

State of Idaho
DEPARTMENT OF INSURANCE

C.L. "BUTCH" OTTER
Governor

700 West State Street, 3rd Floor
P.O. Box 83720
Boise, Idaho 83720-0043
Phone (208)334-4250
Fax (208)334-4398
Website: <http://www.doi.idaho.gov>

DEAN L. CAMERON
Director

BULLETIN NO. 18-01

DATE: January 24, 2018
TO: Health Insurance Carriers in Idaho's Individual Market
FROM: Dean Cameron, Director
SUBJECT: Provisions for Health Carriers Submitting State-Based Health Benefit Plans

Pursuant to Governor Otter's Executive Order 2018-02, the Idaho Department of Insurance ("Department") has outlined the provisions that will be required for new health products to comply with Idaho Code, Title 41, Chapter 52. Such plans will be identified as "state-based health benefit plans" or "state-based plans" and will not be subject to the federal restrictions applied to "grandfathered" or "transitional" plans.

Carriers must file the forms and rates for each state-based plan with the Department, and must not market or sell the plans until the Department has finished reviewing and closed the filing. The Department will review these plans against the following requirements, in addition to other applicable provisions found in Title 41:

1. Carrier participation in Idaho Exchange: A carrier must offer an exchange-certified health plan in the individual market as a condition to offering a state-based plan within the same service area. If a carrier discontinues offering exchange-certified health plans, any state-based plans offered by that carrier will also be considered discontinued.
2. Guaranteed issue and renewability: Carriers must provide guaranteed availability and issuance of coverage in any state-based plan offered. Dependents under age 26 must be eligible for coverage. No special enrollment period is needed to enroll in any state-based plan. Such policies must be guaranteed renewable in accordance with Idaho Code.
3. Preexisting condition coverage: Carriers are prohibited from applying a preexisting condition exclusion period, provided there is continuous prior coverage. As required by Title 41, carriers must waive any preexisting condition exclusion for any applicant with evidence of qualifying previous coverage within 63 days of when the new state-based plan coverage takes effect.
4. Minimum health benefits: Title 41 requires that all health benefit plans cover certain minimum health benefits, and carriers may offer additional benefits beyond that minimum. The minimum required benefits for these plans include (with examples as sub-bullets):
 - Outpatient/ambulatory patient services
 - Provider office visits
 - Outpatient surgery (facility and provider)
 - Anesthesia services
 - Chronic disease treatment

- Emergency care
 - Emergency room
 - Transportation
- Hospitalization
 - Inpatient facilities and providers, including surgery
 - Inpatient laboratory and medications
- Maternity and newborn care (maternity must be included in at least one state-based plan)
 - Obstetrician visits and other physician care
 - Hospital costs
 - Newborns added to their parent's policy are covered from the moment of birth, regardless of health condition
- Mental health and substance use disorder services
 - Inpatient evaluation, diagnosis, and treatment
 - Outpatient evaluation, diagnosis, and treatment
 - Must be in accordance with mental health and substance use disorder parity rules
- Prescription drugs
 - Generic
 - Brand-name
 - Specialty drugs
- Rehabilitation treatment
 - Hospital-based rehabilitation
 - Outpatient and office-based rehabilitation
- Laboratory services
 - Diagnostic laboratory
 - Diagnostic and therapeutic radiological services
- Preventive care
 - Physicals
 - Immunizations

Additional benefits: Carriers may offer benefits beyond the minimum. Any additional benefits may be included as part of the base contract or as an optional rider. Such optional riders will be permitted as long as there is an appropriate, corresponding premium filed and justified.

5. Premium rates: The Department intends to enforce the rating restrictions on premium rates delineated in Title 41. State-based plans and exchange-certified health plans must comprise a single risk pool, with one market-wide adjusted index rate. The carrier's rate filing for state-based plans must justify each adjustment from the market-wide adjusted index rate; and carriers must not include plan-level adjustments beyond: cost-sharing design, provider network, delivery system characteristics, covered benefits, and administrative costs. Those adjustments must not account for any actual or expected health status of the individuals that choose or are expected to choose a particular health benefit plan.

The resulting plan adjusted index rate must be filed, along with the base rate for each state-based plan, which by law must not be less than 50% of the plan's index rate. From the plan adjusted index rate, the following consumer-level adjustments may be applied to determine an applicant's premium:

- Age – Carriers may define their own unisex age curve for state-based plans; however, at some future point a standardized age curve may be established. Age rating must not exceed a 5:1 ratio among individuals or dependents ages 20 and older. The same age factor must apply to all

dependent children up to age 26. The dependent child factor must fall within the 5:1 ratio, and a premium may be charged for each child. In calibrating the plan adjusted index rate for the carrier's state-based plan age curve, carriers must use the same population distribution as the exchange-certified health plans.

- Tobacco use – If used, it must be a single factor that does not vary by age or geography.
 - Geography – The six allowable geographic rating areas must not differ from those defined by the Department in Appendix D of the [2018 Idaho Standards for Health Benefit Plans](#). Carriers must not use expected health status or claims in setting the area factors. Any differences between exchange-certified health plan geographic rating area factors and state-based plan area factors must be justified.
 - Medical underwriting/risk factor – Underwriting criteria must be limited to those questions found on the [Idaho Universal Health Statement Addendum](#) and available claims data. The resulting risk factor must follow Idaho Code and therefore must not result in a premium more than 50% above or below the carrier's filed plan adjusted index rate after applying all allowable case characteristics.
6. Annual limits: The Department will consider health plans with an overall annual dollar benefit limit of no less than \$1 million per individual. Any individual reaching \$1 million in annual paid benefits must be assisted by the carrier in transitioning without a break in coverage to one of the carrier's exchange-certified health plans.
7. Maximum out-of-pocket: Maximum out-of-pocket provisions shall be inclusive of all deductibles, copayments, coinsurances, or other cost-sharing for all minimum health benefits. The maximum out-of-pocket is allowed to be partitioned to have a separate maximum for specific services, such as a medical maximum out-of-pocket separate from a prescription drug maximum out-of-pocket.
8. Disclosure: A carrier that elects to offer a state-based plan that is not fully compliant with federal non-group health insurance requirements must disclose on the face page of the policy that:
- The policy is not fully compliant with federal health insurance requirements.
 - Any preexisting condition is covered provided there is qualifying prior coverage.

Title 41 References

- Relevant definitions: [41-4202](#), [41-5203](#), and [41-3903](#)
- Guaranteed issue/renewability: [41-5207](#) and [41-5208\(3\)](#)
- Preexisting condition exclusions: [41-5208\(3\)](#)
- Standards for policy provisions: [41-4203](#) – individual
- Minimum standards for benefits: [41-4204](#) – individual; [41-3903\(1\)](#) – managed care
- Maternity and newborn coverage: [41-2140](#) – individual; [41-3923](#) – managed care
- Premium rates: [41-5206](#)
- Fair marketing standards: [41-5212](#)