TITLE 41
INSURANCE

CHAPTER 47
SMALL EMPLOYER HEALTH INSURANCE AVAILABILITY ACT

41-4701. SHORT TITLE. This chapter shall be known and may be cited as the "Small Employer Health Insurance Availability Act."

[41-4701, added 1993, ch. 176, sec. 1, p. 435.]

41-4702. PURPOSE. The purpose and intent of this chapter is to promote the availability of health insurance coverage to small employers 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, to provide for establishment of a reinsurance program, and to improve the overall fairness and efficiency of the small group health insurance market.

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

[41-4702, added 1993, ch. 176, sec. 1, p. 435; am. 2000, ch. 472, sec. 1, p. 1603.]

41-4703. 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 a small employer carrier is in compliance with the provisions of section 41-4706, 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 small employer 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, for each class of business as to a rating period, the lowest premium rate charged or that could have been charged under a rating system for that class of business by the small employer carrier to small employers with similar case characteristics for health benefit plans with the same or similar coverage.

(5) "Board" means the board of directors of the small employer reinsurance program and the individual high risk reinsurance pool as provided for in section 41-5502, Idaho Code.

(6) "Carrier" means any entity that provides, or is authorized to provide, health insurance in this state. For the 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.

(7) "Case characteristics" means demographic or other objective characteristics of a small employer that are considered by the small employer carrier in the determination of premium rates for the small employer, provided that claim experience, health status and duration of coverage shall not be case characteristics for the purposes of this chapter.

(8) "Catastrophic health benefit plan" means a higher limit health benefit plan developed pursuant to section 41-4712, Idaho Code.

(9) "Class of business" means all or a separate grouping of small employers established pursuant to section 41-4705, Idaho Code.

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

(11) "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.

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

(13) "Eligible employee" means an employee who works on a full-time basis and has a normal work week of thirty (30) or more hours or, by agreement between the employer and the carrier, an employee who works between twenty (20) and thirty (30) hours per week. The term includes a sole proprietor, a partner of a partnership, and an independent contractor, if the sole proprietor, partner or independent contractor is included as an employee under a health benefit plan of a small employer, but does not include an employee who works on a part-time, temporary, seasonal or substitute basis. The term eligible employee may include public officers and public employees without regard to the number of hours worked when designated by a small employer.

(14) "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.

(15) "Health benefit plan" means any hospital or medical policy or certificate, any subscriber contract provided by a hospital or professional service corporation, or managed care organization subscriber contract. 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 issues for a period of twelve (12) months or less.

(16) "Index rate" means, for each class of business as to a rating period for small employers with similar case characteristics, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate.

(17) "Late enrollee" means an eligible employee or dependent who requests enrollment in a health benefit plan of a small employer following the initial enrollment period during which the individual is entitled to enroll under the terms of the health benefit plan, provided that the initial enrollment period is a period of at least thirty (30) days. However, an eligible employee or dependent shall not be considered a late enrollee if:

(a) The individual meets each of the following:

(i) The individual was covered under qualifying previous coverage at the time of the initial enrollment;

(ii) The individual lost coverage under qualifying previous coverage as a result of termination of employment or eligibility, or the involuntary termination of the qualifying previous coverage; and

(iii) The individual requests enrollment within thirty (30) days after termination of the qualifying previous coverage.

(b) The individual is employed by an employer which offers multiple health benefit plans and the individual elects a different plan during an open enrollment period.

(c) A court has ordered coverage be provided for a spouse or minor or dependent child under a covered employee's health benefit plan and request for enrollment is made within thirty (30) days after issuance of the court order.

(d) The individual first becomes eligible.

(e) If an individual seeks to enroll a dependent during the first sixty (60) days of eligibility, the coverage of the dependent shall become effective:

(i) In the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received;

(ii) In the case of a dependent's birth, as of the date of such birth; or

(iii) In the case of a dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

(18) "New business premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or offered or which could have been charged or offered by the small employer carrier to small employers with similar case characteristics for newly issued health benefit plans with the same or similar coverage.

(19) "Plan of operation" means the plan of operation of the program established pursuant to section 41-4711, Idaho Code.

(20) "Plan year" means the year that is designated as the plan year in the plan document of a group health benefit plan, except that if the plan document does not designate a plan year or if there is no plan document, the plan year is:

(a) The deductible/limit year used under the plan;

(b) If the plan does not impose deductibles or limits on a yearly basis, then the plan year is the policy year;

(c) If the plan does not impose deductibles or limits on a yearly basis or the insurance policy is not renewed on an annual basis, then the plan year is the employer's taxable year; or

(d) In any other case, the plan year is the calendar year.

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

(22) "Program" means the Idaho small employer reinsurance program created in section 41-4711, Idaho Code.

(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 other group or individual health insurance policy or health benefit arrangement whether or not subject to the state insurance laws, including coverage provided by a health maintenance 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 small employer carrier are assumed to be in effect.

(25) "Reinsuring carrier" means a small employer carrier participating in the reinsurance program pursuant to section 41-4711, 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 small employer carrier whose application is approved by the director pursuant to section 41-4710, Idaho Code.

(28) "Small employer" means any person, firm, corporation, partnership or association that is actively engaged in business that employed an average of at least two (2) but no more than fifty (50) eligible employees on business days during the preceding calendar year and that employs at least two (2) but no more than fifty (50) eligible employees on the first day of the plan year, the majority of whom were and are employed within this state. In determining the number of eligible employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of state taxation, shall be considered one (1) employer.

(29) "Small employer basic health benefit plan" means a lower cost health benefit plan developed pursuant to section 41-4712, Idaho Code.

(30) "Small employer carrier" means a carrier that offers health benefit plans covering eligible employees of one (1) or more small employers in this state.

(31) "Small employer catastrophic health benefit plan" means a higher limit health benefit plan developed pursuant to section 41-4712, Idaho Code.

(32) "Small employer standard health benefit plan" means a health benefit plan developed pursuant to section 41-4712, Idaho Code.

[41-4703, added 1993, ch. 176, sec. 1, p. 435; am. 1994, ch. 427, sec. 2, p. 1349; am. 1995, ch. 360, sec. 2, p. 1237; am. 1997, ch. 321, sec. 12, p. 964; am. 1998, ch. 143, sec. 1, p. 507; am. 2000, ch. 472, sec. 2, p. 1604; am. 2001, ch. 296, sec. 8, p. 1064; am. 2003, ch. 267, sec. 1, p. 707; am. 2007, ch. 148, sec. 2, p. 428; am. 2009, ch. 125, sec. 8, p. 398; am. 2013, ch. 266, sec. 13, p. 689.]

41-4704. APPLICABILITY AND SCOPE. With the exception of a health benefit plan subject to regulation under chapter 52, title 41, Idaho Code, and 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 the employees of a small employer in this state if any of the following conditions are met:

(1) Any portion of the premium or benefits is paid by or on behalf of the small employer;

(2) An eligible employee or dependent is reimbursed, whether through wage adjustments or otherwise, by or on behalf of the small employer for any portion of the premium;

(3) The health benefit plan is treated by the employer or any of the eligible employees or dependents as part of a plan or program for the purposes of section 162, section 125 or section 106 of the United States internal revenue code.

(4) (a) Except as provided in subsection (b) 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 small employers in this state by such affiliated carriers were issued by one (1) carrier.

(b) An affiliated carrier that is a health maintenance 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.

(c) Unless otherwise authorized by the director, a small employer carrier shall not enter into one (1) or more ceding arrangements with respect to health benefit plans delivered or issued for delivery to small employers 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 and 41-511, Idaho Code, shall apply if a small employer 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 small employers in this state.

[41-4704, added 1993, ch. 176, sec. 1, p. 438; am. 1994, ch. 427, sec. 3, p. 1352; am. 1995, ch. 360, sec. 3, p. 1240.]

41-4705. ESTABLISHMENT OF CLASSES OF BUSINESS. (1) A small employer carrier may establish a separate class of business only to reflect substantial differences in expected claims experience or administrative costs related to the following reasons:

(a) The small employer carrier uses more than one (1) type of system for the marketing and sale of health benefit plans to small employers;

(b) The small employer carrier has acquired a class of business from another small employer carrier; or

(c) The small employer carrier provides coverage to one (1) or more association groups that meet the requirements of section 41-2202, Idaho Code.

(2) A small employer carrier may establish up to nine (9) separate classes of business under the provisions of subsection (1) of this section.

(3) The director may establish regulations to provide for a period of transition in order for a small employer carrier to come into compliance with the provisions of subsection (2) of this section in the instance of acquisition of an additional class of business from another small employer carrier.

(4) The director may approve the establishment of additional classes of business upon application to the director and a finding by the director that

such action would enhance the efficiency and fairness of the small employer marketplace.

[41-4705, added 1993, ch. 176, sec. 1, p. 439.]

41-4706. 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 index rate for a rating period for any class of business shall not exceed the index rate for any other class of business by more than twenty percent (20%).

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

(c) The percentage increase in the premium rate charged to a small employer 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 small employer carrier is no longer enrolling new small employers, the small employer 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 small employer carrier is actively enrolling new small employers;

(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 employees or dependents of the small employer as determined from the small employer carrier's rate manual for the class of business; and

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

(d) Adjustments in rates for claim experience, health status and duration of coverage shall not be charged to individual employees or dependents. Any such adjustment shall be applied uniformly to the rates charged for all employees and dependents of the small employer.

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

(f) (i) Small employer carriers shall apply rating factors, including case characteristics, consistently with respect to all small employers in a class of business. Rating factors shall produce premiums for identical groups which differ only by the amounts attributable to plan design and do not reflect differences due to the nature of the groups assumed to select particular health benefit plans; and

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

(g) For the 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.

(h) The small employer 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.

(i) A small employer 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.

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

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

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

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

(2) A small employer carrier shall not transfer a small employer involuntarily into or out of a class of business. A small employer carrier shall not offer to transfer a small employer into or out of a class of business unless such offer is made to transfer all small employers in the class of business without regard to case characteristics, claim experience, health status or duration of coverage since issue.

(3) 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 small employers included within a class of business of a small employer carrier for one (1) or more rating periods upon a filing by the small employer carrier and a finding by the director either that the suspension is reasonable in light of the financial condition of the small employer carrier or that the suspension would enhance the efficiency and fairness of the marketplace for small employer health insurance.

(4) In connection with the offering for sale of any health benefit plan to a small employer, a small employer 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 a specified small employer are established or adjusted based upon the actual or expected variation in claims costs or actual or expected variation in health status of the employees of the small employer and their dependents;

(b) The provisions of the health benefit plan concerning the small employer 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.
(5) (a) Each small employer 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 small employer carrier shall file with the director annually on or before March 15, an actuarial certification certifying that the carrier is in compliance with the provisions of this chapter and that the rating methods of the small employer 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 small employer carrier at its principal place of business.
(c) A small employer 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 small employer carrier or as ordered by a court of competent jurisdiction.

[41-4706, added 1993, ch. 176, sec. 1, p. 439; am. 1994, ch. 427, sec. 4, p. 1353; am. 1995, ch. 360, sec. 4, p. 1240; am. 1997, ch. 232, sec. 1, p. 676; am. 2000, ch. 415, sec. 1, p. 1321; am. 2000, ch. 472, sec. 3, p. 1607; am. 2002, ch. 99, sec. 1, p. 269; am. 2004, ch. 360, sec. 1, p. 1076; am. 2007, ch. 148, sec. 3, p. 431.]

41-4707. RENEWABILITY OF COVERAGE. (1) A health benefit plan subject to the provisions of this chapter shall be renewable with respect to all eligible employees or dependents, at the option of the small employer, except in any of the following cases:
(a) Nonpayment of the required premiums;
(b) Fraud or intentional misrepresentation of material fact by the small employer;
(c) Noncompliance with the carrier's minimum participation requirements;
(d) Noncompliance with the carrier's employer contribution requirements;
(e) In the case of health benefit plans that are made available in the small employer market only through one (1) or more associations as defined in section 41-2202, Idaho Code, the membership of an employer 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;
(f) The small employer no longer meets the requirements of section 41-4703(28), Idaho Code;

(g) The small employer carrier elects, at the time of coverage renewal, to discontinue offering a particular health benefit plan delivered or issued for delivery to small employers 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 employees 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 employers and employees or dependents 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 employers;

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

(iv) In exercising the option to discontinue the health benefit plan and in offering the option to purchase all other health benefit plans under the provisions of this paragraph, act uniformly without regard to:

1. The claims experience of an affected employer;

2. Any health status-related factor relating to any affected employee or dependent; or

3. Any health status-related factor relating to any new employee or dependent who may become eligible for the coverage; and

(v) Offer the new products at rates that comply with section 41-4706(1)(c), Idaho Code.

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

(i) Provide advance notice of its decision under this paragraph to the director in each state in which it is licensed; and

(ii) Provide notice of the decision not to renew coverage to all affected small employers 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 small employers; or

(i) 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 small employers in finding replacement coverage.

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

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

[41-4707, added 1993, ch. 176, sec. 1, p. 443; am. 1994, ch. 427, sec. 5, p. 1356; am. 1995, ch. 360, sec. 12, p. 1262; am. 1997, ch. 321, sec. 13, p. 968; am. 1998, ch. 143, sec. 2, p. 511; am. 2000, ch. 472, sec. 4, p. 1611; am. 2006, ch. 353, sec. 2, p. 1080.]

41-4708. AVAILABILITY OF COVERAGE -- PREEXISTING CONDITIONS -- PORTABILITY. (1) Every small employer carrier shall, as a condition of offering health benefit plans in this state to small employers, actively offer to small employers all benefit plans, including the small employer basic health benefit plan, the small employer standard health benefit plan, and the small employer catastrophic health benefit plan.

(2) (a) A small employer carrier shall file with the director, in a format and manner prescribed by the director, the small employer basic, standard and catastrophic 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 a small employer 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 small employer carrier, disapprove the continued use by a small employer carrier of a basic, standard or catastrophic health benefit plan on the grounds that the plan does not meet the requirements of this chapter.

(3) Health benefit plans covering small employers 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 a condition, whether physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received during the six (6) months immediately preceding the effective date of coverage.

(b) Genetic information shall not be considered as a condition described in this subsection in the absence of a diagnosis of the condition related to such information.

(c) A health benefit plan shall waive any time period applicable to a preexisting condition exclusion or limitation period with respect to particular services for the period of time an individual was previously covered by qualifying previous coverage that provided benefits with respect to such services, provided that the qualifying previous coverage was continuous to a date not more than sixty-three (63) days prior to the effective date of the new coverage. The period of continuous coverage shall not include any waiting period for the effective date of the new coverage applied by the employer or the carrier. This paragraph does

not preclude application of any waiting period applicable to all new enrollees under the health benefit plan.

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

(e) (i) Except as provided in paragraph (e)(iv) of this subsection, requirements used by a small employer carrier in determining whether to provide coverage to a small employer, including requirements for minimum participation of eligible employees and minimum employer contributions, shall be applied uniformly among all small employers with the same number of eligible employees applying for coverage or receiving coverage from the small employer carrier.

(ii) A small employer carrier may vary application of minimum participation requirements and minimum employer contribution requirements only by the size of the small employer group.

(iii) In applying minimum participation requirements with respect to a small employer, a small employer carrier shall not consider employees or dependents who have qualifying existing coverage in determining whether the applicable percentage of participation is met.

(iv) A small employer carrier shall not increase any requirement for minimum employee participation or any requirement for minimum employer contribution applicable to a small employer at any time after the small employer has been accepted for coverage.

(f) (i) If a small employer carrier offers coverage to a small employer, the small employer carrier shall offer coverage to all of the eligible employees of a small employer and their dependents. A small employer carrier shall not offer coverage to only certain individuals in a small employer group or to only part of the group, except in the case of late enrollees as provided in paragraph (d) of this subsection.

(ii) A small employer carrier shall not modify a basic, standard or catastrophic health benefit plan with respect to a small employer or any eligible employee or dependent through riders, endorsements or otherwise, to restrict or exclude coverage for certain diseases or medical conditions otherwise covered by the health benefit plan.

(4) (a) A small employer 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 a small employer, where the small employer is not physically located in the carrier's established geographic service area;

(ii) To an employee, when the employee does not work or reside within the carrier's established geographic service area; or

(iii) Within an area where the small employer 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 the members

of such groups because of its obligations to existing group policyholders and enrollees.

(b) A small employer carrier that cannot offer coverage pursuant to the provisions of subsection (4)(a)(iii) of this section may not offer coverage in the applicable area to new cases of employer groups with more than fifty (50) eligible employees or to any small employer groups 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 small employer groups.

(5) A small employer carrier shall not be required to provide coverage to small employers 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 small employers in accordance with the provisions of subsection (1) of this section would place the small employer carrier in a financially impaired condition.

[41-4708, added 1993, ch. 176, sec. 1, p. 443; am. 1994, ch. 427, sec. 6, p. 1357; am. 1995, ch. 360, sec. 5, p. 1244; am. 1997, ch. 321, sec. 14, p. 969; am. 1998, ch. 143, sec. 3, p. 512; am. 2000, ch. 472, sec. 5, p. 1612.]

41-4708B. CONVERSION PLAN -- WHEN REQUIRED. Any group carrier doing business in the state of Idaho that does not have an individual product on file with the department of insurance shall provide a conversion plan to all group insureds. The conversion plan shall provide benefits at least equal to the standard health benefit plan developed pursuant to section 41-4712, Idaho Code. The premium under the plan shall not exceed one hundred twenty-five percent (125%) of the index rate for groups.

[41-4708B, added 1996, ch. 124, sec. 2, p. 439.]

41-4709. NOTICE OF INTENT TO OPERATE AS A RISK-ASSUMING CARRIER OR A REINSURING CARRIER. (1) (a) Each small employer 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. A small employer carrier seeking to operate as a risk-assuming carrier shall make an application pursuant to the provisions of section 41-4710, 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 small employer 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.

[41-4709, added 1993, ch. 176, sec. 1, p. 446.]

41-4710. APPLICATION TO BECOME A RISK-ASSUMING CARRIER. (1) A small employer 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 small employer groups;

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

(d) The carrier's experience with managing the risk of small employer groups; and

(e) The extent to which a carrier has and will be able to maintain reinsurance pursuant to the provisions of subsection (4)(c) of section 41-4704, Idaho Code.

(3) The director shall provide public notice of an application by a small employer 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 small employers in compliance with the provisions of section 41-4708, Idaho Code, without the protection afforded by the program;

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

(c) The carrier has failed to provide coverage to eligible small employers as required in section 41-4708, Idaho Code.

(5) A small employer 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 small employer carrier is subject to assessment for additional funding pursuant to the provisions of subsection (12)(c) of section 41-4711, Idaho Code.

[41-4710, added 1993, ch. 176, sec. 1, p. 447.]

41-4711. SMALL EMPLOYER CARRIER REINSURANCE PROGRAM. (1) All carriers shall be subject to the provisions of this section.

(2) There is hereby created an independent public body corporate and politic to be known as the Idaho small employer health reinsurance program. The program will perform an essential governmental function in the exercise of powers conferred upon it in this act and any assessments imposed or collected pursuant to the operation of the program shall at all times be free from taxation of every kind.

(3) The program shall operate subject to the supervision and control of the board established in section 41-5502, Idaho Code.

(4) Each carrier shall make a filing with the director containing the carrier's earned health insurance premium derived from health benefit plans delivered or issued for delivery to small employers in this state in the previous calendar year.

(5) The board shall submit to the director a plan of operation and thereafter any amendments thereto necessary or suitable to assure the fair, reasonable and equitable administration of the program. The director may, after notice and hearing, approve the plan of operation if the director determines it to be suitable to assure the fair, reasonable and equitable administration of the program, and to provide for the sharing of program gains or losses on an equitable and proportionate basis in accordance with the provisions of this section. The plan of operation shall become effective upon written approval by the director.

(6) If the board fails to submit a suitable plan of operation, the director shall, after notice and hearing, adopt and promulgate a temporary plan of operation. The director shall approve the plan of operation submitted by the board, or adopt a temporary plan of operation if the board fails to submit a suitable plan. The director shall amend or rescind any plan adopted under the provisions of this subsection at the time a plan of operation is submitted by the board and approved by the director.

(7) The plan of operation shall:

(a) Establish procedures for handling and accounting of program assets and moneys and for an annual fiscal reporting to the director;

(b) Establish procedures for selecting an administrator, which shall be properly licensed in this state, and setting forth the powers and duties of the administrator;

(c) Establish procedures for reinsuring risks in accordance with the provisions of this section;

(d) Establish procedures for collecting assessments from carriers to fund claims and administrative expenses incurred or estimated to be incurred by the program; and

(e) Provide for any additional matters necessary for the implementation and administration of the program.

(8) The program shall have the general powers and authority granted under the laws of this state to insurance companies and health maintenance organizations licensed to transact business, except the power to issue health benefit plans directly to either groups or individuals. In addition thereto, the program shall have the specific authority to:

(a) Enter into contracts as are necessary or proper to carry out the provisions and purposes of this chapter, including the authority, with the approval of the director, to enter into contracts with similar programs of other states for the joint performance of common functions or with persons or other organizations for the performance of administrative functions;

(b) Sue or be sued, including taking any legal actions necessary or proper to recover any assessments and penalties for, on behalf of, or against the program or any carrier;

(c) Take any legal action necessary to avoid the payment of improper claims against the program;

(d) Define the health benefit plans, which plans shall allow coordination of benefits, for which reinsurance will be provided, and to issue reinsurance policies, in accordance with the requirements of this chapter;

(e) Establish rules, conditions and procedures for reinsuring risks under the program, including broad discretion to operate the small employer reinsurance program;

(f) Establish actuarial functions as appropriate for the operation of the program;

(g) Assess carriers in accordance with the provisions of subsection (12) of this section, and to make advance interim assessments of carriers as may be reasonable and necessary for organizational and interim operating expenses. Any interim assessments shall be credited as offsets against any regular assessments due following the close of the fiscal year;

(h) Appoint appropriate legal, actuarial and other committees as necessary to provide technical assistance in the operation of the program, policy and other contract design, and any other function within the authority of the program;

(i) Borrow money to effect the purposes of the program. Any notes or other evidence of indebtedness of the program not in default shall be legal investments for carriers and may be carried as admitted assets.

(9) A carrier may reinsure with the program as provided for in this subsection:

(a) With respect to a small employer basic, standard or catastrophic health benefit plan, the program shall reinsure the level of coverage provided and, with respect to other plans, the program shall reinsure up to the level of coverage provided in a small employer basic, standard or catastrophic health benefit plan.

(b) A small employer carrier may reinsure an entire employer group within sixty (60) days of the commencement of the group's coverage under a health benefit plan.

(c) A small employer carrier may reinsure an eligible employee or dependent within a period of sixty (60) days following the commencement of the coverage with the small employer. A newly eligible employee or dependent of the reinsured small employer may be reinsured within sixty (60) days of the commencement of his coverage. Newborn dependents of insureds are not eligible for reinsurance unless a parent is already reinsured.

(d) (i) The program shall not reimburse a reinsuring carrier with respect to the claims of a reinsured employee or dependent until the carrier has incurred an initial level of claims for such employee or dependent of five thousand dollars ($5,000) in a calendar year for benefits covered by the program. In addition, the reinsuring carrier shall be responsible for ten percent (10%) of the next fifty thousand dollars ($50,000) of benefit payments during a calendar year and the program shall reinsure the remainder.

(ii) The board annually may adjust the initial level of claims and the maximum limit to be retained by the carrier to reflect increases in costs and utilization within the standard market for health benefit plans within the state. The adjustment shall not be less than the annual change in the medical component of the "Consumer Price Index for All Urban Consumers" of the department of labor, bureau of labor statistics, unless the board proposes and the director approves a lower adjustment factor.

(e) A reinsuring carrier may terminate reinsurance with the program for one (1) or more of the reinsured employees or dependents on any anniversary of the health benefit plan.

(f) A reinsuring carrier shall apply all managed care and claims handling techniques, including utilization review, individual case

management, preferred provider provisions, and other managed care provisions or methods of operation consistently with respect to reinsured and nonreinsured business.

(10) (a) The board, as part of the plan of operation, shall establish a methodology for determining premium rates to be charged by the program for reinsuring small employers pursuant to this section. The methodology shall include a system for classification of small employers that reflects the types of case characteristics commonly used by small employer carriers in the state. The methodology shall provide for the development of base reinsurance premium rates, subject to the approval of the director, and shall be set at levels which reasonably approximate gross premiums charged to small employers by small employer carriers for health benefit plans with benefits similar to the standard health benefit plan, adjusted to reflect retention levels required under the provisions of this chapter.

(b) Premiums for the program shall be as established by the board.

(c) The board periodically shall review the methodology established under the provisions of paragraph (10)(a) of this section, including the system of classification and any rating factors, to assure that it reasonably reflects the claims experience of the program. The board may propose changes to the methodology which shall be subject to the approval of the director.

(d) The board may consider adjustments to the premium rates charged by the program to reflect the use of effective cost containment and managed care arrangements.

(11) If a health benefit plan for a small employer is entirely or partially reinsured with the program, the premium charged to the small employer for any rating period for the coverage issued shall meet the requirements relating to premium rates set forth in section 41-4706, Idaho Code.

(12) (a) Prior to March 1 of each year, the board shall determine and report to the director the program net loss for the previous calendar year, including administrative expenses and incurred losses for the year, taking into account investment income and other appropriate gains and losses.

(b) Any net loss for the year shall be recouped by assessments of carriers.

(c) (i) For the assessment of March 1, 1995, and prior to March 1 of each succeeding year, the board shall determine and file with the director an estimate of the assessments needed to fund the losses incurred by the program in the previous calendar year.

(ii) The assessments shall be determined by multiplying net losses, if net earnings are negative, as defined by subsection (12)(a) of this section, by a fraction, the numerator of which shall be the carrier's total premiums earned in the preceding calendar year from all health benefit plans and policies or certificates of insurance for specific disease, and hospital confinement indemnity in this state as reported in the carrier's annual report pursuant to subsection (16) of this section, and the denominator of which shall be the total premiums earned in the preceding calendar year from all health benefit plans and policies or certificates of insurance for specific disease and hospital confinement indemnity in this state.

(d) If assessments exceed net losses of the program, the excess shall be held at interest and used by the board to offset future losses or to reduce program premiums. As used in this paragraph, "future losses" includes reserves for incurred but not reported claims.

(e) Each carrier's proportion of the assessment shall be determined annually by the board based on annual statements and other reports deemed necessary by the board and filed by the carriers with the board or with the director.

(f) The plan of operation shall provide for the imposition of an interest penalty for late payment of assessments.

(g) A carrier may seek from the director a deferment from all or part of an assessment imposed by the board. The director may defer all or part of the assessment of a carrier if the director determines that the payment of the assessment would place the carrier in a financially impaired condition. If all or part of an assessment against a carrier is deferred the amount deferred shall be assessed against the other carriers in a manner consistent with the basis for assessment set forth in this subsection. The carrier receiving the deferment shall remain liable to the program for the amount deferred and shall be prohibited from reinsuring any groups with the program until such time as it pays the assessments.

(13) (a) Neither the participation in the program as reinsuring carriers, the establishment of rates, forms or procedures, nor any other joint or collective action required under the provisions of this chapter shall be the basis of any legal action, criminal or civil liability, or penalty against the program or any of its reinsuring carriers either jointly or separately.

(b) Neither the board nor its employees shall be liable for any obligations of the program. No member or employee of the board shall be liable, and no cause of action of any nature may arise against them, for any act or omission related to the performance of their powers and duties under this chapter, unless such act or omission constitutes willful or wanton misconduct. The board may provide for indemnification of, and legal representation for, its members and employees.

(14) The board, as part of the plan of operation, shall develop standards setting forth the manner and levels of compensation to be paid to agents for the sale of small employer basic, standard and catastrophic health benefit plans. In establishing such standards, the board shall take into consideration the need to assure the broad availability of coverages, the objectives of the program, the time and effort expended in placing the coverage, the need to provide ongoing service to the small employer, the levels of compensation currently used in the industry and the overall costs of coverage to small employers selecting these plans.

(15) The program shall be exempt from any and all taxes.

(16) Each carrier shall file with the director, in a form and manner to be prescribed by the director, an annual report. The report shall state the number of resident persons insured under the carrier's health benefit plan.

(17) If a reinsuring small employer carrier attempts to reinsure or reinsures an entire employer group, an employee, or a dependent of such employee that, immediately prior to the commencement of such coverage, it covered under a health benefit plan, the board shall assess all costs and losses incurred by the program for claims and administrative expenses relating to such group, employee or dependent of such employee only to the said reinsuring small employer carrier.

(18) Subsection (17) of this section shall apply to assessments made for the 1994 calendar year and each year thereafter.

[41-4711, added 1993, ch. 176, sec. 1, p. 447; am. 1994, ch. 427, sec. 7, p. 1360; am. 1995, ch. 360, sec. 6, p. 1247; am. 1997, ch. 321, sec. 15, p. 972; am. 2000, ch. 472, sec. 6, p. 1615; am. 2002, ch. 197, sec. 1, p. 557; am. 2003, ch. 267, sec. 2, p. 710.]

41-4712. SMALL EMPLOYER HEALTH BENEFIT PLANS. (1) The board, in addition to its other powers and duties, shall establish the form and level of coverages, including benefit levels, cost-sharing levels, exclusions and limitations for the small employer basic, standard and catastrophic health benefit plans to be made available by small employer carriers pursuant to section 41-4708, Idaho Code, with an emphasis on making coverage available for preventive care.

(2) The board shall also design a small employer basic, standard and catastrophic health benefit plan which each contain benefit and cost-sharing levels that are consistent with the basic method of operation and the benefit plans of managed care organizations, including any restrictions imposed by federal law. The plans or changes established by the board may include cost containment features such as:

(a) Utilization review of health care services, including review of medical necessity of hospital and physician services;

(b) Case management;

(c) Selective contracting with hospitals, physicians and other health care providers;

(d) Reasonable benefit differentials applicable to providers that participate or do not participate in arrangements using restricted network provisions; and

(e) Other managed care provisions.

(3) The board shall submit the plans or changes approved by the board to the director for approval not later than March 1 of each year. The director shall promulgate the approved plans pursuant to the provisions of section 41-4715, Idaho Code.

(4) Small employer carriers desiring to issue a small employer basic, standard or catastrophic health benefit plan differing from the form and level of coverage approved by the board and the director shall submit such plan to the board for review to insure that such proposed plan is commensurate with the benefit levels, cost-sharing levels, exclusions, and limitations for the plan developed and approved pursuant to the provisions of this section.

(5) The board may appoint an advisory committee to assist in the development of and any changes to the small employer basic, standard and catastrophic health benefit plans.

[41-4712, added 1993, ch. 176, sec. 1, p. 453; am. 1994, ch. 427, sec. 8, p. 1365; am. 1995, ch. 360, sec. 7, p. 1253; am. 1997, ch. 321, sec. 16, p. 977; am. 2000, ch. 472, sec. 7, p. 1620.]

41-4713. PERIODIC MARKET EVALUATION. The board, in consultation with members of the committee, shall study and report at least every three (3) years to the director on the effectiveness of chapters 47 and 52, title 41, Idaho Code. The report shall analyze the effectiveness of the chapters in promoting rate stability, product availability, and coverage affordabil-

ity. The report may contain recommendations for actions to improve the overall effectiveness, efficiency and fairness of the small group and individual health insurance marketplace. The report shall address whether carriers and agents are fairly and actively marketing or issuing health benefit plans to small employers and individuals in fulfillment of the purposes of the chapters. The report may contain recommendations for market conduct or other regulatory standards or action.

[41-4713, added 1993, ch. 176, sec. 1, p. 454; am. 1994, ch. 427, sec. 9, p. 1366.]

41-4715. ADMINISTRATIVE PROCEDURES. The director shall promulgate rules and regulations in accordance with the provisions of chapter 52, title 67, Idaho Code, for the implementation and administration of the small employer health coverage reform act.

[41-4715, added 1993, ch. 176, sec. 1, p. 454.]

41-4716. STANDARDS TO ASSURE FAIR MARKETING. (1) Each small employer carrier shall actively market health benefit plan coverage, including the small employer basic, standard and catastrophic health benefit plans, to eligible small employers in the state.

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

(i) Encouraging or directing small employers to refrain from filing an application for coverage with the small employer carrier because of the health status, claims experience, industry, occupation or geographic location of the small employer;

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

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

(3) (a) Except as provided in subsection (2)(b) of this section, no small employer 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 varied because of the health status, claims experience, industry, occupation or geographic location of the small employer.

(b) The provisions of subsection (a) of this section 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 percentage shall not vary because of the health status, claims experience, industry, occupation or geographic area of the small employer.

(4) A small employer carrier shall provide reasonable compensation, as provided under the plan of operation of the program, to an agent, if any, for the sale of a small employer basic, standard or catastrophic health benefit plan.

(5) No small employer 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 small employers placed by the agent with the small employer carrier.

(6) No small employer carrier or agent may induce or otherwise encourage a small employer to separate or otherwise exclude an employee from health coverage or benefits provided in connection with the employee's employment.

(7) Denial by a small employer carrier of an application for coverage from a small employer shall be in writing and shall state the reason or reasons for the denial.

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

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

(b) If a small employer 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 small employers in this state, the third-party administrator shall be subject to the provisions of this section as if it were a small employer carrier.

[41-4716, added 1993, ch. 176, sec. 1, p. 454; am. 1994, ch. 427, sec. 11, p. 1367; am. 1997, ch. 321, sec. 18, p. 979; am. 2000, ch. 472, sec. 8, p. 1621.]