TITLE 41
INSURANCE

CHAPTER 52
INDIVIDUAL HEALTH INSURANCE AVAILABILITY ACT

41-5201. SHORT TITLE. This chapter shall be known and may be cited as the "Individual Health Insurance Availability Act."

[41-5201, added 1994, ch. 427, sec. 1, p. 1338.]

41-5202. PURPOSE. The purpose and intent of this chapter is to promote the availability of health insurance coverage to persons not covered by employment based insurance regardless of their health status or claims experience, to prevent abusive rating practices, to require disclosure of rating practices to purchasers, to establish rules regarding renewability of coverage, to establish limitations on the use of preexisting condition exclusions, and to improve the overall fairness and efficiency of the individual health insurance market.

This chapter is not intended to provide a comprehensive solution to the problem of affordability of health care or health insurance.

[41-5202, added 1994, ch. 427, sec. 1, p. 1338; am. 1997, ch. 321, sec. 19, p. 980; am. 2000, ch. 472, sec. 10, p. 1623.]

41-5203. DEFINITIONS. As used in this chapter:

(1) "Actuarial certification" means a written statement by a member of the American academy of actuaries or other individual acceptable to the director that an individual carrier is in compliance with the provisions of section 41-5206, Idaho Code, based upon the person's examination and including a review of the appropriate records and the actuarial assumptions and methods used by the individual carrier in establishing premium rates for applicable health benefit plans.

(2) "Affiliate" or "affiliated" means any entity or person who directly or indirectly through one (1) or more intermediaries, controls or is controlled by, or is under common control with, a specified entity or person.

(3) "Agent" means a producer as defined in section 41-1003(8), Idaho Code.

(4) "Base premium rate" means, as to a rating period, the lowest premium rate charged or that could have been charged under a rating system by the individual carrier to individuals with similar case characteristics for health benefit plans with the same or similar coverage.

(5) "Carrier" means any entity that provides health insurance in this state. For purposes of this chapter, carrier includes an insurance company, a hospital or professional service corporation, a fraternal benefit society, a health maintenance organization, any entity providing health insurance coverage or benefits to residents of this state as certificate holders under a group policy issued or delivered outside of this state, and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation.

(6) "Case characteristics" means demographic or other objective characteristics of an individual that are considered by the individual carrier in the determination of premium rates for the individual, provided that

claim experience, health status and duration of coverage shall not be case characteristics for the purposes of this chapter.

(7) "Control" shall be defined in the same manner as in section 41-3802(2), Idaho Code.

(8) "Dependent" in any new or renewing plan means a spouse, an unmarried child under the age of twenty-five (25) years and who receives more than one-half (1/2) of his financial support from the parent, or an unmarried child of any age who is medically certified as disabled and dependent upon the parent.

(9) "Director" means the director of the department of insurance of the state of Idaho.

(10) "Eligible individual" means an Idaho resident individual or dependent of an Idaho resident:

(a) Who is under the age of sixty-five (65) years, is not eligible for coverage under a group health plan, part A or part B of title XVIII of the social security act (medicare), or a state plan under title XIX (medicaid) or any successor program, and who does not have other health insurance coverage; or

(b) Who is a federally eligible individual (one who meets the eligibility criteria set forth in the federal health insurance portability and accountability act of 1996, Public Law 104-191, Sec. 2741(b) (HIPAA)).

An "eligible individual" can be the dependent of an eligible employee, which eligible employee is receiving health insurance benefits subject to the regulation of title 41, Idaho Code.

(11) "Enhanced short-term plan" means an individual health benefit plan that:

(a) Has an initial period of less than twelve (12) months and is renewable at the option of the individual for up to the number of months established by rules issued pursuant to section 41-5214, Idaho Code; and

(b) Otherwise meets the standards established by rules issued pursuant to section 41-5214, Idaho Code.

(12) "Established geographic service area" means a geographic area, as approved by the director and based on the carrier's certificate of authority to transact insurance in this state, within which the carrier is authorized to provide coverage.

(13) "Health benefit plan" means any hospital or medical policy or certificate, any subscriber contract provided by a hospital or professional service corporation, or health maintenance organization subscriber contract and includes enhanced short-term plans. Health benefit plan does not include policies or certificates of insurance for specific disease, hospital confinement indemnity, accident-only, credit, dental, vision, medicare supplement, long-term care, or disability income insurance, student health benefits only, coverage issued as a supplement to liability insurance, worker's compensation or similar insurance, automobile medical payment insurance, or nonrenewable short-term coverage issued for a period of twelve (12) months or less.

(14) "Index rate" means, as to a rating period for individuals with similar case characteristics, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate.

(15) "Individual basic health benefit plan" means a lower cost health benefit plan developed pursuant to chapter 55, title 41, Idaho Code, prior to April 1, 2017.

(16) "Individual carrier" means a carrier that offers health benefit plans covering eligible individuals and their dependents.

(17) "Individual catastrophic A health benefit plan" means a higher limit health benefit plan developed pursuant to chapter 55, title 41, Idaho Code, prior to April 1, 2017.

(18) "Individual catastrophic B health benefit plan" means a health benefit plan with limits higher than an individual catastrophic A health benefit plan developed pursuant to chapter 55, title 41, Idaho Code, prior to April 1, 2017.

(19) "Individual HSA compatible health benefit plan" means a health savings account compatible health benefit plan developed pursuant to chapter 55, title 41, Idaho Code, prior to April 1, 2017.

(20) "Individual standard health benefit plan" means a health benefit plan developed pursuant to chapter 55, title 41, Idaho Code, prior to April 1, 2017.

(21) "New business premium rate" means, as to a rating period, the lowest premium rate charged or offered or which could have been charged or offered by the individual carrier to individuals with similar case characteristics for newly issued health benefit plans with the same or similar coverage.

(22) "Premium" means all moneys paid by an individual and eligible dependents as a condition of receiving coverage from a carrier, including any fees or other contributions associated with the health benefit plan.

(23) "Qualifying previous coverage" and "qualifying existing coverage" mean benefits or coverage provided under:

(a) Medicare or medicaid, civilian health and medical program for uniformed services (CHAMPUS), the Indian health service program, a state health benefit risk pool, or any other similar publicly sponsored program; or

(b) Any group or individual health insurance policy or health benefit arrangement whether or not subject to the state insurance laws, including coverage provided by a managed care organization, hospital or professional service corporation, or a fraternal benefit society, that provides benefits similar to or exceeding benefits provided under the basic health benefit plan.

(24) "Rating period" means the calendar period for which premium rates established by a carrier are assumed to be in effect.

(25) "Reinsuring carrier" means a carrier participating in the Idaho individual high-risk reinsurance pool established in chapter 55, title 41, Idaho Code.

(26) "Restricted network provision" means any provision of a health benefit plan that conditions the payment of benefits, in whole or in part, on the use of health care providers that have entered into a contractual arrangement with the carrier to provide health care services to covered individuals.

(27) "Risk-assuming carrier" means a carrier whose application is approved by the director pursuant to section 41-5210, Idaho Code.

[41-5203, added 1994, ch. 427, sec. 1, p. 1338; am. 1995, ch. 360, sec. 8, p. 1254; am. 1997, ch. 321, sec. 20, p. 980; am. 2000, ch. 472, sec. 11, p. 1623; am. 2001, ch. 296, sec. 10, p. 1068; am. 2004, ch. 285, sec. 1, p. 802; am. 2005, ch. 353, sec. 1, p. 1111; am. 2007, ch. 148, sec. 4, p. 434; am. 2009, ch. 125, sec. 9, p. 401; am. 2013, ch. 266, sec. 14, p. 692; am. 2017, ch. 281, sec. 11, p. 741; am. 2019, ch. 301, sec. 1, p. 893.]

41-5204. APPLICABILITY AND SCOPE. To the extent permitted by federal law, the provisions of this chapter shall apply to any health benefit plan delivered or issued for delivery in the state of Idaho that provides coverage to eligible individuals or their dependents if not otherwise subject to the provisions of chapter 22, 40, 47 or 55, title 41, Idaho Code.

(1) Except as provided in subsection (2) of this section, for the purposes of this chapter, carriers that are affiliated companies or that are eligible to file a consolidated tax return shall be treated as one (1) carrier and any restrictions or limitations imposed in this chapter shall apply as if all health benefit plans delivered or issued for delivery to individuals in this state by such affiliated carriers were insured by one (1) carrier.

(2) An affiliated carrier that is a managed care organization having a certificate of authority pursuant to the provisions of chapter 39, title 41, Idaho Code, may be considered to be a separate carrier for the purposes of this chapter.

(3) Unless otherwise authorized by the director, an individual carrier shall not enter into one (1) or more ceding arrangements with respect to health benefit plans delivered or issued for delivery to individuals in this state if such arrangements would result in less than fifty percent (50%) of the insurance obligation or risk for such health benefit plans being retained by the ceding carrier. The provisions of sections 41-510, 41-511 and 41-515, Idaho Code, shall apply if an individual carrier cedes or assumes all of the insurance obligation or risk with respect to one (1) or more health benefit plans delivered or issued for delivery to individuals in this state.

[41-5204, added 1994, ch. 427, sec. 1, p. 1340; am. 2000, ch. 472, sec. 12, p. 1626; am. 2017, ch. 76, sec. 3, p. 208.]

41-5206. RESTRICTIONS RELATING TO PREMIUM RATES. (1) Premium rates for health benefit plans subject to the provisions of this chapter shall be subject to the following provisions:

(a) The premium rates charged during a rating period to individuals with similar case characteristics for the same or similar coverage, or the rates that could be charged to such individuals under the rating system, shall not vary from the index rate by more than fifty percent (50%) of the index rate.

(b) The percentage increase in the premium rate charged to an individual for a new rating period may not exceed the sum of the following:

(i) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a health benefit plan into which the individual carrier is no longer enrolling new individuals, the individual carrier shall use the percentage change in the base premium rate, provided that such change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the individual carrier is actively enrolling new individuals.

(ii) Any adjustment, not to exceed fifteen percent (15%) annually and adjusted pro rata for rating periods of less than one (1) year, due to the claim experience, health status or duration of coverage of the individual or dependents as determined from the individual carrier's rate manual; and

(iii) Any adjustment due to change in coverage or change in the case characteristics of the individual as determined from the individual carrier's rate manual.

(c) Premium rates for health benefit plans shall comply with the requirements of this section notwithstanding any assessments paid or payable by carriers pursuant to section 41-4711, Idaho Code, or chapter 55, title 41, Idaho Code.

(d) (i) Individual carriers shall apply rating factors, including case characteristics, consistently with respect to all individuals. Rating factors shall produce premiums for identical individuals which differ only by the amounts attributable to plan design and do not reflect differences due to the nature of the individuals assumed to select particular health benefit plans; and

(ii) An individual carrier shall treat all health benefit plans issued or renewed in the same calendar month as having the same rating period.

(e) For purposes of this subsection, a health benefit plan that utilizes a restricted provider network shall not be considered similar coverage to a health benefit plan that does not utilize such a network, provided that utilization of the restricted provider network results in substantial differences in claims costs.

(f) The individual carrier shall not use case characteristics, other than age, individual tobacco use, geography as defined by rule of the director, or gender, without prior approval of the director.

(g) An individual carrier may utilize age as a case characteristic in establishing premium rates, provided that the same rating factor shall be applied to all dependents under twenty-five (25) years of age, and the same rating factor may be applied on an annual basis as to individuals or nondependents twenty (20) years of age or older.

(h) The director may establish rules to implement the provisions of this section and to assure that rating practices used by individual carriers are consistent with the purposes of this chapter, including rules that:

(i) Assure that differences in rates charged for health benefit plans by individual carriers are reasonable and reflect objective differences in plan design, not including differences due to the nature of the individuals assumed to select particular health benefit plans;

(ii) Prescribe the manner in which case characteristics may be used by individual carriers; and

(iii) Prescribe the manner in which an individual carrier is to demonstrate compliance with the provisions of this section, including requirements that an individual carrier provide the director with actuarial certification as to such compliance.

(2) The director may suspend for a specified period the application of subsection (1)(a) of this section as to the premium rates applicable to one (1) or more individuals for one (1) or more rating periods upon a filing by the individual carrier and a finding by the director either that the suspension is reasonable in light of the financial condition of the individual carrier or that the suspension would enhance the efficiency and fairness of the marketplace for individual health insurance.

(3) In connection with the offering for sale of any health benefit plan to an individual, an individual carrier shall make a reasonable disclosure, as part of its solicitation and sales materials, of all of the following:

(a) The extent to which premium rates for an individual are established or adjusted based upon the actual or expected variation in claims costs or actual or expected variation in health status of the individual and his dependents;

(b) The provisions of the health benefit plan concerning the individual carrier's right to change premium rates and the factors, other than claim experience, that affect changes in premium rates;

(c) The provisions relating to renewability of policies and contracts; and

(d) The provisions relating to any preexisting condition provision.

(4) (a) Each individual carrier shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

(b) Each individual carrier shall file with the director annually on or before September 15, an actuarial certification certifying that the carrier is in compliance with the provisions of this chapter and that the rating methods of the individual carrier are actuarially sound. Such certification shall be in a form and manner, and shall contain such information, as specified by the director. A copy of the certification shall be retained by the individual carrier at its principal place of business.

(c) An individual carrier shall make the information and documentation described in subsection (4)(a) of this section available to the director upon request. Except in cases of violations of the provisions of this chapter, the information shall be considered proprietary and trade secret information and shall not be subject to disclosure by the director to persons outside of the department except as agreed to by the individual carrier or as ordered by a court of competent jurisdiction.

[41-5206, added 1994, ch. 427, sec. 1, p. 1341; am. 1995, ch. 360, sec. 9, p. 1256; am. 1997, ch. 232, sec. 2, p. 679; am. 2000, ch. 415, sec. 2, p. 1324; am. 2000, ch. 472, sec. 13, p. 1626; am. 2002, ch. 99, sec. 2, p. 272; am. 2004, ch. 360, sec. 2, p. 1079; am. 2007, ch. 148, sec. 5, p. 436.]

41-5207. RENEWABILITY OF COVERAGE. (1) A health benefit plan subject to the provisions of this chapter shall be renewable with respect to the individual or dependents, at the option of the individual, except in any of the following cases:

(a) Nonpayment of the required premiums;

(b) Fraud or intentional misrepresentation of material fact by the individual insured or his representatives. An individual whose coverage is terminated for fraud or misrepresentation shall not be deemed to be an "eligible individual" for a period of twelve (12) months from the effective date of the termination of the individual's coverage and shall not be deemed to have "qualifying previous coverage" under chapter 22, 47 or 52, title 41, Idaho Code;

(c) The individual ceases to be an eligible individual as defined in section 41-5203(10), Idaho Code;

(d) In the case of health benefit plans that are made available in the individual market only through one (1) or more associations, as defined in section 41-2202, Idaho Code, the membership of an individual in the association, on the basis of which the coverage is provided ceases, but only if the coverage is terminated under this paragraph uniformly without regard to any health status-related factor relating to any covered individual;

(e) The individual carrier elects, at the time of coverage renewal, to discontinue offering a particular health benefit plan delivered or issued for delivery to individuals in this state. Unless otherwise authorized in advance by the department of insurance, a carrier may discontinue a product only after the product has been in use for at least thirty-six (36) consecutive months, provided the carrier may not discontinue more than fifteen percent (15%) of its total number of individuals and dependents in all lines of business regulated by this chapter in a twelve (12) month period. The carrier shall:

(i) Provide advance written or electronic notice of its decision under this paragraph to the director;

(ii) Provide notice of the discontinuation to all affected individuals at least ninety (90) calendar days prior to the date the particular health benefit plan will be discontinued by the carrier, provided that notice to the director under the provisions of this paragraph shall be provided at least fourteen (14) calendar days prior to the notice to the affected individuals;

(iii) Offer to each affected individual, on a guaranteed issue basis, the option to purchase all other health benefit plans currently being offered by the carrier to individuals in this state;

(iv) Act uniformly without regard to any health status-related factor of an affected individual or dependent of an affected individual who may become eligible for the coverage; and

(v) Offer the new products at rates that comply with section 41-5206(1)(b), Idaho Code.

(f) The individual carrier elects to nonrenew all of its health benefit plans delivered or issued for delivery to individuals in this state. In such a case the carrier shall:

(i) Provide advance notice of its decision under this paragraph to the director; and

(ii) Provide notice of the decision not to renew coverage to all affected individuals and to the director at least one hundred eighty (180) calendar days prior to the nonrenewal of any health benefit plans by the carrier. Notice to the director under the provisions of this paragraph shall be provided at least three (3) working days prior to the notice to the affected individuals;

(g) The director finds that the continuation of the coverage would:

(i) Not be in the best interests of the policyholders or certificate holders; or

(ii) Impair the carrier's ability to meet its contractual obligations.

In such instance, the director shall assist affected individuals in finding replacement coverage; or

(h) The plan is an enhanced short-term plan that has reached the limit of renewability established in rules issued by the director and the individual carrier offers the individual the opportunity to reapply for coverage in accordance with the rules issued by the director.

(2) An individual carrier that elects not to renew a health benefit plan under the provisions of subsection (1)(f) of this section shall be prohibited from writing new business in the individual market in this state for a period of five (5) years from the date of notice to the director.

(3) In the case of an individual carrier doing business in one (1) established geographic service area of the state, the rules set forth in this section shall apply only to the carrier's operations in that service area.

[41-5207, added 1994, ch. 427, sec. 1, p. 1344; am. 1995, ch. 360, sec. 13, p. 1263; am. 1997, ch. 321, sec. 21, p. 983; am. 1999, ch. 392, sec. 1, p. 1089; am. 2000, ch. 472, sec. 14, p. 1629; am. 2006, ch. 353, sec. 3, p. 1082; am. 2019, ch. 301, sec. 2, p. 896.]

41-5208. AVAILABILITY OF COVERAGE -- PREEXISTING CONDITIONS -- PORTABILITY.

(1) (a) Every individual carrier shall, as a condition of offering health benefit plans in this state to individuals, actively offer health benefit plans to individuals, including the individual basic health benefit plan, the individual standard health benefit plan, the individual catastrophic A health benefit plan, the individual catastrophic B health benefit plan and the individual HSA compatible health benefit plan.

(b) An individual carrier shall issue an individual basic, standard, catastrophic A, catastrophic B or HSA compatible health benefit plan to any eligible individual that applies for such plan and agrees to make the required premium payments and to satisfy the other reasonable provisions of the health benefit plan not inconsistent with the provisions of this chapter.

(2) (a) An individual carrier shall file with the director, in a format and manner prescribed by the director, the basic, standard, catastrophic, and HSA compatible health benefit plans to be used by the carrier. A health benefit plan filed pursuant to the provisions of this paragraph may be used by an individual carrier beginning thirty (30) days after it is filed unless the director disapproves its use.

(b) The director at any time may, after providing notice and an opportunity for a hearing to the individual carrier, disapprove the continued use by an individual carrier of a basic, standard, catastrophic, or HSA compatible health benefit plan on the grounds that the plan does not meet the requirements of this chapter.

(3) Health benefit plans covering eligible individuals shall comply with the following provisions:

(a) A health benefit plan shall not deny, exclude or limit benefits for a covered individual for covered expenses incurred more than twelve (12) months following the effective date of the individual's coverage due to a preexisting condition. A health benefit plan shall not define a preexisting condition more restrictively than:

(i) A condition that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care or treatment during the six (6) months immediately preceding the effective date of coverage;

(ii) A condition for which medical advice, diagnosis, care or treatment was recommended or received during the six (6) months immediately preceding the effective date of coverage; or

(iii) A pregnancy existing on the effective date of coverage.

(b) A health benefit plan shall waive any time period applicable to a preexisting condition exclusion or limitation period for the period of time an individual was previously covered by qualifying previous coverage, 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. As provided in section 2741(b) of the federal health insurance portability and accountability act of 1996 (42 U.S.C. 300gg-41(b)), with regard to federally eligible individuals under HIPAA, any limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the first day of coverage shall not apply, whether or not any medical advice, diagnosis, care or treatment was recommended or received before that day, and whether or not the condition would have caused an ordinarily prudent person to seek medical advice, diagnosis, care or treatment before that day.

(c) An individual carrier shall not modify a basic, standard, catastrophic A, catastrophic B or HSA compatible health benefit plan with respect to an individual or any dependent through riders, endorsements, or otherwise, to restrict or exclude coverage for certain diseases or medical conditions otherwise covered by the health benefit plan.

(d) In the case of an individual who is eligible for the credit for health insurance costs under section 35 of the Internal Revenue Code of 1986, the preexisting condition limitation shall not apply only if the individual maintained creditable health insurance coverage for an aggregate period of three (3) months as of the date on which the individual seeks to enroll in pool coverage, not counting any period prior to a sixty-three (63) day break in coverage.

(4) (a) An individual carrier shall not be required to offer coverage or accept applications pursuant to the provisions of subsection (1) of this section in the case of the following:

(i) To an individual, where the individual is not residing in the carrier's established geographic service area;

(ii) Within an area where the individual carrier reasonably anticipates, and demonstrates to the satisfaction of the director, that it will not have the capacity within its established geographic service area to deliver service adequately to individuals because of its obligations to existing groups or individuals.

(b) An individual carrier that cannot offer coverage pursuant to the provisions of subsection (4)(a)(ii) of this section may not offer coverage in the applicable area to new employer groups with more than fifty (50) eligible employees or to any small employer groups or to any individuals until the later of one hundred eighty (180) days following each such refusal or the date on which the carrier notifies the director that it has regained capacity to deliver services to individuals and groups.

(5) An individual carrier shall not be required to provide coverage to individuals pursuant to the provisions of subsection (1) of this section for any period of time for which the director determines that requiring the acceptance of individuals in accordance with the provisions of subsection (1)

of this section would place the individual carrier in a financially impaired condition.

[41-5208, added 1994, ch. 427, sec. 1, p. 1344; am. 1995, ch. 360, sec. 10, p. 1259; am. 1997, ch. 321, sec. 22, p. 984; am. 2000, ch. 472, sec. 15, p. 1630; am. 2004, ch. 285, sec. 2, p. 804; am. 2004, ch. 332, sec. 1, p. 988; am. 2005, ch. 353, sec. 2, p. 1113.]

41-5209. NOTICE OF INTENT TO OPERATE AS A RISK-ASSUMING CARRIER OR A REINSURING CARRIER. (1) (a) Each individual carrier shall notify the director within thirty (30) days of the effective date of this chapter of the carrier's intention to operate as a risk-assuming carrier or a reinsuring carrier. An individual carrier seeking to operate as a risk-assuming carrier shall make an application pursuant to the provisions of section 41-5210, Idaho Code.

(b) The decision shall be binding for a five (5) year period except that the initial decision shall be binding for two (2) years. The director may permit a carrier to modify its decision at any time for good cause shown.

(c) The director shall establish an application process for individual carriers seeking to change their status under the provisions of this subsection.

(2) A reinsuring carrier that applies and is approved to operate as a risk-assuming carrier shall not be permitted to continue to reinsure any health benefit plan with the program. Such a carrier shall pay a prorated assessment based upon business issued as a reinsuring carrier for any portion of the year that the business was reinsured.

[41-5209, added 1994, ch. 427, sec. 1, p. 1346.]

41-5210. APPLICATION TO BECOME A RISK-ASSUMING CARRIER. (1) An individual carrier may apply to become a risk-assuming carrier by filing an application with the director in a form and manner prescribed by the director.

(2) The director shall consider the following factors in evaluating an application filed under the provisions of subsection (1) of this section:

(a) The carrier's financial condition;

(b) The carrier's history of rating and underwriting individuals;

(c) The carrier's commitment to market fairly to all individuals in the state or its established geographic service area, as applicable;

(d) The carrier's experience with managing the risk of individuals; and

(e) The extent to which a carrier has and will be able to maintain reinsurance pursuant to the provisions of subsection (3) of section 41-5204, Idaho Code.

(3) The director shall provide public notice of an application by an individual carrier to be a risk-assuming carrier and shall provide at least a sixty (60) day period for public comment prior to making a decision on the application. If the application is not acted upon within ninety (90) days of the receipt of the application by the director, the carrier may request a hearing.

(4) The director may rescind the approval granted to a risk-assuming carrier under the provisions of this section if the director finds that:

(a) The carrier's financial condition will no longer support the assumption of risk from issuing coverage to individuals in compliance

with the provisions of section 41-5208, Idaho Code, without the protection afforded by the program;

(b) The carrier has failed to market fairly to all individuals in the state or its established geographic service area, as applicable; or

(c) The carrier has failed to provide coverage to eligible individuals as required in section 41-5208, Idaho Code.

(5) An individual carrier electing to be a risk-assuming carrier shall not be subject to the provisions of section 41-4711, Idaho Code, except to the extent such individual carrier is subject to assessment for additional funding pursuant to the provisions of subsection (12)(c) of section 41-4711, Idaho Code.

[41-5210, added 1994, ch. 427, sec. 1, p. 1347.]

41-5211. ADMINISTRATIVE PROCEDURES. The director shall promulgate rules in accordance with the provisions of chapter 52, title 67, Idaho Code, for the implementation and administration of the individual health coverage reform act.

[41-5211, added 1994, ch. 427, sec. 1, p. 1347.]

41-5212. STANDARDS TO ASSURE FAIR MARKETING. (1) Each individual carrier shall actively market health benefit plan coverage, including the individual basic, standard, catastrophic A, catastrophic B, and HSA compatible health benefit plans, to eligible individuals in the state. If an individual carrier denies coverage to an individual on the basis of the health status or claims experience of the individual or dependents, the individual carrier shall offer the individual the opportunity to purchase an individual basic, standard, catastrophic A, catastrophic B, or HSA compatible health benefit plan.

(2) (a) Except as provided in subsection (2)(b) of this section, no individual carrier or agent shall, directly or indirectly, engage in the following activities:

(i) Encouraging or directing individuals to refrain from filing an application for coverage with the individual carrier because of the health status, claims experience, industry, occupation or geographic location of the individual or dependents.

(ii) Encouraging or directing individuals to seek coverage from another carrier because of the health status, claims experience, industry, occupation or geographic location of the individual.

(b) The provisions of subsection (2)(a) of this section shall not apply with respect to information provided by an individual carrier or agent to an individual regarding the established geographic service area or a restricted network provision of an individual carrier.

(3) (a) Except as provided in subsection (2)(b) of this section, no individual carrier shall, directly or indirectly, enter into any contract, agreement or arrangement with an agent that provides for or results in the compensation paid to an agent for the sale of a health benefit plan to be carried because of the health status, claims experience, industry, occupation or geographic location of the individual.

(b) The provisions of paragraph (a) of this subsection shall not apply with respect to a compensation arrangement that provides compensation to an agent on the basis of percentage of premium, provided that the per-

centage shall not vary because of the health status, claims experience, industry, occupation or geographic area of the individual.

(4) An individual carrier shall provide reasonable compensation, as provided under the plan of operation of the individual high risk reinsurance pool, to an agent, if any, for the sale of an individual basic, standard, catastrophic A, catastrophic B, or HSA compatible health benefit plan.

(5) No individual carrier may terminate, fail to renew or limit its contract or agreement of representation with an agent for any reason related to the health status, claims experience, occupation or geographic location of the individuals placed by the agent with the individual carrier.

(6) Denial by an individual carrier of an application for coverage from an individual shall be in writing and shall state the reason or reasons for the denial.

(7) The director may establish rules setting forth additional standards to provide for the fair marketing and broad availability of health benefit plans to individuals in this state.

(8) (a) A violation of the provisions of this section by an individual carrier or an agent shall be an unfair trade practice pursuant to the provisions of section 41-1302, Idaho Code.

(b) If an individual carrier enters into a contract, agreement or other arrangement with a third party administrator to provide administrative, marketing or other services related to the offering of health benefit plans to individuals in this state, the third party administrator shall be subject to the provisions of this section as if it were an individual carrier.

[41-5212, added 1994, ch. 427, sec. 1, p. 1347; am. 1995, ch. 360, sec. 11, p. 1260; am. 1997, ch. 321, sec. 23, p. 986; am. 2000, ch. 472, sec. 16, p. 1632; am. 2005, ch. 353, sec. 3, p. 1115.]

41-5214. ENHANCED SHORT-TERM PLANS. The director shall adopt reasonable rules to establish specific standards for enhanced short-term plans. The standards shall be in addition to and in accordance with applicable laws of this state, including this chapter. The standards:

(1) Shall include requirements for renewability that are consistent with federal law regarding short-term, limited duration insurance; and

(2) May include, but need not be limited to:

(a) A scope of covered benefits, which may be as broad as the scope of covered benefits required to be included in individual health benefit plans that are not deemed short-term, limited duration insurance under federal law;

(b) Restrictions on premium rate increases when an enhanced short-term plan ceases to be renewable and the individual policyholder reapplies for coverage from the same carrier; and

(c) Conversion of enhanced short-term plans into fully renewable coverage upon a finding by the director that the conversion complies with law and is in the best interests of the public.

[41-5214, added 2019, ch. 301, sec. 3, p. 897.]

CHAPTER 53
MEDICAL CARE SAVINGS ACCOUNT ACT [REPEALED]