. Domestic Hemp Production Program. The final rule incorporates modifications based on public comments and lessons learned during the 2020 growing season.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Chanel Tewalt, Deputy Director at (208)332-8500 or chanel.tewalt@isda.idaho.gov.

Anyone may submit written comments regarding the proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before November 24, 2021.

DATED this Monday, October 25, 2021.

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THE FOLLOWING IS THE PROPOSED TEXT OF FEE DOCKET NO. 02-0107-2101
(New Chapter)

IDAPA 02 – DEPARTMENT OF AGRICULTURE

02.01.07 RULES GOVERNING HEMP

000. LEGAL AUTHORITY.
This chapter is adopted under the legal authority of Sections 22-1702, 22-1703, 22-1704, 22-1705, and 22-1706, Idaho Code. (11-1-21)

001. SCOPE.
These rules govern the licensing, production, handling, and research of hemp. (11-1-21)

002. INCORPORATION BY REFERENCE.

01. Domestic Hemp Production Program. 7 CFR Part 990. (11-1-21)


003. – 009. (RESERVED)

010. DEFINITIONS.
In addition to the definitions in 7 CFR Part 990, the USDA Final Hemp Rule, and Section 22-1703, Idaho Code, the following definitions apply to the interpretation and enforcement of these rules: (11-1-21)

01. Accepted Laboratory. A laboratory capable of testing pursuant to rule requirements and which is a state department of agriculture laboratory or a laboratory accredited in accordance with International Organization for Standardization ISO/IEC 17025:2017 and capable of THC quantitation by gas chromatography-mass spectrometry or high-pressure liquid chromatography. The Idaho State Police Forensic Laboratory is excluded from this definition. After December 31, 2022, accepted laboratories also must be registered with the U.S. Drug Enforcement Agency under the Controlled Substances Act, 21 CFR part 1301.13. (11-1-21)

02. Acceptable Hemp THC Level. The total delta-9 tetrahydrocannabinol content of hemp on a dry weight basis, that, when reported with the measurement of uncertainty, produces a range that includes a result of three-tenths percent (0.3%) total tetrahydrocannabinol or less, as defined in the 2018 Farm Bill. (11-1-21)

03. Department. The Idaho State Department of Agriculture. (11-1-21)

04. Entity. A corporation, general partnership, joint stock company, association, limited partnership, limited liability partnership, limited liability company, series limited liability company, irrevocable trust, estate, charitable organization, other similar organization, or an institution of higher education. (11-1-21)

05. Harvest. To cut, gather, take, or remove all or part of hemp plants growing in a lot for the purpose of distribution, disposal, cloning, handling, sale, or any other use. (11-1-21)

06. Key Participant. A person who has direct or indirect financial interest in the entity producing hemp, such as an owner or partner in a partnership. A key participant also includes persons in a corporate entity at executive levels. (11-1-21)
07. **License.** A hemp producer or hemp handler license issued by the Department. (11-1-21)

08. **Lot.** A contiguous area in a field, greenhouse, or indoor growing structure containing the same variety or strain of hemp throughout. (11-1-21)

09. **Measurement of Uncertainty.** The parameter, associated with the result of a measurement, that characterizes the dispersion of the values that could reasonably be attributed to the particular quantity subject to measurement. (11-1-21)

10. **Producer.** A producer includes an owner, operator, landlord, or tenant who shares in the risk of producing a crop and who is entitled to share in the crop available for marketing from the farm or facility, or would have shared had the crop been produced. A producer includes a grower of seed. (11-1-21)

11. **Total THC.** The sum of tetrahydrocannabinolic acid and delta-9 tetrahydrocannabinol. (11-1-21)

011. **ABBREVIATIONS.**

01. **USDA.** The U.S. Department of Agriculture. (11-1-21)

02. **THC.** Tetrahydrocannabinol. (11-1-21)

03. **FSA.** The U.S. Department of Agriculture Farm Service Agency. (11-1-21)

012. – 199. (RESERVED)

200. **DEPARTMENT INFORMATION.**

01. **Department Reporting.** The Department will provide to USDA all hemp information required by federal regulation including a hemp producer report, a hemp disposal report, and an annual state report pursuant to deadlines established by USDA. (11-1-21)

201. – 299. (RESERVED)

300. **LICENSES.**

01. **Requirement.** Any person or entity shall have an active hemp license from the Department for planting, propagating, producing, handling, or processing hemp in Idaho. (11-1-21)

02. **Application.** An applicant for a producer or handler license must apply on a form prescribed by the Department. (11-1-21)

a. An applicant and any key participants must include in the application a criminal history report conducted as a fingerprint background check by the Idaho State Police or Federal Bureau of Investigation completed no more than sixty (60) days before the application submission. (11-1-21)

03. **Annual Application Period and Fees.** The application period is September 1 through December 31 of each year for the next calendar year, or a late fee of two hundred fifty dollars ($250) applies to each late application. Applications must be complete and include a nonrefundable application fee according to Subsection 301.01 of this rule. (11-1-21)

04. **Application Approval.** An applicant will be notified when the application has been approved or denied. Upon notification of approval of a license application, the applicant must remit to the Department the appropriate license fees according to Subsection 301.01 of this rule. Upon receipt of payment of the license fee, the license will be issued. (11-1-21)

05. **License Not Transferable.** All licenses are non-transferable. (11-1-21)
06. **Producer License.** A producer license authorizes a person or entity to obtain and possess hemp seed for planting; to cultivate and harvest hemp; to transport their own hemp crop; to dispose of or remediate their own hemp; as well as possess and market plant parts. (11-1-21)

07. **Handler License.** A handler license authorizes a person or entity to obtain and possess hemp, including seed, for processing but not intended for the license holder’s own cultivation. (11-1-21)

08. **Ineligibility.** No license will be issued to an ineligible person or entity. (11-1-21)

a. A person who has had a hemp license revoked by the Department, USDA, another state, Indian nation, or U.S. territory is ineligible to apply for participation in the hemp program for a period of five (5) years from the date of revocation. (11-1-21)

b. A person who has been convicted of a felony relating to a controlled substance under federal law or the law of any state may not, before the tenth anniversary of the date of the conviction, hold a license, or be a key participant, or be a governing person of a business entity that holds a license unless the person was lawfully growing hemp under the 2014 Farm Bill before December 20, 2018, and whose conviction also occurred before December 20, 2018. (11-1-21)

c. A person who materially falsifies any information contained in a license application to the Department, or submitted an application to the Department, USDA, another state, Indian nation, or U.S. territory with any materially false statements or misrepresentations is ineligible for a license. (11-1-21)

d. A person under the age of eighteen (18) years of age at the time the application is submitted to the Department is ineligible for a license. (11-1-21)

e. A person or entity with three (3) negligent violations in a five (5) year period is ineligible to produce hemp for a period of five (5) years from the date of the third violation. (11-1-21)

09. **License Expiration.** A license is valid from January 1 until December 31 of each year, except for a license issued as a result of a late application which is valid from date of issuance until December 31 of that year. (11-1-21)

10. **License Amendment.** Any change to the required information on an approved license requires a licensee to submit a license amendment on a form prescribed by the Department within ten (10) business days of the change. Changes may be subject to Subsection 301.01 of this rule. (11-1-21)

11. **Additional Responsibilities.** A license holder must notify the Department of any theft of hemp materials, whether growing or not, within forty-eight (48) hours of discovery. (11-1-21)

12. **Suspension.** A hemp license may be suspended when a licensee has engaged in conduct violating hemp law or rule, or when a licensee failed to comply with a written order related to a negligent violation. (11-1-21)

a. A suspended license may be restored after a waiting period of one (1) year. (11-1-21)

b. Any person or entity whose license has been suspended may be required to comply with a corrective action plan to fully restore the license. (11-1-21)

13. **Revocation.** A hemp license will be revoked if the licensee:

a. Pleads guilty to, or is convicted of, any felony related to a controlled substance; or (11-1-21)

b. Made any materially false statement with regard to this rule to the Department with a culpable mental state greater than negligence; or (11-1-21)

c. Was found to be growing cannabis exceeding the acceptable hemp THC level with a culpable
mental state greater than negligence; or

d. Negligently violated law or rule three (3) times in five (5) years.

14. No License For Official Duties. Department employees and law enforcement are not required to have a license for handling hemp in performance of official duties.

301. FEES.

01. Licensing and Inspection Fees. Hemp program fees are as follows:

<table>
<thead>
<tr>
<th>Fee Type</th>
<th>Grower</th>
<th>Handler</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual application</td>
<td>$100</td>
<td>$100</td>
</tr>
<tr>
<td>Annual license</td>
<td>$500</td>
<td>$1,000</td>
</tr>
<tr>
<td>Modification to application information</td>
<td>$250</td>
<td>$500</td>
</tr>
<tr>
<td>Producer pre-harvest inspection and other inspections</td>
<td>$250/lot + $35/hour for travel to site + actual costs for shipping samples</td>
<td></td>
</tr>
<tr>
<td>Handler annual site inspection and other inspections</td>
<td>$500/site + $35/hour for travel to site</td>
<td></td>
</tr>
</tbody>
</table>

a. Applicants seeking to produce and handle hemp require both license types. The annual application fee is charged only for the first license type.

02. Other Costs. Licensees pay the costs of background checks and required testing directly to the entity providing the service.

302. – 399. (RESERVED)

400. PRODUCER RECORDS.

01. Producer Records. Producers shall maintain the following records for three (3) years and make them available during normal business hours for the Department to review at the location where hemp is being grown:

a. All documents related to the information required in the license application;

b. Source of hemp seed;

c. Total acreage of industrial hemp planted, harvested, and disposed;

d. Record of all handlers sold to and quantities sold to each entity;

e. Variety and strain for each lot;

f. All records, documents, and forms regarding the disposal or remediation of hemp;
g. Copies of all records submitted to the Department, USDA, or law enforcement related to hemp, as well as any supporting documentation.

02. Submission of Information to USDA. All license holders shall report to their local USDA FSA office consistent with USDA requirements.

401. – 499. (RESERVED)

500. INSPECTION OF PRODUCERS.

01. Verification. Inspections may be scheduled by the Department to verify information provided by the licensee. Any growing sites that do not conform to the license must be destroyed or the license must be amended.

02. Access. The Department shall have access to hemp sites and may enter property where hemp is planted, stored, propagated, produced, or handled for the purpose of inspections, sample collections, testing, or investigation pursuant to Idaho Code and this rule.

03. Harvest Notification. A producer license holder must submit a sample request form to the Department at least thirty-five (35) days prior to the expected harvest date.

04. Procedure. The sampling procedure is determined by the Department’s Sampling Protocol. Inspections and sampling are subject to Subsection 301.01 of this rule.

05. Inspection and Sampling. ISDA will conduct inspections and collect samples of each lot not more than thirty (30) days before the hemp is harvested. The industrial hemp may be harvested only after the official sample is collected. The producer licensee or a key participant must be present at the inspection.

06. Harvest. The license holder will harvest the crop no more than thirty (30) days following the date of sample collection by the Department.

a. If the licensee fails to complete harvest within thirty (30) days of sample collection, secondary samples of each lot to be harvested must be collected by the Department and submitted for testing.

i. The license holder must notify the Department of a delay in harvesting by submitting a request form for subsequent sample collection from each lot to be harvested. Additional sampling is subject to Subsection 301.01 of this rule.

07. Lots Not Commingled. Harvested hemp lots may not be commingled with hemp from other harvested lots or other material.

08. Movement. No hemp may leave the control of the producer licensee until the licensee receives notification from the Department that the lot complies with this rule.

501. TRANSPLANTING.

01. Transplanting. To transplant hemp, a producer licensee must submit transplant information with his or her license application or submit a lot change request on a form provided by the agency.

02. Lots Not Divided. No licensee will divide a lot from the initial area of cultivation for transplant into more than one transplantation area for on-farm production.

03. Transplant Sales. Selling hemp transplants for wholesale or retail requires a producer license and a handler license.

502. – 599. (RESERVED)
600. INSPECTION OF HANDLERS.

01. Handler Inspection. The Department will inspect all handler locations annually. The licensee or a key participant must be present at the scheduled inspection. The Department may perform random inspections during normal business hours. A sample may be pulled at an inspection. Scheduled handler inspections are subject to Subsection 301.01 of this rule. (11-1-21)

02. Handler Duties. (11-1-21)

a. The licensee may not acquire or accept hemp from any source other than a person licensed by the Department, the USDA, or a state or tribe with a hemp plan approved by USDA. (11-1-21)

b. Licensed handlers shall not sell, offer, or transfer within Idaho any hemp products not in compliance with Section 37-2701, Idaho Code. (11-1-21)

03. Handler Records. Handlers shall maintain the following records for three (3) years and make them available during normal business hours for the Department to review at the facility where hemp is being handled; (11-1-21)

a. Records of all hemp crop acquisitions with the corresponding producer name, producer address, copy of producer license number, quantity purchased, and transaction date; (11-1-21)

b. Records of all unprocessed hemp sold including name, address, and license number of the person or entity to whom the product was sold in addition to the quantity sold and transaction date; (11-1-21)

c. Records of hemp products made by licensee including description of each type of product, quantity sold, and date of distribution; and (11-1-21)

d. All records regarding the disposal of products exceeding the acceptable hemp THC level. (11-1-21)

601. – 699. (RESERVED)

700. SAMPLES AND TESTING.

01. Sampling Protocol. Sampling will be conducted according to the Department’s Sampling Protocol. The Department will send samples to an accepted laboratory selected by the license holder at the time of sampling. The licensee bears the full cost of laboratory testing. (11-1-21)

02. Laboratory Testing. An accepted laboratory must use appropriate and validated methods and procedures for all testing activities and evaluate the measurement of uncertainty. Samples must be tested using post-decarboxylation or a similarly reliable method by which the total THC concentration level reported accounts for the conversion of THCA into THC. An accepted laboratory will analyze regulatory samples according to the Department’s Testing Protocol and the following steps: (11-1-21)

a. Maintain the chain of custody of each sample; (11-1-21)

b. Retain the sample for a minimum of thirty (30) business days from the sample submission date; (11-1-21)

c. Not commingle hemp from one (1) lot with hemp from any other lot; (11-1-21)

d. Send the test results of official samples to the Department, license holder and USDA no later than the fifteenth business day from the sample submission date; and (11-1-21)

e. Determine and report total delta-9 THC concentration level on a dry weight basis, and the
measurement of uncertainty must be estimated and reported with the test results. (11-1-21)

03. **Test Results.** Any test result of a sample showing, with acceptable quality control passing, that the total THC content of the sample exceeds the acceptable hemp THC level shall be conclusive evidence that hemp from the lot represented by the sample contains a THC concentration in excess of that allowed. (11-1-21)

   a. If the results of a test conclude that the THC levels of a sample exceed the acceptable hemp THC level, the laboratory will promptly notify the producer, the Department, and the USDA. (11-1-21)

04. **Holding for Test Results.** No hemp may be transferred or enter the stream of commerce until the license holder is notified that the hemp lot sampled and tested is compliant with an acceptable THC level when the application of the measurement of uncertainty is applied. (11-1-21)

05. **Retesting.** A license holder may request a retest of the original sample within five (5) days from the date the license holder receives the results of the first test. (11-1-21)

   a. Retests must be performed by the laboratory that conducted the initial test. (11-1-21)
   b. The laboratory must use the original sample used in the first test for the retest. (11-1-21)
   c. The results of the retest are final. (11-1-21)

701. – 799. (RESERVED)

800. **DISPOSAL.**

01. **Hemp Above the Acceptable Hemp THC Level.** No more than five (5) calendar days after notification that material from a hemp lot has tested above the acceptable THC level, the licensee must notify the Department of the licensee’s decision to either destroy or remediate the entire non-compliant hemp lot and by which method according to the Department’s Disposal and Remediation Protocol. (11-1-21)

02. **Disposal.** The licensee must dispose of non-compliant hemp with chemical or mechanical destruction to render the material non-retrievable, non-ingestible, and unfit to enter the stream of commerce. (11-1-21)

03. **Remediation.** Lots may be remediated according to the Department’s Disposal and Remediation Protocol.

   a. Remediated hemp will be resampled and retested according to Subsection 500.04 and Section 700 of this rule. Remediated hemp that fails the re-test must be destroyed and is not eligible for additional remediation efforts. (11-1-21)

04. **Verification.** The Department must inspect and document disposal or remediation of non-compliant hemp. (11-1-21)

05. **Other Hemp Disposal.** Disposal is required for any of the following:

   a. Hemp plants located in an area that is not licensed, (11-1-21)
   b. Hemp plants not accounted for in required reporting, or (11-1-21)
   c. Hemp lots that have been destroyed due to pests, weeds, disease, poor stand, natural disaster, or a weather event such as a flood or hail. (11-1-21)

06. **Reporting.** All hemp disposed of, for any reason, must be reported to and verified by the Department and may be subject to Subsection 301.01 of this rule. (11-1-21)
07. Costs. All costs for disposal, remediation, and related activities will be paid by the license holder or land owner. (11-1-21)

08. USDA Notification. The Department will provide to USDA information about non-compliant plants, sites, and related test results. (11-1-21)

801. – 899. (RESERVED)

900. VIOLATIONS.

01. Negligent Acts. Negligent acts include:
   a. Failure to provide an accurate legal description of land where hemp is produced; (11-1-21)
   b. Failure to obtain a license; or (11-1-21)
   c. Production of hemp exceeding the acceptable THC level. (11-1-21)

02. License holders shall not be subject to more than one (1) negligent violation per calendar year. (11-1-21)

03. Corrective Actions. Upon any determination that a negligent act related to the growth or handling of hemp has occurred, the Department will institute a corrective action plan which must include:
   a. A reasonable date to correct the negligent act; and (11-1-21)
   b. A requirement to periodically report to the Department regarding compliance with the corrective action plan for a period of not less than two (2) consecutive calendar years. (11-1-21)

04. Agency Inspection. The Department will conduct inspections to determine if the corrective action plan was implemented. (11-1-21)

05. Not Subject to Criminal Enforcement. As a result of a negligent violation, a licensee is not subject to criminal enforcement action. (11-1-21)

06. Non-negligent Violations. Violations with a culpable mental state greater than negligence, including knowingly growing hemp containing a delta-9-THC concentration that exceeds three-tenths percent (0.3%) on a dry weight basis will be reported by the Department to the Idaho State Police and the U.S. Attorney General. (11-1-21)

07. Penalties and Procedure. Penalties, including license suspension or revocation, and due process procedures are governed under Section 22-1705(5), Idaho Code, and the Idaho Administrative Procedure Act, Chapter 52, Title 67, Idaho Code. (11-1-21)

901. – 999. (RESERVED)
AUTHORITY: As authorized by Section 36-104, Idaho Code, and in compliance with Section 36-105(3), Idaho Code, the Commission adopts proclamations establishing seasons and limits for hunting, fishing, and trapping in Idaho.

AVAILABILITY OF OFFICIAL PROCLAMATIONS: Hunters, anglers, and trappers are advised to consult the text of the Commission's official proclamation before hunting, fishing, or trapping. All proclamations are available on-line at https://idfg.idaho.gov/rules, with print versions available at Idaho Department of Fish and Game offices and license vendors.

DESCRIPTIVE SUMMARY: The Commission meeting schedule and meeting agendas are available on-line at https://idfg.idaho.gov/about/commission/archive, with opportunities for public comment generally scheduled at its January, March, May, July, and November meetings.


On September 1, 2021, the Commission took the following proclamation actions:

1. Adopted a proclamation with 2022 elk and deer tag limits for nonresidents, including outfitter tag allocation.
2. Amended the 2019-2021 fishing proclamation to reduce 2021 fall steelhead limits in the Snake, Salmon, and Clearwater Rivers.
3. Amended the proclamation for the 2021 Coho Salmon season to add a fishery in the Snake River.
4. Amended the proclamation providing the 2021 upland game bird season, making a correction for a pheasant season closing date, which is consistent with the printed brochure.
5. Amended the proclamation providing 2021 bighorn sheep seasons and limits by changing a bighorn sheep hunt area boundary for the 2021 season due to wildfire impacts.

On October 7, 2021, the Commission took the following proclamation actions:

1. Amended the 2019-2021 fishing proclamation to reduce 2021 fall steelhead limits in the Clearwater, North Fork Clearwater, Middle Fork Clearwater, and South Fork Clearwater rivers.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning proclamations, contact Owen Moroney at (208) 334-3715.
AUTHORITY: In compliance with Sections 67-5220(1) and 67-5220(2), Idaho Code, notice is hereby given that this agency intends to promulgate rules and desires public comment prior to initiating formal rulemaking procedures. This negotiated rulemaking action is authorized pursuant to Sections 56-202(b), and 56-264, Idaho Code.

MEETING SCHEDULE: A public meeting on the negotiated rulemaking will be held as follows:

<table>
<thead>
<tr>
<th>WebEx/Teleconference Meeting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Link to see screen: <a href="https://idhw.webex.com/idhw/onstage/g.php?MTID=e1072a793a6ef58740c7fcb5e0892df57">https://idhw.webex.com/idhw/onstage/g.php?MTID=e1072a793a6ef58740c7fcb5e0892df57</a></td>
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<td>Join by Phone: US Toll 1-415-655-0003 or 1-720-650-7664</td>
</tr>
<tr>
<td>Meeting number (access code): 2467 615 8964</td>
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<tr>
<td>Meeting password: 1234</td>
</tr>
</tbody>
</table>

Requests for accommodation must be made not later than five (5) days prior to the meeting to the agency address below.

METHOD OF PARTICIPATION: Persons wishing to participate in the negotiated rulemaking must do any of the following:

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

Upon conclusion of the negotiated rulemaking, any unresolved issues, all key issues considered, and conclusion reached during the negotiated rulemaking will be addressed in a written summary. The summary will be made available to interested persons who contact the agency or, if the agency chooses, the summary may be posted on the agency website.

DESCRIPTIVE SUMMARY AND STATEMENT OF PURPOSE: The following is a statement in nontechnical language of the substance and purpose of the intended negotiated rulemaking and the principal issues involved:

This negotiated rulemaking is being conducted for rule changes prompted by the court-approved K.W. v. Armstrong lawsuit settlement agreement, which requires the Department to adopt and implement a new resource allocation model that will determine personal supports budgets for adult developmental disability program participants by June 2022.

Under the court-approved K.W. v. Armstrong lawsuit settlement agreement, the rules are being revised regarding:
1. Prior authorization of adult developmental disability services, including participant budget development;
2. Adult Developmental disability eligibility and functional assessments process;
3. Services offered, limitations of services and qualifications of providers; and
4. Other provisions as may be determined necessary.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS, OBTAINING DRAFT COPIES: Draft rule language can be found in the following locations: (1) on the “What’s New” Tab located on the Department’s My Choice Matters webpage located at: https://healthandwelfare.idaho.gov/services-programs/whats-new, and (2) on the Department’s Public Notices and Meetings webpage located at: https://healthandwelfare.idaho.gov/about-dhw/public-meetings. For assistance on technical questions concerning this negotiated rulemaking, contact Karen Westbrook, 208-364-1960.

Anyone may submit written comments regarding this negotiated rulemaking. All written comments must be directed to the undersigned and must be delivered on or before November 26, 2021.

DATED this 24th day of October, 2021.

Tamara Prisock
DHW – Administrative Rules Unit
450 W. State Street – 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
phone: (208) 334-5500; fax: (208) 334-6558
e-mail: dhwrules@dhw.idaho.gov
AUTHORITY: In compliance with Sections 67-5220(1) and 67-5220(2), Idaho Code, notice is hereby given that this agency intends to promulgate rules and desires public comment prior to initiating formal rulemaking procedures. This negotiated rulemaking action is authorized pursuant to Sections 56-202(b), 56-203, 56-253, and 56-264, Idaho Code.

MEETING SCHEDULE: A public meeting on the negotiated rulemaking will be held as follows:

<table>
<thead>
<tr>
<th>Tuesday, November 16, 2021 – 2:00 p.m. (MT)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>WebEx/Teleconference Meeting</strong></td>
</tr>
<tr>
<td><strong>Link to see screen:</strong></td>
</tr>
<tr>
<td><a href="https://idhw.webex.com/idhw/onstage/g.php?MTID=e1072a793a6e58740c7fcb5e0892df57">https://idhw.webex.com/idhw/onstage/g.php?MTID=e1072a793a6e58740c7fcb5e0892df57</a></td>
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Under the court-approved K.W. v. Armstrong lawsuit settlement agreement, the rules are being revised regarding:
1. Support broker requirements and limitations;
2. Participant budget development; and
3. Other provisions as may be determined necessary.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS, OBTAINING DRAFT COPIES: Draft rule language can be found in the following locations: (1) on the “What’s New” Tab located on the Department’s My Choice Matters webpage located at: https://healthandwelfare.idaho.gov/services-programs/whats-new, and (2) on the Department’s Public Notices and Meetings webpage located at: https://healthandwelfare.idaho.gov/about-dhw/public-meetings. For assistance on technical questions concerning this negotiated rulemaking, contact Karen Westbrook, 208-364-1960.

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DATED this 24th day of October, 2021.

Tamara Prisock
DHW – Administrative Rules Unit
450 W. State Street – 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
phone: (208) 334-5500; fax: (208) 334-6558
e-mail: dhwrules@dhw.idaho.gov
AUTHORITY: In compliance with Sections 67-5220(1) and 67-5220(2), Idaho Code, notice is hereby given that this agency intends to promulgate rules and desires public comment prior to initiating formal rulemaking procedures. This negotiated rulemaking action is authorized pursuant to Section 39-5209, Idaho Code, and Title 39, Chapter 52, Idaho Code.

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

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<tr>
<th>Date</th>
<th>Time</th>
<th>Meeting Details</th>
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<td>Join by Meeting ID</td>
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<tr>
<td>Meeting ID: 865 4302 8877 – Passcode: 589113</td>
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<td>One Tap Mobile</td>
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METHOD OF PARTICIPATION: Persons wishing to participate in the negotiated rulemaking must do any of the following:

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

Upon conclusion of the negotiated rulemaking, any unresolved issues, all key issues considered, and conclusion reached during the negotiated rulemaking will be addressed in a written summary. The summary will be made available to interested persons who contact the agency or, if the agency chooses, the summary may be posted on the agency website.

In the event that consensus cannot be reached on all Sections of the rule, the Council will determine the language to be proposed.

DESCRIPTIVE SUMMARY AND STATEMENT OF PURPOSE: The following is a statement in nontechnical language of the substance and purpose of the intended negotiated rulemaking and the principal issues involved:

Under Executive Order 2020-01: Zero-Based Regulation, the Council on Domestic Violence and Victim Assistance is striving to prevent the accumulation of costly, ineffective, and outdated regulations and reduce regulatory burden to achieve a more efficient operation of government. The rule changes are intended to perform a comprehensive review of this chapter by collaborating with the public to streamline or simplify this rule language. The primary focus of stakeholder meetings is to re-evaluate the portions of the rules which allocate the grant funding streams administered by the Council. These have not been substantially revised since 1990 and are outdated. Public
and stakeholder comment and discussion is requested as the Council is seeking to ensure that the way grant funds are distributed throughout the State is fair, transparent, directs funds where they are most needed, and ensures the availability of victim services in both rural and urban areas of the state with services available throughout Idaho.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS, OBTAINING DRAFT COPIES: For assistance on technical questions concerning this negotiated rulemaking or to obtain a preliminary draft copy of the rule text (if available), contact Executive Director, Heather A. Cunningham, heather.cunningham@icdv.idaho.gov, (208)332-1542. Materials pertaining to the negotiated rulemaking, including any available preliminary rule drafts, can be found on the Idaho Council on Domestic Violence & Victim Assistance web site at the following web address: https://icdv.idaho.gov.

Anyone may submit written comments regarding this negotiated rulemaking. All written comments must be directed to the undersigned and must be delivered on or before April 22, 2022.

DATED this 24th day of September, 2021.

Tamara Prisock
DHW – Administrative Rules Unit
450 W. State Street – 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
phone: (208) 334-5500; fax: (208) 334-6558
e-mail: dhwrules@dhw.idaho.gov
NOTICE OF OMNIBUS RULEMAKING – AMENDMENT TO TEMPORARY RULE

EFFECTIVE DATE: A temporary rule was adopted under this docket number in the July 21, 2021, Idaho Administrative Bulletin, Vol. 21-7SE, pages 2950 through 2980. The effective date of the amendments to the temporary rule is November 3, 2021.

AUTHORITY: In compliance with Section 67-5226, Idaho Code, notice is hereby given this agency has amended a temporary rule. The action is authorized pursuant to Sections 41-211 and 41-4404, Idaho Code.

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

Amendments are being made to the following temporary rule chapter:

IDAPA 18.04.10, Medicare Supplement Insurance Standards.

This amendment to the temporary rule provides guidance regarding a statutory deadline for companies offering Medicare Supplement plans. It includes guidance on community rating, prohibiting issue age rating, and allowing for an annual period during which a policyholder may change carriers. This guidance is a result of input from carriers on how to implement changes to statute since passage of Senate Bill No. 1143, as amended.

TEMPORARY RULE JUSTIFICATION: Pursuant to Sections 67-5226(1) and 67-5226(2), Idaho Code, the Governor has found that temporary adoption of the rules is appropriate for the following reasons:

This temporary rule is necessary for insurance companies to be in compliance with deadlines in amendments to governing law. The Idaho Legislature passed and the Governor signed into law, Senate Bill No. 1143, as amended, revising provisions regarding standards for Medicare Supplement policies issued after February 28, 2022. The law authorizes the Director to adopt reasonable rules to establish specific standards for policy provisions. This temporary rule provides the implementation guidelines necessary for companies to continue to offer and rate compliant insurance policies after the statutory deadline of February 28, 2022.

FEE SUMMARY: This rulemaking does not impose a fee or charge.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the amendment to temporary rule, contact Weston Trexler, (208) 334-4214, weston.trexler@doi.idaho.gov.

DATED this 3rd day of November, 2021.

Dean L. Cameron, Director
Idaho Department of Insurance
700 W. State Street, 3rd Floor
P.O. Box 83720, Boise, ID 83720-0043
Phone: (208) 334-4250
Fax: (208) 334-4398
THE FOLLOWING IS THE AMENDED TEXT FOR TEMPORARY RULE CHAPTER 18.04.10

IDAPA 18 – IDAHO DEPARTMENT OF INSURANCE

18.04.10 – MEDICARE SUPPLEMENT INSURANCE STANDARDS

000. LEGAL AUTHORITY.
Title 41, Chapters 2 and 44, Idaho Code. (7-1-21)T

001. TITLE AND SCOPE.

01. Title. IDAPA 18.04.10, “Medicare Supplement Insurance Standards.” (7-1-21)T

02. Scope.

a. Except as specifically provided in Sections 046, 051, 066, and 077, this chapter applies to:

i. All Medicare supplement policies delivered or issued for delivery in this state; and

ii. All certificates issued under group Medicare supplement policies, which certificates have been delivered or issued for delivery in this state. (7-1-21)T

b. This chapter does not apply to a policy or contract of one (1) or more employers or labor organizations, or of the trustees of a fund established by one (1) or more employers or labor organizations, or combination thereof, for employees or former employees, or a combination thereof, for members or former members, or a combination thereof, of the labor organization. (7-1-21)T

002. INCORPORATION BY REFERENCE.
This chapter incorporates by reference Appendixes A (Refund Calculation and Calculation of Benchmark forms Model Regulation 651 pages 651-94 to 651-97), B (Form for Reporting Medicare Supplement Policies, page 651-98), and C (Disclosure Statements pages 651-99 to 651-108), and all other outlines of coverage and specific plan designs of the National Association of Insurance Commissioners (NAIC) Model Regulation 651 (pages 651-42 to 651-85) implementing the Medicare supplement insurance minimum standards (2018). The Model Regulation is available from the National Association of Insurance Commissioners and from the Idaho Department of Insurance. (7-1-21)T

003. -- 009. (RESERVED)

010. DEFINITIONS.

01. Applicant.

a. In the case of an individual Medicare supplement policy, the person who seeks to contract for insurance benefits; and

b. In the case of a group Medicare supplement policy, the proposed certificate holder. (7-1-21)T

02. Bankruptcy. A Medicare Advantage organization that is not an issuer has filed, or has had filed against it, a petition for declaration of bankruptcy and has ceased doing business in the state. (7-1-21)T
03. **Continuous Period of Creditable Coverage.** The period during which an individual was covered by creditable coverage, if during the period of the coverage the individual had no breaks in coverage greater than sixty-three (63) days.

04. **Creditable Coverage.**

a. With respect to an individual, coverage of the individual provided under any of the following:

i. A group health plan;

ii. Health insurance coverage;

iii. Part A or Part B of Title XVIII of the Social Security Act (Medicare);

iv. Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928;

v. Title 10, Chapter 55, United States Code (CHAMPUS);

vi. A medical care program of the Indian Health Service or of a tribal organization;

vii. A state health benefits risk pool;

viii. A health plan offered under Title 5, Chapter 89, United States Code (Federal Employees Health Benefits Program);

ix. A public health plan as defined in federal regulation; and

x. A health benefit plan under Section 5(e) of the Peace Corps Act (22 United States Code 2504(e)).

b. Creditable coverage does not include one (1) or more, or any combination of, the following:

i. Coverage only for accident or disability income insurance, or any combination thereof;

ii. Coverage issued as a supplement to liability insurance;

iii. Liability insurance, including general liability insurance and automobile liability insurance;

iv. Workers’ compensation or similar insurance;

v. Automobile medical payment insurance;

vi. Credit-only insurance;

vii. Coverage for on-site medical clinics; and

viii. Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

c. Creditable coverage does not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are not an integral part of the plan:

i. Limited scope dental or vision benefits;
ii. Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and (7-1-21)

iii. Such other similar, limited benefits as are specified in federal regulations. (7-1-21)

d. Creditable coverage does not include the following benefits if offered as independent, non-coordinated benefits:

i. Coverage only for a specified disease or illness; and (7-1-21)

ii. Hospital indemnity or other fixed indemnity insurance. (7-1-21)

e. Creditable coverage does not include the following if it is offered as a separate policy, certificate, or contract of insurance:

i. Medicare supplemental health insurance as defined under Section 1882(g)(1) of the Social Security Act; (7-1-21)

and

ii. Coverage supplemental to the coverage provided under Title 10, Chapter 55, United States Code; (7-1-21)

iii. Similar supplemental coverage provided to coverage under a group health plan. (7-1-21)

f. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) specifically addressed separate, noncoordinated benefits in the group market at PHSA Section 2721(d)(2) and the individual market at Section 2791(c)(3). HIPAA also references excepted benefits at PHSA Sections 2701(c)(1), 2721(d), 2763(b) and 2791(c). In addition, credible coverage has been addressed in an interim final rule (62 Fed. Reg. At 16960-16962 (April 8, 1997)) issued by the Secretary of Health and Human Services, pursuant to HIPAA, and may be addressed in subsequent regulations. (7-1-21)


06. Insolvency. When an issuer, licensed to transact the business of insurance in this state, has had a final order of liquidation entered against it with a finding of insolvency by a court of competent jurisdiction in the issuer’s state of domicile. (7-1-21)

07. Medicare Advantage Plan. A plan of coverage for health benefits under Medicare Part C as defined in 42 U.S.C. 1395w-28 (b)(1), and includes:

a. Coordinated care plans which provide health care services, including but not limited to managed care organization (with or without a point-of-service option), plans offered by provider-sponsored organizations, and preferred provider organization plans; (7-1-21)

b. Medical savings account plans coupled with a contribution into a Medicare Advantage medical savings account; and (7-1-21)

c. Medicare Advantage private fee-for-service plans. (7-1-21)

08. Medicare Supplement Policy. As defined in Section 41-4402 and in addition, “Medicare Supplement Policy” does not include Medicare Advantage plans established under Medicare Part C. Outpatient Prescription Drug plans established under Medicare Part D, or any Health Care Prepayment Plan (HCPP) that provides benefits pursuant to an agreement under Section 1833(a)(1)(A) of the Social Security Act; provided, however, that under Section 104(c) of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), policies that are advertised, marketed or designed primarily to cover out-of-pocket costs under Medicare Advantage Plans (established under Medicare Part C) need to comply with the Medicare supplement requirements of...
Section 1882(o) of the Social Security Act.

**09. Pre-Standardized Medicare Supplement Benefit Plan.** A group or individual policy of Medicare supplement insurance issued prior to July 1, 1992.

**10. 1990 Standardized Medicare Supplement Benefit Plan.** A group or individual policy of Medicare supplement insurance issued on or after July 1, 1992 and with an effective date for coverage prior to June 1, 2010 and includes Medicare supplement insurance policies and certificates renewed on or after that date which are not replaced by the issuer at the request of the insured.

**11. 2010 Standardized Medicare Supplement Benefit Plan.** A group or individual policy of Medicare supplement insurance with an effective date for coverage issued on or after June 1, 2010.

**12. Secretary.** The Secretary of the United States Department of Health and Human Services.

**011. POLICY DEFINITIONS AND TERMS.**

No policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy or certificate unless the policy or certificate contains definitions or terms which conform to the requirements of this section.

**01. Accident, Accidental Injury, or Accidental Means.** To employ “result” language and does not include words that establish an accidental means test or use words such as “external, violent, visible wounds” or similar words of description or characterization.

a. The definition will not be more restrictive than the following: “Injury or injuries for which benefits are provided means accidental bodily injury sustained by the insured person which is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while insurance coverage is in force.”

b. The definition may provide that injuries cannot include injuries for which benefits are provided or available under any workers’ compensation, employer’s liability or similar law, or motor vehicle no-fault plan, unless banned by law.

**02. Benefit Period or Medicare Benefit Period.** Will not be defined more restrictively than as defined in the Medicare program.

**03. Convalescent Nursing Home, Extended Care Facility, or Skilled Nursing Facility.** Will not be defined more restrictively than as defined in the Medicare program.

**04. Health Care Expenses.** For purposes of Section 051, expenses of managed care organizations associated with the delivery of health care services, which expenses are analogous to incurred losses of insurers.

**05. Hospital.** Defined in relation to its status, facilities, and available services or to reflect its accreditation by the Joint Commission on Accreditation of Hospitals, but not more restrictively than as defined in the Medicare program.

**06. Medicare.** Is defined in the policy and certificate, substantially as “The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended,” or “Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof.”

**07. Medicare Eligible Expenses.** Expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.
08. **Physician.** Will not be defined more restrictively than as defined in the Medicare program. (7-1-21)

09. **Sickness.** Will not be defined to be more restrictive than the following: “Sickness means illness or disease of an insured person which first manifests itself after the effective date of insurance and while the insurance is in force.” The definition may be further modified to exclude sicknesses or diseases for which benefits are provided under any workers’ compensation, occupational disease, employer’s liability, or similar law. (7-1-21)

**012. POLICY PROVISIONS.**

01. **Medicare Supplement Policy.** Except for permitted preexisting condition clauses as described in Paragraph 022.01.a., no policy or certificate may be advertised, solicited, or issued for delivery in this state as a Medicare supplement policy if the policy or certificate contains limitations or exclusions on coverage that are more restrictive than those of Medicare. (7-1-21)

02. **Waivers.** No Medicare supplement policy or certificate may use waivers to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions. (7-1-21)

03. **Duplicate Benefits.** No Medicare supplement policy or certificate in force in this state may contain benefits which duplicate benefits provided by Medicare. (7-1-21)

04. **Outpatient Prescription Drugs.**

a. A Medicare supplement policy with benefits for outpatient prescription drugs cannot be issued after December 31, 2005. (7-1-21)

b. After December 31, 2005, a Medicare supplement policy with benefits for outpatient prescription drugs will not be renewed after the policyholder enrolls in Medicare Part D unless:

i. The policy is modified to eliminate outpatient prescription coverage for expenses of outpatient prescription drugs incurred after the effective date of the individual’s coverage under a Part D plan; and

ii. Premiums are adjusted to reflect the elimination of outpatient prescription drug coverage at the time of Medicare Part D enrollment, accounting for any claims paid, if applicable. (7-1-21)

**013. 021. (RESERVED)**

**022. BENEFIT STANDARDS FOR 2010 STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN POLICIES OR CERTIFICATES ISSUED FOR DELIVERY WITH AN EFFECTIVE DATE FOR COVERAGE ON OR AFTER JUNE 1, 2010.**

The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state with an effective date for coverage on or after June 1, 2010. No policy or certificate may be advertised, solicited, delivered, or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit standards. No issuer may offer any 1990 Standardized Medicare supplement benefit plan for sale on or after June 1, 2010. Benefit standards applicable to Medicare supplement policies and certificates issued with an effective date for coverage prior to June 1, 2010 remain in effect. (7-1-21)

01. **General Standards.** The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this regulation. (7-1-21)

a. A Medicare supplement policy or certificate cannot exclude or limit benefits for losses incurred more than six (6) months from the effective date of coverage because it involved a preexisting condition. The policy or certificate will not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage. (7-1-21)

b. A Medicare supplement policy or certificate will not indemnify against losses resulting from
sickness on a different basis than losses resulting from accidents. (7-1-21)

c. A Medicare supplement policy or certificate provides that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, copayment, or coinsurance amounts. Premiums may be modified to correspond with such changes. (7-1-21)

d. No Medicare supplement policy or certificate may provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium. (7-1-21)

e. Each Medicare supplement policy is guaranteed renewable. (7-1-21)

i. The issuer cannot cancel or nonrenew the policy solely on the ground of health status of the individual. (7-1-21)

ii. The issuer cannot cancel or nonrenew the policy for any reasons other than nonpayment of premium or material representation. (7-1-21)

iii. If the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under Subparagraph 022.01.e.v., the issuer offers certificateholders an individual Medicare supplement policy which (at the option of the certificateholder):

(1) Provides for continuation of the benefits contained in the group policy; or (7-1-21)

(2) Provides for benefits that meet the requirements of this Subsection. (7-1-21)

iv. If an individual is a certificateholder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer:

(1) Offers the certificateholder the conversion opportunity described in Subparagraph 022.01.e.iii.; or (7-1-21)

(2) At the option of the group policyholder, offers the certificateholder continuation of coverage under the group policy. (7-1-21)

v. If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy offers coverage to all persons covered under the old group policy on its date of termination. Coverage under the new policy cannot exclude preexisting conditions that would have been covered under the group policy being replaced. (7-1-21)

f. Terminations of a Medicare supplement policy or certificate need to be without prejudice to any continuous loss that commenced while the policy was in force. Such extension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss. (7-1-21)

g. A Medicare supplement policy or certificate provides that benefits and premiums under the policy or certificate may be suspended at the request of the policyholder or certificateholder for the period (not to exceed twenty-four (24) months) in which the policyholder or certificateholder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificateholder notifies the issuer of the policy or certificate within ninety (90) days after the date the individual becomes entitled to assistance. (7-1-21)

i. If suspension occurs and if the policyholder or certificateholder loses entitlement to medical assistance, the policy or certificate is automatically reinstated (effective as of the date of termination of entitlement) as of the termination of entitlement if the policyholder or certificateholder provides notice of loss of entitlement.
within ninety (90) days after the date of loss and pays the premium attributable to the period, effective as of the date of termination of entitlement.

ii. Each Medicare supplement policy provides that benefits and premiums under the policy may be suspended (for any period that may be provided by federal regulation) at the request of the policyholder if the policyholder is entitled to benefits under Section 226 (b) of the Social Security Act and is covered under a group health plan (as defined in Section 1862 (b)(1)(A)(v) of the Social Security Act). If suspension occurs and if the policyholder or certificateholder loses coverage under the group health plan, the policy is automatically reinstated (effective as of the date of loss of coverage) if the policyholder provides notice of loss of coverage within (90) days after the date of the loss and pays the premium attributed to the period, effective as of the date of termination of enrollment in the group health plan.

iii. Reinstatement of coverages as described in Subparagraphs 022.01.g.i. and 022.01.g.ii.;

(1) Does not provide for any waiting period with respect to treatment of preexisting conditions;

(2) Provides for resumption of coverage that is substantially equivalent to coverage in effect before the date of suspension; and

(3) Provides for classification of premiums on terms at least as favorable to the policyholder or certificateholder as the premium classification terms that would have applied to the policyholder or certificateholder had the coverage not been suspended.

h. An issuer makes available to each prospective policyholder and certificateholder a policy form or certificate form containing only the basic (core) benefits, as defined in Subsection 022.02.

i. If an issuer makes available any of the additional benefits described in Subsection 022.03, or offers standardized benefit Plans K or L (as described in Paragraphs 022.04.h. and 022.04.i.), then the issuer makes available to each prospective policyholder and certificateholder, in addition to a policy form or certificate form with only the basic (core) benefits as described in Paragraph 022.01.h., a policy form or certificate form containing either standardized benefit Plan C (as described in Paragraph 022.04.c.) or standardized benefit Plan F (as described in Paragraph 022.04.e.).

j. No groups, packages or combinations of Medicare supplement benefits other than those listed in this section are offered for sale in this state, except as may be permitted in Subsection 022.05 and in Section 031.

k. Benefit plans are uniform in structure, language, designation and format to the standard benefit plans listed in this Subsection and conform to the definitions in Section 010. Each benefit is structured in accordance with the format provided in Subsections 022.02 and 022.03; or, in the case of plans K or L, in Paragraphs 022.04.h. and 022.04.i., and list the benefits in the order shown. For purposes of this section, “structure, language, and format” means style, arrangement and overall content of benefit.

l. In addition to the benefit plan designations prescribed in Paragraph 022.01.k., an issuer may use other designations to the extent permitted by law.

02. Standards for Basic (Core) Benefits Common to Medicare Supplement Insurance Benefit Plans A, B, C, D, F, F with High Deductible, G, M, and N. Every issuer of Medicare supplement insurance benefit plans makes available a policy or certificate including only the following basic “core” package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare Supplement Insurance Benefit Plans in addition to the basic core package, but not in lieu of it.

a. Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the sixty-first day through the ninetieth day in any Medicare benefit period;

b. Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not
covered by Medicare for each Medicare lifetime inpatient reserve day used; (7-1-21)

c. Upon exhaustion of the Medicare hospital inpatient coverage including the lifetime reserve days, coverage of one hundred percent (100%) of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five (365) days. The provider will accept the issuer’s payment as payment in full and will not bill the insured for any balance; (7-1-21)

d. Coverage under Medicare Parts A and B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations; (7-1-21)

e. Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible; (7-1-21)

f. Hospice Care. Coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses. (7-1-21)

03. Standards for Additional Benefits. The following additional benefits are included in Medicare supplement benefit Plans B, C, D, F, F with High Deductible, G, M, and N as provided by Section 022. (7-1-21)

a. Medicare Part A Deductible. Coverage for one hundred percent (100%) of the Medicare Part A inpatient hospital deductible amount per benefit period. (7-1-21)

b. Medicare Part A Deductible. Coverage for fifty percent (50%) of the Medicare Part A inpatient hospital deductible amount per benefit period. (7-1-21)

c. Skilled Nursing Facility Care. Coverage for the actual billed charges up to the coinsurance amount from the twenty-first day through the one hundredth day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A. (7-1-21)

d. Medicare Part B Deductible. Coverage for one hundred percent (100%) of the Medicare Part B deductible amount per calendar year regardless of hospital confinement. (7-1-21)

e. One Hundred Percent (100%) of the Medicare Part B Excess Charges. Coverage for all the difference between the actual Medicare Part B charges as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge. (7-1-21)

f. Medically Necessary Emergency Care in a Foreign Country. Coverage to the extent not covered by Medicare for eighty percent (80%) of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first sixty (60) consecutive days of each trip outside the United States, subject to a calendar year deductible of two hundred fifty dollars ($250), and a lifetime maximum benefit of fifty thousand dollars ($50,000). For purposes of this benefit, “emergency care” means care needed immediately because of an injury or an illness of sudden and unexpected onset. (7-1-21)
applicable to Medicare supplement policies and certificates with an effective date of coverage before June 1, 2010 do not change.

a. An issuer makes available to each prospective policyholder and certificateholder a policy form or certificate form containing only the basic (core) benefits, as defined in Subsection 022.02.

b. If an issuer makes available any of the additional benefits described in Subsection 022.03, or offers standardized benefit Plans K or L (as described in Paragraphs 024.02.h. and 024.02.i.), then the issuer makes available to each prospective policyholder and certificateholder, in addition to a policy form or certificate form with only the basic (core) benefits as described in Paragraph 024.01.a., a policy form or certificate form containing either standardized benefit Plan C (as described in Paragraph 024.02.c.) or standardized benefit Plan F (as described in Paragraph 024.02.e.).

c. No groups, packages or combinations of Medicare supplement benefits other than those listed in this section are offered for sale in this state, except as may be permitted in Subsection 024.03 and in Section 031.

d. Benefit plans are uniform in structure, language, designation and format to the standard benefit plans listed in this Subsection and conform to the definitions in Section 010. Each benefit is structured in accordance with the format provided in Subsections 022.02 and 022.03; or, in the case of plans K or L, in Paragraphs 024.02.h. and 024.02.i., and list the benefits in the order shown. For purposes of this section, “structure, language, and format” means style, arrangement and overall content of benefit.

e. In addition to the benefit plan designations prescribed in Paragraph 024.01.d., an issuer may use other designations to the extent permitted by law.

024. Make-up of 2010 Standardized Benefit Plans.

a. Standardized Medicare supplement benefit Plan A includes only the following: The basic (core) benefits as defined in Subsection 022.02.

b. Standardized Medicare supplement benefit Plan B includes only the following: The basic (core) benefit as defined in Subsection 022.02, plus one hundred percent (100%) of the Medicare Part A deductible as defined in Paragraph 022.03.a.

c. Standardized Medicare supplement benefit Plan C includes only the following: The basic (core) benefit as defined in Subsection 022.02, plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, one hundred percent (100%) of the Medicare Part B deductible, and medically necessary emergency care in a foreign country as defined in Paragraphs 022.03.a., 022.03.c., 022.03.d., and 022.03.f., respectively.

d. Standardized Medicare supplement benefit Plan D includes only the following: The basic (core) benefit (as defined in Subsection 022.02), plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in Paragraphs 022.03.a., 022.03.c., and 022.03.f., respectively.

e. Standardized Medicare supplement benefit [regular] Plan F includes only the following: The basic (core) benefit as defined in Subsection 022.02, plus one hundred percent (100%) of the Medicare Part A deductible, the skilled nursing facility care, one hundred percent (100%) of the Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in Paragraphs 022.03.a., and 022.03.c., through 022.03.f., respectively.

f. Standardized Medicare supplement benefit Plan F with High Deductible includes only the following: One hundred percent (100%) of covered expenses following the payment of the annual deductible set forth in Subparagraph 024.02.f.ii. The basic (core) benefit as defined in Subsection 022.02, plus one hundred percent (100%) of the
Medicare Part A deductible, skilled nursing facility care, one hundred percent (100%) of the Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in Paragraphs 022.03.a., and 022.03.c., through 022.03.f., respectively. (7-1-21)

ii. The annual deductible in Plan F with High Deductible consists of out-of-pocket expenses, other than premiums, for services covered by [regular] Plan F, and is in addition to any other specific benefit deductibles. The basis for the deductible is one thousand five hundred dollars ($1,500) and is adjusted annually from 1999 by the Secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars ($10). (7-1-21)

Standardized Medicare supplement benefit Plan G includes only the following: The basic (core) benefit as defined in Subsection 022.02, plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in Paragraphs 022.03.a., 022.03.c., 022.03.e., and 022.03.f., respectively. Effective January 1, 2020, the standardized benefit plans described in Paragraph 025.01.d. (Redesignated Plan G High Deductible) may be offered to any individual who was eligible for Medicare prior to January 1, 2020.

Standardized Medicare supplement benefit Plan K is mandated by the Medicare Prescription Drug, Improvement and Modernization Act of 2003, and includes only the following:

i. Part A Hospital Coinsurance sixty-first through ninetieth days: Coverage of one hundred percent (100%) of the Part A hospital coinsurance amount for each day used from the sixty-first through the ninetieth day in any Medicare benefit period.

ii. Part A Hospital Coinsurance ninety-first through one hundred fiftieth day: Coverage of one hundred percent (100%) of the Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the ninety-first through the one hundred fiftieth day in any Medicare benefit period;

iii. Part A Hospitalization After One Hundred Fiftieth Day: Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent (100%) of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five (365) days. The provider accepts the issuer’s payment as payment in full and will not bill the insured for any balance;

iv. Medicare Part A Deductible: Coverage for fifty percent (50%) of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in Subparagraph 024.02 022.04.h.x.

v. Skilled Nursing Facility Care: Coverage for fifty percent (50%) of the coinsurance amount for each day used from the twenty-first day through the one hundredth day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in Subparagraph 024.02 022.04.h.x.

vi. Hospice Care: Coverage for fifty percent (50%) of cost sharing for all Part A Medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in Subparagraph 024.02 022.04.h.x.

vii. Blood: Coverage for fifty percent (50%), under Medicare Part A or B, of the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in Subparagraph 024.02 022.04.h.x.

viii. Part B Cost Sharing: Except for coverage provided in Subparagraph 024.02 022.04.h.x., coverage for fifty percent (50%) of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Part B deductible until the out-of-pocket limitation is met as described in Subparagraph 024.02 022.04.h.x.
ix. Part B Preventive Services: Coverage of one hundred percent (100%) of the cost sharing for Medicare Part B preventive services after the policyholder pays the Part B deductible; and

x. Cost Sharing After Out-of-Pocket Limits: Coverage of one hundred percent (100%) of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of four thousand dollars ($4,000) in 2006, indexed each year by the appropriate inflation adjustment specified by the Secretary.

i. Standardized Medicare supplement Plan L is mandated by the Medicare Prescription Drug, Improvement and Modernization Act of 2003, and includes only the following:

ii. The benefits described in Subparagraphs 024.02 022.04.h.i. through 024.02 022.04.h.iii., and

iii. The benefit described in Subparagraph 024.02 022.04.h.ix.

j. Standardized Medicare supplement Plan M includes only the following: The basic (core) benefit as defined in Subsection 022.02, plus fifty percent (50%) of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in Paragraphs 022.03.b., 022.03.c., and 022.03.f., respectively.

k. Standardized Medicare supplement Plan N includes only the following: The basic (core) benefit as defined in Subsection 022.02, plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in foreign country as defined in Paragraphs 022.03.a., 022.03.c., and 022.03.f., respectively, with copayments in the following amounts:

025. New or Innovative Benefits. An issuer may, with the prior approval of the director, offer policies or certificates with new or innovative benefits, in addition to the standardized benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits include only benefits that are appropriate to Medicare supplement insurance, are new or innovative, are not otherwise available, and are cost-effective. Approval of new or innovative benefits cannot adversely impact the goal of Medicare supplement simplification. New or innovative benefits cannot include an outpatient prescription drug benefit. New or innovative benefits cannot be used to change or reduce benefits, including a change of any cost-sharing provision, in any standardized plan.

023. -- 024. (RESERVED)

025. STANDARD MEDICARE SUPPLEMENT BENEFIT PLANS FOR 2020 STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN POLICIES OR CERTIFICATES ISSUED FOR DELIVERY TO INDIVIDUALS NEWLY ELIGIBLE FOR MEDICARE ON OR AFTER JANUARY 1, 2020.

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires the following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state to individuals newly eligible for Medicare on or after January 1, 2020. No policy or certificate that provides coverage of the Medicare Part B deductible may be advertised, solicited, delivered or issued for delivery in this state as a
Medicare supplement policy or certificate to individuals newly eligible for Medicare on or after January 1, 2020. All policies need to comply with the following benefit standards. Benefit plan standards applicable to Medicare supplement policies and certificates issued to individuals eligible for Medicare before January 1, 2020, remain subject to the requirements of Section 024.022.

01. Benefit Requirements. The standards and requirements of Section 024 apply to all Medicare supplement policies or certificates delivered or issued for delivery to individuals newly eligible for Medicare on or after January 1, 2020, with the following exceptions:

a. Standardized Medicare supplement benefit Plan C is redesignated as Plan D and provides the benefits contained in Paragraph 024.02 022.04.c. but will not provide coverage for one hundred percent (100%) or any portion of the Medicare Part B deductible.

b. Standardized Medicare supplement benefit Plan F is redesignated as Plan G and provides the benefits contained in Paragraph 024.02 022.04.e. but will not provide coverage for one hundred percent (100%) or any portion of the Medicare Part B deductible.

c. Standardized Medicare supplement benefit plans C, F, and F with High Deductible will not be offered to individuals newly eligible for Medicare on or after January 1, 2020.

d. Standardized Medicare supplement benefit Plan F with High Deductible is redesignated as Plan G with High Deductible and provides the benefits contained in Paragraph 024.02 022.04.f., but will not provide coverage for one hundred percent (100%) or any portion of the Medicare Part B deductible; provided further that, the Medicare Part B deductible paid by the beneficiary is considered an out-of-pocket expense in meeting the annual high deductible.

e. The reference to Plans C or F contained in Paragraph 024 022.01.b.i. is deemed a reference to Plans D or G for purposes of this section.

02. Applicability to Certain Individuals. This section applies only to individuals that are newly eligible for Medicare on or after January 1, 2020:

a. By reason of attaining age sixty-five (65) on or after January 1, 2020; or

b. By reason of entitlement to benefits under part A pursuant to section 226(b) or 226A of the Social Security Act, or who is deemed eligible for benefits under section 226(a) of the Social Security Act on or after January 1, 2020.

03. Guaranteed Issue for Eligible Persons. For purposes of Subsection 041.05, in the case of any individual newly eligible for Medicare on or after January 1, 2020, any reference to a Medicare supplement policy C or F (including F with High Deductible) is deemed a reference to Medicare supplement policy D or G (including G with High Deductible) respectively that meet the requirements of Subsection 025.01.

04. Offer of Redesignated Plans to Individuals Other Than Newly Eligible. On or after January 1, 2020, the standardized benefit plans described in Paragraph 025.01.d. may be offered to any individual who was eligible for Medicare prior to January 1, 2020 in addition to the standardized plans described in Subsection 024.02 022.04.

026.—030. (RESERVED)

024. Medicare Select Policies and Certificates. This section applies to Medicare Select policies and certificates, as defined in this section. No policy or certificate may be advertised as a Medicare Select policy or certificate unless it meets the requirements of this section.

04. Definitions. For the purposes of Section 024:

(7-1-21)T
a. Complaint. Any dissatisfaction expressed by an individual concerning a Medicare Select issuer or its network providers.

b. Grievance. Dissatisfaction expressed in writing by an individual insured under a Medicare Select policy or certificate with the administration, claims practices, or provision of services concerning a Medicare Select issuer or its network providers.

c. Medicare Select issuer. An issuer offering or seeking to offer a Medicare Select policy or certificate.

d. Medicare Select policy or Medicare Select certificate. Respectively a Medicare supplement policy or certificate that contains restricted network provisions.

e. Network provider. A provider of health care, or a group of providers of health care, which has entered into a written agreement with the issuer to provide benefits insured under a Medicare Select policy.

f. Restricted network provision. Any provision which conditions the payment of benefits, in whole or in part, on the use of network providers.

g. Service area. The geographic area approved by the director within which an issuer is authorized to offer a Medicare Select policy.

02. Authorization to Issue Medicare Select Policy or Certificate. The director may authorize an issuer to offer a Medicare Select policy or certificate, pursuant to Section 031 of this chapter and Section 4358 of the Omnibus Budget Reconciliation Act (OBRA) of 1990, if the director finds that the issuer has satisfied all of the requirements of this chapter.

03. Filing Requirements. A Medicare Select issuer will not issue a Medicare Select policy or certificate in this state until its plan of operation has been approved by the director.

04. Proposed Plan of Operation. A Medicare Select issuer files a proposed plan of operation with the director in a format prescribed by the director. The plan of operation contains at least the following information:

a. Evidence that all covered services that are subject to restricted network provisions are available and accessible through network providers, including a demonstration that:

i. Services can be provided by network providers with reasonable promptness with respect to geographic location, hours of operation, and after-hour care. The hours of operation and availability of after-hour care reflect usual practice in the local area. Geographic availability reflects the usual travel times within the community.

ii. The number of network providers in the service area is sufficient, with respect to current and expected policyholders, either to deliver adequately all services that are subject to a restricted network provision or to make appropriate referrals.

iii. There are written agreements with network providers describing specific responsibilities.

iv. Emergency care is available twenty-four (24) hours per day and seven (7) days per week.

v. In the case of covered services that are subject to a restricted network provision and are provided on a prepaid basis, there are written agreements with network providers prohibiting the providers from billing or otherwise seeking reimbursement from or recourse against any individual insured under a Medicare Select policy or certificate. This subparagraph does not apply to supplemental charges or coinsurance amounts as stated in the Medicare Select policy or certificate.
b. A statement or map providing a clear description of the service area.

c. A description of the grievance procedure to be utilized.

d. A description of the quality assurance program, including:
   i. The formal organizational structure;
   ii. The written criteria for selection, retention, and removal of network providers; and
   iii. The procedures for evaluating quality of care provided by network providers, and the process to initiate corrective action when warranted.

e. A list and description, by specialty, of the network providers.

f. Copies of the written information proposed to be used by the issuer to comply with Subsection 031.08.

g. Any other information requested by the director.

Proposed Changes to the Plan of Operation. A Medicare Select issuer files any proposed changes to the plan of operation, except for changes to the list of network providers, with the director prior to implementing the changes. Changes are considered approved by the director after thirty (30) days unless specifically disapproved. An updated list of network providers is filed with the director at least quarterly.

Restrictions. A Medicare Select policy or certificate cannot restrict payment for covered services provided by non-network providers if:

a. The services are for symptoms requiring emergency care or are immediately needed for an unforeseen illness, injury or a condition; and

b. It is not reasonable to obtain services through a network provider.

Payment for Full Coverage. A Medicare Select policy or certificate provides payment for full coverage under the policy for covered services that are not available through network providers.

Full and Fair Disclosure. A Medicare Select issuer makes full and fair disclosure in writing of the provisions, restrictions and limitations of the Medicare Select policy or certificate to each applicant. This disclosure includes at least the following:

a. An outline of coverage sufficient to permit the applicant to compare the coverage and premiums of the Medicare Select policy or certificate with:
   i. Other Medicare supplement policies or certificates offered by the issuer; and
   ii. Other Medicare Select policies or certificates.

b. A description (including address, phone number and hours of operation) of the network providers, including primary care physicians, specialty physicians, hospitals and other providers.

c. A description of the restricted network provisions, including payments for coinsurance and deductibles when providers other than network providers are utilized. Except to the extent specified in the policy or certificate, expenses incurred when using out-of-network providers do not count toward the out-of-pocket annual limit contained in plans K and L.

d. A description of coverage for emergency and urgently needed care and other out-of-service area coverage.
e. A description of limitations on referrals to restricted network providers and to other providers. (7-1-21)T

f. A description of the policyholder’s rights to purchase any other Medicare supplement policy or certificate offered by the issuer. (7-1-21)T

g. A description of the Medicare Select issuer’s quality assurance program and grievance procedure. (7-1-21)T

10. Medicare Select Policy or Certificate. Prior to the sale of a Medicare Select policy or certificate, a Medicare Select issuer obtains from the applicant a signed and dated form stating that the applicant has received the information provided pursuant to Subsection 031.08 and that the applicant understands the restrictions of the Medicare Select policy or certificate. (7-1-21)T

11. Complaints and Grievances. A Medicare Select issuer has and uses procedures for hearing complaints and resolving written grievances from the subscribers. The procedures will be aimed at mutual agreement for settlement and may include arbitration procedures. (7-1-21)T

a. The grievance procedure is described in the policy and certificates and in the outline of coverage. (7-1-21)T

b. At the time the policy or certificate is issued, the issuer provides detailed information to the policyholder describing how a grievance may be registered with the issuer. (7-1-21)T

c. Grievances will be considered in a timely manner and transmitted to appropriate decision makers who have authority to fully investigate the issue and take corrective action. (7-1-21)T

d. If a grievance is found to be valid, corrective action is taken promptly. (7-1-21)T

e. All concerned parties are notified about the results of a grievance. (7-1-21)T

f. The issuer reports no later than each March 31 to the director regarding its grievance procedure in a format prescribed by the director containing the number of grievances filed in the past year and a summary of the subject, nature and resolution of such grievances. (7-1-21)T

11. Initial Purchase. At the time of initial purchase, a Medicare Select issuer makes available to each applicant for a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate offered by the issuer. (7-1-21)T

12. Comparable or Lesser Benefits. (7-1-21)T

a. At the request of an individual insured under a Medicare Select policy or certificate, a Medicare Select issuer makes available to the individual insured the opportunity to purchase a Medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer makes the policies or certificates available without requiring evidence of insurability after the Medicare Select policy or certificate has been in force for six (6) months. (7-1-21)T

b. For the purposes of Subsection 031.12, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one (1) or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this Paragraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for at-home recovery services or coverage for Part B excess charges. (7-1-21)T

12. Continuation of Coverage. Medicare Select policies and certificates provide for continuation of coverage in the event the Secretary determines that Medicare Select policies and certificates issued pursuant to this section should be discontinued due to either the failure of the Medicare Select program to be re-authorized under law.
or its substantial amendment.

a. Each Medicare Select issuer makes available to each individual insured under a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer makes the policies and certificates available without requiring evidence of insurability.

b. For the purposes of Subsection 031.13, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one (1) or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this Paragraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for at-home recovery services or coverage for Part B excess charges.

14. Requests for Data. A Medicare Select issuer complies with reasonable requests for data made by state or federal agencies, including the United States Department of Health and Human Services, for the purpose of evaluating the Medicare Select Program.

0326. -- 035. (RESERVED)

036. OPEN ENROLLMENT.

01. Offer of Coverage. (7-1-21)

a. An issuer cannot deny or condition the issuance or effectiveness of any Medicare supplement policy or certificate available for sale in this state, nor discriminate in the pricing of a policy or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant in the case of an application for a policy or certificate that is submitted prior to or during the six (6) month period beginning with:

i. The first day of the first month in which an individual is both sixty-five (65) years of age or older and is enrolled for benefits under Medicare Part B. (7-1-21)

ii. January 1, 2018 or the first day of the first month of Medicare Part B eligibility due to disability or end stage renal disease, whichever is later, for an individual that is both under sixty-five (65) years of age and enrolled for benefits under Medicare Part B; or (11-3-21)

iii. The first day of the first month after the individual receives written notice of retroactive enrollment under Medicare Part B due to a retroactive eligibility decision made by the Social Security Administration. (7-1-21)

b. Each Medicare supplement policy and certificate currently available from an issuer is made available to all applicants who qualify under Paragraph 036.01.a. without regard to age. (7-1-21)

02. Treatment of Preexisting Conditions. (7-1-21)

a. If an applicant qualifies under Subsection 036.01 and applies during the time period referenced in Subsection 036.01 and, as of the date of application, has had a continuous period of creditable coverage of at least six (6) months, the issuer cannot exclude benefits based on a preexisting condition.

b. If the applicant qualifies under Subsection 036.01 and submits an application during the time period referenced in Subsection 036.01 and, as of the date of application, has had a continuous period of creditable coverage that is less than six (6) months, the issuer reduces the period of any preexisting condition exclusion by the aggregate of the period of creditable coverage applicable to the applicant as of the enrollment date. The Secretary specifies the manner of the reduction under this Subsection.

c. Except as provided in Paragraphs 036.02.a. and 02.b., and Sections 041 and 081, nothing in this chapter prevents the exclusion of benefits under a policy, during the first six (6) months, based on a preexisting condition for which the policyholder or certificateholder received treatment or was diagnosed during the six (6)
Discrimination in Pricing. An issuer cannot discriminate in the pricing of a Medicare supplement policy or certificate issued pursuant to Subsection 036.01, except on the basis of the following criteria:

a. Issue age; and

b. Smoking or tobacco use.

GUARANTEED ISSUE FOR ELIGIBLE PERSONS.

01. Guaranteed Issue.

a. Eligible persons are those individuals described in Subsection 041.02 who seek to enroll under the policy during the period specified in Subsection 041.03. Eligible persons are those individuals described in Subsection 041.03, and who submit evidence of the date of termination or disenrollment or Medicare Part D enrollment with the application for a Medicare supplement policy.

b. With respect to eligible persons, an issuer cannot deny or condition the issuance or effectiveness of a Medicare supplement policy described in Subsection 041.05 that is offered and is available for issuance to new enrollees by the issuer, cannot discriminate in the pricing of such a Medicare supplement policy because of health status, claims experience, receipt of health care, or medical condition, and will not impose an exclusion of benefits based on a preexisting condition under such a Medicare supplement policy.

02. Eligible Persons. An eligible person is an individual described here in any part of Subsection 041.02:

a. The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare; and the plan terminates, or the plan ceases to provide all such supplemental health benefits to the individual; or the individual is enrolled under an employee welfare benefit plan that is primary to Medicare and the plan terminates or the plan ceases to provide all health benefits to the individual because the individual leaves the plan;

b. The individual is enrolled with a Medicare Advantage organization under a Medicare Advantage plan under Part C of Medicare, and any of the following circumstances apply, or the individual is sixty-five (65) years of age or older and is enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provider under Section 1894 of the Social Security Act, and there are circumstances similar to those described below that would permit discontinuance of the individual’s enrollment with such provider if such individual were enrolled in a Medicare Advantage plan:

i. The certification of the organization or plan under this part has been terminated;

ii. The organization has terminated or discontinued providing the plan in the area in which the individual resides;

iii. The individual is no longer eligible to elect the plan because of a change in the individual’s place of residence or other change in circumstances specified by the Secretary, but not including termination of the individual’s enrollment on the basis described in Section 1851(g)(3)(B) of the federal Social Security Act (where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under Section 1856), or the plan is terminated for all individuals within a residence area;

iv. The individual demonstrates, in accordance with guidelines established by the Secretary:

(a) That the organization offering the plan substantially violated a material provision of the organization’s contract under this part in relation to the individual, including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such
covered care in accordance with applicable quality standards; or

(b) The organization, or agent, or other entity acting on the organization’s behalf, materially misrepresented the plan’s provisions in marketing the plan to the individual; or

(c) The individual meets such other exceptional conditions as the Secretary may provide.

c. The individual is enrolled with:

i. An eligible organization under a contract under Section 1876 of the Social Security Act (Medicare cost);

ii. A similar organization operating under demonstration project authority, effective for periods before April 1, 1999;

iii. An organization under an agreement under Section 1833(a)(1)(A) of the Social Security Act (health care prepayment plan); or

iv. An organization under a Medicare Select policy; and

d. The enrollment ceases under the same circumstances that would permit discontinuance of an individual’s election of coverage under Paragraph 041.02.b.

e. The individual is enrolled under a Medicare supplement policy and the enrollment ceases because:

i. Of the insolvency of the issuer or bankruptcy of the non-issuer organization; or

ii. Of other involuntary termination of coverage or enrollment under the policy;

iii. The issuer of the policy substantially violated a material provision of the policy; or

iv. The issuer, or an agent or other entity acting on the issuer’s behalf, materially misrepresented the policy’s provisions in marketing the policy to the individual.

f. The individual was enrolled under a Medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any Medicare Advantage organization under a Medicare Advantage plan under Part C of Medicare, any eligible organization under a contract under Section 1876 of the Social Security Act (Medicare cost), any similar organization operating under demonstration project authority, any PACE provider under Section 1894 of the Social Security Act, or a Medicare Select policy; and

g. The subsequent enrollment under Paragraph 041.02.f. is terminated by the enrollee during any period within the first twelve (12) months of such subsequent enrollment (during which the enrollee is permitted to terminate such subsequent enrollment under Section 1851(e) of the federal Social Security Act); or

h. The individual, upon first becoming eligible for benefits under Part A of Medicare, enrolls in a Medicare Advantage plan under Part C of Medicare, or with a PACE provider under Section 1894 of the Social Security Act, and disenrolls from the plan or program by not later than twelve (12) months after the effective date of enrollment.

i. The individual enrolls in a Medicare Part D plan during the initial enrollment period and at the time of enrollment in Part D, was enrolled under Medicare supplement policy that covers outpatient prescription drugs and the individual terminates enrollment in the Medicare supplement policy and submits evidence of enrollment in Medicare Part D along with the application for a policy described in Paragraph 041.05.e.

j. The individual is enrolled in a Medicare Supplement policy, and, on or after March 1, 2022, voluntarily terminates enrollment and enrolls in another Medicare Supplement policy.
03. **Guaranteed Issue Time Periods.**

a. In the case of an individual described in Paragraph 041.02.a., the guaranteed issue period begins on the later of the date the individual receives a notice of termination or cessation of all supplemental health benefits (or, if a notice is not received, notice that a claim has been denied because of a termination or cessation); or the date that the applicable coverage terminates or ceases; and ends sixty-three (63) days thereafter;

b. In the case of an individual described in Paragraphs 041.02.b., 041.02.c., 041.02.f., or 041.02.h., whose enrollment is terminated involuntarily, the guaranteed issue period begins on the date that the individual receives a notice of termination and ends sixty-three (63) days after the date the applicable coverage is terminated;

c. In the case of an individual described in Paragraph 041.02.e., the guaranteed issue period begins on the earlier of:

i. The date that the individual receives a notice of termination, a notice of the issuer’s bankruptcy or insolvency, or other such similar notice if any; and

ii. The date that the applicable coverage is terminated, and ends on the date that is sixty-three (63) days after the date the coverage is terminated;

d. In the case of an individual described in Paragraph 041.02.b. and Subparagraph 041.02.e.iii., Paragraph 041.02.f., or 041.02.h., who disenrolls voluntarily, the guaranteed issue period begins on the date that is sixty (60) days before the effective date of the disenrollment and ends on the date that is sixty-three (63) days after the effective date; and

e. In the case of an individual described in Paragraph 041.02.i., the guaranteed issue period begins on the date the individual receives notice pursuant to Section 1882(v)(2)(B) of the Social Security Act from the Medicare supplement issuer during the sixty-day (60) period immediately preceding the initial Part D enrollment period and ends on the date that is sixty-three (63) days after the effective date of the individual’s coverage under Medicare Part D; and

f. In the case of an individual described in Subsection 041.02 but not described in the preceding provisions of Subsection 041.03, the guaranteed issue period begins on the effective date of disenrollment and ends on the date that is sixty-three (63) days after the effective date.

g. In the case of an individual described in Paragraph 041.02.j., the guaranteed issue period begins on the individual’s birthday and ends sixty-three (63) days thereafter.

04. **Extended Medigap Access for Interrupted Trial Periods.**

a. In the case of an individual described in Paragraph 041.02.f. (or so described, pursuant to this paragraph) whose enrollment with an organization or provider described in Paragraph 041.02.f. is involuntarily terminated within the first twelve (12) months of enrollment, and who, without an intervening enrollment, enrolls with another such organization or provider, the subsequent enrollment is deemed an initial enrollment described in Paragraph 041.02.f.;

b. In the case of an individual described in Paragraph 041.02.h. (or so described, pursuant to this paragraph) whose enrollment with a plan or in a program described in Paragraph 041.02.h. is involuntarily terminated within the first twelve (12) months of enrollment, and who, without an intervening enrollment, enrolls in another such plan or program, the subsequent enrollment is deemed an initial enrollment described in Paragraph 041.02.h.; and

c. For purposes of Paragraphs 041.02.f. and 041.02.h., no enrollment of an individual with an organization or provider described in Paragraph 041.02.f. or with a plan or in a program described in Paragraph 041.02.h. may be deemed an initial enrollment under this paragraph after the two-year period beginning on the date
on which the individual first enrolled with such an organization, provider, plan or program. (7-1-21)T

05. Products to Which Eligible Persons are Entitled. The Medicare supplement policy to which eligible persons are entitled under:

a. Paragraphs 041.02.a. through 041.02.e. is a Medicare supplement policy which has a benefit package classified as Plan A, B, C, or F (including F with a high deductible), K or L offered by any issuer. (7-1-21)T

b. Subject to Paragraph 041.05.c., Paragraph 041.02.g. is the same Medicare supplement policy in which the individual was most recently previously enrolled, if available from the same issuer, or, if not so available, a policy described in Paragraph 041.05.a. (7-1-21)T

c. After December 31, 2005, if the individual was most recently enrolled in a Medicare supplement policy with an outpatient prescription drug benefit, a Medicare supplement policy described in Subsection 041.05 is:

i. The policy available from the same issuer but modified to remove outpatient prescription drug coverage; or (7-1-21)T

ii. At the election of the policyholder, an A, B, C, F (including F with a high deductible), K or L policy that is offered by any issuer; (7-1-21)T

d. Paragraph 041.02.h. includes any Medicare supplement policy offered by any issuer. (7-1-21)T

e. Paragraph 041.02.i. is a Medicare supplement policy that has a benefit package classified as Plan A, B, C, F (including F with a high deductible), K, or L and that is offered and is available for issuance to new enrollees by the same issuer that issued the individual’s Medicare supplement policy with outpatient prescription drug coverage. (7-1-21)T

f. Paragraph 041.02.j. includes any comparable or lesser Medicare policy offered by any issuer. For the purposes of this paragraph, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one (1) or more significant benefits not included in the Medicare Supplement policy or certificate being replaced. (11-3-21)T

06. Notification Provisions. (7-1-21)T

a. At the time of an event described in Subsection 041.02 because of which an individual loses coverage or benefits due to the termination of a contract or agreement, policy, or plan, the organization that terminates the contract or agreement, the issuer terminating the policy, or the administrator of the plan being terminated, respectively, notifies the individual of the individual’s rights under this Section, and of the obligations of issuers of Medicare supplement policies under Subsection 041.01. Such notice is communicated contemporaneously with the notification of termination. (7-1-21)T

b. At the time of an event described in Subsection 041.02 because of which an individual ceases enrollment under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment, the issuer offering the policy, or the administrator of the plan, respectively, notifies the individual of the individual’s rights under this section, and of the obligations of issuers of Medicare supplement policies under Subsection 041.01. Such notice is communicated within ten (10) working days of the issuer receiving notification of disenrollment. (7-1-21)T

07. Discrimination in Pricing. With respect to eligible persons, an issuer cannot discriminate in the pricing of a Medicare supplement policy or certificate issued pursuant to Subsection 041.01, except on the basis of the following criteria:

a. Issue age; and (7-1-21)T

b. Smoking or tobacco use. (7-1-21)T
042. -- 045. (RESERVED)

046. STANDARDS FOR CLAIMS PAYMENT.

01. Compliance. An issuer will comply with Section 1882(c)(3) of the Social Security Act (as enacted by Section 4081(b)(2)(C) of the Omnibus Budget Reconciliation Act of 1987 (OBRA) 1987, Pub. L. No. 100-203) by:

a. Accepting a notice from a Medicare carrier on dually assigned claims submitted by participating physicians and suppliers as a claim for benefits in place of any other claim form needed and making a payment determination on the basis of the information contained in that notice;

b. Notifying the participating physician or supplier and the beneficiary of the payment determination;

c. Paying the participating physician or supplier directly;

d. Furnishing, at the time of enrollment, each enrollee with a card listing the policy name, number and a central mailing address to which notices from a Medicare carrier may be sent;

e. Paying user fees for claim notices; and

f. Providing to the Secretary, at least annually, a central mailing address to which all claims may be sent by Medicare carriers.

02. Certification. Compliance with the requirements set forth in Subsection 046.01 is certified on the Medicare supplement insurance experience reporting form.

047. -- 050. (RESERVED)

051. LOSS RATIO STANDARDS AND REFUND OR CREDIT OF PREMIUM.

01. Loss Ratio Standards.

a. A Medicare supplement policy form or certificate form will not be delivered or issued for delivery unless the policy form or certificate form can be expected, as estimated for the entire period for which rates are computed to provide coverage, to return to policyholders and certificateholders in the form of aggregate benefits (not including anticipated refunds or credits) provided under the policy form or certificate form.

i. At least seventy-five percent (75%) of the aggregate amount of premiums earned in the case of group policies; or

ii. At least sixty-five percent (65%) of the aggregate amount of premiums earned in the case of individual policies;

b. Calculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a managed care organization on a service rather than reimbursement basis and earned premiums for the period and in accordance with accepted actuarial principles and practices. Incurred health care expenses where coverage is provided by a managed care organization will not include:

i. Home office and overhead costs;

ii. Advertising costs;

iii. Commissions and other acquisition costs;
iv. Taxes; (7-1-21)T
v. Capital costs; (7-1-21)T
vi. Administrative costs; and (7-1-21)T
vii. Claims processing costs. (7-1-21)T

c. All filings of rates and rating schedules demonstrate that expected claims in relation to premiums comply with the requirements of this section when combined with actual experience to date. Filings of rate revisions also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards. Demonstrations, at a minimum, account for:

i. Lapse rates; (7-1-21)T
ii. Medical trend and rationale for trend; (7-1-21)T
iii. Assumptions regarding future premium rate revisions; and (7-1-21)T
iv. Interest rates for discounting and accumulating. (7-1-21)T

d. For purposes of applying Paragraphs 051.01.a. and 056.05.b., only, policies issued as a result of solicitations of individuals through the mails or by mass media advertising (including both print and broadcast advertising) are individual policies. (7-1-21)T

02. Refund or Credit Calculation

a. An issuer collects and files with the director by May 31 of each year the data contained in the applicable reporting form as defined by NAIC Model Regulation (Attachments) and accessible on the Department website for each type in a standard Medicare supplement benefit plan. (7-1-21)T

b. If on the basis of the experience as reported the benchmark ratio since inception (ratio one (1)) exceeds the adjusted experience ratio since inception (ratio three (3)), then a refund or credit calculation is needed. The refund calculation is done on a statewide basis for each type in a standard Medicare supplement benefit plan. For purposes of the refund or credit calculation, experience on policies issued within the reporting year is excluded. (7-1-21)T

c. For policies or certificates issued prior to July 1, 1992, the issuer makes the refund or credit calculation separately for all individual policies (including all group policies subject to an individual loss ratio standard when issued) combined and all other group policies combined for experience after July 1, 1992. (7-1-21)T

d. A refund or credit is made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credit exceeds a de minimis level. The refund includes interest from the end of the calendar year to the date of the refund or credit at a rate specified by the Secretary, but in no event less than the average rate of interest for thirteen (13) week Treasury notes. A refund or credit against premiums due is made by September 30 following the experience year upon which the refund or credit is based. (7-1-21)T

03. Annual Filing of Premium Rates. An issuer of Medicare supplement policies and certificates in this state annually files its rates, rating schedule, and supporting documentation including ratios of incurred losses to earned premiums by policy duration for approval by the director in accordance with the filing requirements and procedures prescribed by the director. The supporting documentation demonstrates in accordance with actuarial standards of practice using reasonable assumptions that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. The demonstration excludes active life reserves. An expected third-year loss ratio which is greater than or equal to the applicable percentage is demonstrated for policies or certificates in force less than three (3) years. As soon as practicable, but prior to the effective date of enhancements in Medicare benefits, every issuer of Medicare supplement policies or certificates in this state files with the director, in
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accordance with the applicable filing procedures of this state: (7-1-21)T

a. Appropriate premium adjustments necessary to produce loss ratios as anticipated for the current premium for the applicable policies or certificates. The supporting documents accompanying the filing need to justify the adjustment. (7-1-21)T

i. An issuer’s adjustments need to produce an expected loss ratio under the policy or certificate that conforms to minimum loss ratio standards for Medicare supplement policies and which are expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current premiums by the issuer for the Medicare supplement policies or certificates. No premium adjustment which would modify the loss ratio experience under the policy other than the adjustments described herein is made with respect to a policy at any time other than upon its renewal date or anniversary date. (7-1-21)T

ii. If an issuer fails to make premium adjustments acceptable to the director, the director may order premium adjustments, refunds, or premium credits deemed necessary to achieve the loss ratio prescribed by Section 051. (7-1-21)T

b. Any appropriate riders, endorsements, or policy forms needed to accomplish the Medicare supplement policy or certificate modifications necessary to eliminate benefit duplications with Medicare. The riders, endorsements, or policy forms provides a clear description of the Medicare supplement benefits provided by the policy or certificate. (7-1-21)T

04. Public Hearings. The director may conduct a public hearing to gather information concerning a request by an issuer for an increase in a rate for a policy form or certificate form issued before or after the effective date of July 1, 1992 if the experience of the form for the previous reporting period is not in compliance with the applicable loss ratio standard. The determination of compliance is made without consideration of any refund or credit for the reporting period. Public notice of the hearing is furnished in a manner deemed appropriate by the director. (7-1-21)T

052. -- 055. (RESERVED)

056. FILING AND APPROVAL OF POLICIES AND CERTIFICATES AND PREMIUM RATES.

01. Filing of Policy Forms. (7-1-21)T

a. An issuer cannot deliver or issue for delivery a policy or certificate to a resident of this state unless the policy form or certificate form has been filed with and approved by the director in accordance with filing requirements and procedures prescribed by the director. (7-1-21)T

b. An issuer would file any riders or amendments to policy or certificate forms to delete outpatient prescription drug benefits as prescribed by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 only with the director in the state in which the policy or certificate was issued. (7-1-21)T

02. Filing of Premium Rates. (7-1-21)T

a. An issuer cannot use or change premium rates for a Medicare supplement policy or certificate unless the rates, rating schedule, and supporting documentation have been filed with and approved by the director in accordance with the filing requirements and procedures prescribed by the director. (7-1-21)T

b. Except as provided in Subsection 051.03, the insured cannot receive more than one (1) rate increase in any twelve (12) month period. (7-1-21)T

03. Except as provided in Paragraph 056.03.a., an issuer will not file for approval more than one (1) form of a policy or certificate of each type for each standard Medicare supplement benefit plan. (7-1-21)T

a. An issuer may offer, with the approval of the director, up to three (3) additional policy forms or certificate forms of the same type for the same standard Medicare supplement benefit plan, one (1) or each of the...
following cases:

i. The inclusion of new or innovative benefits;

ii. The addition of either direct response or agent marketing methods;

iii. The addition of either guaranteed issue or underwritten coverage;

b. For the purposes of Section 056, “type” means an individual policy, a group policy, an individual Medicare Select policy, or a group Medicare Select policy.

04. Availability of Policy Form or Certificate. Except as provided in Paragraph 056.04.a., an issuer continuously makes available for purchase any policy form or certificate form. A policy form or certificate form would not be considered available for purchase unless the issuer has actively offered it for sale continuously during the previous twelve (12) months.

a. An issuer may discontinue the availability of a policy form or certificate form if the issuer provides to the director in writing its decision at least thirty (30) days prior to discontinuing the availability of the form of the policy or certificate. After receipt of this notice by the director, the issuer no longer offers for sale the policy form or certificate form in this state.

b. An issuer that discontinues the availability of a policy form or certificate form pursuant to Paragraph 056.04.a. will not file for approval a new policy form or certificate form of the same type for the same standard Medicare supplement benefit plan as the discontinued form for a period of five (5) years after the issuer provides notice to the director of the discontinuance. The period of discontinuance may be reduced if the director determines that a shorter period is appropriate.

c. The sale or other transfer of Medicare supplement business to another issuer is considered a discontinuance for the purposes of Subsection 056.04.

d. A change in the rating structure or methodology is considered a discontinuance under this Subsection 056.04 unless the issuer complies with the following requirements:

i. The issuer provides an actuarial memorandum, in a form and manner prescribed by the director, describing the manner in which the revised rating methodology and resultant rates differ from the existing rating methodology and existing rates.

ii. The issuer does not subsequently put into effect a change of rates or rating factors that would cause the percentage differential between the discontinued and subsequent rates as described in the actuarial memorandum to change. The director may approve a change to the differential which is in the public interest.

05. Experience of Policy Forms.

a. Except as provided in Paragraph 056.05.b., the experience of all policy forms or certificate forms of the same type in a standard Medicare supplement benefit plan is combined for purposes of the refund or credit calculation prescribed in Section 051.

b. Forms assumed under an assumption reinsurance agreement are not combined with the experience of other forms for purposes of the refund or credit calculation.

c. The experience of all policy forms or certificate forms for standardized Medicare supplement benefit plans of the same type is combined for purposes of the rate change filing. Generally, any applicable percentage increase is filed and applied uniformly across all standardized plans within the same type, unless doing so would violate the federal lifetime loss ratio standards for specific forms within the same type.

06. Attained Age Rating. With respect to Medicare supplement policies that conform to the Standard Benefit Plans under IDAPA 18.04.10, this chapter:
a. It is an unfair practice and an unfair method of competition for any issuer, insurer, or licensee to use the increasing age of an insured, subscriber or participant as the basis for increasing premiums or prepayment charges for policyholders who initially purchase a policy after January 1, 1995. This chapter explicitly authorizes both issue age ratings and community ratings consistent with the prohibition of attained age ratings and allows companies to resubmit for approval issue age ratings previously rejected. For issue-age rated policies:

i. For an individual who is sixty-five (65) years of age or older, the filed rate for any given age will not exceed the rate for any higher issue-age, similarly rated individual; and

ii. For an individual who is under sixty-five (65) years of age, the premium is no greater than one hundred fifty percent (150%) of the premium for an issue-age sixty-five (65) similarly rated individual, while the individual’s attained age is less than sixty-five (65). Upon attaining age sixty-five (65), a policyholder with an issue-age less than sixty-five (65) is charged the same premium rate as an issue-age sixty-five (65), similarly rated individual.

b. For policies issued after February 28, 2022, it is an unfair practice and an unfair method of competition for any issuer, insurer, or licensee to use the increasing age or issue age of an insured, subscriber or participant as a basis for premiums. For such community-rated policies:

i. For an individual who is eligible for Medicare Part B only due to disability or end stage renal disease, the premium is no greater than one hundred fifty percent (150%) of the premium for an enrollee otherwise eligible for Medicare Part B; and

ii. Upon attaining Medicare Part B eligibility due to age, a policyholder who was previously eligible for Medicare Part B only due to disability or end stage renal disease is to be charged the same premium rate as an individual eligible for Medicare Part B due to age.

07. Rating by Area and Gender. With respect to Medicare supplement policies that conform to the Standard Benefit Plans under this chapter, it is an unfair practice and an unfair method of competition for any issuer, insurer, or licensee to use area or gender for rating purpose.

08. Other Rating Requirements. With respect to Medicare supplement policies that conform to the Standard Benefit Plans under this chapter, sold to residents of this State on or after January 1, 2018:

a. Any rate adjustments are uniform between 1990 Standardized and later Standardized plans throughout the lifetime of the policies, unless doing so would violate the federal lifetime loss ratio standards for specific forms within the same type.

b. The rating by the issuer does not differentiate on the basis of the reason for eligibility for Medicare Part B, except for an individual, at any given age, described at Subparagraph 056.06.c.i.

c. No discount or underwriting factor of less than 1.0 will be available to policies issued outside of open enrollment, per Section 036, or guaranteed issue, per Section 041, unless the greatest discount or lowest underwriting factor is automatically applied to all policies issued under open enrollment and guaranteed issue.

d. For issue-ages sixty-five (65) and greater, the filed rate for any given age will not exceed the rate for any higher issue-age, similarly rated individual.
charged the same premium rate as an issue-age sixty-five (65), similarly rated individual. (7-1-21)T

c. For any given age, the rating by the issuer does not differentiate on the basis of the reason for eligibility for Medicare Part B. (7-1-21)T

b. For policies issued after February 28, 2022, it is an unfair practice and an unfair method of competition for any issuer to require application or policy fees or to vary premium rates based on payment terms including, without limitation, payment method or frequency of payment. (11-3-21)T

c. Nothing in this Subsection is construed to limit the ability of an issuer of a Medicare supplement policy or certificate to apply a discount or underwriting factor for:

i. Multiple Medicare Supplement policies issued to individuals residing within the same household. (11-3-21)T

or:

ii. Non-smoking or non-tobacco use. (11-3-21)T

057. -- 060. (RESERVED)

061. PERMITTED COMPENSATION ARRANGEMENTS.

01. Commissions. An issuer or other entity may provide commission or other compensation to an agent or other representative for the sale of a Medicare supplement policy or certificate only if the first-year commission or other first-year compensation is no more than two hundred percent (200%) of the commission or other compensation paid for selling or servicing the policy or certificate in the second year or period. An issuer or other entity will not vary commission or otherwise pay commission differentials based upon variables such as age, guarantee issue status, or on any other basis. (7-1-21)T

02. Compensation in Subsequent Years. The commission or other compensation provided in subsequent renewal years needs to be the same as that provided in the second year or period and be provided for no fewer than five (5) renewal years. (7-1-21)T

03. Renewal Compensation. No issuer or other entity provides compensation to its agent or other producers and no agent or producer receives compensation greater than the renewal compensation payable by the replacing issuer on renewal policies or certificates if an existing policy or certificate is replaced. (7-1-21)T

04. Compensation. For purposes of Section 061, compensation includes pecuniary or non-pecuniary remuneration of any kind relating to the sale or renewal of the policy or certificate, including but not limited to bonuses, gifts, prizes, awards, and finder’s fees. (7-1-21)T

062. -- 065. (RESERVED)

066. DISCLOSURE PROVISIONS.

01. General Rules.

a. Medicare supplement policies and certificates includes a renewal or continuation provision. The language or specifications of the provision is consistent with the type of contract issued. The provision is appropriately captioned and appears on the first page of the policy, and includes any reservation by the issuer of the right to change premiums. (7-1-21)T

b. Except for riders or endorsements by which the issuer effectuates a request made in writing by the insured, exercises a specifically reserved right under a Medicare supplement policy, or is needed to reduce or eliminate benefits to avoid duplication of Medicare benefits, all riders or endorsements added to a Medicare supplement policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy requires a signed acceptance by the insured. After the date of policy or certificate issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term is
agreed to in writing and signed by the insured, unless the benefits are prescribed by the minimum standards for Medicare supplement policies, or if the increased benefits or coverage is prescribed by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge is set forth in the policy. (7-1-21)

c. Medicare supplement policies or certificates do not provide for the payment of benefits based on standards described as “usual and customary,” “reasonable and customary,” or words of similar import. (7-1-21)

d. If a Medicare supplement policy or certificate contains any limitations with respect to preexisting conditions, such limitations appear as a separate paragraph of the policy and be labeled as “Preexisting Condition Limitations.” (7-1-21)

e. Medicare supplement policies and certificates have a notice prominently printed on the first page of the policy or certificate or attached thereto, stating in substance that the policyholder or certificateholder has the right to return the policy or certificate within thirty (30) days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the insured person is not satisfied for any reason. (7-1-21)

f. Issuers of accident and sickness policies or certificates that provide hospital or medical expense coverage on an expense incurred or indemnity basis to persons eligible for Medicare provide to those applicants a “Guide to Health Insurance for People with Medicare” in the form developed jointly by the National Association of Insurance Commissions and the Centers for Medicare & Medicaid Services and in a type size no smaller than twelve (12) point type. Delivery of the Guide is made whether or not the policies or certificates are advertised, solicited or issued as Medicare supplement policies or certificates. Except in the case of direct response issuers, delivery of the Guide will be made to the applicant at the time of application and acknowledgment of receipt of the Guide is obtained by the issuer. Direct response issuers deliver the Guide to the applicant upon request but not later than at the time the policy is delivered. (7-1-21)

g. For the purposes of Section 066, “form” means the language, format, type size, type proportional spacing, bold character, and line spacing. (7-1-21)

02. Notice Requirements. (7-1-21)

a. As soon as practicable, but no later than thirty (30) days prior to the annual effective date of any Medicare benefit changes, an issuer notifies its policyholders and certificateholders of modifications it has made to Medicare supplement insurance policies or certificates in a format acceptable to the director. The notice will:

i. Include a description of revisions to the Medicare program and a description of each modification made to the coverage provided under the Medicare supplement policy or certificate, and (7-1-21)

ii. Inform each policyholder or certificateholder as to when any premium adjustment is to be made due to changes in Medicare. (7-1-21)

b. The notice of benefit modifications and any premium adjustments is in outline form and in clear and simple terms so as to facilitate comprehension. (7-1-21)

c. The notices cannot contain or be accompanied by any solicitation. (7-1-21)


04. Outline of Coverage Requirements for Medicare Supplement Policies. (7-1-21)

a. Issuers provide an outline of coverage to all applicants at the time application is presented to the prospective applicant and, except for direct response policies, obtain an acknowledgment of receipt of the outline from the applicant; and (7-1-21)
b. If an outline of coverage is provided at the time of application and the Medicare supplement policy or certificate is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate accompanies the policy or certificate when it is delivered and contains the following statement, in no less than twelve (12) point type, immediately above the company name:

“NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued.”

(7-1-21)

c. The outline of coverage provided to applicants pursuant to this section consists of four (4) parts: a cover page, premium information, disclosure pages, and charts displaying the features of each benefit plan offered by the issuer. The outline of coverage is in the language and format prescribed below in no less than twelve (12) point type. All plans are shown on the cover page, and the plans that are offered by the issuer are prominently identified. Premium information for plans that are offered are shown on the cover page or immediately following the cover page and is prominently displayed. The premium and mode is stated for all plans that are offered to the prospective applicant. All possible premiums for the prospective applicant are illustrated.

(7-1-21)

05. Notice Regarding Policies or Certificates Which Are Not Medicare Supplement Policies.

(7-1-21)

a. Any accident and sickness insurance policy or certificate other than Medicare supplement policy and policy issued pursuant to a contract under Section 1876 of the Federal Social Security Act (42 U.S.C. Section 1395 et seq.), disability income policy; or other policy identified in Paragraph 001.02.b., issued for delivery in this state to persons eligible for Medicare notifies insureds under the policy that the policy is not a Medicare supplement policy or certificate. The notice is either printed or attached to the first page of the outline of coverage delivered to insureds under the policy, or if no outline of coverage is delivered, to the first page of the policy, or certificate delivered to insureds. The notice is no less than twelve (12) point type and contains the following language:

“THIS [POLICY OR CERTIFICATE] IS NOT A MEDICARE SUPPLEMENT [POLICY OR CONTRACT]. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company.”

(7-1-21)

b. Applications provided to persons eligible for Medicare for the health insurance policies or certificates described in Paragraph 066.04.a. disclose, using the applicable NAIC Model Regulation as incorporated by reference in Section 002 and referenced as Appendix C. The disclosure statement is provided as a part of, or together with, the application for the policy or certificate. (7-1-21)

067. -- 070. (RESERVED)

071. REQUIREMENTS FOR APPLICATION FORMS AND REPLACEMENT COVERAGE.

01. Application Forms. Application forms include the following questions designed to elicit information as to whether, as of the date of the application, the applicant currently has another Medicare supplement, Medicare Advantage, Medicaid coverage, or another health insurance policy or certificate in force or whether a Medicare supplement policy or certificate is intended to replace any other accident and sickness policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and agent containing such questions and statements may be used.

(7-1-21)

02. Statements.

a. You do not need more than one (1) Medicare supplement policy.

(7-1-21)

b. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

(7-1-21)

c. You may be eligible for benefits under Medicaid and not need a Medicare supplement policy.

(7-1-21)

d. If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under
your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for twenty-four (24) months. You need to request this suspension within ninety (90) days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is not longer available, a substantially equivalent policy) will be reinstated if requested within ninety (90) days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

(e) If you are eligible for and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within ninety (90) days of losing your employer or union-based health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

(f) Counseling services are available through the Senior Health Insurance Benefit Advisors program (SHIBA), to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

03. Agents. Agents will list any other health insurance policies they have sold to the applicant.

(a) List policies sold which are still in force.

(b) List policies sold in the past five (5) years which are no longer in force.

04. Direct Response Issuer. In the case of a direct response issuer, a copy of the application or supplemental form, signed by the applicant, and acknowledged by the insurer, is returned to the applicant by the insurer upon delivery of the policy.

05. Notice Regarding Replacement of Medicare Supplement Coverage. Upon determining that a sale will involve replacement of Medicare supplement coverage, any issuer, other than a direct response issuer, or its agent, furnishes the applicant, prior to issuance or delivery of the Medicare supplement policy or certificate, a notice regarding replacement of Medicare supplement coverage. One (1) copy of the notice signed by the applicant and the agent, except where the coverage is sold without an agent, is provided to the applicant and an additional signed copy is retained by the issuer. A direct response issuer delivers to the applicant at the time of the issuance of the policy the notice regarding replacement of Medicare supplement coverage.

06. SHIBA and Consumer Assistance Link. The notice prescribed in Subsection 071.05 for an issuer is provided in the NAIC Model Regulation as incorporated by reference in Section 002 of this rule, which includes NAIC Appendices A, B, and C and all other outlines of coverage and specific plan designs which can be accessed on the Idaho Department of Insurance website. To obtain a copy of the NAIC Model Regulation, contact SHIBA at the Idaho Department of Insurance.

072. FILING REQUIREMENTS FOR ADVERTISING. An issuer provides a copy of any Medicare supplement advertisement intended for use in this state whether through written, radio, or television medium to the director for review or approval by the director.

073. STANDARDS FOR MARKETING.

01. Issuer. An issuer, directly or through its producers:
a. Establishes marketing procedures to assure that any comparison of policies by its agents or other producers will be fair and accurate. (7-1-21)T

b. Establishes marketing procedures to assure excessive insurance is not sold or issued. (7-1-21)T

c. Displays prominently by type, stamp, or other appropriate means, on the first page of the policy the following: “Notice to buyer: This policy may not cover all of your medical expenses.” (7-1-21)T

d. Inquires and makes every reasonable effort to identify whether a prospective applicant or enrollee for Medicare supplement insurance already has accident and sickness insurance and the types and amounts of any such insurance. (7-1-21)T

e. Establishes auditable procedures for verifying compliance with this Subsection 073.01. (7-1-21)T

02. Banned Acts and Practices. In addition to the practices banned in Title 41, Chapter 13, Idaho Code, the following acts and practices are banned:

a. Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert an insurance policy or to take out a policy of insurance with another insurer. (7-1-21)T

b. High pressure tactics. Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance. (7-1-21)T

c. Cold lead advertising. Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company. (7-1-21)T

03. Banned Terms. The terms “Medicare supplement,” “Medigap,” “Medicare wrap-around,” and words of similar import cannot be used unless the policy is issued in compliance with this chapter. (7-1-21)T

074. -- 075. (RESERVED)

076. APPROPRIATENESS OF RECOMMENDED PURCHASE AND EXCESSIVE INSURANCE. In recommending the purchase or replacement of any Medicare supplement policy or certificate, an agent makes reasonable efforts to determine the appropriateness of a recommended purchase or replacement. Any sale of Medicare supplement policy or certificate that will provide an individual more than one Medicare supplement policy or certificate is banned. An issuer cannot issue a Medicare supplement policy or certificate to an individual enrolled in Medicare Part C unless the effective date of the coverage is after the termination date of the individual’s Part C coverage. (7-1-21)T

077. REPORTING OF MULTIPLE POLICIES.

01. Reporting. On or before March 1 of each year, an issuer reports the following information for every individual resident of this state for which the issuer has in force more than one (1) Medicare supplement policy or certificate:

a. Policy and certificate number, and (7-1-21)T

b. Date of issuance. (7-1-21)T

02. Grouping by Individual Policyholder. The items set forth above need to be grouped by individual policyholder. (7-1-21)T
081. PROHIBITION AGAINST PREEXISTING CONDITIONS, WAITING PERIODS, ELIMINATION PERIODS AND PROBATIONARY PERIODS IN REPLACEMENT POLICIES OR CERTIFICATES.

01. Waiving of Time Periods. If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate, the replacing issuer waives any time periods applicable to preexisting conditions, waiting periods, elimination periods and probationary periods in the new Medicare supplement policy or certificate for similar benefits to the extent such time was spent under the original policy. (7-1-21)T

02. Replacing Policy. If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate which has been in effect for at least six (6) months, the replacing policy does not provide any time period applicable to preexisting conditions, waiting periods, elimination periods, and probationary periods for benefits similar to those contained in the original policy or certificate. (7-1-21)T

082. PROHIBITION AGAINST USE OF GENETIC INFORMATION AND REQUESTS FOR GENETIC TESTING.

This section applies to all policies with policy years beginning on or after May 21, 2009. (7-1-21)T

01. Banned Provisions. An issuer of a Medicare supplement policy or certificate: (7-1-21)T

a. Does not deny or condition the issuance of effectiveness of the policy or certificate (including the imposition of any exclusion of benefits under the policy based on a preexisting condition) on the basis of the genetic information with respect to such individual; and (7-1-21)T

b. Does not discriminate in the pricing of the policy or certificate (including the adjustment of premium rates) of an individual on the basis of the genetic information with respect to such individual. (7-1-21)T

02. Denial of Coverage. Nothing in Subsection 082.01 is construed to limit the ability of an issuer, to the extent otherwise permitted by law, from: (7-1-21)T

a. Denying or conditioning the issuance or effectiveness of the policy or certificate or increasing the premium for a group based on the manifestation of a disease or disorder of an insured or applicant; or (7-1-21)T

b. Increasing the premium for any policy issued to an individual based on the manifestation of a disease or disorder of an individual who is covered under the policy (in such case, the manifestation of a disease or disorder in one individual will not also be used as genetic information about other group members and to further increase the premium for the group). (7-1-21)T

03. Genetic Testing. An issuer of a Medicare supplement policy or certificate cannot request or require an individual or a family member of such individual to undergo a genetic test. (7-1-21)T

04. Payment. Subsection 082.03 does not preclude an issuer of a Medicare supplement policy or certificate from obtaining and using the results of a genetic test in making a determination regarding payment (as defined for the purposes of applying the regulations promulgated under part C of title XI and Section 264 of the Health Insurance Portability and Accountability Act of 1996, as may be revised from time to time) and consistent with Subsection 082.01. (7-1-21)T

05. Information. For purposes of carrying out Subsection 082.04, an issuer of a Medicare supplement policy or certificate may request only the minimum amount of information necessary to accomplish the intended purpose. (7-1-21)T

06. Allowed Genetic Testing. Notwithstanding Subsection 082.03, an issuer of a Medicare supplement policy may request, but not require, that an individual or a family member of such individual undergo a genetic test if each of the following conditions is met: (7-1-21)T

a. The request is made pursuant to research that complies with part 46 of title 45, Code of Federal
Regulations, or equivalent Federal regulations, and any applicable State or local law or rules for the protection of human subjects in research.

b. The issuer clearly indicates to each individual, or in the case of a minor child, to the legal guardian of such child, to whom the request is made that:

i. Compliance with the request is voluntary; and

ii. Non-compliance will have no effect on enrollment status or premium or contribution amounts.

c. No genetic information collected or acquired under Subsection 082.06 is used for underwriting, determination of eligibility to enroll or maintain enrollment status, premium rates, or the issuance, renewal, or replacement of a policy or certificate.

d. The issuer notifies the Secretary in writing that the issuer is conducting activities pursuant to the exception provided for under Subsection 082.06, including a description of the activities conducted.

e. The issuer complies with such other conditions as the Secretary may by regulation require for activities conducted under Subsection 082.06.

f. An issuer of a Medicare supplement policy or certificate cannot request, require, or purchase genetic information for underwriting purposes.

g. An issuer of a Medicare supplement policy or certificate cannot request, require or purchase genetic information with respect to any individual prior to such individual’s enrollment under the policy in connection with such enrollment.

h. If an issuer of Medicare supplement policy or certificate obtains genetic information incidental to the requesting, requiring, or purchasing of other information concerning an individual, such request, requirement, or purchase is not considered a violation of Paragraph 082.06.g. if such request, requirement, or purchase is not in violation of Paragraph 082.06.f.

07. Definitions. For the purposes of this section only:

a. “Issuer of a Medicare supplement policy or certificate” includes third-party administrator, or other person acting for or on behalf of such issuer.

b. “Family member” means, with respect to an individual, any other individual who is a first-degree, second-degree, third-degree, or fourth-degree relative of such individual.

c. “Genetic information” means, with respect to any individual, information about such individual’s genetic tests, the genetic tests of family members of such individual, and the manifestation of a disease or disorder in family members of such individual. Such term includes, with respect to any individual, any request for, or receipt of, genetic services, or participation in clinical research which includes genetic services, by such individual or any family member of such individual. Any reference to genetic information concerning an individual or family member of an individual who is a pregnant woman, includes genetic information of any fetus carried by such pregnant woman, or with respect to an individual or family member utilizing reproductive technology, includes genetic information of any embryo legally held by an individual or family member. The term “genetic information” does not include information about the sex or age of any individual.

d. “Genetic services” means a genetic test, genetic counseling (including obtaining, interpreting, or assessing genetic information), or genetic education.

e. “Genetic test” means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, that detect genotypes, mutations, or chromosomal changes. The term “genetic test” does not mean an analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes; or an analysis of proteins...
or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved.

f. “Underwriting purposes” means:

i. Rules for, or determination of, eligibility (including enrollment and continued eligibility) for benefits under the policy;

ii. The computation of premium or contribution amounts under the policy;

iii. The application of any preexisting condition exclusion under the policy; and

iv. Other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits.

083. -- 999. (RESERVED)
EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2022 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved or rejected in part by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved or rejected in part 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 Sections 41-211 and 41-2314, 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 purpose of this rule is to protect the interest of debtors and Idaho residents by providing a system of rate, policy form, and operating standards for the transaction of credit life and credit disability insurance. This rulemaking clarifies language, removes duplicative language, and moves information to the Department's website.

There are no changes to the pending rule and it is being adopted as originally proposed. The complete text of the proposed rule was published in the September 1, 2021, Idaho Administrative Bulletin, Vol. 21-9, pages 17-23.

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

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Weston Trexler, (208) 334-4214, weston.trexler@doi.idaho.gov.

DATED this October 5, 2021.

Dean L. Cameron, Director
Idaho Department of Insurance
700 W. State Street, 3rd Floor
P.O. Box 83720
Boise, ID 83720-0043
Phone: (208) 334-4250
Fax: (208) 334-4398
**EFFECTIVE DATE:** This rule has been adopted by the agency and is now pending review by the 2022 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved or rejected in part by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved or rejected in part by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

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

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

This rule sets forth uniform requirements for providing coverage to newborn and newly adopted children in accordance with Sections 41-2140, 41-2210, 41-3437, 41-3923, 41-4023, and 41-4123, Idaho Code. This rulemaking clarifies language and incorporates the provisions of Rule No. 18.04.09 - Complications of Pregnancy.

There are no changes to the pending rule and it is being adopted as originally proposed. The complete text of the proposed rule was published in the September 1, 2021, Idaho Administrative Bulletin, Vol. 21-9, pages 28-29.

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

**ASSISTANCE ON TECHNICAL QUESTIONS:** For assistance on technical questions concerning this pending rule, contact Weston Trexler, (208) 334-4214, weston.trexler@doi.idaho.gov.

DATED this October 5, 2021.

Dean L. Cameron, Director
Idaho Department of Insurance
700 W. State Street, 3rd Floor
P.O. Box 83720
Boise, ID 83720-0043
Phone: (208) 334-4250
Fax: (208) 334-4398
IDAPA 18 – DEPARTMENT OF INSURANCE
18.04.07 – RESTRICTIONS ON DISCRETIONARY CLAUSES IN HEALTH INSURANCE CONTRACTS
DOCKET NO. 18-0407-2101 (NEW CHAPTER)
NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2022 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved or rejected in part by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved or rejected in part 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 Sections 41-211, 41-1302, and 41-1842, Idaho Code.

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

This rule sets forth uniform requirements regarding the use of discretionary clauses to be followed by health carriers transacting insurance in Idaho. This chapter does not apply to a health insurance contract for group coverage offered by or through an employer to its employees. Title 41 Chapters 13 and 18 regulate trade practices and the insurance contract, respectively.

There are no changes to the pending rule and it is being adopted as originally proposed. The complete text of the proposed rule was published in the September 1, 2021, Idaho Administrative Bulletin, Vol. 21-9, pages 31-31.

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

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Weston Trexler, (208) 334-4214, weston.trexler@doi.idaho.gov.

DATED this October 5, 2021.

Dean L. Cameron, Director
Idaho Department of Insurance
700 W. State Street, 3rd Floor
P.O. Box 83720
Boise, ID 83720-0043
Phone: (208) 334-4250
Fax: (208) 334-4398
EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2022 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved or rejected in part by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved or rejected in part 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 Sections 41-211, 41-1025, and 41-5820, Idaho Code.

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

This rule prescribes 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.

There are no changes to the pending rule and it is being adopted as originally proposed. The complete text of the proposed rule was published in the September 1, 2021, Idaho Administrative Bulletin, Vol. 21-9, pages 61-66.

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

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Weston Trexler, (208) 334-4214, weston.trexler@doi.idaho.gov.

DATED this October 5, 2021.

Dean L. Cameron, Director
Idaho Department of Insurance
700 W. State Street, 3rd Floor
P.O. Box 83720
Boise, ID 83720-0043
Phone: (208) 334-4250
Fax: (208) 334-4398
AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 40-312 and 67-5229, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearings concerning this rulemaking will be held as follows:

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tuesday, November 16, 2021</td>
<td>3:00 p.m. to 5:00 p.m. (MT)</td>
<td>Participation in-person is available at the following location: ITD Headquarters: East Annex (Southeast area of the ITD Headquarters campus) 3293 West Jordan St. Boise, ID 83703 Participation via phone or Webex is also available: Join Online Webex Meeting Meeting Number (Access Code): 2459 562 6772 Meeting Password: 1234 Join by phone at: 1-844-740-1264 (USA Toll Free)</td>
</tr>
</tbody>
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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:

As the Idaho Transportation Department (ITD) continues its efforts to address utility accommodation for those seeking access to the state’s right-of-way (ROW), ITD is proposing rule changes to address the permitting process for small wireless facilities. The proposed changes bring clarity to the Department’s accommodation of these utilities in the state’s ROW.

ITD incorporates by reference the July 2003 Edition of the Utility Accommodation Policy (UAP) in IDAPA 39.03.43 Rules Governing Utilities on State Highway Right-of-Way. Some proposed changes in this rule occur within the incorporated document.

Although the UAP referenced in IDAPA 39.03.43 addresses all utilities, the focus of this rulemaking is to update portions that directly relate to small wireless facility permitting and accommodation; criteria, standards and policy.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased:
The new fees being added to this chapter relate to the installation and location of small wireless facilities in the state’s ROW. The assessed fees are in accordance with the Federal Communications Commission’s Declaratory Ruling and Third Report and Order, WT Docket No. 17-79, WC Docket No. 17-84, FCC 18-133, (Sept. 26, 2018). The fees address applications for access and new installations.

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


**INCORPORATION BY REFERENCE:** Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into this rule:

The Department’s Utility Accommodation Policy (UAP) was incorporated by reference in 1990 with only several updates since then, the most recent in July 2003. This is the official policy for governing occupancy of state highway rights-of-way by utility facilities. This policy applies to maintenance of existing utilities, new utility installations and existing utility installations to be retained or adjusted as a result of highway construction or reconstruction, as well as the relocation of utility facilities that are found to constitute a hazard to the traveling public on all rights-of-way under the jurisdiction of the ITD.

**ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS:** For assistance on technical questions concerning the proposed rule, please contact Robert Beachler, Planning Broadband Program Manager, at (208) 772-1216. Materials pertaining to this rulemaking, including any available preliminary rule drafts, can be found on the Idaho Transportation Department’s website at the following web address: https://itd.idaho.gov/rulemaking/.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before November 24, 2021.

DATED this 22nd Day of October 2021.

Ramón S. Hobdey-Sánchez, J.D.
Office of Governmental Affairs
Idaho Transportation Department
3311 W. State St.
Boise, ID 83707-1129
Phone: 208-334-8810
ramon.hobdey-sanchez@itd.idaho.gov

THE FOLLOWING IS THE PROPOSED TEXT OF FEE DOCKET NO. 39-0343-2102
(New Chapter)

39.03.43 – RULES GOVERNING UTILITIES ON STATE HIGHWAY RIGHT-OF-WAY

000. **LEGAL AUTHORITY.**
Under authority of Sections 40-312(3) and 67-5229, Idaho Code, the Idaho Transportation Board adopts this rule.
001. SCOPE.
The purpose of the policy is to regulate the location, design and methods for installing, relocating, adjusting and maintaining utilities on State highway right-of-way (ROW) when such use and occupancy is legal, in the public interest and will not adversely affect the highway or its users. The policy applies to new utility installations, to existing utility installations to be retained, relocated, maintained or adjusted because of highway construction or reconstruction, and to the relocation of utility facilities which are found to constitute a definite hazard to the traveling public.

002. ADMINISTRATIVE APPEALS.
Administrative appeals under this chapter shall be governed by Section 2.4 “Administrative Appeal” of the “Utility Accommodation Policy” incorporated by reference.

003. INCORPORATION BY REFERENCE.
The Idaho Transportation Department incorporates by reference the 2022 Edition of the “Utility Accommodation Policy.” This publication is available for public review on the Department’s website at http://itd.idaho.gov.

004. SMALL WIRELESS FACILITIES.

01. Definitions.
      i. The facilities:
         (1) Are mounted on structures fifty (50) feet or less in height including their antennas; or
         (2) Are mounted on structures no more than ten percent (10%) taller than other adjacent structures; or
         (3) Do not extend existing structures on which they are located to a height of more than fifty (50) feet or by more than ten percent (10%), whichever is greater.
      ii. Each antenna associated with the deployment, excluding associated antenna equipment is no more than three (3) cubic feet in volume;
      iii. All other wireless equipment associated with the structure, including the wireless equipment associated with the antenna and any pre-existing associated equipment on the structure, is no more than twenty-eight (28) cubic feet in volume;
      iv. The facilities do not require antenna structure registration under FCC Ruling 18-133 Part 17; Guide for Utility Management General Information 100.00 6/2021 100-4;
      v. The facilities are not located on Tribal lands, as defined under 36 CFR 800.16(x); and
      vi. The facilities do not result in human exposure to radiofrequency radiation in excess of the applicable safety standards.
   b. Fifth-Generation (5G). 5G wireless technology which require new infrastructure in the form of small cell facilities.

02. Small Wireless Facility Fees.
   a. Federal Communications Commission (FCC). Per the Declaratory Ruling and Third Report and Order, WT Docket No. 17-79, WC Docket No. 17-84, FCC 18-133, (Sept. 26, 2018), the fee schedule is as follows:
i. Five hundred dollars ($500) for non-recurring fees, including a single up-front application that includes up to five (5) SWFs, with an additional one hundred dollars ($100) for each SWF beyond five (5) (colocation/attachment); (    )

ii. One thousand dollars ($1,000) for non-recurring fees for a new pole (not a collocation) intended to support one (1) or more SWF; and (    )

iii. Two hundred seventy dollars ($270) per SWF per year for all recurring fees, including any possible ROW access fee or fee for attachment to structures in the ROW. (    )

005. – 999. (RESERVED)
NOTICE OF OMNIBUS RULEMAKING – AMENDMENT TO TEMPORARY RULE

EFFECTIVE DATE: A temporary rule was adopted under this docket number in the July 21, 2021, Idaho Administrative Bulletin, Vol. 21-7SE, pages 5341 through 5364. The effective date of the amendments to the temporary rule is October 13, 2021.

AUTHORITY: In compliance with Section 67-5226, Idaho Code, notice is hereby given this agency has amended a temporary rule. The action is authorized pursuant to Section 20-1004, Idaho Code.

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

Amendments are being made to the following temporary rule chapter:

IDAPA 50.01.01, Rules of the Commission of Pardons and Parole.

The Commission is updating statute references in the rules as the Parole Commission now has its own chapter in Idaho Code. The Commission has made changes that better reflect current business practices, to include signing and storage of minutes, review of disciplinary offense reports and victims’ conditions by the Executive Director, consistent requirements for hearing attendance and notification of commutation decisions. In addition, the Commission has added an extradition waiver requirement to the general conditions of parole and clarified that Commission warrants do not allow bond.

The Commission has added the amount of an assessed administrative fee for returned Interstate Compact bonds as required in by statute. This amount was inadvertently removed several years ago but has not changed. This modification now makes the Commission’s chapter a fee chapter.

With the changes to Idaho Code, the Commission gained the authority for rulemaking on foreign national treaty requests and respites and reprieves; and the current language adds processes for those types of petitions.

TEMPORARY RULE JUSTIFICATION: Pursuant to Sections 67-5226(1) and 67-5226(2), Idaho Code, the Governor has found that temporary adoption of the rules is appropriate for the following reasons:

These temporary rules are necessary to protect the public health, safety, and welfare of the citizens of Idaho, and confer a benefit on its citizens.

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

IDAPA 50.01.01.250.09.b.iii. Interstate Compact fee of $95.00 for administrative costs to the Commission of Pardons and Parole to offset the cost of administration of the bond paid by offenders, offenders families or others when requesting an Interstate Compact to transfer parole supervision. Authorized by Section 20-1005 Idaho Code.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the temporary rules, contact Mary Schoeler (208) 334-2520.

DATED this 14th day of October, 2021.

Ashley Dowell, Executive Director
Idaho Commission of Pardons and Parole
3056 Elder St.
000. LEGAL AUTHORITY.
This chapter is adopted in accordance with Section 20-9-1101, Idaho Code, which provides that the Commission has the power to establish rules, policies, or procedures in compliance with Title 67, Chapter 52, Idaho Code.

001. SCOPE.
The rules govern parole, pardons, firearm rights restoration, remission of fines, and commutations for the state of Idaho; and other matters within the authority of the Commission.

002. – 009. (RESERVED)

010. DEFINITIONS.

01. Absconder. An offender who has fled supervision, whose whereabouts are unknown, and for whom a warrant for a violation of supervision has been issued or requested.

02. Case Manager. For purposes of reference, the case manager is an Idaho Department of Correction employee who is involved with assisting offenders regarding their problems, needs, and adjustments. Such case manager may have the title of psycho-social rehabilitation specialist, counselor, social worker, psych-tech, or clinician.


04. Commission Warrant. Warrant of arrest for alleged parole violation issued by the Executive Director or a Commissioner. This warrant is a non-bondable warrant.

05. Commissioner. A member of the Commission who is appointed by the Governor to carry out decision-making functions regarding parole, parole revocations, pardons, commutations, remission of fines, and firearm rights restoration.

06. Commutation. Clemency powers pursuant to Article IV, Section 7 of the Idaho Constitution and Sections 20-9-1104, 20-1016 and 20-9-1112, 20-1102, Idaho Code, granted to the Commission or to the Commission with the approval of the Governor, as required by law, which allow for a sentence to be modified, including a final discharge from the remaining period of parole.

07. Concurrent Sentence. Sentence served at the same time as another.

08. Conditions of Parole. Conditions under which an offender is released to parole supervision.

09. Confidential. Privileged from disclosure.

10. Consecutive Sentence. Sentence served upon completion of another sentence or before beginning another sentence.
11. **Decision.** A determination arrived at after consideration, a conclusion.

12. **Detainer.** A document authorizing the detention of an offender in custody for a new felony crime or parole violation. Offender may be housed in a county jail or a correctional institution in state or out of state.

13. **Determinate Sentence.** Fixed portion of the sentence. During this time period when an offender is not eligible for release on parole.

14. **Dispositional Hearing.** A hearing held before the Commissioners to render a decision whether to reinstate, modify, or revoke parole.

15. **DOR (Disciplinary Offense Report).** A report describing rule violations, behavioral issues, or both, committed by an offender while incarcerated.

16. **Escape.** Flight from confinement.

17. **Executive Session.** Any meeting or part of a meeting of the Commission that is closed to the public for deliberation on certain matters, as set forth in Section 20-213A, Idaho Code.

18. **File or Case Review.** Review of central file, Commission file, and/or additional information submitted, without testimony or interview of offender or parolee.

19. **Full Term Release Date.** The date an offender completes the term of sentence.

20. **Hearing.** The opportunity to be interviewed by the Commission, a Commissioner, or other designated Commission staff.

21. **Hearing Officer.** An impartial person employed by the Commission and selected by the Executive Director to conduct an interview and take testimony from an offender regarding offender’s history, criminal record, social history, present condition of offender, and offense.

22. **Hearing Session/Session.** A series of hearings conducted by the Commission.

23. **Indeterminate Sentence.** Portion of sentence following the determinate sentence, during which time an offender is eligible for release on parole.

24. **Member or Members.** A member of the Commission, Commissioner, or Commissioners.

25. **NCIC (National Crime Information Center).**

26. **Non-Technical Violation.** Violation of parole by absconding or the commission of, and conviction for, a felony or misdemeanor offense.

27. **Offender.** A person under the legal care, custody, supervision, or authority of the board of correction, including a person within or outside Idaho pursuant to agreement with another state or contractor.

28. **On-Site Parole Violation Hearing.** Parole violation hearing to determine guilt or innocence of the alleged parole violation which must be held reasonably near the site of the alleged violation(s).

29. **Open Parole Date.** Tentative parole granted without setting an actual tentative release date and subject to release by Commission authorization; offender’s parole eligibility date has passed when a tentative parole date is granted. A tentative parole date will become an open parole date if the tentative parole date passes without the offender being released to an acceptable plan on the specific date.
Pardon. Clemency powers pursuant to Article IV, Section 7 of the Idaho Constitution and Section 20-2404, Idaho Code, granted to the Commission or to the Commission with the approval of the Governor as required by law, which allows for sparing the applicant from punishment for a crime, removing any other effects, penalties, or disabilities that the conviction carries or stem from that conviction, and restoring the applicant’s civil rights.

Parole. Conditional release from a penal institution under a contractual agreement between the Commission of Pardons and Parole and offender. Parole is not a right, but is a matter of grace.

Parole Eligibility Date. The earliest date that an offender may be eligible for parole release, which coincides with the date that the indeterminate portion of the offender's sentence begins. In the event there are multiple sentences, the sentence having the latest indeterminate begin date will be used as the offender's parole eligibility date.

Parole Hearing Interview. An interview conducted by a hearing officer for the purpose of gathering information and testimony from the offender regarding the offender's history, criminal record, social history, present condition, instant offense, and other factors, when the offender is scheduled for a forthcoming parole consideration hearing.

Parole Violation Hearing. A fact-finding hearing conducted by a hearing officer to determine a parolee's guilt or innocence of alleged violations of parole. The hearings are conducted for both technical and non-technical violations, and may be held on site, or at a location as determined by the Executive Director or the hearing officer.

Parolee. Offender being supervised on parole.

Preliminary Hearing. A hearing conducted by an objective representative of the supervising authority or an individual appointed by the Executive Director to determine if there is probable cause to believe the alleged violations of the parole contract occurred.

Risk Assessment. Validated tool developed to determine risk of recidivating based on offender criminogenic needs.

Self-Initiated Parole Reconsideration (SIPR). A process in which an offender may request reconsideration of the last decision of the Commission.

Session. See “Hearing Session.”

Respite. The temporary suspension of the execution of a sentence other than death until the next session of the Commission.

Reprieve. The temporary suspension of the execution of a sentence of death until the next session of the Commission.

Supervising Authority. The agency responsible for community supervision of parolees which is Idaho Department of Correction.

Technical Violation. Violation of parole by not conforming to conditions of parole, but not to include absconding or a new criminal conviction.
established by the constitution and Idaho Code.

101. HEARINGS.

01. Conduct of Hearings. All hearings of the Commission will be conducted in accordance with the open meeting law as provided in Chapter 2, Title 74, Idaho Code, and as modified by Section 20-1003, Idaho Code. The Commission will conduct each hearing assigned and scheduled before them. Each Commissioner will have an opportunity to ask questions or provide comments, or both. The Executive Director or Commission staff may provide information during the hearing or ask questions.

02. Deliberations. Receipt and exchange of information or opinion relating to a decision concerning the granting, revoking, reinstating, or denial of parole, or related decisions, to include commutations, pardons, and restoration of firearm rights. Deliberations will be made in executive session. Votes of individual members will not be made public. A written record of the vote by each Commission member will be kept confidential and privileged from disclosure and, provided, for all lawful purposes as outlined by Section 20-213A, Idaho Code.

102. HEARING SESSIONS.

The Executive Director or designee will schedule hearing sessions according to the number of hearings required for the specific month.

103. BUSINESS MEETINGS.

The Commission schedules a business meeting at least quarterly or at the call of the Executive Director and notice of such meetings must comply with the open meeting law requirements. Such meeting may be cancelled at the vote of a majority of the Commission or by the Executive Director if the scheduled business cannot be conducted.

104. RECORD OF HEARINGS AND BUSINESS MEETINGS.

01. Minutes of Hearings and Case Reviews.

a. Summary minutes of individual hearings and case reviews shall be maintained in the Commission office and will be approved and signed by the Executive Director, or a Commissioner, or designee of the Executive Director.

b. Audio recordings of open hearings may be made and may be maintained by the Commission office in digital format. The recordings will be subject to disclosure pursuant to the Idaho Public Records Act, Title 74, Chapter 1, Idaho Code. Executive sessions will not be recorded.

02. Minutes of Business Meetings. Summary minutes of business meetings are reviewed by Commissioners who are present at the next business meeting. The summary minutes as approved by the Commissioners will be signed by the Executive Director or designee. Summary minutes of business meetings are maintained in the Commission office and published on the Commission’s website when the summary minutes are approved.

03. Official Record of Parole Hearing or Case Review. The official record of a parole hearing or case review will be the summary minutes, once signed, of that hearing or review. The official record will be maintained in the Commission office and subject to public disclosure pursuant to the Idaho Public Records Act, Title 74, Chapter 1, Idaho Code.

105. PREVIOUS DECISIONS.

The Commission reserves the right to review or reconsider any previous decision for any reason and to take whatever action is agreed upon. The Executive Director may bring forward any case determined to need review before the next hearing session. Information may be sent by electronic mail if considered an emergency.

106. (RESERVED)

107. APA APPLICABILITY.

The Commission has the authority to establish rules under Chapter 52, Title 67, Idaho Code (Administrative
108. RIGHTS, POWERS, AND AUTHORITY OF THE COMMISSION.

01. Decision to Release to Parole. The Commission has the authority to decide whether or not any offender eligible for parole may be released to parole. (7-1-21)T

02. Advisory Commission to Board of Correction. The Commission may act as the advisory Commission to the board of correction. The Commission has any and all authority necessary to fulfill the duties and responsibilities and other duties imposed upon it by law under Section 20-201(2), Idaho Code, and other applicable provisions of Idaho law. (7-1-21)T

109. -- 149. (RESERVED)

150. COMMISSION AND STAFF.

01. Commission Members. The Commission is composed of seven (7) members. (7-1-21)T

02. Commission Staff. (7-1-21)T

a. The Commission has delegated to the Executive Director the authority to approve recommended conditions of parole following the hearing process, allow for emergency suspension of a condition at the request of the Department of Correction, review Disciplinary Offense Reports and take action by executive decision, issue Commission warrants, issue parole release documents, and all other official documents pertaining, but not limited to paroles, commutations, pardons, firearms rights restoration, and remissions of fines. (7-1-21)T

b. The Executive Director assumes all authority and duties as may be delegated by the Commission and the governor. (7-1-21)T

03. Service of Process on Commissioners or Commission Staff. All service of summons, complaints, subpoenas and other legal process for any cause of action arising from or related to the actions, duties or employment of the Commission or any employee of the Commission, shall be made upon the deputy attorneys general assigned to the Commission in the manner and form required by state and federal rules of procedure. (7-1-21)T

151. -- 199. (RESERVED)

200. HEARING PROCESS.

01. Information for Scheduled Commission Hearings. (7-1-21)T

a. A schedule of Commission hearings will be prepared prior to a hearing session and may be updated as necessary at any time. The hearing schedule will be available five (5) business days prior to a hearing session. The hearing schedule may be revised due to offender movement between institutions or other circumstances and may not be published earlier. A person may obtain the offender’s hearing date by contacting the Commission office or on the commission website at www.parole.idaho.gov. (7-1-21)T

b. The hearing schedule will reflect the date, location and starting time of each hearing session and a list of offenders scheduled for hearings and will be published on the Commission website. (7-1-21)T

02. Location of Hearings. (7-1-21)T

a. The Executive Director will determine the location of hearings, based upon available information when the schedule is set. Due to circumstances beyond the Commission’s control, it may be necessary to change the location and date of a hearing or hearing session. (7-1-21)T

b. It may be necessary to continue a hearing to a later date to allow for the offender’s personal
03. **Interview Method.** For parole hearings, commutation hearings, pardon hearings, remission of fines hearings, and restoration of firearm rights hearings, an interview may be conducted face-to-face, by telephone, or by other electronic means. The interview may be conducted by a hearing officer or other designee of the Executive Director. If an interview is not required, the offender may simply appear before the Commission for a hearing. (7-1-21)T

a. An in-depth investigational report explaining the offender’s social history, criminal history, present condition, and offense will be prepared for the Commission. The in-depth investigational report for parole consideration is exempt from public disclosure pursuant to Section 20-223 20-1005, Idaho Code. (7-1-21)T

b. The Commission will determine if it will conduct another hearing or make a decision based upon the report. (7-1-21)T

04. **Psychological Reports, Mental Health Evaluations, Sex Offender Risk Assessment (SORA), Substance Abuse Evaluation, or Other.** (7-1-21)T

a. A psychological report, or SORA, or both, will be prepared for the Commission for all offenders serving a commitment for a sex offense, or whose history and conduct indicate an offender may be a sexually dangerous person as described in Section 20-223 20-1005, Idaho Code. (7-1-21)T

b. The Commission, the Executive Director, or a hearing officer can order any psychological report, evaluation, or assessment for an offender serving a commitment for any crime. (7-1-21)T

c. All psychological, SORA, substance abuse evaluations, and mental health reports will be maintained in a confidential manner. (7-1-21)T

05. **Interview/Hearing.** The offender who is the subject of the interview/hearing may be required to be present at a scheduled interview/hearing unless presence is excused by the Commission or except as provided below. (7-1-21)T

a. Parole Consideration Hearing. The offender who is the subject of a hearing may be required to be present at a scheduled hearing. If the offender declines to be present at a parole consideration hearing, the offender is required to complete and submit the “Inmate Refusal to Participate in Parole Interview/Hearing Process” form and state the reason for not participating to the Commission. A decision may will be made by the Commission based upon available information. (7-1-21)T

b. Parole Violation Hearing. The parolee is required to be present at the violation hearing, unless waived by the offender parolee as explained in Subsection Rule 400.06.f. (7-1-21)T

e. Commutation. The offender is required to be present at the scheduled commutation hearing unless the Commission determines otherwise. (7-1-21)T

d. Pardon and Remission of Fine. The Commission may make such appearance mandatory or may make a final decision based upon the information that is available. (7-1-21)T

c. Medical Parole. The offender is encouraged to be present at the hearing; the Commission may make such an appearance mandatory or may make a final decision based on information available. (7-1-21)T

f. Restoration of Firearm Rights. The Commission may make such appearance mandatory or may make a final decision based upon the information that is available. (7-1-21)T

06. **Witnesses and Documents.** The Commission allows for the participation of attorneys, families supporters of the offender, parolee, victims, and others who have a direct relationship to the specific hearing or offender/parolee. (7-1-21)T
a. Persons who want to participate in testify at a hearing must notify the Commission staff five (5) days in advance of the scheduled hearing. Minors will not be allowed to attend or testify at the hearings without prior approval of the Executive Director.

b. All written documents and letters to be considered must be submitted seven (7) days in advance of the scheduled hearing to ensure they will be considered; other documents may be allowed by unanimous consent from the presiding Commissioners present or the Executive Director.

c. An attorney or others as determined by the Executive Director or Commission may be seated with the offender/parolee at the hearing.

d. Verbal testimony by witnesses, victims, and attorneys may be limited by the number of persons allowed to give testimony and by a certain time limit. The Commission will allow the attorney representing the offender/parolee a designated time frame to provide information to the Commission. Victims will be allowed to testify. Victim testimony is normally taken following comments of offender’s attorney and family or friends of the offender/parolee. All persons who testify will direct their comments to the relevance of parole relevant to the proceedings.

e. Any communication outside the hearing process directed to a Commissioner is prohibited. Communication from any person concerning a hearing, a decision, Commission practice, or to relay a concern, must be forwarded to the Executive Director.

07. Recusal by Commissioner. It is the responsibility of a Commissioner who has personal knowledge of a case or other conflict to decide whether to recuse himself from participating in deliberations and voting. The Commissioner must inform the Executive Director of the potential conflict and recusal.

a. A Commissioner may remove themselves from the hearing. The Commissioner may step down from the panel and leave the room during the hearing and deliberations.

08. Decisions.

a. Unless otherwise specified below, any decision of the full Commission requires a majority vote of four (4) Commissioners. Panels of less than the full commission are identified below.

i. Two (2) members of the Commission may meet to make decisions on the disposition of parole violations. Such decisions must be unanimous. In the event they are not unanimous, then the parole violation disposition decision will be continued and made by a majority of the full Commission at the next quarterly meeting, pursuant to Section 20-210 20-1002, Idaho Code.

ii. Three (3) members of the Commission may meet to make decisions to grant or deny parole. Such decisions must be unanimous. In the event they are not unanimous, then the decision to grant or deny parole will be continued and made by a majority of the full Commission at the next quarterly meeting, pursuant to Section 20-210 20-1002, Idaho Code.

b. Decisions will be given orally following the hearing and deliberation of a case by the Commission. The decision may be sent to the offender in writing with specific information/conditions.

c. Following the decision being given orally, further testimony is allowed only at the discretion of the Commission, or the Executive Director, or hearing officer.

d. In the case of a review without a Commission hearing, the decision will be published within a reasonable time on the Commission website.

e. Any decision made by the Commission may be reconsidered at any time. The Commission or Executive Director may bring forward any case determined to need reconsideration before the next hearing session as described in Section pursuant to Rule 105.
09. Rules of Conduct at Hearings. (7-1-21)T

a. All persons attending any hearing will conduct themselves in a manner that does not disrupt the proceedings or they may be removed from the hearing room and/or facility. (7-1-21)T (10-13-21)T

b. All persons attending a hearing or hearing session must abide by security policies and pertinent statutes of the department of correction, the facility where the hearing is being held, and pertinent statutes including being subject to search. The number of witnesses allowed in the hearing room will follow the security policies of the institution; and all persons may be screened through metal detectors or similar technology and will be subject to search facility. (7-1-21)T (10-13-21)T

c. Audio recording or video recording of any hearing or any hearing session may only be permitted unless allowed at the discretion of the Commission or the Executive Director, such recordings will proceed only at the direction of the Commission or the Executive Director as to the placement, manner, and type of equipment. (7-1-21)T (10-13-21)T

d. The media is invited to attend any open hearing of the Commission. (7-1-21)T

i. Media interviews with offenders, or witnesses, victims, Commission, or staff will not be allowed during the hearing process, and neither the Commission nor its staff will be responsible for arranging such interviews with persons other than the Commission or its staff. (7-1-21)T

ii. During the hearing process, interviews with victims are not allowed without the express consent of the victim individual. (7-1-21)T (10-13-21)T

iii. Arrangements for interviewing the Commission or staff should be made in advance. (7-1-21)T

10. Review of Respites and Reprieves Granted by the Governor. (10-13-21)T

a. Approval of Respite or Reprieve. If the Governor approves a petition for a respite or reprieve, the Commission will review the respite or reprieve at the next regularly scheduled session of the full Commission. At that time, the Commission shall either determine the respite or reprieve is no longer appropriate or continue the respite or reprieve until the matter can be scheduled for a commutation or pardon hearing as outlined in these rules. (10-13-21)T

201. -- 249. (RESERVED)

250. PAROLE.

01. Parole Consideration. The Commission will use clear, evidence-based parole guidelines in making parole decisions, while still maintaining discretion in individual cases. (7-1-21)T (10-13-21)T

a. The Commission may release an offender to parole on or after the date of parole eligibility, or not at all. (7-1-21)T

b. Parole consideration is determined by the individual merits of each case. (7-1-21)T

c. Parole guidelines will include the use of a validated risk and needs assessment. Other decisions will consider factors to be included, but are not limited to: (7-1-21)T (10-13-21)T

i. Seriousness of and aggravating factors involved in the crime. (7-1-21)T

ii. Mitigating factors involved in the crime or related to the offender’s circumstances. (7-1-21)T

iii. Prior criminal history of the offender. (7-1-21)T
iv. Failure or success of past probation and parole. (7-1-21)T

v. Institutional history to include conformance to established rules, overall behavior, involvement in programs, jobs, and custody level at time of the hearing, and overall behavior disciplinary and corrective action. (7-1-21)T (10-13-21)T

vi. Evidence of the development of a positive social attitude and the willingness to fulfill the obligations of a good citizen. (7-1-21)T

vii. Information or reports regarding physical or psychological condition. (7-1-21)T

viii. The strength and stability of the proposed parole plan, including adequate home placement and employment or maintenance and care. (7-1-21)T (10-13-21)T

ix. Outcome of a validated risk and needs assessment. (7-1-21)T

x. Compliance with any order of restitution entered pursuant to Section 19-5304, Idaho Code. (7-1-21)T

02. Primary Review. For all offenders eligible for parole, a review for the purpose of setting the initial parole hearing will be conducted. (7-1-21)T

a. The Executive Director or a designee will conduct the primary review following receipt of the sentence calculation from the Department of Correction’s central records unit. The month and year of the initial parole hearing will be established based upon the sentence calculation. The Commission is responsible for conducting the primary review to set the initial hearing once an official sentence calculation document has been received from the Department of Correction. (7-1-21)T (10-13-21)T

i. In cases where an offender is serving both a court-ordered retained jurisdiction period and a current sentence of imprisonment, the primary review will not be conducted on the imprisonment case until the court-retained jurisdiction case has been concluded. (7-1-21)T

ii. In cases where the offender has a death sentence, or a life without parole sentence, a primary review will not be conducted. (7-1-21)T

iii. In cases with specified fixed terms, the initial hearing will be scheduled approximately six (6) months prior to the offender’s parole eligibility date based on the sentence calculation. An initial hearing will not be scheduled until all fixed terms (consecutive and concurrent) the offender is currently serving are within six (6) months of completion. (7-1-21)T

iv. If an offender escapes prior to the primary review or the initial hearing, the review or hearing will be conducted within a reasonable time of notification of the offender’s return to custody, taking into consideration any additional new commitments, changes in sentence calculation, and the time to conduct an interview and report. (7-1-21)T (10-13-21)T

v. If an offender is committed to the department of correction and such offender is eligible for parole immediately, or within the first six (6) months of their incarceration, the initial parole hearing will be scheduled within six (6) months from the month the Commission was notified of the commitment. (7-1-21)T

vi. Initial parole hearings will be scheduled based on the sentence calculation prepared by Idaho Department of Correction. (7-1-21)T

03. General Conditions of Parole. The Commission establishes rules and conditions for every offender released to parole. Rules and conditions of parole will be provided in writing and acknowledged signed by the parolee. Parolee will sign the agreement indicating the parolee’s understanding of the conditions of parole. Conditions of parole include:

(7-1-21)T (10-13-21)T
a. The parolee is required to enter into and comply with an agreement of supervision with the Idaho Department of Correction. The agreement of supervision shall include provisions setting forth potential sanctions for a violation of the conditions imposed and potential rewards for compliance with the conditions imposed, as such sanctions and rewards are set forth in rules of the Board. (7-1-21)

b. The parolee will go directly to the destination approved by the Commission and, upon arrival, report as instructed to the parole officer or person whose name and address appear on the arrival notice; any deviation in travel plans will require prior permission from the Commission staff. (7-1-21)

c. The parolee will:

i. Work diligently in a lawful occupation or a program approved by the Commission or supervising officer and not change employment or designated program without written permission from the Commission or supervising officer. (7-1-21)

ii. Support dependents to the best of parolee’s ability. (10-13-21)

d. The parolee must submit a complete and truthful report to the assigned parole officer as instructed. (2-1-21)

e. If at any time it becomes necessary to communicate with the assigned parole officer or other official designee who is unavailable, communication will be directed to the district section supervisor. (7-1-21)

f. The parolee will:

i. Obey all municipal, county, state, and federal laws. (7-1-21)

ii. Not engage in conduct that is, or is intended to may be, harmful to himself or others. (7-1-21)

iii. Not purchase, own, sell, or have in the parolee’s control, to include storing in residence, vehicle, etc., any type of firearm for whatever purpose. (7-1-21)

iv. Not have in the parolee’s control any dangerous weapons used, or intended to be used, for other than normal purposes, such as knives for household use. (7-1-21)

g. The parolee will:

i. Abstain from use of alcoholic beverages. (7-1-21)

ii. Abstain completely from the possession, procurement, use, or sale of narcotics or controlled substances, except as prescribed by a licensed medical practitioner. (7-1-21)

iii. Freely cooperate and voluntarily submit to medical and chemical tests and examinations for the purpose of determining if parolee is using or under the influence of alcohol, narcotics, or other substances, which may be at the parolee’s expense. (7-1-21)

iv. Participate in treatment programs as specified by the Commission or ordered by the parole officer. (7-1-21)

h. A parolee will submit to a search of person or property, or both, to include residence and vehicle, at any time and place by the supervisory authority or at the direction of the Commission, and the parolee waives the constitutional right to be free from such searches. (7-1-21)

i. The parolee is fully advised that written permission is required to:

ii. Willfully change employment and must work diligently in a lawful occupation or a program
approved by the supervising officer:

ii. Willfully change residence; or

iii. Leave the assigned district.

j. The parolee will be available for not abscond from supervision and will not actively avoid supervision.

k. Parolee will waive all rights relating to extradition proceedings if taken into custody outside the State of Idaho for failing to comply with conditions of parole and will freely and voluntarily return to the State of Idaho to answer the allegations of parole violations.

04. Special Conditions of Parole.

a. In addition to general conditions of parole, the Commission may add special conditions of parole appropriate to the individual case.

b. The Commission delegates the authority to the Executive Director to add additional special conditions before an offender has been released to parole or while on parole, after the offender has signed a statement acknowledging the special conditions and to allow for emergency suspension of a condition at the request of the Department of Correction.

05. Medical Parole. The Commission may parole an offender for medical reasons pursuant to Section 20-223(8) 20-1006, Idaho Code.

a. Consideration will occur when the offender is permanently incapacitated or terminally ill and when the Commission reasonably believes the offender no longer poses a threat to the safety of society.

b. An offender or designated Department of Correction personnel may petition the Commission to consider medical parole.

e. The Commission may conduct an actual hearing or review of the case, or may designate Commission staff to provide additional information, which will require specific medical information in reference to the offender's condition, as well as a treatment or care plan if released, and any other information deemed necessary.

06. Discharge from Parole. When the maximum sentence has expired, a final discharge will be issued by the Commission, unless a Commission warrant was issued before the full-term release date.

07. Detainers.

a. The Commission may grant a parole to any county, state, or federal detainer that has been lodged against an offender.

i. While in the custody of the detaining jurisdiction, the parolee is serving parole and is subject to all rules of the housing facility and may be required to submit monthly reports to Commission staff or the supervising authority.

ii. If the parolee is released from custody by the detaining jurisdiction, the parolee must contact the Commission office immediately and must report to the nearest Idaho probation and parole office within five (5) days of release or as otherwise instructed by the Commission staff. The parolee must abide by all regular rules of parole and any special conditions ordered by the Commission.

b. The Commission may grant an offender parole to a federal immigration detainer in order that the offender may be deported to the country of citizenship for deportation proceedings.
If the parolee is granted a release on bond or is allowed to remain in the United States, the parolee must contact both the Commission office immediately and the nearest Idaho probation and parole office within five (5) days of release or as otherwise instructed by the Commission staff. (7-1-21)T(10-13-21)T

If the parolee is deported from the United States to the country of citizenship, the parolee is not to return to the United States and doing so is considered a failure to obey the law and is in violation of the parole contract. (7-1-21)T(10-13-21)T

The Commission considers this type of parole grant an unsupervised parole, but the parolee is not obligated to submit monthly reports nor maintain contact with the Commission as long as he remains outside of the United States. (7-1-21)T

08. Special Progress Reports Miscellaneous File Review. A special progress report miscellaneous file review request may be submitted by the supervising authority to request modification of a special condition of parole or advise the Commission of problems that have developed request permission for international travel. (7-1-21)T(10-13-21)T

09. Interstate Compact. (10-13-21)T

a. An offender must be eligible for transfer of supervision to another state under the Interstate Compact and the receiving state must accept the transfer before the offender is released on parole. (7-1-21)T

i. Any person under state parole who applies for a transfer of supervision to another state shall be required to post an application fee pursuant to Section 20-225A, Idaho Code, payable to Idaho Department of Correction, in addition to the Commission's bond. (7-1-21)T

b. Any offender granted parole under the Interstate Compact may be required to post a bond prior to release or prior to such acceptance under the interstate compact. The amount of the bond set by the Commission is five hundred dollars ($500). (7-1-21)T

i. A bond may be posted by the offender, the offender's family, or other interested party. The bond must be posted at the Commission office. A cashier check, or money order, or online payment shall be the only acceptable means of posting bond. (7-1-21)T(10-13-21)T

ii. Failure to successfully complete parole may be is grounds for forfeiture of the bond. (7-1-21)T(10-13-21)T

iii. Upon successful completion or discharge of parole without violation, the amount of the bond may be returned to payee less an amount of ninety-five dollars ($95) for administrative costs as determined by Commission rule. (7-1-21)T(10-13-21)T

iv. A request must be made for return of the bond within one (1) year of discharge of the offense for which the offender was serving parole. (7-1-21)T

251. -- 299. (RESERVED)

300. VICTIMS.

01. Notice of Victim Rights. The Commission will advise the victims of their constitutional and statutory rights to be notified at Parole Commission proceedings. The Commission will use all tools at its disposal and will exercise all due diligence to notify victims of their rights if this official notice has not been received. (7-1-21)T(10-13-21)T

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

a. The victim is invited to attend all hearings, except executive sessions, pertinent to the case and to provide testimony. Testimony may be provided verbally in the hearing or in writing prior to the hearing.
b. The Executive Director and the Commission may allow for the victim’s testimony away from the actual hearing process.

301. -- 349. (RESERVED)

350. PAROLE PLAN AND RELEASE PROCEDURES.

01. Parole Plan. A parole plan approved by Department of Correction probation and parole staff should provide a positive re-entry into the community for the offender.

a. The proposed parole plan should be available at the parole hearing interview and parole consideration hearing and should include a stable residence, employment or maintenance and care plan, as well as treatment for alcohol or drug problems, mental health problems, sex offender treatment, after care treatment, or any other treatment deemed necessary. The plan will be developed to manage and mitigate offender risk and will address the offender’s needs.

b. Educational programs may be considered, but the offender must demonstrate how normal living, treatment, and transportation expenses, etc., will be paid for.

c. All parole plans will be investigated by the supervising authority in the area in which the prospective parolee plans to reside.

02. Tentative Parole Dates. All parole release dates granted by the Commission are tentative.

a. The parole plan must be approved and received at the Commission office before the actual release date can be set to allow time for processing the release.

b. Should the offender have disciplinary problems following the parole hearing, or the Commission receives information that was not available at the time of the hearing, the Commission may reconsider its decision, and void the tentative parole date if the Commission receives information that was not available at the time of the hearing or the offender has disciplinary problems following the parole hearing.

03. Contract. Prior to any release to parole, the offender must sign a contract with the Commission and acknowledge all general and special conditions of parole.

a. The parolee will be issued reporting instructions that will include the address and the telephone number of contact information for the supervising office.

351. -- 399. (RESERVED)

400. PAROLE DISPOSITION PROCESS.

01. Initiated. The parole disposition process is initiated by a written or verbal report describing the conditions of parole that are alleged to have been violated. The parolee is required to be present at the violation or revocation hearing, unless waived by the offender.

02. Warrants. A warrant may be issued for the offender’s arrest.

a. A supervising authority may issue an agent’s warrant to authorize local law enforcement to transport the parolee to the appropriate jurisdiction to be housed pending an appearance before the Commission, pursuant to Section 20-227, Idaho Code.

b. After receipt of a report of violation, a Commission warrant may be issued by the Executive
Director or by a member or members of the Commission. There is no bond on this warrant and issuance of this warrant suspends the offender’s parole until a determination has been made on the merits of the case. The time that a parolee is considered to be a fugitive from justice will not be counted towards the time on parole or as part of the sentence.

i. Following arrest on a Commission warrant, the Executive Director or the Commission will decide if the parolee will be released to continue parole.

ii. If the location of the offender is unknown, the warrant will be entered into National Crime Information Center or other law enforcement database and will designate from which states the Commission will extradite the offender once arrested. At any time the Executive Director or designee may change the area of extradition.

iii. If an offender is being held in custody on new charges in a state outside of Idaho, the warrant may be placed as a detainer only, and written notice of this action will be submitted to the holding facility. The time limits prescribed by law for service of the factual allegations of the violation of the conditions of parole will begin on the date the holding facility notifies the Commission either the warrant has been served or is notified the offender is available for return to Idaho, whichever is earlier.

iv. If the offender is arrested in a state other than Idaho and refuses extradition to Idaho, it may be necessary to request a governor’s warrant.

03. Notice of Hearing Rights.

a. Every parolee arrested on a Commission warrant for alleged violation(s) of parole is entitled to a fair and impartial hearing of the factual allegations of violation of the conditions of parole.

b. The parolee shall be provided written, pertinent due process including written notice of the date, time, and location of any and all public hearings involved in the disposition process.

04. Witnesses. The accusing parole officer or alleged parole violator may present witnesses in support or defense of the allegations of parole violation or in defense of the charges.

a. The Commission has no subpoena power to compel any witness to attend a hearing. The alleged parole violator may make a timely written request to the Commission office for certain adverse witnesses to be available for cross-examination, and such request must include the name, address, telephone number, email, and relationship to the case; the hearing officer will make reasonable efforts to request their participation. However, it is the alleged parole violator’s responsibility and the accusing parole officer’s responsibility to notify their witnesses of the date, time, and location of any and all hearings or change of hearings.

b. If it is determined by the hearing officer or the Executive Director that the identification of an informant or the personal appearance of a witness would subject such person to potential risk or harm, confrontation or cross-examination will not be allowed, and the record will reflect such determination.

05. Attorney. The alleged parole violator may utilize the services of an attorney at any public hearing conducted during the disposition process.

a. An attorney will be paid at the alleged parole violator’s expense.
b. It is the alleged parole violator’s responsibility to notify his attorney of the date, time, and location of any and all hearings or change of hearings. The alleged parole violator’s attorney may make a request of the Commission office to be notified of any hearings and if requested in writing, the Commission office will provide the attorney with copies of reports or documents that are subject to disclosure according to the public records act. (7-1-21)

c. Commission Provided Attorney. Prior to a hearing, the alleged parole violator may request legal representation be provided by the Commission. The Executive Director or designee will determine if the facts presented by the alleged parole violation or the circumstances of the alleged parole violator demonstrate that alleged parole violator does not understand the proceedings and is otherwise incapable of representing himself. (7-1-21)

i. If a hearing officer, after meeting with the alleged parole violator, believes that the individual is not able to fully understand the hearing proceedings or is otherwise incapable of representing himself, the hearing officer shall notify the Executive Director. Upon receipt of such notification, the Executive Director or the Commission will make an attorney available to assist the alleged parole violator at the Commission’s expense if the facts presented demonstrate that the alleged parole violator meets the criteria for Commission-provided attorney. In reaching this decision, the Executive Director or Commission shall:

(1) Review the case file and documents regarding the alleged parole violator’s personal history, including his physical and mental health status. (7-1-21)

(2) Consider the alleged parole violator’s ability and capacity to understand the proceedings. (7-1-21)

(3) Order a current or competency assessment if such would be helpful in making a decision regarding the request for counsel. (7-1-21)

ii. Specific time limits provided for in these rules may be waived at the discretion of the Executive Director when an attorney is requested or provided, or both, at Commission expense. (7-1-21)

06. Violation and Disposition Hearings. The alleged parole violator will be notified of any and all hearing dates and locations reasonably in advance of any public hearings. The hearing officer or Executive Director will determine the location of all hearings. The parolee is required to be present at the violation or disposition hearing, unless waived by the offender. (2-1-21)

a. The alleged parole violator may request a continuance of, or waive any hearing, subject to the final determination of the hearing officer, Executive Director, or the Commission. (7-1-21)

b. Violation Hearings. The type of violations raised in the allegations will determine the type of disposition hearing available to the alleged parole violator. (7-1-21)

i. Non-technical violations. If the alleged parole violator is accused of violation of parole by absconding supervision or the commission of and conviction for being convicted of a felony or misdemeanor offense, the subject is not entitled to a preliminary hearing, but is entitled to a hearing to determine guilt or innocence of the alleged parole violation within a reasonable time following service of a copy of the report of violation. (7-1-21)

ii. Technical violations. If the alleged parole violator is accused of a violation of parole other than by absconding supervision or the commission of and conviction for being convicted of a felony or misdemeanor offense, the subject is entitled to a preliminary hearing by the supervising authority within a reasonable amount of time. An on-site hearing will be conducted by a Commission hearing officer to determine guilt or innocence within thirty (30) days from the date the accused was served with the copy of the report of violation. (7-1-21)

e.iii. Preliminary hearing. A technical parole violator is entitled to a preliminary hearing to establish whether there is probable cause to believe the violations may have occurred, and such hearing will be conducted by staff of the supervising authority or as otherwise directed by the Executive Director. The alleged parole violator is entitled to a verbal or written decision within a reasonable time following the preliminary hearing. If it is determined
at the preliminary hearing that there is no probable cause to support the allegations of violation of the conditions of parole, the parolee will be released to continue parole.  

On-Site Violation Hearing. A technical parole violator is entitled to an on-site fact-finding hearing conducted by a hearing officer. The on-site hearing is conducted reasonably near the site of the alleged parole violation(s). The Executive Director or hearing officer will determine where the hearing will be conducted. In situations where the violation(s) occurred outside the state of Idaho, the Executive Director or hearing officer will determine the location of the hearing. Based on Interstate Compact rules, an on-site hearing may not be possible if charged and arrested in a state other than Idaho.

Violation Hearing. In most cases, a hearing officer will conduct a fact-finding or violation hearing and will make a finding on each allegation as to the guilt or innocence of the alleged parole violator and may dismiss some or all allegations. If a hearing officer is unavailable, the Executive Director will appoint someone to conduct the hearing.

The parolee shall have the right to appear at a violation hearing and personally address respond to the allegations of violation of the conditions of parole, at said violation hearing, including the right to present witnesses, and present evidence.

The parolee may confront and cross-examine adverse witnesses who have given information on which the charges have been based unless it would subject such person to potential risk or harm as determined by the hearing officer.

The alleged parole violator is entitled to a verbal or written decision within twenty (20) days. When a verbal decision has been rendered at the conclusion of the hearing, such finding must be noted in the hearing officer's report. If the allegations have been proven by a preponderance of the evidence, the report will be submitted to the Commission for a disposition hearing. When a written decision is rendered, such decision will be issued within twenty (20) days of the violation hearing.

Prior to a disposition hearing, the hearing officer will prepare a report of findings summarizing the violation hearing, to include testimony, and will make specific findings for each allegation.

Disposition Hearing. If finding of guilt was made on one (1) or more of the violations, the Commission will consider whether to reinstate the offender on parole on the same or modified conditions, or to revoke parole. The Commission will consider all options available and will state its reasoning if parole is revoked. The type of violations raised in the allegations and recommendations will determine the type of disposition hearing available to the alleged parole violator.

Absentia Hearing. The Commission can hold a disposition hearing without the alleged parole violator’s appearance if the alleged parole violator has signed the proper document waiving the right to appear before the Commission, and the Commission accepts such a waiver. The Commission will accept waivers in cases where new criminal charges result in a new commitment or incarceration or if the alleged parole violator has absconded supervision and is re-incarcerated in another state.

Miscellaneous Hearing Information.

The Commission, through the Executive Director, shall designate the county, state, or other facility where the alleged parole violator shall be held. The Commission’s order shall be sufficient authority by law to direct any county sheriff or the Board of Correction to hold an alleged parole violator in custody until such time as the Commission directs his removal or transfer.

The alleged parole violator can request a continuance of any hearing. The hearing officer, Executive Director, or the Commission will determine if the continuance will be granted. If a continuance is granted at the alleged parole violator’s request, said request will constitute a waiver of any and all time limits involved.

Findings/Decisions.
a. Following arrest on a Commission warrant, the Executive Director or the Commission will decide if the parolee will be released to continue parole. (7-1-21)

b. If it is determined at the preliminary hearing that there is no probable cause to support the allegations of violation of the conditions of parole, the parolee will be released to continue parole. (7-1-21)

c. Prior to a disposition hearing, the hearing officer will prepare a report of findings summarizing the violation hearing, to include testimony, and will make specific findings for each allegation. (7-1-21)

408. **Forfeiture of Time on Parole.** If parole is revoked, the time during which the offender was on parole from the parole release date to the arrest date on any agent’s warrant or Commission warrant may be forfeited, in whole or in part. **Credit of Time on Parole.** If parole is revoked, the time during which the offender was on parole from the parole release date to the arrest date on the agent’s warrant or Commission warrant is not credited toward the sentence unless the Commission, in their discretion, chooses to credit the time in whole or in part per Idaho Code 20-1007.

a. Any time the offender is incarcerated on an agent’s warrant and/or a Commission warrant will be credited toward the sentence, including discretionary jail time. (7-1-21)

b. The offender will not receive credit for incarceration time if the incarceration was for a new crime and the Commission and parole officer did not initiate violation proceedings warrant was not served. (7-1-21)

c. The offender must provide the hearing officer or the Executive Director with dates of incarceration and the location of the incarceration. (7-1-21)

401. -- 449. (RESERVED)

450. **COMMUTATIONS.**
A Commutation may be considered for a person convicted of any misdemeanor or felony crime to modify a sentence imposed by the sentencing jurisdiction. (7-1-21)

01. **Petition.** A petition must be submitted to initiate the process. Only forms approved by the Commission will be accepted and must be completed correctly per the instructions on the form. (7-1-21)

a. The petition must contain the reason a modification of sentence is requested and the precise modification which is requested, such as the following.

   i. Change a consecutive sentence to concurrent. (7-1-21)

   ii. Reduce the maximum length of sentence. (7-1-21)

   iii. Reduce the minimum fixed term of a sentence. (7-1-21)

   iv. Change a fixed sentence to indeterminate. (7-1-21)

   v. Change a sentence in any other manner not described. (7-1-21)

b. The Commission may consider one (1) application from any one (1) person in any twelve (12) month period from the date of denial. (7-1-21)

c. Petitions may be considered at any time by the Commission but are usually scheduled for consideration in the quarterly sessions in January, April, July, and October. (7-1-21)

d. Petitions must be received no later than the first day of the month prior to the next designated quarterly hearing session for which the offender is applying. (7-1-21)
e. Review or deliberation on the petition by the Commission will be conducted in executive session. (7-1-21)T

f. Any petition may be continued for additional information or for further consideration. (7-1-21)T

g. The petitioner will be sent written notice of the decision. (7-1-21)T

h. The petition is limited to no more than six (6) pages; the petition will not be considered if the document exceeds this number. (7-1-21)T

i. An alleged parole violator is not eligible to file a petition until the violation has been adjudicated. (7-1-21)T

j. The petition is limited to no more than six (6) pages; the petition will not be considered if the document exceeds this number. (7-1-21)T

k. The Commission will not consider a commutation for early discharge from parole in any case until the parolee has served at least one (1) year on parole as outlined in Section 20-243, Idaho Code. (7-1-21)T

l. A parole officer, parole officer designee, or parole officer supervisor can petition the Commission to consider an early discharge upon reaching the timelines established in this section. (7-1-21)T

m. If the parolee is permanently incapacitated or terminally ill, the Commission may consider and grant an early discharge from parole after one (1) year for any crime. (7-1-21)T

02. Commutation Hearing. The scheduling of a hearing is at the complete discretion of the Commission; if a commutation hearing is scheduled, the Commission will determine the date of the hearing. (7-1-21)T

a. Notice of a commutation hearing will be published in a newspaper of general circulation at Boise, Idaho, at least once a week for four (4) consecutive weeks immediately prior to the hearing. (7-1-21)T

b. A copy of the notice of publication will be mailed to the prosecuting attorney of the county from which the petitioner was committed. (7-1-21)T

c. Victims of the offender will be notified in writing when a hearing is scheduled. (7-1-21)T

d. Written notice of the hearing date, time, and location will be sent to the applicant at the address given on the application or as otherwise requested. (7-1-21)T

i. The Commission may make such appearance mandatory, make a final decision based upon the information available, or continue the hearing to a later date in order for the applicant to attend or may deny the commutation. (7-1-21)T

j. The applicant will be given written notice of the decision and such notice will be sent to the last known address. (7-1-21)T

k. The decision and supporting documents regarding a commutation will be filed with the Secretary of State and the Executive Director will provide all notice that a commutation is granted consistent with Section 20-240B, Idaho Code. (7-1-21)T

03. Death Sentence.
a. An individual file of each offender under sentence of death may be maintained in the Commission office. Exceptions to the commutation petition page limit may be made by the Executive Director in cases of offenders under sentence of death.

b. At any time, the Commission may review a file, information, or interview an offender without activating the commutation process.

c. Commutation petitions must be initiated by the petitioner or his legal counsel. Legal counsel must provide verification that he has been retained by the petitioner or his family to prepare and submit the petition.

d. The Commission may elect to receive and consider a petition for a death penalty modification at any time.

451. -- 499. (RESERVED)

500. SELF-INITIATED PAROLE RECONSIDERATION.

01. Petition. An incarcerated offender making a request for reconsideration of parole denial must initiate the process by submitting an application.

a. The only acceptable form is the one provided by the Commission, and it must be signed by the offender and Department of Correction case manager.

b. The petition must be typed and completed correctly, per the instructions on the form, or it will not be considered.

c. The petition must state the reason reconsideration is requested and the circumstances that have changed since the last hearing. The offender must have had no disciplinary issues in the year prior to submitted the petition.

d. The Commission will consider one (1) application from the offender who was denied parole one (1) year after the denial of parole initial decision. After the initial SIPR is heard, the Commission will consider applications once per year from the date of the initial SIPR denial.

e. Petitions must be received no later than the first day of the month prior to the next month’s hearing session.

f. Review or deliberation on the petition by the Commission will be conducted in executive session.

g. Any petition may be continued for additional information or for further consideration.

h. The petitioner will be notified of the decision.

i. The petition is limited to four (4) pages; the petition will not be considered if the petition exceeds this number.

02. Hearing. The scheduling of a hearing is at the complete discretion of the Commission.

501. -- 549. (RESERVED)

550. PARDON.

A pardon may be considered for a person convicted of any misdemeanor or felony crime. A pardon does not expunge or remove the crime from the applicant’s criminal history.

01. General. An application for a pardon may not be considered until a period of time has elapsed
since the applicant’s discharge from custody as defined below.

a. Applications for pardon for non-violent and non-sex crimes may be submitted for consideration no sooner than five (5) years after the satisfaction of the sentence on the crime for which they are requesting a pardon.

b. Applications for pardon for violent or sex crimes or other crimes against a person may be submitted for consideration no sooner than ten (10) years after the satisfaction of the sentence on the crime for which they are requesting a pardon.

c. In addition to the provisions of (a) and (b), applications for pardon for vehicular manslaughter pursuant to Section 18-4006(3)(b), Idaho Code or driving under the influence, including any violation of Sections 18-8004, 18-8004C, 18-8005 or 18-8006, Idaho Code, may be submitted for consideration no sooner than fifteen (15) years after that date which the applicant pled guilty to or was found guilty of such a crime.

d. A pardon application will not be considered while an offender is incarcerated or on supervision.

e. The Commission will determine whether a hearing will be granted and the applicant will be notified of the decision in writing.

02. Application. A pardon application can be obtained from the Commission office or on the Commission website.

a. The application must be completed and returned to the Commission office.

i. The completed application must include the reasons why the pardon is requested.

ii. The applicant may attach letters of recommendation or other documents to support the request.

iii. The applicant must include copies of all court judgments and conviction documents, as well as police reports for each crime for which a pardon is requested.

iv. A pardon may be requested only once during a twelve-month (12) period from the date of denial unless otherwise stated by the Commission.

v. An application may not be considered if there is significant law enforcement contact since sentence or discharge.

b. Upon receipt of the completed application and required documentation, eligible applications will be reviewed by the Commission. The Commission may request an investigation of the applicant by Commission staff. The report will contain the following:

i. A criminal records check will be conducted to include any law enforcement contact since the release from supervision or incarceration.

ii. The applicant’s employment history since discharge from supervision or incarceration.

iii. The applicant’s willingness to fulfill the obligations of a law-abiding citizen, including family information, community involvement, volunteer service, hobbies, and related interests.

iv. The applicant’s employment and education status, including any professional or vocational achievements, training, and any additional information as deemed necessary or appropriate.

v. Confirmation that all restitution and fines as ordered by the sentencing court are paid.
vi. An interview with the applicant may be conducted and a summary of the interview provided. Said interview may be conducted in person or by electronic means. (7-1-21)T

03. **Hearing.** The scheduling of a hearing is at the complete discretion of the Commission. If a pardon hearing is scheduled, the Commission will determine the date of the hearing. (7-1-21)T

a. Notice of a pardon hearing shall be published in a newspaper of general circulation at least once a week for four (4) consecutive weeks immediately prior to the hearing. (7-1-21)T

b. A copy of the publication will be mailed to the prosecuting attorney of the county from which the petitioner was sentenced. (7-1-21)T

c. Victims of the offender will be notified in writing when a hearing is scheduled. (7-1-21)T

d. Written notice of the hearing date, time, and location will be sent to the applicant at the address given on the application or as otherwise requested. (7-1-21)T

i. The Commission may make such appearance mandatory, make a final decision based upon the information available, or continue the hearing to a later date in order for the applicant to attend or may deny the pardon. (7-1-21)T

ii. The applicant will be given written notice of the decision and such notice will be sent to the last known address. (7-1-21)T

f. The decision and supporting documents regarding a pardon will be filed with the Secretary of State and the executive director will provide all notice that a pardon is granted consistent with Section 20-240B 20-1018, Idaho Code. (7-1-21)T

551. **RESTORATION OF FIREARMS RIGHTS PURSUANT TO SECTION 18-310, IDAHO CODE.**

01. **General.** An application for restoration of the civil right to ship, transport, possess, or receive a firearm may be considered upon final discharge under Section 18-310(2), Idaho Code. This is not a pardon for the conviction of a crime, nor is the applicant’s criminal record expunged. (7-1-21)T

02. **Application.** An application may not be made until five (5) years after the date of final discharge of the crime for which they are requesting restoration of firearm rights. (7-1-21)T

a. An application may be obtained from the Commission office or on the Commission website. (7-1-21)T

b. The application must be the original and returned to the Commission office. (7-1-21)T

i. The application must request the restoration of the right to ship, transport, possess, or receive a firearm under Section 18-310, Idaho Code. (7-1-21)T

ii. The application must be in writing and legible. (7-1-21)T

iii. All court convictions, judgment orders, including any dismissal documents, as well as police reports related to said convictions must accompany the application. (7-1-21)T

iv. An application may be submitted once every twelve (12) months from the date of denial. (7-1-21)T

v. The petition must state the reason for the request. (7-1-21)T

vi. Review or deliberation on the petition will be conducted in executive session. (7-1-21)T

vii. The Commission will determine whether a hearing will be granted and the applicant will be advised
viii. No applications will be considered for individuals who are incarcerated or on supervision.

c. Upon receipt of the completed application and required documentation, eligible applications will be reviewed by the Commission. The Commission may request an investigation of the applicant by Commission staff. The report shall include, but not be limited to, the following:

i. A criminal records check will be conducted to include any law enforcement contact since release from supervision or incarceration.

ii. The applicant’s employment history since the date of final discharge of the crime for which they are requesting restoration of firearm rights.

iii. The applicant’s willingness to fulfill the obligations of a law-abiding citizen, including family information, community involvement, volunteer service, hobbies, and related interests.

iv. The applicant’s employment and education status, including any professional or vocational achievements, training and any additional information as deemed necessary or appropriate.

v. Confirmation that all restitution and fines as ordered by the sentencing court have been paid.

vi. An interview with the applicant may be conducted and a summary of the interview provided. The interview may be conducted in person or by electronic means.

03. Hearing. The scheduling of a hearing is at the complete discretion of the Commission or the Executive Director.

a. If a hearing is scheduled, the Commission will determine the date of the hearing.

b. Any hearing may be continued for additional information.

c. Written notice of the hearing date, time, and location will be sent to the applicant at the address given on the application or as otherwise requested.

i. The Commission may [shall] make such appearance mandatory or may make a final decision based upon the information available deny the restoration of firearm rights.

d. The applicant will be given written notice of the decision and such notice will be sent to the last known address.

04. Authority to Grant. The Commission has the full and final authority and discretion to grant restoration of civil rights to ship, transport, possess, or receive a firearm under Section 18-310, Idaho Code, except as provided therein.

552. -- 599. (RESERVED)

600. REMISSION OF FINE OR PENALTY PURSUANT TO SECTION 20-210.4 20-1004, IDAHO CODE.

01. Request. An application for remission of fine or penalty must be made to the Commission.

a. The application must be in writing.

b. The application must outline the reasons action is requested to remit such fine or penalty.
c. The applicant must submit a certified copy of the judgment or order assessing said fine or penalty.

02. Review. The Commission will review the application to remit a fine or penalty.
   a. The Commission will usually review such application on a month designated as a quarterly session, but may make such review during any session. The review will be conducted by the full Commission.
   b. The Commission will conduct such review in executive session.
   c. Any application may be continued for further consideration or additional information.
   d. The Commission will determine whether a hearing will be granted and the applicant will be notified of the decision in writing.

03. Hearing. The scheduling of a hearing is at the complete discretion of the Commission.
   a. If a hearing is scheduled, the Commission will determine the date of the hearing.
   b. If a hearing is scheduled, notice of the hearing will be published in a newspaper of general circulation at Boise, Idaho, at least once a week for four (4) consecutive weeks immediately prior to the hearing.
   c. A copy of the notice of publication will be mailed to the prosecuting attorney of the county from which the petitioner was sentenced.
   d. All rules of procedure governing hearings will apply to such scheduled hearing.
   e. Written notice of the hearing date, time, and location will be sent to the applicant at the last known address.
   i. The Commission may make such appearance mandatory or may make a final decision based upon the information which is available to deny the remission of fine or penalty.
   ii. The Commission may continue the hearing to a later date for any reason.

04. Satisfaction of Judgment. If the Commission determines that such fine or penalty is to be remitted, an official document of such action will be submitted to the clerk of the court where said fine or penalty was assessed, and this will constitute a satisfaction of the judgment. The decision and supporting documents regarding a remission of fine or penalty will be filed with the Secretary of State consistent with Section 20-1018 Idaho Code.

601. -- 799. (RESERVED)

800. FOREIGN NATIONAL TREATY TRANSFER PURSUANT TO SECTION 20-104 20-1014, IDAHO CODE.

Under Section 20-104, Idaho Code, an offender may be transferred, upon request, to his country of citizenship if a treaty exists between his country and the United States. The Commission’s decision is only a recommendation to the Governor, as the Governor will have final approval of the transfer.

04. Request for Transfer. An offender may be transferred upon request to his country of citizenship which he believes to be in effect between the United States and the United States. The Commission may request additional information from the applicant, the victim, the Department, or any other source.

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01. **Governors Authorization.** Subject to the terms of a treaty and on behalf of the state of Idaho, the Governor has authorized the Commission to consent to transfers or exchanges of offenders and take any other action necessary to initiate the participation of the state in such treaty.

02. **Request for Transfer.** An offender may request a transfer to a foreign county when the offender meets the requirements enumerated below. The Commission will receive the request and relevant documents from the Department of Correction. The Commission may request additional information from the offender, any victims, the Department, or any other source the Commission deems appropriate.

   a. The offender must be a citizen or national of the foreign country to which he is requesting a transfer.

   b. The United States and the foreign country must be parties to a treaty that provides for the transfer or exchange of convicted offenders.

   c. The offender must not be serving a life sentence.

   d. The offender cannot be less than two (2) years from his parole eligibility date.

   e. The offender must meet the Department of Justice’s guidelines for international transfer applications.

03. **Schedule for Review of Application.** The Commission will schedule the application for review during a scheduled hearing session at a time and place of its choosing. **Hearing.** The full Commission may review a transfer request that meets all the requirements under the law in a hearing.

   a. The Commission has complete discretion and authority to make a recommendation to the Governor, may require the offender’s appearance or may make a final decision based upon the materials with the request and other information which is available. The offender is not entitled to be personally present, to have counsel, to present witnesses or evidence, or to have any particular evidence considered.

   b. The offender is not entitled to be personally present, to have counsel, to present witnesses or evidence, to have any particular evidence considered or to designate the location or time. The Commission may continue the hearing to a later date for any reason. The Commission will schedule the application for review during a scheduled hearing session at a time and place of its choosing.

04. **Issuance of Written Recommendation.** Following the Commission’s consideration, a non-binding written recommendation will be issued to the Governor for his consideration. A copy of the recommendation will be sent to the Department’s central records. **Decision.**

   a. The offender is not entitled to appeal the Commission’s recommendation or the Governor’s decision.

   b. The offender may reapply two (2) years from the date of denial by either the Governor or the Commission.

05. **Approval of Transfer Request.** If the Governor Commission approves the transfer request, and the receiving country accepts the offender for transfer, the request packet is sent to the Department of Justice for consideration and approval. Once the Department of Justice approves the transfer, the offender is under the jurisdiction of the Department of Justice.

801. -- 999. (RESERVED)
AUTHORITY: In compliance with Section 39-3611, Idaho Code, notice is hereby given that this agency has issued a final decision on the Payette Subbasin – Dry Buck Creek, Anderson Creek, and Sand Hollow TMDL – E. coli.

DESCRIPTIVE SUMMARY: The Department of Environmental Quality (DEQ) hereby gives notice of the final decision on the Payette Subbasin – Dry Buck Creek, Anderson Creek, and Sand Hollow TMDLs – E. coli. The final decision may be appealed to the Board of Environmental Quality by initiating a contested case in accordance with Sections 39-107(5), 67-5240 et seq., Idaho Code, and IDAPA 58.01.23, “Rules of Administrative Procedure Before the Board of Environmental Quality.” The petition initiating a contested case must be filed with the undersigned hearing coordinator within thirty-five (35) days of the publication date of this notice in the Idaho Administrative Bulletin.

The area covered by Payette Subbasin – Dry Buck Creek, Anderson Creek, and Sand Hollow TMDLs – E. coli (Hydrologic Unit Code 17050122) establishes three (3) E. coli TMDLs on a water quality impaired stream reach (assessment units). DEQ has submitted this TMDL to the U.S. Environmental Protection Agency for approval under the Clean Water Act.

AVAILABILITY OF THE TMDL: Electronic copy of the TMDL can be obtained at https://www2.deq.idaho.gov/admin/LEIA/api/document/download/16233 or by contacting Graham Freeman, TMDL Program Coordinator, 208-373-0461, graham.freeman@deq.idaho.gov

Dated this 3rd day of November, 2021.

Paula J. Wilson
Hearing Coordinator
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IDAPA 02 – DEPARTMENT OF AGRICULTURE

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LEGAL NOTICE

Summary of Proposed Rulemakings

PUBLIC NOTICE OF INTENT
TO PROPOSE OR PROMULGATE NEW OR CHANGED AGENCY RULES

The following agencies of the state of Idaho have published the complete text and all related, pertinent information concerning their intent to change or make the following rules in the latest publication of the state Administrative Bulletin.

The proposed rule public hearing request deadline is November 17, 2021, unless otherwise posted.
The proposed rule written comment submission deadline is November 24, 2021, unless otherwise posted.
(Temp & Prop) indicates the rulemaking is both Temporary and Proposed.
(*PH) indicates that a public hearing has been scheduled.

IDAPA 02 – IDAHO STATE DEPARTMENT OF AGRICULTURE
PO Box 7249, Boise, Idaho 83707
02-0107-2101, Rules Governing Hemp. New Fee Chapter conforms with the legislative intent and requirements of House Bill 126, the Industrial Hemp Research and Development Act, through the licensing, production, handling and research of hemp.

IDAPA 39 – IDAHO TRANSPORTATION DEPARTMENT
3311 W State St, Boise, ID 83707-1129
*39-0343-2102, Rules Governing Utilities on State Highway Right-of-Way. (*PH) New Fee Chapter regulates the location, design, and methods for installing, relocating, adjusting, and maintaining utilities on State highway right-of-way (ROW), to include the permitting process for small wireless facilities.

NOTICES OF AMENDMENT TO TEMPORARY RULE ONLY

IDAPA 18 – DEPARTMENT OF INSURANCE
18-0000-2100, affecting IDAPA 18.04.10 – Medicare Supplement Insurance Standards. (eff.11-3-21)T

IDAPA 50 – IDAHO COMMISSION OF PARDONS AND PAROLE
50-0101-2100, affecting IDAPA 50.01.01 – Rules of the Commission of Pardons and Parole. (eff. 10-13-21)T

NOTICES OF INTENT TO PROMULGATE RULES – NEGOTIATED RULEMAKING
(Please see the Administrative Bulletin for dates and times of meetings and other participant information)

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE
16-0310-2101, Medicaid Enhanced Plan Benefits
16-0313-2101, Consumer-Directed Services
16-0504-2101, Grant Funding for the Idaho Council on Domestic Violence and Victim Assistance

Please refer to the Idaho Administrative Bulletin November 3, 2021, Volume 21-11, for the notices and text of all rulemakings, proclamations, negotiated rulemaking and public hearing information and schedules, executive orders of the Governor, and agency contact information.

Issues of the Idaho Administrative Bulletin can be viewed at www.adminrules.idaho.gov/

Office of the Administrative Rules Coordinator, Division of Financial Management P.O. Box 83720, Boise, ID 83720-0032 Phone: 208-334-3900; Email: adminrules@dfm.idaho.gov
CUMULATIVE RULEMAKING INDEX OF IDAHO ADMINISTRATIVE RULES

Office of the Administrative Rules Coordinator
Division of Financial Management
Office of the Governor
July 1, 1993 – Present

This index provides a history of all agency rulemakings beginning with the first Administrative Bulletin in July 1993 to the most recent Bulletin publication. It tracks all rulemaking activities on each chapter of rules by the rulemaking docket numbers and includes negotiated, temporary, proposed, pending and final rules, public hearing notices, vacated rulemaking notices, notice of legislative actions taken on rules, and executive orders of the Governor.

ABRIDGED RULEMAKING INDEX OF IDAHO ADMINISTRATIVE RULES

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Office of the Administrative Rules Coordinator
Division of Financial Management

March 20, 2020 – November 3, 2021

(PLR 2021) – Final Effective Date Is Pending Legislative Review in 2021
(eff. date) L – Denotes Adoption by Legislative Action
(eff. date) T – Temporary Rule Effective Date
SCR # – denotes the number of a Senate Concurrent Resolution (Legislative Action)
HCR # – denotes the number of a House Concurrent Resolution (Legislative Action)

(This Abridged Index includes all active rulemakings.)
**IDAPA 01 — IDAHO BOARD OF ACCOUNTANCY**

**MOVED AND REDESIGNATED** 01.01.01, Idaho Accountancy Rules

01-0000-2000  IDAPA 01 – IDAHO BOARD OF ACCOUNTANCY – Notice of Legislative and Executive Action Affecting the Idaho Board of Accountancy Under the Department of Self-Governing Agencies – House Bill 318, Session Law 96, and Executive Order 2020-10 and Assignment of New IDAPA Designation Number Under the Division of Occupational and Professional Licenses – Redesignated as IDAPA 24, Title 30, Chapter 01 – Bulletin Vol. 20-7 (eff. 7-1-20)

24-0000-2000  IDAPA 24 – DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSES – Notice of Legislative and Executive Action Affecting Certain Boards and Commissions Under the Department of Self-Governing Agencies – House Bill 318, Session Law 96, and Executive Order 2020-10 and Assignment of New IDAPA Designation Number Under the Division of Occupational and Professional Licenses – Redesignated as IDAPA 24, Title 30, Chapter 01 – Bulletin Vol. 20-7 (eff. 7-1-20)

01-0101-2000F Idaho Accountancy Rules – Notice of Omnibus Rulemaking – Adoption of Temporary (Fee) Rule – Reauthorizes Title 01, Chapter 01 – Bulletin Vol. 20-4SE (eff. 3-20-20)

**IDAPA 02 – IDAHO DEPARTMENT OF AGRICULTURE**

02-0000-2100  Rules of the Idaho Department of Agriculture – Notice of Omnibus Rulemaking – Proposed Rule – Reauthorizes Title 01, Chapter 03; Title 02, Chapters 02, 05; Title 03, Chapter 01; Title 04, Chapters 04, 13-15, 17, 20, 21, 23-25, 27, 29, 30; and Title 05, Chapter 01 – Bulletin Vol. 21-10SE

02-0000-2100  Rules of the Idaho Department of Agriculture – Notice of Omnibus Rulemaking – Adoption of Temporary Rule – Recission of Previous Temporary Rule Under Dockets 02-0106-2002, 02-0414-2001, and 02-0414-2102 – Reauthorizes Title 01, Chapter 03; Title 02, Chapters 02, 05; Title 03, Chapter 01; Title 04, Chapters 04, 13-15, 17, 20, 21, 23-25, 27, 29, 30; and Title 05, Chapter 01 – Bulletin Vol. 21-7SE (eff. 7-1-21)

02-0000-2100F Rules of the Idaho Department of Agriculture – Notice of Omnibus Rulemaking – Adoption of Temporary (Fee) Rule – Reauthorizes Title 01, Chapters 04, 05; Title 02, Chapters 07, 11-15; Title 03, Chapter 03; Title 04, Chapters 03, 05, 19, 26, 32; and Title 06, Chapters 01, 02, 04-06, 09, 10, 33 – Bulletin Vol. 21-10SE

02-0000-2100F Rules of the Idaho Department of Agriculture – Notice of Omnibus Rulemaking – Adoption of Temporary (Fee) Rule and Recission of Previous Temporary Rule Under Docket 02-0000-2000F – Reauthorizes Title 01, Chapter 04, 05; Title 02, Chapters 07, 11-15; Title 03, Chapter 03; Title 04, Chapters 03, 05, 19, 26, 32; and Title 06, Chapters 01, 02, 04-06, 09, 10, 33 – Bulletin Vol. 21-7SE (eff. 7-1-21)

02-ZBRR-2101 Rules of the Idaho Department of Agriculture – Notice of Intent to Promulgate Rules – Zero-Based Regulation Negotiated Rulemaking – Negotiates Title 04, Chapters 05, 13, 19, 21, 27; and Title 06, Chapters 06, 09, 33 – Bulletin Vol. 21-4

02-0000-2000F Rules of the Idaho Department of Agriculture – Notice of Omnibus Rulemaking – Amendment to Temporary Rule – Amends Title 03, Chapter 03 – Bulletin Vol. 21-6 (eff. 5-18-21) (temporary rule rescinded)

02-0000-2000F Rules of the Idaho Department of Agriculture – Notice of Omnibus Rulemaking – Adoption of Pending Fee Rule – Reauthorizes Title 01, Chapters 04, 05; and Title 06, Chapter 33 – Bulletin Vol. 20-11SE (PLR 2021)

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02-0701-2000F Rules of the Idaho Hop Growers Commission – Notice of Omnibus Rulemaking – Adoption of Temporary (Fee) Rule – Reauthorizes Title 07, Chapter 01 – Bulletin Vol. 20-4SE (eff. 3-20-20)T


02-0801-2000F Rules of the Idaho Sheep and Goat Health Board – Notice of Omnibus Rulemaking – Adoption of Temporary (Fee) Rule – Reauthorizes Title 08, Chapter 01 – Bulletin Vol. 20-4SE (eff. 3-20-20)T

02.01.06, Rules Governing the Labeling of Hemp Receptacles

02-0106-2001 Adoption of Temporary Rule (New Chapter), Bulletin Vol. 20-1 (eff. 11-26-19)T (Expired)

02-0106-2002 Adoption of Temporary Rule (New Chapter), Bulletin Vol. 20-4 (eff. 3-20-20)T (temporary rule rescinded)

02.01.07, Rules Governing Hemp

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02-0000-2000FA Rules of the Idaho Department of Agriculture – Notice of Omnibus Rulemaking – Adoption of Pending Fee Rule – Reauthorizes Title 02, Chapter 14 – Bulletin Vol. 20-4SE (eff. 3-20-20)T


02-0214-2001 Notice of Intent to Promulgate a Rule (New Chapter) – Negotiated Rulemaking, Bulletin Vol. 20-6

02.03.03, Rules Governing Pesticide and Chemigation Use and Application


02-0303-2001 Notice of Intent to Promulgate a Rule (New Chapter) – Negotiated Rulemaking, Bulletin Vol. 20-6

02-0000-2000F Rules of the Idaho Department of Agriculture – Notice of Omnibus Rulemaking – Amendment to Temporary Rule – Amends Title 03, Chapter 03 – Bulletin Vol. 21-6 (eff. 5-18-21)T

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02.04.14, Rules Governing Dairy Byproduct

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02-0414-2001 Adoption of Temporary Rule, Bulletin Vol. 20-4 (eff. 3-20-20)T (rule rescinded)
02.04.19, Rules Governing Domestic Cervidae  
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07-0000-2000F Rules of the Division of Building Safety – Notice of Omnibus Rulemaking – Adoption of Temporary (Fee) Rule – Reauthorizes Title 02, Chapter 02 – Bulletin Vol. 20-4SE (eff. 3-20-20)T

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07-0000-2000F Rules of the Division of Building Safety – Notice of Omnibus Rulemaking – Adoption of Temporary (Fee) Rule – Reauthorizes Title 03, Chapter 01 – Bulletin Vol. 20-4SE (eff. 3-20-20)T

(MOVED AND REDESIGNATED) 07.03.03, Rules for Modular Buildings

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(MOVED AND REDESIGNATED) 07.03.09, Rules Governing Manufactured Homes – Consumers Complaints – Dispute Resolution

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24-0000-2000 IDAPA 24 – DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSES – Notice of Legislative and Executive Action Affecting Certain Boards and Commissions Under the Department of Self-Governing Agencies – House Bill 318, Session Law 96, and Executive Order 2020-10 and Assignment of New IDAPA Designation Number Under the Division of Occupational and Professional Licenses – Redesignated as IDAPA 24, Title 39, Chapter 33 – Bulletin Vol. 20-7 (eff. 7-1-20)

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**07-0000-2000F** Rules of the Division of Building Safety – Notice of Omnibus Rulemaking – Adoption of Temporary (Fee) Rule – Reauthorizes Title 03, Chapter 12 – Bulletin Vol. 20-4SE (eff. 3-20-20)T

(MOVED AND REDESIGNATED) 07.03.13, Rules Governing Mobile Home Rehabilitation

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