

Dear Senators PATRICK, Martin, Schmidt, and
Representatives BARBIERI, Clow, Smith:

The Legislative Services Office, Research and Legislation, has received the enclosed rules of
the Department of Insurance:

IDAPA 18.01.10 - Producers Handling of Fiduciary Funds - Proposed Rule (Docket No.
18-0110-1601);

IDAPA 18.01.54 - Rule to Implement the NAIC Medicare Supplement Insurance Minimum Standards
Model Act - - Proposed Rule (Docket No. 18-0154-1601).

Pursuant to Section 67-454, Idaho Code, a meeting on the enclosed rules may be called by the
cochairmen or by two (2) or more members of the subcommittee giving oral or written notice to Research
and Legislation no later than fourteen (14) days after receipt of the rules' analysis from Legislative
Services. The final date to call a meeting on the enclosed rules is no later than 10/06/2016. If a meeting is
called, the subcommittee must hold the meeting within forty-two (42) days of receipt of the rules' analysis
from Legislative Services. The final date to hold a meeting on the enclosed rules is 11/04/2016.

The germane joint subcommittee may request a statement of economic impact with respect to a
proposed rule by notifying Research and Legislation. There is no time limit on requesting this statement,
and it may be requested whether or not a meeting on the proposed rule is called or after a meeting has
been held.

To notify Research and Legislation, call 334-4834, or send a written request to the address on the
memorandum attached below.



Eric Milstead
Director

Legislative Services Office

Idaho State Legislature

Serving Idaho's Citizen Legislature

MEMORANDUM

TO: Rules Review Subcommittee of the Senate Commerce & Human Resources Committee and the House Business Committee

FROM: Senior Legislative Research Analyst - Elizabeth Bowen

DATE: September 19, 2016

SUBJECT: Department of Insurance

IDAPA 18.01.10 - Producers Handling of Fiduciary Funds - Proposed Rule (Docket No. 18-0110-1601)

IDAPA 18.01.54 - Rule to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act - - Proposed Rule (Docket No. 18-0154-1601)

The Department of Insurance submits notice of proposed rulemaking at IDAPA 18.01.10 and 18.01.54.

18.01.10

The proposed rule provides that cash collateral for bail bonds shall be treated by bail agents as fiduciary funds and therefore subject to rules on handling fiduciary funds. The purpose appears to be safeguarding the collateral. Negotiated rulemaking was conducted, and there is no negative impact on the state general fund. The Department states that this rulemaking is authorized pursuant to Sections 41-211, 41-1024, and 41-1025, Idaho Code.

18.01.54

The proposed rule requires all Medicare Supplement (Medigap) insurance carriers to offer coverage to individuals under 65 years of age who are eligible for Medicare. The rule further provides that pricing for a supplement policy shall not be discriminatory, with some exceptions, including for smoking or other tobacco use. The rule also sets rating requirements for supplement policies.

Negotiated rulemaking was conducted, and there is no negative impact on the state general fund. The Department states that this rulemaking is authorized pursuant to Sections 41-211 and 41-4409, Idaho Code.

cc: Department of Insurance
Thomas A. Donovan

IDAPA 18 - IDAHO DEPARTMENT OF INSURANCE

18.01.10 - PRODUCERS HANDLING OF FIDUCIARY FUNDS

DOCKET NO. 18-0110-1601

NOTICE OF RULEMAKING - PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 41-211, 41-1024 and 41-1025, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than September 21, 2016.

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

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

The existing rule is proposed to be amended concerning bail to provide deposit rules for cash collateral similar to that of other funds that insurance producers receive from clients, namely, to treat cash collateral as fiduciary funds.

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

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

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the July 6, 2016 Idaho Administrative Bulletin, [Volume 16-7, page 70](#).

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

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS, OBTAINING DRAFT COPIES: For assistance on technical questions concerning this proposed rule, contact Thomas A. Donovan at (208) 334-4214, or at tom.donovan@doi.idaho.gov.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the attention of the undersigned and must be delivered either by hard copy or via email to the same email address for questions set forth above on or before Wednesday, September 28, 2016.

DATED this 5th Day of August, 2016.

Dean L. Cameron, Director
Idaho Department of Insurance
700 W. State Street, 3rd Floor
P.O. Box 83720
Boise, ID 83702-0043
Phone: (208) 334-4250
Fax: (208) 334-4398

THE FOLLOWING IS THE PROPOSED TEXT OF DOCKET NO. 18-0110-1601
(Only Those Sections With Amendments Are Shown.)

000. LEGAL AUTHORITY.

This rule is promulgated pursuant to authority granted by Sections 41-211, ~~and~~ 41-1024, and 41-1025, Idaho Code. (4-11-06)()

001. TITLE AND SCOPE.

01. Title. The title of this chapter is IDAPA 18.01.10, "Producers Handling of Fiduciary Funds." (4-11-06)

02. Scope. This rule will affect "Producers," as defined in Section ~~41-1003, Idaho Code~~ 18.01.10.010 of this rule, including bail agents who handle funds held in a fiduciary capacity. (4-11-06)()

(BREAK IN CONTINUITY OF SECTIONS)

010. DEFINITIONS.

01. Cash Collateral. All funds received as collateral by a producer in connection with a bail bond transaction in the form of cash, check, money order, other negotiable instrument, debit or credit card payment, or other electronic funds transfer, given as security to obtain a bail bond, as referenced in Section 41-1043, Idaho Code. ()

~~02.~~ **Fiduciary Fund Account.** A financial account established to hold fiduciary funds as provided in Section 016. (4-11-06)

~~03.~~ **Fiduciary Funds.** All premiums, return premiums, premium taxes, funds as collateral, and fees received by a producer. Fiduciary funds shall include: (4-11-06)()

a. All funds paid to a producer for selling, soliciting or negotiating policies of insurance except for those earned fees recognized by statute as earned by the producer upon receipt which are payable to the producer and not the insurance company, pursuant to Section 41-1030, Idaho Code. (4-11-06)

b. All funds received by a producer from or on behalf of a client or premium finance company that are to be paid to an insurance company, its agents, or to the producer's employer. (4-11-06)

c. All funds provided to a producer by an insurance company or its agents that are to be paid to a policyholder or claimant pursuant to a contract of insurance. (4-11-06)

d. All checks or other negotiable instruments collected by the producer that are made payable to the insurer. (4-11-06)

e. Cash collateral. ()

~~04.~~ **Premium.** The consideration for insurance by whatever name called, and as more fully defined by Section 41-1803, Idaho Code. (4-11-06)

~~05.~~ **Producer.** A person required to be licensed under the laws of this state to sell, solicit or negotiate insurance, including, without limitation, bail agents as described in Section 41-1039, Idaho Code. (4-11-06)()

~~056.~~ **Receive.** To collect or otherwise take actual or constructive possession of fiduciary funds. Receiving, includes but is not limited to, taking possession of money, checks, or other negotiable instruments. If fiduciary funds are in the form of a credit or offset on an account or other liability for the benefit of the consumer, without the producer actually taking possession of the funds, then constructive receipt shall be deemed to have occurred on the due date to the insurer. (4-11-06)

011. -- 013. (RESERVED)

014. FIDUCIARY FUND ACCOUNT.

01. **Payable to an Insurer.** Fiduciary funds that are in the form of a check or another negotiable instrument that is made payable to an insurer as described in Subsection 010.02.d. shall be remitted to the insurer within the time period as set forth in the terms and conditions as required by the insurer, or if not specified, then within twenty one (21) days of receipt. (4-11-06)

02. **Payable to a Policyholder.** Fiduciary funds that are in the form of a check or another negotiable instrument that is made payable to a policyholder or claimant as described in Subsection 010.02.c. shall be remitted to the policyholder or claimant within fourteen (14) days of receipt or as required by the terms of the policy of insurance, the insurer, or applicable law. (4-11-06)

03. **All Other Fiduciary Funds.** All other fiduciary funds received by the producer, except as described under Subsections 014.01 and 014.02 must be deposited into a fiduciary fund account according to the following schedule: (4-11-06)

a. If in the form of cash, within seven (7) days of receipt, except that, when a producer holds fiduciary funds in the form of cash that exceed two thousand dollars (\$2,000), such funds must be deposited within three (3) business days. (4-11-06)

b. If in the form of checks, money orders, ~~or~~ other negotiable instruments, debit or credit card payments, or other electronic funds transfer, received or collected by the producer, within seven (7) days of receipt, except that the producer may remit such funds to the following: (4-11-06)()

i. Another licensed producer or licensed business entity, subject to the time frames of Subsection 014.03.b.; or (4-11-06)

ii. A person designated by the insurer who has the obligation to remit the fiduciary funds to the insurer subject to the time frames of Subsection 014.03.b. (4-11-06)

04. **Document the Receipt of Fiduciary Funds.** A producer who receives fiduciary funds shall document the receipt of those funds in sufficient detail to determine, at a minimum, the date received, the name of the payee, and the amount received. If the producer receives cash, including cash collateral, the producer shall give the payer a detailed receipt at the time of payment. The receipt shall include an indication that cash was received, the date received, the amount received, the payer's name, the payee's name, the purpose of payment, and any other information important to the transaction. The producer shall maintain the receipt records as records of a transaction, and keep those records for a period of at least five (5) years. (4-11-06)()

015. DEPOSIT OF OTHER FUNDS IN ACCOUNT.

A producer may deposit other additional funds for the sole purpose of: (4-11-06)

01. ~~Establishing~~ Reserves for ~~Payment of~~ Return Premiums. Establishing reserves for payment of return premiums. (4-11-06)()

02. ~~Advancing~~ Funds ~~Sufficient~~ to Pay Bank Charges. Advancing funds sufficient to pay bank charges. (4-11-06)()

03. **Contingencies.** For any contingencies that may arise in the business of receiving and transmitting premium or return premium funds or cash collateral (any such deposit is hereinafter referred to as "voluntary

deposit”).

(4-11-06)()

(BREAK IN CONTINUITY OF SECTIONS)

019. PERMISSIBLE DISTRIBUTION OF FIDUCIARY FUNDS.

Distributions from a fiduciary fund account shall only be made for the following purposes, and in the manner stated: (4-11-06)

01. Remit Premiums. To remit premiums to an insurer or an insurer’s designee pursuant to a contract of insurance; (4-11-06)

02. Return Premiums. To return premiums to an insured or other person or entity entitled to the premiums; (4-11-06)

03. Remit Surplus Lines Taxes and Stamping Fees. To remit surplus lines taxes and stamping fees collected to the appropriate state; (4-11-06)

04. Reimburse Voluntary Deposits. To reimburse voluntary deposits made by the producer to the extent that the funds in the fiduciary account exceed the amount necessary to meet all fiduciary obligations, only if the reimbursement can be matched and identified with the previous voluntary deposit. (4-11-06)

05. Transfer or Withdraw Accrued Interest. To transfer or withdraw accrued interest to the extent that fiduciary fund account funds exceed the amount necessary to meet all fiduciary obligations, only if the reimbursement can be matched and identified with the previous interest deposit by the financial institution. (4-11-06)

06. Transfer or Withdraw Actual Commissions. To transfer or withdraw actual commissions and those earned fees recognized as earned by the producer, upon receipt, which are payable to the producer, only if the commissions and fees can be matched and identified with funds previously deposited in the fiduciary account. (4-11-06)

07. Pay Charges Imposed. To pay charges imposed by the financial institution that directly relate to the operation and maintenance of the fiduciary funds account to the extent that fiduciary account funds exceed fiduciary obligations; and (4-11-06)

08. Transfer Funds. To transfer funds from one (1) fiduciary fund account to another fiduciary fund account. (4-11-06)

09. Return Cash Collateral. To return cash collateral to the person who deposited the cash collateral with the producer within fourteen (14) days of the date notice is received that the obligation, the satisfaction of which was secured by the cash collateral, has been discharged. ()

10. Convert Cash Collateral. To convert cash collateral where the defendant or other responsible party fails to satisfy the obligation of the bail bond and the bail or obligation was not exonerated by the court but instead executed by the court, provided such conversion is compliant with the contract between the producer and the person who deposited the cash collateral. ()

(BREAK IN CONTINUITY OF SECTIONS)

022. TIMELY DISBURSEMENT OF FIDUCIARY FUNDS.

In addition to the requirements of Section 014, after receiving fiduciary funds, a producer shall: (4-11-06)

01. Remit Premiums. Remit premiums directly to an insurer or an insurer’s designee within the time period as set forth in the terms and conditions as required by the insurer, or if not specified, within fourteen (14) days

of receipt; (4-11-06)

02. Return Money Received. Return to the payer the money received as a premium deposit which is retained by the producer or returned to the producer by the insurer to the payer by the earlier of: (4-11-06)

a. Fourteen (14) days from the date the premium is received by the producer from the insurer, or (4-11-06)

b. Fourteen (14) days from the date the insurer notifies the insurance applicant that coverage has been denied if the producer retained the premium deposit. (4-11-06)

03. Refund Received from the Insurer. Issue a refund received from the insurer within fourteen (14) days by disbursing money to the insured or other party entitled thereto by notifying the insured that the refund is being applied to an outstanding amount owed or to be owed by the insured. If the producer is applying the refund to an outstanding amount owed by the insured, the producer shall obtain the insured's permission and provide the insured a detailed description of the amount owed to which the refund is being applied. (4-11-06)

04. Dispute of Entitlement of Funds. If there is a dispute as to entitlement of funds under Subsections 022.01 or 022.03, notify the parties of the dispute and seek to resolve the dispute and document the steps taken to resolve the dispute. (4-11-06)

05. Funds Held for More Than Ninety Days. If fiduciary funds within the scope of Subsections 022.01 or 022.03 are held for more than ninety (90) days, investigate to determine the entitlement to fiduciary funds and pay those fiduciary funds when due to the appropriate person in accordance with this section. (4-11-06)

06. Return Cash Collateral. Return cash collateral to the person who deposited the cash collateral with the producer within fourteen (14) days of the date notice is received that the obligation, the satisfaction of which was secured by the cash collateral, is discharged. ()

IDAPA 18 - IDAHO DEPARTMENT OF INSURANCE

18.01.54 - RULE TO IMPLEMENT THE NAIC MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS MODEL ACT

DOCKET NO. 18-0154-1601

NOTICE OF RULEMAKING - PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 41-211 and 41-4409, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than September 21, 2016.

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

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

The existing rule is proposed to be amended to require all Medicare Supplement (aka Medigap) carriers to offer coverage to pre-65 Medicare eligible individuals; clarify the requirement to account for interest in projections; require experience and rate increases to be pooled among all plans offered by a company; and clarify rating/underwriting factors that can be used and when (e.g. smoking and pre-65).

Twenty-five states now require insurance companies to sell Medigap to all ages enrolled in Part B. Under age 65 Medicare beneficiaries have limited options for payment of Medicare deductible and co-payments. We seek to expand Medicare beneficiaries' options.

The NAIC Medicare Supplement Guidance Manual states: "Interest must be considered in calculating the anticipated lifetime and future loss ratios, otherwise loss ratios will be overstated." Yet, carriers have not included interest because our rule does not state it is required.

In reviewing rate increases, the department has requested that rate increases be applied equally to all of a carrier's plans, rather than varying the increases based on the more variable experience of specific plans. This keeps the premiums more representative of the benefit differences, rather than reflecting the morbidity of the enrollees of specific plans. The proposed changes will require that approach for future rate increases.

Current rule disallows gender and geographic area as rating factors, but other factors are not clearly allowed/disallowed during open enrollment or outside of open enrollment, other than disallowing broad terms of "health status, claims experience, receipt of health care, or medical condition."

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

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

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the July 6, 2016 Idaho Administrative Bulletin, [Volume 16-7, page 73](#).

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

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS, OBTAINING DRAFT COPIES: For assistance on technical questions concerning this proposed rule, contact Thomas A. Donovan at (208) 334-4214, or at tom.donovan@doi.idaho.gov.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the attention of the undersigned and must be delivered either by hard copy or via email to the same email address for questions set forth above on or before Wednesday, September 28, 2016.

DATED this 5th Day of August, 2016.

Dean L. Cameron, Director
Idaho Department of Insurance
700 W. State Street, 3rd Floor
P.O. Box 83720
Boise, ID 83702-0043
Phone: (208) 334-4250
Fax: (208) 334-4398

THE FOLLOWING IS THE PROPOSED TEXT OF DOCKET NO. 18-0154-1601
(Only Those Sections With Amendments Are Shown.)

026. OPEN ENROLLMENT.

01. Offer of Coverage. ()

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

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

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

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

b. Each Medicare supplement policy and certificate currently available from an issuer shall be made available to all applicants who qualify under ~~this Subsection~~ Paragraph 026.01.a. without regard to age. (3-29-10)()

02. Treatment of Preexisting Conditions. ()

a. If an applicant qualifies under Subsection 026.01 and submits an application during the time period referenced in Subsection 026.01 and, as of the date of application, has had a continuous period of creditable coverage of at least six (6) months, the issuer shall not exclude benefits based on a preexisting condition. (3-29-10)

b. If the applicant qualifies under Subsection 026.01 and submits an application during the time period referenced in Subsection 026.01 and, as of the date of application, has had a continuous period of creditable coverage that is less than six (6) months, the issuer shall reduce the period of any preexisting condition exclusion by

the aggregate of the period of creditable coverage applicable to the applicant as of the enrollment date. The Secretary of Health and Human Services shall specify the manner of the reduction under this Subsection. (3-29-10)

c. Except as provided in ~~Subsection Paragraphs 026.01~~2.a. and b., and Sections 027 and 038, ~~Subsection 026.01~~ nothing in this rule shall ~~not~~ be construed as preventing the exclusion of benefits under a policy, during the first six (6) months, based on a preexisting condition for which the policyholder or certificateholder received treatment or was otherwise diagnosed during the six (6) months before the coverage became effective. (3-29-10)()

03. Discrimination in Pricing. An issuer shall not discriminate in the pricing of a Medicare supplement policy or certificate issued pursuant to Subsection 026.01, except on the basis of the following criteria: ()

a. Issue age; and ()

b. Smoking or tobacco use. ()

027. GUARANTEED ISSUE FOR ELIGIBLE PERSONS.

01. Guaranteed Issue. (4-5-00)

a. Eligible persons are those individuals described in Subsection 027.02 who seek to enroll under the policy during the period specified in Subsection 027.03, and who submit evidence of the date of termination or disenrollment or Medicare Part D enrollment with the application for a Medicare supplement policy. (3-29-10)

b. With respect to eligible persons, an issuer shall not deny or condition the issuance or effectiveness of a Medicare supplement policy described in Subsection 027.05 that is offered and is available for issuance to new enrollees by the issuer, shall not discriminate in the pricing of such a Medicare supplement policy because of health status, claims experience, receipt of health care, or medical condition, and shall not impose an exclusion of benefits based on a preexisting condition under such a Medicare supplement policy. (3-29-10)

02. Eligible Persons. An eligible person is an individual described here in any part of Subsection 027.02: (3-29-10)

a. The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare; and the plan terminates, or the plan ceases to provide all such supplemental health benefits to the individual; or the individual is enrolled under an employee welfare benefits plan that is primary to Medicare and the plan terminates or the plan ceases to provide all health benefits to the individual because the individual leaves the plan; (4-5-00)

b. The individual is enrolled with a Medicare Advantage organization under a Medicare Advantage plan under Part C of Medicare, and any of the following circumstances apply, or the individual is sixty-five (65) years of age or older and is enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provider under Section 1894 of the Social Security Act, and there are circumstances similar to those described below that would permit discontinuance of the individual's enrollment with such provider if such individual were enrolled in a Medicare Advantage plan: (4-11-06)

i. The certification of the organization or plan under this part has been terminated; (4-11-06)

ii. The organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides; (4-11-06)

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

- area; (4-11-06)
- iv. The individual demonstrates, in accordance with guidelines established by the Secretary of Health and Human Services: (3-29-10)
- (a) That the organization offering the plan substantially violated a material provision of the organization's contract under this part in relation to the individual, including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards; or (3-29-10)
- (b) The organization, or agent, or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual; or (3-29-10)
- (c) The individual meets such other exceptional conditions as the Secretary may provide. (3-29-10)
- c.** The individual is enrolled with: (4-5-00)
- i. An eligible organization under a contract under Section 1876 of the Social Security Act (Medicare cost); (5-3-03)
- ii. A similar organization operating under demonstration project authority, effective for periods before April 1, 1999; (4-5-00)
- iii. An organization under an agreement under Section 1833(a)(1)(A) of the Social Security Act (health care prepayment plan); or (5-3-03)
- iv. An organization under a Medicare Select policy; and (4-5-00)
- d.** The enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under Paragraph 027.02.b. (3-29-10)
- e.** The individual is enrolled under a Medicare supplement policy and the enrollment ceases because: (4-5-00)
- i. Of the insolvency of the issuer or bankruptcy of the non-issuer organization; or (4-5-00)
- ii. Of other involuntary termination of coverage or enrollment under the policy; (4-5-00)
- iii. The issuer of the policy substantially violated a material provision of the policy; or (4-5-00)
- iv. The issuer, or an agent or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual. (4-5-00)
- f.** The individual was enrolled under a Medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any Medicare Advantage organization under a Medicare Advantage plan under Part C of Medicare, any eligible organization under a contract under Section 1876 of the Social Security Act (Medicare cost), any similar organization operating under demonstration project authority, any PACE provider under Section 1894 of the Social Security Act, or a Medicare Select policy; and (4-11-06)
- g.** The subsequent enrollment under Paragraph 027.02.f. is terminated by the enrollee during any period within the first twelve (12) months of such subsequent enrollment (during which the enrollee is permitted to terminate such subsequent enrollment under Section 1851(e) of the federal Social Security Act); or (3-29-10)
- h.** The individual, upon first becoming eligible for benefits under Part A of Medicare at age sixty-five (65), enrolls in a Medicare Advantage plan under Part C of Medicare, or with a PACE provider under Section 1894 of the Social Security Act, and disenrolls from the plan or program by not later than twelve (12) months after the effective date of enrollment. (4-11-06)

i. The individual enrolls in a Medicare Part D plan during the initial enrollment period and at the time of enrollment in Part D, was enrolled under Medicare supplement policy that covers outpatient prescription drugs and the individual terminates enrollment in the Medicare supplement policy and submits evidence of enrollment in Medicare Part D along with the application for a policy described in Paragraph 027.05.e. (3-29-10)

03. Guaranteed Issue Time Periods. (5-3-03)

a. In the case of an individual described in Paragraph 027.02.a., the guaranteed issue period begins on the later of the date the individual receives a notice of termination or cessation of all supplemental health benefits (or, if a notice is not received, notice that a claim has been denied because of a termination or cessation); or the date that the applicable coverage terminates or ceases; and ends sixty-three (63) days thereafter; (3-29-10)

b. In the case of an individual described in Paragraphs 027.02.b., 027.02.c., 027.02.f., or 027.02.h., whose enrollment is terminated involuntarily, the guaranteed issue period begins on the date that the individual receives a notice of termination and ends sixty-three (63) days after the date the applicable coverage is terminated; (3-29-10)

c. In the case of an individual described in Paragraph 027.02.e., the guaranteed issue period begins on the earlier of: (3-29-10)

i. The date that the individual receives a notice of termination, a notice of the issuer's bankruptcy or insolvency, or other such similar notice if any; and (5-3-03)

ii. The date that the applicable coverage is terminated, and ends on the date that is sixty-three (63) days after the date the coverage is terminated; (5-3-03)

d. In the case of an individual described in Paragraph 027.02.b. and Subparagraph 027.02.e.iii., and Subparagraph 027.02.e.iv., Paragraph 027.02.f., or 027.02.h., who disenrolls voluntarily, the guaranteed issue period begins on the date that is sixty (60) days before the effective date of the disenrollment and ends on the date that is sixty-three (63) days after the effective date; and (3-29-10)

e. In the case of an individual described in Paragraph 027.02.i., the guaranteed issue period begins on the date the individual receives notice pursuant to Section 1882(v)(2)(B) of the Social Security Act from the Medicare supplement issuer during the sixty-day (60) period immediately preceding the initial Part D enrollment period and ends on the date that is sixty-three (63) days after the effective date of the individual's coverage under Medicare Part D; and (3-29-10)

f. In the case of an individual described in Subsection 027.02 but not described in the preceding provisions of Subsection 027.03, the guaranteed issue period begins on the effective date of disenrollment and ends on the date that is sixty-three (63) days after the effective date. (3-29-10)

04. Extended Medigap Access for Interrupted Trial Periods. (5-3-03)

a. In the case of an individual described in Paragraph 027.02.f. (or deemed to be so described, pursuant to this Paragraph) whose enrollment with an organization or provider described in Paragraph 027.02.f. is involuntarily terminated within the first twelve (12) months of enrollment, and who, without an intervening enrollment, enrolls with another such organization or provider, the subsequent enrollment shall be deemed to be an initial enrollment described in Paragraph 027.02.f.; (3-29-10)

b. In the case of an individual described in Paragraph 027.02.h. (or deemed to be so described, pursuant to this Paragraph) whose enrollment with a plan or in a program described in Paragraph 027.02.h. is involuntarily terminated within the first twelve (12) months of enrollment, and who, without an intervening enrollment, enrolls in another such plan or program, the subsequent enrollment shall be deemed to be an initial enrollment described in Paragraph 027.02.h.; and (3-29-10)

c. For purposes of Paragraphs 027.02.f. and 027.02.h., no enrollment of an individual with an

organization or provider described in Paragraph 027.02.f. or with a plan or in a program described in Paragraph 027.02.h. may be deemed to be an initial enrollment under this Paragraph after the two-year period beginning on the date on which the individual first enrolled with such an organization, provider, plan or program. (3-29-10)

05. Products to Which Eligible Persons are Entitled. The Medicare supplement policy to which eligible persons are entitled under: (4-11-06)

a. Paragraphs 027.02.a. through 027.02.e. is a Medicare supplement policy which has a benefit package classified as Plan A, B, C, or F (including F with a high deductible), K or L offered by any issuer. (3-29-10)

b. Subject to Paragraph 027.05.c., Paragraph 027.02.g. is the same Medicare supplement policy in which the individual was most recently previously enrolled, if available from the same issuer, or, if not so available, a policy described in Paragraph 027.05.a. (3-29-10)

c. After December 31, 2005, if the individual was most recently enrolled in a Medicare supplement policy with an outpatient prescription drug benefit, a Medicare supplement policy described in Subsection 027.05 is: (3-29-10)

i. The policy available from the same issuer but modified to remove outpatient prescription drug coverage; or (4-11-06)

ii. At the election of the policyholder, an A, B, C, F (including F with a high deductible), K or L policy that is offered by any issuer; (4-11-06)

d. Paragraph 027.02.h. shall include any Medicare supplement policy offered by any issuer. (3-29-10)

e. Paragraph 027.02.i. is a Medicare supplement policy that has a benefit package classified as Plan A, B, C, F (including F with a high deductible), K, or L and that is offered and is available for issuance to new enrollees by the same issuer that issued the individual's Medicare supplement policy with outpatient prescription drug coverage. (3-29-10)

06. Notification Provisions. (4-5-00)

a. At the time of an event described in Subsection 027.02 of this rule because of which an individual loses coverage or benefits due to the termination of a contract or agreement, policy, or plan, the organization that terminates the contract or agreement, the issuer terminating the policy, or the administrator of the plan being terminated, respectively, shall notify the individual of his or her rights under this Section, and of the obligations of issuers of Medicare supplement policies under Subsection 027.01. Such notice shall be communicated contemporaneously with the notification of termination. (3-29-10)

b. At the time of an event described in Subsection 027.02 because of which an individual ceases enrollment under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment, the issuer offering the policy, or the administrator of the plan, respectively, shall notify the individual of his or her rights under this Section, and of the obligations of issuers of Medicare supplement policies under Subsection 027.01. Such notice shall be communicated within ten (10) working days of the issuer receiving notification of disenrollment. (3-29-10)

07. Discrimination in Pricing. With respect to eligible persons, an issuer shall not discriminate in the pricing of a Medicare supplement policy or certificate issued pursuant to Subsection 027.01, except on the basis of the following criteria: ()

a. Issue age; and ()

b. Smoking or tobacco use. ()

(BREAK IN CONTINUITY OF SECTIONS)

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

01. Loss Ratio Standards. (4-5-00)

a. A Medicare supplement policy form or certificate form shall not be delivered or issued for delivery unless the policy form or certificate form can be expected, as estimated for the entire period for which rates are computed to provide coverage, to return to policyholders and certificateholders in the form of aggregate benefits (not including anticipated refunds or credits) provided under the policy form or certificate form. (4-5-00)

i. At least seventy-five percent (75%) of the aggregate amount of premiums earned in the case of group policies; or (4-5-00)

ii. At least sixty-five percent (65%) of the aggregate amount of premiums earned in the case of individual policies; (4-5-00)

b. Calculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a managed care organization on a service rather than reimbursement basis and earned premiums for the period and in accordance with accepted actuarial principles and practices. Incurred health care expenses where coverage is provided by a managed care organization shall not include: (4-11-06)

i. Home office and overhead costs; (4-11-06)

ii. Advertising costs; (4-11-06)

iii. Commissions and other acquisition costs; (4-11-06)

iv. Taxes; (4-11-06)

v. Capital costs; (4-11-06)

vi. Administrative costs; and (4-11-06)

vii. Claims processing costs. (4-11-06)

c. All filings of rates and rating schedules shall demonstrate that expected claims in relation to premiums comply with the requirements of this Section when combined with actual experience to date. Filings of rate revisions shall also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards. Demonstrations shall, at a minimum, account for: ~~(3-29-10)~~ ()

i. Lapse rates; ()

ii. Medical trend and rationale for trend; ()

iii. Assumptions regarding future premium rate revisions; and ()

iv. Interest rates for discounting and accumulating. ()

d. For purposes of applying Paragraphs 029.01.a. and 030.05.b., only, policies issued as a result of solicitations of individuals through the mails or by mass media advertising (including both print and broadcast advertising) shall be deemed to be individual policies. (3-29-10)

e. For policies issued prior to July 1, 1992, expected claims in relation to premiums shall meet: (4-5-00)

- i. The originally filed anticipated loss ratio when combined with the actual experience since inception; (4-5-00)
- ii. The appropriate loss ratio requirement from Subparagraphs 029.01.a.i. and 029.01.a.ii. when combined with actual experience beginning with July 1, 1992 to date; and (3-29-10)
- iii. The appropriate loss ratio requirement from Subparagraphs 029.01.a.i. and 029.01.a.ii. over the entire future period for which the rates are computed to provide coverage. (3-29-10)

02. Refund or Credit Calculation. (4-5-00)

a. An issuer shall collect and file with the director by May 31 of each year the data contained in the applicable reporting form as defined by NAIC Model Regulation (Attachments) and accessible by the Internet website at <http://www.doi.idaho.gov> for each type in a standard Medicare supplement benefit plan. (4-11-06)

b. If on the basis of the experience as reported the benchmark ratio since inception (ratio one (1)) exceeds the adjusted experience ratio since inception (ratio three (3)), then a refund or credit calculation is required. The refund calculation shall be done on a statewide basis for each type in a standard Medicare supplement benefit plan. For purposes of the refund or credit calculation, experience on policies issued within the reporting year shall be excluded. (4-5-00)

c. For the purpose of Section 029, policies or certificates issued prior to July 1, 1992, the issuer shall make the refund or credit calculation separately for all individual policies (including all group policies subject to an individual loss ratio standard when issued) combined and all other group policies combined for experience after July 1, 1992. The first report shall be due by May 31, 1994. (3-29-10)

d. A refund or credit shall be made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credit exceeds a de minimis level. The refund shall include interest from the end of the calendar year to the date of the refund or credit at a rate specified by the Secretary of Health and Human Services, but in no event shall it be less than the average rate of interest for thirteen (13) week Treasury notes. A refund or credit against premiums due shall be made by September 30 following the experience year upon which the refund or credit is based. (4-5-00)

03. Annual Filing of Premium Rates. An issuer of Medicare supplement policies and certificates issued before or after the effective date of July 1, 1992, in this state shall file annually its rates, rating schedule, and supporting documentation including ratios of incurred losses to earned premiums by policy duration for approval by the director in accordance with the filing requirements and procedures prescribed by the director. The supporting documentation shall also demonstrate in accordance with actuarial standards of practice using reasonable assumptions that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. The demonstration shall exclude active life reserves. An expected third-year loss ratio which is greater than or equal to the applicable percentage shall be demonstrated for policies or certificates in force less than three (3) years. As soon as practicable, but prior to the effective date of enhancements in Medicare benefits, every issuer of Medicare supplement policies or certificates in this state shall file with the director, in accordance with the applicable filing procedures of this state: (4-5-00)

a. Appropriate premium adjustments necessary to produce loss ratios as anticipated for the current premium for the applicable policies or certificates. The supporting documents necessary to justify the adjustment shall accompany the filing. (4-5-00)

b. An issuer shall make premium adjustments necessary to produce an expected loss ratio under the policy or certificate to conform to minimum loss ratio standards for Medicare supplement policies and which are expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current premiums by the issuer for the Medicare supplement policies or certificates. No premium adjustment which would modify the loss ratio experience under the policy other than the adjustments described herein shall be made with respect to a policy at any time other than upon its renewal date or anniversary date. (4-5-00)

c. If an issuer fails to make premium adjustments acceptable to the director, the director may order

premium adjustments, refunds, or premium credits deemed necessary to achieve the loss ratio required by Section 029. (3-29-10)

d. Any appropriate riders, endorsements, or policy forms needed to accomplish the Medicare supplement policy or certificate modifications necessary to eliminate benefit duplications with Medicare. The riders, endorsements, or policy forms shall provide a clear description of the Medicare supplement benefits provided by the policy or certificate. (4-5-00)

04. Public Hearings. The director may conduct a public hearing to gather information concerning a request by an issuer for an increase in a rate for a policy form or certificate form issued before or after the effective date of July 1, 1992 if the experience of the form for the previous reporting period is not in compliance with the applicable loss ratio standard. The determination of compliance is made without consideration of any refund or credit for the reporting period. Public notice of the hearing shall be furnished in a manner deemed appropriate by the director. (4-5-00)

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

01. Filing of Policy Forms. (3-29-10)

a. An issuer shall not deliver or issue for delivery a policy or certificate to a resident of this state unless the policy form or certificate form has been filed with and approved by the director in accordance with filing requirements and procedures prescribed by the director. (3-29-10)

b. An issuer shall file any riders or amendments to policy or certificate forms to delete outpatient prescription drug benefits as required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 only with the director in the state in which the policy or certificate was issued. (3-29-10)

02. Filing of Premium Rates. (3-29-10)

a. An issuer shall not use or change premium rates for a Medicare supplement policy or certificate unless the rates, rating schedule, and supporting documentation have been filed with and approved by the director in accordance with the filing requirements and procedures prescribed by the director. (3-29-10)

b. Except as provided in Subsection 029.03, the insured shall not receive more than one (1) rate increase in any twelve (12) month period. (3-29-10)

03. Except as provided in Paragraph 030.03.a., an issuer shall not file for approval more than one (1) form of a policy or certificate of each type for each standard Medicare supplement benefit plan. (3-29-10)

a. An issuer may offer, with the approval of the director, up to ~~four (4)~~ **three (3)** additional policy forms or certificate forms of the same type for the same standard Medicare supplement benefit plan, one (1) or each of the following cases: (4-5-00)()

i. The inclusion of new or innovative benefits; (4-5-00)

ii. The addition of either direct response or agent marketing methods; (4-5-00)

iii. The addition of either guaranteed issue or underwritten coverage; (4-5-00)

~~iv. The offering of coverage to individuals for Medicare by reason of disability. (4-5-00)~~

b. For the purposes of ~~Subsection 030.03~~, "type" means an individual policy, a group policy, an individual Medicare Select policy, or a group Medicare Select policy. (3-29-10)()

04. Availability of Policy Form or Certificate. Except as provided in Paragraph 030.04.a., an issuer shall continue to make available for purchase any policy form or certificate form issued after the effective date of this rule. A policy form or certificate form shall not be considered to be available for purchase unless the issuer has

actively offered it for sale in the previous twelve (12) months. (3-29-10)

a. An issuer may discontinue the availability of a policy form or certificate form if the issuer provides to the director in writing its decision at least thirty (30) days prior to discontinuing the availability of the form of the policy or certificate. After receipt of this notice by the director, the issuer shall no longer offer for sale the policy form or certificate form in this state. (4-5-00)

b. An issuer that discontinues the availability of a policy form or certificate form pursuant to Paragraph 030.04.a. shall not file for approval a new policy form or certificate form of the same type for the same standard Medicare supplement benefit plan as the discontinued form for a period of five (5) years after the issuer provides notice to the director of the discontinuance. The period of discontinuance may be reduced if the director determines that a shorter period is appropriate. (3-29-10)

c. The sale or other transfer of Medicare supplement business to another issuer shall be considered a discontinuance for the purposes of Subsection 030.04. (3-29-10)

d. A change in the rating structure or methodology shall be considered a discontinuance under this Subsection 030.04 unless the issuer complies with the following requirements: (3-29-10)

i. The issuer provides an actuarial memorandum, in a form and manner prescribed by the director, describing the manner in which the revised rating methodology and resultant rates differ from the existing rating methodology and existing rates. (4-5-00)

ii. The issuer does not subsequently put into effect a change of rates or rating factors that would cause the percentage differential between the discontinued and subsequent rates as described in the actuarial memorandum to change. The director may approve a change to the differential which is in the public interest. (4-5-00)

05. Experience of Policy Forms. (4-5-00)

a. Except as provided in Paragraph 030.05.b., the experience of all policy forms or certificate forms of the same type in a standard Medicare supplement benefit plan shall be combined for purposes of the refund or credit calculation prescribed in Section 029. (3-29-10)

b. Forms assumed under an assumption reinsurance agreement shall not be combined with the experience of other forms for purposes of the refund or credit calculation. (4-5-00)

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

06. Attained Age Rating Prohibited. With respect to Medicare supplement policies that conform to the Standard Benefit Plans developed by the National Association of Insurance Commissioners and adopted by the State of Idaho July 1, 1992, under IDAPA 18.01.54, "Rule to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act," sold to residents of this state and all those sold on or after January 1, 1995, it is an unfair practice and an unfair method of competition for any issuer, insurer, or licensee to use the increasing age of an insured, subscriber or participant as the basis for increasing premiums or prepayment charges for policyholders who initially purchase a policy after January 1, 1995. This rule explicitly authorizes both issue age ratings and community ratings consistent with the prohibition of attained age ratings and allows companies to resubmit for approval issue age ratings previously rejected. (3-29-10)

07. Rating by Area and Gender Prohibited. With respect to Medicare supplement policies that conform to the Standard Benefit Plans developed by the National Association of Insurance Commissioners and adopted by the State of Idaho, July 1, 1992, under IDAPA 18.01.54, "Rule to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act," sold to residents of this State and all those sold on or after January 1, 1999, it is an unfair practice and an unfair method of competition for any issuer, insurer, or licensee to use area or gender for rating purpose. (3-29-10)

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

a. Any rate adjustments will be uniform between 1990 Standardized and 2010 Standardized plans throughout the lifetime of the policies, unless doing so would violate the federal lifetime loss ratio standards for specific forms within the same type. ()

b. No discount or underwriting factor of less than 1.0 will be available to policies issued outside of open enrollment, per Section 026, or guaranteed issue, per Section 027, unless the greatest discount or lowest underwriting factor is automatically applied to all policies issued under open enrollment and guaranteed issue. ()

c. For issue-ages sixty-five (65) and greater, the filed rate for any given age must not exceed the rate for any higher issue-age, similarly rated individual. ()

d. For issue-ages sixty-four (64) or less, the premium shall not exceed one hundred fifty percent (150%) of the premium for an issue-age sixty-five (65), similarly rated individual, while the individual's attained age is less than sixty-five (65). Upon attaining age sixty-five (65), a policyholder with an issue-age less than sixty-five (65) shall be charged the same premium rate as an issue-age sixty-five (65), similarly rated individual. ()

e. For any given age, the rating by the issuer shall not differentiate on the basis of the reason for eligibility for Medicare Part B. ()