IDAPA 18 – IDAHO DEPARTMENT OF INSURANCE

Market Oversight

18.04.12 – The Small Employer Health Insurance and Availability Act

Who does this rule apply to?
This rule applies to carriers that provide health benefit plans to small employers and all health benefit plans sold to small employers, directly, through associations or other groupings of small employers.

What is the purpose of this rule?
The purpose of this rule is to promote broader spreading of risk in the small employer marketplace.

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

Insurance -
- 41-02, et seq., Idaho Code – The Department of Insurance
- 41-47, et seq., Idaho Code – Small Employer Health Insurance Availability Act

Who do I contact for more information on this rule?

Department of Insurance
700 W. State Street, 3rd Floor
Boise, ID 83720-0043

P.O. Box 83720
Boise, ID 83720-0043
Phone: 1(800) 721-3272 or (208) 334-4250
Fax: (208) 334-4398
Email: rulesreview@doi.idaho.gov
Web: https://doi.idaho.gov/

Table of Contents

18.04.12 – The Small Employer Health Insurance and Availability Act

000. LEGAL AUTHORITY.
Title 41, Chapters 2 and 47, Idaho Code. (7-1-21)T

001. TITLE AND SCOPE.

01. Title. IDAPA 18.04.12, "The Small Employer Health Insurance and Availability Act." (7-1-21)T

02. Scope. The Act and this chapter are intended to promote broader spreading of risk in the small employer marketplace and to regulate all health benefit plans sold to small employers, whether sold directly or through associations or other groupings of small employers. Carriers that provide health benefit plans to small employers are intended to be subject to all of the provisions of the Act and this chapter. (7-1-21)T

002. -- 009. (RESERVED)

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

01. Associate Member. Any individual who participates in an employee benefit plan (as defined in 29 U.S.C. Section 1002(1)) that is a multi-employer plan (as defined in 29 U.S.C. Section 1002(37A)), other than the following: (7-1-21)T

a. An individual (or the beneficiary of such individual) who is employed by a participating employer within a bargaining unit covered by at least one (1) of the collective bargaining agreements under or pursuant to which the employee benefit plan is established or maintained; or (7-1-21)T

b. An individual who is a present or former employee (or a beneficiary of such employee) of the sponsoring employee organization, of an employer who is or was a party to at least one (1) of the collective bargaining agreements under or pursuant to which the employee benefit plan is established or maintained, or of the employee benefit plan (or of a related plan). (7-1-21)T

02. Expense. The cost incurred for a covered service or supply. A physician or other licensed practitioner orders or prescribes the service or supply. Expense is considered incurred on the date the service or supply is received. Expense does not include any charge: (7-1-21)T

a. For a service or supply that is not medically necessary; or (7-1-21)T

b. That is in excess of reasonable and customary charge for a service or supply. (7-1-21)T

03. Geographic Area. A sector of land, as designated by the health carrier, which employers sitused within receive a specified rating factor. Geographic areas are limited to no more than six (6) designated areas, with no area being smaller than a county. (7-1-21)T

04. Medically Necessary Service or Supply. One that is ordered by a physician and that the small employer carrier or a qualified party determines is: (7-1-21)T

a. Provided for the diagnosis or direct treatment of an injury or sickness; (7-1-21)T

b. Appropriate and consistent with the symptoms and findings of diagnosis and treatment of the insured persons injury or sickness; (7-1-21)T

c. Is not considered experimental or investigative; (7-1-21)T

d. Provided in accord with generally accepted medical practice; (7-1-21)T

e. The most appropriate supply or level of service which can be provided on a cost-effective basis. The fact that the insured person's physician prescribes services or supplies does not automatically mean such service or supply are medically necessary and covered by the policy. (7-1-21)T

05. New Entrant. An eligible employee, or the dependent of an eligible employee, who becomes part of an employer group after the initial period for enrollment in a health benefit plan. (7-1-21)T

06. Pre-Existing Condition. (7-1-21)T

a. A condition, whether physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received during the six (6) months immediately preceding the effective date of coverage; (7-1-21)T

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

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

d. Genetic information will not be considered as a condition described in this definition in the absence of a diagnosis of the condition related to such information. (7-1-21)T

07. Risk Characteristic. The health status, claims experience, duration of coverage, or any similar characteristic related to the health status or claims experience of a small employer group or of any member of a small employer group. Such characteristics can include family composition, group size, industry. (7-1-21)T

08. Risk Load. The percentage above the applicable base premium rate that is charged by a small employer carrier to the rates of the small employer group, to reflect the risk characteristics of the small employer group. (7-1-21)T

011. ASSESSMENTS.
Prior to March 1st of each year the Board determines and files with the Director an estimate of the assessments needed to fund the losses incurred by the Idaho Small Employer Reinsurance Program in the previous calendar year. This interim assessment is based on the assessment formula set forth in Section 41-4711(12)(c), Idaho Code. Initial or interim assessments paid will be credited to each carrier's account when the amounts needed to fund losses and pay program expenses are known. (7-1-21)T

012. -- 014. (RESERVED)

015. APPLICABILITY.

01. Applicability. This chapter applies to any health benefit plan provided on a group basis, that: (7-1-21)T

a. Meets one (1) or more of the conditions set forth in Section 41-4704, Idaho Code; and (7-1-21)T

b. Offers coverage to two (2) or more eligible employees of a small employer located in this state, without regard to whether the policy or certificate was issued in this state. (7-1-21)T

02. Group Policy or Trust Arrangement. The provisions of the Act and this chapter applies to a health benefit plan provided to a small employer or to the eligible employees of a small employer without regard to whether the health benefit plan is offered under or provided through a group policy or trust arrangement of any size sponsored by an association or discretionary group unless such health benefit plan(s) are subject to Title 41, Chapter 52, Idaho Code. (7-1-21)T

03. Group Policy or Trust Arrangement. The provisions of the Act and this chapter applies to a health benefit plan provided to a small employer or to the eligible employees of a small employer without regard to whether the health benefit plan is offered under or provided through a group policy or trust arrangement of any size sponsored by an association or discretionary group. (7-1-21)T

04. Subsequent Employment of More Than Fifty Eligible Employees. If a small employer is issued a health benefit plan under the terms of the Act, the provisions of the Act and this chapter continue to apply to the health benefit plan in the case that the small employer subsequently employs more than fifty (50) eligible employees. A carrier providing coverage to such an employer, within sixty (60) days of becoming aware that the employer has more than fifty (50) eligible employees but no later than the anniversary date of the employer's health benefit plan,

notifies the employer that the protections provided under the Act and this chapter cease to apply to the employer if such employer fails to renew its current health benefit plan or elects to enroll in a different health benefit plan. (7-1-21)T

05. Employer Subsequently Becomes a Small Employer. If a health benefit plan is issued to an employer that is not a small employer as defined in the Act, but subsequently the employer becomes a small employer (due to the loss or change of work status of one or more employees), the terms of the Act do not apply to the health benefit plan. The carrier providing a health benefit plan to such an employer does not become a small employer carrier under the terms of the Act solely because the carrier continues to provide coverage under the health benefit plan to the employer. (7-1-21)T

06. Time Period for Notification of Options to Employer. A carrier providing coverage to an employer described in Subsection 015.05, within sixty (60) days of becoming aware that the employer has fifty (50) or fewer eligible employees, notifies the employer of the options and protections available to the employer under the Act, including the employer's option to purchase a small employer health benefit plan from any small employer carrier. (7-1-21)T

07. Employees in More Than One State. If a small employer has employees in more than one (1) state, the provisions of the Act and this chapter apply to a health benefit plan issued to the small employer if: (7-1-21)T

a. The majority of eligible employees of such small employer are employed in this state; or (7-1-21)T

b. If no state contains a majority of the eligible employees of the small employer, the primary business location of the small employer is in this state. (7-1-21)T

08. Laws of This State or Another State. In determining whether the laws of this state or another state apply to a health benefit plan issued to a small employer described in Subsection 015.07, the provisions of the paragraph is applied as of the date the health benefit plan was issued to the small employer for the period that the health benefit plan remains in effect. (7-1-21)T

09. Health Benefit Plan Subject to The Act and This Chapter. If a health benefit plan is subject to the Act and this chapter, the provisions of the Act and this chapter applies to all individuals covered under the health benefit plan, whether they reside in this state or in another state. (7-1-21)T

10. When Is a Small Employer Carrier Not Subject to the Act and This Chapter. A carrier that is not operating as a small employer carrier in this state does not become subject to the provisions of the Act and this chapter solely because a small employer that was issued a health benefit plan in another state by that carrier moves to this state. (7-1-21)T

016. -- 020. (RESERVED)

021. ESTABLISHMENT OF CLASSES OF BUSINESS.

01. Supporting Documentation for Establishment of Classes of Business. A small employer carrier that establishes more than one class of business pursuant to the provisions of Section 41-4705, Idaho Code, maintains on file for inspection by the Director the following information with respect to each class of business so established: (7-1-21)T

a. A description of each criterion employed by the carrier (or any of its agents) for determining membership in the class of business; (7-1-21)T

b. A statement describing the justification for establishing the class as a separate class of business and documentation that the establishment of the class of business is intended to reflect substantial differences in expected claims experience or administrative costs related to the reasons set forth in Section 41-4705, Idaho Code; and (7-1-21)T

c. A statement disclosing that, if any, health benefit plans are currently available for purchase in the class and any significant limitations related to the purchase of such plans. (7-1-21)T

02. Group Size Is Not a Class of Business. A carrier will not directly or indirectly use group size as a criterion for establishing eligibility for a health benefit plan or for a class of business. (7-1-21)T

022. -- 027. (RESERVED)

028. TRANSITION FOR ASSUMPTIONS OF BUSINESS FROM ANOTHER CARRIER.

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

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

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

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

02. Time Frame for Filing Plan to Assume or Cede Entire Insurance Obligation. A carrier domiciled in this state that proposes to assume or cede the entire insurance obligation and/or risk of one or more small employer health benefit plans from another carrier makes a filing for approval with the Director at least sixty (60) days prior to the date of the proposed assumption. The Director may approve the transaction if the Director finds that the transaction is in the best interests of the individuals insured under the health benefit plans to be transferred and is consistent with the purposes of the Act and this chapter. The Director will not approve the transaction until at least thirty (30) days after the date of the filing; except that, if the ceding carrier is in hazardous financial condition, the Director may approve the transaction as soon as the Director deems reasonable. (7-1-21)T

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

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

b. Describe whether the assuming carrier will maintain the assumed health benefit plans as a separate class of business (pursuant to Subsection 028.08 or will incorporate them into an existing class of business (pursuant to Subsection 028.09). If the assumed health benefit plans will be incorporated into an existing class of business, the filing will describe the class of business of the assuming carrier into which the health benefit plans will be incorporated; (7-1-21)T

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

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

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

f. Describe any other potential material effects of the assumption on the coverage provided to the small employers covered by the health benefit plans to be assumed; and (7-1-21)T

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

04. Informational Filings in Other States. A small employer carrier prescribed to make a filing under

Subsection 028.02 will also make an informational filing with the Insurance Supervisory Official of each state in which there are small employer health benefit plans that would be included in the transaction. The informational filing to each state will be made concurrently with the filing made under Subsection 028.02 and will include at least the information specified in Subsection 028.03 for the small employer health benefit plans in that state. (7-1-21)T

05. Other Considerations in the Transfer and Assumption of the Entire Insurance Obligation. A small employer carrier will not transfer or assume the entire insurance obligation and/or risk of a health benefit plan covering a small employer in this state unless it complies with the following provisions: (7-1-21)T

a. The carrier has provided notice to the Director at least sixty (60) days prior to the date of the proposed assumption. The notice contains the information specified in Subsection 028.03 for the health benefit plans covering small employers in this state. (7-1-21)T

b. If the assumption of a class of business would result in the assuming small employer carrier being out of compliance with the limitations related to premium rates contained in Section 41-4706(1)(a), Idaho Code, the assuming carrier makes a filing with the Director pursuant to Section 41-4706(3), Idaho Code, seeking suspension of the application of Section 41-4706(1)(a), Idaho Code. (7-1-21)T

c. An assuming carrier seeking suspension of the application of Section 41-4706(1)(a), Idaho Code, will not complete the assumption of health benefit plans covering small employers in this state unless the Director grants the suspension requested pursuant to Paragraph 028.05.b. (7-1-21)T

d. Unless a different period is approved by the Director, a suspension of the application of Section 41-4706(1)(a), Idaho Code, with respect to an assumed class of business, is for no more than fifteen (15) months and, with respect to each individual small employer, lasts only until the anniversary date of such employer's coverage (except that the period with respect to an individual small employer may be extended beyond its first anniversary date for a period of up to twelve (12) months if the anniversary date occurs within three (3) months of the date of assumption of the class of business). (7-1-21)T

06. Exceptions to Ceding or Assumption of Business. Except as provided in Subsection 028.02, a small employer carrier will not cede or assume the entire insurance obligation and/or risk for a small employer health benefit plan unless the transaction includes the ceding to the assuming carrier of the entire class of business within Idaho which includes such health benefit plan. (7-1-21)T

07. Requirements for Ceding Less Than an Entire Class of Business. A small employer carrier may cede less than an entire class of business to an assuming carrier if: (7-1-21)T

a. One (1) or more small employers in the class have exercised their right under contract to reject, either directly or by implication, the ceding of their health benefit plans to another carrier. In that instance, the transaction includes each health benefit plan in the class of business except those health benefit plans for which a small employer has rejected the proposed cession; or (7-1-21)T

b. After a written request from the transferring carrier, the Director determines that the transfer of less than the entire class of business is in the best interests of the small employers insured in that class of business. (7-1-21)T

08. Separate Class of Business. Except as provided in Subsection 028.09, a small employer carrier that assumes one (1) or more health benefit plans from another carrier will maintain such health benefit plans as a separate class of business. (7-1-21)T

09. Provisions for Exceeding the Maximum Number of Classes of Business. A small employer carrier that assumes one or more health benefit plans from another carrier may exceed the limitation contained in Section 41-4705(2), Idaho Code, (relating to the maximum number of classes of business a carrier may establish) due solely to such assumption for a period of up to fifteen (15) months after the date of the assumption, provided that the carrier complies with the following provisions: (7-1-21)T

a. Upon assumption of the health benefit plans, such health benefit plans are maintained as a separate

class of business. During the fifteen-month (15) period following the assumption, each of the assumed small employer health benefit plans are transferred by the assuming small employer carrier into a single class of business operated by the assuming small employer carrier. The assuming small employer carrier selects the class of business into which the assumed health benefit plans will be transferred in a manner such that the transfer results in the least possible change to the benefits and rating method of the assumed health benefit plans. (7-1-21)T

b. The transfers authorized in Paragraph 028.09.a. occurs with respect to each small employer on the anniversary date of the small employer's coverage, except that the period with respect to an individual small employer may be extended beyond its first anniversary date for a period of up to twelve (12) months if the anniversary date occurs within three (3) months of the date of assumption of the class of business. (7-1-21)T

c. A small employer carrier making a transfer pursuant to Paragraph 028.09.a. may alter the benefits of the assumed health benefit plans to conform to the benefits currently offered by the carrier in the class of business into which the health benefit plans have been transferred. (7-1-21)T

d. The premium rate for an assumed small employer health benefit plan is not modified by the assuming small employer carrier until the health benefit plan is transferred pursuant to Paragraph 028.09.a. Upon transfer, the assuming small employer carrier calculates a new premium rate for the health benefit plan from the rate manual established for the class of business into which the health benefit plan is transferred. In making such calculation, the risk load applied to the health benefit plan is no higher than the risk load applicable to such health benefit plan prior to the assumption. (7-1-21)T

e. During the fifteen-month (15) period provided in this Subsection, the transfer of small employer health benefit plans from the assumed class of business in accordance with this subsection is considered a violation of Section 41-4706(2), Idaho Code. (7-1-21)T

10. Restrictions to Apply Eligibility Requirements by Assuming Carrier. An assuming carrier will not apply eligibility requirements, including minimum participation and contribution requirements, with respect to an assumed health benefit plan (or with respect to any health benefit plan subsequently offered to a small employer covered by such an assumed health benefit plan) that are more stringent than the requirements applicable to such health benefit plan prior to the assumption. (7-1-21)T

11. Request for Extension of the Transition Period. The Director may approve a longer period of transition upon application of a small employer carrier. The application is made within sixty (60) days from assumption of the class of business and clearly states the justification for a longer transition period. (7-1-21)T

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

a. Reduce or diminish any legal or contractual obligation or requirement, including any obligation provided in Section 41-511, Idaho Code, of the ceding or assuming carrier related to the transaction; (7-1-21)T

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

c. Reduce or diminish the protections related to an assumption reinsurance transaction provided in Section 41-511, Idaho Code, or otherwise provided by law. (7-1-21)T

029. -- 035. (RESERVED)

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

01. Separate Rate Manual for Each Class of Business. A small employer carrier develops a separate rate manual for each class of business. Base premium rates and new business premium rates charged to small employers by the small employer carrier are computed solely from the applicable rate manual developed pursuant to this Section. To the extent that a portion of the premium rates charged by a small employer carrier is based on the carrier's discretion, the manual specifies the criteria and factors considered by the carrier in exercising such

discretion. (7-1-21)T

02. Requirements for Adjustments to Rating Method. A small employer carrier will not modify the rating method used in the rate manual for a class of business until the change has been approved as provided in this Section. The Director may approve a change to a rating method if the Director finds that the change is reasonable, actuarially appropriate, and consistent with the purposes of the Act and this chapter. (7-1-21)T

03. Information for Review of Modification of Rating Method. A carrier may modify the rating method for a class of business only with prior approval of the Director. A carrier requesting to change the rating method for a class of business makes a filing with the Director at least thirty (30) days prior to the proposed date of the change. The filing contains at least the following information: (7-1-21)T

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

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

c. A description of how the change in rating method would affect the premium rates currently charged to small employers in the class of business, including an estimate from a qualified actuary of the number of groups or individuals (and a description of the types of groups or individuals) whose premium rates may change by more than ten percent (10%) due to the proposed change in rating method (not generally including increases in premium rates applicable to all small employers in a health benefit plan); (7-1-21)T

d. A certification from a qualified actuary that the new rating method would be based on objective and credible data and would be actuarially sound and appropriate; and (7-1-21)T

e. A certification from a qualified actuary that the proposed change in rating method would not produce premium rates for small employers that would be in violation of Section 41-4706, Idaho Code. (7-1-21)T

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

a. A change in the number of case characteristics used by a small employer carrier to determine premium rates for health benefit plans in a class of business (a small employer will not use case characteristics other than age, individual tobacco use, geography or gender without prior approval of the Director); (7-1-21)T

b. A change in the manner or procedures by which insureds are assigned into categories for the purpose of applying a case characteristic to determine premium rates for health benefit plans in a class of business; (7-1-21)T

c. A change in the method of allocating expenses among health benefit plans in a class of business; or (7-1-21)T

d. A change in a rating factor with respect to any case characteristic if the change would produce a change in premium for any small employer that exceeds ten percent (10%). (7-1-21)T

e. For the purpose of this Subsection, a change in a rating factor means the cumulative change with respect to such factor considered over a twelve (12) month period. If a small employer carrier changes rating factors with respect to more than one case characteristic in a twelve (12) month period, the carrier considers the cumulative effect of all such changes in applying the ten percent (10%) test. (7-1-21)T

05. Rate Manual to Specify Case Characteristics and Rate Factors to Be Applied. The rate manual developed pursuant to Subsection 036.01 specifies the case characteristics and rate factors to be applied by the small employer carrier in establishing premium rates for the class of business. (7-1-21)T

06. Uniform Application of Case Characteristics. A small employer carrier uses the same case characteristics as defined in Section 41-4706(1)(h), Idaho Code, in establishing premium rates for each health benefit plan in a class of business and applies them in the same manner in establishing premium rates for each such health

benefit plan. Case characteristics are applied without regard to the risk characteristics of a small employer. (7-1-21)T

07. Base Premium Rates and Any Difference in New Business Rate. The rate manual developed pursuant to Subsection 036.01 clearly illustrates the relationship among the base premium rates charged for each health benefit plan in the class of business. If the new business premium rate is different than the base premium rate for a health benefit plan, the rate manual illustrates the difference. (7-1-21)T

08. Reasonable and Objective Rate Differences. Differences among base premium rates for health benefit plans are based solely on the reasonable and objective differences in the design and benefits of the health benefit plans and will not be based in any way on the actual or expected health status or claims experience of the small employer groups that choose or are expected to choose a particular health benefit plan. A small employer carrier applies case characteristics and rate factors within a class of business in a manner that assures that premium differences among health benefit plans for identical small employer groups vary only due to reasonable and objective differences in the design and benefits of the health benefit plans and are not due to the actual or expected health status or claims experience of the small employer groups that choose or are expected to choose a particular health benefit plan. (7-1-21)T

09. Two-Step Process. The rate manual developed pursuant to Subsection 036.01 provides for premium rates to be developed in a two-step process. In the first step, a base premium rate is developed for the small employer group without regard to any risk characteristics of the group. In the second step, the resulting base premium rate may be adjusted by a risk load, subject to the provisions of Section 41-4706, Idaho Code, to reflect the risk characteristics of the group. (7-1-21)T

10. Exception to Application Fee, Underwriter Fee, or Other Fees. Except as provided in Subsection 036.11, a premium charged to a small employer for a health benefit plan will not include a separate application fee, underwriting fee, or any other separate fee or charge. (7-1-21)T

11. Uniform Application of Fees. A carrier may charge a separate fee with respect to a health benefit plan provided the fee is applied in a uniform manner to every health benefit plan in a class of business. All such fees are premium and are included in determining compliance with the Act and this chapter. (7-1-21)T

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

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

14. Guidelines Issued by Director. The rate manual and rating practices of a small employer carrier will comply with any guidelines issued by the Director. (7-1-21)T

15. Application of Restrictions Related to Changes in Premium Rates. The restrictions related to changes in premium rates are set forth in Section 41-4706(1)(c), Idaho Code, and are applied as follows: (7-1-21)T

a. A small employer carrier revises its rate manual each rating period to reflect changes in base premium rates and changes in new business premium rates. (7-1-21)T

b. If, for any health benefit plan with respect to any rating period, the percentage change in the new business premium rate is less than or the same as the percentage change in the base premium rate, the change in the new business premium rate is the change in the base premium rate for the purposes of Sections 41-4706(1)(c)(i), Idaho Code. (7-1-21)T

c. If, for any health benefit plan with respect to any rating period, the percentage change in the new business premium rate exceeds the percentage change in the base premium rate, the health benefit plan is considered a health benefit plan into which the small employer carrier is no longer enrolling new small employers for the purposes of Section 41-4706(1)(c)(i), Idaho Code. (7-1-21)T

d. If, for any rating period, the change in the new business premium rate for a health benefit plan differs from the change in the new business premium rate for any other health benefit plan in the same class of business by more than twenty percent (20%), the carrier makes a filing with the Director containing a complete explanation of how the respective changes in new business premium rates were established and the reason for the difference. The filing is made within thirty (30) days of the beginning of the rating period. (7-1-21)T

e. A small employer carrier keeps on file for a period of at least six (6) years the calculations used to determine the change in base premium rates and new business premium rates for each health benefit plan for each rating period. (7-1-21)T

16. Change in Premium Rate. Except as provided in Subsection 036.17, a change in premium rate for a small employer produces a revised premium rate that is no more than the following: (7-1-21)T

a. The base premium rate for the small employer, given its present composition, (as shown in the rate manual as revised for the rating period), multiplied by; (7-1-21)T

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

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

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

17. Plans No Longer Enrolling New Business. In the case of a health benefit plan into which a small employer carrier is no longer enrolling new small employers, a change in premium rate for a small employer will produce a revised premium rate that is no more than the base premium rate for the small employer (given its present composition and as shown in the rate manual in effect for the small employer at the beginning of the previous rating period), multiplied by Paragraphs 036.17.a. and 036.17.b. (7-1-21)T

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

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

ii. The percentage change in the new business premium for the most similar health benefit plan into which the small employer carrier is enrolling new small employers. (7-1-21)T

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

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

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

18. Limitations on Revised Premium Rate. Notwithstanding the provisions of Subsections 036.16 and 036.17, a change in premium rate for a small employer will not produce a revised premium rate that would exceed the limitations on rates provided in Section 41-4706(1)(b), Idaho Code. (7-1-21)T

19. Waiver Request for a Taft-Hartley Trust. A representative of a Taft-Hartley trust (including a carrier upon the written request of such a trust) may file a written request with the Director for the waiver of application of the provisions of Section 41-4706(1), Idaho Code, with respect to such trust. (7-1-21)T

20. Provisions for Which Trust Is Seeking Waiver. A request made under Subsection 036.19 identifies the provisions for which the trust is seeking the waiver and describes, with respect to each provision, the extent to which application of such provision would: (7-1-21)T

a. Adversely affect the participants and beneficiaries of the trust; and (7-1-21)T

b. Require modifications to one (1) or more of the collective bargaining agreements under or pursuant

to which the trust was or is established or maintained. (7-1-21)T

21. Waiver Not for an Individual or Associate Member. A waiver granted under this provision will not apply to an individual who participates in the trust because the individual is an associate member of an employee organization or the beneficiary of such an individual. (7-1-21)T

037. -- 045. (RESERVED)

046. REQUIREMENT TO INSURE ENTIRE GROUPS.

01. Offer of Coverage. A small employer carrier that offers coverage to a small employer will offer to provide coverage to each eligible employee and to each dependent of an eligible employee. Except as provided in Subsection 046.02, the small employer carrier provides the same health benefit plan to each such employee and dependent. (7-1-21)T

02. Choice of Health Benefit Plans. A small employer carrier may offer the employees of a small employer the option of choosing among one (1) or more health benefit plans, provided that each eligible employee may choose any of the offered plans. The choice among benefit plans will not be limited, restricted or conditioned based upon the risk characteristics of the eligible employees or their dependents. (7-1-21)T

03. Participation Requirement. The small employer carrier may impose reasonable minimum participation requirements for issuance of coverage to small employers, subject to prior approval from the Director. (7-1-21)T

04. Employer Census and Supporting Documentation. A small employer carrier will require each small employer that applies for coverage, as part of the application process, to prepare or provide an employer census of dependents and eligible employees as defined in Sections 41-4703(11) and 41-4703(13), Idaho Code. The small employer carrier may require the small employer to provide appropriate supporting documentation (such as the W-2 Summary Wage and Tax Form) or a certification of information by a Small Employer as to the current census information. (7-1-21)T

05. Waiver for Documentation of Coverage. A small employer carrier will secure a waiver with respect to each eligible employee and each dependent of such an eligible employee who declines an offer of coverage under a health benefit plan provided to a small employer. The waiver is signed by the eligible employee (on behalf of such employee or the dependent of such employee) and certifies that the individual who declined coverage was informed of the availability of coverage under the health benefit plan. The waiver form requires that the reason for declining coverage be stated on the form, and includes a statement informing the eligible employee of the special enrollment rights provided within the Section 41-4703(17)(d) and (e), Idaho Code, and includes a written warning of the penalties imposed on late enrollees. Waivers are maintained by the small employer carrier for a period of six (6) years. (7-1-21)T

06. Refusal to Provide Information. A small employer carrier will not issue coverage to a small employer that refuses to provide the list prescribed under Subsection 046.04 or a waiver prescribed under Subsection 046.05, except if the excluded individual has coverage under a health benefit plan or other health benefit arrangement that provides benefits similar to or exceeding benefits provided under the basic health benefit plan. (7-1-21)T

07. Induced Declinations. A small employer carrier will not issue coverage to a small employer if the carrier, or an agent for such carrier, has reason to believe that the small employer has induced or pressured an eligible employee (or dependent of an eligible employee) to decline coverage due to a health status related factor of the individual. (7-1-21)T

08. Agent Notification to Small Employer Carrier. An agent will notify a small employer carrier, prior to submitting an application for coverage with the carrier on behalf of a small employer, of any circumstances that would indicate that the small employer has induced or pressured an eligible employee (or dependent of an eligible employee) to decline coverage due to the individual's risk characteristics. (7-1-21)T

09. New Entrants. New entrants to a small employer group are offered an opportunity to enroll in the

health benefit plan currently held by such group based upon the provisions of Section 41-4708, Idaho Code. A new entrant that does not exercise the opportunity to enroll in the health benefit plan within the period provided by the small employer carrier may be treated as a late enrollee by the carrier, provided that the period provided to enroll in the health benefit plan extends at least thirty (30) days after the date the new entrant is notified of their opportunity to enroll. The period of continuous coverage will not include any waiting period for the effective date of the new coverage applied by the employer to all new enrollees under the Employee Benefit Plan. If a small employer carrier has offered more than one health benefit plan to a small employer group pursuant to Subsection 046.02, the new entrant is offered the same choice of health benefit plans as the other members of the group. (7-1-21)T

10. Waiting Period. A small employer carrier will not apply a waiting period, elimination period or other similar limitation of coverage (other than an exclusion for pre-existing medical conditions consistent with Section 41-4708(3), Idaho Code). (7-1-21)T

11. Risk Characteristics. New entrants to a group are accepted for coverage by the small employer carrier without any restrictions or limitations on coverage related to the risk characteristics of the employees or their dependents, except that a carrier may exclude or limit coverage for pre-existing medical conditions, consistent with the provisions provided in Section 41-4708(3), Idaho Code. (7-1-21)T

12. Risk Load. A small employer carrier may assess a risk load to the premium rate associated with a new entrant, consistent with the requirements of Section 41-4706, Idaho Code. The risk load is the same risk load charged to the small employer group immediately prior to acceptance of the new entrant into the group. (7-1-21)T

13. Rescission Employer Misstatements. When material application misstatements are found, rescission action by the carrier may be taken at the carrier's option against the coverage of an entire small employer (including employees and dependents) and is limited to circumstances under which the application misstatements have been made by the small employer. When rescission action is taken, per Section 41-4707(1)(b), Idaho Code, premiums are refunded less any claims which had been paid prior to the date the rescission was initiated. At the carrier's option, the carrier may seek to recover any amounts of claims paid in excess of premiums paid. The applicable contract or coverage is considered null and void. (7-1-21)T

047. -- 054. (RESERVED)

055. APPLICATION TO REENTER STATE.

Restrictions on offering small group health insurance. A carrier that has been banned from writing coverage for small employers in this state pursuant to Section 41-4707(2), Idaho Code, will not resume offering health benefit plans to small employers in this state until the carrier has made a petition to the Director to be reinstated as a small employer carrier and the petition has been approved by the Director. In reviewing a petition, the Director may ask for such information and assurances as the Director finds reasonable and appropriate. (7-1-21)T

056. -- 059. (RESERVED)

060. QUALIFYING PREVIOUS AND QUALIFYING EXISTING COVERAGES.

01. Previous Coverage or Existing Coverage. In determining whether a health benefit plan or other health benefit arrangement (whether public or private) is considered qualifying previous coverage or qualifying existing coverage for the purposes of Sections 41-4703(17), 41-4703(23), and 41-4708(3)(c), Idaho Code, a small employer carrier interprets the Act no less favorably to an insured individual than the following: (7-1-21)T

a. A health benefit plan, certificate, or other health benefit arrangement is considered employer-based if an employer sponsors the plan or arrangement or makes a contribution to the plan or arrangement. (7-1-21)T

02. Source of Previous or Existing Coverage. A small employer carrier will ascertain the source of previous or existing coverage of each eligible employee and each dependent of an eligible employee at the time such employee or dependent initially enrolls into the health benefit plan provided by the small employer carrier. The small employer carrier has the responsibility to contact the source of such previous or existing coverage to resolve any questions about the benefits or limitations related to such previous or existing coverage. (7-1-21)T

03. Certification of Creditable Coverage. Small employer carriers will provide written certification of creditable coverage to individuals in accordance with this Subsection. (7-1-21)T

a. A small employer carrier satisfies the certification requirements if another person provides the certificate, but only to the extent that information relating to the individual's creditable coverage and waiting or affiliation period has been provided by another person. (7-1-21)T

b. To the extent coverage under a health benefit plan consists of group coverage, the plan satisfies the certification requirements if the small employer carrier offering the coverage is prescribed to provide the certificates of creditable coverage to individuals pursuant to an agreement between the plan and the carrier. (7-1-21)T

c. A small employer carrier is not obligated to provide information regarding health benefit plan coverage provided to an individual by another person. (7-1-21)T

i. If an individual's coverage under a policy ceases before the individual's coverage under the group health plan ceases, the entity that issued the policy provides sufficient information to the small employer carrier, or to another person designated by the carrier, to enable the carrier, or other person, to provide a certificate that reflects the period of coverage under the policy, after the individual's coverage under the group health plan ceases. (7-1-21)T

ii. The provision of the information pursuant to Subparagraph 060.03.c.i. to the new carrier satisfies the entity's obligation to provide an automatic certificate. (7-1-21)T

iii. The carrier providing the information about creditable coverage cooperates with other carriers in responding to any request for additional information. (7-1-21)T

iv. If the individual's coverage under a group health plan ceases, the carrier that issued the group policy provides an automatic certificate of coverage. (7-1-21)T

d. A small employer carrier provides a certification of creditable coverage, without charge, to participants or dependents who are or were covered under the group health benefit plan. (7-1-21)T

e. A small employer carrier provides a certificate at the time a request is made on behalf of an individual if the request is made not later than twenty-four (24) months after the date the individual's coverage ceased under the plan. (7-1-21)T

i. Each small employer carrier establishes a procedure for individuals to request and receive certificates. Upon a receipt of the request, the small employer carrier provides the certificate by the earliest date that the carrier, acting in a reasonable and prompt fashion, can provide the certificate. (7-1-21)T

f. The certificate provided includes: (7-1-21)T

i. The date the certificate was issued; (7-1-21)T

ii. The name of the group health plan that provided the coverage described in the certificate; (7-1-21)T

iii. The name of the participant or dependent with respect to whom the certificate applies, and any other information necessary for the plan providing the coverage specified in the certificate to identify the individual, such as the individual's identification number under the plan; (7-1-21)T

iv. The name, address, and telephone number of the plan administrator prescribed to provide the certificate; (7-1-21)T

v. The telephone number to call for further information regarding the certificate; (7-1-21)T

vi. Either a statement that the individual has at least twelve (12) months of creditable coverage, disregarding days of creditable coverage before a significant break in coverage; or the date any waiting period or

affiliation period, if applicable, began and the date creditable coverage began; and (7-1-21)T

vii. The date creditable coverage ended, unless the certificate indicates that the creditable coverage is continuing as of the date of the certificate. (7-1-21)T

g. Small employer carriers may provide a certificate by first-class mail, at the participant's last known address. (7-1-21)T

h. The model for the certification of coverage may be found on the Department of Insurance Internet website. (7-1-21)T

061. -- 066. (RESERVED)

067. RESTRICTIVE RIDERS.
Except as permitted in Section 41-4708(3), Idaho Code, a small employer carrier will not modify or restrict any health benefit plan with respect to any eligible employee or dependent of an eligible employee, through riders, endorsements or otherwise, for the purpose of restricting or excluding the coverage or benefits provided to such employee or dependent for specific diseases, medical conditions, including but not limited to pregnancy, or services otherwise covered by the plan. (7-1-21)T

068. -- 074. (RESERVED)

075. RULES RELATED TO FAIR MARKETING.

01. Small Employer Carrier to Actively Market. A small employer carrier actively markets each of its health benefit plans to small employers in this state. (7-1-21)T

02. Marketing Mandated Plans. In marketing the mandated health benefit plans to small employers, a small employer carrier uses at least the same sources and methods of distribution that it uses to market other health benefit plans to small employers. Any producer authorized by a small employer carrier to market health benefit plans to small employers in the state is also authorized to market the mandated health benefit plans. (7-1-21)T

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

a. A general description of the benefits and base rates contained in all actively marketed, including but not limited to the mandated, health benefit plans; and (7-1-21)T

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

04. Timeliness of Price Quote. A small employer carrier provides a price quote to a small employer (directly or through an authorized producer) within ten (10) working days of receiving a request for a quote and such information as is necessary to provide the quote. A small employer carrier notifies a small employer (directly or through an authorized producer) within five (5) working days of receiving a request for a price quote of any additional information needed by the small employer carrier to provide the quote. (7-1-21)T

05. Toll-Free Telephone Service. A small employer carrier establishes and maintains a toll-free telephone service to provide information to small employers regarding the availability of small employer health benefit plans in this state. The service provides information to callers on how to apply for coverage from the carrier. The information may include the names and phone numbers of producers located geographically proximate to the caller or such other information reasonably designed to assist the caller to locate an authorized producer or to apply for coverage. (7-1-21)T

06. Restrictions as to Contribution to Association. The small group carrier will not require a small employer to join or contribute to any association or group as a condition of being accepted for coverage by the small

employer carrier, except that, if membership in an association or other group is a requirement for accepting a small employer into a particular health benefit plan, a small employer carrier may apply such requirement, subject to the requirements of Section 41-4708, Idaho Code. (7-1-21)T

07. No Requirement to Qualify for Other Insurance Product. A small employer carrier will not require, as a condition to the offer of sale of a health benefit plan to a small employer, that the small employer purchase or qualify for any other insurance product or service. (7-1-21)T

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

09. Annual Filing Requirement. A small employer carrier files annually the following information with the Director related to health benefit plans issued by the small employer carrier to small employers in this state on forms prescribed by the Director: (7-1-21)T

a. The number of small employers that were covered under health benefit plans in the previous calendar year (separated as to newly issued plans and renewals); (7-1-21)T

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

c. The number of small employer health benefit plans in force in each county (or by five (5) digit zip code) of the state as of December 31 of the previous calendar year; (7-1-21)T

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

e. The number of small employer health benefit plans that were terminated or non renewed (for reasons other than nonpayment of premium) by the carrier in the previous calendar year; and (7-1-21)T

f. The number of health benefit plans that were issued to residents that were uninsured for at least sixty-three (63) days prior to issue. (7-1-21)T

10. Total Number of Residents. All carriers file annually with the Director, on forms prescribed by the Director, the total number of residents, including spouses and dependents, covered during the previous calendar year under all health benefit plans issued in this state. This includes residents covered under reinsurance by way of excess loss or stop loss plans. (7-1-21)T

11. Filing Date. The information described in Subsections 075.09 and 075.10 is filed no later than March 15, each year. (7-1-21)T

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

076. -- 080. (RESERVED)

081. LIMITATIONS AND EXCLUSIONS.

01. Allowances. A health benefit plan will not limit or exclude coverage by type of illness, accident, treatment, or medical condition, except as follows: (7-1-21)T

a. Any service not medically necessary or appropriate unless specifically included within the coverage provisions. (7-1-21)T

b. Custodial, convalescent or intermediate level care or rest cures. (7-1-21)T

c. Services that are experimental or investigational. (7-1-21)T

d. Services eligible for coverage by Workers' Compensation, Medicare or CHAMPUS. (7-1-21)T

e. Services for which no charges are made or for which no charges would be made in the absence of insurance or for which the insured has no legal obligation to pay. (7-1-21)T

f. Services for weight control, nutrition, and smoking cessation, including self-help and training programs as well as prescription drugs, used in conjunction with such programs and services. (7-1-21)T

g. Cosmetic surgery and services, except for treatment or surgery for congenital anomaly and mastectomy reconstruction as described in the Women's Health and Cancer Rights Act. (7-1-21)T

h. Artificial insemination, infertility treatment, and the treatment of sexual dysfunction not related to organic disease. (7-1-21)T

i. Services for reversal of elective, surgically or pharmaceutically induced infertility. (7-1-21)T

j. Vision therapy, tests, glasses, contact lenses and other vision aids. Radial keratotomy, myopic keratomileusis and any surgery involving corneal tissue to alter or correct myopia, hyperopia or stigmatic error. Vision tests and glasses will be covered for children under the age of twelve (12), except in catastrophic health benefit plans. (7-1-21)T

k. For treatment of weak, strained, or flat feet, including orthopedic shoes or other supportive devices, or for cutting, removal, or treatment of corns, calluses, or nails other than corrective surgery, or for metabolic or peripheral vascular disease. (7-1-21)T

l. One thousand dollars ($1,000) per year limit, subject to the policy deductible, coinsurance, or copayment, on manipulative therapy and related treatment, including heat treatments and ultrasound, of the musculoskeletal structure for other than fractures and dislocations of the extremities. (7-1-21)T

m. Dental care or treatment, except for injury sustained while insured under this policy, or as a result of nondental disease covered by the policy. (7-1-21)T

n. Hearing or speech tests without illness being suspect. (7-1-21)T

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

p. Private room accommodation charges in excess of the institution's most common semi-private room charge except when prescribed as medically necessary. (7-1-21)T

q. Services performed by a member of the insured's family or of the insured's spouse's family. Family includes parents or grandparents of the insured or spouse and any descendants of such parents or grandparents. (7-1-21)T

r. Care incurred before the effective date of the person's coverage. (7-1-21)T

s. Immunizations and medical exams and tests of any kind not related to treatment of covered injury or disease, except as specifically stated in the policy. (7-1-21)T

t. Injury or sickness caused by war or armed international conflict. (7-1-21)T

u. Sex change operations and treatment in connection with transsexualism. (7-1-21)T

v. Marriage and family and child counseling except as specifically allowed in the policy. (7-1-21)T

w. Acupuncture. (7-1-21)T

x. Private duty nursing except as specifically allowed in the policy. (7-1-21)T

y. Services received from a medical or dental department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group. (7-1-21)T

z. Services incurred after the date of termination of a covered person's coverage except as allowed by any extension of benefits provision of the policy. (7-1-21)T

aa. Expenses for personal hygiene and convenience items such as air conditioners, humidifiers, and physical fitness equipment. (7-1-21)T

bb. Charges for failure to keep a scheduled visit, charges for completion of any form, and charges for medical information. (7-1-21)T

cc. Charges for screening examinations except as otherwise provided in the policy. (7-1-21)T

dd. Charges for wigs or cranial prostheses, hair analysis, hair loss and baldness. (7-1-21)T

ee. Pre-existing conditions, except as provided specifically in the policy. (7-1-21)T

i. A health benefit plan will not deny, exclude or limit benefits for a covered individual for covered expenses incurred more than twelve (12) months following the effective date of the individual's coverage due to a pre-existing condition. (7-1-21)T

ii. A health benefit plan waives any time period applicable to a pre-existing condition exclusion or limitation period with respect to particular services for the period of time an individual was previously covered by qualifying previous coverage that provided benefits with respect to such services, provided that the qualifying previous coverage was continuous to a date not more than sixty-three (63) days prior to the effective date of the new coverage. This provision does not preclude application of any waiting period applicable to all new enrollees under the health benefit plan. (7-1-21)T

iii. A health benefit plan may exclude coverage for late enrollees for the greater of twelve (12) months or for a twelve (12) months pre-existing condition exclusion; provided that if both a period of exclusion from coverage and a pre-existing condition exclusion are applicable to a late enrollee, the combined period will not exceed twelve (12) months from the date the individual enrolls for coverage under the health benefit plan. (7-1-21)T

082. -- 999. (RESERVED)

Subject Index