PENDING RULES

COMMITTEE RULES
REVIEW BOOK

Submitted for Review Before

Senate Commerce &
Human Resources Committee

68th Idaho Legislature
Second Regular Session – 2026

Prepared by:

Office of the Administrative Rules Coordinator
Division of Financial Management

January 2026

SENATE COMMERCE & HUMAN RESOURCES COMMITTEE

ADMINISTRATIVE RULES REVIEW

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18.04.05 – SELF-FUNDED HEALTH CARE PLANS RULE

DOCKET NO. 18-0405-2501 (ZBR CHAPTER REWRITE)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2026 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. Should the pending rule be approved, it will become final and effective on July 1 following the Second Regular Session of the Sixty-eighth Idaho Legislature, unless the concurrent resolution states a different effective date.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section(s) 41-211 and 41-4020, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change:

This rule was presented as part of the Department of Insurance's plan to review each rule according to the Governor's Executive Order 2020-01: Zero-Based Regulation, and pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. This chapter supplements the provisions of Title 41, Chapter 40, Idaho Code, Self-Funded Health Care Plans by providing application requirements, dates, definitions, effective dates; and requirements for contribution rates, contracts, services, and records.

There are no changes to the pending rule, and it is being adopted as originally proposed. The complete text of the proposed rule was published in the August 6, 2025 Idaho Administrative Bulletin, Vol. 25-8, pages 56-60.

FEE SUMMARY: Pursuant to Section 67-5224(2)(d), Idaho Code, a pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature. The following is a description of the fee or charge imposed or increased in this rulemaking: 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: No fiscal impact.

ASSISTANCE WITH TECHNICAL QUESTIONS: For assistance with technical questions concerning this pending rule, contact Weston Trexler, (208) 334-4214, weston.trexler@doi.idaho.gov.

DATED this 3rd day of October, 2025.

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

THE FOLLOWING NOTICE PUBLISHED WITH THE 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 41-4020, Idaho Code.

PUBLIC HEARING SCHEDULE: A public hearing concerning this rulemaking will be held as follows:

Thursday, August 7, 2025
2:00 p.m. – 4:00 p.m.

In-person participation is available at:
Department of Insurance
700 W. State St. 3rd Floor
Boise, ID 83702

Web meeting link:
Click here to join the meeting
Meeting ID: 237 139 719 159 3
Passcode: jk3o9Ur2
Download Teams | Join on the web

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: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

The purpose of this chapter supplements the provisions of Title 41, Chapter 40, Idaho Code, Self-Funded Health Care Plans by providing application requirements, dates, definitions, effective dates; and requirements for contribution rates, contracts, services, and records.

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

No fee or charge imposed or increased.

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 as a result of this rulemaking: None.

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 May 7, 2025, Idaho Administrative Bulletin, Volume 25-5, pages 52-53 under docket number 18-ZBRR-2501.

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: None.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Weston Trexler, (208) 334-4214, weston.trexler@doi.idaho.gov.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or August 27, 2025.

DATED this 2nd day of July, 2025.

THE FOLLOWING IS THE TEXT OF ZBR DOCKET NO. 18-0405-2501

18.04.05 – SELF-FUNDED HEALTH CARE PLANS RULE

000. LEGAL AUTHORITY.
~~Title 41, Chapter 2,~~ Sections 41-244 and 41-4020, Idaho Code. ~~(3-31-22)~~( )

001. ~~TITLE AND~~ SCOPE.

~~01.~~ ~~Title~~. ~~IDAPA 18.04.05, "Self-Funded Health Care Plans Rule."~~ ~~(3-31-22)~~

~~02.~~ ~~Scope~~. ~~This rule~~ chapter supplements the provisions of Title 41, Chapter 40, Idaho Code, Self-Funded Health Care Plans. ~~(3-31-22)~~( )

002. -- 0~~09~~23. (RESERVED)

~~010. DEFINITIONS.~~

~~01. "All Contributions to Be Paid in Advance."~~ ~~All contributions are to be paid in advance of the period of time for which the contribution is made.~~ ~~(3-31-22)~~

~~02. "Deposited in and Disbursed from a Trust Fund."~~ ~~All contributions based on calculated rates in accordance with Section 028 of this rule are deposited into the trust fund and all expenses are paid out of the trust fund.~~ ~~(3-31-22)~~

~~011. -- 020. (RESERVED)~~

~~021. QUALIFICATION OF PLAN.~~
~~In order for a plan to qualify under Title 41, Chapter 40, Idaho Code, the plan's trust will be established by agreement between the employer or employers or a postsecondary education institution and the trustee of the trust, for the sole purpose of providing health care benefits to employees of the employer or employers or to students of the postsecondary educational institution.~~ ~~(3-31-22)~~

~~022. REGISTRATION.~~

~~01. Registration Requisite~~. ~~No self-funded plan, unless exempted from registration by Section 41-4003, Idaho Code, will be organized and permitted to operate in the state of Idaho without securing a Certificate of Registration from the Director.~~ ~~(3-31-22)~~

~~02. Specific Plans~~. ~~Any plans covering the employees of a common employer are a single plan in respect to the exemption for registration allowed in Section 41-4003, Idaho Code. Any combinations of plans under the effective control of a single administrator, trustee, and/or employer, or group of administrators, trustees and/or~~

~~employers utilizing or attempting to utilize the exempt dollar amounts permitted under Section 41-4003, Idaho Code in order to avoid registration of any such plans are deemed to be contrary to the intent of Title 41, Chapter 40, Idaho Code, and are expressly banned by this rule.~~ ~~(3-31-22)~~

~~**03. Beneficiary Within State**. Registration is mandatory of plans that cover any beneficiary working or residing within this state, unless the plans are otherwise exempted by Section 41-4003(2), Idaho Code.~~ ~~(3-31-22)~~

~~**023. (RESERVED)**~~

024. INVESTIGATION OF PROPOSED APPLICATION FOR REGISTRATION.
The Director may ~~make an investigation of~~ investigate matters accompanying the application for registration including an examination specified in Section 41-4013, Idaho Code. Costs of any investigation or examination, or both, will be borne by the trust fund of the plan. ~~(3-31-22)~~( )

025. CONTRIBUTIONS RECEIVABLE.
The trust fund may take credit in any financial statement for contributions receivable which are not in excess of ninety (90) days past due. (3-31-22)

026. TRUST FUND RESERVES AND SURPLUS.

01. Reserve Requirements. The trust fund of the plan is to continuously maintain reserves sufficient, as certified by a qualified actuary as being necessary, to fully fund payment of all benefits in effect at the time a claim arises. This reserve needs to adequately provide for all reasonably estimated future claim payments, adjustment expenses, and litigation expenses on claims which have arisen, including claims incurred but not reported, extended benefits and maternity benefits, if any. (3-31-22)

02. Reserves for Disability Income Benefits. Reserves established for disability income benefits cannot be less than the Minimum Reserve Standards for Group Health Insurance Contracts set forth the in the NAIC's Accounting Practices and Procedures Manual unless it can be proven to the satisfaction of the Director that a lower reserve can be actuarially justified. (3-31-22)

03. Certification by Actuary. Reserves need~~s~~ to be certified annually by a qualified actuary. Such certification needs to be accompanied by a statement describing bases used in reserve determination. The certification will be in a form acceptable to the Director. ~~(3-31-22)~~( )

04. Insolvent Condition. If determination of surplus reveals a deficiency in surplus, the Director may allow the plan up to ninety (90) days to accumulate prescribed surplus. The plan is deemed insolvent when it is either unable to pay its obligations or its assets do not exceed all its liabilities, including prescribed reserves. (3-31-22)

027. BONDING.

01. Certified Copy of Bond. The plan will submit to the Director a certified copy of the fidelity bond or equivalent coverage, ~~as prescribed under~~ pursuant to Section 41-4014(3), Idaho Code. ~~(3-31-22)~~( )

02. Scope of Coverage. The fidelity bond or equivalent coverage will cover every trustee, officer, director, and employee of the plan. (3-31-22)

03. Cancellation of Bond Requirements. The fidelity bond or equivalent coverage needs to contain language stating that it is noncancellable except upon not less than thirty (30) days advance notice in writing to the trustee and the Director. ~~A~~ The surety is to forward a copy of any notice ~~cancelling a bond prescribed under Title 41, Chapter 40, Idaho Code, is to be forwarded~~ such bond to the Director ~~by the surety~~ at the same time it is forwarded to the trustee. ~~(3-31-22)~~( )

~~**04. Third Party Administrator**. Any party that provides any one of the following services to the plan needs to be licensed as a third party administrator:~~ ~~(3-31-22)~~

~~**a.** Directly or indirectly underwrites;~~ ~~(3-31-22)~~

~~**b.** Collects or handles charges or contributions; or~~ ~~(3-31-22)~~

~~**c.** Adjusts or settles claims on members or beneficiaries of the plan.~~ ~~(3-31-22)~~

028. CONTRIBUTION RATES.

01. Contribution Rate Calculation. Contribution rates will be calculated at least annually by a qualified actuary. The contribution rate calculations should break down and designate the rate for the employer and the rate per employee, or the rate for the postsecondary educational institution and the rate per student. (3-31-22)

02. Employer Contributions. Employer contributions will be based on filed rates, paid in advance on a periodic basis during the period of coverage or at the beginning of the period of coverage. (3-31-22)

~~**03. Annual Filing of Rates**. The annual filing of rates with the Director will include a breakdown as prescribed under Subsection 028.01.~~ ~~(3-31-22)~~

029. CONTRACTS AND SERVICES.

01. Affiliated Contracts. All contracts for goods or services provided to the plan by any plan sponsor, employer, third party administrator, or other affiliated entity or employee or agent thereof, will be in writing, setting forth in detail the rights and duties of each party to the writing; regardless of whether compensation, fees, or other consideration is paid or exchanged directly or indirectly. (3-31-22)

02. Contracts for Services. All contracts for services directly affecting the plan including, but not limited to, accounting services, legal services, custodial agreements, and agreements for lease, rent, or insurance coverage to be performed or entered into on behalf of the plan will be agreed to by the board of trustees and the other party. (3-31-22)

03. Recordkeeping and Writing. Contracts and agreements valued at greater than five hundred dollars ($500.00) entered into by the plan, will be in writing and approved by resolution of the board of trustees, and placed in the minutes and records of the plan. (3-31-22)

04. Fiduciary Duty. ~~By entering into contracts and agreements, t~~The trustees are not permitted to transfer or avoid their statutory fiduciary responsibilities. ~~(3-31-22)~~( )

030. RECORDS.

01. Board Actions. Any and all acts, resolutions, appointments, or delegations, or other decisions of the board of trustees will be in writing and placed in the minutes and records of the plan. (3-31-22)

02. Complete Records. The full and accurate records and accounts of the plan include, but are not limited to, minutes of the meetings of the board of trustees that document the acts, resolutions, appointments or delegations of the trustees; any and all correspondence between the board of trustees and contractors; accounting and actuarial records; and any and all records, correspondence, minutes, or statements as prescribed by law or the trust agreement. (3-31-22)

031. ANNUAL STATEMENT.

The trustee will file an annual statement within ninety (90) days after the close of each fiscal year of the ~~P~~plan and at such other time as may be determined by the Director. A quarterly statement will be filed with the Director within sixty (60) days of the end of each quarter in a form acceptable to the Director. ~~(3-31-22)~~( )

032. -- 999. (RESERVED)

IDAPA 18 – IDAHO DEPARTMENT OF INSURANCE

18.04.06 – GOVERNMENTAL SELF-FUNDED EMPLOYEE HEALTH CARE PLANS RULE

DOCKET NO. 18-0406-2501 (ZBR CHAPTER REWRITE)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2026 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. Should the pending rule be approved, it will become final and effective on July 1 following the Second Regular Session of the Sixty-eighth Idaho Legislature, unless the concurrent resolution states a different effective date.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 41-211, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change:

This rule was presented as part of the Department of Insurance's plan to review each rule according to the Governor's Executive Order 2020-01: Zero-Based Regulation, and pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. This chapter is to supplement the provisions of Title 41, Chapter 41, Idaho Code, Joint Public Agency Self-Funded Health Care Plans by providing application requirements, rules, dates, and definitions.

There are no changes to the pending rule, and it is being adopted as originally proposed. The complete text of the proposed rule was published in the August 6, 2025, Idaho Administrative Bulletin, Vol. 25-8, pages 61-64.

FEE SUMMARY: Pursuant to Section 67-5224(2)(d), Idaho Code, a pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature. The following is a description of the fee or charge imposed or increased in this rulemaking: 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: No fiscal impact.

ASSISTANCE WITH TECHNICAL QUESTIONS: For assistance with technical questions concerning this pending rule, contact Weston Trexler, (208) 334-4214, weston.trexler@doi.idaho.gov.

DATED this 3rd day of October, 2025.

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

THE FOLLOWING NOTICE PUBLISHED WITH THE 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 Section 41-211, Idaho Code.

PUBLIC HEARING SCHEDULE: A public hearing concerning this rulemaking will be held as follows:

Thursday, August 7, 2025
2:00 p.m. – 4:00 p.m.

In-person participation is available at:
Department of Insurance
700 W. State St. 3rd Floor
Boise, ID 83702

Web meeting link:
Click here to join the meeting
Meeting ID: 237 139 719 159 3
Passcode: jk3o9Ur2
Download Teams | Join on the web

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: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

The purpose of this chapter is to supplement the provisions of Title 41, Chapter 41, Idaho Code, Joint Public Agency Self-Funded Health Care Plans by providing application requirements, rules, dates, and definitions.

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

No fee or charge imposed or increased.

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 as a result of this rulemaking: None.

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 May 7, 2025, Idaho Administrative Bulletin, Volume 25-5, pages 52-53 under docket number 18-ZBRR-2501.

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: None.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Weston Trexler, (208) 334-4214, weston.trexler@doi.idaho.gov.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before August 27, 2025.

DATED this 2nd day of July, 2025.

THE FOLLOWING IS THE TEXT OF ZBR DOCKET NO. 18-0406-2501

18.04.06 – GOVERNMENTAL SELF-FUNDED EMPLOYEE HEALTH CARE PLANS RULE

000. LEGAL AUTHORITY.
~~Title 41, Chapter 2,~~ Sections 41-211 and 41-4120 Idaho Code. ~~(3-31-22)~~( )

001. ~~TITLE AND~~ SCOPE.

~~01.~~ ~~Title~~. ~~IDAPA 18.04.06, "Governmental Self-Funded Employee Health Care Plans Rule."~~ ~~(3-31-22)~~

~~02.~~ ~~Scope~~. ~~The purpose of t~~This ~~rule is to~~ chapter supplements the provisions of Title 41, Chapter 41, Idaho Code, Joint Public Agency Self-Funded Health Care Plans by providing: ~~(3-31-22)~~( )

a. Dates of, and requirements for, application for registration; ~~(3-31-22)~~( )

~~b.~~ ~~Requirements for application for registration;~~ ~~(3-31-22)~~

~~c~~b. Rules regarding investigation of applications; and ~~(3-31-22)~~( )

~~d~~c. Definition of needed liabilities; and establishment of reserve bases~~; and~~. ~~(3-31-22)~~( )

~~e.~~ ~~To provide an effective date.~~ ~~(3-31-22)~~

002. -- 02~~0~~2. (RESERVED)

~~021. QUALIFICATION OF PLAN.~~
~~In order to qualify under Title 41, Chapter 41, Idaho Code, the plan's trust needs to be established by agreement between the public agency employers or joint powers entity and the trustee of the trust, for the sole purpose of providing health care benefits to employees of the public agency employer or employers.~~ ~~(3-31-22)~~

~~022. REGISTRATION.~~

~~01. Registration Requisite~~. ~~No joint public agency self-funded plan, unless exempted from registration by Section 41-4103, Idaho Code, will be organized and permitted to operate in the state of Idaho without securing a certificate of registration from the Director of insurance.~~ ~~(3-31-22)~~

~~02. Beneficiary Within State~~. ~~Registration is mandatory of plans that cover any beneficiary working or residing within this state, unless the plans are exempted by Section 41-4103, Idaho Code.~~ ~~(3-31-22)~~

023. APPLICATION FOR REGISTRATION.

~~**01. Application**. The application needs to include each of the requirements set out in Section 41-4105, Idaho Code. The projected income and disbursement statement referenced in Section 41-4105(2)(d), Idaho Code, needs to be certified by an actuary meeting the qualifications of Section 41-4105(2)(d), Idaho Code, and accompanied by a description of assumptions used in projecting income and disbursements together with bases used to estimate amounts reserved for claims. (3-31-22)~~

~~**02. Joint Powers Agreement**. The joint powers agreement needs to comply with Title 41, Chapter 41 and, to the extent not in conflict with Title 41, the joint powers agreement needs to also comply with Title 67, Chapter 23, Idaho Code. The joint powers agreement needs to contain, at a minimum, the conditions set forth in Section 41-4104, Idaho Code. (3-31-22)~~

0~~3~~1. **Trust Agreement.** ~~(3-31-22)~~

~~**a.** The trust agreement will comply with Title 41, Chapter 41, Idaho Code, and, to the extent not in conflict with Title 41, the trust agreement needs to also comply with Title 68, Idaho Code, and Title 15, Chapter 7, Idaho Code. The trust agreement will contain, at a minimum, the conditions set forth in Section 41-4104, Idaho Code. (3-31-22)~~

~~**b.**~~ The term irrevocable as used in Section 41-4104(1), Idaho Code, means that the plan sponsor cannot retain a power to alter, amend, revoke or terminate the transfer in trust. The trustee may, pursuant to the terms of the trust agreement, amend the terms of the trust agreement for the purpose of complying with applicable law. ~~(3-31-22)~~(____)

0~~4~~2. **Biographical Affidavit**. The application needs to be accompanied by a biographical affidavit for each trustee on a form acceptable to Director. (3-31-22)

024. INVESTIGATION OF PROPOSED APPLICATION FOR REGISTRATION.
The Director may make an investigation of matters accompanying the application for registration as deemed necessary including an examination specified in Section 41-4113, Idaho Code. (3-31-22)

025. CONTRIBUTIONS RECEIVABLE.
The trust fund may take credit in any financial statement for contributions receivable which are not in excess of ninety (90) days past due. (3-31-22)

026. TRUST FUND RESERVES.

01. Reserve Requirements. The trust fund of a plan needs to continuously maintain reserves, pursuant to Section 41-4110, Idaho Code, from inception of the plan, sufficient to fully fund payment of all benefits at the time a claim arises. This reserve needs to adequately provide for all reasonably estimated future claim payments, adjustment expenses, and litigation expenses on claims which have arisen, including claims incurred but not reported, extended benefits and maternity benefits, if any. (3-31-22)

02. Reserves for Disability Income Benefits. Reserves established for disability income benefits cannot be less than reserves determined by the Minimum Reserve Standards for Group Health Insurance Contracts set forth the in the NAIC's Accounting Practices and Procedures Manual unless it can be proven to the satisfaction of the Director that a lower reserve can be actuarially justified. (3-31-22)

03. Certification by Actuary. Reserves needs to be certified annually by an actuary who meets the requirements of Section 41-4105(2)(d), Idaho Code, and such certification needs to be accompanied by a statement describing bases used in reserve determination. The certification will be in a form acceptable to the Director. (3-31-22)

04. Insolvent Condition. (3-31-22)

a. Insolvency means that the plan is unable to pay its obligations when they are due, or when its admitted assets do not exceed its liabilities, including needed reserves. (3-31-22)

b. If the determination of reserves reveals an insolvent condition, the Director may allow the plan a period of time not exceeding ninety (90) days to accumulate needed reserves. (3-31-22)

027. BONDING OR DISHONESTY INSURANCE.

01. Certified Copy of Bond. The plan will furnish ~~A~~ a certified copy of the fidelity bond or dishonesty policy, as prescribed under Section 41-4114(3), Idaho Code, ~~will be furnished~~ to the Director ~~by the plan~~.
~~(3-31-22)~~( )

02. Cancellation of Bond Requirements. The bond or dishonesty policy will contain language stating that the bond or policy is noncancellable except upon not less than thirty (30) days advance notice in writing to the trustee and the Director. ~~A~~ The surety or policy provider is to forward a copy of any notice cancelling a bond or dishonesty policy prescribed under Chapter 41 ~~is to be forwarded to the Director by the surety or policy provider~~ to the Director at the same time it is forwarded to the board. ~~(3-31-22)~~( )

028. ~~ANNUAL~~ QUARTERLY STATEMENT.
~~The trustee will file an annual statement within ninety (90) days after the close of each fiscal year of the plan and at such other time as may be determined by the Director.~~ A quarterly statement, per Idaho Code 41-4111(4), will be filed with the Director within sixty (60) days of the end of each quarter in a form acceptable to the Director.
~~(3-31-22)~~( )

029. -- 999. (RESERVED)

IDAPA 18 – IDAHO DEPARTMENT OF INSURANCE

18.04.11 – LONG-TERM CARE INSURANCE MINIMUM STANDARDS

DOCKET NO. 18-0411-2501 (ZBR CHAPTER REWRITE)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2026 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. Should the pending rule be approved, it will become final and effective on July 1 following the Second Regular Session of the Sixty-eighth Idaho Legislature, unless the concurrent resolution states a different effective date.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section(s) 41-211 and 41-4608, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change:

This rule was presented as part of the Department of Insurance's plan to review each rule according to the Governor's Executive Order 2020-01: Zero-Based Regulation, and pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. The purpose of this chapter is to promote the public interest and availability of long-term care insurance coverage. The intent is to protect applicants from unfair sales and enrollment practices and facilitate public understanding, comparison, flexibility, and innovation in the development of long-term care insurance.

There are no changes to the pending rule, and it is being adopted as originally proposed. The complete text of the proposed rule was published in the August 6, 2025, Idaho Administrative Bulletin, Vol. 25-8, pages 65-100.

FEE SUMMARY: Pursuant to Section 67-5224(2)(d), Idaho Code, a pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature. The following is a description of the fee or charge imposed or increased in this rulemaking: 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: No fiscal impact.

ASSISTANCE WITH TECHNICAL QUESTIONS: For assistance with technical questions concerning this pending rule, contact Weston Trexler, (208) 334-4214, weston.trexler@doi.idaho.gov.

DATED this 3rd day of October, 2025.

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

THE FOLLOWING NOTICE PUBLISHED WITH THE 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 41-4608, Idaho Code.

PUBLIC HEARING SCHEDULE: A public hearing concerning this rulemaking will be held as follows:

Thursday, August 7, 2025
2:00 p.m. – 4:00 p.m.

In-person participation is available at:
Department of Insurance
700 W. State St. 3rd Floor
Boise, ID 83702

Web meeting link:
Click here to join the meeting
Meeting ID: 237 139 719 159 3
Passcode: jk3o9Ur2
Download Teams | Join on the web

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: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

The purpose of this chapter is to promote the public interest and availability of long-term care insurance coverage. The intent is to protect applicants from unfair sales and enrollment practices and facilitate public understanding, comparison, flexibility, and innovation in the development of long-term care insurance.

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

No fee or charge imposed or increased.

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 as a result of this rulemaking: None.

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 May 7, 2025, Idaho Administrative Bulletin, Volume 25-5, pages 52-53 under docket number 18-ZBRR-2501.

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:

No changes are proposed to the materials incorporated by reference. Pursuant to 67-5202, Idaho Code, and to align with rulemaking standards, the incorporation by reference section will provide a specific reference with a direct link to the material.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Weston Trexler, (208) 334-4214, weston.trexler@doi.idaho.gov.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before August 27, 2025.

DATED this 2nd day of July, 2025.

THE FOLLOWING IS THE TEXT OF ZBR DOCKET NO. 18-0411-2501

18.04.11 – LONG-TERM CARE INSURANCE MINIMUM STANDARDS

000. LEGAL AUTHORITY.
~~Title 41, Chapters 2 and 46,~~Section 41-211, Section 41-4608, Idaho Code. ~~(3-31-22)~~( )

001. ~~TITLE AND~~ SCOPE.

~~01.~~ ~~Title~~. ~~IDAPA 18.04.11, "Long-Term Care Insurance Minimum Standards."~~ ~~(3-31-22)~~

~~02.~~ ~~Purpose~~. ~~The purpose of this chapter is to promote the public interest, to promote the availability of long-term care insurance coverage, to protect applicants for long-term care insurance, as defined, from unfair or deceptive sales or enrollment practices, to facilitate public understanding and comparison of long-term care insurance coverages, and to facilitate flexibility and innovation in the development of long-term care insurance.~~ ~~(3-31-22)~~

~~03.~~ ~~Scope and Applicability~~. ~~Except as specifically provided,~~ this chapter applies to all long-term care insurance policies including qualified long-term care insurance contracts and life insurance policies that accelerate benefits for long-term care delivered or issued for delivery in this state; certain provisions of this chapter apply only to qualified long-term care insurance. Additionally, this chapter is intended to apply to policies having indemnity benefits that are triggered by activities of daily living and sold as disability income insurance, if: ~~(3-31-22)~~( )

a. The benefits of the disability income policy are dependent upon or vary in amount based on the receipt of long-term care services; (3-31-22)

b. The disability income policy is advertised, marketed or offered as insurance for long-term care services; or (3-31-22)

c. Benefits under the policy may commence after the policyholder has reached Social Security's normal retirement age unless benefits are designed to replace lost income or pay for specific expenses other than long-term care services. (3-31-22)

002. INCORPORATION OF DOCUMENTS BY REFERENCE.

~~**01. Forms**. Documents incorporated by reference may be obtained from the Idaho Department of Insurance website.~~ (3-31-22)

02~~1~~1. Documents Incorporated by Reference. This chapter incorporates by reference the following documents, appendices, and attachments of the National Association of Insurance Commissioners (NAIC) Long-Term Care Model Regulation. ~~The Model Regulation is available from the NAIC and from the Idaho Department of Insurance~~ Long-Term Care Model Regulation as published in 2017. ~~(3-31-22)~~( )

a. Rescission Reporting Form for Long-Term Care, Appendix A. (3-31-22)

b. Personal Worksheet, Appendix B. (3-31-22)

c. Things You Should Know Before You Buy Long-Term Care Insurance, Appendix C. (3-31-22)

d. Suitability Letter, Appendix D. (3-31-22)

e. Claims Denial Reporting Form, Appendix E. (3-31-22)

f. Instructions, Appendix F. (3-31-22)

g. Replacement and Lapse Reporting Form, Appendix G. (3-31-22)

h. Outline of Coverage. (3-31-22)

i. Notice to Applicant Regarding Replacement of Individual Accident and Sickness or Long-Term Care Insurance, Attachment I. (3-31-22)

j. Notice to Applicant Regarding Replacement of Accident and Sickness or Long-Term Care Insurance, Attachment II. (3-31-22)

003. -- 009. (RESERVED)

010. DEFINITIONS.
~~For the purpose of this rule, the following definitions apply i~~In addition to those found in Title 41, Chapter 46, Idaho Code, the following definitions apply. ~~(3-31-22)~~( )

01. Exceptional Increase. ~~Means o~~ Only those increases filed by an insurer as exceptional for which the director determines the need for the premium rate increase is justified due to changes in Idaho laws or rules applicable to long-term care coverage, or due to increased and unexpected utilization that affects the majority of insurers of similar products. ~~(3-31-22)~~( )

a. Except as provided in Section 025, Premium Rate Schedule Increases, exceptional increases are subject to the same requirements as other premium rate schedule increases. (3-31-22)

b. The director may request a review by an independent actuary or a professional actuarial body of the basis for a request that an increase be considered an exceptional increase. (3-31-22)

c. The director, in determining that the necessary basis for an exceptional increase exists, will determine any potential offsets to higher claims costs. (3-31-22)

02. Incidental. As used in Subsection 025.10, the value of the long-term care benefits provided is less than ten percent (10%) of the total value of the benefits provided over the life of the policy. These values are measured as of the date of issue. (3-31-22)

03. Qualified Actuary. ~~Means a~~ A member in good standing of the American Academy of Actuaries. ~~(3-31-22)~~( )

011. POLICY DEFINITIONS.
~~For the purpose of this rule, n~~ No long-term care insurance policy delivered or issued for delivery in this state may use the terms set forth below, unless the terms are defined in the policy~~. In relation to the Qualified Long-Term Care plans,~~ and such definitions ~~are to~~ satisfy ~~definitions as amended by the U.S. Treasury Department and~~ the following requirements. ~~(3-31-22)~~( )

01. Activities of Daily Living. At least bathing, continence, dressing, eating, toileting, and transferring. (3-31-22)

02. Acute Condition. The individual is medically unstable. Such an individual requires frequent monitoring by medical professionals, such as physicians and registered nurses, to maintain the individual's health status. (3-31-22)

03. Adult Day Care. A program for six (6) or more individuals, of social and health-related services provided during the day in a community group setting for the purpose of supporting frail, impaired elderly or other disabled adults who can benefit from care in a group setting outside the home. (3-31-22)

04. Bathing. Washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower. (3-31-22)

05. Cognitive Impairment. A deficiency in a person's short or long-term memory, orientation as to person, place and time, deductive or abstract reasoning, or judgment as it relates to safety awareness. (3-31-22)

06. Continence. The ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag). (3-31-22)

07. Dressing. Putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs. (3-31-22)

08. Eating. Feeding oneself by getting food into the body from a receptacle (such as a plate, cup, or table) or by a feeding tube or intravenously. (3-31-22)

09. Hands-On Assistance. Physical assistance (minimal, moderate, or maximal) without which the individual would not be able to perform the activity of daily living. (3-31-22)

10. Home Health Care Services. Medical and non-medical services, provided to ill, disabled, or infirm persons in their residences. Such services may include homemaker services, assistance with activities of daily living, and respite care services. (3-31-22)

11. Mental or Nervous Disorder. Limited to neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder. (3-31-22)

12. Personal Care. The provision of hands-on services to assist an individual with activities of daily living. (3-31-22)

13. Similar Policy Forms. ~~Means a~~ All of the long-term care insurance policies and certificates issued by an insurer in the same long-term care benefit classification as the policy form being considered. Certificates of groups that meet the definition in Section 41-4603(4)(a), Idaho Code, are not considered similar to certificates or policies issued as long-term care insurance, but are similar to other comparable certificates with the same long-term care benefit classifications. For purposes of determining similar policy forms, long-term care benefit classifications are defined as follows: ~~(3-31-22)~~( )

a. Institutional long-term care benefits only; (3-31-22)

b. Non-institutional long-term care benefits only; or (3-31-22)

c. Comprehensive long-term care benefits. (3-31-22)

14. Skilled Nursing Care, Personal Care, Home Care, Specialized Care, Assisted Living Care and Other Services. Defined in relation to the level of skill prescribed, the nature of the care and the setting in which care need be delivered. (3-31-22)

15. Toileting. Getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene. (3-31-22)

16. Transferring. Moving into or out of a bed, chair, or wheelchair. (3-31-22)

17. All Providers of Services. All providers of services including but not limited to Skilled Nursing Facility, Extended Care Facility, Convalescent Nursing Home, Personal Care Facility, Specialized Care Providers, Assisted Living Facility, and Home Care Agency is defined in relation to the services and facilities prescribed to be available and the licensure, certification, registration or degree status of those providing or supervising the services. When the definition requires that the provider be appropriately licensed, certified or registered, it also states what requirements a provider need meet in lieu of licensure, certification or registration when the state in which the service is to be furnished does not require a provider of these services to be licensed, certified or registered, or when the state licenses, certifies or registers the provider of services under another name. (3-31-22)

012. POLICY PRACTICES AND PROVISIONS.

01. Renewability. The terms "guaranteed renewable" and "noncancellable" cannot be used in any individual long-term care insurance policy without further explanatory language in accordance with the disclosure requirements of Section 014 ~~of this rule~~. ~~(3-31-22)~~( )

a. A policy issued to an individual cannot contain renewal provisions other than "guaranteed renewable" or "noncancellable." (3-31-22)

b. The term "guaranteed renewable" may be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums and when the insurer has no unilateral right to make any change in any provision of the policy or rider while the insurance is in force, and cannot decline to renew, except that rates may be revised by the insurer on a class basis. (3-31-22)

c. The term "noncancellable" may be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums during which period the insurer has no right to unilaterally make any change in any provision of the insurance or in the premium rate. (3-31-22)

d. The term "level premium" may only be used when the insurer does not have the right to change the premium ~~for a specified period for the life of the policy~~. ~~(3-31-22)~~( )

e. In addition to the other requirements of Subsection 01~~1~~2.01, a qualified long-term care insurance contract is guaranteed renewable, within the meaning of Section 7702B(b)(1)(C) of the Internal Revenue Code of 1986 as amended. ~~(3-31-22)~~( )

02. Limitations and Exclusions. A policy cannot be delivered or issued for delivery in this state as long-term care insurance if the policy limits or excludes coverage by type of illness, treatment, medical condition or accident, except as follows: (3-31-22)

a. Preexisting conditions or diseases; (3-31-22)

b. Mental or nervous disorders; however, this does not permit exclusion or limitation of benefits on the basis of Alzheimer's Disease; (3-31-22)

c. Alcoholism and drug addiction; (3-31-22)

d. Illness, treatment, or medical condition arising out of: (3-31-22)

i. War or act of war (whether declared or undeclared); (3-31-22)

ii. Participation in a felony, riot, or insurrection; (3-31-22)

iii. Service in the armed forces or units auxiliary thereto; (3-31-22)

iv. Suicide (sane or insane), attempted suicide, or intentionally self-inflicted injury; or (3-31-22)

v. Aviation (this exclusion applies only to non-fare-paying passengers). (3-31-22)

e. Treatment provided in a government facility (unless prescribed by law), services for which benefits are available under Medicare or other governmental program (except Medicaid), any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law, services provided by a member of the covered person's immediate family, and services for which no charge is normally made in the absence of insurance; (3-31-22)

f. Expenses for services or items available or paid under another long-term care insurance or health insurance policy; or (3-31-22)

g. In the case of a qualified long-term care insurance contract, expenses for services or items to the extent that the expenses are reimbursable under Title XVIII of the Social Security Act or would be so reimbursable but for the application of a deductible or coinsurance amount. (3-31-22)

h. Subsection 01~~1~~2.02 is not intended to prohibit exclusions and limitations by type of provider. However, no long-term care issuer may deny a claim because services are provided in a state other than the state of policy issue under the following conditions: ~~(3-31-22)~~( )

i. When the state other than the state of policy issue does not have the provider licensing, certification or registration prescribed in the policy, but where the provider satisfies the policy requirements outlined for providers in lieu of licensure, certification or registration; or (3-31-22)

ii When the state other than the state of policy issue licenses, certifies or registers the provider under another name. For purposes of this Subsection 01~~1~~2.02.h. "state of policy issue" means the state in which the individual policy or certificate was originally issued. ~~(3-31-22)~~( )

iii. Subsection 01~~1~~2.02 is not intended to prohibit territorial limitations. ~~(3-31-22)~~( )

03. Extension of Benefits. Termination of long-term care insurance is without prejudice to any benefits payable for institutionalization if the institutionalization began while the long-term care insurance was in force and continues without interruption after termination. The extension of benefits beyond the period the long-term care insurance was in force may be limited to the duration of the benefit period, if any, or to payment of the maximum benefits and may be subject to any policy waiting period, and all other applicable provisions of the policy. (3-31-22)

04. Continuation or Conversion. (3-31-22)

a. Group long-term care insurance issued in this state on or after ~~the effective date of Section 011~~ July 1, 1993, provides covered individuals with a basis for continuation or conversion of coverage. ~~(3-31-22)~~( )

b. For the purposes of Section 01~~1~~2, "a basis for continuation of coverage" means a policy provision that maintains coverage under the existing group policy when the coverage would otherwise terminate and which is subject only to the continued timely payment of premium when due. Group policies that restrict provision of benefits and services to, or contain incentives to use certain providers or facilities, may provide continuation benefits that are substantially equivalent to the benefits of the existing group policy. The director makes a determination as to the substantial equivalency of benefits, and in doing so, takes into consideration the differences between managed care and non-managed care plans, including, but not limited to, provider system arrangements, service availability, benefit levels and administrative complexity. ~~(3-31-22)~~( )

c. For the purposes of Section 01~~1~~2, "a basis for conversion of coverage" means a policy provision that an individual whose coverage under the group policy would otherwise terminate or has been terminated for any reason, including discontinuance of the group policy in its entirety or with respect to an insured class, and who has been continuously insured under the group policy (and any group policy which it replaced) for at least six (6) months immediately prior to termination, is entitled to the issuance of a converted policy by the insurer under whose group policy he or she is covered, without evidence of insurability. ~~(3-31-22)~~( )

d. For the purposes of Section 01~~1~~2, "converted policy" means an individual policy of long-term care insurance providing benefits identical to or benefits determined by the director to be substantially equivalent to or in excess of those provided under the group policy from which conversion is made. Where the group policy from which conversion is made restricts provision of benefits and services to, or contains incentives to use certain providers or facilities, the director, in making a determination as to the substantial equivalency of benefits, takes into consideration the differences between managed care and non-managed care plans, including, but not limited to, provider system arrangements, service availability, benefit levels and administrative complexity. ~~(3-31-22)~~( )

e. Written application for the converted policy is made and the first premium due, if any, is paid as directed by the insurer not later than thirty-one (31) days after termination of coverage under the group policy. The converted policy is ~~issued~~ effective on the day following the termination of coverage under the group policy and is renewable annually. ~~(3-31-22)~~( )

f. Unless the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy is calculated on the basis of the insured's age at inception of coverage under the group policy from which conversion is made. Where the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy is calculated on the basis of the insured's age at inception of coverage under the group policy replaced. (3-31-22)

g. Continuation of coverage or issuance of a converted policy is mandatory, except where: (3-31-22)

i. Termination of group coverage resulted from an individual's failure to make any prescribed payment of premium or contribution when due; or (3-31-22)

ii. The terminating coverage is replaced not later than thirty-one (31) days after termination, by group coverage effective on the day following the termination of coverage: (3-31-22)

(1) Providing benefits identical to or benefits determined by the director to be substantially equivalent to or in excess of those provided by the terminating coverage; and (3-31-22)

(2) The premium for which is calculated in a manner consistent with the requirements of Subsection 01~~1~~2.04.f. ~~(3-31-22)~~( )

h. Notwithstanding any other provision of Section 01~~1~~2, a converted policy issued to an individual who at the time of conversion is covered by another long-term care insurance policy that provides benefits on the basis of incurred expenses, may contain a provision that results in a reduction of benefits payable if the benefits provided under the additional coverage, together with the full benefits provided by the converted policy, would result in payment of more than one hundred percent (100%) of incurred expenses. The provision is only included in the converted policy if the converted policy also provides for a premium decrease or refund which reflects the reduction in benefits payable. ~~(3-31-22)~~( )

i. The converted policy may provide that the benefits payable under the converted policy, together with the benefits payable under the group policy from which conversion is made, cannot exceed those that would have been payable had the individual's coverage under the group policy remained in force and effect. (3-31-22)

j. Notwithstanding any other provision of Section 01~~1~~2, an insured individual whose eligibility for group long-term care coverage is based upon the individual's relationship to another person is entitled to continuation of coverage under the group policy upon termination of the qualifying relationship by death or dissolution of marriage. ~~(3-31-22)~~( )

k. For the purposes of Section 01~~1~~2 a "managed-care plan" is a health care or assisted living arrangement designed to coordinate patient care or control costs through utilization review, case management or use of specific provider networks. ~~(3-31-22)~~( )

05. Discontinuance and Replacement. If a group long-term care policy is replaced by another group long-term care policy issued to the same policyholder, the succeeding insurer offers coverage to all persons covered under the previous group policy on its date of termination. Coverage provided or offered to individuals by the insurer and premiums charged to persons under the new group policy: (3-31-22)

a. Will not result in an exclusion for preexisting conditions that would have been covered under the group policy being replaced; and (3-31-22)

b. Cannot vary or depend on the individual's health or disability status, claim experience or use of long-term care services. (3-31-22)

06. Premium Changes. (3-31-22)

a. The premium charged to an insured cannot increase due to either: (3-31-22)

i. The increasing age of the insured at ages beyond sixty-five (65); or (3-31-22)

ii. The duration the insured has been covered under the policy. (3-31-22)

b. The purchase of additional coverage is not considered a premium rate increase, but for purposes of the calculation prescribed under Section 032, the portion of the premium attributable to the additional coverage is added to and considered part of the initial annual premium. (3-31-22)

c. A reduction in benefits is not considered a premium change, but for purpose of the calculation prescribed under Section 032, the initial annual premium is based on the reduced benefits. (3-31-22)

07. Electronic Enrollment for Group Policies. (3-31-22)

a. In the case of a group defined in Section 41-4603(4)(a), Idaho Code, any requirement that a signature of an insured be obtained by a producer or insurer is satisfied if: (3-31-22)

i. The consent is obtained by telephonic or electronic enrollment by the group policyholder or insurer. A verification of enrollment information is provided to the enrollee; (3-31-22)

ii. The telephonic or electronic enrollment provides necessary and reasonable safeguards to assure the accuracy, retention, and prompt retrieval of records; and (3-31-22)

iii. The telephonic or electronic enrollment provides necessary and reasonable safeguards to assure that the confidentiality of individually identifiable information, "privileged information," is maintained. (3-31-22)

b. The insurer makes available, upon request of the director, records that will demonstrate the insurer's ability to confirm enrollment and coverage amounts. (3-31-22)

013. UNINTENTIONAL LAPSE.

01. Notice Before Lapse or Termination. Each insurer offering long-term care insurance, as a protection against unintentional lapse, complies with the following: (3-31-22)

a. No individual long-term care policy or certificate is issued until the insurer has received from the applicant either a written designation of at least one (1) person, in addition to the applicant, who is to receive notice of lapse or termination of the policy or certificate for nonpayment of premium, or a written waiver dated and signed by the applicant electing not to designate additional persons to receive notice. The applicant has the right to designate at

least one (1) person who is to receive the notice of termination, in addition to the insured. Designation cannot constitute acceptance of any liability on the third party for services provided to the insured. The form used for the written designation will provide space clearly designated for listing at least one (1) person. The designation includes each person's full name and home address. In the case of an applicant who elects not to designate an additional person, the waiver states: "Protection against unintended lapse. I understand that I have the right to designate at least one (1) person other than myself to receive notice of lapse or termination of this long-term care insurance policy for nonpayment of premium. I understand that notice will not be given until thirty (30) days after a premium is due and unpaid. I elect NOT to designate a person to receive this notice." The insurer notifies the insured of the right to change this written designation, no less often than once every two (2) years. (3-31-22)

b. When the policyholder or certificate holder pays premium for a long-term care insurance policy or certificate through a payroll or pension deduction plan, the requirements contained in Subsection 013.01.a. need not be met until sixty (60) days after the policyholder or certificate holder is no longer on such a payment plan. The application or enrollment form for such policies or certificates clearly indicates the payment plan selected by the applicant. (3-31-22)

c. Lapse or termination for nonpayment of premium. No individual long-term care policy or certificate can lapse or be terminated for nonpayment of premium unless the insurer, at least thirty (30) days before the effective date of the lapse or termination, has given notice to the insured and to those persons designated pursuant to Subsection 013.01.a., at the address provided by the insured for purposes of receiving notice of lapse or termination. Notice is given by first class United States mail, postage prepaid; and notice cannot be given until thirty (30) days after a premium is due and unpaid. Notice is deemed to have been given as of five (5) days after the date of mailing. (3-31-22)

02. Reinstatement. In addition to the requirement in Subsection 013.01, a long-term care insurance policy or certificate includes a provision that provides for reinstatement of coverage, in the event of lapse if the insurer is provided proof that the policyholder or certificate holder was cognitively impaired or had a loss of functional capacity before the grace period contained in the policy expired. This option is available to the insured if requested within five (5) months after termination and allows for the collection of past due premium, where appropriate. The standard of proof of cognitive impairment or loss of functional capacity cannot be more stringent than the benefit eligibility criteria on cognitive impairment or the loss of functional capacity contained in the policy and certificate. (3-31-22)

014. REQUISITE DISCLOSURE PROVISIONS.

01. Renewability. Individual long-term care insurance policies will contain a renewability provision. (3-31-22)

a. The provision is appropriately captioned, appears on the first page of the policy, and clearly states that the coverage is guaranteed renewable or noncancellable. This provision cannot apply to policies that do not contain a renewability provision, and under which the right to nonrenewal is reserved solely to the policyholder. ~~(3-31-22)~~( )

b. A long-term care insurance policy or certificate, other than one where the insurer does not have the right to change the premium, includes a statement that the premium rates may change. (3-31-22)

02. Riders and Endorsements. Except for riders or endorsements by which the insurer effectuates a request made in writing by the insured under an individual long-term care insurance policy, all riders or endorsements added to an individual long-term care insurance policy after date of issue or at reinstatement or renewal that reduce or eliminate benefits or coverage in the policy requires signed acceptance by the individual insured. After the date of policy issue, any rider or endorsement that increases benefits or coverage with a concomitant increase in premium during the policy term is agreed to in writing signed by the insured, except if the increased benefits or coverage are prescribed by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge is set forth in the policy, rider or endorsement. (3-31-22)

03. Payment of Benefits. A long-term care insurance policy that provides for the payment of benefits based on standards described as "usual and customary," "reasonable and customary," or words of similar import

includes a definition of these terms and an explanation of the terms in its accompanying outline of coverage. (3-31-22)

04. Limitations. If a long-term care insurance policy or certificate contains any limitations with respect to preexisting conditions, the limitations appears as a separate paragraph of the policy or certificate and is labeled as "Preexisting Condition Limitations." (3-31-22)

05. Other Limitations or Conditions on Eligibility for Benefits. A long-term care insurance policy or certificate containing any limitations or conditions for eligibility other than those banned in Section 41-4605(4)(b)(i), Idaho Code, sets forth a description of the limitations or conditions, including any prescribed number of days of confinement, in a separate paragraph of the policy or certificate and labels such paragraph "Limitations or Conditions on Eligibility for Benefits." (3-31-22)

06. Disclosure of Tax Consequences. With regard to life insurance policies that provide an accelerated benefit for long-term care, a disclosure statement is prescribed at the time of application for the policy or rider and at the time the accelerated benefit payment request is submitted that receipt of these accelerated benefits may be taxable, and that assistance should be sought from a personal tax advisor. The disclosure statement is prominently displayed on the first page of the policy or rider and any other related documents. Subsection 014.06 cannot apply to qualified long-term care insurance contracts. (3-31-22)

07. Benefit Triggers. Activities of daily living and cognitive impairment is used to measure an insured's need for long-term care and is described in the policy or certificate in a separate paragraph and is labeled "Eligibility for the Payment of Benefits." Any additional benefit triggers need to be explained. If these triggers differ for different benefits, explanation of the trigger accompanies each benefit description. If an attending physician or other specified person needs to certify a certain level of functional dependency to be eligible for benefits, this too needs to be specified. (3-31-22)

08. Qualified Contracts. A qualified long-term care insurance contract includes a disclosure statement in the policy and in the outline of coverage as contained in Section 035 that the policy is intended to be a qualified long-term care insurance contract under Section 7702B (b) of the Internal Revenue Code of 1986, as amended. (3-31-22)

09. Non-Qualified Contracts. A non-qualified long-term care insurance contract includes a disclosure statement in the policy and in the outline of coverage as contained in Section 035 that the policy is not intended to be a qualified long-term care insurance contract. (3-31-22)

10. Requisite Disclosure of Rating Practices to Consumers. (3-31-22)

a. Subsection 014.10 applies ~~as follows:~~ ~~(3-31-22)~~

~~i. Except as provided in Subsection 014.10.a.ii., Subsection 014.10 applies~~ to any long-term care policy or certificate issued in this state ~~on or after July 1, 2001.~~ ~~(3-31-22)~~

~~ii. For certificates issued on or after the effective date of this amended rule under a group long-term care insurance policy as defined in Section 41-4603(4)(a), Idaho Code, which policy was in force at the time this amended rule became effective, the provisions of Subsection 014.10 applies~~ on the policy anniversary following January 1, 2002. ~~(3-31-22)~~( )

b. Other than policies for which no applicable premium rate or rate schedule increases can be made, insurers provide all of the information listed in Subsection 014.10.b. to the applicant at the time of application or enrollment, unless the method of application does not allow for delivery at that time. In such a case, an insurer provides all information listed in Subsection 014.10.b. to the applicant no later than at the time of delivery of the policy or certificate. (3-31-22)

i. A statement that the policy may be subject to rate increases in the future; (3-31-22)

ii. An explanation of potential future premium rate revisions, and the policyholder's or

certificateholder's option in the event of a premium rate revision; (3-31-22)

iii. The premium rate or rate schedules applicable to the applicant that will be in effect until a request is made for an increase; and (3-31-22)

iv. A general explanation for applying premium rate or rate schedule adjustments that includes a description of when premium rate or rate schedule adjustments will be effective (e.g., next anniversary date, next billing date, etc.); and the right to a revised premium rate or rate schedule as provided in Subsection 014.10.b.ii., if the premium rate or rate schedule is changed. (3-31-22)

c. Information regarding each premium rate increase on this policy form or similar forms over the past ten (10) years for this state or any other state that, at a minimum, identifies: (3-31-22)

i. The policy forms for which premium rates have been increased; (3-31-22)

ii. The calendar years when the form was available for purchase; and (3-31-22)

iii. The amount or percent of each increase. The percentage may be expressed as a percentage of the premium rate prior to the increase, and may also be expressed as minimum and maximum percentages if the rate increase is variable by rating characteristics. (3-31-22)

d. The insurer may, in a fair manner, provide additional explanatory information related to the rate increases. (3-31-22)

e. An insurer has the right to exclude from the disclosure premium rate increases that only apply to blocks of business acquired from other nonaffiliated insurers or the long-term care policies acquired from other nonaffiliated insurers when those increases occurred prior to acquisition. (3-31-22)

~~**f.** If an acquiring insurer files for a rate increase on a long-term care policy form acquired from nonaffiliated insurers or a block of policy forms acquired from nonaffiliated insurers on or before the later of the effective date of Subsection 014.10 or the end of a twenty-four (24) month period following the acquisition of the block of policies, the acquiring insurer may exclude that rate increase from the disclosure. However, the nonaffiliated selling company includes the disclosure of that rate increase in accordance with Subsection 014.10.c.~~ ~~(3-31-22)~~

~~**g.** If the acquiring insurer in Subsection 014.10.f. above files for a subsequent rate increase, even within the twenty-four (24) month period, on the same policy form acquired from nonaffiliated insurers or block of policy forms acquired from insurers referenced in Subsection 014.10.f., the acquiring insurer will make all disclosures prescribed by Subsection 014,10.c., including disclosure of the earlier rate increase referenced in Subsection 014.10.f.~~ ~~(3-31-22)~~

~~**h**~~**f.** An applicant signs an acknowledgment at the time of application, unless the method of application does not allow for signature at that time, that the insurer made the disclosure prescribed under Subsections 014.10.b. and 014.10.c. If because of the method of application the applicant cannot sign an acknowledgment at the time of application, the applicant signs no later than at the time of delivery of the policy or certificate. (3-31-22)

~~**i**~~**g.** An insurer uses the forms in Appendices B and F to comply with the disclosure requirements of Subsection 014.10.b. and Subsection 014.10.~~h~~f. ~~(3-31-22)~~( )

~~**j**~~**h.** An insurer provides notice of an upcoming premium rate schedule increase to all policyholders or certificateholders, if applicable, at least thirty (30) days prior to the implementation of the premium rate schedule increase by the insurer. The notice includes the information prescribed by Subsection 014.10.b., when the increase is implemented. (3-31-22)

015. PROHIBITION AGAINST POST-CLAIMS UNDERWRITING.

01. Health Conditions. All applications for long-term care insurance policies or certificates except those that are guaranteed issue contains clear and unambiguous questions designed to ascertain the health condition

of the applicant. (3-31-22)

02. Medication. If an application for long-term care insurance contains a question that asks whether the applicant has had medication prescribed by a physician, it will also ask the applicant to list the medication that has been prescribed. If the medications listed in the application were known by the insurer, or should have been known at the time of application, to be directly related to a medical condition for which coverage would be denied, then the policy or certificate cannot be rescinded for that condition. (3-31-22)

03. Non-Guaranteed Issue. Except for policies or certificates which are guaranteed issue: (3-31-22)

a. The following language is set out conspicuously and in close conjunction with the applicant's signature block on an application for a long-term care insurance policy or certificate: Caution: If your answers on this application are incorrect or untrue, (company) has the right to deny benefits or rescind your policy. (3-31-22)

b. The following language, or language substantially similar to the following, is set out conspicuously on the long-term care insurance policy or certificate at the time of delivery:
"Caution: The issuance of this long-term care insurance (policy) (certificate) is based upon your responses to the questions on your application. A copy of your (application) (enrollment form) (is enclosed) (was retained by you when you applied). If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address: (insert address)." (3-31-22)

c. Prior to issuance of a long-term care policy or certificate to an applicant aged eighty (80) or older, the insurer obtains one (1) of the following: ~~(3-31-22)~~( )

i. A report of a physical examination; (3-31-22)

ii. An assessment of functional capacity; (3-31-22)

iii. An attending physician's statement; or (3-31-22)

iv. Copies of medical records. (3-31-22)

04. Delivery of Application or Enrollment and Form. A copy of the completed application or enrollment form (whichever is applicable) is delivered to the insured no later than at the time of delivery of the policy or certificate unless it was retained by the applicant at the time of application. (3-31-22)

05. Record of Rescissions. Every insurer or other entity selling or issuing long-term care insurance benefits maintains a record of all policy or certificate rescissions, both state and countrywide, except those that the insured voluntarily effectuated and annually furnishes this information to the insurance director in the format prescribed by the National Association of Insurance Commissioners in Appendix A. (3-31-22)

016. MINIMUM STANDARDS FOR HOME HEALTH AND COMMUNITY CARE BENEFITS IN LONG-TERM CARE INSURANCE POLICIES.

01. Limitations or Exclusions. A long-term care insurance policy or certificate cannot, if it provides benefits for home health care or community care services, limit or exclude benefits: (3-31-22)

a. By requiring that the insured or claimant would need care in a skilled nursing facility if home health care services were not provided; (3-31-22)

b. By requiring that the insured or claimant first or simultaneously receive nursing or therapeutic services, or both, in a home, community, or institutional setting before home health care services are covered; (3-31-22)

c. By limiting eligible services to services provided by registered nurses or licensed practical nurses; (3-31-22)

d. By requiring that a nurse or therapist provide services covered by the policy that can be provided by a home health aide, or other licensed or certified home care worker acting within the scope of their licensure or certification; (3-31-22)

e. By excluding coverage for personal care services provided by a home health aide; (3-31-22)

f. By requiring that the provision of home health care services be at a level of certification or licensure greater than that prescribed by the eligible service; (3-31-22)

g. By requiring that the insured or claimant have an acute condition before home health care services are covered; (3-31-22)

h. By limiting benefits to services provided by Medicare-certified agencies or providers; or (3-31-22)

i. By excluding coverage for adult day care services. (3-31-22)

02. Coverage Equivalency. A long-term care insurance policy or certificate, if it provides for home health or community care services, provides total home health or community care coverage that is a dollar amount equivalent to at least one-half (1/2) of one (1) year's coverage available for nursing home benefits under the policy or certificate, at the time covered home health or community care services are being received. This requirement cannot apply to policies or certificates issued to residents of continuing care retirement communities. (3-31-22)

03. Maximum Coverage. Home health care coverage may be applied to the non-home health care benefits provided in the policy or certificate when determining maximum coverage under the terms of the policy or certificate. (3-31-22)

017. REQUIREMENT TO OFFER INFLATION PROTECTION.

01. Inflation Protection Offer. No insurer may offer a long-term care insurance policy unless the insurer also offers to the policyholder in addition to any other inflation protection the option to purchase a policy that provides for benefit levels to increase with benefit maximums or reasonable durations which are meaningful to account for reasonably anticipated increases in the costs of long-term care services covered by the policy. Insurers will offer to each policyholder, at the time of purchase, the option to purchase a policy with an inflation protection feature no less favorable than one (1) of the following: (3-31-22)

a. Increases benefit levels annually in a manner so that the increases are compounded annually at a rate not less than five percent (5%); (3-31-22)

b. Guarantees the insured individual the right to periodically increase benefit levels without providing evidence of insurability or health status as long as the option for the previous period has not been declined. The amount of the additional benefit is no less than the difference between the existing policy benefit and that benefit compounded annually at a rate of at least five percent (5%) for the period beginning with the purchase of the existing benefit and extending until the year in which the offer is made; or (3-31-22)

c. Covers a specified percentage of actual or reasonable charges and does not include a maximum specified indemnity amount or limit. (3-31-22)

d. With respect to inflation protection for a Partnership policy only: (3-31-22)

i. If the policy is sold to an individual who has not attained age sixty-one (61) as of the date of purchase, the policy will provide some level of automatic compound annual inflation protection; (3-31-22)

ii. If the policy is sold to an individual who has attained age sixty-one (61) but has not attained age 76 as of the date of purchase, the policy will provide some level of automatic annual inflation protection; and (3-31-22)

iii. If the policy is sold to an individual who has attained age seventy-six (76) as of the date of

purchase, the policy may (but is not prescribed to) provide some level of inflation protection. (3-31-22)

02. Group Offer. Where the policy is issued to a group, the prescribed offer in Subsection 017.01 is made to the group policyholder; except, if the policy is issued to a group defined in Section 41-4603(4)(d), Idaho Code, other than to a continuing care retirement community, the offering is made to each proposed certificate holder. ~~(3-31-22)~~(____)

03. Requirements for Life Insurance Policies. The offer in Subsection 017.01 above is not prescribed of life insurance policies or riders containing accelerated long-term care benefits. (3-31-22)

04. Outline of Coverage. Insurers include the following information in or with the outline of coverage: (3-31-22)

a. A graphic comparison of the benefit levels of a policy that increases benefits over the policy period with a policy that does not increase benefits. The graphic comparison shows benefit levels over at least a twenty (20) year period. (3-31-22)

b. Any expected premium increases or additional premiums to pay for automatic or optional benefit increases. (3-31-22)

c. An insurer may use a reasonable hypothetical, or a graphic demonstration, for the purposes of this disclosure. (3-31-22)

05. Continuation of Inflation Protection. Inflation protection benefit increases under a policy which contains these benefits continue without regard to an insured's age, claim status or claim history, or the length of time the person has been insured under the policy. (3-31-22)

06. Premium Disclosures. An offer of inflation protection that provides for automatic benefit increases includes an offer of a premium which the insurer expects to remain constant. The offer discloses in a conspicuous manner that the premium may change in the future unless the premium is guaranteed to remain constant . (3-31-22)

07. Rejection of Offer. Inflation protection as provided in Subsection 017.01 is included in a long-term care insurance policy unless an insurer obtains a rejection of inflation protection signed by the policyholder as prescribed in Subsection 017.07. The rejection may be either in the application or on a separate form. The rejection is considered a part of the application and states: "I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of this policy with and without inflation protection. Specifically, I have reviewed Plans _____, and I reject inflation protection (signature line: _____)." (3-31-22)

018. REQUIREMENTS FOR APPLICATION FORMS AND REPLACEMENT COVERAGE.

01. Application Forms. Application forms include the following questions designed to elicit information as to whether, as of the date of the application, the applicant has another long-term care insurance policy or certificate in force or whether a long-term care policy or certificate is intended to replace any other accident and sickness or long-term care policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and producer, except where the coverage is sold without a producer, containing the questions may be used. With regard to a replacement policy issued to a group defined by Section 41-4603(a), Idaho Code, the following questions may be modified only to the extent necessary to elicit information about health or long-term care insurance policies other than the group policy being replaced, provided that the certificate holder has been notified of the replacement. ~~(3-31-22)~~(____)

a. Do you have another long-term care insurance policy or certificate in force (including insurance, Fraternal Benefit Societies, Managed Care Organization) or other similar organizations? (3-31-22)

b. Did you have another long-term care insurance policy or certificate in force during the last twelve (12) months? (3-31-22)

i. If so, with which company? (3-31-22)

ii. If that policy lapsed, when did it lapse? (3-31-22)

c. Are you covered by Medicaid? (3-31-22)

d. Do you intend to replace any of your medical or health insurance coverage with this policy (certificate)? (3-31-22)

02. Other Policy Disclosures. Producers list any other health insurance policies they have sold to the applicant. (3-31-22)

a. List policies sold that are still in force. (3-31-22)

b. List policies sold in the past five (5) years that are no longer in force. (3-31-22)

03. Solicitations Other Than Direct Response. Upon determining that a sale will involve replacement, an insurer, other than an insurer using direct response solicitation methods, or its producer furnishes the applicant, prior to issuance or delivery of the individual long-term care insurance policy, a notice regarding replacement of accident and sickness or long-term care coverage. One (1) copy of the notice is retained by the applicant and an additional copy signed by the applicant is retained by the insurer. The prescribed notice is in a form based on the NAIC Model Regulation Attachment I. (3-31-22)

04. Direct Response Solicitations. Insurers using direct response solicitation methods deliver a notice regarding replacement of accident and sickness or long-term care coverage to the applicant upon issuance of the policy. The prescribed notice is in a form based on the NAIC Model Regulation Attachment II. (3-31-22)

05. Notice of Replacement. Where replacement is intended, the replacing insurer notifies, in writing, the existing insurer of the proposed replacement. The existing policy is identified by the insurer, name of the insured and policy number or address including zip code. Notice is made within five (5) working days from the date the application is received by the insurer or the date the policy is issued, whichever is sooner. (3-31-22)

06. Life Insurance Policy Replacement. Life insurance policies that accelerate benefits for long-term care comply with Section 018 if the policy being replaced is a long-term care insurance policy. If the policy being replaced is a life insurance policy, the insurer complies with the replacement requirements of IDAPA 18.03.04, "Replacement of Life Insurance and Annuities." If a life insurance policy that accelerates benefits for long-term care is replaced by another such policy, the replacing insurer complies with both the long-term care and the life insurance replacement requirements. (3-31-22)

019. REPORTING REQUIREMENTS.

01. Maintenance of Producer Records. Every insurer maintains records for each producer of that producer's amount of replacement sales as a percent of the producer's total annual sales and the number of lapses of long-term care insurance policies sold by the producer as a percent of the producer's total annual sales, in the format of Appendix G. (3-31-22)

02. Producers Experiencing Lapses and Replacements. Every insurer reports annually by June 30 the ten percent (10%) of its producers with the greatest percentages of lapses and replacements as measured by Subsection 019.01. (3-31-22)

03. Purpose of Reports. Reported replacement and lapse rates do not alone constitute a violation of insurance laws or necessarily imply wrongdoing. The reports are for the purpose of reviewing more closely producer activities regarding the sale of long-term care insurance. (3-31-22)

04. Lapsed Policies. Every insurer reports annually by June 30, the number of lapsed policies as a percent of its total annual sales and as a percent of its total number of policies in force as of the end of the preceding calendar year. ~~(3-31-22)~~( )

05. Replacement Policies. Every insurer reports annually by June 30 the number of replacement policies sold as a percent of its total annual sales and as a percent of its total number of policies in force as of the preceding calendar year. (3-31-22)

06. Claims Denied. Every insurer reports annually by June 30, for qualified long-term care insurance contracts, the number of claims denied for each class of business, expressed as a percentage of claims denied, other than claims denied for failure to meet the waiting period or because of an applicable preexisting condition, in the format of Appendix E. (3-31-22)

07. Policies and Reports. For purposes of Section 019, "policy" means only long-term care insurance and "report" means on a statewide basis. (3-31-22)

a. Policy means only long-term care insurance; (3-31-22)

b. Claim means any request for payment of benefits under a policy regardless of whether the benefit claimed is covered under the policy or any terms or conditions of the policy have been met; (3-31-22)

c. Denied means the insurer refused to pay a claim for any reason; and (3-31-22)

d. Report means on a statewide basis. (3-31-22)

08. Filing. Reports prescribed under Section 019 are filed with the Director. (3-31-22)

020. ~~LICENSING.~~(RESERVED)

~~No producer is authorized to sell, solicit, or negotiate with respect to long-term care insurance except as authorized by Title 41, Chapter 10, Producer Licensing.~~ ~~(3-31-22)~~

021. ~~DISCRETIONARY POWERS OF DIRECTOR~~PLAN INNOVATION.

The director may upon written request and after an administrative hearing, issue an order to modify or suspend a specific provision or provisions of this ~~rule~~ chapter with respect to a specific long-term care insurance policy or certificate upon a written finding that: ~~(3-31-22)~~( )

01. General Requirement. The modification or suspension would be in the best interest of the insureds; the purposes to be achieved could not be effectively or efficiently achieved without the modification or suspension; and the modification or suspension is necessary to the development of an innovative and reasonable approach for insuring long-term care; or (3-31-22)

02. Residential Care Community. The policy or certificate is to be issued to residents of a life care or continuing care retirement community or some other residential community for the elderly and the modification or suspension is reasonably related to the special needs or nature of such a community; or (3-31-22)

03. Other Insurance Products. The modification or suspension is necessary to permit long-term care insurance to be sold as part of, or in conjunction with, another insurance product. (3-31-22)

022. RESERVE STANDARDS.

01. Acceleration of Benefits Under Life Policies. When long-term care benefits are provided through the acceleration of benefits under group or individual life policies or riders to such policies, policy reserves for the benefits are determined in accordance with Section 41-612, Idaho Code, Standard Valuation Law – Life Insurance. Claim reserves will also be established in the case when the policy or rider is in claim status. (3-31-22)

02. Decrement Models. Reserves for policies and riders subject to Section 022 should be based on the multiple decrement model utilizing all relevant decrements except for voluntary termination rates. Single decrement approximations are acceptable if the calculation produces essentially similar reserves, if the reserve is clearly more conservative, or if the reserve is immaterial. The calculations may take into account the reduction in life insurance benefits due to the payment of long-term care benefits. However, in no event can the reserves for the long-term care

benefit and the life insurance benefit be less than the reserves for the life insurance benefit assuming no long-term care benefit. (3-31-22)

03. Considerations Impacting Projected Claim Costs. Any applicable valuation morbidity table is certified as appropriate as a statutory valuation table by a member of the American Academy of Actuaries. In the development and calculation of reserves for policies and riders subject to Section 022, due regard is given to the applicable policy provisions, marketing methods, administrative procedures and all other considerations which have an impact on projected claim costs, including, but not limited to, the following: (3-31-22)

a. Definition of insured events; (3-31-22)

b. Covered long-term care facilities; (3-31-22)

c. Existence of home convalescence care coverage; (3-31-22)

d. Definition of facilities; (3-31-22)

e. Existence or absence of barriers to eligibility; (3-31-22)

f. Premium waiver provision; (3-31-22)

g. Renewability; (3-31-22)

h. Ability to raise premiums; (3-31-22)

i. Marketing method; (3-31-22)

j. Underwriting procedures; (3-31-22)

k. Claims adjustment procedures; (3-31-22)

l. Waiting period; (3-31-22)

m. Maximum benefit; (3-31-22)

n. Availability of eligible facilities; (3-31-22)

o. Margins in claim costs; (3-31-22)

p. Optional nature of benefit; (3-31-22)

q. Delay in eligibility for benefit; (3-31-22)

r. Inflation protection provisions; and (3-31-22)

s. Guaranteed insurability option. (3-31-22)

04. Benefits Not Covered in Section 022. When long-term care benefits are provided other than as in Subsection 022.01 above, reserves are determined in accordance with Section 41-608, Idaho Code~~, "Reserve for Disability Insurance."~~ ~~(3-31-22)~~( )

023. LOSS RATIO.
Section 023 applies to all (group and individual) long-term care insurance policies or certificates except those covered under Sections 024 and 025 of this chapter. (3-31-22)

01. Expected Loss Ratios. Benefits under long-term care insurance policies are reasonable in relation to premiums provided the expected loss ratio is at least sixty percent (60%), calculated in a manner which provides

for adequate reserving of the long-term care insurance risk. In evaluating the expected loss ratio, due consideration is given to all relevant factors, including: (3-31-22)

a. Statistical credibility of incurred claims experience and earned premiums; (3-31-22)

b. The period for which rates are computed to provide coverage; (3-31-22)

c. Experienced and projected trends; (3-31-22)

d. Concentration of experience within early policy duration; (3-31-22)

e. Expected claim fluctuation; (3-31-22)

f. Experience refunds, adjustments or dividends; (3-31-22)

g. Renewability features; (3-31-22)

h. All appropriate expense factors; (3-31-22)

i. Interest; (3-31-22)

j. Experimental nature of the coverage; (3-31-22)

k. Policy reserves; (3-31-22)

l. Mix of business by risk classification; and (3-31-22)

m. Product features such as long elimination periods, high deductibles and high maximum limits. (3-31-22)

02. Policies That Accelerate Benefits. Subsection 023.01 cannot apply to life insurance policies that accelerate benefits for long-term care. A life insurance policy that funds long-term care benefits entirely by accelerating the death benefit is considered to provide reasonable benefits in relation to premiums paid, if the policy complies with all of the following provisions: (3-31-22)

a. The interest credited internally to determine cash value accumulations, including long-term care, if any, are guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy; (3-31-22)

b. The portion of the policy that provides life insurance benefits meets the nonforfeiture requirements of Section 41-1927, Idaho Code, Standard Nonforfeiture Law – Life Insurance. (3-31-22)

c. The policy meets the disclosure requirements of Sections 41-4605(9), 41-4605(10), and 41-4605(11), Idaho Code. (3-31-22)

i. Any policy illustration ~~that~~ meets the applicable requirements of the NAIC Life Insurance Illustrations Model Regulation. ~~(3-31-22)~~( )

d. An actuarial memorandum is filed with the insurance department that includes: (3-31-22)

i. A description of the basis on which the long-term care rates were determined; (3-31-22)

ii. A description of the basis for the reserves; (3-31-22)

iii. A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance; (3-31-22)

iv. A description and a table of each actuarial assumption used. For expenses, an insurer will include percent of premium dollars per policy and dollars per unit of benefits, if any; (3-31-22)

v. A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives; (3-31-22)

vi. The estimated average annual premium per policy and the average issue age; (3-31-22)

vii. A statement as to whether underwriting is performed at the time of application. The statement indicates whether underwriting is used and, if used, the statement includes a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement indicates whether the enrollee or any dependent will be underwritten and when underwriting occurs; and (3-31-22)

viii. A description of the effect of the long-term care policy provision on the prescribed premiums, nonforfeiture values and reserves on the underlying life insurance policy, both for active lives and those in long-term care claim status. (3-31-22)

024. FILING REQUIREMENT.

Prior to an insurer or similar organization offering group long-term care insurance to a resident of this state pursuant to Section 41-4604, Idaho Code~~, Extraterritorial Jurisdiction -- Group Long-Term Care Insurance~~, it files with the director evidence that the group policy or certificate thereunder has been approved by a state having statutory or regulatory long-term care insurance requirements substantially similar to those adopted in this state. ~~(3-31-22)~~( )

01. Initial Filing Requirements. ~~(3-31-22)~~

~~**a.** Subsection 024.01 applies to any long-term care policy issued in this state on or after July 1, 2001. (3-31-22)~~

~~**b.**~~ An insurer will provide the following information ~~listed in Subsection 024.01~~ to the director thirty (30) days prior to making the long-term care insurance form available for sale.: ~~(3-31-22)~~( )

~~e~~**a.** A copy of the disclosure documents prescribed in Section 014. (3-31-22)

~~d~~**b.** An actuarial certification consisting of at least the following: (3-31-22)

i. A statement that the initial premium rate schedule is sufficient to cover anticipated costs under moderately adverse experience and that the premium rate schedule is reasonably expected to be sustainable over the life of the form with no future premium increases anticipated; (3-31-22)

ii. A statement that the policy design and coverage provided have been reviewed and taken into consideration; (3-31-22)

iii. A statement that the underwriting and claims adjudication processes have been reviewed and taken into consideration. (3-31-22)

e. A complete description of the basis for contract reserves that are anticipated to be held under the form, to include: (3-31-22)

i. Sufficient detail or sample calculations provided so as to have a complete depiction of the reserve amounts to be held; (3-31-22)

ii. A statement that the assumptions used for reserves contain reasonable margins for adverse experience; (3-31-22)

iii. A statement that the net valuation premium for renewal years does not increase (except for attained-age rating where permitted; and (3-31-22)

iv. A statement that the difference between the gross premium and the net valuation premium for renewal years is sufficient to cover expected renewal expenses; or if such a statement cannot be made, a complete description of the situations where this does not occur; (3-31-22)

v. An aggregate distribution of anticipated issues may be used as long as the underlying gross premiums maintain a reasonably consistent relationship; (3-31-22)

vi. If the gross premiums for certain age groups appear to be inconsistent with this requirement, the director may request a demonstration under Subsection 024.02 based on a standard age distribution; and (3-31-22)

vii. A statement that the premium rate schedule is not less than the premium rate schedule for existing similar policy forms also available from the insurer except for reasonable differences attributable to benefits; or, (3-31-22)

viii. A comparison of the premium schedules for similar policy forms that are currently available from the insurer with an explanation of the differences. (3-31-22)

02. Actuarial Demonstration. The director may request an actuarial demonstration that benefits are reasonable in relation to premiums. The actuarial demonstration includes either premium and claim experience on similar policy forms, adjusted for any premium or benefit differences, relevant and credible data from other studies, or both. (3-31-22)

a. In the event the director requests additional information under this provision, the period referred to in Subsection 024.01.b. of this section does not include the period of time during which the insurer is preparing the requested information. (3-31-22)

025. PREMIUM RATE SCHEDULE INCREASES.

01. Premium Rate Increase Notice. An insurer provides notice of a pending premium rate schedule increase, including an exceptional increase, to the director at least thirty (30) days prior to the notice to the policyholders and includes: (3-31-22)

a. Information prescribed by Section 014. (3-31-22)

b. Certification by a qualified actuary that: (3-31-22)

i. If the requested premium rate schedule increase is implemented and the underlying assumptions, which reflect moderately adverse conditions, are realized, no further premium rate schedule increases are anticipated; and (3-31-22)

ii. The premium rate filing is in compliance with the provisions of this Section 025. (3-31-22)

02. Actuarial Memorandum. The actuarial memorandum justifying the rate schedule change request includes: (3-31-22)

a. Lifetime projections of earned premiums and incurred claims based on the filed premium rate schedule increase; and the method of assumptions used in determining the projected values, including reflection of any assumptions that deviate from those used for pricing other forms currently available for sale: (3-31-22)

i. Annual values for the past five (5) years preceding and the three (3) years following the valuation date are provided separately; (3-31-22)

ii. The projections include the development of the lifetime loss ratio, unless the rate of increase is an exceptional increase; (3-31-22)

iii. The projections demonstrate compliance with Subsection 025.03; and (3-31-22)

iv. For exceptional increases; (3-31-22)

(1) The projected experience should be limited to the increases in claims expenses attributable to the approved reasons for the exceptional increase; and (3-31-22)

(2) In the event the director determines as provided in Subsection 010.09.c. that offsets may exist, the insurer uses appropriate net projected experience. (3-31-22)

b. Disclosure of how reserves have been incorporated in this rate increase will trigger contingent benefit upon lapse. (3-31-22)

c. Disclosure of the analysis performed to determine why a rate adjustment is necessary, which pricing assumptions were not realized and why, and what other actions taken by the company have been relied on by the actuary. (3-31-22)

d. A statement that policy design, underwriting and claims adjudication practices have been taken into consideration; and in the event that it is necessary to maintain consistent premium rates for new certificates and certificates receiving a rate increase, the insurer will need to file composite rates reflecting projections of new certificates. (3-31-22)

e. A statement that renewal premium rate schedules are not greater than new business premium rate schedules except for differences attributable to benefits, unless sufficient justification is provided to the director; and sufficient information for review of the premium rate schedule increase by the director. (3-31-22)

03. Premium Rate Schedule Increases. All premium rate schedule increases are determined in accordance with the following requirements: (3-31-22)

a. Exceptional increases provide that seventy percent (70%) of the present value of projected additional premiums from the exceptional increase will be returned to policyholders in benefits. (3-31-22)

b. Premium rate schedule increases are calculated such that the sum of the accumulated value of incurred claims, without the inclusion of active life reserves, and the present value of future projected incurred claims, without the inclusion of active life reserves, will not be less than the sum of the following: (3-31-22)

i. The accumulated value of the initial earned premium times fifty eight percent (58%); (3-31-22)

ii. Eighty-five percent (85%) of the accumulated value of prior premium rate schedule increases on an earned basis; (3-31-22)

iii. The present value of future projected initial earned premiums times fifty-eight percent (58%); and (3-31-22)

iv. Eighty-five percent (85%) of the present value of future projected premiums not in Subsection 025.03.b.iii. on an earned basis. (3-31-22)

c. In the event that a policy form has both exceptional and other increases, the values in Subsections 025.03.b.ii. and 025.03.b.iv., will also include seventy percent (70%) for exceptional rate increase amounts. (3-31-22)

d. All present and accumulated values used to determine rate increases use the maximum valuation interest rate for contract reserves. The actuary discloses as part of the actuarial memorandum the use of any appropriate averages. (3-31-22)

04. Projections Filed for Review. For each rate increase that is implemented, the insurer files for review by the director updated projections, as defined in Subsection 025.02.a., annually for the following three (3) years and include a comparison of actual results to projected values. The director may extend the period to greater

than three (3) years if actual results are not consistent with projected values from prior projections. For group insurance policies that meet the conditions in Subsection 025.13, the projections prescribed by this Subsection 025.04 are provided to the policyholder in lieu of filing with the director. (3-31-22)

05. Revised Premium Rate. If any premium rate in the revised premium rate schedule is greater than 200 percent (200%) of the comparable rate in the initial premium schedule, lifetime projections, as defined in Subsection 025.02.a., are filed for review by the director every five (5) years following the end of the prescribed period in Subsection 025.04. For group insurance policies that meet the conditions in Subsection 025.13, the projections prescribed by Subsection 025.05 are provided to the policyholder in lieu of filing with the director. (3-31-22)

06. Actual and Projected Experience. If the director has determined that the actual experience following a rate increase does not adequately match the projected experience and that the current projections under moderately adverse conditions demonstrate that incurred claims will not exceed proportions of the premium specified in Subsection 025.03, the director may require the insurer to implement any of the following: (3-31-22)

a. Premium rate schedule adjustments; or (3-31-22)

i. Other measures to reduce the difference between the projected and actual experience. (3-31-22)

b. In determining whether the actual experience adequately matches the projected experience, consideration should be given to Subsection 025.02.d. and 025.02.e., if applicable. (3-31-22)

07. Contingent Benefit upon Lapse. If the majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse, the insurer files: (3-31-22)

a. A plan, subject to director approval, for improved administration or claims processing designed to eliminate the potential for further deterioration of the policy form requiring further premium rate schedule increases, or both, or to demonstrate that appropriate administration and claims processing have been implemented or are in effect. If the director should determine that such appropriate administration and claims processing functions have not been addressed, provisions of Subsection 025.08 may be applied; and (3-31-22)

b. The original anticipated lifetime loss ratio, and the premium rate schedule increase that would have been calculated according to Subsection 025.03 had the greater of the original anticipated lifetime loss ratio or fifty-eight percent (58%) been used in the calculations described in Subsections 025.03.b.i. and 025.03.b.iii. (3-31-22)

08. Additional Rate Increase Filings. For a rate increase filing that meets the following criteria, the director reviews, for all policies included in the filing, the projected lapse rates and past lapse rates during the twelve (12) months following each increase to determine if significant adverse lapse has occurred or is anticipated: (3-31-22)

a. The rate increase is not the first rate increase requested for the specific policy form or forms; (3-31-22)

b. The rate increase is not an exceptional increase; and (3-31-22)

c. The majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse. (3-31-22)

d. In the event significant adverse lapse has occurred, is anticipated in the filing or is evidenced in the actual results as presented in the updated projections provided by the insurer following the requested rate increase, the director may determine that a rate spiral exists. Following the determination that a rate spiral exists, the director may require the insurer to offer, without underwriting, to all in force insureds subject to the rate increase option to replace existing coverage with one or more reasonably comparable products being offered by the insurer or its affiliates. The offer will; (3-31-22)

i. Be subject to the approval of the director; (3-31-22)

ii. Be based on actuarially sound principles, but not be based on attained age; and (3-31-22)

iii. Provide that the maximum benefits under any new policy accepted by an insured is reduced by comparable benefits already paid under the existing policy. (3-31-22)

e. The insurer maintains the experience of all the replacement insureds separate from the experience of insureds originally issued the policy forms. In the event of a request for a rate increase on the policy form, the rate increase is limited to the lesser of: (3-31-22)

i. The maximum rate increase determined based on the combined experience; and (3-31-22)

ii. The maximum rate increase determined based only on the experience of the insureds originally issued the form plus ten percent (10%). (3-31-22)

09. Persistent Practice of Inadequate Rate Filings. If the director determines that the insurer has exhibited a persistent practice of filing inadequate initial premium rates for long-term care insurance, the director may, in addition to the provisions of Subsection 025.08 of this section, prohibit the insurer from either of the following: (3-31-22)

a. Filing and marketing comparable coverage for a period of up to five (5) years; or (3-31-22)

b. Offering all other similar coverages and limiting marketing of new applications to the products subject to recent premium rate schedule increases. (3-31-22)

10. Exceptions. Subsection 025.01 and 025.09 does not apply to policies for which the long-term care benefits provided by the policy are incidental, as defined in Subsection 010.12, if the policy complies with all of the following provisions: (3-31-22)

a. The interest credited internally to determine cash value accumulations, including long-term care, if any, are guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy; (3-31-22)

b. The portion of the policy that provides insurance benefits other than long-term care coverage meets the nonforfeiture requirements as applicable in any of the following: (3-31-22)

i. Section 41-1927, Idaho Code~~, Standard Nonforfeiture Law-Life Insurance~~; ~~(3-31-22)~~( )

ii. Section 41-1927A, Idaho Code~~, Standard Nonforfeiture Law for Individual Deferred Annuities~~; ~~(3-31-22)~~( )

iii. IDAPA 18.03.03, Subsection 018.02~~, "Variable Contracts."~~ ~~(3-31-22)~~( )

11. Exceptions for Disclosure and Performance Standards. The policy meets the disclosure requirements of Sections 41-4605(9), 41-4605(10) and 41-4605(11), Idaho Code~~, pertaining to the Disclosure and Performance Standards for Long-term Care Coverage~~. ~~(3-31-22)~~( )

12. Exception If Actuarial Memorandum Filed Which Includes Defined Information. An actuarial memorandum is filed with the Department of Insurance that includes: (3-31-22)

a. A description of the basis on which the long-term care rates were determined; (3-31-22)

b. A description of the basis for the reserves; (3-31-22)

c. A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance; (3-31-22)

d. A description and a table of each actuarial assumption used. For expenses, an insurer will include percent of premium dollars per policy and dollars per unit of benefits, if any; (3-31-22)

e. A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives; (3-31-22)

f. The estimated average annual premium per policy and the average issue age; (3-31-22)

g. A statement as to whether underwriting is performed at the time of application. The statement indicates whether underwriting is used and, if used, the statement includes a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement indicates whether the enrollee or any dependent will be underwritten and when underwriting occurs; and (3-31-22)

h. A description of the effect of the long-term care policy provision on the prescribed premiums, nonforfeiture values and reserves on the underlying insurance policy, both for active lives and those in long-term care claims status. (3-31-22)

13. Exceptions for Association Plans. Premium Rate Schedule Increases Subsections 025.06 and 025.08 cannot apply to group insurance policies as defined in Section 41-4603(4)(a), Idaho Code, where: (3-31-22)

a. The policies insure two hundred fifty (250) or more persons and the policyholder has five thousand (5,000) or more eligible employees of a single employer; or (3-31-22)

b. The policyholder, and not the certificate holders, pay a material portion of the premium, which cannot be less than twenty percent (20%) of the total premium for the group in the calendar year prior to the year a rate increase is filed. ~~(3-31-22)~~( )

026. FILING REQUIREMENTS FOR ADVERTISING.

01. Filing and Retention. Every Insurer, Fraternal Benefit Society, Managed Care Organization, or other similar organization providing long-term care insurance or benefits in this state provides a copy of any long-term care insurance advertisement intended for use in this state whether through written, radio, or television medium to the Director of Insurance of this state for review and approval by the Director. In addition, all advertisements are retained by the insurer or other entity for at least five (5) years from the date the advertisement was first used; or until the filing of the next regular report of examination of the insurer, whichever is the longer period of time. (3-31-22)

02. Exemptions. The director may exempt from these requirements any advertising form or material when, in the director's opinion, this requirement cannot be reasonably applied. (3-31-22)

027. STANDARDS FOR MARKETING AND PRODUCER TRAINING.

01. General Provisions. Every Insurer, Fraternal Benefit Society, Managed Care Organization or other similar organization marketing long-term care insurance coverage in this state, directly or through its producers, will: (3-31-22)

a. Establish marketing procedures and producer training requirements to assure that any marketing activities, including any comparison of policies by its producers will be fair and accurate. (3-31-22)

b. Establish marketing procedures to assure excessive insurance is not sold or issued. (3-31-22)

c. Display prominently by type, stamp or other appropriate means, on the first page of the outline of coverage and policy the following: "Notice to buyer: This policy cannot cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations." (3-31-22)

d. Provide copies of the disclosure forms prescribed in Subsection 014.10. (3-31-22)

e. Provide an explanation of contingent benefit upon lapse as provided for in Subsection 032.04.b. and if applicable, the additional contingent benefit upon lapse provided to policies with fixed or limited premium paying period in Subsection 032.04.c. (3-31-22)

f. ~~Inquire and m~~Make every reasonable effort to identify whether a prospective applicant or enrollee for long-term care insurance already has accident and sickness or long-term care insurance, and the types and amounts of any such insurance~~,~~; except that in the case of qualified long-term care insurance contracts, an inquiry into whether a prospective applicant or enrollee for long-term care insurance has accident and sickness insurance is not prescribed. ~~(3-31-22)~~(____)

g. Establish auditable procedures for verifying compliance with Subsection 027.01. (3-31-22)

h. At solicitation, provide written notice to the prospective policyholder and certificate holder that Senior Health Insurance Benefits Advisors/SHIBA the program is available and the name, address and telephone number of the program. ~~(3-31-22)~~(____)

i. For long-term care insurance policies and certificates, use the terms "noncancellable" or "level premium" only when the policy or certificate conforms to Subsection 01~~1~~2.01.c. of this chapter. ~~(3-31-22)~~(____)

02. Banned Practices. In addition to the practices banned in Title 41, Chapter 13, Idaho Code, ~~Trade Practices and Frauds,~~ the following acts and practices are banned: ~~(3-31-22)~~(____)

a. Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on or convert any insurance policy, or to take out a policy of insurance with another insurer. (3-31-22)

b. High Pressure Tactics. Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance. (3-31-22)

c. Cold Lead Advertising. Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance producer or insurance company. (3-31-22)

d. Misrepresentation. Misrepresenting a material fact in selling or offering to sell a long-term care insurance policy. (3-31-22)

03. Associations. With respect to the obligations set forth in Subsection 027.03, the primary responsibility of an association, as defined in Section 41-4603(4)(b), Idaho Code, when endorsing or selling long-term care insurance is to educate its members concerning long-term care issues in general so that its members can make informed decisions. Associations provide objective information regarding long-term care insurance policies or certificates endorsed or sold by such associations to ensure that members of such associations receive a balanced and complete explanation of the features in the policies or certificates that are being endorsed or sold. (3-31-22)

a. The insurer files with the insurance department the following material: (3-31-22)

i. The policy and certificate; (3-31-22)

ii. A corresponding outline of coverage; and (3-31-22)

iii. All advertisements to be utilized. (3-31-22)

b. The association discloses in any long-term care insurance solicitation: (3-31-22)

i. The specific nature and amount of the compensation arrangements (including all fees,

commissions, administrative fees and other forms of financial support) that the association receives from endorsement or sale of the policy or certificate to its members; and (3-31-22)

ii. A brief description of the process under which the policies and the insurer issuing the policies were selected. (3-31-22)

c. If the association and the insurer have interlocking directorates or trustee arrangements, the association discloses that fact to its members. (3-31-22)

d. The board of directors of associations selling or endorsing long-term care insurance policies or certificates reviews and approves the insurance policies as well as the compensation arrangements made with the insurer. (3-31-22)

e. The association also will: (3-31-22)

i. At the time of the association's decision to endorse, engage the services of a person with expertise in long-term care insurance not affiliated with the insurer to conduct an examination of the policies, including its benefits, features, and rates, and update the examination thereafter in the event of material change; (3-31-22)

ii. Actively monitor the marketing efforts of the insurer and its producers; and (3-31-22)

iii. Review and approve all marketing materials or other insurance communications used to promote sales or sent to members regarding the policies or certificates. (3-31-22)

iv. Subsections 027.03.e.i. through 027.03.e.iii. cannot apply to qualified long-term care insurance contracts. (3-31-22)

f. No group long-term care insurance policy or certificate may be issued to an association unless the insurer files with the state insurance department the information prescribed in Section 027. (3-31-22)

g. The insurer cannot issue a long-term care policy or certificate to an association or continue to market such a policy or certificate unless the insurer certifies annually that the association has complied with the requirements set forth in Section 027. (3-31-22)

h. Failure to comply with the filing and certification requirements of Section 027 constitutes an unfair trade practice in violation of Title 41, Chapter 13, Idaho Code~~, Trade Practices and Frauds~~. ~~(3-31-22)~~( )

04. Producer Training Requirements. An individual cannot sell, solicit or negotiate long-term care insurance unless the individual is licensed as an insurance producer for life and disability (accident and health insurance) and has completed a one-time training course and ongoing training every twenty-four (24) months thereafter. The training meets the requirements set forth in this Subsection 027.04. Such training requirements may be approved as continuing education course under IDAPA 18.06.04, "Continuing Education." (3-31-22)

a. The one-time training course prescribed by this section is no less than eight (8) hours. In addition to the one-time training course, an individual who sells, solicits, or negotiates long-term care insurance completes the ongoing training prescribed by this Subsection 027.04, which is no less than four (4) hours every twenty four (24) months. (3-31-22)

b. The training prescribed under Subsection 027.04.a. consists of topics related to long-term care insurance, long-term care services and qualified state long-term care insurance partnership program, including, but not limited to: (3-31-22)

i. State and federal regulations and requirements and the relationship between qualified state long-term care insurance partnership programs and other public and private coverage of long-term care services, including Medicaid; (3-31-22)

ii. Available long-term care services and providers; (3-31-22)

iii. Changes or improvements in long-term care services or providers; (3-31-22)

iv. Alternatives to the purchase of private long-term care insurance; (3-31-22)

v. The effect of inflation on benefits and the importance of inflation protection; and (3-31-22)

vi. Consumer suitability standards and guidelines. (3-31-22)

c. The training prescribed by Subsection 027.04. cannot include any sales or marketing information, materials, or training, other than those prescribed by state and federal law. (3-31-22)

d. Insurers subject to this rule obtain verification that a producer receives training prescribed by Subsection 027.04 before a producer is permitted to sell, solicit or negotiate the insurer's long-term care insurance products, maintain records subject to the state's record retention requirements, and make that verification available to the director upon request. An insurer maintains records with respect to the training of its producers concerning the distribution of its long-term care Partnership policies that will allow the Department of Insurance to provide assurance to the Division of Medicaid that the producers have received the training as prescribed by Subsection 027.04 and that producers have demonstrated an understanding of the Partnership policies and their relationship to public and private coverage of long-term care including Medicaid in this state. These records are maintained in accordance with the state's record retention requirements and made available to the director upon request. (3-31-22)

e. The satisfaction of these training requirements in any state satisfy the training requirements of this state. (3-31-22)

028. SUITABILITY.

01. Life Insurance Policies That Accelerate Benefits. Section 028 cannot apply to life insurance policies that accelerate benefits for long-term care. (3-31-22)

02. General Provisions. Every Insurer, Fraternal Benefit Society, Managed Care Organization or other similar organization marketing long-term care insurance (the "issuer") will: (3-31-22)

a. Develop and use suitability standards to determine whether the purchase or replacement of long-term care insurance is appropriate for the needs of the applicant; (3-31-22)

b. Train its producers in the use of its suitability standards; and (3-31-22)

c. Maintain a copy of its suitability standards and make them available for inspection upon request by the director. (3-31-22)

03. Determination of Standards. To determine whether the applicant meets the standards developed by the issuer; (3-31-22)

a. The producer and issuer develop procedures that take the following into consideration: (3-31-22)

i. The ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage; (3-31-22)

ii. The applicant's goals or needs with respect to long-term care and the advantages and disadvantages of insurance to meet these goals or needs; and (3-31-22)

iii. The values, benefits, and costs of the applicant's existing insurance, if any, when compared to the values, benefits and costs of the recommended purchase or replacement. (3-31-22)

b. The issuer and producer, if involved, make reasonable efforts to obtain the information set out in Subsection 028.03. The efforts include presentation to the applicant, at or prior to application, the "Long-Term Care

Insurance Personal Worksheet." The personal worksheet used by the issuer contains, at a minimum, the information in the format contained in the NAIC Model Regulations in Appendix B, in not less than twelve (12) point type. The issuer may request the applicant to provide additional information to comply with its suitability standards. A copy of the issuer's personal worksheet is filed with the director. (3-31-22)

i. Copies of NAIC Model Regulations for Long-Term Care Insurance Minimum Standards Appendixes B, C, and D can be found at the Idaho Department of Insurance website. (3-31-22)

c. A completed personal worksheet is returned to the issuer prior to the issuer's consideration of the applicant for coverage, except the personal worksheet need not be returned for sales of employer group long-term care insurance to employees and their spouses. (3-31-22)

d. The sale or dissemination outside the company or agency by the issuer or producer of information obtained through the personal worksheet in the NAIC Model Regulations, Appendix B is banned. (3-31-22)

04. Appropriateness. The issuer uses the suitability standards it has developed pursuant to Section 028 in determining whether issuing long-term care insurance coverage to an applicant is appropriate. (3-31-22)

05. Use of Standards. Producers use the suitability standards developed by the issuer in marketing long-term care insurance. (3-31-22)

06. Disclosure Form. At the same time as the personal worksheet is provided to the applicant, the disclosure form entitled "Things You Should Know Before You Buy Long-Term Care Insurance" is provided. The form is in the format contained in the NAIC Model Regulations, Appendix C, in not less than twelve (12) point type. (3-31-22)

07. Rejection and Alternatives. If the issuer determines that the applicant does not meet its financial suitability standards, or if the applicant has declined to provide the information, the issuer may reject the application. In the alternative, the issuer sends the applicant a letter similar to the NAIC Model Regulations, Appendix D. However, if the applicant has declined to provide financial information, the issuer may use some other method to verify the applicant's intent. Either the applicant's returned letter or a record of the alternative method of verification is made part of the applicant's file. (3-31-22)

08. Reporting. The issuer reports annually to the director the total number of applications received from residents of this state, the number of those who declined to provide information on the personal worksheet, the number of applicants who did not meet the suitability standards, and the number of those who chose to confirm after receiving a suitability letter. (3-31-22)

029. PROHIBITION AGAINST PREEXISTING CONDITIONS AND PROBATIONARY PERIODS IN REPLACEMENT POLICIES OR CERTIFICATES.

If a long-term care insurance policy or certificate replaces another long-term care policy or certificate, the replacing insurer waives any time periods applicable to preexisting conditions and probationary periods in the new long-term care policy for similar benefits to the extent that similar exclusions have been satisfied under the original policy. (3-31-22)

030. AVAILABILITY OF NEW SERVICES OR PROVIDERS.

01. Notification to Policyholder. An insurer notifies the policyholder of the availability of a new long-term care policy that provides coverage for new long-term care services or providers material in nature and not previously available through the insurer to the general public. The notice is provided within twelve (12) months of the date the new policy is made available for sale in this state. (3-31-22)

02. Exceptions to Notification Requirements. Notwithstanding Subsection 030.01, notification is not ~~prescribed~~ needed for any ~~policy issued prior to the effective date of this Section 030 or to any~~ policyholder who is currently eligible for benefits, within an elimination period or on claim, or who previously has been in claim status, or who would not be eligible to apply for coverage due to issue age limitations under the new policy. The insurer may ~~require~~ expect that policyholders meet all eligibility requirements, including underwriting and payment of the

prescribed premium to add such new services or providers. ~~(3-31-22)~~( )

03. New Coverage. The insurer makes the new coverage available in one of the following ways: (3-31-22)

a. By adding a rider to the existing policy and charging a separate premium for the new rider based on the insured's attained age; (3-31-22)

b. By exchanging the existing policy or certificate for one with an issue age based on the present age of the insured and recognizing past insured status by granting premium credits toward the premiums for the new policy or certificate. The premium credits are based on premiums paid or reserves held for the prior policy or certificate. (3-31-22)

c. By exchanging the existing policy or certificate for a new policy or certificate in which consideration for past insured status is recognized by setting the premium for the new policy or certificate at the issue age of the policy or certificate being exchanged. The cost of the new policy or certificate may recognize the difference in reserves between the new policy or certificate and the original policy or certificate; or (3-31-22)

d. By an alternative program developed by the insurer that meets the intent of Section 030 if the program is filed with and approved by the Director. (3-31-22)

04. Proprietary Policy. An insurer is not prescribed to notify policyholders of a new proprietary policy created and filed for use in a limited distribution channel. For purposes of this Subsection 030.04, "limited distribution channel" means through a discrete entity, such as a financial institution or brokerage, for which specialized products are available that are not available for sale to the general public. Policyholders that purchased such a proprietary policy are notified when a new long-term care policy that provides coverage for new long-term care services or providers material in nature is made available to that limited distribution channel. (3-31-22)

05. Exchanges and Not Replacements. Policies issued pursuant to this Section 030 are considered exchanges and not replacements. These exchanges are not subject to Section 018, and Section 028, and the reporting requirements of Section 019.01. through 019.05. of this rule. (3-31-22)

06. Employer Sponsored Plan. Where the policy is offered through an employer, labor organization, professional, trade or occupational association, the prescribed notification in Subsection 030.01 is made to the offering entity. However, if the policy is issued to a group defined in Section 41-4603 (04) (d), Idaho Code, Long Term Care Insurance Act, the notification is made to each certificateholder. (3-31-22)

07. Nothing Prohibits an Insurer From Offering Coverage. Nothing in this Section 030 prohibits an insurer from offering any policy, rider, certificate or coverage change to any policyholder or certificate-holder. However, upon request any policyholder may apply for currently available coverage that includes the new services or providers. The insurer may require that policyholders meet eligibility requirements, including underwriting and payment of the prescribed premium to add such new services or providers. (3-31-22)

08. Not Applicable to Life Insurance Policies. This Section 030 does not apply to life insurance policies or riders containing accelerated long-term care benefits. (3-31-22)

031. RIGHT TO REDUCE COVERAGE AND LOWER PREMIUMS.

01. Reduction of Coverage. Every long-term care insurance policy and certificate includes a provision that allows the policyholder or certificateholder to reduce coverage and lower the policy or certificate premium in at least one of the following ways: (3-31-22)

a. Reducing the maximum benefit; or (3-31-22)

b. Reducing the daily, weekly or monthly benefit amount. (3-31-22)

c. The insurer may also offer other reduction options that are consistent with the policy or certificate

design or the carrier's administrative processes. (3-31-22)

02. Implementing a Reduction in Coverage. The provision includes a description of the ways in which coverage may be reduced and the process for requesting and implementing a reduction in coverage. (3-31-22)

03. Determination of Premium for Reduced Coverage. The age to determine the premium for the reduced coverage is based on the age used to determine the premiums for the coverage currently in force. (3-31-22)

04. Limitations for the Reduction of Coverage. The insurer may limit any reduction in coverage to plans or options available for that policy form and to those for which benefits will be available after consideration of claims paid or payable. (3-31-22)

05. Notification in Regard to the Possible Lapse of Policy. If a policy or certificate is about to lapse, the insurer provides a written reminder to the policyholder or certificateholder of their right to reduce coverage and premiums in the notice prescribed by Subsection 013.01.c. of this rule. (3-31-22)

06. Not Applicable to Life Insurance Policies or Riders Containing Accelerated Benefits. This Section 031 does not apply to life insurance policies or riders containing accelerated long-term care benefits. (3-31-22)

07. Compliance Requirements. The requirements of this Section 031 apply to any long-term care policy issued in this state on or after November 1, 2007. Compliance with this Section 031 may be accomplished by policy replacement, exchange or by adding the prescribed provision via amendment or endorsement to the policy. (3-31-22)

032. NONFORFEITURE BENEFIT REQUIREMENT.

01. Life Insurance Policies That Accelerate Benefits. Section 032 does not apply to life insurance policies or riders containing accelerated long-term care benefits. (3-31-22)

02. Nonforfeiture Benefits. To comply with the requirement to offer a nonforfeiture benefit pursuant to the provisions of Section 41-4607, Idaho Code, every Insurer, Fraternal Benefit Society, Managed Care Organization, or other similar organization marketing long-term care insurance coverage in this state satisfies the following: (3-31-22)

a. A policy or certificate offered with nonforfeiture benefits will have coverage elements, eligibility, benefit triggers and benefit length that are the same as coverage to be issued without nonforfeiture benefits. The nonforfeiture benefit included in the offer is the benefit described in Subsection 032.04.e. (3-31-22)

b. The offer is in writing if the nonforfeiture benefit is not described in the Outline of Coverage or other materials given to the prospective policyholder. (3-31-22)

03. Contingent Benefit. If the offer prescribed under Section 41-4607, Idaho Code, is rejected, the insurer provides the contingent benefit upon lapse described in Section 032. Even if this offer is accepted for a policy with a fixed or limited premium paying period, the contingent benefit on lapse in Subsection 032.04.b.i. still applies. (3-31-22)

04. Rejection of Offer. After rejection of the offer prescribed under Section 41-4607, Idaho Code, as it pertains to nonforfeiture benefits, for individual and group policies without nonforfeiture benefits issued after ~~the effective date of Section 032~~ April 5, 2000, the insurer provides a contingent benefit upon lapse. ~~(3-31-22)~~( )

a. In the event a group policyholder elects to make the nonforfeiture benefit an option to the certificate holder, a certificate provides either the nonforfeiture benefit or the contingent benefit upon lapse. (3-31-22)

b. A contingent benefit on lapse is triggered every time an insurer increases the premium rates to a level which results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth within Subsection 032.04 based on the insured's issue age, and the policy or

certificate lapses within one hundred twenty (120) days of the due date of the premium so increased. Unless otherwise prescribed, policyholders are notified at least thirty (30) days prior to the due date of the premium reflecting the rate increase.

Table: Issue Age - Percent Increase Over Initial Premium

Issue Age	Percent Increase Over Initial Premium		Issue Age	Percent Increase Over Initial Premium
29 and under	200%		72	36%
30-34	190%		73	34%
35-39	170%		74	32%
40-44	150%		75	30%
45-49	130%		76	28%
50-54	110%		77	26%
55-59	90%		78	24%
60	70%		79	22%
61	66%		80	20%
62	62%		81	19%
63	58%		82	18%
64	54%		83	17%
65	50%		84	16%
66	48%		85	15%
67	46%		86	14%
68	44%		87	13%
69	42%		88	12%
70	40%		89	11%
71	38%		90 and over	10%

(3-31-22)

i. A contingent benefit on lapse is also triggered for policies with a fixed or limited premium paying period every time an insurer increases the premium rates to a level that results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth below based on the insured's issue age, the policy or certificate lapses within one hundred twenty (120) days of the due date of the premium so increased, and the ratio in Subsection 032.04.d.ii. is forty percent (40%) or more. Unless otherwise prescribed, policyholders are notified at least thirty (30) days prior to the due date of the premium reflecting the rate increase.

Triggers For A Substantial Premium Increase

Issue Age	Percent Increase Over Initial Premium
Under 65	50%
65-80	30%

Issue Age	Percent Increase Over Initial Premium
Over 80	10%

This provision is in addition to the contingent benefit provided by Subsection 032.04.b. and where both are triggered, the benefit provided is at the option of the insured. (3-31-22)

c. On or before the effective date of a substantial premium increase as defined in Subsection 032.04.b., the insurer: (3-31-22)

i. Offers to reduce policy benefits provided by the current coverage without the requirement of additional underwriting so that premium payments are not increased; (3-31-22)

ii. Offers to convert the coverage to a paid-up status with a shortened benefit period in accordance with the terms of Subsection 032.04.e. This option may be elected at any time during the one hundred twenty (120) day period referenced in Subsection 032.04.b.; and (3-31-22)

iii. Notifies the policyholder or certificate holder that a default or lapse at any time during the one hundred twenty (120) day period referenced in Subsection 032.04.b. is the election of the offer to convert in Subsection 032.04.c.ii. unless the automatic option in Subsection 032.04.d.iii. applies. (3-31-22)

d. On or before the effective date of a substantial premium increase as defined in Subsection 032.04.b.i., the insurer: (3-31-22)

i. Offers to reduce policy benefits provided by the current coverage without the requirement of additional underwriting so that premium payments are not increased; (3-31-22)

ii. Offers to convert the coverage to a paid-up status where the amount payable for each benefit is ninety percent (90%) of the amount payable in effect immediately prior to lapse times the ratio of the number of completed months of paid premiums divided by the number of months in the premium paying period. This option may be elected at any time during the one hundred twenty (120) day period referenced in Subsection 032.04.b.i.; and (3-31-22)

iii. Notifies the policyholder or certificateholder that a default or lapse at any time during the one hundred twenty (120) day period referenced in Subsection 032.04.b.i. is the election of the offer to convert in Subsection 032.04.d.ii. above if the ratio is forty percent (40%) or more. (3-31-22)

e. Benefits continued as nonforfeiture benefits, including contingent benefits upon lapse, in accordance with Subsection 032.04.b. but not Subsection 032.04.b.i. are described in Subsection 032.04.e. (3-31-22)

i. For purposes of this Subsection 032.04.e., attained age rating is defined as a schedule of premiums starting from the issue date which increases age at least one percent (1%) per year prior to age fifty (50), and at least three percent (3%) per year beyond age fifty (50); (3-31-22)

ii. For purposes of Subsection 032.04.e., the nonforfeiture benefit is of a shortened benefit period providing paid-up long-term care insurance coverage after lapse. The same benefits (amounts and frequency in effect at the time of lapse but not increased thereafter) will be payable for a qualifying claim, but the lifetime maximum dollars or days of benefits are determined as specified in Subsection 032.04.e.iii.; (3-31-22)

iii. The standard nonforfeiture credit will be equal to one hundred percent (100%) of the sum of all premiums paid, including the premiums paid prior to any changes in benefits. The insurer may offer additional shortened benefit period options, as long as the benefits for each duration equal or exceed the standard nonforfeiture credit for that duration. However, the minimum nonforfeiture credit cannot be less than thirty (30) times the daily nursing home benefit at the time of lapse. In either event, the calculation of the nonforfeiture credit is subject to the limitation of Subsection 032.04.f.; (3-31-22)

iv. The nonforfeiture benefit begins not later than the end of the third year following the policy or certificate issue date. The contingent benefit upon lapse is effective during the first three (3) years as well as thereafter. (3-31-22)

v. Notwithstanding Subsection 032.04.e.iv. for a policy or certificate with attained age rating, the nonforfeiture benefit begins on the earlier of: (3-31-22)

(1) The end of the tenth year following the policy or certificate issue date; or (3-31-22)

(2) The end of the second year following the date the policy or certificate is no longer subject to attained age rating. (3-31-22)

vi. Nonforfeiture credits may be used for all care and services qualifying for benefits under the terms of the policy or certificate, up to the limits specified in the policy or certificate. (3-31-22)

f. All benefits paid by the insurer while the policy or certificate is in premium paying status and in the paid-up status will not exceed the maximum benefits which would be payable if the policy or certificate had remained in premium paying status. (3-31-22)

g. There is no difference in the minimum nonforfeiture benefits as prescribed under Section 032 for group and individual policies. (3-31-22)

h. For certificates issued ~~on or after the effective date of this Section 032,~~ under a group long-term care insurance policy as defined in Section 41-4603(4)(a), Idaho Code, which policy was in force ~~at the time this rule became effective~~ on April 5, 2000, only the ~~provisions of Section 032 cannot apply.~~ ~~(3-31-22)~~

~~i.~~ ~~The~~ last sentence in Subsection 032.03 and Subsection 032.04.b.i. and Subsection 032.04.d. ~~applies to any long-term care insurance policy defined in Section 41-4603(4)(a), Idaho Code one (1) year after adoption~~ apply after April 30, 2008. ~~(3-31-22)~~( )

i. Premiums charged for a policy or certificate containing nonforfeiture benefits or a contingent benefit on lapse are subject to the loss ratio requirements of Section 023 or Section 025, whichever is applicable, treating the policy as a whole. (3-31-22)

j. To determine whether contingent nonforfeiture upon lapse provisions are triggered under Subsection 032.04.b. or 032.04.b.i., a replacing insurer that purchased or assumed a block or blocks of long-term care insurance policies from another insurer calculates the percentage increase based on the initial annual premium paid by the insured when the policy was first purchased from the original insurer. (3-31-22)

k. A nonforfeiture benefit for qualified long-term care insurance contracts that are level premium contracts is offered that meets the following requirements: (3-31-22)

i. The nonforfeiture provision is appropriately captioned; (3-31-22)

ii. The nonforfeiture provision provides a benefit available in the event of a default on the payment of any premiums and states that the amount of the benefit may be adjusted subsequent to being initially granted only as necessary to reflect changes in claims, persistency and interest as reflected in changes in rates for premium paying contracts filed for review with the Director for the same contract form; and (3-31-22)

iii. The nonforfeiture provision provides at least one (1) of the following: (3-31-22)

(1) Reduced paid-up insurance; (3-31-22)

(2) Extended term insurance; (3-31-22)

(3) Shortened benefit period; or (3-31-22)

(4) Other similar offerings approved by the Director. (3-31-22)

033. STANDARDS FOR BENEFIT TRIGGERS.

01. Conditions of Benefits Payment. A long-term care insurance policy conditions the payment of benefits on a determination of the insured's ability to perform activities of daily living and on cognitive impairment. Eligibility for the payment of benefits is not more restrictive than requiring either a deficiency in the ability to perform not more than three (3) of the activities of daily living or the presence of cognitive impairment. (3-31-22)

02. Activities of Daily Living. Insurers may use activities of daily living to trigger covered benefits in addition to those contained in Subsection 033.02 as long as they are defined in the policy. Activities of daily living includes at least the following as defined in Section 010 and in the policy. (3-31-22)

a. Bathing; (3-31-22)

b. Continence; (3-31-22)

c. Dressing; (3-31-22)

d. Eating; (3-31-22)

e. Toileting; and (3-31-22)

f. Transferring. (3-31-22)

03. Additional Provisions. An insurer may use additional provisions for the determination of when benefits are payable under a policy or certificate; however the provisions cannot restrict, and are not in lieu of, the requirements contained in Subsections 033.01 and 033.02. (3-31-22)

04. Determinations of Deficiency. For purposes of Section 033 the determination of a deficiency cannot be more restrictive than: (3-31-22)

a. Requiring the hands-on assistance of another person to perform the prescribed activities of daily living; or (3-31-22)

b. If the deficiency is due to the presence of ~~a~~ cognitive impairment, needing supervision or verbal cueing by another person ~~is needed~~ to protect the insured or others. ~~(3-31-22)~~( )

05. Assessments. Assessments of activities of daily living and cognitive impairment are performed by licensed or certified professionals, such as physicians, nurses or social workers. (3-31-22)

06. Appeals. Long-term care insurance policies include a clear description of the process for appealing and resolving benefit determinations. (3-31-22)

07. Effective Date. The requirements set forth in Section 033 are effective ~~within twelve (12) months of the effective date of the rule~~ April 5, 2000 and apply ~~as follows:~~ ~~(3-31-22)~~

~~**a.** Except as provided in Subsection 033.07.b. the provisions of Section 033 apply~~ to a long-term care policy issued in this state ~~on or after the effective date of the rule.~~ ~~(3-31-22)~~

~~**b.**~~ ~~F~~ after to that date, other than for certificates issued ~~on or after the effective date of Section 033,~~ under a group long-term care insurance policy as defined in Section 41-4603(4)(a), Idaho Code, which was in force ~~at the time this rule became effective, the provisions of Section 033 do not apply~~ prior to that date. ~~(3-31-22)~~( )

034. ADDITIONAL STANDARDS FOR BENEFIT TRIGGERS FOR QUALIFIED LONG-TERM CARE INSURANCE CONTRACTS.

01. Definitions. For purposes of Section 034 the following definitions apply: (3-31-22)

a. Qualified long-term care services means services that meet the requirements of Section 7702B(a)(1) of the Internal Revenue Code of 1986, as amended, as follows: necessary diagnostic, preventive, therapeutic, curative, treatment, mitigation, and rehabilitative services and maintenance or personal care services which are prescribed by a chronically ill individual, and are provided pursuant to a plan of care prescribed by a licensed health care practitioner. (3-31-22)

b. Chronically ill individual has the meaning prescribed for this term by Section 7702B(c)(2) of the Internal Revenue Code of 1986, as amended. Under this provision, a chronically ill individual means any individual who has been certified by a licensed health care practitioner as: (3-31-22)

i. Being unable to perform (without substantial assistance from another individual) at least two (2) activities of daily living for a period of at least ninety (90) days due to a loss of functional capacity; or (3-31-22)

ii. Requiring substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment. (3-31-22)

c. The term chronically ill individual cannot include an individual meeting these requirements unless within the preceding twelve (12) month period a licensed health care practitioner has certified that the individual meets these requirements. (3-31-22)

d. Licensed health care practitioner means a physician, as defined in Section 1861(r)(1) of the Social Security Act, and a registered professional nurse, licensed social worker, or other individual who meets requirements prescribed by the Secretary of the Treasury. (3-31-22)

e. Maintenance or personal care services means any care, the primary purpose of which is the provision of needed assistance with any of the disabilities, the existence of which leads to the conclusion that the individual is a chronically ill individual (including the protection from threats to health and safety due to severe cognitive impairment). (3-31-22)

02. The Chronically Ill. A qualified long-term care insurance contract pays for qualified long-term care services received by a chronically ill individual provided pursuant to a plan of care prescribed by a licensed health care practitioner. (3-31-22)

03. Payments and Conditions. A qualified long-term care insurance contract conditions the payment of benefits on a determination of the insured's inability to perform activities of daily living for an expected period of at least ninety (90) days due to a loss of functional capacity; or to severe cognitive impairment. (3-31-22)

04. Certifications by Professionals. Certifications regarding activities of daily living and cognitive impairment prescribed pursuant to Subsection 034.03 are performed by licensed or certified professionals, such as physicians, registered professional nurses, licensed social workers, or other individuals who meet requirements prescribed by the Secretary of the Treasury. (3-31-22)

05. Certifications by Carrier. Certification prescribed pursuant to Subsection 034.03 may be performed by a licensed health care professional at the direction of the carrier as is reasonably necessary with respect to a specific claim, except that when a licensed health care practitioner has certified that an insured is unable to perform activities of daily living for an expected period of at least ninety (90) days due to a loss of functional capacity and the insured is in claim status, the certification cannot be rescinded and additional certifications cannot be performed until after the expiration of the ninety (90) day period. (3-31-22)

06. Appeals. Qualified long-term care contracts include a clear description of the process for appealing and resolving benefit determinations. (3-31-22)

035. STANDARD FORMAT OUTLINE OF COVERAGE.
Section 035 of the rule implements, interprets and makes specific, the provisions of Section 41-4605(7)(a), Idaho Code, in prescribing a standard format and the content of an outline of coverage. (3-31-22)

01. Format. The outline of coverage is a freestanding document, using no smaller than ten (10) point type. Text that is capitalized or underscored in the standard format outline of coverage may be emphasized by other means that provide prominence equivalent to the capitalization or underscoring. (3-31-22)

02. Content. The outline of coverage contains no material of an advertising nature. (3-31-22)

03. Standard Form. Use of the text and sequence of text of the standard format outline of coverage is mandatory, unless otherwise specifically indicated. Format for the outline of coverage is published on the Department of Insurance website. (3-31-22)

036. REQUIREMENT TO DELIVER SHOPPER'S GUIDE.

01. Approved Format. A long-term care insurance shopper's guide in the format developed by the National Association of Insurance Commissioners, or a guide developed or approved by the director, is provided to all prospective applicants of a long-term care insurance policy or certificate. (3-31-22)

a. In the case of producer solicitations, a producer will deliver the shopper's guide prior to the presentation of an application or enrollment form. (3-31-22)

b. In the case of direct response solicitations, the shopper's guide will be presented in conjunction with any application or enrollment form. (3-31-22)

02. Exceptions. Life insurance policies or riders containing accelerated long-term care benefits are not obligated to furnish the above-referenced guide, but furnish the policy summary prescribed under Section 41-4605(9), Idaho Code, Disclosure and Performance Standards for Long-Term Care Insurance. (3-31-22)

037. PENALTIES.
In addition to any other penalties provided by the laws of this state any insurer and any producer found to have violated any requirement of this state relating to the marketing of such insurance or of IDAPA 18.04.11, "Long-Term Care Insurance Minimum Standards," is subject to an administrative penalty of up to three (3) times the amount of any commissions paid for each policy involved in the violation or up to ten thousand dollars ($10,000), whichever is greater. (3-31-22)

038. -- 999. (RESERVED)

IDAPA 18 – IDAHO DEPARTMENT OF INSURANCE

18.04.12 – THE SMALL EMPLOYER HEALTH INSURANCE AND AVAILABILITY ACT

DOCKET NO. 18-0412-2501 (ZBR CHAPTER REWRITE)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2026 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. Should the pending rule be approved, it will become final and effective on July 1 following the Second Regular Session of the Sixty-eighth Idaho Legislature, unless the concurrent resolution states a different effective date.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section(s) 41-211 and 41-4715, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change:

This rule was presented as part of the Department of Insurance's plan to review each rule according to the Governor's Executive Order 2020-01: Zero-Based Regulation, and pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. The purpose of this chapter is to promote broader spreading of risk in the small employer marketplace.

There are no changes to the pending rule, and it is being adopted as originally proposed. The complete text of the proposed rule was published in the August 6, 2025, Idaho Administrative Bulletin, Vol. 25-8, pages 101-118.

FEE SUMMARY: Pursuant to Section 67-5224(2)(d), Idaho Code, a pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature. The following is a description of the fee or charge imposed or increased in this rulemaking: 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:

No fiscal impact.

ASSISTANCE WITH TECHNICAL QUESTIONS: For assistance with technical questions concerning this pending rule, contact Weston Trexler, (208) 334-4214, weston.trexler@doi.idaho.gov.

DATED this 3rd day of October, 2025.

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

THE FOLLOWING NOTICE PUBLISHED WITH THE 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 41-4715, Idaho Code.

PUBLIC HEARING SCHEDULE: A public hearing concerning this rulemaking will be held as follows:

Thursday, August 7, 2025
2:00 p.m. – 4:00 p.m.

In-person participation is available at:
Department of Insurance
700 W. State St. 3rd Floor
Boise, ID 83702

Web meeting link:
Click here to join the meeting
Meeting ID: 237 139 719 159 3
Passcode: jk3o9Ur2
Download Teams | Join on the web

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: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

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

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

No fee or charge imposed or increased.

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 as a result of this rulemaking: None.

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 May 7, 2025, Idaho Administrative Bulletin, Volume 25-5, pages 52-53 under docket number 18-ZBRR-2501.

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: None.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Weston Trexler, (208) 334-4214, weston.trexler@doi.idaho.gov.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before August 27, 2025.

DATED this 2nd day of July, 2025.

THE FOLLOWING IS THE TEXT OF ZBR DOCKET NO. 18-0412-2501

18.04.12 – THE SMALL EMPLOYER HEALTH INSURANCE AND AVAILABILITY ACT

000. LEGAL AUTHORITY.
~~Title 41, Chapters 2 and 47~~Section 41-211 and Section 41-4715, Idaho Code. ~~(3-31-22)~~( )

001. ~~TITLE AND~~ SCOPE.

~~01.~~ ~~Title~~. ~~IDAPA 18.04.12, "The Small Employer Health Insurance and Availability Act."~~ ~~(3-31-22)~~

~~02.~~ ~~Scope~~. ~~The Act and t~~This chapter ~~are~~ is intended to promote broader spreading of risk in the small employer marketplace and to regulate all health benefit plans sold to small employers, whether sold directly or through associations or other groupings of small employers. Carriers that provide health benefit plans to small employers are intended to be subject to all of the provisions of ~~the Act~~ Title 41, Chapter 47 and this chapter.
~~(3-31-22)~~( )

002. -- 009. (RESERVED)

010. DEFINITIONS.
~~As used in this chapter:~~ ~~(3-31-22)~~

01. Associate Member. Any individual who participates in an employee benefit plan (as defined in 29 U.S.C. Section 1002(1)) that is a multi-employer plan (as defined in 29 U.S.C. Section 1002(37A)), other than the following: (3-31-22)

a. An individual (or the beneficiary of such individual) who is employed by a participating employer within a bargaining unit covered by at least one (1) of the collective bargaining agreements under or pursuant to which the employee benefit plan is established or maintained; or (3-31-22)

b. An individual who is a present or former employee (or a beneficiary of such employee) of the sponsoring employee organization, of an employer who is or was a party to at least one (1) of the collective bargaining agreements under or pursuant to which the employee benefit plan is established or maintained, or of the employee benefit plan (or of a related plan). (3-31-22)

02. Expense. The cost incurred for a covered service or supply. A physician or other licensed practitioner orders or prescribes the service or supply. Expense is considered incurred on the date the service or supply is received. Expense does not include any charge: (3-31-22)

a. For a service or supply that is not medically necessary; or (3-31-22)

b. ~~That is i~~In excess of reasonable and customary charge for a service or supply. ~~(3-31-22)~~( )

03. Geographic Area. A sector of land, as designated by the health carrier, ~~which~~ that employers ~~situsedd~~ located within receive a specified rating factor. Geographic areas are limited to no more than six (6) designated areas, with no area being smaller than a county. ~~(3-31-22)~~(____)

04. Medically Necessary Service or Supply. One that is ordered by a physician and that the small-employer carrier or a qualified party determines is: ~~(3-31-22)~~(____)

a. Provided for the diagnosis or direct treatment of an injury or sickness; (3-31-22)

b. Appropriate and consistent with the symptoms and findings of diagnosis and treatment of the insured persons injury or sickness; (3-31-22)

c. Is not considered experimental or investigative; (3-31-22)

d. Provided in accord with generally accepted medical practice; (3-31-22)

e. The most appropriate supply or level of service which can be provided on a cost-effective basis. The fact that the insured person's physician prescribes services or supplies does not automatically mean such service or supply are medically necessary and covered by the policy. (3-31-22)

05. New Entrant. An eligible employee, or the dependent of an eligible employee, who becomes part of an employer group after the initial period for enrollment in a health benefit plan. (3-31-22)

~~**06. Pre-Existing Condition**.~~ ~~(3-31-22)~~

~~**a.** A condition, whether physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received during the six (6) months immediately preceding the effective date of coverage;~~ ~~(3-31-22)~~

~~**b.** A condition for which medical advice, diagnosis, care or treatment was recommended or received during the six (6) months immediately preceding the effective date of coverage; or~~ ~~(3-31-22)~~

~~**c.** A pregnancy existing on the effective date of coverage.~~ ~~(3-31-22)~~

~~**d.** Genetic information will not be considered as a condition described in this definition in the absence of a diagnosis of the condition related to such information.~~ ~~(3-31-22)~~

0~~7~~6. **Risk Characteristic**. The health status, claims experience, duration of coverage, or any similar characteristic related to the health status or claims experience of a small employer group or of any member of a small employer group. Such characteristics can include family composition, group size, industry. (3-31-22)

0~~8~~7. **Risk Load**. The percentage above the applicable base premium rate that is charged by a small employer carrier to the rates of the small employer group, to reflect the risk characteristics of the small employer group. (3-31-22)

~~**011. ASSESSMENTS.**~~
~~Prior to March 1st of each year the Board determines and files with the Director an estimate of the assessments needed to fund the losses incurred by the Idaho Small Employer Reinsurance Program in the previous calendar year. This interim assessment is based on the assessment formula set forth in Section 41-4711(12)(c), Idaho Code. Initial or interim assessments paid will be credited to each carrier's account when the amounts needed to fund losses and pay program expenses are known.~~ ~~(3-31-22)~~

01~~2~~1. -- 014. (RESERVED)

015. APPLICABILITY.

01. Applicability. This chapter applies to any health benefit plan provided on a group basis, that: (3-31-22)

a. Meets one (1) or more of the conditions set forth in Section 41-4704, Idaho Code; and (3-31-22)

b. Offers coverage to two (2) or more eligible employees of a small employer located in this state, without regard to whether the policy or certificate was issued in this state. (3-31-22)

02. Group Policy or Trust Arrangement. The provisions of the Act and this chapter applies to a health benefit plan provided to a small employer or to the eligible employees of a small employer without regard to whether the health benefit plan is offered under or provided through a group policy or trust arrangement of any size sponsored by an association or discretionary group unless such health benefit plan(s) are subject to Title 41, Chapter 52, Idaho Code. (3-31-22)

~~**03. Group Policy or Trust Arrangement**. The provisions of the Act and this chapter applies to a health benefit plan provided to a small employer or to the eligible employees of a small employer without regard to whether the health benefit plan is offered under or provided through a group policy or trust arrangement of any size sponsored by an association or discretionary group.~~ ~~(3-31-22)~~

0**4**3. **Subsequent Employment of More Than Fifty Eligible Employees**. If a small employer is issued a health benefit plan under the terms of the Act, the provisions of the Act and this chapter continue to apply to the health benefit plan in the case that the small employer subsequently employs more than fifty (50) eligible employees. A carrier providing coverage to such an employer, within sixty (60) days of becoming aware that the employer has more than fifty (50) eligible employees but no later than the anniversary date of the employer's health benefit plan, notifies the employer that the protections provided under the Act and this chapter cease to apply to the employer if such employer fails to renew its current health benefit plan or elects to enroll in a different health benefit plan. (3-31-22)

0**5**4. **Employer Subsequently Becomes a Small Employer**. If a health benefit plan is issued to an employer that is not a small employer as defined in the Act, but subsequently the employer becomes a small employer (due to the loss or change of work status of one or more employees), the terms of the Act do not apply to the health benefit plan. The carrier providing a health benefit plan to such an employer does not become a small employer carrier under the terms of the Act solely because the carrier continues to provide coverage under the health benefit plan to the employer. (3-31-22)

0**6**5. **Time Period for Notification of Options to Employer**. A carrier providing coverage to an employer described in Subsection 015.05, within sixty (60) days of becoming aware that the employer has fifty (50) or fewer eligible employees, notifies the employer of the options and protections available to the employer under the Act, including the employer's option to purchase a small employer health benefit plan from any small employer carrier. (3-31-22)

0**7**6. **Employees in More Than One State**. If a small employer has employees in more than one (1) state, the provisions of the Act and this chapter apply to a health benefit plan issued to the small employer if: (3-31-22)

a. The majority of eligible employees of such small employer are employed in this state; or (3-31-22)

b. If no state contains a majority of the eligible employees of the small employer, the primary business location of the small employer is in this state. (3-31-22)

0**8**7. **Laws of This State or Another State**. In determining whether the laws of this state or another state apply to a health benefit plan issued to a small employer described in Subsection 015.07, the provisions of the paragraph is applied as of the date the health benefit plan was issued to the small employer for the period that the health benefit plan remains in effect. (3-31-22)

0**9**8. **Health Benefit Plan Subject to The Act and This Chapter**. If a health benefit plan is subject to the Act and this chapter, the provisions of the Act and this chapter applies to all individuals covered under the health

benefit plan, whether they reside in this state or in another state. (3-31-22)

~~10~~09. **When Is a Small Employer Carrier Not Subject to the Act and This Chapter**. A carrier that is not operating as a small employer carrier in this state does not become subject to the provisions of the Act and this chapter solely because a small employer that was issued a health benefit plan in another state by that carrier moves to this state. (3-31-22)

016. -- 020. (RESERVED)

021. ESTABLISHMENT OF CLASSES OF BUSINESS.

01. Supporting Documentation for Establishment of Classes of Business. A small employer carrier that establishes more than one class of business pursuant to the provisions of Section 41-4705, Idaho Code, maintains on file for inspection by the Director the following information with respect to each class of business so established: (3-31-22)

a. A description of each criterion employed by the carrier (or any of its agents) for determining membership in the class of business; (3-31-22)

b. A statement describing the justification for establishing the class as a separate class of business and documentation that the establishment of the class of business is intended to reflect substantial differences in expected claims experience or administrative costs related to the reasons set forth in Section 41-4705, Idaho Code; and (3-31-22)

c. A statement disclosing that, if any, health benefit plans are currently available for purchase in the class and any significant limitations related to the purchase of such plans. (3-31-22)

02. Group Size Is Not a Class of Business. A carrier will not directly or indirectly use group size as a criterion for establishing eligibility for a health benefit plan or for a class of business. (3-31-22)

022. -- 027. (RESERVED)

028. TRANSITION FOR ASSUMPTIONS OF BUSINESS FROM ANOTHER CARRIER.

01. Conditions for Transfer or Assumption of Entire Insurance Obligation. A small employer carrier will not transfer or assume the entire insurance obligation and/or risk of a health benefit plan covering a small employer in this state unless: (3-31-22)

a. The transaction received any necessary approval of the insurance supervisory official of the state of domicile of the assuming carrier; (3-31-22)

b. The transaction received any necessary approval of the insurance supervisory official of the state of domicile of the ceding carrier; and, (3-31-22)

c. The transaction meets the other requirements of this Section. (3-31-22)

02. Time Frame for Filing Plan to Assume or Cede Entire Insurance Obligation. A carrier domiciled in this state that proposes to assume or cede the entire insurance obligation and/or risk of one or more small employer health benefit plans from another carrier makes a filing for approval with the Director at least sixty (60) days prior to the date of the proposed assumption. The Director may approve the transaction if the Director finds that the transaction is in the best interests of the individuals insured under the health benefit plans to be transferred and is consistent with the purposes of the Act and this chapter. The Director will not approve the transaction until at least thirty (30) days after the date of the filing; except that, if the ceding carrier is in hazardous financial condition, the Director may approve the transaction as soon as the Director deems reasonable. (3-31-22)

03. Filing Requirements. The filing for Subsection 028.02 will: (3-31-22)

a. Describe the class of business (including any eligibility requirements) of the ceding carrier from which the health benefit plans will be ceded; (3-31-22)

b. Describe whether the assuming carrier will maintain the assumed health benefit plans as a separate class of business (pursuant to Subsection 028.08 or will incorporate them into an existing class of business (pursuant to Subsection 028.09). If the assumed health benefit plans will be incorporated into an existing class of business, the filing will describe the class of business of the assuming carrier into which the health benefit plans will be incorporated; (3-31-22)

c. Describe whether the health benefit plans being assumed are currently available for purchase by small employers; (3-31-22)

d. Describe the potential effect of the assumption, if any, on the benefits provided by the health benefit plans to be assumed; (3-31-22)

e. Describe the potential effect of the assumption, if any on the premiums for the health benefit plans to be assumed; (3-31-22)

f. Describe any other potential material effects of the assumption on the coverage provided to the small employers covered by the health benefit plans to be assumed; and (3-31-22)

g. Include any other information prescribed by the Director. (3-31-22)

04. Informational Filings in Other States. A small employer carrier prescribed to make a filing under Subsection 028.02 will also make an informational filing with the Insurance Supervisory Official of each state in which there are small employer health benefit plans that would be included in the transaction. The informational filing to each state will be made concurrently with the filing made under Subsection 028.02 and will include at least the information specified in Subsection 028.03 for the small employer health benefit plans in that state. (3-31-22)

05. Other Considerations in the Transfer and Assumption of the Entire Insurance Obligation. A small employer carrier will not transfer or assume the entire insurance obligation and/or risk of a health benefit plan covering a small employer in this state unless it complies with the following provisions: (3-31-22)

a. The carrier has provided notice to the Director at least sixty (60) days prior to the date of the proposed assumption. The notice contains the information specified in Subsection 028.03 for the health benefit plans covering small employers in this state. (3-31-22)

b. If the assumption of a class of business would result in the assuming small employer carrier being out of compliance with the limitations related to premium rates contained in Section 41-4706(1)(a), Idaho Code, the assuming carrier makes a filing with the Director pursuant to Section 41-4706(3), Idaho Code, seeking suspension of the application of Section 41-4706(1)(a), Idaho Code. (3-31-22)

c. An assuming carrier seeking suspension of the application of Section 41-4706(1)(a), Idaho Code, will not complete the assumption of health benefit plans covering small employers in this state unless the Director grants the suspension requested pursuant to Paragraph 028.05.b. (3-31-22)

d. Unless a different period is approved by the Director, a suspension of the application of Section 41-4706(1)(a), Idaho Code, with respect to an assumed class of business, is for no more than fifteen (15) months and, with respect to each individual small employer, lasts only until the anniversary date of such employer's coverage (except that the period with respect to an individual small employer may be extended beyond its first anniversary date for a period of up to twelve (12) months if the anniversary date occurs within three (3) months of the date of assumption of the class of business). (3-31-22)

06. Exceptions to Ceding or Assumption of Business. Except as provided in Subsection 028.02, a small employer carrier will not cede or assume the entire insurance obligation and/or risk for a small employer health benefit plan unless the transaction includes the ceding to the assuming carrier of the entire class of business within Idaho which includes such health benefit plan. (3-31-22)

07. Requirements for Ceding Less Than an Entire Class of Business. A small employer carrier may cede less than an entire class of business to an assuming carrier if: (3-31-22)

a. One (1) or more small employers in the class have exercised their right under contract to reject, either directly or by implication, the ceding of their health benefit plans to another carrier. In that instance, the transaction includes each health benefit plan in the class of business except those health benefit plans for which a small employer has rejected the proposed cession; or (3-31-22)

b. After a written request from the transferring carrier, the Director determines that the transfer of less than the entire class of business is in the best interests of the small employers insured in that class of business. (3-31-22)

08. Separate Class of Business. Except as provided in Subsection 028.09, a small employer carrier that assumes one (1) or more health benefit plans from another carrier will maintain such health benefit plans as a separate class of business. (3-31-22)

09. Provisions for Exceeding the Maximum Number of Classes of Business. A small employer carrier that assumes one or more health benefit plans from another carrier may exceed the limitation contained in Section 41-4705(2), Idaho Code, (relating to the maximum number of classes of business a carrier may establish) due solely to such assumption for a period of up to fifteen (15) months after the date of the assumption, provided that the carrier complies with the following provisions: (3-31-22)

a. Upon assumption of the health benefit plans, such health benefit plans are maintained as a separate class of business. During the fifteen-month (15) period following the assumption, each of the assumed small employer health benefit plans are transferred by the assuming small employer carrier into a single class of business operated by the assuming small employer carrier. The assuming small employer carrier selects the class of business into which the assumed health benefit plans will be transferred in a manner such that the transfer results in the least possible change to the benefits and rating method of the assumed health benefit plans. (3-31-22)

b. The transfers authorized in Paragraph 028.09.a. occurs with respect to each small employer on the anniversary date of the small employer's coverage, except that the period with respect to an individual small employer may be extended beyond its first anniversary date for a period of up to twelve (12) months if the anniversary date occurs within three (3) months of the date of assumption of the class of business. (3-31-22)

c. A small employer carrier making a transfer pursuant to Paragraph 028.09.a. may alter the benefits of the assumed health benefit plans to conform to the benefits currently offered by the carrier in the class of business into which the health benefit plans have been transferred. (3-31-22)

d. The premium rate for an assumed small employer health benefit plan is not modified by the assuming small employer carrier until the health benefit plan is transferred pursuant to Paragraph 028.09.a. Upon transfer, the assuming small employer carrier calculates a new premium rate for the health benefit plan from the rate manual established for the class of business into which the health benefit plan is transferred. In making such calculation, the risk load applied to the health benefit plan is no higher than the risk load applicable to such health benefit plan prior to the assumption. (3-31-22)

e. During the fifteen-month (15) period provided in this Subsection, the transfer of small employer health benefit plans from the assumed class of business in accordance with this subsection is considered a violation of Section 41-4706(2), Idaho Code. (3-31-22)

10. Restrictions to Apply Eligibility Requirements by Assuming Carrier. An assuming carrier will not apply eligibility requirements, including minimum participation and contribution requirements, with respect to an assumed health benefit plan (or with respect to any health benefit plan subsequently offered to a small employer covered by such an assumed health benefit plan) that are more stringent than the requirements applicable to such health benefit plan prior to the assumption. (3-31-22)

11. Request for Extension of the Transition Period. The Director may approve a longer period of

transition upon application of a small employer carrier. The application is made within sixty (60) days from assumption of the class of business and clearly states the justification for a longer transition period. (3-31-22)

12. Additional Information. Nothing in this Section or in the Act is intended to: (3-31-22)

a. Reduce or diminish any legal or contractual obligation or requirement, including any obligation provided in Section 41-511, Idaho Code, of the ceding or assuming carrier related to the transaction; (3-31-22)

b. Authorize a carrier not admitted to transact the business of insurance in this state to offer or insure health benefit plans in this state; or (3-31-22)

c. Reduce or diminish the protections related to an assumption reinsurance transaction provided in Section 41-511, Idaho Code, or otherwise provided by law. (3-31-22)

029. -- 035. (RESERVED)

036. RESTRICTIONS RELATING TO PREMIUM RATES.
The following provisions are applicable for all small employer health benefit plans. (3-31-22)

01. Separate Rate Manual for Each Class of Business. A small employer carrier develops a separate rate manual for each class of business. Base premium rates and new business premium rates charged to small employers by the small employer carrier are computed solely from the applicable rate manual developed pursuant to this Section. To the extent that a portion of the premium rates charged by a small employer carrier is based on the carrier's discretion, the manual specifies the criteria and factors considered by the carrier in exercising such discretion. (3-31-22)

02. Requirements for Adjustments to Rating Method. A small employer carrier will not modify the rating method used in the rate manual for a class of business until the change has been approved as provided in this Section. The Director may approve a change to a rating method if the Director finds that the change is reasonable, actuarially appropriate, and consistent with the purposes of the Act and this chapter. (3-31-22)

~~**03. Information for Review of Modification of Rating Method**. A carrier may modify the rating method for a class of business only with prior approval of the Director. A carrier requesting to change the rating method for a class of business makes a filing with the Director at least thirty (30) days prior to the proposed date of the change. The filing contains at least the following information:~~ ~~(3-31-22)~~

~~**a.** The reasons the change in rating method is being requested;~~ ~~(3-31-22)~~

~~**b.** A complete description of each of the proposed modifications to the rating method;~~ ~~(3-31-22)~~

~~**c.** A description of how the change in rating method would affect the premium rates currently charged to small employers in the class of business, including an estimate from a qualified actuary of the number of groups or individuals (and a description of the types of groups or individuals) whose premium rates may change by more than ten percent (10%) due to the proposed change in rating method (not generally including increases in premium rates applicable to all small employers in a health benefit plan);~~ ~~(3-31-22)~~

~~**d.** A certification from a qualified actuary that the new rating method would be based on objective and credible data and would be actuarially sound and appropriate; and~~ ~~(3-31-22)~~

~~**e.** A certification from a qualified actuary that the proposed change in rating method would not produce premium rates for small employers that would be in violation of Section 41-4706, Idaho Code.~~ ~~(3-31-22)~~

043. Change in Rating Method. For the purpose of this Section, a change in rating method means: (3-31-22)

a. A change in the number of case characteristics used by a small employer carrier to determine premium rates for health benefit plans in a class of business (a small employer will not use case characteristics other

than age, individual tobacco use, geography or gender without prior approval of the Director); (3-31-22)

b. A change in the manner or procedures by which insureds are assigned into categories for the purpose of applying a case characteristic to determine premium rates for health benefit plans in a class of business; (3-31-22)

c. A change in the method of allocating expenses among health benefit plans in a class of business; or (3-31-22)

d. A change in a rating factor with respect to any case characteristic if the change would produce a change in premium for any small employer that exceeds ten percent (10%). (3-31-22)

e. For the purpose of this Subsection, a change in a rating factor means the cumulative change with respect to such factor considered over a twelve (12) month period. If a small employer carrier changes rating factors with respect to more than one case characteristic in a twelve (12) month period, the carrier considers the cumulative effect of all such changes in applying the ten percent (10%) test. (3-31-22)

~~**05. Rate Manual to Specify Case Characteristics and Rate Factors to Be Applied**. The rate manual developed pursuant to Subsection 036.01 specifies the case characteristics and rate factors to be applied by the small employer carrier in establishing premium rates for the class of business. (3-31-22)~~

~~**06. Uniform Application of Case Characteristics**. A small employer carrier uses the same case characteristics as defined in Section 41-4706(1)(h), Idaho Code, in establishing premium rates for each health benefit plan in a class of business and applies them in the same manner in establishing premium rates for each such health benefit plan. Case characteristics are applied without regard to the risk characteristics of a small employer. (3-31-22)~~

~~**07. Base Premium Rates and Any Difference in New Business Rate**. The rate manual developed pursuant to Subsection 036.01 clearly illustrates the relationship among the base premium rates charged for each health benefit plan in the class of business. If the new business premium rate is different than the base premium rate for a health benefit plan, the rate manual illustrates the difference. (3-31-22)~~

~~**08. Reasonable and Objective Rate Differences**. Differences among base premium rates for health benefit plans are based solely on the reasonable and objective differences in the design and benefits of the health benefit plans and will not be based in any way on the actual or expected health status or claims experience of the small employer groups that choose or are expected to choose a particular health benefit plan. A small employer carrier applies case characteristics and rate factors within a class of business in a manner that assures that premium differences among health benefit plans for identical small employer groups vary only due to reasonable and objective differences in the design and benefits of the health benefit plans and are not due to the actual or expected health status or claims experience of the small employer groups that choose or are expected to choose a particular health benefit plan. (3-31-22)~~

~~**09. Two-Step Process**. The rate manual developed pursuant to Subsection 036.01 provides for premium rates to be developed in a two-step process. In the first step, a base premium rate is developed for the small employer group without regard to any risk characteristics of the group. In the second step, the resulting base premium rate may be adjusted by a risk load, subject to the provisions of Section 41-4706, Idaho Code, to reflect the risk characteristics of the group. (3-31-22)~~

~~10~~04. ~~**Exception to** **Application Fee, Underwriter Fee, or Other Fees**. Except as provided in Subsection 036.11, a premium charged to a small employer for a health benefit plan~~ A carrier will not ~~include~~ charge a small employer or employee a separate application fee, underwriting fee, or any other separate fee ~~or charge~~ beyond the premium for the health benefit plan. ~~(3-31-22)~~( )

~~**11. Uniform Application of Fees**. A carrier may charge a separate fee with respect to a health benefit plan provided the fee is applied in a uniform manner to every health benefit plan in a class of business. All such fees are premium and are included in determining compliance with the Act and this chapter. (3-31-22)~~

~~**12. Uniform Allocation of Administration Expenses**. The rate manual developed pursuant to~~

~~Subsection 036.01 describes the method of allocating administrative expenses to the health benefit plans in the class of business for which the manual was developed.~~ ~~(3-31-22)~~

~~13~~05. **Rate Manual to be Maintained for a Period of Six Years**. Each rate manual developed pursuant to Subsection 036.01 is maintained by the carrier for a period of six (6) years. Updates and changes to the manual are maintained with the manual. (3-31-22)

~~14. Guidelines Issued by Director~~. ~~The rate manual and rating practices of a small employer carrier will comply with any guidelines issued by the Director.~~ ~~(3-31-22)~~

~~15. Application of Restrictions Related to Changes in Premium Rates~~. ~~The restrictions related to changes in premium rates are set forth in Section 41-4706(1)(c), Idaho Code, and are applied as follows:~~ ~~(3-31-22)~~

~~a. A small employer carrier revises its rate manual each rating period to reflect changes in base premium rates and changes in new business premium rates.~~ ~~(3-31-22)~~

~~b. If, for any health benefit plan with respect to any rating period, the percentage change in the new business premium rate is less than or the same as the percentage change in the base premium rate, the change in the new business premium rate is the change in the base premium rate for the purposes of Sections 41-4706(1)(c)(i), Idaho Code.~~ ~~(3-31-22)~~

~~c. If, for any health benefit plan with respect to any rating period, the percentage change in the new business premium rate exceeds the percentage change in the base premium rate, the health benefit plan is considered a health benefit plan into which the small employer carrier is no longer enrolling new small employers for the purposes of Section 41-4706(1)(c)(i), Idaho Code.~~ ~~(3-31-22)~~

~~d. If, for any rating period, the change in the new business premium rate for a health benefit plan differs from the change in the new business premium rate for any other health benefit plan in the same class of business by more than twenty percent (20%), the carrier makes a filing with the Director containing a complete explanation of how the respective changes in new business premium rates were established and the reason for the difference. The filing is made within thirty (30) days of the beginning of the rating period.~~ ~~(3-31-22)~~

~~e. A small employer carrier keeps on file for a period of at least six (6) years the calculations used to determine the change in base premium rates and new business premium rates for each health benefit plan for each rating period.~~ ~~(3-31-22)~~

~~16. Change in Premium Rate~~. ~~Except as provided in Subsection 036.17, a change in premium rate for a small employer produces a revised premium rate that is no more than the following:~~ ~~(3-31-22)~~

~~a. The base premium rate for the small employer, given its present composition, (as shown in the rate manual as revised for the rating period), multiplied by;~~ ~~(3-31-22)~~

~~b. One (1) plus the sum of:~~ ~~(3-31-22)~~

~~i. The risk load applicable to the small employer during the previous rating period; and~~ ~~(3-31-22)~~

~~ii. Fifteen percent (15%) (prorated for periods of less than one (1) year).~~ ~~(3-31-22)~~

~~17. Plans No Longer Enrolling New Business~~. ~~In the case of a health benefit plan into which a small employer carrier is no longer enrolling new small employers, a change in premium rate for a small employer will produce a revised premium rate that is no more than the base premium rate for the small employer (given its present composition and as shown in the rate manual in effect for the small employer at the beginning of the previous rating period), multiplied by Paragraphs 036.17.a. and 036.17.b.~~ ~~(3-31-22)~~

~~a. One (1) plus the lesser of:~~ ~~(3-31-22)~~

~~i. The change in the base rate; or~~ ~~(3-31-22)~~

~~ii. The percentage change in the new business premium for the most similar health benefit plan into which the small employer carrier is enrolling new small employers.~~ ~~(3-31-22)~~

~~**b.** One (1) plus the sum of:~~ ~~(3-31-22)~~

~~i. The risk load applicable to the small employer during the previous rating period; and~~ ~~(3-31-22)~~

~~ii. Fifteen percent (15%) (prorated for periods of less than one (1) year).~~ ~~(3-31-22)~~

~~**18. Limitations on Revised Premium Rate**. Notwithstanding the provisions of Subsections 036.16 and 036.17, a change in premium rate for a small employer will not produce a revised premium rate that would exceed the limitations on rates provided in Section 41-4706(1)(b), Idaho Code.~~ ~~(3-31-22)~~

~~19~~06. **Waiver Request for a Taft-Hartley Trust**. A representative of a Taft-Hartley trust (including a carrier upon the written request of such a trust) may file a written request with the Director for the waiver of application of the provisions of Section 41-4706(1), Idaho Code, with respect to such trust. (3-31-22)

~~20~~07. **Provisions for Which Trust Is Seeking Waiver**. A request made under Subsection 036.~~19~~16 identifies the provisions for which the trust is seeking the waiver and describes, with respect to each provision, the extent to which application of such provision would: ~~(3-31-22)~~( )

a. Adversely affect the participants and beneficiaries of the trust; and (3-31-22)

b. Require modifications to one (1) or more of the collective bargaining agreements under or pursuant to which the trust was or is established or maintained. (3-31-22)

~~21~~08. **Waiver Not for an Individual or Associate Member**. A waiver granted under this provision will not apply to an individual who participates in the trust because the individual is an associate member of an employee organization or the beneficiary of such an individual. (3-31-22)

037. -- 045. (RESERVED)

046. REQUIREMENT TO INSURE ENTIRE GROUPS.

01. Offer of Coverage. A small employer carrier that offers coverage to a small employer will offer to provide coverage to each eligible employee and to each dependent of an eligible employee. Except as provided in Subsection 046.02, the small employer carrier provides the same health benefit plan to each such employee and dependent. (3-31-22)

02. Choice of Health Benefit Plans. A small employer carrier may offer the employees of a small employer the option of choosing among one (1) or more health benefit plans, provided that each eligible employee may choose any of the offered plans. The choice among benefit plans will not be limited, restricted or conditioned based upon the risk characteristics of the eligible employees or their dependents. (3-31-22)

03. Participation Requirement. The small employer carrier may impose reasonable minimum participation requirements for issuance of coverage to small employers, subject to prior approval from the Director. (3-31-22)

04. Employer Census and Supporting Documentation. A small employer carrier ~~will~~ may require each small employer that applies for coverage, as part of the application process, to prepare or provide an employer census of dependents and eligible employees as defined in Sections 41-4703(11) and 41-4703(13), Idaho Code. The small employer carrier may require the small employer to provide appropriate supporting documentation (such as the W-2 Summary Wage and Tax Form) or a certification of information by a Small Employer as to the current census information. ~~(3-31-22)~~( )

05. Waiver for Documentation of Coverage. A small employer carrier will secure a waiver with

respect to each eligible employee and each dependent of such an eligible employee who declines an offer of coverage under a health benefit plan provided to a small employer. The waiver is signed by the eligible employee (on behalf of such employee or the dependent of such employee) and certifies that the individual who declined coverage was informed of the availability of coverage under the health benefit plan. The waiver form requires that the reason for declining coverage be stated on the form, and includes a statement informing the eligible employee of the special enrollment rights provided within the Section 41-4703(17)(d) and (e), Idaho Code, and includes a written warning of the penalties imposed on late enrollees. Waivers are maintained by the small employer carrier for a period of six (6) years. (3-31-22)

06. Refusal to Provide Information. A small employer carrier ~~will not issue~~ may deny coverage to a small employer that refuses to provide the list prescribed under Subsection 046.04 or a waiver prescribed under Subsection 046.05, except if the excluded individual has coverage under a health benefit plan or ~~other~~ similar health benefit arrangement ~~that provides benefits similar to or exceeding benefits provided under the basic health benefit plan~~. ~~(3-31-22)~~( )

07. Induced Declinations. A small employer carrier will not issue coverage to a small employer if the carrier, or an agent for such carrier, has reason to believe that the small employer has induced or pressured an eligible employee (or dependent of an eligible employee) to decline coverage due to a health status related factor of the individual. (3-31-22)

08. Agent Notification to Small Employer Carrier. An agent will notify a small employer carrier, prior to submitting an application for coverage with the carrier on behalf of a small employer, of any circumstances that would indicate that the small employer has induced or pressured an eligible employee (or dependent of an eligible employee) to decline coverage due to the individual's risk characteristics. (3-31-22)

09. New Entrants. New entrants to a small employer group are offered an opportunity to enroll in the health benefit plan currently held by such group based upon the provisions of Section 41-4708, Idaho Code. A new entrant that does not exercise the opportunity to enroll in the health benefit plan within the period provided by the small employer carrier may be treated as a late enrollee by the carrier, provided that the period provided to enroll in the health benefit plan extends at least thirty (30) days after the date the new entrant is notified of their opportunity to enroll. The period of continuous coverage will not include any waiting period for the effective date of the new coverage applied by the employer to all new enrollees under the Employee Benefit Plan. If a small employer carrier has offered more than one health benefit plan to a small employer group pursuant to Subsection 046.02, the new entrant is offered the same choice of health benefit plans as the other members of the group. (3-31-22)

10. Waiting Period. A small employer carrier will not apply a waiting period, elimination period or other similar limitation of coverage (other than an exclusion for pre-existing medical conditions consistent with Section 41-4708(3), Idaho Code). (3-31-22)

11. Risk Characteristics. New entrants to a group are accepted for coverage by the small employer carrier without any restrictions or limitations on coverage related to the risk characteristics of the employees or their dependents, except that a carrier may exclude or limit coverage for pre-existing medical conditions, consistent with the provisions provided in Section 41-4708(3), Idaho Code. (3-31-22)

~~**12. Risk Load**. A small employer carrier may assess a risk load to the premium rate associated with a new entrant, consistent with the requirements of Section 41-4706, Idaho Code. The risk load is the same risk load charged to the small employer group immediately prior to acceptance of the new entrant into the group.~~ ~~(3-31-22)~~

1~~3~~2. Rescission Employer Misstatements. When material application misstatements are found, rescission action by the carrier may be taken at the carrier's option against the coverage of an entire small employer (including employees and dependents) and is limited to circumstances under which the application misstatements have been made by the small employer. When rescission action is taken, per Section 41-4707(1)(b), Idaho Code, premiums are refunded less any claims which had been paid prior to the date the rescission was initiated. At the carrier's option, the carrier may seek to recover any amounts of claims paid in excess of premiums paid. The applicable contract or coverage is considered null and void. (3-31-22)

047. -- 054. (RESERVED)

055. APPLICATION TO REENTER STATE.
Restrictions on offering small group health insurance. A carrier that has been banned from writing coverage for small employers in this state pursuant to Section 41-4707(2), Idaho Code, will not resume offering health benefit plans to small employers in this state until the carrier has made a petition to the Director to be reinstated as a small employer carrier and the petition has been approved by the Director. In reviewing a petition, the Director may ask for such information and assurances as the Director finds reasonable and appropriate. (3-31-22)

056. -- 059. (RESERVED)

060. QUALIFYING PREVIOUS AND QUALIFYING EXISTING COVERAGES.

01. Previous Coverage or Existing Coverage. In determining whether a health benefit plan or other health benefit arrangement (whether public or private) is considered qualifying previous coverage or qualifying existing coverage for the purposes of Sections 41-4703(17), 41-4703(23), and 41-4708(3)(c), Idaho Code, a small employer carrier interprets the Act no less favorably to an insured individual than the following: (3-31-22)

a. A health benefit plan, certificate, or other health benefit arrangement is considered employer-based if an employer sponsors the plan or arrangement or makes a contribution to the plan or arrangement. (3-31-22)

02. Source of Previous or Existing Coverage. A small employer carrier will ascertain the source of previous or existing coverage of each eligible employee and each dependent of an eligible employee at the time such employee or dependent initially enrolls into the health benefit plan provided by the small employer carrier. The small employer carrier has the responsibility to contact the source of such previous or existing coverage to resolve any questions about the benefits or limitations related to such previous or existing coverage. (3-31-22)

03. Certification of Creditable Coverage. Small employer carriers will provide written certification of creditable coverage to individuals in accordance with this Subsection. (3-31-22)

a. A small employer carrier satisfies the certification requirements if another person provides the certificate, but only to the extent that information relating to the individual's creditable coverage and waiting or affiliation period has been provided by another person. (3-31-22)

b. To the extent coverage under a health benefit plan consists of group coverage, the plan satisfies the certification requirements if the small employer carrier offering the coverage is prescribed to provide the certificates of creditable coverage to individuals pursuant to an agreement between the plan and the carrier. (3-31-22)

c. A small employer carrier is not obligated to provide information regarding health benefit plan coverage provided to an individual by another person. (3-31-22)

i. If an individual's coverage under a policy ceases before the individual's coverage under the group health plan ceases, the entity that issued the policy provides sufficient information to the small employer carrier, or to another person designated by the carrier, to enable the carrier, or other person, to provide a certificate that reflects the period of coverage under the policy, after the individual's coverage under the group health plan ceases. (3-31-22)

ii. The provision of the information pursuant to Subparagraph 060.03.c.i. to the new carrier satisfies the entity's obligation to provide an automatic certificate. (3-31-22)

iii. The carrier providing the information about creditable coverage cooperates with other carriers in responding to any request for additional information. (3-31-22)

iv. If the individual's coverage under a group health plan ceases, the carrier that issued the group policy provides an automatic certificate of coverage. (3-31-22)

d. A small employer carrier provides a certification of creditable coverage, without charge, to participants or dependents who are or were covered under the group health benefit plan. (3-31-22)

e. A small employer carrier provides a certificate ~~at the time a~~ upon request ~~is made~~ on behalf of an individual or automatically if ~~the~~ such request is not made ~~not later than twenty-four (24) months after~~ within thirty (30) days of the date the individual's coverage ceased under the plan. ~~(3-31-22)~~( )

i. Each small employer carrier establishes a procedure for individuals to request and receive certificates. Upon a receipt of the request, the small employer carrier provides the certificate by the earliest date that the carrier, acting in a reasonable and prompt fashion, can provide the certificate. (3-31-22)

f. The certificate provided includes: (3-31-22)

i. The date the certificate was issued; (3-31-22)

ii. The name of the group health plan that provided the coverage described in the certificate; (3-31-22)

iii. The name of the participant or dependent with respect to whom the certificate applies, and any other information necessary for the plan providing the coverage specified in the certificate to identify the individual, such as the individual's identification number under the plan; (3-31-22)

iv. The name, address, and telephone number of the plan administrator prescribed to provide the certificate; (3-31-22)

v. The telephone number to call for further information regarding the certificate; (3-31-22)

vi. Either a statement that the individual has at least twelve (12) months of creditable coverage, disregarding days of creditable coverage before a significant break in coverage; or the date any waiting period or affiliation period, if applicable, began and the date creditable coverage began; and (3-31-22)

vii. The date creditable coverage ended, unless the certificate indicates that the creditable coverage is continuing as of the date of the certificate. (3-31-22)

g. Small employer carriers may provide a certificate by first-class mail, at the participant's last known address. (3-31-22)

~~**h.** The model for the certification of coverage may be found on the Department of Insurance Internet website.~~ ~~(3-31-22)~~

061. -- 066. (RESERVED)

067. RESTRICTIVE RIDERS.
Except as permitted in Section 41-4708(3), Idaho Code, a small employer carrier will not modify or restrict any health benefit plan with respect to any eligible employee or dependent of an eligible employee, through riders, endorsements or otherwise, for the purpose of restricting or excluding the coverage or benefits provided to such employee or dependent for specific diseases, medical conditions, including but not limited to pregnancy, or services otherwise covered by the plan. (3-31-22)

068. -- 074. (RESERVED)

075. RULES RELATED TO FAIR MARKETING.

01. Small Employer Carrier to Actively Market. A small employer carrier actively markets each of its health benefit plans to small employers in this state. (3-31-22)

~~**02. Marketing Mandated Plans**. In marketing the mandated health benefit plans to small employers, a small employer carrier uses at least the same sources and methods of distribution that it uses to market other health benefit plans to small employers. Any producer authorized by a small employer carrier to market health benefit plans to small employers in the state is also authorized to market the mandated health benefit plans.~~ ~~(3-31-22)~~

0~~3~~2. Offer in Writing. A small employer carrier offers all small group health benefit plans to any small employer that applies for or makes an inquiry regarding health insurance coverage from the small employer carrier. The offer may be provided directly to the small employer or delivered through a producer. The offer is in writing and includes at least the following information: (3-31-22)

a. A general description of the benefits and base rates contained in all actively marketed~~, including but not limited to the mandated, health benefit plans;~~ and ~~(3-31-22)~~( )

b. Information describing how the small employer may enroll in the plans. (3-31-22)

0~~4~~3. Timeliness of Price Quote. A small employer carrier provides a price quote to a small employer (directly or through an authorized producer) within ten (10) working days of receiving a request for a quote and such information as is necessary to provide the quote. A small employer carrier notifies a small employer (directly or through an authorized producer) within five (5) working days of receiving a request for a price quote of any additional information needed by the small employer carrier to provide the quote. (3-31-22)

~~**05. Toll-Free Telephone Service**. A small employer carrier establishes and maintains a toll-free telephone service to provide information to small employers regarding the availability of small employer health benefit plans in this state. The service provides information to callers on how to apply for coverage from the carrier. The information may include the names and phone numbers of producers located geographically proximate to the caller or such other information reasonably designed to assist the caller to locate an authorized producer or to apply for coverage.~~ ~~(3-31-22)~~

0~~6~~4. Restrictions as to Contribution to Association. The small group carrier will not require a small employer to join or contribute to any association or group as a condition of being accepted for coverage by the small employer carrier, except that, if membership in an association or other group is a requirement for accepting a small employer into a particular health benefit plan, a small employer carrier may apply such requirement, subject to the requirements of Section 41-4708, Idaho Code. (3-31-22)

0~~7~~5. No Requirement to Qualify for Other Insurance Product. A small employer carrier will not require, as a condition to the offer of sale of a health benefit plan to a small employer, that the small employer purchase or qualify for any other insurance product or service. (3-31-22)

~~**08. Plans Subject to Requirements**. Carriers offering group health benefit plans in this state are responsible for determining whether the plans are subject to the requirements of the Act and this chapter.~~ ~~(3-31-22)~~

~~**09. Annual Filing Requirement**. A small employer carrier files annually the following information with the Director related to health benefit plans issued by the small employer carrier to small employers in this state on forms prescribed by the Director:~~ ~~(3-31-22)~~

~~**a.** The number of small employers that were covered under health benefit plans in the previous calendar year (separated as to newly issued plans and renewals);~~ ~~(3-31-22)~~

~~**b.** The number of small employers that were covered under the each mandated health benefit plan in the previous calendar year (separated as to newly issued plans and renewals).~~ ~~(3-31-22)~~

~~**c.** The number of small employer health benefit plans in force in each county (or by five (5) digit zip code) of the state as of December 31 of the previous calendar year;~~ ~~(3-31-22)~~

~~**d.** The number of small employer health benefit plans that were voluntarily not renewed by small employers in the previous calendar year;~~ ~~(3-31-22)~~

~~**e.** The number of small employer health benefit plans that were terminated or non-renewed (for reasons other than nonpayment of premium) by the carrier in the previous calendar year; and~~ ~~(3-31-22)~~

~~**f.** The number of health benefit plans that were issued to residents that were uninsured for at least~~

~~sixty-three (63) days prior to issue.~~ ~~(3-31-22)~~

~~**10. Total Number of Residents**. All carriers file annually with the Director, on forms prescribed by the Director, the total number of residents, including spouses and dependents, covered during the previous calendar year under all health benefit plans issued in this state. This includes residents covered under reinsurance by way of excess loss or stop loss plans.~~ ~~(3-31-22)~~

~~**11. Filing Date**. The information described in Subsections 075.09 and 075.10 is filed no later than March 15, each year.~~ ~~(3-31-22)~~

~~**12. Specific Data**. For purposes of this section, health benefit plan information includes policies or certificates of insurance for specific disease, hospital confinement indemnity and stop loss coverages.~~ ~~(3-31-22)~~

076. -- 080. (RESERVED)

081. LIMITATIONS AND EXCLUSIONS.

01. Allowances. A health benefit plan will not limit or exclude coverage by type of illness, accident, treatment, or medical condition, except as follows: (3-31-22)

a. Any service not medically necessary or appropriate unless specifically included within the coverage provisions. (3-31-22)

b. Custodial, convalescent or intermediate level care or rest cures. (3-31-22)

c. Services that are experimental or investigational. (3-31-22)

d. Services eligible for coverage by Workers' Compensation, Medicare or CHAMPUS. (3-31-22)

e. Services for which no charges are made or for which no charges would be made in the absence of insurance or for which the insured has no legal obligation to pay. (3-31-22)

f. Services for weight control, nutrition, and smoking cessation, including self-help and training programs as well as prescription drugs, used in conjunction with such programs and services. (3-31-22)

g. Cosmetic surgery and services, except for treatment or surgery for congenital anomaly and mastectomy reconstruction as described in the Women's Health and Cancer Rights Act. (3-31-22)

h. Artificial insemination, infertility treatment, and the treatment of sexual dysfunction not related to organic disease. (3-31-22)

i. Services for reversal of elective, surgically or pharmaceutically induced infertility. (3-31-22)

j. Vision therapy, tests, glasses, contact lenses and other vision aids. Radial keratotomy, myopic keratomileusis and any surgery involving corneal tissue to alter or correct myopia, hyperopia or stigmatic error. Vision tests and glasses will be covered for children under the age of twelve (12), except in catastrophic health benefit plans. (3-31-22)

k. For treatment of weak, strained, or flat feet, including orthopedic shoes or other supportive devices, or for cutting, removal, or treatment of corns, calluses, or nails other than corrective surgery, or for metabolic or peripheral vascular disease. (3-31-22)

l. One thousand dollars ($1,000) per year limit, subject to the policy deductible, coinsurance, or copayment, on manipulative therapy and related treatment, including heat treatments and ultrasound, of the musculoskeletal structure for other than fractures and dislocations of the extremities. (3-31-22)

m. Dental care or treatment, except for injury sustained while insured under this policy, or as a result

of nondental disease covered by the policy. (3-31-22)

n. Hearing or speech tests without illness being suspect. (3-31-22)

o. Hearing aids, auditory osseointegrated (bone conduction) devices, cochlear implants and examination for or fitting of them~~;~~ -- except for congenital or acquired hearing loss that without intervention may result in cognitive or speech development deficits of a covered dependent child~~;~~ -- covering not less than one (1) device every thirty-six (36) months per ear with loss and not less than forty-five (45) language/speech therapy visits during the first twelve (12) months after delivery of the covered device. ~~(3-31-22)~~( )

p. Private room accommodation charges in excess of the institution's most common semi-private room charge except when prescribed as medically necessary. (3-31-22)

q. Services performed by a member of the insured's family or of the insured's spouse's family. Family includes parents or grandparents of the insured or spouse and any descendants of such parents or grandparents. (3-31-22)

r. Care incurred before the effective date of the person's coverage. (3-31-22)

s. Immunizations and medical exams and tests of any kind not related to treatment of covered injury or disease, except as specifically stated in the policy. (3-31-22)

t. Injury or sickness caused by war or armed international conflict. (3-31-22)

u. Sex change operations and treatment in connection with transsexualism. (3-31-22)

v. Marriage and family and child counseling except as specifically allowed in the policy. (3-31-22)

w. Acupuncture. (3-31-22)

x. Private duty nursing except as specifically allowed in the policy. (3-31-22)

y. Services received from a medical or dental department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group. (3-31-22)

z. Services incurred after the date of termination of a covered person's coverage except as allowed by any extension of benefits provision of the policy. (3-31-22)

aa. Expenses for personal hygiene and convenience items such as air conditioners, humidifiers, and physical fitness equipment. (3-31-22)

bb. Charges for failure to keep a scheduled visit, charges for completion of any form, and charges for medical information. (3-31-22)

cc. Charges for screening examinations except as otherwise provided in the policy. (3-31-22)

dd. Charges for wigs or cranial prostheses, hair analysis, hair loss and baldness. (3-31-22)

ee. Pre-existing conditions, except as provided ~~specifically in the policy~~ by Section 41-4708, Idaho Code. ~~(3-31-22)~~( )

~~i. A health benefit plan will not deny, exclude or limit benefits for a covered individual for covered expenses incurred more than twelve (12) months following the effective date of the individual's coverage due to a pre-existing condition. (3-31-22)~~

~~ii. A health benefit plan waives any time period applicable to a pre-existing condition exclusion or limitation period with respect to particular services for the period of time an individual was previously covered by~~

~~qualifying previous coverage that provided benefits with respect to such services, provided that the qualifying previous coverage was continuous to a date not more than sixty-three (63) days prior to the effective date of the new coverage. This provision does not preclude application of any waiting period applicable to all new enrollees under the health benefit plan.~~ ~~(3-31-22)~~

~~iii. A health benefit plan may exclude coverage for late enrollees for the greater of twelve (12) months or for a twelve (12) months pre-existing condition exclusion; provided that if both a period of exclusion from coverage and a pre-existing condition exclusion are applicable to a late enrollee, the combined period will not exceed twelve (12) months from the date the individual enrolls for coverage under the health benefit plan.~~ ~~(3-31-22)~~

082. -- 999. (RESERVED)

IDAPA 18 – IDAHO DEPARTMENT OF INSURANCE

18.04.13 – THE INDIVIDUAL HEALTH INSURANCE AVAILABILITY ACT

DOCKET NO. 18-0413-2501 (ZBR CHAPTER REWRITE)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2026 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. Should the pending rule be approved, it will become final and effective on July 1 following the Second Regular Session of the Sixty-eighth Idaho Legislature, unless the concurrent resolution states a different effective date.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section(s) 41-211 and 41-5211, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change:

This rule was presented as part of the Department of Insurance's plan to review each rule according to the Governor's Executive Order 2020-01: Zero-Based Regulation, and pursuant to Section 67-5220(1), Idaho Code negotiated rulemaking was conducted. The purpose of this chapter promotes broader spreading of risk in the individual marketplace.

There are no changes to the pending rule, and it is being adopted as originally proposed. The complete text of the proposed rule was published in the August 6, 2025, Idaho Administrative Bulletin, Vol. 25-8, pages 119-134.

FEE SUMMARY: Pursuant to Section 67-5224(2)(d), Idaho Code, a pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature. The following is a description of the fee or charge imposed or increased in this rulemaking: 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:

No fiscal impact.

ASSISTANCE WITH TECHNICAL QUESTIONS: For assistance with technical questions concerning this pending rule, contact Weston Trexler, (208) 334-4214, weston.trexler@doi.idaho.gov.

DATED this 3rd day of October, 2025.

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

THE FOLLOWING NOTICE PUBLISHED WITH THE 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 41-5211, Idaho Code.

PUBLIC HEARING SCHEDULE: A public hearing concerning this rulemaking will be held as follows:

Thursday, August 7, 2025
2:00 p.m. – 4:00 p.m.

In-person participation is available at:
Department of Insurance
700 W. State St. 3rd Floor
Boise, ID 83702

Web meeting link:
Click here to join the meeting
Meeting ID: 237 139 719 159 3
Passcode: jk3o9Ur2
Download Teams | Join on the web

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: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

The purpose of this chapter promotes broader spreading of risk in the individual marketplace.

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

No fee or charge imposed or increased.

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 as a result of this rulemaking: None.

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 May 7, 2025, Idaho Administrative Bulletin, Volume 25-5, pages 52-53 under docket number 18-ZBRR-2501.

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:

No changes are proposed to the materials incorporated by reference. Pursuant to 67-5202, Idaho Code, and to align with rulemaking standards, the incorporation by reference section will have a reference to find these materials on the Department's website.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Weston Trexler, (208) 334-4214, weston.trexler@doi.idaho.gov.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before August 27, 2025.

DATED this 2nd day of July 2025.

THE FOLLOWING IS THE TEXT OF ZBR DOCKET NO. 18-0413-2501

18.04.13 – THE INDIVIDUAL HEALTH INSURANCE AVAILABILITY ACT

000. LEGAL AUTHORITY.
~~Title 41, Chapters 2, 52, and 55,~~Section 41-211, Section 41-5206, and Section 41-5211 Idaho Code. ~~(3-31-22)~~( )

001. ~~TITLE AND~~ SCOPE.

~~**01. Title**. IDAPA 18.04.13, "The Individual Health Insurance Availability Act." (3-31-22)~~

~~**02. Scope**. The Act and t~~This chapter ~~are~~ is intended to promote broader spreading of risk in the individual marketplace. ~~The Act~~ Title 41, Chapter 52 and this chapter ~~are intended to~~ regulate all health benefit plans sold to eligible individuals. Carriers that provide health benefit plans to eligible individuals are ~~intended to be~~ subject to ~~all of the provisions of~~ the Act and this chapter. ~~(3-31-22)~~( )

002. INCORPORATION BY REFERENCE.
The Outline of Coverage for Individual Major Medical Expense Coverage is incorporated by reference into this chapter from the April 1999 version of the National Association of Insurance Commissioners Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Act and may be found on the Department website. ~~(3-31-22)~~( )

003. -- 009. (RESERVED)

010. DEFINITIONS.
~~As used in this chapter:~~ ~~(3-31-22)~~

01. Geographic Area. Geographic areas are limited to six (6) designated areas, with no area being smaller than a county. (3-31-22)

02. Risk Characteristic. Risk Characteristic means the health status, claims experience, duration of coverage, or any similar characteristic related to the health status or claims experience of an individual. Such characteristics can include family composition. (3-31-22)

03. Risk Load. Risk Load means the percentage above the applicable base premium rate that is charged by an individual carrier to the rates of the eligible individual, to reflect the risk characteristics of the eligible individual. (3-31-22)

04. Idaho Resident. Idaho resident means a person who is able to provide satisfactory proof of having resided in Idaho, as their place of domicile for a continuous six (6) month period, for purposes of being an eligible individual pursuant to Section 41-5203(10), Idaho Code. The six (6) month residency requirements would be waived for eligible individuals based on the Health Insurance Portability and Accountability Act of 1996. (3-31-22)

011. POLICY DEFINITIONS.
An insurance policy subject to this chapter will not apply definitions more restrictive than the following: (3-31-22)

01. Accident. "Accident," "accidental injury," and "accidental" is to employ "result" language and does not include words that establish an accidental means test or use words such as "external, violent, visible wounds" or similar words of description or characterization. (3-31-22)

a. "Injury" or "injuries" means accidental bodily injury ~~sustained by the insured person that is the direct cause of the condition for which benefits are provided~~, independent of disease or bodily infirmity or any other cause, and that occurs while the insurance is in force. ~~(3-31-22)~~( )

b. It may exclude injuries for which benefits are provided~~:~~ under workers' compensation, employers' liability, or similar law; or under a motor vehicle no-fault plan, unless the motor vehicle no-fault plan provides for coordination of benefits; or for injuries occurring while the insured person is engaged in any activity pertaining to a trade, business, employment or occupation for wage or profit. ~~(3-31-22)~~( )

~~i. Under workers' compensation, employers' liability, or similar law; or~~ ~~(3-31-22)~~

~~ii. Under a motor vehicle no-fault plan, unless the motor vehicle no-fault plan provides for coordination of benefits; or~~ ~~(3-31-22)~~

~~iii. For injuries occurring while the insured person is engaged in any activity pertaining to a trade, business, employment or occupation for wage or profit.~~ ~~(3-31-22)~~

02. Convalescent Nursing Home. Includes "extended care facility," or "skilled nursing facility." Is to be defined in relation to its status, facility and available services. (3-31-22)

a. Such home or facility is to: (3-31-22)

i. Be operated pursuant to law; (3-31-22)

ii. Be approved for payment of Medicare benefits or be qualified to receive approval for payment of Medicare benefits, if so requested; (3-31-22)

iii. Be primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a duly licensed physician; (3-31-22)

iv. Provide continuous twenty-four (24) hours per day nursing service by or under the supervision of a registered nurse; and (3-31-22)

v. Maintain a daily medical record of each patient. (3-31-22)

b. Such home or facility definition may exclude: (3-31-22)

i. A home, facility or part of a home or facility used primarily for rest; (3-31-22)

ii. A home or facility for the aged or for the care of drug addicts or alcoholics; or (3-31-22)

iii. A home or facility primarily used for the care and treatment of mental or nervous disorders, or for custodial or educational care. (3-31-22)

03. Home Health Care Agency. An agency approved under Medicare, or that is licensed to provide

home health care under applicable state law. (3-31-22)

04. Hospice. A facility licensed, certified or registered in accordance with state law that provides a formal program of care that is: (3-31-22)

a. For terminally ill patients whose life expectancy is less than six (6) months; (3-31-22)

b. Provided on an inpatient or outpatient basis; and (3-31-22)

c. Directed by a physician. (3-31-22)

05. Hospital. Is defined in relation to its status, facilities and available services or to reflect its accreditation by the Joint Commission on Accreditation of Healthcare Organizations, Accreditation of Rehabilitation Facilities or by Medicare. (3-31-22)

a. The term "hospital" may: (3-31-22)

i. Be an institution licensed to operate as a hospital pursuant to law; (3-31-22)

ii. Be primarily and continuously engaged in providing or operating, either on its premises or in facilities available to the hospital on a prearranged basis and under the supervision of a staff of licensed physicians, medical, diagnostic and major surgical facilities for the medical care and treatment of sick or injured persons on an inpatient basis for which a charge is made; and (3-31-22)

iii. Provide twenty-four (24) hour nursing service by or under the supervision of registered nurses. (3-31-22)

b. The term "hospital" may exclude, unless the facility otherwise meets the requirements: (3-31-22)

i. Convalescent homes or, convalescent, rest, or nursing facilities; (3-31-22)

ii. Facilities affording primarily the care and treatment of mental or nervous disorders, or for custodial educational, or rehabilitative care; (3-31-22)

iii. Facilities for the aged, drug addicts, or alcoholics; or (3-31-22)

iv. A military or veterans' hospital, a soldiers' home or a hospital contracted for or operated by any national government or government agency for the treatment of members or ex-members of the armed forces, except for services rendered on an emergency basis where a legal liability for the patient exists for charges made to the individual for the services. (3-31-22)

06. Mental or Nervous Disorders. Neurosis, psychoneurosis, psychosis, or mental or emotional disease or disorder of any kind. (3-31-22)

~~**07. Pre-existing Condition**.~~ ~~(3-31-22)~~

~~**a.** A condition or disease that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care or treatment during the six (6) months immediately preceding the effective date of coverage; (3-31-22)~~

~~**b.** A condition or disease for which medical advice, diagnosis, care or treatment was recommended or received during the six (6) months immediately preceding the effective date of coverage; or (3-31-22)~~

~~**c.** A pregnancy existing on the effective date of coverage.~~ ~~(3-31-22)~~

087. Sickness or Illness. ~~A sickness or disease of an insured person that first manifests itself after the effective date of insurance and while the insurance is in force. It may be further modified to exclude sickness or~~

~~disease for which benefits are provided under a worker's compensation, occupational disease, employers' liability or similar law~~ A sickness or disease of an insured person that presents itself after the effective date of insurance and while the insurance is in force. It may exclude sickness or disease for which benefits are provided under a worker's compensation, occupational disease, employers' liability or similar law. ~~(3-31-22)~~( )

~~**09. Total Disability**. An individual not engaged in any employment or occupation for which the individual is or becomes qualified by reason of education, training or experience, and is not in fact engaged in any employment or occupation for wage or profit.~~ (3-31-22)

~~**a.** It may be defined in relation to the inability of the person to perform duties but will not be based solely upon an individual's inability to:~~ (3-31-22)

~~i. Perform "any occupation whatsoever," "any occupational duty," or "any and every duty of his occupation"; or~~ (3-31-22)

~~ii. Engage in a training or rehabilitation program.~~ (3-31-22)

~~**b.** An insurer may require the complete inability of the person to perform all of the substantial and material duties of his or her regular occupation or words of similar import. An insurer may require care by a provider other than the insured or a member of the insured's immediate family.~~ (3-31-22)

012. ASSESSMENTS.
The Board, prior to March 1st of each year, determines and files with the Director an estimate of the assessments needed to fund the losses incurred by the Idaho ~~Small Employer and~~ Individual ~~Health~~ High Risk Reinsurance Program. ~~The March 1, 2001 assessment anticipated by Section 41-4711, Idaho Code, will consist of the amounts needed to cover the claims cost of the individual policies issued on or before June 30, 2000. This interim assessment is based on the assessment formula set forth in Section 41-4711(12)(c), Idaho Code. Initial or interim assessments paid, on behalf of the Idaho Individual High Risk Reinsurance Pool, will be credited to each carrier's account when the amounts needed to fund losses and pay program expenses are known.~~ ~~(3-31-22)~~( )

013. -- 027. (RESERVED)

028. TRANSITION FOR ASSUMPTIONS OF BUSINESS FROM ANOTHER CARRIER.

01. Conditions for Transfer or Assumption of Entire Insurance Obligation. An individual carrier will not transfer or assume the entire insurance obligation and/or risk of a health benefit plan covering an individual in this state unless: (3-31-22)

a. The transaction received any necessary approval of the insurance supervisory official of the state of domicile of the assuming carrier; (3-31-22)

b. The transaction received any necessary approval of the insurance supervisory official of the state of domicile of the ceding carrier; and, (3-31-22)

c. The transaction meets the other requirements of this Section. (3-31-22)

02. Time Frame for Filing Plan to Assume or Cede Entire Insurance Obligation. A carrier domiciled in this state that proposes to assume or cede the entire insurance obligation and/or risk of one or more individual health benefit plans from another carrier makes a filing for approval with the Director at least sixty (60) days prior to the date of the proposed assumption. The Director may approve the transaction if the Director finds that the transaction is in the best interests of the individuals insured under the health benefit plans to be transferred and is consistent with the purposes of the Act and this chapter. The Director will not approve the transaction until at least thirty (30) days after the date of the filing; except that, if the ceding carrier is in hazardous financial condition, the Director may approve the transaction as soon as the Director deems reasonable. (3-31-22)

03. Filing Requirements. The filing for Subsection 028.02 will: (3-31-22)

a. Describe the health benefit plan (including any eligibility requirements) of the ceding carrier from which the health benefit plans will be ceded; (3-31-22)

b. Describe whether the assuming carrier will maintain the assumed health benefit plans (pursuant to Subsection 028.08) or will incorporate them into existing business (pursuant to Subsection 028.09). If the assumed health benefit plans will be incorporated into existing business, the filing will describe the business of the assuming carrier into which the health benefit plans will be incorporated; (3-31-22)

c. Describe whether the health benefit plans being assumed are currently available for purchase by eligible individuals; (3-31-22)

d. Describe the potential effect of the assumption, if any, on the benefits provided by the health benefit plans to be assumed; (3-31-22)

e. Describe the potential effect of the assumption, if any, on the premiums for the health benefit plans to be assumed; (3-31-22)

f. Describe any other potential material effects of the assumption on the coverage provided to the eligible individuals covered by the health benefit plans to be assumed; and (3-31-22)

g. Include any other information prescribed by the Director. (3-31-22)

04. Informational Filings in Other States. An individual carrier prescribed to make a filing under Subsection 028.02 will also make an informational filing with the Insurance Supervisory Official of each state in which there are individual health benefit plans that would be included in the transaction. The informational filing to each state will be made concurrently with the filing made under Subsection 028.02 and will include at least the information specified in Subsection 028.03 for the individual health benefit plans in that state. (3-31-22)

05. Considerations in the Transfer and Assumption of the Entire Insurance Obligation. An individual carrier will not transfer or assume the entire insurance obligation and/or risk of a health benefit plan covering an eligible individual in this state unless it complies with the following provisions: (3-31-22)

a. The carrier has provided notice to the Director at least sixty (60) days prior to the date of the proposed assumption. The notice contains the information specified in Subsection 028.03 for the health benefit plans covering eligible individuals in this state. (3-31-22)

b. If the assumption of a health benefit plan would result in the assuming individual carrier being out of compliance with the limitations related to premium rates contained in Section 41-5206(1)(a), Idaho Code, the assuming carrier makes a filing with the Director pursuant to Section 41-5206(2), Idaho Code, seeking suspension of the application of Section 41-5206(1)(a), Idaho Code. (3-31-22)

c. An assuming carrier seeking suspension of the application of Section 41-5206(1)(a), Idaho Code, will not complete the assumption of health benefit plans covering eligible individuals in this state unless the Director grants the suspension requested pursuant to Paragraph 028.05.b. (3-31-22)

d. Unless a different period is approved by the Director, a suspension of the application of Section 41-5206(1)(a), Idaho Code, with respect to assumed one (1) or more health benefit plans, is for no more than fifteen (15) months and, with respect to each individual, lasts only until the anniversary date of such individual's coverage (except that the period with respect to an individual may be extended beyond such individual first anniversary date for a period of up to twelve (12) months if the anniversary date occurs within three (3) months of the date of assumption of the health benefit plan). (3-31-22)

06. Exceptions to Ceding or Assumption of Business. Except as provided in Subsection 028.02, an individual carrier will not cede or assume the entire insurance obligation or risk for an individual health benefit plan unless the transaction includes the ceding to the assuming carrier of all business within Idaho which includes such health benefit plan. (3-31-22)

07. Requirements for Ceding Less Than Entire Business. An Individual carrier may cede less than an entire health benefit plan to an assuming carrier if: (3-31-22)

a. One (1) or more eligible individuals in the health benefit plan have exercised their right under contract to reject, either directly or by implication, the ceding of their health benefit plans to another carrier. In that instance, the transaction includes each health benefit plan with the exception of those health benefit plans for which an eligible individual has rejected the proposed cession; or (3-31-22)

b. After a written request from the transferring carrier, the Director determines that the transfer of less than all health benefit plans is in the best interests of the eligible individuals insured. (3-31-22)

08. Separate Health Benefit Plans. Except as provided in Subsection 028.09, an individual carrier that assumes one (1) or more health benefit plans from another carrier may maintain such health benefit plans as a separate health benefit plan. (3-31-22)

09. Restrictions to Apply Eligibility Requirements by Assuming Carrier. An assuming carrier will not apply eligibility requirements, with respect to an assumed health benefit plan (or with respect to any health benefit plan subsequently offered to an eligible individual covered by such an assumed health benefit plan) that are more stringent than the requirements applicable to such health benefit plan prior to the assumption. (3-31-22)

10. Request for Extension of the Transition Period. The Director may approve a longer period of transition upon application of an individual carrier. The application is made within sixty (60) days from assumption of the health benefit plan and clearly states the justification for a longer transition period. (3-31-22)

11. Additional Information. Nothing in this Section or in the Act is intended to: (3-31-22)

a. Reduce or diminish any legal or contractual obligation or requirement, including any obligation provided in Section 41-511, Idaho Code, of the ceding or assuming carrier related to the transaction; (3-31-22)

b. Authorize a carrier not admitted to transact the business of insurance in this state to offer or insure health benefit plans in this state; or (3-31-22)

c. Reduce or diminish the protections related to an assumption reinsurance transaction provided in Section 41-511, Idaho Code, or provided by law. (3-31-22)

029. -- 035. (RESERVED)

036. RESTRICTIONS RELATING TO PREMIUM RATES.
The following provisions are applicable for all individual health benefit plans. (3-31-22)

01. Rate Manual. An individual carrier develops a rate manual for all individual business. Base premium rates and new business premium rates charged to eligible individuals by the individual carrier are computed solely from the applicable rate manual developed pursuant to this Section. To the extent that a portion of the premium rates charged by an individual carrier is based on the carrier's discretion, the manual specifies the criteria and factors considered by the carrier in exercising such discretion. (3-31-22)

02. Requirements for Adjustments to Rating Method. An individual carrier will not modify the rating method used in the rate manual for its individual business until the change has been approved as provided in this Section. The Director may approve a change to a rating method if the Director finds that the change is reasonable, actuarially appropriate, and consistent with the purposes of the Act and this chapter. (3-31-22)

~~**03. Information for Review of Modification of Rating Method**. A carrier may modify the rating method for its individual business only with prior approval of the Director. A carrier requesting to change the rating method for its individual business makes a filing with the Director at least thirty (30) days prior to the proposed date of the change. The filing contains at least the following information: (3-31-22)~~

~~**a.** The reasons the change in rating method is being requested; (3-31-22)~~

~~**b.** A complete description of each of the proposed modifications to the rating method; (3-31-22)~~

~~**c.** A description of how the change in rating method would affect the premium rates currently charged to eligible individuals in the health benefit plan, including an estimate from a qualified actuary of the number of individuals (and a description of the types of individuals) whose premium rates may change by more than ten percent (10%) due to the proposed change in rating method (not generally including increases in premium rates applicable to all individuals in a health benefit plan); (3-31-22)~~

~~**d.** A certification from a qualified actuary that the new rating method would be based on objective and credible data and would be actuarially sound and appropriate; and (3-31-22)~~

~~**e.** A certification from a qualified actuary that the proposed change in rating method would not produce premium rates for eligible individuals that would be in violation of Section 41-5206, Idaho Code. (3-31-22)~~

043. Change in Rating Method. For the purpose of this Section a change in rating method means: (3-31-22)

a. A change in the number of case characteristics used by an individual carrier to determine premium rates for health benefit plans in its individual business (an individual carrier will not use case characteristics other than age, individual tobacco use, geography or gender without prior approval of the Director); (3-31-22)

b. A change in the method of allocating expenses among health benefit plans; or (3-31-22)

c. A change in a rating factor with respect to any case characteristic if the change would produce a change in premium for any individual that exceeds ten percent (10%). (3-31-22)

d. For the purpose of this Subsection, a change in a rating factor means the cumulative change with respect to such factor considered over a twelve (12) month period. If an individual carrier changes rating factors with respect to more than one case characteristic in a twelve (12) month period, the carrier considers the cumulative effect of all such changes in applying the ten percent (10%) test. (3-31-22)

~~**05. Rate Manual to Specify Case Characteristics and Rate Factors**. The rate manual developed pursuant to Subsection 036.01 specifies the case characteristics and rate factors to be applied by the individual carrier in establishing premium rates for the health benefit plans. (3-31-22)~~

~~**06. Prior Approval of Case Characteristics**. An individual carrier will not use case characteristics other than those specified in Section 41-5206(1)(f), Idaho Code, without the prior approval of the Director. An individual carrier seeking such an approval makes a filing with the Director for a change in rating method under Subsection 036.02. (3-31-22)~~

~~**07. Uniform Application of Case Characteristics**. An individual carrier uses the same case characteristics in establishing premium rates for each health benefit plan and applies them in the same manner in establishing premium rates for each such health benefit plan. Case characteristics are applied without regard to the risk characteristics of an eligible individual. (3-31-22)~~

~~**08. Base Premium Rates and Any Difference in New Business Rate**. The rate manual developed pursuant to Subsection 036.01 clearly illustrates the relationship among the base premium rates charged for each health benefit plan. If the new business premium rate is different than the base premium rate for a health benefit plan, the rate manual illustrates the difference. (3-31-22)~~

~~**09. Reasonable and Objective Rate Differences**. Differences among base premium rates for health benefit plans are based solely on the reasonable and objective differences in the design and benefits of the health benefit plans and cannot be based in any way on the actual or expected health status or claims experience of the eligible individual or groups that choose or are expected to choose a particular health benefit plan. An individual carrier applies case characteristics and rate factors within its health benefit plans in a manner that assures that premium differences among health benefit plans for identical individuals vary only due to reasonable and objective~~

~~differences in the design and benefits of the health benefit plans and are not due to the actual or expected health status or claims experience of the individuals that choose or are expected to choose a particular health benefit plan.~~ ~~(3-31-22)~~

~~**10. Two-Step Process**. The rate manual developed pursuant to Subsection 036.01 provides for premium rates to be developed in a two (2) step process. In the first step, a base premium rate is developed for the eligible individual without regard to any risk characteristics. In the second step, the resulting base premium rate may be adjusted by a risk load, subject to the provisions of Section 41-5206, Idaho Code, to reflect the risk characteristics of the individual.~~ ~~(3-31-22)~~

~~11~~04. ~~Exception to~~ **Application Fee, Underwriter Fee or Other Fees**. ~~Except as provided in Subsection 036.12, a premium charged to an individual for a health benefit plan~~ A carrier will not ~~include~~ charge an individual a separate application fee, underwriting fee, or any other separate fee ~~or charge~~ beyond the premium for a health benefit plan. ~~(3-31-22)~~( )

~~**12. Uniform Application of Fees**. A carrier may charge a separate fee with respect to a health benefit plan provided the fee is applied in a uniform manner to all health benefit plans. All such fees are premium and are included in determining compliance with the Act and this chapter.~~ ~~(3-31-22)~~

~~**13. Uniform Allocation of Administration Expenses**. The rate manual developed pursuant to Subsection 036.01 describes the method of allocating administrative expenses to the health benefit plans for which the manual was developed.~~ ~~(3-31-22)~~

~~14~~05. **Rate Manual to be Maintained for a Period of Six Years**. Each rate manual developed pursuant to Subsection 036.01 is maintained by the carrier for a period of six (6) years. Updates and changes to the manual are maintained with the manual. (3-31-22)

~~**15. Guidelines Issued by Director**. The rate manual and rating practices of an individual carrier comply with any guidelines issued by the Director.~~ ~~(3-31-22)~~

~~**16. Application of Restrictions Related to Changes in Premium Rates**. The restrictions related to changes in premium rates are set forth in Section 41-5206(1)(b), Idaho Code, and are applied as follows:~~ ~~(3-31-22)~~

~~**a.** An individual carrier revises its rate manual each rating period to reflect changes in base premium rates and changes in new business premium rates.~~ ~~(3-31-22)~~

~~**b.** If, for any health benefit plan with respect to any rating period, the percentage change in the new business premium rate is less than or the same as the percentage change in the base premium rate, the change in the new business premium rate is the change in the base premium rate for the purposes of Sections 41-5206(1)(b)(i) and 41-5206(1)(d)(i), Idaho Code.~~ ~~(3-31-22)~~

~~**c.** If for any health benefit plan with respect to any rating period, the percentage change in the new business premium rate exceeds the percentage change in the base premium rate, the health benefit plan is considered a health benefit plan into which the individual carrier is no longer enrolling new eligible individuals for the purposes of Section 41-5206(1)(b)(i), Idaho Code.~~ ~~(3-31-22)~~

~~**d.** If, for any rating period, the change in the new business premium rate for a health benefit plan differs from the change in the new business premium rate for any other health benefit plan by more than twenty percent (20%), the carrier makes a filing with the Director containing a complete explanation of how the respective changes in new business premium rates were established and the reason for the difference. The filing is made within thirty (30) days of the beginning of the rating period.~~ ~~(3-31-22)~~

~~**e.** An individual carrier keeps on file for a period of at least six (6) years the calculations used to determine the change in base premium rates and new business premium rates for each health benefit plan for each rating period.~~ ~~(3-31-22)~~

~~**17. Change in Premium Rate**. Except as provided in Subsection 036.18, a change in premium rate for~~

~~an eligible individual produces a revised premium rate that is no more than the following:~~ ~~(3-31-22)~~

~~**a.** The base premium rate for the eligible individual, given its present composition, (as shown in the rate manual as revised for the rating period), multiplied by:~~ ~~(3-31-22)~~

~~**b.** One (1) plus the sum of:~~ ~~(3-31-22)~~

~~i. The risk load applicable to the eligible individual during the previous rating period; and~~ ~~(3-31-22)~~

~~ii. Fifteen percent (15%) (prorated for periods of less than one (1) year).~~ ~~(3-31-22)~~

~~**18. Plans No Longer Enrolling New Business**. In the case of a health benefit plan into which an Individual carrier is no longer enrolling new Individuals, a change in premium rate for an Individual will produce a revised premium rate that is no more than the base premium rate for the Individual (given its present composition and as shown in the rate manual in effect for the Individual at the beginning of the previous rating period), multiplied by Paragraphs 036.18.a. and 036.18.b.;~~ ~~(3-31-22)~~

~~**a.** One (1) plus the lesser of:~~ ~~(3-31-22)~~

~~i. The change in the base rate; or~~ ~~(3-31-22)~~

~~ii. The percentage change in the new business premium for the most similar health benefit plan into which the Individual carrier is enrolling new Individuals.~~ ~~(3-31-22)~~

~~**b.** One (1) plus the sum of:~~ ~~(3-31-22)~~

~~i. The risk load applicable to the Individual during the previous rating period; and~~ ~~(3-31-22)~~

~~ii. Fifteen percent (15%) (prorated for periods of less than one (1) year).~~ ~~(3-31-22)~~

~~**19. Limitations on Revised Premium Rate**. Notwithstanding the provisions of Subsections 036.17 and 036.18, a change in premium rate for an Individual will not produce a revised premium rate that would exceed the limitations on rates provided in Section 41-5206, Idaho Code.~~ ~~(3-31-22)~~

037. -- 045. (RESERVED)

046. REQUIREMENT TO INSURE INDIVIDUALS.

01. Offer of Coverage. An individual carrier that offers coverage to an individual will offer to provide coverage to each eligible individual and to each eligible dependent of an eligible individual. (3-31-22)

02. Risk Characteristics. Individuals are accepted for coverage by the individual carrier without any restrictions or limitations on coverage related to the risk characteristics of the Individual or their dependents, except that a carrier may exclude or limit coverage for pre-existing medical conditions, consistent with the provisions provided in Section 41-5208(3), Idaho Code. (3-31-22)

~~**03. Risk Load**. An individual carrier may assess a risk load to the premium rate associated with a new entrant, consistent with the requirements of Section 41-5206, Idaho Code. The risk load is the same risk load charged to the Individual immediately prior to acceptance of the new entrant into the health benefit plan.~~ ~~(3-31-22)~~

043. Rescission. When material application misstatements are found, rescission action by the carrier may be taken at the carrier's option. When rescission action is taken, premiums are refunded less any claims which had been paid prior to the date the rescission was initiated. At the carrier's option, the carrier may seek to recover any amounts of claims paid in excess of premiums paid. The applicable contract or coverage is considered null and void. (3-31-22)

054. Coverage Rescinded for Fraud or Misrepresentation. Any individual whose coverage is

subsequently rescinded for fraud or misrepresentation will not be an "eligible individual" for a period of twelve (12) months from the effective date of the termination of the individual coverage and cannot be deemed to have "qualifying previous coverage" under Title 41, Chapter 22, 47, 52, or 55, Idaho Code; provided such limitations are not in conflict with the Health Insurance Portability and Accountability Act of 1996. (3-31-22)

065. Certification of Creditable Coverage. (3-31-22)

a. Individual carriers will provide written certification of creditable coverage to individuals in accordance with this Subsection. (3-31-22)

b. The certification of creditable coverage is provided: (3-31-22)

i. At the time an individual ceases to be covered under the health benefit plan or otherwise becomes covered under a COBRA continuation provision; (3-31-22)

ii. In the case of an individual who becomes covered under a COBRA continuation provision, at the time the individual ceases to be covered under that provision; and (3-31-22)

iii. The individual carrier provides ~~S~~such certification ~~is automatically provided by the individual carrier or at the time a~~ upon request ~~is made~~ on behalf of an individual or automatically if ~~the~~ such request is not made ~~not later than twenty-four (24) months after~~ within thirty (30) days of the date of cessation of coverage described in Paragraphs 046.06.b.i. and 046.06.b.ii.~~, whichever is later.~~ ~~(3-31-22)~~( )

c. The certificate of creditable coverage contains: (3-31-22)

i. Written certification of the period of creditable coverage of the individual under the health benefit plan; and (3-31-22)

ii. The waiting period, if any, and if applicable, affiliation period imposed with respect to the individual for any coverage under the health benefit plan. (3-31-22)

047. -- 054. (RESERVED)

055. APPLICATION TO REENTER STATE.

01. Restrictions on Offering Individual Health Insurance. An individual carrier that has been banned from writing coverage for individuals in this state pursuant to Section 41-5207(2), Idaho Code, will not resume offering health benefit plans to individuals in this state until the carrier has made a petition to the Director to be reinstated as an individual carrier and the petition has been approved by the Director. In reviewing a petition, the Director may ask for such information and assurances as the Director finds reasonable and appropriate. (3-31-22)

02. Geographic Service Areas. In the case of an individual carrier doing business in an established geographic service area of the state, if the individual carrier elects to non-renew a health benefit plan under Section 41-5207(3), Idaho Code, the individual carrier is banned from offering health benefit plans to individuals in that service area for a period of five (5) years. (3-31-22)

056. -- 059. (RESERVED)

060. QUALIFYING PREVIOUS AND QUALIFYING EXISTING COVERAGES.

01. Previous Coverage or Existing Coverage. In determining whether a health benefit plan or other health benefit arrangement (whether public or private) is considered qualifying previous coverage or qualifying existing coverage for the purposes of Sections 41-5203(20), and 41-5208(3), Idaho Code, an individual carrier interprets the Act no less favorably to an insured individual than the following: (3-31-22)

a. An individual carrier ascertains the source of previous or existing coverage of each eligible individual and each dependent of an eligible individual at the time such individual or dependent initially enrolls into

the health benefit plan provided by the individual carrier. (3-31-22)

061. -- 066. (RESERVED)

067. RESTRICTIVE RIDERS.
Except as permitted in Section 41-5208(3), Idaho Code, an individual carrier will not modify or restrict any health benefit plan with respect to any eligible individual or dependent of an eligible individual, through riders, endorsements or otherwise, for the purpose of restricting or excluding the coverage or benefits provided to such individual or dependent for specific diseases, medical conditions or services otherwise covered by the plan. (3-31-22)

068. -- 074. (RESERVED)

075. RULES RELATED TO FAIR MARKETING.

01. Individual Carrier to Actively Market. An individual carrier actively markets each of its health benefit plans to individuals in this state. (3-31-22)

02. Offer. An individual carrier offers all health benefit plans to any individual that applies for or makes an inquiry regarding health insurance coverage from the individual carrier. ~~The offer may be provided directly to the individual or delivered through a producer.~~ The offer is in writing and includes at least the following information: ~~(3-31-22)~~( )

a. A general description of the benefits contained in the all actively marketed health benefit plans; and (3-31-22)

b. Information describing how the individual may enroll in the plans. (3-31-22)

043. Timeliness of Price Quote. An individual carrier provides a price quote to an individual (directly or through an authorized producer) within fifteen (15) working days of receiving a request for a quote and such information as is necessary to provide the quote. An individual carrier notifies an individual (directly or through an authorized producer) within ten (10) working days of receiving a request for a price quote of any additional information needed by the individual carrier to provide the quote. (3-31-22)

~~**05. Restrictions as to Application Process**. An individual carrier will not apply more stringent or detailed requirements related to the application process for the mandated health benefit plans than are applied for other health benefit plans offered by the carrier.~~ ~~(3-31-22)~~

~~**06. Denial of Coverage**. If an individual carrier denies coverage under a health benefit plan to an individual on the basis of a risk characteristic, the denial is in writing and maintained in the individual carrier's office. This written denial states with specificity the risk characteristic(s) of the individual that made it ineligible for the health benefit plan it requested (for example, health status). The denial is accompanied by a written explanation of the availability of any mandated health benefit plans from the individual carrier. The explanation includes at least the following:~~ ~~(3-31-22)~~

~~**a.** A general description of the benefits contained in each such plan;~~ ~~(3-31-22)~~

~~**b.** A price quote for each such plan; and~~ ~~(3-31-22)~~

~~**c.** Information describing how the individual may enroll in such plans.~~ ~~(3-31-22)~~

~~**d.** The written information described in this paragraph may be provided within the time periods provided in Subsection 075.04 directly to the individual or delivered through an authorized producer.~~ ~~(3-31-22)~~

~~**07. Premium Rate Charged**. The price quote prescribed under Paragraph 075.06.b. is for the lowest premium rate charged under the rating system for a health benefit plan for which the individual is eligible.~~ ~~(3-31-22)~~

~~**08. Toll-Free Telephone Service**. An individual carrier establishes and maintains a toll-free telephone service to provide information to individuals regarding the availability of individual health benefit plans in this state. The service provides information to callers on how to apply for coverage from the carrier. The information may include the names and phone numbers of producers located geographically proximate to the caller or such other information reasonably designed to assist the caller to locate an authorized producer or to apply for coverage. (3-31-22)~~

0~~9~~4. **No Requirement to Qualify for Other Insurance Product**. An individual carrier will not require, as a condition to the offer of sale of a health benefit plan to an individual, that the individual purchase or qualify for any other insurance product or service. (3-31-22)

~~**10. Plans Subject to Requirements**. Carriers offering individual health benefit plans in this state are responsible for determining whether the plans are subject to the requirements of the Act and this chapter. (3-31-22)~~

~~**11. Annual Filing Requirement**. An individual carrier files annually the following information with the Director related to health benefit plans issued by the individual carrier to individuals in this state on forms prescribed by the Director: (3-31-22)~~

~~**a.** The number of individuals that were covered under health benefit plans in the previous calendar year (separated as to newly issued plans and renewals); (3-31-22)~~

~~**b.** The number of individuals that were covered under each mandated health benefit plan in the previous calendar year (separated as to newly issued plans and renewals). (3-31-22)~~

~~**c.** The number of individual health benefit plans in force in each county (or by five (5) digit zip code) of the state as of December 31 of the previous calendar year; (3-31-22)~~

~~**d.** The number of individual health benefit plans that were voluntarily not renewed by Individuals in the previous calendar year; (3-31-22)~~

~~**e.** The number of individual health benefit plans that were terminated or non renewed (for reasons other than nonpayment of premium) by the carrier in the previous calendar year; and (3-31-22)~~

~~**f.** The number of health benefit plans that were issued to residents that were uninsured for at least the sixty-three (63) days prior to issue. (3-31-22)~~

~~**12. Total Number of Residents**. All carriers file annually with the Director, on forms prescribed by the Director, the total number of residents, including spouses and dependents, covered during the previous calendar year under all health benefit plans issued in this state. This includes residents covered under reinsurance by way of excess loss and stop loss plans. (3-31-22)~~

~~**13. Filing Date**. The information described in Subsections 075.11 and 075.12 is filed no later than March 15, each year. (3-31-22)~~

~~**14. Specific Data**. For purposes of this section, health benefit plan information includes policies or certificates of insurance for specific disease, hospital confinement indemnity, reinsurance by way of excess loss, and stop loss coverages. (3-31-22)~~

076. -- 080. (RESERVED)

081. BANNED POLICY PROVISIONS.

01. Probationary or Waiting Period. ~~Except as provided in Subsection 081.02 for a pre-existing condition, a~~ A policy cannot contain provisions establishing a probationary or waiting period during which no coverage is provided under the policy. ~~(3-31-22)~~( )

~~**02. Pre-existing Conditions**. A policy will not deny, exclude or limit benefits for covered expenses~~

~~incurred more than twelve (12) months following the effective date of the coverage due to a pre-existing condition.~~ ~~(3-31-22)~~

~~**a.** A policy waives any time period applicable to a pre-existing condition exclusion or limitation period with respect to particular services for the period of time an individual was previously covered by qualifying previous coverage to the extent such previous coverage 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.~~ ~~(3-31-22)~~

~~**b.** A carrier will not modify a policy with respect to an individual or dependent through riders, endorsements, or otherwise, to restrict or exclude coverage for specifically named pre-existing conditions otherwise covered by the policy.~~ ~~(3-31-22)~~

0~~3~~2. **Exclusions**. A policy cannot limit or exclude coverage by type of illness, accident, treatment or medical condition, except that a policy may include one or more of the following limitations or exclusions: (3-31-22)

~~**a.** Pre-existing conditions, except for congenital anomalies of a covered dependent child;~~ ~~(3-31-22)~~

~~**b.** Mental or nervous disorders, alcoholism and drug addiction;~~ ~~(3-31-22)~~

~~**c.** Pregnancy, except for complications of pregnancy;~~ ~~(3-31-22)~~

~~**d**~~**a.** Illness, treatment or medical condition arising out of: (3-31-22)

i. War or act of war (whether declared or undeclared); participation in a felony, riot or insurrections; service in the armed forces or units auxiliary to it; (3-31-22)

ii. Suicide (sane or insane), attempted suicide or intentionally self-inflicted injury; and (3-31-22)

iii. Professional aviation for wage or profit; (3-31-22)

~~**e**~~**b.** Cosmetic surgery, except that "cosmetic surgery" cannot include reconstructive surgery when the service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part; reconstructive surgery because of congenital disease or anomaly of a covered dependent child; or involuntary complications related to a cosmetic procedure; (3-31-22)

~~**f**~~**c.** Foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet; (3-31-22)

~~**g**~~**d.** Care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion, or subluxation in the human body for purposes of removing nerve interference and the effects of it, where the interference is the result of or related to distortion, misalignment or subluxation of, or in the vertebral column; (3-31-22)

~~**h**~~**e.** Benefits in excess of Medicare eligible expense, if enrolled in Medicare or other governmental program (except Medicaid), or benefits provided under a state or federal worker's compensation law, employers liability or occupational disease law, or motor vehicle no-fault law unless the motor vehicle no-fault plan provides for coordination of benefits; services performed by a member of the covered person's immediate family; and services for which no charge is normally made in the absence of insurance; (3-31-22)

~~**i**~~**f.** Dental care or treatment; (3-31-22)

~~**j**~~**g.** Eye glasses and the examination for the prescription or fitting of them; (3-31-22)

~~**k**~~**h.** Rest cures, custodial care, transportation, and routine physical examinations; (3-31-22)

~~**l**~~**i.** Territorial limitations; (3-31-22)

~~m~~j. Hearing aids, auditory osseointegrated (bone conduction) devices, cochlear implants and examination for or fitting of them, except for congenital or acquired hearing loss that without intervention may result in cognitive or speech development deficits of a covered dependent child, covering not less than one (1) device every thirty-six (36) months per ear with loss and not less than forty-five (45) language/speech therapy visits during the first twelve (12) months after delivery of the covered device; (3-31-22)

~~n~~k. Missed or cancelled appointments; completion of claim forms or records copying; failure to vacate a room on or before the facility's established discharge hour; educational and training services except as provided by the policy; over the counter medical supplies, consumable or disposable supplies, including but not limited to elastic stockings, ace bandages, gauze, alcohol swabs or dressings; (3-31-22)

~~o~~l. Treatment, services or supplies not prescribed by or upon the direction of a licensed provider, acting within the scope of his or her license; (3-31-22)

~~p~~m. Services rendered prior to the effective date of coverage or after termination of coverage, except as provided by an extension of benefits provision; and (3-31-22)

~~q~~n. The reversal of an elective sterilization procedure, including but not limited to vasovasostomy or salpingoplasty. (3-31-22)

082. GENERAL MINIMUM STANDARDS.
An insurance policy subject to this chapter cannot be offered, delivered or issued for delivery, continued or renewed in this state unless it meets the following minimum standards. (3-31-22)

01. Outline of Coverage. An insurer will deliver an outline of coverage to an applicant or enrollee with the sale, which complies with the model outline of coverage established by the National Association of Insurance Commissioners ("NAIC"), incorporated herein in Section 002. (3-31-22)

a. If an outline of coverage was delivered at the time of application or enrollment and the policy is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy will accompany the policy when it is delivered and contain the following statement in no less than twelve (12) point type, immediately above the company name: "NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon (application) (enrollment), and the coverage originally applied for has not been issued." (3-31-22)

b. In any case where the prescribed outline of coverage is inappropriate for the coverage provided by the policy, an alternate outline of coverage is to be submitted to the Director for prior written approval. (3-31-22)

02. Coverage of Dependents. A policy will consider as an eligible dependent a child who is chiefly dependent on the insured for support and maintenance and who is incapable of self-sustaining employment due to intellectual disability or physical disability on the date that the child's coverage would otherwise terminate under the policy due to the attainment of a specified age for children. The policy may require that within thirty-one (31) days of such date the company receives due proof of the incapacity, in order for the insured to elect to continue the policy in force with respect to the child, or that a separate converted policy be issued at the option of the insured or policyholder. ~~(3-31-22)~~( )

03. Limitation on Termination of Coverage of Dependent. A policy cannot provide for termination of coverage of a covered dependent solely because of the occurrence of an event specified for termination of coverage of the insured, other than nonpayment of premium. In addition, the policy will provide that in the event of the insured's death, the spouse or dependent of the insured, if covered under the policy, will become the insured. (3-31-22)

~~**04. Continuous Loss Extension**. Termination of the policy will be without prejudice to a continuous loss that commenced while the policy was in force. Such extension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. (3-31-22)~~

~~**05. Pregnancy Benefit Extension**. In the event the insurer cancels or refuses to renew, policies providing pregnancy benefits will provide for an extension of benefits as to pregnancy commencing while the policy is in force and for which benefits would have been payable had the policy remained in force. (3-31-22)~~

064. Expenses of Live Donor. A policy providing coverage for the recipient in a transplant operation also provides reimbursement of any medical expenses of a live donor to the extent that benefits remain and are available under the recipient's policy or certificate, after benefits for the recipient's own expenses have been paid. (3-31-22)

075. Fractures or Dislocations. A policy providing coverage for fractures or dislocations will not provide benefits only for "full or complete" fractures or dislocations. (3-31-22)

086. Coinsurance. Except for out-of-network benefits offered as part of a managed care plan, a coinsurance percentage will not exceed fifty percent (50%) of covered charges. A coinsurance percentage for out-of-network benefits offered as part of a managed care plan will not exceed sixty percent (60%) of covered charges. (3-31-22)

083. -- 100. (RESERVED)

101. DISCLOSURE PROVISIONS.

01. Requisite Provisions. Each policy will include a renewal, continuation or nonrenewal provision. The language or specification of the provision will be consistent with the type of contract to be issued. The provision will be appropriately captioned, will appear on the first page of the policy, and will clearly state the duration, where limited, of renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed. (3-31-22)

02. Added Riders or Endorsements. Riders or endorsements added to a policy after date of issue or at reinstatement or renewal that reduce or eliminate benefits or coverage in the policy require signed acceptance by the policyholder. After date of policy issue, any rider or endorsement that increases benefits or coverage with a concomitant increase in premium during the policy term will be agreed to in writing and signed by the policyholder, except if the increased benefits or coverage is prescribed by law. (3-31-22)

03. Separate Additional Premium. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge is set forth in the policy. (3-31-22)

04. Requisite Definition of Terms. A policy that provides for the payment of benefits based on standards described as "usual and customary," "reasonable and customary," or words of similar import will include a definition of the terms and an explanation of the terms in its accompanying outline of coverage. (3-31-22)

05. Pre-existing Conditions Limitations. If a policy contains any limitations with respect to pre-existing conditions, the limitations will appear as a separate paragraph of the policy and be labeled as "Pre-existing Condition Limitations." (3-31-22)

06. Requisite Notice. All policies will have a notice prominently printed on the first page of the policy stating in substance that the policyholder has the right to return the policy within ten (10) days of its delivery and have the premium refunded if, after examination of the policy, the policyholder holder is not satisfied for any reason. (3-31-22)

102. -- 999. (RESERVED)

IDAPA 18 – IDAHO DEPARTMENT OF INSURANCE

18.04.14 – COORDINATION OF BENEFITS

DOCKET NO. 18-0414-2501 (ZBR CHAPTER REWRITE)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2026 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. Should the pending rule be approved, it will become final and effective on July 1 following the Second Regular Session of the Sixty-eighth Idaho Legislature, unless the concurrent resolution states a different effective date.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section(s) 41-211 and 41-2141, and 41-2216, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change:

This rule was presented as part of the Department of Insurance's plan to review each rule according to the Governor's Executive Order 2020-01: Zero-Based Regulation, and pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. The purpose of this chapter allows plans to include a coordination of benefits (COB) provision; establish a uniform order of benefit determination; provides authority for the transfer of information and funds; reduces duplication of benefits and claim payment delays; requires COB provisions be consistent with this rule; and provides efficiency in processing claims.

There are no changes to the pending rule, and it is being adopted as originally proposed. The complete text of the proposed rule was published in the August 6, 2025, Idaho Administrative Bulletin, Vol. 25-8, pages 135-144.

FEE SUMMARY: Pursuant to Section 67-5224(2)(d), Idaho Code, a pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature. The following is a description of the fee or charge imposed or increased in this rulemaking: 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:

No fiscal impact.

ASSISTANCE WITH TECHNICAL QUESTIONS: For assistance with technical questions concerning this pending rule, contact Weston Trexler, (208) 334-4214, weston.trexler@doi.idaho.gov.

DATED this 3rd day of October, 2025.

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

THE FOLLOWING NOTICE PUBLISHED WITH THE 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, 41-2141, and 41-2216, Idaho Code.

PUBLIC HEARING SCHEDULE: A public hearing concerning this rulemaking will be held as follows:

Thursday, August 7, 2025
2:00 p.m. – 4:00 p.m.

In-person participation is available at:
Department of Insurance
700 W. State St. 3rd Floor
Boise, ID 83702

Web meeting link:
Click here to join the meeting
Meeting ID: 237 139 719 159 3
Passcode: jk3o9Ur2
Download Teams | Join on the web

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: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

The purpose of this chapter allows plans to include a coordination of benefits (COB) provision; establish a uniform order of benefit determination; provides authority for the transfer of information and funds; reduces duplication of benefits and claim payment delays; requires COB provisions be consistent with this rule; and provides efficiency in processing claims.

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

No fee or charge imposed or increased.

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 as a result of this rulemaking: None.

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 May 7, 2025, Idaho Administrative Bulletin, Volume 25-5, pages 52-53 under docket number 18-ZBRR-2501.

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:

No changes are proposed to the materials incorporated by reference. Pursuant to 67-5202, Idaho Code, and to align with rulemaking standards, the incorporation by reference section will provide specific references with direct links to the materials stated within the chapter.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Weston Trexler, (208) 334-4214, weston.trexler@doi.idaho.gov.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before August 27, 2025.

DATED this 2nd day of July, 2025.

THE FOLLOWING IS THE TEXT OF ZBR DOCKET NO. 18-0414-2501

18.04.14 – COORDINATION OF BENEFITS

000. LEGAL AUTHORITY.
~~Title 41, Chapters 2, 21, 22 and 34,~~Section 41-211, Section 41-2141, Section 41-2216, and Section 41-3434 Idaho Code. ~~(3-31-22)~~( )

001. ~~TITLE AND~~ SCOPE.

~~01.~~ ~~Title~~. ~~IDAPA 18.04.14, "Coordination of Benefits."~~ ~~(3-31-22)~~

~~02.~~ ~~Scope~~. ~~This chapter applies to all plans, as defined~~ below. It allows plans to include a coordination of benefits (COB) provision unless banned by federal law; establish a uniform order of benefit determination under which plans pay claims; provide authority for the orderly transfer of necessary information and funds between plans; reduce duplication of benefits by permitting a reduction of the benefits to be paid by plans that, pursuant to these rules, do not pay their benefits first; reduce claims payment delays; and require that COB provisions be consistent with this rule; and provide greater efficiency in the processing of claims when a person is covered under more than one (1) plan. ~~(3-31-22)~~( )

002. INCORPORATION BY REFERENCE.
This rule incorporates by reference the full text of the National Association of Insurance Commissioners (NAIC) Model Coordination of Benefits Contract Provisions (Appendix A) and the NAIC Consumer Explanatory Booklet (Appendix B), published as part of the NAIC 2013 Coordination of Benefits model regulation and available on the Idaho Department of Insurance website. (3-31-22)

003. -- 009. (RESERVED)

010. DEFINITIONS.
~~As used in this chapter, these words and terms have the following meanings, unless the context clearly indicates otherwise:~~ ~~(3-31-22)~~

01. Allowable Expense. Any health care expense including coinsurance or copayments, and without reduction for any applicable deductible that is covered in full or in part by any of the plans covering the person. If a

plan is advised by a covered person that all plans covering the person are high-deductible health plans and the person intends to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code of 1986, the primary high-deductible health plan's deductible is not an allowable expense, except for any health care expense incurred that will not be subject to the deductible as described in Section 223 (c) (2) (C) of the Internal Revenue Code of 1986. An expense that a provider by law or in accordance with contractual agreement is banned from charging a covered person is not an allowable expense. An expense or a portion of an expense that is not covered by any of the plans is not an allowable expense. (3-31-22)

a. The following are examples of expenses or services that are not an allowable expense: (3-31-22)

i. If a covered person is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room (unless the patient's stay in the private hospital room is medically necessary in terms of generally accepted medical practice, or one of the plans provides coverage for private hospital rooms) is not an allowable expense. (3-31-22)

ii. If a person is covered by two (2) or more plans that compute their benefit payments on the basis of usual and customary fees, or relative value schedule reimbursement or other similar reimbursement methodology, any amount charged by the provider in excess of the highest reimbursement amount for a specified benefit is not an allowable expense. (3-31-22)

iii. If a person is covered by two (2) or more plans that provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees is not an allowable expense. (3-31-22)

iv. If a person is covered by one plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangement is the allowable expense for all plans. However, if the provider has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the provider's contract permits, that negotiated fee or payment is the allowable expense used by the secondary plan to determine its benefits. (3-31-22)

b. The definition of the "allowable expense" may exclude certain types of coverage or benefits such as dental care, vision care, prescription drug or hearing aids. A plan that limits the application of COB to certain coverages or benefits may limit the definition of Allowable Expenses in its contract to expenses that are similar to the expenses that it provides. When COB is restricted to specific coverages or benefits in a contract the definition of "~~A~~allowable ~~E~~expense" includes similar expenses to which COB applies. ~~(3-31-22)~~(____)

c. When a plan provides benefits in the form of service, the reasonable cash value of each service will be considered as an allowable expense and a benefit paid. (3-31-22)

d. The amount of the reduction may be excluded from allowable expense when a covered person's benefits are reduced under a primary plan: (3-31-22)

i. Because the covered person does not comply with the plan provisions concerning second surgical opinions or precertification of admissions or services: or (3-31-22)

ii. Because the covered person has a lower benefit because the covered person did not use a preferred provider. (3-31-22)

02. Birthday. Refers only to month and day in a calendar year and does not include the year in which the individual is born. (3-31-22)

03. Claim. A request that benefits of a plan be provided or paid. The benefits claimed may be in the form of: (3-31-22)

a. Services (including supplies); (3-31-22)

b. Payment for all or a portion of the expenses incurred; (3-31-22)

c. A combination of Paragraphs 010.03.a. and 010.03.b. of this chapter; or (3-31-22)

d. An indemnification. (3-31-22)

04. Closed Panel Plan. A plan that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the plan, and that excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member. (3-31-22)

05. Consolidated Omnibus Budget Reconciliation Act of 1985 or "COBRA". Coverage provided under a right of continuation pursuant to federal law. (3-31-22)

06. Coordination of Benefits (COB). A provision establishing an order in which plans pay their claims, and permitting secondary plans to reduce their benefits so that the combined benefits of all plans do not exceed total allowable expenses. (3-31-22)

07. Custodial Parent. The parent awarded custody by a court decree. In the absence of a court decree, the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation. (3-31-22)

08. Group-Type Contract. A contract that is not available to the general public and is obtained and maintained only because of membership in or a connection with a particular organization or group, including blanket coverage. Group-type contract does not include an individually underwritten and issued guaranteed renewable policy even if the policy is purchased through payroll deduction at a premium savings to the insured since the insured would have the right to maintain or renew the policy independently of continued employment with the employer. (3-31-22)

09. High-Deductible Health Plan. Has the meaning given the term under Section 223 of the Internal Revenue Code of 1986, as amended by the Medicare Prescription Drug, Improvement and Modernization Act of 2003. (3-31-22)

10. Hospital Indemnity Benefits. The benefits not related to expenses incurred. The term does not include reimbursement-type benefits even if they are designed or administered to give the insured the right to elect indemnity-type benefits at the time of claim. (3-31-22)

11. Plan. A form of coverage with which coordination is allowed. Separate parts of a plan for members of a group that are provided through alternative contracts that are intended to be part of a coordinated package of benefits are considered one plan and there is no COB among the separate parts of the plan. If a plan coordinates benefits, its contract states the types of coverage that will be considered in applying the COB provision of that contract. Whether the contract uses the term "plan," or some other term such as "program," the contractual definition may be no broader than this definition. The definition of "plan" in the incorporated Appendix A is an example. (3-31-22)

a. Plan includes: (3-31-22)

i. Group and nongroup insurance contracts and subscriber contracts; (3-31-22)

ii. Uninsured group or group-type coverage arrangements; (3-31-22)

iii. Group and nongroup coverage through closed panel plans; (3-31-22)

iv. Group-type contracts; (3-31-22)

v. The medical care components of long-term care contracts, such as skilled nursing care; (3-31-22)

vi. Medicare or other governmental benefits, except as provided in Subparagraph 010.11.b.ix. of this

chapter. That part of the definition of plan may be limited to the hospital, medical and surgical benefits of the governmental program. (3-31-22)

vii. The medical benefits coverage in automobile "no fault" and traditional automobile "fault" type contracts. No plan is prescribed to coordinate benefits provided that it pays benefits as a primary plan. If a plan coordinates benefits, it will do so in compliance with the provisions of this chapter. (3-31-22)

viii. Group and nongroup insurance contracts and subscriber contracts that pay or reimburse for the cost of dental or vision care. (3-31-22)

b. Plan does not include: (3-31-22)

i. Hospital indemnity coverage or other fixed indemnity coverage; (3-31-22)

ii. School accident-type coverages, such as contracts that cover students for accidents only, including athletic injuries, either on a twenty-four (24) hour basis or on a "to and from school" basis; (3-31-22)

iii. Specified disease or specified accident coverage; (3-31-22)

iv. Accident only coverage; (3-31-22)

v. Benefits provided in long-term care insurance policies for non-medical services; for example, personal care, adult daycare, homemaker services, assistance with activities of daily living, respite care, and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services; ~~(3-31-22)~~( )

vi. Limited benefit health coverage as defined in IDAPA 18.04.08, "Individual Disability and Group Supplemental Disability Insurance Minimum Standards Rule." (3-31-22)

vii. Medicare supplement policies; (3-31-22)

viii. A state plan under Medicaid; or (3-31-22)

ix. A governmental plan which, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan. (3-31-22)

12. Policyholder. The primary insured named in a non-group insurance policy. (3-31-22)

13. Primary Plan. A plan whose benefits for a person's health care coverage needs to be determined without taking the existence of any other plan into consideration. A plan is a primary plan if; (3-31-22)

a. The plan either has no order of benefit determination rules, or its rules differ from those permitted by this rule; or (3-31-22)

b. All plans that cover the person use the order of benefit determination prescribed by this rule, and under those rules the plan determines its benefits first. (3-31-22)

14. Secondary Plan. A plan that is not a primary plan. (3-31-22)

011. -- 020. (RESERVED)

021. USE OF MODEL COB CONTRACT PROVISION.

01. Coordination of Benefits. The incorporated by reference Appendix A contains a model COB provision for use in contracts. The use of this model COB provision is subject to the provisions of Subsections 021.02 through 021.04 and the provisions of Section 022. (3-31-22)

02. Coordination of Benefits Attachment. The incorporated by reference Appendix B is a plain language description of the COB process that explains to the covered person how health plans will implement coordination of benefits. It is not intended to replace or change the provisions that are set forth in the contract. Its purpose is to explain the process by which two (2) or more plans will pay for or provide benefits. (3-31-22)

03. Application of Requirements. The COB provision contained in the incorporated by reference Appendix A and the plain language explanation in the incorporated by reference Appendix B do not have to use the specific words and format as shown. Changes may be made to fit the language and style of the rest of the contract or to reflect differences among plans that provide services, that pay benefits for expenses incurred and that indemnify. No substantive changes are permitted. (3-31-22)

04. Limits on COB Provisions. A COB provision will not be used that permits a plan to reduce benefits on the basis that: (3-31-22)

a. Another plan exists and the covered person did not enroll in that plan; (3-31-22)

b. A person is or could have been covered under another plan~~, except with respect to Part B of Medicare~~; or ~~(3-31-22)~~( )

c. A person has elected an option under another plan providing a lower level of benefits than another option that could have been elected. (3-31-22)

05. "Always Excess" or "Always Secondary." No plan may contain a provision that its benefits are "always excess" or "always secondary" except in accordance with this rule. (3-31-22)

06. Closed Panel Provider. Under the terms of a closed panel plan, benefits are not payable if the covered person does not use the services of a closed panel provider. In most instances, COB does not occur if a covered person is enrolled in two (2) or more closed panel plans and obtains services from a provider in one of the closed panel plans because the other closed panel plan (the one whose providers were not used) has no liability. However, COB may occur during the plan year when the covered person receives emergency services that would have been covered by both plans; the secondary plan will use the provisions of Section 023 of this chapter to determine the amount it should pay for the benefit. (3-31-22)

07. Plan Requirements. No plan may use a COB provision, or any other provision that allows it to reduce its benefits with respect to any other coverage its insured may have that does not meet the definition of plan under Subsection 010.11 of this rule. (3-31-22)

022. RULES FOR COORDINATION OF BENEFITS.

01. Order of Benefit Payments. When a person is covered by two (2) or more plans, the rules for determining the order of benefit payments are as follows: (3-31-22)

a. The primary plan pays or provides its benefits as if the secondary plan or plans did not exist. (3-31-22)

b. If the primary plan is a closed panel plan and the secondary plan is not a closed panel plan, the secondary plan pays or provides benefits as if it were the primary plan when a covered person uses a non-panel provider, except for emergency services or authorized referrals that are paid or provided by the primary plan. (3-31-22)

c. When multiple contracts providing coordinated coverage are treated as a single plan under this rule, Section 022 of this chapter applies only to the plan as a whole, and coordination among the component contracts is governed by the terms of the contracts. If more than one (1) carrier pays or provides benefits under the plan, the carrier designated as primary within the plan is responsible for the plan's compliance with this rule. (3-31-22)

d. If a person is covered by more than one (1) secondary plan, the order of benefit determination requirements of this rule decide the order in which secondary plan benefits are determined in relation to each other.

Each secondary plan takes into consideration the benefits of the primary plan or plans and the benefits of any other plan, which, under the requirements of this rule, has its benefits determined before those of that secondary plan. (3-31-22)

02. Consistent Order of Benefit Provisions. Except as provided in Paragraph 022.02.a. of this chapter, a plan that does not contain order of benefit determination provisions that are consistent with this rule is always the primary plan unless the provisions of both plans, regardless of the provisions of Subsection 022.02 of this chapter, state that the complying plan is primary. (3-31-22)

a. Coverage that is obtained by virtue of membership in a group and designed to supplement ~~a~~ part of a basic package of benefits may provide that the supplementary coverage is excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits. ~~(3-31-22)~~( )

b. A plan may take into consideration the benefits paid or provided by another plan only when, under the requirements of this rule, it is secondary to that other plan. (3-31-22)

03. Order of Benefit Determination. Each plan determines its order of benefits using the first of the following rules that applies. (3-31-22)

a. The plan that covers the person other than as a dependent, for example, as an employee, member, subscriber, policyholder or retiree, is the primary plan and the plan that covers the person as a dependent is the secondary plan. However, if the person is a Medicare beneficiary and, as a result of the provisions of Title XVIII of the Social Security Act and implementing rules, Medicare is: (3-31-22)

i. Secondary to the plan covering the person as a dependent; and (3-31-22)

ii. Primary to the plan covering the person as other than a dependent (e.g. a retired employee), then the order of benefits is reversed so that the plan covering the person as an employee, member, subscriber, policyholder or retiree, is the secondary plan and the other plan covering the person as a dependent is the primary plan. (3-31-22)

b. Unless there is a court decree stating otherwise, plans covering a dependent child determine the order of benefits as follows: (3-31-22)

i. For a dependent child whose parents are married or are living together, whether or not they have ever been married: (3-31-22)

(1) The plan of the parent whose birthday falls earlier in the calendar year is primary plan; or (3-31-22)

(2) If both parents have the same birthday, the plan that has covered the parent longest is the primary plan. (3-31-22)

ii. For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married: (3-31-22)

(1) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the primary plan. This does not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provisions; (3-31-22)

(2) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph 022.03.b.i. of this chapter determine the order of benefits; (3-31-22)

(3) If a court decree states that the parents have joint custody without specifying that one (1) parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph 022.03.b.i. of this chapter determine the order of benefits; or (3-31-22)

(4) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows: (3-31-22)

(a) The plan covering the custodial parent; (3-31-22)

(b) The plan covering the custodial parent's spouse; (3-31-22)

(c) The plan covering the noncustodial parent; and then (3-31-22)

(d) The plan covering the noncustodial parent's spouse. (3-31-22)

(5) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits is determined, as applicable under Subparagraph 022.03.b.i. or 022.03.b.ii. of this chapter as if those individuals were parents of the child. (3-31-22)

(6) For a dependent child who has coverage under either or both parents' plans and also has their own coverage as a dependent under a spouse's plan, the provisions of Paragraph 022.02.e. apply. In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits is determined by applying the birthday rule in Subparagraph 022.02.b.i. to the dependent child's parent(s) and the dependent's spouse. (3-31-22)

c. The plan that covers a person as an active employee; that is, an employee who is neither laid-off nor retired or as a dependent of an active employee is the primary plan. The plan covering that same person as a retired or laid-off employee or as a dependent of a retired or laid-off employee is the secondary plan. If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. Coverage provided an individual as a retired worker and as a dependent of that individual's spouse as an active worker will be determined under Paragraph 022.03.a. of this chapter. (3-31-22)

d. If a person whose coverage is provided pursuant to COBRA or under a right of continuation pursuant to federal or state law is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the primary plan and the plan covering that same person pursuant to COBRA or under a right of continuation pursuant to state or other federal law is the secondary plan. If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. This provision does not apply if the rule in Paragraph 022.03.a. of this chapter can determine the order of benefits. (3-31-22)

e. If the preceding rules do not determine the order of benefits, the plan that covered the person for the longer period of time is the primary plan and the plan that covered the person for a shorter period of time is the secondary plan. (3-31-22)

i. To determine the length of time a person has been covered under a plan, two (2) successive plans are treated as one (1) if the covered person was eligible under the second plan within twenty-four (24) hours after the coverage under the first plan ended. (3-31-22)

ii. The start of a new plan does not include: (3-31-22)

(1) A change in the amount or scope of a plan's benefits; (3-31-22)

(2) A change in the entity that pays, provides or administers the plan's benefits; or (3-31-22)

(3) A change from one type of plan to another such as from a single employer plan to a multiple employer plan. (3-31-22)

iii. The person's length of time covered under a plan is measured from the person's first date of coverage under that plan. If that date is not readily available for a group plan, the date the person first became a member of the group is used as the date from which to determine the length of time the person's coverage under the present plan has been in force. (3-31-22)

f. If none of the preceding rules determines the order of benefits, the allowable expenses are shared equally between the plans. (3-31-22)

023. PROCEDURE TO BE FOLLOWED BY SECONDARY PLAN.
In determining the amount to be paid by the secondary plan on a claim, should the plan wish to coordinate benefits, the secondary plan calculates the benefits it would have paid on the claim in the absence of other health care coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan. The secondary plan may reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim do not exceed one hundred percent (100%) of the total allowable expense for that claim. In addition, the secondary plan credits to its plan deductible any amounts it would have credited to its deductible in the absence of other benefit care coverage. (3-31-22)

024. NOTICE TO COVERED PERSONS.
A plan, in its explanation of benefits provided to covered persons, includes the following language: "If you are covered by more than one (1) health benefit plan, you should file all your claims with each plan." (3-31-22)

025. MISCELLANEOUS PROVISIONS.

01. Benefits in the Form of Services. A secondary plan that provides benefits in the form of services may recover the reasonable cash value of the services from the primary plan, to the extent that benefits for the services are covered by the primary plan and have not already been paid or provided by the primary plan. Nothing in this provision requires a plan to reimburse a covered person in cash for the value of services provided by a plan which provides benefits in the form of services. (3-31-22)

02. Complying Plan Versus Noncomplying Plan. A plan with order of benefit determination rules that comply with this rule (complying plan) may coordinate its benefits with a plan that is "excess" or "always secondary" or that uses order of benefit determination rules that are inconsistent with those contained in this rule (noncomplying plan) on the following basis: (3-31-22)

a. If the complying plan is the primary plan, it pays or provides its benefits first; (3-31-22)

b. If the complying plan is the secondary plan, it pays or provides its benefits first, but the amount of the benefits payable is determined as if the complying plan were the secondary plan. In such a situation, the payment is the limit of the complying plan's liability; and (3-31-22)

c. If the noncomplying plan does not provide the information needed by the complying plan to determine its benefits within a reasonable time after it is requested to do so, the complying plan assumes that the benefits of the noncomplying plan are identical to its own and pays its benefits accordingly. If, within two (2) years of payment, the complying plan receives information as the actual benefits of the noncomplying plan, it adjusts payments accordingly. (3-31-22)

i. If the noncomplying plan reduces its benefits so that the covered person receives less in benefits than the covered person would have received had the complying plan paid or provided its benefits as the secondary plan and the noncomplying plan paid or provided its benefits as the primary plan, and governing state law allows the right of subrogation set forth below, then the complying plan advances to the covered person or on behalf of the covered person an amount equal to the difference. (3-31-22)

ii. In no event does the complying plan advance more than the complying plan would have paid had it been the primary plan less any amount it previously paid for the same expense or services. In consideration of the advance, the complying plan is subrogated to all rights of the covered person against the noncomplying plan. The advance by the complying plan is to be without prejudice to any claim it may have against the noncomplying plan in

the absence of such subrogation. (3-31-22)

03. COB Versus Subrogation. COB differs from subrogation. Provisions for one may be included in health care benefits contracts without compelling the inclusion or exclusion of the other. (3-31-22)

04. Timely Payment of Benefits. If the plans cannot agree on the order of benefits within thirty (30) calendar days after the plans have received all of the information needed to pay the claim, the plans immediately pay the claim in equal shares and determine their relative liabilities following payment, except that no plan is obligated to pay more than it would have paid had it been primary. (3-31-22)

026. -- 999. (RESERVED)

IDAPA 18 – IDAHO DEPARTMENT OF INSURANCE

18.04.15 – RULES GOVERNING SHORT-TERM HEALTH INSURANCE COVERAGE

DOCKET NO. 18-0415-2501 (ZBR CHAPTER REWRITE)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE AND TEMPORARY RULE

LINK: LSO Rules Analysis Memo

EFFECTIVE DATE: The effective date of this temporary rule is October 15, 2025. The pending rule has been adopted by the agency and is now pending review by the 2026 Idaho State Legislature and must be approved by concurrent resolution to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. If the Legislature approves the pending rule, it will become final and effective on July 1, 2026, unless the concurrent resolution states a different effective date.

AUTHORITY: In compliance with Sections 67-5224 and 67-5226, Idaho Code, notice is hereby given this agency has adopted a temporary rule and a pending rule. The action is authorized pursuant to Sections 67-5226, 41-211, 41-4207, and 41-5214, Idaho Code.

DESCRIPTIVE SUMMARY: The following is the required finding and concise statement of its supporting reasons for adopting a temporary rule and a pending rule:

This pending rule was presented as part of the Department of Insurance's plan to review each rule according to the Governor's Executive Order 2020-01: Zero-Based Regulation, and pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. This chapter implements Title 41, Chapter 21, 42, and 52, Idaho Code regarding short-term limited-duration insurance by defining requirements for enhanced short-term plans and nonrenewable short-term coverage, including minimum standards for benefits, rating rules, enrollment, renewability, and required disclosure provisions.

Due to recent events, the Department of Insurance (DOI) determined that a temporary rule is necessary to (A) protect public health and safety and (B) to reduce a regulatory burden. Further, on August 7, 2025, the U.S. Departments of Labor, HHS, and Treasury (hereinafter, the "Federal Departments") issued a statement that the Federal Departments do not intend to prioritize enforcement actions for violations related to failing to meet the definition of Short-Term Limited Duration Insurance (STLDI) related to the 2024 rules.

Acting on this guidance, the DOI is authorizing carriers and producers that sell STLDI to follow the durations set forth under this temporary rule. https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/short-term-limited-duration-insurance/stldi-statement-08-07-2025.

There are no changes to the pending rule, and it is being adopted as originally proposed. The complete text of the proposed rule was published in the August 6, 2025, Idaho Administrative Bulletin, Vol. 25-8, pages 145-151.

TEMPORARY RULE JUSTIFICATION: Pursuant to Sections 67-5226(1)(a) and (c), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate for the following reasons:

Due to recent increases in the cost of health insurance and the expiration of the enhanced tax credit, Idaho consumers are faced with a significant impact on their ability to obtain coverage. This temporary rule is necessary to protect public health and safety by ensuring that Idahoans have the ability to access Short-Term Limited Duration Insurance (STLDI) during open enrollment which commences on October 15.

Additionally, the DOI sought to eliminate burdensome requirements or regulations that were costly or harmful to consumers. For example, the DOI removed the 6-month duration maximum on traditional STLDI, instead allowing such plans to continue until the end of the calendar year.

FEE SUMMARY: Pursuant to Section 67-5224(2)(d), Idaho Code, a pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature. The following is a description of the fee or charge imposed or increased in this rulemaking: 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: No fiscal impact.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the temporary and pending rule, contact Weston Trexler, (208) 334-4214, weston.trexler@doi.idaho.gov.

DATED this 20th day of October, 2025.

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

THE FOLLOWING NOTICE PUBLISHED WITH THE 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, 41-4207, and 41-5214, Idaho Code.

PUBLIC HEARING SCHEDULE: A public hearing concerning this rulemaking will be held as follows:

Thursday, August 7, 2025
2:00 p.m. – 4:00 p.m.

In-person participation is available at:
Department of Insurance
700 W. State St. 3rd Floor
Boise, ID 83702

Web meeting link:
Click here to join the meeting
Meeting ID: 237 139 719 159 3
Passcode: jk3o9Ur2
Download Teams | Join on the web

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: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

This chapter implements Title 41, Chapter 21, 42, and 52, Idaho Code regarding short-term limited-duration insurance by defining requirements for enhanced short-term plans and nonrenewable short-term coverage, including minimum standards for benefits, rating rules, enrollment, renewability, and required disclosure provisions.

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

No fee or charge imposed or increased.

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 as a result of this rulemaking: None.

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 May 7, 2025, Idaho Administrative Bulletin, Volume 25-5, pages 52-53 under docket number 18-ZBRR-2501.

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: None.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Weston Trexler, (208) 334-4214, weston.trexler@doi.idaho.gov.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before August 27, 2025.

DATED this 2nd day of July, 2025.

THE FOLLOWING IS THE TEXT OF ZBR DOCKET NO. 18-0415-2501

18.04.15 – RULES GOVERNING SHORT-TERM HEALTH INSURANCE COVERAGE

000. LEGAL AUTHORITY.
~~Title 41, Chapters 2, 21, 42, and 52,~~Section 41-211, Section 41-4203, Section 41-4204, and Section 41-5211 Idaho Code. ~~(3-31-22)~~( )

001. ~~TITLE AND~~ SCOPE.

~~**01. Title**. IDAPA 18.04.15, "Rules Governing Short-Term Health Insurance Coverage." (3-31-22)~~

~~**02. Purpose and Scope**.~~ IThis chapter implements Title 41, Chapters 21, 42, and 52, Idaho Code~~, regarding short-term, limited-duration insurance by defining rules for enhanced short-term plans and nonrenewable short-term coverage, including minimum standards for benefits, rating rules, enrollment, renewability, and disclosure provisions~~. ~~(3-31-22)~~( )

~~**03. Applicability**. This rule applies to all enhanced short-term plans and nonrenewable short-term coverage that provide medical expense coverage.~~ ~~(3-31-22)~~

002. -- 009. (RESERVED)

010. DEFINITIONS.
In addition to the applicable definitions in Chapters 21, 42, and 52, Idaho Code, the following definitions apply:

(3-31-22)

01. Benchmark Medical Plan. The health benefit plan identified by the U.S. Department of Health and Human Services to be applicable in establishing minimum benefit coverages by Qualified Health Plans within Idaho, excluding any supplements for pediatric dental or vision. (3-31-22)

02. Exchange. Has the meaning set forth in Section 41-6103, Idaho Code. (3-31-22)

03. Nonrenewable Short-term Coverage. Short-term, limited-duration insurance that is not renewable, has a total duration ~~of six (6) months or less in total~~ not to exceed twelve (12) months, and does not extend past the end of the current calendar year, and is not an Enhanced Short-term Plan ~~under Section 41-5203(11), Idaho Code, and this rule~~. ~~(3-31-22)~~( )

~~**04. Preexisting Condition**.~~ ~~(3-31-22)~~

~~**a.** A condition for which an ordinarily prudent person would seek medical advice, diagnosis, care or treatment during the six (6) months immediately preceding the effective date of coverage;~~ ~~(3-31-22)~~

~~**b.** A condition for which medical advice, diagnosis, care or treatment was recommended or received during the six (6) months immediately preceding the effective date of coverage; or~~ ~~(3-31-22)~~

~~**c.** A pregnancy existing on the effective date of coverage.~~ ~~(3-31-22)~~

0~~5~~4. **Qualified Health Plan or QHP**. A health plan certified as such by the Exchange. (3-31-22)

0~~6~~5. **Reissuance or Replace**. The practice of issuing a short-term, limited-duration insurance policy covering at least one individual having short-term, limited-duration insurance coverage within sixty-three (63) days of the policy's effective date. (3-31-22)

0~~7~~6. **Short-term, Limited-duration Insurance**. Health insurance coverage pursuant to a contract that has a specified expiration date less than twelve (12) months after the original effective date of the contract and, including renewals or extensions, has a total duration of no longer than thirty-six (36) months. (3-31-22)

011. GENERAL RULES FOR ~~ENHANCED~~ SHORT-TERM ~~PLANS~~, LIMITED-DURATION INSURANCE.
Short-term, Limited-duration Insurance is subject to the provisions of IDAPA 18.04.13, Sections 081, 082, and 101. ( )

012. GENERAL RULES FOR ENHANCED SHORT-TERM PLANS.

01. Application of Requirements. Any short-term, limited-duration insurance that, including renewals, reissuance or extensions, has a total duration of ~~longer than six (6)~~ twelve (12) months or longer is subject to the requirements applicable to enhanced short-term plans. ~~(3-31-22)~~( )

02. Guaranteed Issue. Enhanced short-term plans are only to be offered on a guaranteed issue basis. (3-31-22)

03. Portability. Enhanced short-term plan coverage is qualifying previous coverage ~~under Title 41, Chapter 52, Idaho Code. Preexisting condition exclusions are to be waived for the period of time an individual was previously covered by an enhanced short-term plan or other qualifying previous coverage~~. ~~(3-31-22)~~( )

04. Requirement to Offer Exchange Plans. To offer an enhanced short-term plan, a carrier is to offer individual QHPs through the Exchange in the same service area. (3-31-22)

~~**012. GENERAL RULES FOR NONRENEWABLE SHORT-TERM COVERAGE.**~~
~~Nonrenewable short-term coverage is subject to the provisions of IDAPA 18.04.13, Sections 081, 082, and 101.~~ ~~(3-31-22)~~

013. -- 019. (RESERVED)

020. ENROLLMENT.

~~**01. Enhanced Short-term Plans**. There are two exclusive options for enhanced short-term plan enrollment.~~ ~~(3-31-22)~~

~~a~~**01. Year-round Enrollment**. ~~If a~~ A carrier will allow~~s~~ year-round enrollment ~~in enhanced short-term plans, the following provisions apply:~~. ~~(3-31-22)~~( )

~~i~~**02. Preexisting Conditions**. A preexisting condition exclusion period~~, as defined at Subsection 010.04,~~ may be applied, subject to Section 41-5208, Idaho Code. ~~(3-31-22)~~( )

~~ii. The policy is to be offered on a plan year basis, not a calendar year basis.~~ ~~(3-31-22)~~

~~**b.** Annual Open Enrollment Period. If a carrier restricts enrollment in enhanced short-term plans to an annual open enrollment period, the following apply:~~ ~~(3-31-22)~~

~~i. No preexisting condition exclusion period may be applied.~~ ~~(3-31-22)~~

~~ii. The beginning and ending dates of the open enrollment period are identical to those for enrollment in QHPs, unless the Director allows an extension of the open enrollment period for enhanced short-term plans after determining it is in the public interest.~~ ~~(3-31-22)~~

~~iii. Special enrollment periods are to be allowed to the same extent as QHP enrollment.~~ ~~(3-31-22)~~

~~**02. Nonrenewable Short-term Coverage**. Nonrenewable short-term coverage is to be offered on a year-round basis.~~ ~~(3-31-22)~~

021. RENEWAL AND REISSUANCE.

01. Enhanced Short-term Plans Renewals. (3-31-22)

a. A policy is to be renewable at the option of the enrollee, consistent with Section 41-5207, Idaho Code. (3-31-22)

b. No new application or questions concerning the health or medical condition of the covered individuals may be requested to effectuate the renewal. (3-31-22)

~~**c.** A policy is not to be renewable beyond thirty-six (36) consecutive months.~~ ~~(3-31-22)~~

~~d~~**c.** Upon exhaustion of a policy's renewability due to duration or age, the policyholder is eligible for enrollment into fully renewable coverage, including all of the current carrier's QHPs~~, when an enhanced short-term policy has been in effect for at least eleven (11) months~~. The carrier will provide to the policyholder ~~T~~timely notification of eligibility ~~is to be provided to the policyholder~~ plus the notification of any offer of reissuance. ~~(3-31-22)~~( )

02. Enhanced Short-term Plans Reissuances. Upon exhausting renewability due to duration or age, the following provisions apply to reissuance: (3-31-22)

a. No new application or questions concerning the health or medical condition of the covered individuals may be requested for reissuance. (3-31-22)

b. The reissuance premium rate is a change in premium rate subject to ~~IDAPA 18.04.13.036.17~~ Section 41-5206, Idaho Code. ~~(3-31-22)~~( )

03. Nonrenewable Coverage. Carriers are not to renew nonrenewable short-term coverage and are not to reissue or replace nonrenewable short-term coverage issued by the same or another carrier. (3-31-22)

022. RATING REQUIREMENTS.

01. Enhanced Short-term Plans. In addition to the requirements applicable to individual health benefit plans, the following rating requirements apply: (3-31-22)

a. Premium rates do not vary by gender. (3-31-22)

b. Geographic rating areas are identical to those used for Exchange-offered QHPs. (3-31-22)

c. Medical underwriting criteria may be used to ascertain the risk characteristics of an applicant, if the criteria are limited to those in the Universal Health Statement Addendum and available claims data. (3-31-22)

~~**d.** Enhanced short-term plans comprise a single risk pool with the carrier's other actively marketed individual health benefit plans subject to Title 41, Chapter 52, Idaho Code.~~ ~~(3-31-22)~~

ed. The rating period is on a calendar year basis, whereby the rates filed apply to all enrollees uniformly during a given calendar year and premium rate changes occur at the start of a new calendar year. (3-31-22)

02. Nonrenewable Short-term Coverage. The following rating requirements apply: (3-31-22)

a. The rates cannot utilize case characteristics other than age, individual tobacco use, and geography but may vary by the duration of coverage requested. (3-31-22)

b. Case characteristics are applied uniformly, without regard to the risk characteristics of an eligible individual. (3-31-22)

c. The premium rate is not affected by an applicant's risk characteristics or health status. (3-31-22)

d. The premium rate remains the same for the duration of the policy. (3-31-22)

023. -- 029. (RESERVED)

030. MINIMUM STANDARDS FOR BENEFITS.

01. Minimum Covered Benefits. ~~(3-31-22)~~

~~**a.** Daily hospital room and board expenses subject only to limitations based on average daily cost of the semiprivate room rate in the area where the insured resides;~~ ~~(3-31-22)~~

~~**b.** Miscellaneous hospital services;~~ ~~(3-31-22)~~

~~**c.** Surgical services;~~ ~~(3-31-22)~~

~~**d.** Anesthesia services;~~ ~~(3-31-22)~~

~~**e.** In-hospital medical services; and~~ ~~(3-31-22)~~

~~**f.** Out-of-hospital care, consisting of physicians' services rendered on an ambulatory basis where coverage is not provided elsewhere in the policy for diagnosis and treatment of sickness or injury, diagnostic x-ray, laboratory services, radiation therapy, and hemodialysis ordered by a physician.~~ ~~(3-31-22)~~

~~**02. Minimum Additional Benefits**. A separate premium corresponding to additional benefits offered through a rider is to be filed and actuarially justified. A policy is to provide not fewer than three (3) of the following additional benefits:~~ ~~(3-31-22)~~

~~a. In-hospital private duty registered nurse services; (3-31-22)~~

~~b. Convalescent nursing home care; (3-31-22)~~

~~c. Diagnosis and treatment by a radiologist or physiotherapist; (3-31-22)~~

~~d. Rental of special medical equipment, as defined by the insurer in the policy; (3-31-22)~~

~~e. Artificial limbs or eyes, casts, splints, trusses or braces; (3-31-22)~~

~~f. Treatment for functional nervous disorders, and mental and emotional disorders; or (3-31-22)~~

~~g. Out-of-hospital prescription drugs and medications. (3-31-22)~~

~~03.~~ **~~Enhanced Short-term Plans Covered Benefits~~**~~.~~ The following covered benefits and limitations are to be provided, consistent with the Benchmark Medical Plan~~, including:~~. ~~(3-31-22)~~( )

a. Ambulatory (outpatient) patient services; (3-31-22)

b. Emergency services; (3-31-22)

c. Hospitalization; (3-31-22)

~~d. Maternity and newborn care; (3-31-22)~~

~~e. Mental health and substance use disorder services, including behavioral health treatment; (3-31-22)~~

~~f~~**d.** Generic ~~P~~prescription drugs; ~~(3-31-22)~~( )

~~g~~**e.** Rehabilitative and habilitative services and devices; and ~~(3-31-22)~~( )

~~h~~**f.** Laboratory services~~; and~~. ~~(3-31-22)~~( )

~~i. Preventive and wellness services and chronic disease management. (3-31-22)~~

0~~3~~2. Prescription Drug Formulary. If a prescription drug coverage formulary is applied, the applicable formulary drug list is to: (3-31-22)

a. Include at least one drug in every United States Pharmacopeia (USP) category and class; (3-31-22)

b. Cover a range of drugs across a broad distribution of therapeutic categories and classes and recommended drug treatment regimens that treat all covered disease states, and does not discourage enrollment by any group of enrollees; and (3-31-22)

c. Provide appropriate access to drugs included in broadly accepted treatment guidelines and indicative of then-current general best practices. (3-31-22)

0~~5~~3. Cost Sharing. (3-31-22)

a. Except for out-of-network benefits offered as part of a managed care plan, a coinsurance percentage is not to exceed fifty percent (50%) of covered charges. A coinsurance percentage for out-of-network benefits offered as part of a managed care plan is not to exceed sixty percent (60%) of covered charges. (3-31-22)

b. The maximum out-of-pocket is to be stated in the policy and in aggregate is not to exceed ~~four percent (4%) of the aggregate annual limit under the policy for each covered person~~ the limits for QHPs. All

deductibles, copayments, coinsurance and any other cost-sharing are applicable to the maximum out-of-pocket. Within the aggregate maximum, the policy may include separate out-of-pocket limits applicable to particular services. ~~(3-31-22)~~( )

c. The annual limit is no less than one million dollars ($1,000,000) for each ~~covered person~~ insured. ~~(3-31-22)~~( )

~~**d.** Enhanced short-term plans are to provide coverage for and not impose any cost sharing requirements for preventive and wellness services consistent with QHP requirements. (3-31-22)~~

~~**06. Applicability of Mental Health Parity**. Enhanced short-term plans are to meet the requirements of Section 2726 of the Public Health Service Act (Mental Health Parity and Addiction Equity Act) in the same manner and extent as QHPs. (3-31-22)~~

0~~7~~4. **Benefit Requirements**. The minimum benefits imposed by Subsection~~s~~ 030.01~~, 030.02, and 030.03~~ may be subject to all applicable deductibles, coinsurance and general policy exceptions and limitations. Except as ~~dis~~allowed by Subsection~~s~~ 030.03~~, 030.05, and 030.06, a policy may also have special or internal limitations for nursing facilities, transplants, experimental treatments, services covered under Subsection 030.02, and other special or internal limitations authorized by the Director. Except as authorized by this Subsection through the application of special or internal limitations~~, a policy will cover~~, after any deductibles or coinsurance provisions are met, the usual, customary and reasonable charges, as determined consistently by the carrier~~ and as subject to prior written approval by the Director~~ or another rate agreed to between the insurer and provider, for covered services up to the annual limit. ~~(3-31-22)~~( )

031. -- 039. (RESERVED)

040. DISCLOSURE PROVISIONS.
Polices subject to this chapter will include in the application for coverage, any application materials, and the insurance contract, the following language in at least 14-point type:

"This coverage is not required to comply with certain federal market requirements for health insurance, principally those contained in the Affordable Care Act. Be sure to check your policy carefully to make sure you are aware of any exclusions or limitations regarding coverage of preexisting conditions or health benefits (such as hospitalization, emergency services, maternity care, preventive care, prescription drugs, and mental health and substance use disorder services). Your policy might also have lifetime and/or annual dollar limits on health benefits. If this coverage expires or you lose eligibility for this coverage, you might have to wait until an open enrollment period to get other health insurance coverage." (3-31-22)

041. -- 999. (RESERVED)

IDAPA 18 – IDAHO DEPARTMENT OF INSURANCE

18.06.05 – MANAGING GENERAL AGENTS

DOCKET NO. 18-0605-2501 (ZBR CHAPTER REWRITE)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2026 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. Should the pending rule be approved, it will become final and effective on July 1 following the Second Regular Session of the Sixty-eighth Idaho Legislature, unless the concurrent resolution states a different effective date.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 41-211, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change:

This rule was presented as part of the Department of Insurance's plan to review each rule according to the Governor's Executive Order 2020-01: Zero-Based Regulation, and pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. The purpose of this chapter implements and administers provisions in the Managing General Agent Act, which includes governing qualifications and procedures for acquiring the status as a Managing General Agent.

There are no changes to the pending rule, and it is being adopted as originally proposed. The complete text of the proposed rule was published in the August 6, 2025, Idaho Administrative Bulletin, Vol. 25-8, pages 152-155.

FEE SUMMARY: Pursuant to Section 67-5224(2)(d), Idaho Code, a pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature. The following is a description of the fee or charge imposed or increased in this rulemaking: 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:

No fiscal impact.

ASSISTANCE WITH TECHNICAL QUESTIONS: For assistance with technical questions concerning this pending rule, contact Weston Trexler, (208) 334-4214, weston.trexler@doi.idaho.gov.

DATED this 3rd day of October, 2025.

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

THE FOLLOWING NOTICE PUBLISHED WITH THE 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 Section 41-211, Idaho Code.

PUBLIC HEARING SCHEDULE: A public hearing concerning this rulemaking will be held as follows:

Thursday, August 7, 2025
2:00 p.m. – 4:00 p.m.

In-person participation is available at:
Department of Insurance
700 W. State St. 3rd Floor
Boise, ID 83702

Web meeting link:
Click here to join the meeting
Meeting ID: 237 139 719 159 3
Passcode: jk3o9Ur2
Download Teams | Join on the web

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: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

The purpose of this chapter implements and administers provisions in the Managing General Agent Act, which includes governing qualifications and procedures for acquiring the status as a Managing General Agent.

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

No fee or charge imposed or increased.

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 as a result of this rulemaking: None.

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 May 7, 2025, Idaho Administrative Bulletin, Volume 25-5, pages 52-53 under docket number 18-ZBRR-2501.

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: None.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Weston Trexler, (208) 334-4214, weston.trexler@doi.idaho.gov.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before August 27, 2025.

DATED this 2nd day of July, 2025.

THE FOLLOWING IS THE TEXT OF ZBR DOCKET NO. 18-0605-2501

18.06.05 – MANAGING GENERAL AGENTS (MGA)

000. LEGAL AUTHORITY.
~~Managing General Agent Act (MGA Act), Title 41, Chapters 15 and 2,~~Section 41-211, Idaho Code. ~~(3-31-22)~~( )

001. ~~TITLE AND~~ SCOPE.
~~IDAPA 18.06.05, "Managing General Agents."~~ This chapter implements and administers provisions of ~~the MGA Act~~ Title 41, Chapter 15, Idaho Code. ~~(3-31-22)~~( )

002. -- 009. (RESERVED)

010. DEFINITIONS.

~~01.~~ ~~Applicability of Statutory Definitions~~. The definitions ~~contained in the MGA Act~~ as set forth in Section 41-1502, Idaho Code, apply. ~~(3-31-22)~~( )

011. NOTICE PROVISIONS.

01. Notice by MGA. Upon licensure and, thereafter, on or before July 1 of each year, any person~~, firm, association or corporation~~ acting in the state of Idaho ~~in the capacity of~~ as an MGA ~~as defined in Section 41-1502(3), Idaho Code,~~ provides notice to the Director ~~of the Department~~, which includes: ~~(3-31-22)~~( )

a. A certified copy of the surety bond prescribed by ~~Subsection 013.01~~ Section 41-1503(3), Idaho Code. ~~(3-31-22)~~( )

b. Proof of insurance coverage as prescribed by ~~Subsection~~ Section 013.~~02~~. ~~(3-31-22)~~( )

c. The appropriate nonrefundable designation fee prescribed by IDAPA 18.01.02. (3-31-22)

d. A list of all names and addresses of insurers doing business in the State of Idaho or Idaho domestic insurers with which the MGA has a contract and a verified statement on a form provided by the Department that the contract(s) contain the provisions prescribed by Section 41-1504, Idaho Code. (3-31-22)

02. Notice by Insurer. In addition to those items specified in Section 41-1505(5), Idaho Code notice by the insurer will include: ~~(3-31-22)~~( )

a. The name and address of the MGA; (3-31-22)

b. Proof that the MGA has met the bonding requirements of Section 41-1503(3), Idaho Code; ( )

~~b~~**c.** Proof that the MGA has met ~~the bonding and~~ insurance requirements of Section 013; ~~(3-31-22)~~( )

~~e~~**d.** Procedures and timetable for conducting an onsite review of the underwriting and claims processing operation of the MGA as prescribed by Section 41-1505(3), Idaho Code; and (3-31-22)

~~d~~**e.** The name of an officer of the insurer responsible for the contract. (3-31-22)

012. ~~(RESERVED)~~BOND.
The bond amount, as prescribed in Section 41-1503(3), Idaho Code will be adjusted accordingly on or before July 1 of each year. Coverage cannot be written by the insurer or an affiliate of the insurer employing the MGA. ( )

013. ~~SECURITY PAYMENTS~~ERRORS AND OMISSIONS POLICY.

~~**01. Bond**. All MGAs acquire a surety bond for the protection of the insurer and insureds. The bond will be in the amount of fifty thousand dollars ($50,000) or ten percent (10%) of the amount of total funds handled within the preceding year, whichever is greater. The bond amount will be adjusted accordingly on or before July 1 of each year. Coverage cannot be written by the insurer or an affiliate of the insurer employing the MGA.~~ ~~(3-31-22)~~

~~**02. Errors and Omissions Policy**.~~ All MGAs acquire and maintain an errors and omissions insurance policy providing for claims arising out of the MGA's negligent acts, errors or omission. The policy coverage limit is set at two hundred fifty thousand dollars ($250,000) or twenty-five percent (25%) of the gross amount of direct written premiums received by an insurer for the previous calendar year that are attributable to the MGA, whichever is greater. The policy coverage limit will be adjusted accordingly on or before July 1 of each year. Unless approved by the director, coverage will not be written by the insurer or an affiliate of the insurer employing the MGA. ~~(3-31-22)~~( )

014. INDEPENDENT AUDIT OR EXAMINATION.

01. Annual Independent Audit of MGA. An independent audit by a certified public accountant is conducted annually for MGAs currently under contract~~,~~ and is to be contracted for by the insurer. The independent audit will include the following: ~~(3-31-22)~~( )

a. Report of independent certified public accountant; (3-31-22)

b. Balance sheet; (3-31-22)

c. Statement of income; (3-31-22)

d. Statement of cash flow; (3-31-22)

e. Statement of income and retained earnings; (3-31-22)

f. Notes on financial statements - these notes are those prescribed by General Accepted Accounting Principals; and (3-31-22)

g. A copy of a management letter or a narrative statement setting forth what would have been the content of the management letter had such letter been completed. (3-31-22)

02. Examination of MGA. The Department retains authority to examine an MGA notwithstanding the termination of the MGA's contractual authority. Pursuant to the provisions of Title 41, Chapter 2, Idaho Code, ~~the expense of such examination is to be reimbursed to the Department by~~ the insurer employing the MGA reimburses the Department for the expense of such examination. ~~(3-31-22)~~( )

015. TERMINATION OF CONTRACT.

01. Notice to the Department. Notice of the termination of an agreement between an MGA and an

insurer for which the MGA was conducting business in the state of Idaho will include the name of the person~~, firm, association or corporation~~ acting as an MGA under the terms of the contract and the basis for the termination.
~~(3-31-22)~~( )

02. Delivery of Records to Insurer upon Termination of Contract. If the contract between an insurer and an MGA is terminated for any reason, the MGA will, upon request by the insurer, deliver all records to the insurer within ninety (90) days of the request. (3-31-22)

016. -- 999. (RESERVED)

IDAPA 24 – DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSES

24.21.01 – RULES OF THE IDAHO STATE CONTRACTORS BOARD

DOCKET NO. 24-2101-2501 (FEE RULE)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo and Cost/Benefit Analysis (CBA)

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2026 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. Should the pending rule be approved, it will become final and effective on July 1 following the Second Regular Session of the Sixty-eighth Idaho Legislature, unless the concurrent resolution states a different effective date.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 67-2604(1)(g), Idaho Code, and Section 54-5206(1), Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change:

There are no changes to the pending rule, and it is being adopted as originally proposed. The complete text of the proposed rule was published in the October 1, 2025, Idaho Administrative Bulletin, Vol. 25-10, pages 322–323.

FEE SUMMARY: Pursuant to Section 67-5224(2)(d), Idaho Code, a pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature. The following is a description of the fee or charge imposed or increased in this rulemaking:

As authorized in Section 54-5207(1), Idaho Code, the fee(s) in this rulemaking will increase between ten (10) and twenty (20) percent of the current fee. This is to comply with the cash balance requirements of Section 67-2608(3), Idaho Code.

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:

No fiscal impact on the state general fund will occur as a result of these changes.

ASSISTANCE WITH TECHNICAL QUESTIONS: For assistance with technical questions concerning this pending rule, contact Kolby Reddish, Chief Legal Counsel, at (208) 817-6126.

DATED this 30th day of October, 2025.

Kolby K. Reddish
Chief Legal Counsel
PO Box 83720
Boise, ID 83720-0063
Phone: (208) 817-6126
Email: kolby.reddish@dopl.idaho.gov

THE FOLLOWING NOTICE PUBLISHED WITH THE 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 Section 67-2604(1)(g), Idaho Code, and Section 54-5206(1), 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 October 15, 2025.

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: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

An amendment to Rule 400 regarding a potential increase in fees to ensure the sustainability of the State Contractors Board.

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

The increase in fees is between ten (10) and twenty (20) percent of the current fee. Fee authorized by Section 54-5207(1), Idaho Code. This is to comply with the cash balance requirements of Section 67-2608(3), Idaho Code.

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:

No fiscal impact on the state General Fund will occur as a result of these changes.

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 May 7, 2025 Idaho Administrative Bulletin, Vol. 25-5, Pages 60–61.

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: For assistance on technical questions concerning the proposed rule, contact Kolby Reddish, Chief Legal Counsel, at (208) 577-2519.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October, 22, 2025.

DATED this 13th day of August, 2025.

THE FOLLOWING IS THE TEXT OF FEE DOCKET NO. 24-2101-2501

24.21.01 – RULES OF THE IDAHO STATE CONTRACTORS BOARD

400. FEES.
Annual fees may be aggregated for biennial licensure.

FEE TYPE	AMOUNT (Not to Exceed)
Application (includes original registration)	$~~50~~60
Reciprocal	$~~50~~60
Renewal	$~~50~~60
Reinstatement	$~~35~~40
Inactive	$0
Inactive to Active License	The difference between the inactive fee and active license renewal fee

~~(7-1-25)~~(____)

IDAPA 24 – DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSES

24.22.01 – RULES OF THE IDAHO STATE LIQUEFIED PETROLEUM GAS SAFETY BOARD

DOCKET NO. 24-2201-2501 (FEE RULE)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo and Cost/Benefit Analysis (CBA)

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2026 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. Should the pending rule be approved, it will become final and effective on July 1 following the Second Regular Session of the Sixty-eighth Idaho Legislature, unless the concurrent resolution states a different effective date.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 67-2604(1)(g), Idaho Code, and Section 54-5310(11), Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change:

There are no changes to the pending rule, and it is being adopted as originally proposed. The complete text of the proposed rule was published in the October 1, 2025, Idaho Administrative Bulletin, Vol. 25-10, pages 324–325.

FEE SUMMARY: Pursuant to Section 67-5224(2)(d), Idaho Code, a pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature. The following is a description of the fee or charge imposed or increased in this rulemaking:

As authorized in Section 54-5313(3), Idaho Code, the fee(s) in this rulemaking will be increased between fifteen and twenty percent to address the Liquefied Petroleum Gas Safety Board's cash balances.

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:

No fiscal impact on the state general fund will occur as a result of these changes.

ASSISTANCE WITH TECHNICAL QUESTIONS: For assistance with technical questions concerning this pending rule, contact Kolby Reddish, Chief Legal Counsel, at (208) 817-6126.

DATED this 30th day of October, 2025.

Kolby K. Reddish
Chief Legal Counsel
PO Box 83720
Boise, ID 83720-0063
Phone: (208) 817-6126
Email: kolby.reddish@dopl.idaho.gov

THE FOLLOWING NOTICE PUBLISHED WITH THE 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 Section 67-2604(1)(g), Idaho Code, and Section 54-5310(11), 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 October 15, 2025.

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: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

An amendment to Rule 400 regarding a potential increase in fees to address the Liquefied Petroleum Gas Safety Board's cash balances.

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

The increase in fees is between fifteen and twenty percent. Fees authorized by Section 54-5313(3), Idaho Code.

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:

No fiscal impact on the state General Fund will occur as a result of these changes.

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 May 7, 2025 Idaho Administrative Bulletin, Vol. 25-5, Pages 62-63.

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: For assistance on technical questions concerning the proposed rule, contact Kolby Reddish, Chief Legal Counsel, at (208) 577-2519.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October, 22, 2025.

DATED this 13th day of August, 2025.

THE FOLLOWING IS THE TEXT OF FEE DOCKET NO. 24-2201-2501

24.22.01 – RULES OF THE IDAHO STATE LIQUEFIED PETROLEUM GAS SAFETY BOARD

400. FEES.
All fees are non-refundable:

FEE TYPE	AMOUNT (Not to Exceed)	RENEWAL (Not to Exceed)
Application	$~~30~~35	
Individual License	$~~75~~90	$~~75~~90
Endorsement	$~~75~~90	
Dealer-in-training	$50	
Facility License	$~~100~~115	$~~100~~115
Bulk Storage Facility	$~~400~~460	$~~400~~460
Facility Reinspection	$~~125~~150	

~~(3-28-23)~~( )

IDAPA 24 – DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSES

24.28.01 – RULES OF THE BARBER AND COSMETOLOGY SERVICES LICENSING BOARD

DOCKET NO. 24-2801-2501 (FEE RULE)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo and Cost/Benefit Analysis (CBA)

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2026 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. Should the pending rule be approved, it will become final and effective on July 1 following the Second Regular Session of the Sixty-eighth Idaho Legislature, unless the concurrent resolution states a different effective date.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 67-2604(1)(g), Idaho Code, and Section 54-5807(1)(h), Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change:

There are no changes to the pending rule, and it is being adopted as originally proposed. The complete text of the proposed rule was published in the October 1, 2025, Idaho Administrative Bulletin, Vol. 25-10, pages 330–336.

FEE SUMMARY: Pursuant to Section 67-5224(2)(d), Idaho Code, a pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature. The following is a description of the fee or charge imposed or increased in this rulemaking:

The increase proposed is fifteen (15) to twenty (20) percent of the current fees. Fee authorized by Section 54-5807(1)(h), Idaho Code. This increase is necessary to comply with the cash balance expectations of Section 67-2608(3), Idaho Code.

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:

No fiscal impact on the state general fund will occur as a result of these changes.

ASSISTANCE WITH TECHNICAL QUESTIONS: For assistance with technical questions concerning this pending rule, contact Kolby Reddish, Chief Legal Counsel, at (208) 817-6126.

DATED this 30th day of October, 2025.

Kolby K. Reddish
Chief Legal Counsel
PO Box 83720
Boise, ID 83720-0063
Phone: (208) 817-6126
Email: kolby.reddish@dopl.idaho.gov

THE FOLLOWING NOTICE PUBLISHED WITH THE 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 Section 67-2604(1)(g), Idaho Code, and Section 54-5807(1)(h), 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 October 15, 2025.

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: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

An amendment to Rule 400 regarding a potential increase in fees to address the Barber and Cosmetology Services Licensing Board's cash balances. Additionally added the necessary definitions and provisions to allow for Mobile Establishment Licensure under the Board's existing statutory authority.

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

The increase proposed is fifteen (15) to twenty (20) percent of the current fees. Fee authorized by Section 54-5807(1)(h), Idaho Code. This increase is necessary to comply with the cash balance expectations of Section 67-2608(3), Idaho Code.

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:

No fiscal impact on the state General Fund will occur as a result of these changes.

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 May 7, 2025 Idaho Administrative Bulletin, Vol. 25-5, Pages 64-65.

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: For assistance on technical questions concerning the proposed rule, contact Kolby Reddish, Chief Legal Counsel, at (208) 577-2519.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October, 22, 2025.

DATED this 13th day of August, 2025.

THE FOLLOWING IS THE TEXT OF FEE DOCKET NO. 24-2801-2501

24.28.01 – RULES OF THE BARBER AND COSMETOLOGY SERVICES LICENSING BOARD

002. DEFINITIONS.

01. Clean. Removal of debris, washing with soap and water, detergent or chemical "cleaner." Cleaning prepares non-porous items for disinfection, but cleaning does not make multi-use items safe for use. (7-1-24)

02. Disinfect. The process of making a non-porous item safe for use. Disinfecting requires the use of a chemical intended to kill or denature a bacteria, virus or fungus. Items to be disinfected must be cleaned prior to disinfection. Ultraviolet (UV) light is not acceptable for disinfection. (7-1-24)

03. Disinfectant. Disinfectant registered by the United States Environmental Protection Agency (EPA) and is bactericidal, virucidal and fungicidal with effectiveness against staphylococcus aureus (including methicillin-resistant staphylococcus aureus (MRSA)), human immunodeficiency virus (HIV) and hepatitis B (HEPB). This includes EPA registered Sodium Hypochlorite 5.25% or higher (household bleach) with instructions for disinfection, diluted as instructed on the label and observing the contact time listed on the manufacturer's label. Bleach must be active (not expired) with a manufacture date of less than six (6) months prior to use. (7-1-24)

04. First-Aid Kit. A packaged and identifiable assortment of medical supplies, including adhesive bandages, skin antiseptic, disposable gloves, and gauze. (7-1-24)

05. Mobile Establishment. A mobile establishment is a self-contained, enclosed vehicle, trailer, or portable structure that is licensed to provide barbering and cosmetology services outside of a fixed location. ( )

056. Single-Use. Any non-electrical item that cannot be properly cleaned and disinfected. (7-1-24)

067. Sterilize. The eradication of all microbial life through the use of heat, steam or chemical sterilants. Items to be sterilized must be cleaned prior to sterilization. (7-1-24)

078. Sterilant. Autoclaves or dry heat sterilizers approved by and used in accordance with the United States Food and Drug Administration. (7-1-24)

003. -- 099. (RESERVED)

100. LICENSURE.

01. Approved Examination. The National Interstate Council of State Boards of Cosmetology's written and practical examinations. (7-1-24)

02. Additional Licensure Educational Requirements. (7-1-24)

a. Barber License. A currently licensed cosmetologist must complete one hundred (100) hours of barber-related instruction, to include barber theory, haircuts, and shaving. (7-1-24)

b. Barber-Stylist License. A currently licensed cosmetologist must complete one hundred (100) hours of barber-stylist instruction, to include barber theory, haircuts, and shaving. (7-1-24)

c. Cosmetologist License. (7-1-24)

i. A currently licensed barber-stylist must complete three hundred (300) hours of cosmetology instruction, to include nail technology, esthetics, cosmetology theory, and hairstyling. (7-1-24)

ii. A currently licensed barber must complete seven hundred (700) hours of cosmetology instruction, to include working on the hair with chemicals, nail technology, esthetics, cosmetology theory, and hairstyling. (7-1-24)

iii. A currently licensed esthetician or nail technician must complete one thousand four hundred (1,400) hours of cosmetology instruction or two thousand eight hundred (2,800) hours as a cosmetology apprentice. (7-1-24)

~~iv. A currently certificated makeup artist must complete one thousand five hundred fifty (1,500) hours of cosmetology instruction or three thousand one hundred (3,100) hours as a cosmetology apprentice. (7-1-24)~~

~~**d.** Esthetician License. A currently certified makeup artist must complete five hundred fifty (550) hours of esthetics instruction or one thousand one hundred (1,100) hours as an esthetician apprentice.. (7-1-24)~~

ed. Out of State Licensure. A current licensee in another state, territory, possession or country, and who does not meet the qualifications for licensure through endorsement may be credited hours of instruction for practical work experience: (7-1-24)

i. Barber: One Hundred (100) hours as a student or two hundred (200) hours as an apprentice for every six (6) months of practical experience in barbering; (7-1-24)

ii. Barber-Stylist: Two hundred (200) hours as a student or four hundred (400) hours as an apprentice for every six (6) months of practical experience in barber-styling; (7-1-24)

iii. Cosmetologist: Two hundred (200) hours as a student or four hundred (400) hours as apprentice for every six (6) months of practical experience in cosmetology: (7-1-24)

iv. Electrologist: Forty (40) hours as a student or eighty (80) hours as an apprentice for every six (6) months of practical experience in electrology; (7-1-24)

v. Esthetician: Sixty (60) hours as a student or one hundred twenty (120) hours as an apprentice for every six (6) months of practical experience in esthetics; (7-1-24)

vi. Nail Technician: Forty (40) hours as a student or eighty (80) hours as an apprentice for every six (6) months in practical experience in nail technology. (7-1-24)

~~**03. Makeup Artist Certificate Approved Instruction**. Classroom instruction, training, practical experience, or a combination received from a cosmetology school, a cosmetology or esthetics instructor, or a retail cosmetics dealer licensed in this state or another state, territory, possession, or country, or otherwise approved by the board. If an applicant does not have a documented record of sufficient training in makeup artistry, including safety and infection control, the Board may require additional training or other demonstration of competency in that area. (7-1-24)~~

043. Establishment. An establishment may be licensed as primary or contiguous. (7-1-24)

a. An applicant for primary establishment licensure must provide proof of compliance with Rule 200.01.a. A primary establishment license will not be issued if it includes or overlaps any portion of an existing establishment license. (7-1-24)

b. An applicant for contiguous establishment licensure must certify that it is associated with and operates within a currently licensed primary establishment and the primary establishment license holder must certify that the primary establishment is equipped to meet all safety and disinfection requirements. (7-1-24)

c. Establishment licenses cannot be transferred. A change of location or a full change in ownership requires a new license application. In a multiple ownership establishment, an owner may be removed upon written statement by all owners, including the withdrawing owner. (7-1-24)

d. Mobile establishments must comply with all rules regarding licensure, safety, sanitation, disinfection, equipment, and waste disposal as set forth in Title 54, Chapter 58, Idaho Code, and these rules. The requirements of Subsection 200.01.a. for a permanent water source and restroom are satisfied for a mobile establishment if the mobile unit contains a functional sink with hot and cold running water and self-contained fresh water and waste water tanks. Mobile establishments may not be used for residential purposes or any other non-service-related purpose. Mobile establishments must provide a phone number that can be reached during operating hours. ( )

(BREAK IN CONTINUITY OF SECTIONS)

200. PRACTICE STANDARDS.

01. Premises. (7-1-24)

a. A primary establishment must have: (1) a clearly defined and designated working floor space that allows the safe and sanitary practice of cosmetology and/or barber-styling for all stations that may be in operation and provides safe access to restrooms and access areas; (2) a hot and cold running water source and drainage system that are within the perimeters of the primary establishment, separate from restroom facilities, and available to any contiguous establishment or facility that may exist; and (3) restrooms that are accessible from the building in which the primary establishment is located and from any contiguous establishments or facility that may exist and which contain hot and cold running water and drainage separate from the work area facilities. The license holder is responsible for complying with the safety and disinfection requirements and all other applicable statutes and rules for the designated licensed area of the primary establishment, including "common areas." (7-1-24)

b. A contiguous establishment must operate only in the contiguous establishment designated areas within the associated primary establishment. The contiguous establishment license holder is responsible for complying with the safety and disinfection requirements and all other applicable statutes and rules for the contiguous designated area where it operates. (7-1-24)

c. Retail cosmetic dealers must have access to hot and cold running water; access to restroom facilities; disinfectants; single-use samples, wipes, spatulas or other dispensing techniques designed to prevent contamination of the cosmetic product; and a first-aid kit. (7-1-24)

02. Practice Outside of Licensed Establishment. Pursuant to Section 54-5804(2)(c), Idaho Code, a licensee or certificant can provide the following services outside of a licensed establishment: (7-1-24)

a. Hair Styling. Arranging, styling, and dressing of the hair. Trimming may be performed when incidental to the arranging, styling, or dressing, including facial hair such as beards, mustaches, and eyebrows. (7-1-24)

b. Coloring. Wash out topical color, tinted powder, spray or chalk to temporarily camouflage hair. (7-1-24)

c. Temporary Hair Removal. Tweezing of hairs on the face and neck. (7-1-24)

d. Cleansing. Cleansing the face for the limited purpose of removing makeup or debris and cosmetic preparations for the application of makeup. (7-1-24)

e. Nail Services. Application of nail polish by painting without the use of a lamp or light, removal of polish incidental to the painting of the nail, and shaping the nail with a single-use emery board. (7-1-24)

f. Makeup Application. Application of makeup. (7-1-24)

03. Safety And Disinfection for Establishments and Schools. (7-1-24)

a. Establishments and schools must be separated from living areas by substantial walls and/or closable doors. Floors, walls, ceilings, furniture, fixtures, and restrooms must be kept clean and in good repair at all times. A clearly identifiable first-aid kit must be readily accessible. (7-1-24)

b. All instruments and items used by operators must be thoroughly cleaned after each use and then disinfected with a disinfectant or sterilized with a sterilant after cleaning and prior to use on each patron. A disinfectant must be mixed and changed according to the manufacturer's instructions. Disinfection methods of immersion, sprays, and wipes may be used. Contact time listed on the disinfectant's label must be adhered to in all circumstances. Items or surfaces must remain completely immersed in disinfectant or visibly wet, if using sprays or wipes, for the full amount of contact time. (7-1-24)

c. Porous or single use instruments and items must be immediately disposed of in a trash container after each use on a patron or given to the patron to take home for personal use, provided that the instruments may not be brought back to the establishment for future use. Skin cutting instruments, including razor-type callus shavers, credo blades, or other rasps or graters which cut below the skin surface are not permitted in the establishment. (7-1-24)

d. Paraffins, waxes and other multi-patron use products must be covered and maintained free of any foreign contaminants. Only disinfected or unused single-use items may be placed into a container that holds multi-patron use products. These products must be portioned out for each patron in a container or dispensed in a manner that prevents contamination of the unused supply. All portions used on a patron must be disposed of immediately following use. (7-1-24)

e. Pedicure bowls, basins, tubs, drill bits, internal piping, and pumps must be cleaned and disinfected prior to each use as directed by the manufacturer. (7-1-24)

f. Operators and students must wash their hands with running water, soap and a single-use towel prior to providing service to any patron. When hand washing is not practicable, hand sanitizer of at least seventy percent (70%) alcohol may be used. (7-1-24)

g. No animals are allowed in shops or schools except service dogs, as defined by the U.S. Department of Justice Regulations, trained to do work or perform tasks for persons with disabilities. (7-1-24)

h. A current establishment and/or school license, valid operator license(s), a copy of these safety and disinfection rules, and a valid classification card must be conspicuously displayed in the work area of each establishment or school. (7-1-24)

04. Safety and Disinfection for Retail Cosmetics Dealer Facilities ~~and Makeover or Glamour Photography Businesses~~. ~~(7-1-24)~~( )

a. Makeup that comes in a cake, loose, or liquid form must be transferred to a palette with a disinfected or single-use spatula for use with a single patron and in a manner to prevent any contamination. Excess make-up on the palette must be disposed of immediately following use. (7-1-24)

b. Make-up pencils that require a sharpener must be sharpened prior to each use. Sharpeners must be cleaned and disinfected in accordance with Rule 200.03.b. Eyeliner that does not require a sharpener must have a portion transferred to a palette with a disinfected or single-use spatula for use on a single customer. (7-1-24)

c. Single-use applicators must be used in the application of mascara. (7-1-24)

d. Implements and applicators, including brushes, used on customers or made available for use by customers must be stored, cleaned, and disinfected or discarded in accordance with Rule 200.03.b. and c. (7-1-24)

e. Make-up displays should be covered when not in use. When accessible for use by patrons, single-use applicators must be readily available. (7-1-24)

f. A clearly identifiable first-aid kit must be readily accessible on the premises. (7-1-24)

g. A current license/registration, a copy of these safety and disinfection rules, and a valid classification card must be conspicuously displayed in the work area of each facility. (7-1-24)

05. Inspections. ( )

a. A facility, school, or establishment must make improvements within thirty (30) days of an unacceptable "C" classification inspection result. The Board may allow an establishment, school, or facility to continue to operate during that period. The Board may take action prior to any reinspection when the circumstances represent an immediate danger to the public health, safety, or welfare. (7-1-24)

b. Mobile establishments are subject to periodic and initial inspections by the Board. The license holder must permit the Board to inspect the mobile unit at any time during operating hours or as otherwise requested by the Board. A mobile salon shall submit to the Board, upon request, in a manner specified by the Board, an itinerary for a requested time period showing the dates, exact locations and times service is to be provided. Failure to provide accurate information may be determined to be a violation of Rule 200.06.h below. ( )

06. Unprofessional Conduct. The following practices constitute unprofessional conduct. (7-1-24)

a. Use of Methyl Methacrylate acid (MMA). (7-1-24)

b. Use of skin cutting instruments, including razor-type callus shavers, credo blades, or other rasps or graters which cut below the skin surface. The presence of such instruments creates a presumption of the instrument's use. (7-1-24)

c. Use of ultraviolet (UV) sterilizers for disinfection. This does not prohibit the use of ultraviolet dryers or lamps used to dry or cure nail products. (7-1-24)

d. Use of roll-on wax, except that single-use roll-on wax cartridges are acceptable when they are limited to a single client service and disposed of immediately after use. (7-1-24)

e. Placing an item or instrument that has been used on a person or placing a person's body part into a container that holds powder, wax, a compound, solution, or other cosmetic preparation that will be used for more than one (1) patron. (7-1-24)

f. Use of single-use or porous items on more than one (1) patron. The presence of used single-use or porous items, which have not been disposed of in a trash container, creates a presumption of the item's use or intended use on more than one patron. (7-1-24)

g. Failure to adequately supervise, instruct, or train an apprentice. (7-1-24)

h. Interference with an inspection or investigation conducted by or on behalf of the Board. (7-1-24)

i. Performing a service on a patron who has an open sore or a known contagious disease of a nature that may be transmitted by performing the procedure. (7-1-24)

k. Performing services or using machines or devices outside the licensee's area of training, expertise, competence, or scope of practice for the license held. (7-1-24)

201. -- 399. (RESERVED)

400. FEES.

All fees are non-refundable. Annual fees may be aggregated for biennial licensure.

FEE TYPE	AMOUNT (Not to Exceed)	ANNUAL RENEWALFEE (Not to Exceed)
Individual Original License or Certificate	$~~25~~30	$~~25~~30
Application	$~~25~~30	
Instructor License	$~~30~~35	$~~30~~35
Establishment, Dealer, Facility License/Registration	$~~20~~25	$~~20~~25
School License	$~~300~~360	$~~85~~100
Apprentice Registration	$~~25~~30	
Endorsement License	$~~35~~45	
Reinstatement	$35	

~~(7-1-24)~~( )

IDAPA 24 – DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSES

24.32.01 – RULES OF THE IDAHO BOARD OF LICENSURE OF PROFESSIONAL ENGINEERS AND PROFESSIONAL LAND SURVEYORS

DOCKET NO. 24-3201-2501

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2026 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. Should the pending rule be approved, it will become final and effective on July 1 following the Second Regular Session of the Sixty-eighth Idaho Legislature, unless the concurrent resolution states a different effective date.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 54-1208, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change:

This pending rule would move the official fee table for Idaho Board of Professional Engineers and Land Surveyors (IPELS) from a posting on the Division of Occupational and Professional Licensing website into rule to comply with Section 67-9402(2), Idaho Code, requiring "all licensure fees shall be established in statute or rule." Importantly, there are no contemplated changes to the current fee amounts. Instead, the current fees will simply be established in rule.

The changes made from proposed to pending decreased licensing and renewal fees for the Idaho Board of Professional Engineers and Land Surveyors (IPELS) by fifty-eight percent (58%) to sixty-two percent (62%). In addition, the Board added language to allow greater flexibility in temporary fee reductions and removed the renewal fee for Intern Certificates.

The text of the pending rule has been amended in accordance with Section 67-5227, Idaho Code. Only those sections that have changes that differ from the proposed text are printed in this bulletin. The complete text of the proposed rule was published in the October 1, 2025, Idaho Administrative Bulletin, Vol. 25-10, pages 337-338.

FEE SUMMARY: Pursuant to Section 67-5224(2)(d), Idaho Code, a pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature. The following is a description of the fee or charge imposed or increased in this rulemaking:

As authorized in Section 54-1213, Idaho Code, the fees in this rulemaking are not being increased or imposed in a new or different manner. Section 67-9402(2), Idaho Code, requires all fees to be in statute or rule, and this change would move the existing fees into rule.

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:

No fiscal impact on the state general fund will occur as a result of these changes.

ASSISTANCE WITH TECHNICAL QUESTIONS: For assistance with technical questions concerning this pending rule, contact Ryan Bernard, Legislative and Regulatory Affairs Chief, at (775) 870-7926.

DATED this 5th day of December, 2025.

Ryan Bernard
Legislative and Regulatory Affairs Chief
PO Box 83720
Boise, ID 83720-0063
Phone: (775) 870-7926
Email: ryan.bernard@dopl.idaho.gov

THE FOLLOWING NOTICE PUBLISHED WITH THE 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 Section 54-1208, 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 October 15, 2025.

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: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

This rule change would move the official fee table for Idaho Board of Professional Engineers and Land Surveyors (IPELS) from a posting on the Division of Occupational and Professional Licensing website into rule to comply with Section 67-9402(2), Idaho Code, requiring "all licensure fees shall be established in statute or rule." Importantly, there are no contemplated changes to the current fee amounts. Instead, the current fees will simply be established in rule.

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

While the fee is being affected, it is not being increased or imposed in a new or different manner. Section 67-9402(2), Idaho Code, requires all fees to be in statute or rule, and this is moving the existing fees into rule. Fee authorized by Section 54-1213, Idaho Code.

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:

No fiscal impact on the state General Fund will occur as a result of these changes.

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 August 6, 2025 Idaho Administrative Bulletin, Vol. 25-8, Pages 169–170.

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: For assistance on technical questions concerning the proposed rule, contact Kolby Reddish, Chief Legal Counsel, at (208) 577-2519.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October, 22, 2025.

DATED this 13th day of August, 2025.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 24-3201-2501

Italicized red text that is *double underscored* indicates amendments to the proposed text as adopted in the pending rule.

24.32.01 – RULES OF THE IDAHO BOARD OF LICENSURE OF PROFESSIONAL ENGINEERS AND PROFESSIONAL LAND SURVEYORS

400. FEES.

01. Applications and Renewals. All fees are non-refundable. Annual fees may be aggregated for biennial licensure. All fees are set by the Board in the following categories ~~and are accessible on the Division's website.~~:

Application Type	Fee (*Not to Exceed*)
Initial Licensure	$*30*
Licensure by Comity	$*50*
Business Entity Authorization Cert.	$*80*
Faculty Restricted License	$*40*
Intern Certificate	No Fee

Renewal Type	Fee (in US Dollars)
Engineers or Land Surveyors License	$*60*
Business Entity Authorization Cert.	$*50*
Intern Certificate	*No Fee*
Retired License	No Fee

Late Renewal Type	Fee (in US Dollars)
Engineers or Land Surveyors	$*30* per Month (Maximum of $*440* in late fees)
Business Entity Authorized Cert.	$*25* per Month (Maximum of $*450* in late fees)
Intern	No Fee
Retired License	No Fee

~~(7-1-25)~~(_____)

a. Licensure as a professional engineer or professional land surveyor by examination. (3-28-23)

b. Reinstatement of a retired or expired license. (3-28-23)

c. Certification for a business entity applying for a certificate of authorization to practice or offer to practice engineering or land surveying. (3-28-23)

d. Renewals for professional engineers, professional land surveyors, engineer interns, land surveyor interns, and business entities. (3-28-23)

e. Licensure for professional engineers or professional land surveyors by comity. (3-28-23)

IDAPA 24 – DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSES

24.39.30 – RULES OF BUILDING SAFETY (BUILDING CODE RULES)

DOCKET NO. 24-3930-2501

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2026 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. Should the pending rule be approved, it will become final and effective on July 1 following the Second Regular Session of the Sixty-eighth Idaho Legislature, unless the concurrent resolution states a different effective date.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 67-2604, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change:

This rulemaking seeks to make final certain amendments to the permit fee table made through temporary rulemaking earlier this year published in the January 1, 2025, Idaho Administrative Bulletin, Vol. 25-1, Page 78-80. These pending rules adjust permit fees downwards to address the Board's cash balance, while simultaneously reducing costs for licensees.

There are no changes to the pending rule, and it is being adopted as originally proposed. The complete text of the proposed rule was published in the November 5, 2025, Idaho Administrative Bulletin, Vol. 25-11, pages 112-114.

FEE SUMMARY: Pursuant to Section 67-5224(2)(d), Idaho Code, a pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature. The following is a description of the fee or charge imposed or increased in this rulemaking:

There are no newly imposed or increased fees in this rule change. Instead, this rulemaking seeks to finalize the Board's fee reductions that were promulgated through temporary rulemaking earlier this year, reducing building permit fees by thirty percent (30%).

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:

No fiscal impact on the state general fund will occur as a result of these changes.

ASSISTANCE WITH TECHNICAL QUESTIONS: For assistance with technical questions concerning this pending rule, contact Ryan Bernard, Legislative and Regulatory Affairs Chief, at (775) 870-7926.

DATED this 5th day of December, 2025.

Ryan Bernard
Legislative and Regulatory Affairs Chief
PO Box 83720
Boise, ID 83720-0063
Phone: (775) 870-7926
Email: ryan.bernard@dopl.idaho.gov

THE FOLLOWING NOTICE PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. This action is authorized pursuant to Section 67-2604, Idaho Code.

PUBLIC HEARING SCHEDULE: A public hearing concerning this rulemaking will be held as follows:

24.39.30 – Rules Of Building Safety (Building Code Rules)

Wednesday, November 12, 2025
9:00 a.m. (MT)

Attend via Webex: Link
Meeting Number (Access Code): 2868 448 7497
Meeting password: ZnrnMr2ND42

Attend in person at:
Division of Occupational and Professional Licenses
EagleRock Room, Chinden Campus
11341 W. Chinden Blvd., Bldg. 4
Boise, ID 83714

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: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

This rulemaking seeks to make final certain amendments to the permit fee table made through temporary rulemaking earlier this year published in the January 1, 2025 Idaho Administrative Bulletin, Vol. 25-1, Page 78-80. The rulemaking adjusts permit fees downwards to address the Board's cash balance, while simultaneously reducing costs for licensees.

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

There are no newly imposed or increased fees in this rule change. Instead, this rulemaking seeks to make final certain temporary permitting fee reductions.

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:

No fiscal impact on the state general fund will occur as a result of these changes.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1) and 67-5221(1)(j), Idaho Code, negotiated rulemaking was not conducted because DOPL wanted to provide immediate relief to the regulated community by adopting a temporary rule that mirrors the fee reduction in this proposed rule. The Notice of Rulemaking – Adoption of Temporary Rule was published in the January 1, 2025 Idaho Administrative Bulletin, Vol. 25-1, Pages 78-80. Any stakeholder input and all public comments submitted at the scheduled public hearing will be considered.

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: For assistance on technical questions concerning the proposed rule, contact Kolby Reddish, Chief Legal Counsel, at (208) 817-6126.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before November 26, 2025.

DATED this 17th day of October, 2025.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 24-3930-2501

24.39.30 – RULES OF BUILDING SAFETY (BUILDING CODE RULES)

500. PERMITS AND PLAN REVIEW.

01. Annual Permit. In lieu of an individual permit for each minor alteration to an already approved building, the Division may issue an annual permit upon application therefor to any state agency or state governmental organization regularly employing one (1) or more qualified trade persons in the building, structure or on the premises or campus owned or operated by the applicant for the permit. The agency to whom an annual permit is issued shall keep a detailed record of alterations made under such annual permit. The Division shall be allowed access to such records upon request or such records shall be filed with the Division as designated. The permit holder shall request inspections and make the work accessible for inspection as required by the adopted codes and herein. (7-1-24)

02. Plans Not Required. Plans are not required for group U occupancies of Type V conventional light-frame wood construction. (7-1-24)

03. Fees. (7-1-24)

a. Technical Service Fee. One hundred dollars ($100) per hour. (7-1-24)

b. Building Permit Fees. The determination of value or valuation will be made by the administrator and includes the total value of all construction work for which a permit is issued.

TABLE 1-A - BUILDING PERMIT FEES

Total Valuation		Fee
$1 to $500	=	$~~23.50~~16.45
$501 to $2,000	=	$~~23.50~~16.45 for the first $500 plus $~~3.05~~2.14 for each additional $100, or fraction thereof, to and including $2,000
$2,001 to $25,000	=	$~~69.25~~48.48 for the first $2,000 plus $~~14~~9.80 for each additional $1,000, or fraction thereof, to and including $25,000

TABLE 1-A - BUILDING PERMIT FEES		
Total Valuation		**Fee**
$25,001 to $50,000	=	$~~391.75~~274.23 for the first $25,000 plus $~~10.10~~7.07 for each additional $1,000, or fraction thereof, to and including $50,000
$50,001 to $100,000	=	$~~643.75~~450.63 for the first $50,000 plus $~~7~~4.90 for each additional $1,000, or fraction thereof, to and including $100,000
$100,001 to $500,000	=	$~~993.75~~695.63 for the first $100,000 plus $~~5.60~~3.92 for each additional $1,000, or fraction thereof, to and including $500,000
$500,001 to $1,000,000	=	$~~3,233.75~~2,263.63 for the first $500,000 plus $~~4.75~~3.33 for each additional $1,000, or fraction thereof, to and including $1,000,000
$1,000,001 to $5,000,000	=	$~~5,608.75~~3,926.13 for the first $1,000,000 plus $~~3.65~~2.56 for each additional $1,000, or fraction thereof, to and including $5,000,000
$5,000,001 to $10,000,000	=	$~~20,208.75~~14,146.13 for the first $5,000,000 plus $~~2.75~~1.93 for each additional $1,000, or fraction thereof, to and including $10,000,000
$10,000,001 and up	=	$~~33,958.75~~23,771.13 for the first $10,000,000 plus $~~2~~1.40 for each additional $1,000, or fraction thereof

~~(7-1-24)~~(____)

c. Fees for Annual Permits. A fee for inspections performed on annual permits shall be charged at the rate of one hundred dollars ($100) per inspection. The Division shall bill the applicant for annual permits and failure of the applicant to pay the fee within sixty (60) days may result in cancellation of the annual permit. (7-1-24)

d. Plan Review Fees. Plan review fees shall be charged at an hourly rate of one hundred dollars ($100) per hour up to a maximum of sixty-five percent (65%) of the calculated building permit fee with a minimum required fee of forty percent (40%) of the calculated building permit fee. All requests for plan review services shall be accompanied by a payment in the amount of at least forty percent (40%) of the calculated building permit fee. Upon completion of the plan review, any additional fees, above the minimum required, are due to the Division by the requesting party. (7-1-24)

IDAPA 24 – DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSES

24.39.30 – RULES OF BUILDING SAFETY (BUILDING CODE RULES)

DOCKET NO. 24-3930-2502

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo and Incorporation By Reference Synopsis (IBRS)

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2026 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. Should the pending rule be approved, it will become final and effective on July 1 following the Second Regular Session of the Sixty-eighth Idaho Legislature, unless the concurrent resolution states a different effective date.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 39-4107(1), Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change:

This pending rule would have the Idaho Building Code Board adopt the 2024 versions of the International Building Code (IBC); International Residential Code (IRC), and International Energy Conservation Code (IEC)—with exemptions as determined during the rulemaking process. Support for the currently adopted Building Code (IBC 2018) is being phased out including access to the tools and documentation that inspectors rely on to enforce the relevant codes.

After the proposed rule was published, changes were made as a result of public comment and to ensure the Board continued analogous exceptions adopted by the Board to the 2018 Codes. Other updates include: (1) updating footnotes to ensure they align with the modified tables previously adopted by the Board, (2) allowing for an additional floor on wood-framed buildings, and (3) requiring heat detection systems be added within garages to account for the increase in fires caused by lithium-ion batteries.

The text of the pending rule has been amended in accordance with Section 67-5227, Idaho Code. Only those sections that have changes that differ from the proposed text are printed in this bulletin. The complete text of the proposed rule was published in the October 1, 2025, Idaho Administrative Bulletin, Vol. 25-10, pages 358-366.

FEE SUMMARY: Pursuant to Section 67-5224(2)(d), Idaho Code, a pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature. The following is a description of the fee or charge imposed or increased in this rulemaking: 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:

No fiscal impact on the state general fund will occur as a result of these changes.

ASSISTANCE WITH TECHNICAL QUESTIONS: For assistance with technical questions concerning this pending rule, contact Ryan Bernard, Legislative and Regulatory Affairs Chief, at (775) 870-7926.

DATED this 5th day of December, 2025.

Ryan Bernard
Legislative and Regulatory Affairs Chief
PO Box 83720
Boise, ID 83720-0063
Phone: (775) 870-7926
Email: ryan.bernard@dopl.idaho.gov

THE FOLLOWING NOTICE PUBLISHED WITH THE 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 Section 39-4107(1), Idaho Code.

PUBLIC HEARING SCHEDULE: A public hearing concerning this rulemaking will be held as follows:

24.39.30 – Rules of Building Safety (Building Code Rules)

Wednesday, October 15, 2025
9:00 a.m. (MT)

Attend via Webex: Link
Meeting Number (Access Code): 2869 753 1020
Meeting password: eAGqXjPY553

Attend in person at:
Division of Occupational and Professional Licenses
Thunderbolt Room, Chinden Campus
11341 W. Chinden Blvd., Bldg. 4
Boise, ID 83714

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: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

This rule would have the Idaho Building Code Board adopt the 2024 versions of the International Building Code (IBC); International Residential Code (IRC), and International Energy Conservation Code (IEC)—with exemptions as determined during the rulemaking process. Support for the currently adopted Building Code (IBC 2018) is being phased out including access to the tools and documentation that inspectors rely on to enforce the relevant codes.

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:

No fiscal impact on the state General Fund will occur as a result of these changes.

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 August 6, 2025 Idaho Administrative Bulletin, Vol. 25-8, Pages 173-174.

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:

The Division is proposing to incorporate by reference the most recent editions of the International Codes, with exceptions, as published by the International Code Council, into the Rules of Building Safety. Adopting the International Codes through incorporation by reference is necessary because directly reproducing the full text in the Idaho Administrative Code would be unduly cumbersome, expensive, and duplicative. The International Codes comprise hundreds of pages of technical standards and commentary, which are already widely available to professionals, enforcement agencies, and the public in standardized format. By incorporating these codes, the Division ensures uniform application of building and safety standards across the state, reduces the administrative burden of maintaining duplicative text, and facilitates compliance by contractors, inspectors, and design professionals.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Kolby Reddish, Chief Legal Counsel, at (208) 577-2519.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October, 22, 2025.

DATED this 12th day of September, 2025.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 24-3930-2502

Italicized red text that is *double underscored* indicates amendments to the proposed text as adopted in the pending rule.

24.39.30 – RULES OF BUILDING SAFETY (BUILDING CODE RULES)

600. IDAHO BUILDING CODES.
Pursuant to Sections 39-4109 and 39-4109A, Idaho Code, the Board adopts the following international codes with identified amendments: (7-1-24)

01. International Building Code. The ~~2018~~ 2024 Edition, including appendices pertaining to building accessibility, with the following amendments: ~~(7-1-24)~~( )

a. Delete Section 305.2.3 and replace with the following: 305.2.3 Twelve (12) or fewer children in a dwelling unit. A facility such as the above within a dwelling unit and having twelve (12) or fewer children receiving such day care shall be classified as a Group R-3 occupancy or shall comply with the International Residential Code. (7-1-24)

i. Delete Section 308.2.4 and replace with the following: 308.2.4 Five (5) or fewer persons receiving custodial care. A facility with five (5) or fewer persons receiving custodial care shall be classified as a Group R-3 occupancy or shall comply with the International Residential Code. (7-1-24)

ii. Delete Section 308.3.2 and replace with the following: 308.3.2 Five (5) or fewer persons receiving medical care. A facility with five (5) or fewer persons receiving medical care shall be classified as a Group R-3 occupancy. (7-1-24)

iii. Delete Section 308.5.4 and replace with the following: 308.5.4 Persons receiving care in a dwelling

unit. A facility such as the above within a dwelling unit and having twelve (12) or fewer children receiving day care or having five (5) or fewer persons receiving custodial care shall be classified as a Group R-3 occupancy or shall comply with the International Residential Code. (7-1-24)

b. Section 310.4: Add the following: "Dwelling units providing day care for twelve (12) or fewer children". (7-1-24)

c. Section 310.4.1. Delete and replace with the following: 310.4.1 Care facilities within a dwelling. Care facilities for twelve (12) or fewer children receiving day care or for five (5) or fewer persons receiving personal care or custodial care that are within a one- or two-family dwelling are permitted to comply with the International Residential Code. (7-1-24)

d. *Add new section 510.10: Group R-2 buildings of Type VA Construction. Subject to approved siting location by the applicable Planning Official and Fire Code Official, Group R-2 Occupancy buildings of Type VA Construction above the 3-hour fire rated horizontal assembly of a Type IA Construction lower podium building may be permitted to comply with the following, in addition to other applicable provisions of Section 510: ( )*

(1) May be permitted up to five (5) stories, with highest occupied floor not exceeding seventy-five (75) feet above the lowest level of fire department vehicle access, with maximum overall building height not exceeding ninety-five (95) feet above the lowest level of fire department vehicle access. An occupied roof is considered a floor level but not a story. ( )

(2) R-2 Occupancy is the primary use allowed in the upper building with the following exceptions for accessory use areas: ( )

(2.1) B Occupancy rooms or B Occupancy assembly areas accessory to the residential use are allowed at no more than ten percent (10%) of each floor area provided to total occupant load for the sum of B Occupancy areas does not exceed forty-nine (49) persons on each floor. ( )

(2.2) An exterior Group A Occupancy assembly area (patio, deck) serving the residential use with an occupant load less than three hundred (300) persons is allowed directly on the top of the podium 3-hour fire rated horizontal assembly of the lower building. ( )

(2.3) Entry lobbies, mechanical rooms, maintenance rooms, waste and recycling collection, bicycle storage, and similar incidental uses are allowed on any floor. ( )

(3) For building area, the tabular allowable area for a non-sprinklered building of Group R-2 Occupancy of Type VA Construction shall be used and may be increased by twenty-five percent (25%) per floor over the area value listed in the allowable area Table. This area increase is calculated separately and is added in addition to any other area increases allowed for frontage increase and single occupancy, multi-story buildings in this Chapter. Fire walls may be required in order to comply with allowable area provisions. Multiple buildings can be located on top of the Type IA podium building. ( )

(4) All portions of both the upper and lower building must be fully protected throughout with an automatic sprinkler system that complies with Section 903.3.1.1 (NFPA 13). ( )

(5) Exit access travel distance shall be one hundred fifty (150) feet maximum for the Group R-2 Occupancy. ( )

(6) Exterior walls shall be a minimum one-hour fire resistive wall assembly rated for exposure from both sides with noncombustible exterior wall finish materials. ( )

(7) Required interior exit stairways shall be pressurized and at least two (2) exit stairways shall provide roof access for the Fire Department. ( )

(8) Other Special Inspections: *( )*

(8.1) Structural observation shall be conducted by the engineer of record during construction. Report of structural observation adequacy, including key elements of the lateral force resisting system, shall be submitted to the jurisdiction. *( )*

(8.2) Special inspection by an independent third-party firm shall be provided for fire-resistant penetrations with report submitted to the jurisdiction. *( )*

(8.3) Reports on adequacy and balancing of the pressurization of the stairways by an independent third-party firm with report submitted to the jurisdiction. *( )*

(8.4) Where determined is needed by the code official, a survey of the building height may be required with report submitted to the jurisdiction. *( )*

(9) Fire alarm and fire sprinkler systems shall be inspected, tested, and maintained in accordance with NFPA 25 and NFPA 72 on a basis as determined by the applicable Fire Code Official. Inspection reports shall be submitted to the applicable Fire Code Official. *( )*

~~d~~*e*. Add new Section 602.1.2: 602.1.2 Alternative provisions. As an alternative to the construction types defined in Sections 602.2 through 602.5, buildings and structures erected or to be erected, altered, or extended in height or area may be classified as construction type IV-A, IV-B, or IV-C in accordance with the provisions adopted in Paragraph ~~004~~*600*.01.b of these rules. Buildings and structures classified as construction type IV-A, IV-B, or IV-C shall comply with the provisions adopted in Paragraph ~~004~~*600*.01.~~h~~*g* of these rules and all other applicable provisions of this code. ~~(7-1-24)~~*( )*

~~e~~*f*. Table 2902.1 Minimum Number of Required Plumbing Fixtures. Delete footnote [e] and replace with the following: e For business occupancies, excluding restaurants, and mercantile occupancies with an occupant load of thirty (30) or fewer, service sinks shall not be required. (7-1-24)

~~f~~*g*. ~~Table 2902.1 Minimum Number of Required Plumbing Fixtures. Delete footnote f and replace with the following: f Drinking fountains are not required for an occupant load of thirty (30) or fewer~~*Delete Section 2902.6. and replace with the following. 2902.6 Small Occupancies. Drinking fountains shall not be required for an occupant load of (30) or fewer*. ~~(7-1-24)~~*( )*

~~g~~*h*. Section 3113 Relocatable Buildings. Delete. (7-1-24)

~~02. International Building Code, 2021 Edition. The following provisions of the 2021 Edition related to mass timber construction: (7-1-24)~~

~~a. In Section 202, the definitions of the terms MASS TIMBER; NONCOMBUSTIBLE PROTECTION (FOR MASS TIMBER); SECONDARY STRUCTURAL MEMBERS; and WALL, LOAD BEARING; (7-1-24)~~

~~b. Sections 403.3.2, 508.4.4.1, 509.4.1.1, 602.4 through 602.4.3.6, 703.6, 703.7, 704.4, 722.7 through 722.7.2.2, 1705.5.3, 1705.20, 2304.10.1, 3313.1 through 3313.3.3, 3313.5, and 3314.1; (7-1-24)~~

~~c. Tables 504.3, 504.4, 506.2, 601, 705.5, 722.7.1(1), 722.7.1(2), and 1705.5.3, including any note following each table adopted in this subparagraph; and (7-1-24)~~

~~d. In Chapter 35, the referenced standards ANSI/APA PRG 320—2019: Standard for Performance-rated Cross-laminated Timber, referenced in Sections 602.4 and 2303.1.4, and ASTM D3498—03(2011): Standard Specification for Adhesives for Field-Gluing Plywood to Lumber Framing for Floor Systems, referenced in Section 703.7. (7-1-24)~~

0~~3~~2. International Residential Code, ~~2018~~ 2024 Edition. Parts I, II, III, and IX of the ~~2018~~ 2024 Edition for one (1)- and two (2)- family dwellings, with the following amendments: ~~(7-1-24)~~( )

a. Section R101.2 Scope. Delete the exception and replace with the following: Exception: The following shall also be permitted to be constructed in accordance with this code: 1. Owner-occupied lodging houses with five (5) or fewer guestrooms and ten (10) or fewer total occupants. 2. A care facility with five (5) or fewer persons receiving custodial care within a dwelling unit or single-family dwelling. 3. A care facility for five (5) or fewer persons receiving personal care that are within a dwelling unit or single-family dwelling. 4. A care facility with twelve (12) or fewer children receiving day care within a dwelling unit or single-family dwelling. (7-1-24)

b. Section R105.2. Amend Item number 7 under the "Building" subheading Replace the words "24 inches (610 mm)" with "four (4) feet (1219) mm)" (7-1-24)

c. Section R105.2. Add the following exemption under the "Building" subheading: 11. Flag poles. (7-1-24)

d. Section R301.2.1.2 Protection of Openings. Delete. (7-1-24)

~~***e.*** *Table R302.1(1). Delete and replace with the following:*~~

~~***TABLE R302.1(1) - EXTERIOR WALLS***~~

~~***EXTERIOR WALL ELEMENT***~~		~~***MINIMUM FIRE-RESISTANCE RATING***~~	~~***MINIMUM FIRE SEPARATION DISTANCE***~~
~~Walls~~	~~Fire-resistance rated~~	~~1 hour-tested in accordance with ASTM E 119, UL263, or Section 703.3 of the International Building Code with exposure from both sides~~	~~< 3 feet~~
	~~Not fire-resistance rated~~	~~0 hours~~	~~≥ 3 feet~~
~~Projections~~	~~Fire-resistance rated~~	~~1 hour on the underside, or heavy timber, or fire-retardant treated wood[a,b]~~	~~≥ 2 feet to < 3 feet~~
	~~Not fire-resistance rated~~	~~0 hours~~	~~≥ 3 feet~~
~~Openings in Walls~~	~~Not allowed~~	~~N/A~~	~~< 3 feet~~
	~~25% maximum of wall area~~	~~0 hours~~	~~≥ 3 feet to < 5 feet~~
	~~Unlimited~~	~~0 hours~~	~~5 feet~~
~~Penetrations~~	~~All~~	~~Comply with Section R302.4~~	~~< 3 feet~~
		~~None required~~	~~≥ 3 feet~~

~~*For SI: 1 foot = 304.8 mm.*~~
~~*N/A = Not Applicable*~~
~~*aThe fire-resistance rating shall be permitted to be reduced to zero (0) hours on the underside of the eave overhang if fireblocking is provided from the wall top plate to the underside of the roof sheathing.*~~
~~*bThe fire-resistance rating shall be permitted to be reduced to zero (0) hours on the underside of the rake overhang where gable vent openings are not installed.*~~ ~~*(7-1-24)*~~

~~***f***~~***e*****.** Delete Table R302.6 Dwelling-Garage Separation and replace with the following table:

Separation	Material
~~From the residence, attics, and habitable rooms above the garage~~From the dwelling unit and attics, and portions of the dwelling unit above the garage	Not less than 5/8-inch Type X gypsum board or equivalent applied to the garage side
Structure(s) supporting floor/ceiling assemblies used for separation required by this section	
Garages located less than 3 feet from a dwelling unit on the same lot	Not less than 5/8-inch Type X gypsum board or equivalent applied to the interior side of exterior walls that are within this area

~~(7-1-24)~~(____)

~~g~~f. Section R302.13 Fire protection of floors. Delete. (7-1-24)

~~h.~~ ~~Section R303.4. Delete and replace with the following: Mechanical Ventilation. Dwelling units shall be provided with whole-house mechanical ventilation in accordance with Section M1505.4.~~ ~~(7-1-24)~~

~~i~~g. Section R~~313.1~~309.1 Townhouse automatic fire sprinkler systems. Delete the exception and replace with the following: Exception: Automatic residential fire sprinkler systems shall not be required in townhouses where either two (2) one (1)-hour fire-resistance-rated walls or a common two (2)-hour fire-resistance rated wall, as specified in item number 2 of Section R302.2.2 is installed between dwelling units or when additions or alterations are made to existing townhouses that do not have an automatic residential fire sprinkler system installed.
~~(7-1-24)~~(____)

~~j~~h. *Section R~~313.2~~309.2 One- and two-family dwellings automatic fire sprinkler systems. Delete.*
~~(7-1-24)~~(____)

~~k~~i. *Section R~~314.2.2~~310.2.2 Alterations, repairs and additions Exception Item #2. Delete.*
~~(7-1-24)~~(____)

~~l~~j. *Section R~~315.2.2~~311.2.2 Alterations, repairs and additions Exception Item #2. Delete.*
~~(7-1-24)~~(____)

~~m~~k. *Section R~~322.1.10~~306.1.10 As-built elevation documentation. Delete.* ~~(7-1-24)~~(____)

l. *Section R325.3. Delete and replace with the following: Mechanical Ventilation Buildings and dwelling units shall be provided with whole house mechanical ventilation in accordance with Section M1505.4.*
(____)

~~n~~m. Tables R403 Minimum Depth (D) and Width (W) of Crushed Stone Footings (inches), R403.1(1) Minimum Width and Thickness for Concrete Footings for Light-Frame Construction (inches), R403.1(2) Minimum Width and Thickness for Concrete Footings for Light-Frame Construction and Brick Veneer (inches), and R403.1(3) Minimum Width and Thickness for Concrete Footings with Cast-In-Place or Fully Grouted Masonry Wall Construction (inches). Delete. (7-1-24)

n. *Add new Section R330.7.1 Heat Detector Within Garages. A heat detector(s), listed and interconnected to a smoke alarm(s), shall be installed in all attached garages and also in detached garages that do not meet the required fire separation distance and have an electrical service.* (____)

o. Add the following as Table R403.1: (7-1-24)

TABLE R403.1
MINIMUM WIDTH OF CONCRETE, PRECAST, OR MASONRY FOOTINGS (inches)[a]

	LOAD-BEARING VALUE OF SOIL (psf)			
	1,500	**2,000**	**3,000**	**≥ 4,000**
Conventional light-frame construction				
1-Story	12	12	12	12
2-Story	15	12	12	12
3-Story	23	17	12	12
4-inch brick veneer over light frame or 8-inch hollow concrete masonry				
1-Story	12	12	12	12
2-Story	21	16	12	12
3-Story	32	24	16	12
8-inch solid or fully grouted masonry				
1-Story	16	12	12	12
2-Story	29	21	14	12
3-Story	42	32	21	16

For SI: 1 inch = 25.4 mm, 1 pound per square foot = 0.0479 kPa.
[a]Where minimum footing width is twelve (12) inches, use of a single wythe of solid or fully grouted twelve (12)-inch nominal concrete masonry units is permitted. (7-1-24)

p. Section R403.1.1. Delete and replace with the following: R403.1.1 Minimum size. Minimum sizes for concrete and masonry footings shall be as set forth in Table R403.1 and Figure R403.1(1). The footing width (W) shall be based on the load bearing value of the soil in accordance with Table R401.4.1. Spread footings shall be at least six (6) inches in thickness (T). Footing projections (P) shall be at least two (2) inches and shall not exceed the thickness of the footing. The size of footings supporting piers and columns shall be based on the tributary load and allowable soil pressure in accordance with Table R401.4.1. Footings for wood foundations shall be in accordance with the details set forth in Section R403.2 and Figures R403.1(2) and R403.1(3). (7-1-24)

q. *Section 403.4.1 Crushed Stone Footings. Delete* *( )*

r. *Figure R403.1(1) detail five (5) delete "Provide lateral restraint at the base of walls supporting more than 48 inches of unbalance backfill in accordance with R404.1.3.2"* *( )*

~~q~~***s.*** Section R602.10. Delete and replace with the following: Buildings shall be braced in accordance with this Section or, when applicable Section R602.12, or the most current edition of APA System Report SR-102 as an alternate method. Where a building, or portion thereof, does not comply with one (1) or more of the bracing requirements in this Section, those portions shall be designed and constructed in accordance with Section R301.1. (7-1-24)

043. International Existing Building Code. ~~2018~~ 2024 Edition. ~~(7-1-24)~~( )

054. International Energy Conservation Code – Commercial Provisions. The ~~2018~~ 2024 Edition with the following amendments: ~~(7-1-24)~~( )

a. Add new Section C101.~~5~~4.2: C101.~~5~~4.2 Industrial, electronic, and manufacturing equipment. Buildings or portions thereof that are heated or cooled exclusively to maintain the required operating temperature of industrial, electronic, or manufacturing equipment shall be exempt from the provisions of this code. Such buildings or portions thereof shall be separated from connected conditioned space by building thermal envelope assemblies

complying with this code. ~~(7-1-24)~~( )

b. Add the following Exemptions to section C402.1.1: (7-1-24)

i. Exemption ~~4~~1. Accessory utility and storage buildings and sports practice buildings accessory to A, B, and E occupancies where buildings maintain no heating or cooling or where intermittent heating and cooling systems are installed. ~~(7-1-24)~~( )

ii. Exemption ~~5~~2. Buildings for domestic water wells, irrigation wells, sewer pump facilities, and sewer lift station buildings where equipment produces internal heat loads and where intermittent heating or cooling is provided to prevent freezing or overheating of equipment. ~~(7-1-24)~~( )

c. Add the following as exceptions ~~number 7 under~~ to Section C403.5 Economizers (Prescriptive): ~~7~~8. Unusual outdoor air contaminate conditions – Systems where special outside air filtration and treatment for the reduction and treatment of unusual outdoor contaminants, makes an air economizer infeasible. ~~(7-1-24)~~( )

d. *Section C405.2.9 Interior Parking Area Lighting Control – Delete.* ( )

e. *Section C405.2.10 Sleeping unit and Dwelling Unit Lighting and Switched Receptacle Controls – Delete.* ( )

f. *Section C405.4 Horticultural Lighting – Delete.* ( )

g. *Section C405.12 Automatic Receptacle Control – Delete.* ( )

h. *Section C405.13 Energy Monitoring – Delete.* ( )

i. *Section C405.15 Renewable Energy Systems – Delete.* ( )

j. *Section C406.1.2 Additional Renewable and Load Management credit requirements – Delete.* ( )

k. *Section C406.1.1 Exception 2 – Delete.* ( )

l. *Table C406.1.1(2) Limit to Energy Efficiency Credit Carryover from Renewable and Load Management Credits – Delete.* ( )

m. *Section C406.3 Renewable and Load Management Credit Achieved – Delete* ( )

0~~6~~5. International Energy Conservation Code – Residential Provisions. The ~~2018~~ 2024 Edition with the following amendments: ~~(7-1-24)~~( )

a. R202 General Definitions. Add the following to the definition of "Conditioned Space": This definition shall not apply to garage spaces or other similar spaces where heating or cooling is installed for frost protection or intermittent use. (7-1-24)

b. Table R402.1.*2* ~~*Insulation and Fenestration Requirements by Component.*~~ Delete ~~*the rows in climate zones "5 and Marine 4" and "6"*~~ and replace with the following *table and footnotes*:

TABLE R402.1.*2*
INSULATION AND FENESTRATION REQUIREMENTS BY COMPONENT [a]

Climate Zone	Fenestration U- Factor[b]	Skylight[b] U-factor	Glazed Fenestration SHGC[b, e]	Ceiling R-Value	Wood Frame Wall R-Value	Mass Wall R-Value[i]	Floor R-Value	Basement[c] Wall R-Value	Slab[d] R-Value & Depth	Crawlspace[c] Wall R-Value
5	0.32	0.55	NR	38	20 or 13+5[h]	13/17	30[g]	15/19	10, 2 ft	15/19
6	0.30	0.55	NR	49	22 or 13+5[h]	15/20	30[g]	15/19	10, 4 ft	15/19

NR = Not Required
For SI: 1 foot = 304.8 mm.

[a] *R-values are minimums. U-factors and SHGC are maximum. Where insulation is installed in a cavity that is less than the label or design thickness of the insulation, the installed R-value of the insulation shall be not less than the R-value specified in the table.*

[b] *The fenestration U-factor column excludes skylights. The SHGC column applies to all glazed fenestration.*

Exception: *In Climate Zones 1 through 3, skylights shall be permitted to be excluded from glazed fenestration SHGC requirements provided that the SHGC for such skylights does not exceed 0.30.*

[c] *"10/13" means R-10 continuous insulation on the interior of exterior of the home or R-13 cavity insulation on the interior of the basement wall. "15/19" means R-15 continuous insulation on the interior or exterior of the home or R-19 cavity insulation at the interior of the basement wall. Alternatively, compliance with "15/19" shall be R-13 cavity insulation on the interior of the basement wall plus R-5 continuous insulation on the interior of exterior of the home.*

[d] *R-5 insulation shall be provided under the full slab area of a heated slab in addition to the required slab edge insulation R-value for slabs. As indicated in the table. The slab edge insulation for heated slabs shall not be required to extended below the slab.*

[e] *There are no SHGC requirements in the Marine Zone.*

[f] *Basement wall insulation is not required in warm-humid locations as defined by Figure R301.1 and Table R301.1*

[g] *Alternatively, insulation sufficient to fill the framing cavity and providing not less than an R-value of R-19.*

[h] *The first value is cavity insulation, the second value is continuous insulation. Therefore, as an example., "13+5" means R-13 cavity insulation plus R-5 continuous insulation.*

[i] *Mass walls shall be in accordance with Section R402.2.5. The second R-value applies where more than half of the insulation is on the interior of the mass wall.*

[1] *For residential log home building thermal envelop construction requirements see Section R402.6*

~~*(7-1-24)*~~*(____)*

~~***e.*** *Table R402.1.2 - Insulation and Fenestration Requirements by Component. Add the following as footnote k to the Table title: k. For residential log home building thermal envelope construction requirements see Section R402.6.* *(7-1-24)*~~

~~***d***~~***c.*** *Add* Table R402.1.4~~*3 Equivalent U-Factors. Delete the rows in climate zones "5 and Marine 4" and "6" and replace with the following*~~ *with footnotes*:

TABLE R402.1.~~4~~3
EQUIVALENT U-FACTORS[a]

Climate Zone	Fenestration U-factor[b]	Skylight[b] U-factor	Ceiling ~~U-factor~~R-Value	Frame Wall ~~U-factor~~R-Value	Mass Wall ~~U-factor~~[b] R-Value[j]	Floor ~~U-factor~~R-Value	Basement[c] Wall ~~U-factor~~R-Value	Crawlspace[c] Wall ~~U-factor~~R-Value
5	0.32	0.55	0.030	0.060	0.082	0.033	0.050	0.055
6	0.30	0.55	0.026	0.057	0.060	0.033	0.050	0.055

NR = Not Required
For SI: 1 foot = 304.8 mm.
[a] *Nonfenestration U-factors shall be obtained from measurement, calculation or approved source.*
[b] *Mass walls shall be in accordance with Section R402.2.6. Where more than half the insulation is on the interior, the mass wall U-factor shall not exceed 0.17 in climate Zones 6 through 8.*
[c] *In warm-humid locations as defined by figure R301.1, the basement wall U-factor shall not exceed 0.360.*

~~(7-1-24)~~( )

e~~d~~. Section R402.~~4~~5.1.2. Add the following exception: Visual Inspection. The Permit Holder will determine at the time of permit application the method of determining building envelope tightness. A visual inspection shall be considered acceptable in lieu of testing when the items listed ~~in Table R402.4.1.1~~ below, applicable to the method of construction, are field verified. ~~(7-1-24)~~( )

i. Access doors and covers shall be gasketed to allow for repeated entrance. ( )

ii. Framing spaces between windows, doors and skylights shall be sealed. ( )

iii. Recessed light fixtures shall be sealed to drywall or interior air barrier. ( )

iv. HVAC registers and boots shall be sealed to subfloor, walls, or ceilings. ( )

v. Interior joints of top plates shall be sealed. ( )

vi. Narrow cavities (less than one inch) are sealed when not insulated. ( )

vii. Holes created by electrical and plumbing shall be sealed. ( )

viii. Penetrations through the exterior air barrier shall be sealed. ( )

ix Joints in sill plate shall be sealed during subfloor assembly. ( )

f~~e~~. Add new Section R402.~~6~~7: R402.~~6~~7 Residential log home thermal envelope. Residential log home construction shall comply with Section R401 (General), Section R402.~~4~~5 (Air leakage), Section R402.~~5~~6 (Maximum fenestration U-factor and SHGC), Section R403.1 (Controls), the mandatory sections of Sections R403.3 through R403.9, Section R404 (Electrical Power and Lighting Systems *and Renewable Energy Systems*), and either 1., 2., or 3. as follows: 1. Sections R402.2 ~~through~~ *and* R402.~~3~~4, Section R403.3.1 (Insulation), Section R404.1 (~~Lightning~~Lighting equipment), and Table R402.~~6~~7 (Log Home Prescriptive Thermal Envelope Requirements by Component). 2. Section R405 (Simulated Performance Alternative). 3. REScheck (U.S. Department of Energy Building Codes Program). ~~(7-1-24)~~( )

g~~f~~. Add new Table R402.~~6~~7:

TABLE R402.67
LOG HOME PRESCRIPTIVE THERMAL ENVELOPE REQUIREMENTS BY COMPONENT

For SI: 1 foot = 304.8 mm.

Climate Zone	Fenestration U-factor[a]	Skylight U-factor	Glazed Fenestration SHGC	Ceiling R-value	Min. Average Log Size In Inches	Floor R-value	Basement Wall R-value[d]	Slab R-value & Depth[b]	Crawl Space Wall R-value[d]
5, 6 - High efficiency equipment path[c]	0.32	0.60	NR	49	5	30	15/19	10, 4 ft.	10/13
5	0.32	0.60	NR	49	8	30	10/13	10, 2 ft.	10/13
6	0.30	0.60	NR	49	8	30	15/19	10, 4 ft.	10/13

[a]The fenestration U-factor column excludes skylights. The SHGC column applies to all glazed fenestration.

[b]R-5 shall be added to the required slab edge R-values for heated slabs.

[c]90% AFUE natural gas or propane, 84% AFUE oil, or 15 SEER heat pump heating equipment (zonal electric resistance heating equipment such as electric base board electric resistance heating equipment as the sole source for heating is considered compliant with the high efficiency equipment path).

[d]"15/19" means R-15 continuous insulated sheathing on the interior or exterior of the home or R-19 cavity insulation at the interior of the basement wall. "15/19" shall be permitted to be met with R-13 cavity insulation on the interior of the basement wall plus R-5 continuous insulated sheathing on the interior or exterior of the home. "10/13" means R-10 continuous insulated sheathing on the interior or exterior of the home or R-13 cavity insulation at the interior of the basement wall.

~~(7-1-24)~~( )

g. *Section R403.6.1 Heat Recovery in CZ 6 – Delete.* ( )

h. *Section R403.6.3 Testing mechanical ventilation systems – Delete.* ( )

i. *Section R403.7.1 Electric resistance heating – Delete.* ( )

j. *Section R404.2 Interior lighting controls – Delete.* ( )

k. *Section R4.08 Additional efficiency requirements – Delete.* ( )

IDAPA 24 – DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSES

24.39.31 – RULES FOR FACTORY BUILT STRUCTURES

DOCKET NO. 24-3931-2501

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2026 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. Should the pending rule be approved, it will become final and effective on July 1 following the Second Regular Session of the Sixty-eighth Idaho Legislature, unless the concurrent resolution states a different effective date.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 67-2604, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change:

This rulemaking seeks to make final certain amendments to the permit fee table made through temporary rulemaking earlier this year published in the January 1, 2025, Idaho Administrative Bulletin, Vol. 25-1, Pages 81-82. These pending rules adjust permit fees downwards to address the Board's cash balance, while simultaneously reducing costs for licensees.

There are no changes to the pending rule, and it is being adopted as originally proposed. The complete text of the proposed rule was published in the November 5, 2025, Idaho Administrative Bulletin, Vol. 25-1, Pages 115-118.

FEE SUMMARY: Pursuant to Section 67-5224(2)(d), Idaho Code, a pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature. The following is a description of the fee or charge imposed or increased in this rulemaking:

There are no newly imposed or increased fees in this rule change. Instead, this rulemaking seeks to finalize the Board's fee reductions that were promulgated through temporary rulemaking earlier this year, reducing fees by twenty percent (20%) for eleven (11) of the Board's license and permit fees beginning January 1, 2025.

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:

No fiscal impact on the state general fund will occur as a result of these changes.

ASSISTANCE WITH TECHNICAL QUESTIONS: For assistance with technical questions concerning this pending rule, contact Ryan Bernard, Legislative and Regulatory Affairs Chief, at (775) 870-7926.

DATED this 5th day of December, 2025.

Ryan Bernard
Legislative and Regulatory Affairs Chief
PO Box 83720
Boise, ID 83720-0063
Phone: (775) 870-7926
Email: ryan.bernard@dopl.idaho.gov

THE FOLLOWING NOTICE PUBLISHED WITH THE 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 Section 67-2604, Idaho Code.

PUBLIC HEARING SCHEDULE: A public hearing concerning this rulemaking will be held as follows:

24.39.31 – Rules For Factory Built Structures

Wednesday, November 12, 2025
9:00 a.m. (MT)

Attend via Webex: Link
Meeting Number (Access Code): 2868 448 7497
Meeting password: ZnrnMr2ND42

Attend in person at:
Division of Occupational and Professional Licenses
EagleRock Room, Chinden Campus
11341 W. Chinden Blvd., Bldg. 4
Boise, ID 83714

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: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

This rulemaking seeks to make final certain amendments to the permit fee table made through temporary rulemaking earlier this year published in the January 1, 2025 Idaho Administrative Bulletin, Vol. 25-1, Pages 81-82. The rulemaking adjusts permit fees downwards to address the Board's cash balance, while simultaneously reducing costs for licensees.

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

There are no newly imposed or increased fees in this rule change. Instead, this rulemaking seeks to make final certain temporary permitting fee reductions.

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:

No fiscal impact on the state general fund will occur as a result of these changes.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1) and 67-5221(1)(j), Idaho Code, negotiated rulemaking was not conducted because DOPL wanted to provide immediate relief to the regulated community by adopting a temporary rule that mirrors the fee reduction in this proposed rule. The Notice of Rulemaking – Adoption of Temporary Rule was published in the January 1, 2025 Idaho Administrative Bulletin, Vol. 25-1, Pages 81-84. Any stakeholder input and all public comments submitted at the scheduled public hearing will be considered.

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: For assistance on technical questions concerning the proposed rule, contact Kolby Reddish, Chief Legal Counsel, at (208) 817-6126.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before November 26, 2025.

DATED this 17th day of October, 2025.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 24-3931-2501

500. PERMITS, PLAN REVIEWS, AND INSPECTIONS.

01. Modular Building Permit Fees. Permits must be obtained from the Division prior to the construction of structures governed by 39-4303, Idaho Code. Other than as specified in this section, the permit fee schedule for Modular Buildings is as provided in Table 1-A plus ninety dollars ($90) and two and one-half percent (2.5%) of the plumbing, electrical, and HVAC installation costs. The determination of value or valuation is based on the total value of all construction work for which a permit is issued.

TABLE 1-A – MODULAR BUILDING PERMIT FEES

TOTAL VALUATION		FEE
$1 to $500	=	$~~23.50~~18.80
$501 to $2,000	=	$~~23.50~~18.80 for the first $500 plus $~~3.05~~2.44 for each additional $100, or fraction thereof, to and including $2,000
$2,001 to $25,000	=	$~~69.25~~55.40 for the first $2,000 plus $~~14~~11.20 for each additional $1,000, or fraction thereof, to and including $25,000
$25,001 to $50,000	=	$~~391.75~~313.40 for the first $25,000 plus $~~10.10~~8.09 for each additional $1,000, or fraction thereof, to and including $50,000
$50,001 to $100,000	=	$~~643.75~~515 for the first $50,000 plus $~~7~~5.60 for each additional $1,000, or fraction thereof, to and including $100,000
$100,001 to $500,000	=	$~~993.75~~795 for the first $100,000 plus $~~5.60~~4.48 for each additional $1,000, or fraction thereof, to and including $500,000
$500,001 to $1,000,000	=	$~~3,233.75~~2,587 for the first $500,000 plus $~~4.75~~3.80 for each additional $1,000, or fraction thereof, to and including $1,000,000
$1,000,001and up	=	$~~5,608.75~~4,487 for the first $1,000,000 plus $~~3.65~~2.92 for each additional $1,000, or fraction thereof

~~(7-1-24)~~( )

02. Modular Plan Review. The Modular Building fee includes an additional amount equal to sixty-five percent (65%) of the permit fee calculated in accordance with Table 1-A. A fee of sixty-five dollars ($65) per

hour applies to additional plan review required by changes, additions, or revisions to plans. (7-1-24)

03. Manufactured/Mobile Home Installation Permit Fees. Permits must be obtained from the Division prior to the site installation governed by 44-2202, and 39-4004, Idaho Code in accordance with the following schedule: (7-1-24)

a. Single Section Unit. The permit fee is one hundred ~~fifty~~ twenty dollars ($~~150~~120). ~~(7-1-24)~~( )

b. Double Section Unit. The permit fee is ~~two~~ one hundred sixty dollars ($~~200~~160). ~~(7-1-24)~~( )

c. More Than Two Sections. The permit fee for a home consisting of more than two (2) sections is two hundred ~~fifty~~ dollars ($~~250~~200). ~~(7-1-24)~~( )

04. In-Plant Inspection Agency Fees. In-plant inspection fees for manufactured homes produced by Idaho Manufactures as per 39-4003A and 39-4004 of Idaho Code is set at forty-five dollars ($45) per floor. (7-1-24)

05. Inspections at Manufacturing Plants. The Division conducts inspections at the manufacturing plant to determine compliance with codes adopted by Title 39, Chapters 40 and 41, Idaho Code, and Title 54, Chapters 10, 26, and 50, Idaho Code. (7-1-24)

06. Manufactured Home Site Installation Inspections. Installation permits must be obtained from the Division for installations in areas where there is no approved local program, or from a city or county that has by ordinance adopted building codes pursuant to Section 39-4116, Idaho Code, and whose installation program has been approved by the Division. All installations must be inspected and approved by the authority having jurisdiction before the manufactured home is occupied. (7-1-24)

a. Installation inspections shall be conducted in accordance with the Idaho Manufactured Home Installation Standard or the Design Approval Primary Inspection Agency of the manufactured home. (7-1-24)

07. Modular Site Installation Inspection. In order to complete the installation of an Idaho approved Modular Building, approval and inspection of the installation by the enforcement agency having jurisdiction over the site location is required. (7-1-24)

08. Qualifications of Inspectors. All inspectors must be properly certified for the type of inspection being conducted. The Factory Built Structures Board recognizes certifications granted through the National Certification Program Construction Code Inspector program (NCPCCI), the National Inspection Testing Certification program (NITC), the International Association of Electrical Inspectors (IAEI), and the International Code Council (ICC). (7-1-24)

09. Minimum Training Requirements for Inspectors. All manufactured home installation inspectors must complete eight (8) hours of training or instruction germane to the profession. (7-1-24)

10. Rights and Limitations of Local Enforcement Agencies for Modular Buildings. (7-1-24)

a. A local enforcement agency has the right to require a complete set of plans and specifications approved by the Division for each Modular Building to be installed within its jurisdiction, to require that all permits be obtained before delivery of any unit. (7-1-24)

b. A local enforcement agency does not have the right to: open for inspection any Modular Building or component bearing an Insignia to determine compliance with any codes or ordinances; require by ordinance or otherwise that Modular Buildings meet any requirements not equally applicable to on-site construction; or to charge permit or plan review fees for any portion of the structure prefabricated or assembled at a place other than the Building Site. (7-1-24)

11. Division Approval. A city or county that has by ordinance adopted a building code pursuant to Section 39-4116, Idaho Code, is eligible to participate in the inspection of manufactured and mobile homes. Such local installation inspection program must be approved by the Division to provide inspection services if the following

minimum criteria is met: (7-1-24)

a. Inspections are conducted by the city or county employing inspectors holding a valid certification as residential building inspector from the International Code Council; (7-1-24)

b. Inspectors attended training sessions provided or approved by the Division and receive a certificate evidencing successful completion thereof. (7-1-24)

c. Voluntary Withdrawal. A city or county may voluntarily withdraw from participation in the program to inspect manufactured homes upon providing to the Administrator of the Division thirty (30) days written notice of its intention to do so. (7-1-24)

d. Quality Assurance. Any inspected installation is subject to quality assurance reviews by Division of Occupational and Professional Licenses. Findings made by the Division pursuant to such reviews will be forwarded to the inspection authority having jurisdiction. (7-1-24)

i. All inspectors and approved programs are subject to review. (7-1-24)

12. Modular Insignia and Serial Number. (7-1-24)

a. Assigned Insignia are not transferable and are void when not affixed as assigned. (7-1-24)

b. Each Modular Building must bear a legible identifying serial number. Each section of a multiple Modular Building must have the same identifying serial number followed by a numerical sequence identifier or a letter suffix, or both. (7-1-24)

IDAPA 24 – DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSES

24.39.50 – RULES OF THE PUBLIC WORKS CONTRACTORS LICENSE BOARD

DOCKET NO. 24-3950-2501

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2026 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. Should the pending rule be approved, it will become final and effective on July 1 following the Second Regular Session of the Sixty-eighth Idaho Legislature, unless the concurrent resolution states a different effective date.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 67-2604, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change:

This rulemaking seeks to make final certain amendments to the fee table made through temporary rulemaking earlier this year published in the January 1, 2025, Idaho Administrative Bulletin, Vol. 25-1, Pages 86-87. These pending rules add language to the fee table that allows the Board greater capability to reduce fees temporarily to address the Board's existing cash balances and to lower costs for licensees.

There are no changes to the pending rule, and it is being adopted as originally proposed. The complete text of the proposed rule was published in the November 5, 2025, Idaho Administrative Bulletin, Vol. 25-11, pages 119-121.

FEE SUMMARY: Pursuant to Section 67-5224(2)(d), Idaho Code, a pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature. The following is a description of the fee or charge imposed or increased in this rulemaking:

There are no newly imposed or increased fees in this rule change. Instead, this rulemaking seeks to finalize the Board's authority to temporarily reduce fees when necessary. Under this pending fee rule, promulgated through temporary rulemaking earlier this year, the Division implemented fee reductions of seventeen percent (17%) to twenty percent (20%) for seventeen (17) of the Board's license fees beginning January 1, 2025.

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:

No fiscal impact on the state general fund will occur as a result of these changes.

ASSISTANCE WITH TECHNICAL QUESTIONS: For assistance with technical questions concerning this pending rule, contact Ryan Bernard, Legislative and Regulatory Affairs Chief, at (775) 870-7926.

DATED this 5th day of December, 2025.

Ryan Bernard
Legislative and Regulatory Affairs Chief
PO Box 83720
Boise, ID 83720-0063
Phone: (775) 870-7926
Email: ryan.bernard@dopl.idaho.gov

THE FOLLOWING NOTICE PUBLISHED WITH THE 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 Section 67-2604, Idaho Code.

PUBLIC HEARING SCHEDULE: A public hearing concerning this rulemaking will be held as follows:

24.39.50 – Rules Of The Public Works Contractors License Board

Wednesday, November 12, 2025
9:00 a.m. (MT)

Attend via Webex: Link
Meeting Number (Access Code): 2868 448 7497
Meeting password: ZnrnMr2ND42

Attend in person at:
Division of Occupational and Professional Licenses
EagleRock Room, Chinden Campus
11341 W. Chinden Blvd., Bldg. 4
Boise, ID 83714

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: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

This rulemaking seeks to make final certain amendments to the fee table made through temporary rulemaking earlier this year published in the January 1, 2025 Idaho Administrative Bulletin, Vol. 25-1, Pages 86-87. The rulemaking adds language to the fee table that allows the Board greater capability to reduce fees temporarily to address the Board's existing cash balances and to lower costs for licensees.

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

There are no newly imposed or increased fees in this rule change. Instead, this rulemaking seeks to make final increased capability of the Board to temporarily reduce fees if necessary.

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:

No fiscal impact on the state general fund will occur as a result of these changes.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1) and 67-5221(1)(j), Idaho Code, negotiated rulemaking was not conducted because DOPL wanted to provide immediate relief to the regulated community by adopting a temporary rule that mirrors the fee reduction in this proposed rule. The Notice of Rulemaking – Adoption of Temporary Rule was published in the January 1, 2025 Idaho Administrative Bulletin, Vol. 25-1, Pages 86-87. Any stakeholder input and all public comments submitted at the scheduled public hearing will be considered.

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: For assistance on technical questions concerning the proposed rule, contact Kolby Reddish, Chief Legal Counsel, at (208) 817-6126. Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before November 26, 2025.

DATED this 17th day of October, 2025.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 24-3950-2501

24.39.50 – RULES OF THE PUBLIC WORKS CONTRACTORS LICENSE BOARD

400. FEES.

01. Public Works Contractor.

License Class	Initial Fee (Not to exceed)	Renewal Fee (Not to exceed)
Unlimited	$550	$440
AAA	$450	$360
AA	$350	$280
A	$250	$160
B	$150	$120
CC	$125	$100
C	$100	$80
D	$50	$40

~~(7-1-24)~~( )

02. Construction Manager:

License Activity	Fee (Not to exceed)
Initial Licensing	$200
License Renewal	$200
Inactive License	$50
License Reinstatement	$200
Certificate of Authority	$100

~~(7-1-24)~~( )

IDAPA 28 – DEPARTMENT OF COMMERCE

28.02.03 – DEPARTMENT OF COMMERCE GRANT PROGRAM RULES

DOCKET NO. 28-0203-2501 (ZBR CHAPTER REWRITE)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2026 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. Should the pending rule be approved, it will become final and effective on July 1 following the Second Regular Session of the Sixty-eighth Idaho Legislature, unless the concurrent resolution states a different effective date.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 67-4733 and 67-4744, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change:

There are no changes to the pending rule, and it is being adopted as originally proposed. The complete text of the proposed rule was published in the October 1, 2025, Idaho Administrative Bulletin, Volume 25-10, pages 371-378.

FEE SUMMARY: Pursuant to Section 67-5224(2)(d), Idaho Code, a pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature. The following is a description of the fee or charge imposed or increased in this rulemaking: 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:

No Fiscal Impact.

ASSISTANCE WITH TECHNICAL QUESTIONS: For assistance with technical questions concerning this pending rule, contact Ewa Szewczyk, 208-287-0784.

DATED this 4th day of December, 2025.

Ewa Szewczyk
Grants & Contracts Manager Idaho Commerce
700 W State St. Boise, ID 83702
(208) 334-2470
ewa.szewczyk@commerce.idaho.gov
commerce.idaho.gov

THE FOLLOWING NOTICE PUBLISHED WITH THE 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 Section 67-4733 and 67-4744, Idaho Code.

PUBLIC HEARING SCHEDULE: A public hearing concerning this rulemaking will be held as follows:

Friday, October 10th, 1:00 p.m., 2025 MT

In person:
Idaho Department of Commerce
JRW Building
700 W State St. Floor 2
Boise, ID 83702
Clearwater Conference Room

For virtual meeting accommodation please email:
Ewa.Szewczyk@commerce.idaho.gov

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: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

These rules are being presented for approval as part of the department's plan to review each rule every 5 years. Amendments were identified by the agency and presented to stakeholders and are consistent with the Governor's Zero-based Regulation Executive Order. Primary rulemaking objectives are removing items repealed by statute, improving definitions to align programs, and removing redundant language already in statute.

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

There are no fees or charges imposed or increased as a result of this rulemaking.

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 as a result of this rulemaking:

No fiscal impact.

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 2, 2025, Idaho Administrative Bulletin, Volume 25-7, p 126-127.

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:

CDBG handbook was removed from administrative rules and added as an incorporation by reference for clarity and to remove redundant language.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Ewa Szewczyk 208-287-0784.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 22, 2025.

DATED this 29th day of August, 2025.

THE FOLLOWING IS THE TEXT OF ZBR DOCKET NO. 28-0203-2501

28.02.03 – DEPARTMENT OF COMMERCE GRANT PROGRAM RULES

000. LEGAL AUTHORITY.
~~These rules have been adopted pursuant to~~ Sections 67-4702, 67-4703, 67-4715, 67-4717, 67-4718, and 67-4733, Idaho Code. ~~(3-31-22)~~( )

001. ~~TITLE AND~~ SCOPE.

~~01.~~ ~~Title~~. ~~These rules are titled IDAPA 28.02.03, "Department of Commerce Grant Program Rules."~~ ~~(3-31-22)~~

~~02.~~ ~~Scope~~. ~~These~~ rules implement the following Department of Commerce grant programs:1) Idaho Regional Travel and Convention Grant Program; 2) Idaho Gem Grant Program; 3) Rural Community Investment Fund; 4) IGEM Grant Program; 5) Idaho Opportunity Fund; and 6) Idaho Community Development Block Grant Program. ~~(3-31-22)~~( )

002. INCORPORATION BY REFERENCE.
The Department of Commerce adopts and incorporates by reference the following document(s): ( )

01. Housing and Community Development Act of 1974: Title I; sections 210 and 213; title VI; and sections 802, 809, 817, and 819 [Public Law 93–383; 88 Stat. 633; 42 U.S.C. 5301 et seq.][As Amended Through Public Law 113–287, December 19, 2014]. Available here: https://www.govinfo.gov/content/pkg/COMPS-10382/pdf/COMPS-10382.pdf. ( )

003. REFERENCED MATERIAL.

01. 24 CFR Part 570. This source document originally published in 40 FR 24693, June 9, 1975, and the most current version is available here: https://www.ecfr.gov/current/title-24/part-570. ( )

02. Annual Action Plan. As rules for the administration of the Idaho Community Development Block Grant (CDBG), the most current version of this material is available on the department's website here: https://commerce.idaho.gov/communities/community-grants/community-development-block-grant-cdbg/. ( )

002~~3~~4. -- 009. (RESERVED)

010. DEFINITIONS.

~~01.~~ ~~Department~~. ~~The Idaho Department of Commerce as set forth in Section 67-4701, Idaho Code.~~

~~(3-31-22)~~

0~~2~~1. Program Guidelines. Department ~~of Commerce~~ grant programs are administered in accordance with applicable federal and state statutes, these rules, grant resources available on the Department's website, and written grant agreements entered into between the successful applicant and the Department. Collectively these laws, rules, handbooks, grant resources, and grant agreements are referred to as "program guidelines" throughout these rules and each may be enforced by the Department. ~~(3-31-22)~~( )

011. -- 049. (RESERVED)

SUBCHAPTER A – GENERAL GRANT PROGRAM REQUIREMENTS

050. GENERAL GRANT PROGRAM REQUIREMENTS.

01. Application Procedure. All applicants must meet eligibility requirements specified in program guidelines. Eligible applicants must submit a completed application to the Department and meet the requirements specified in program guidelines prior to the application deadline specified therein. (3-31-22)

02. Review of Applications. Unless otherwise specified, all grants will be reviewed, ranked, and selected by the Department and relevant council members if applicable, in accordance with selection criteria specified in program guidelines. All applicants will be notified of their application status in a reasonable timeframe after the application deadline. (3-31-22)

03. Grant Agreement. All applicants selected for funding must enter into a written grant agreement with the Department. The grant will take effect upon the date of award specified in the grant agreement and grant monies cannot be expended until that date. (3-31-22)

04. Amendments to Grant Agreements. Extensions and amendments to grant agreements are only permitted if agreed to in writing and approved by the Department or applicable council members. (3-31-22)

05. Grant Acknowledgment. If required, projects funded by the Department must acknowledge said program as outlined in the program guidelines. (3-31-22)

06. Reporting Requirements. As specified in program guidelines, the grantee must provide regular progress reports to the Department to demonstrate progress toward planned outcomes, as well as a final report demonstrating the outcomes achieved. (3-31-22)

07. Termination of Funding. The grantee may only use the grant funds in accordance with program guidelines. If at any time the Department becomes aware of a grantee's noncompliance with program guidelines, or inappropriate or illegal use of grant funds, the Department may terminate the agreement. The Department may require an audit of grant funds. The Department may further terminate a grant if the project loses viability or is unlikely to meet the intent of the original application. (3-31-22)

08. Limitation on Use of Funds. Program guidelines detail ineligible uses of funds. In addition, funds cannot be used as follows: (3-31-22)

a. Political activities. For political purposes or to engage in lobbying or other partisan political activities. (3-31-22)

b. Religious activities. For the construction, rehabilitation or operation of active churches or religious structures used for religious purposes. (3-31-22)

c. Conflict of interest. If at any time the Department and/or any council member(s) becomes aware of an apparent or potential conflict of interest between a grantee and a private entity which may influence grant funds, the Department may request a meeting with the grantee's representatives. The Department may, at that meeting, terminate the grant if an inappropriate conflict of interest is found. (3-31-22)

09. Rural Community. Communities that are generally less than twenty-five thousand (25,000) in population. (3-31-22)

10. Cost Reimbursable. Department grants are cost reimbursable. Grant payment procedures will be established in the program guidelines. The Department will reimburse allowable costs up to the maximum grant amount for which both receipts and matching funds documentation have been provided. The grantee is responsible for any discrepancies in documentation. (3-31-22)

051. -- 099. (RESERVED)

100. IDAHO REGIONAL TRAVEL AND CONVENTION GRANT PROGRAM.

01. Program Intent. The intent of this program is to provide grant funds to non-profit, incorporated organizations which have in place a viable travel or convention promotion program, or both, in their area of operation. Preference is given to programs with a primary focus of promoting overnight visitation in Idaho. Funds may be used for tourism marketing which has a positive economic impact to the state of Idaho including, but not limited to, the promotion of accommodations, recreational areas, events, conferences, food and beverage, tourism services, culture, attractions, and transportation. (3-31-22)

02. Eligible Applicants. Non-profit entities with a focus on tourism. Entities must provide proof of non-profit status including: State of Idaho Certificate of Incorporation, Articles of Incorporation from the Secretary of State, or a letter of determination from the Internal Revenue Service, and Notice of Employer Identification Number assigned by the Internal Revenue Service. (3-31-22)

03. Review of Applications. The Idaho Travel Council will review applications in accordance with selection criteria specified in program guidelines. (3-31-22)

04. Matching Funds. This grant requires a cash match of twelve and one-half percent (12.5%) of the amount awarded, with further requirements specified in program guidelines. (3-31-22)

05. Distribution of Funds. The Department will reimburse funds to the grantee upon submission and review of complete documentation of funds expended. (3-31-22)

06. Eligible Expenses. (3-31-22)

a. Program intent. Eligible projects under the Regional Travel and Convention Grant Program must be consistent with the legislative declaration of policy in Title 67, Chapter 47, Idaho Code, and the program intent. Programs that are eligible for consideration must fall under the basic definition of travel or convention promotion. (3-31-22)

b. Administrative expense. The following administrative and overhead costs are allowable: (3-31-22)

i. Wages and benefits. Wages and benefits of one (1) designated grant administrator for time directly related to the task of grant administration. Other employee wages and benefits incurred in the execution of the grant program may be used as cash match with documentation. (3-31-22)

ii. Overhead. Reasonable, apportioned overhead costs of the grantee organization required to execute the grant program must be approved by the Idaho Travel Council. The Department will recommend preferred apportionment methods. (3-31-22)

07. Ineligible Expenses. Unless specified otherwise in the program guidelines, this grant program will not fund: (3-31-22)

a. The day-to-day, administrative expenses of organizations that have a travel or convention promotion element; (3-31-22)

b. Projects that have alternative funding sources (for example, regular Chamber of Commerce

budgets) or that have been funded previously with the agency's own funds; or (3-31-22)

c. The promotion of local events; or (3-31-22)

d. No expenses related to grant writing, or grant application are eligible. (3-31-22)

08. Audit Requirement. Grantees who receive one hundred thousand dollars ($100,000) or more in grant funds will have an audit performed by a Certified Public Accountant and submitted to the Department within sixty (60) days following the close of the grant cycle. (3-31-22)

101. -- 149. (RESERVED)

150. IDAHO GEM GRANT (IGG) PROGRAM.

01. Program Intent. The intent of this program is to fund community development projects of rural communities for the purpose of improving the local economy, retaining or creating jobs, promoting the community for economic development and tourism, and assisting business expansion and diversification. (3-31-22)

02. Eligible Applicants. Idaho rural communities ~~under ten thousand (10,000) persons~~ and other Idaho rural communities at the discretion of the Director of the Department of Commerce are eligible to apply for IGGs up to a maximum of ~~fifty~~ one hundred thousand dollars ($~~50~~100,000). IGGs to city and county governments may be administered by their designees as established by formally adopted resolutions. ~~(3-31-22)~~( )

03. Review of Applications. The Department's Director, in his sole discretion, makes all IGG awards. The Director may make grant awards at any time the Director determines it necessary to take advantage of special opportunities that further the primary objectives of the IGG Program. (3-31-22)

04. Matching Funds.This grant may requires a minimum of twenty percent (20%) matching funds of either cash or in-kind donations for the total amount of IGG funds received. Matching funds can be comprised of any combination of cash and in-kind donations and must meet conditions specified in the program guidelines. ~~(3-31-22)~~( )

05. Distribution of Funds. Grantees receive payment of IGG funds on a cost reimbursement basis. Grant payment procedures will be established in the program guidelines. The Department will reimburse allowable costs up to the maximum grant amount for which both receipts and matching funds documentation have been provided. The grantee is responsible for any discrepancies in documentation. (3-31-22)

06. Eligible Expenses. Eligible expenses are specified in program guidelines. (3-31-22)

07. Ineligible Expenses. Funds may not be used for: (3-31-22)

a. Payroll costs for city, county, development corporation or other community agencies. (3-31-22)

b. Real property acquisition. Construction, rehabilitation, or operation of schools, general government facilities, jails or state facilities. (3-31-22)

c. Administrative costs. Expenses related to administering the grant will not be reimbursable to the grantee from grant funds. (3-31-22)

~~**08. Bid Process**. Grantees must contact a minimum of three (3) vendors for quotes or bids for the purchase of goods or services over twenty-five thousand dollars ($25,000). Prior to reimbursement for such costs, the following information must be submitted to the Department: (3-31-22)~~

~~**a.** Item or service purchased. A detailed description of the item or service purchased or to be purchased. (3-31-22)~~

~~**b.** Bid verification. Written documentation of three (3) or more businesses or vendors contacted by~~

~~IGG grantees for bids or quotes listing the businesses or vendors contacted and indicating their response, and a list of all businesses or vendors contacted whether or not a response was received.~~ ~~(3-31-22)~~

~~**c.** Reasons for selection. Grantees justification for the business or vendor selected.~~ ~~(3-31-22)~~

151. -- 199. (RESERVED)

200. RURAL COMMUNITY INVESTMENT FUND (RCIF).

01. Program Intent. This grant provides funds to rural areas in support of economic expansion and job creation, as defined per the program guideline which includes the RCIF Grant Application and Manual. (3-31-22)

02. Eligible Applicants. Applicants for the Idaho Rural Community Block Grants are as follows: (3-31-22)

a. City applicants. Rural cities are those generally less than twenty-five thousand (25,000) in population. Cities contiguous to large cities are not eligible to apply. (3-31-22)

b. County applicants. Counties with less than twenty-five thousand (25,000) population. However, any county may apply for unincorporated communities closely connected to non-metro or rural communities. ~~(3-31-22)~~( )

c. Indian tribes located in Idaho may apply if the project site is located on reservation land and within a community of less than twenty-five thousand (25,000) population. (3-31-22)

03. Review of Applications. Presentations must be made by key elected officials of the applicant to the Department's Economic Advisory Committee (EAC) on the need for the project, the local commitment to the project, the economic impact of the project on the community, and any additional information that should be given special consideration. Applications will be reviewed and ranked on criteria specified in the RCIF Grant Application and Manual. The EAC may recommend standby projects to be funded if enough funds become available at a later time. (3-31-22)

04. Eligible Expenses. Eligible expenses are specified in the RCIF Grant Application and Manual. (3-31-22)

05. Ineligible Expenses. Any activity not authorized in the RCIF Grant Application and manual is ineligible to receive RCBG funds, including: (3-31-22)

a. General conduct of government. Assistance to buildings, or portions thereof, used predominantly for the general conduct of government. Such buildings include, but are not limited to, city halls, courthouses, jails, police stations, state or local government office buildings, and other building used for general government administration affairs. Also ineligible are school buildings, school administration offices, and university and college vocational-technology facilities. (3-31-22)

b. Local government expenses. Expenses to carry out the regular responsibilities of the unit of general local government are not eligible for assistance with RCIF. (3-31-22)

c. Equipment. The purchase of equipment, fixtures, motor vehicles, furnishings or other personal property, which is not an integral structural fixture, is generally ineligible. (3-31-22)

d. Operating and maintenance expenses. (3-31-22)

201. --~~249.~~ ~~(RESERVED)~~

~~250. IDAHO GLOBAL ENTREPRENEURIAL MISSION (IGEM) GRANT PROGRAM.~~

~~01. Program Intent~~. ~~The IGEM Grant Program funds commercialization grants supporting University~~

~~and industry research partnerships for the purpose of enhancing technology transfer and commercialization of research and technologies developed at the Universities to create high-quality jobs and new industries in the private sector in Idaho.~~ ~~(3-31-22)~~

~~**02. Eligible Applicants**. Idaho's public research universities: Boise State University, Idaho State University, and University of Idaho.~~ ~~(3-31-22)~~

~~**03. Industry Partner**. A domestic or foreign entity that designs, produces, or sells goods or services or that contractually agrees to undertake such acts in connection with the technologies licensed or otherwise transferred to the entity by a University, and that is partnered with an Eligible Applicant.~~ ~~(3-31-22)~~

~~**04. Review of Applications**. In selecting IGEM awards, the IGEM Council will give greater weight to proposals that partner with Idaho-based entities.~~ ~~(3-31-22)~~

~~**05. Matching Funds**. This grant requires a monetary or in-kind contribution from the industry partner as outlined in program guidelines.~~ ~~(3-31-22)~~

~~**06. Commercialization Revenue**. Revenue generated through the commercialization of university intellectual property rights in a work authored or an invention conceived or first reduced to practice in the performance of an IGEM grant award are distributed as outlined in Section 67-4731, Idaho Code.~~ ~~(3-31-22)~~

~~251. --~~ 299. (RESERVED)

300. IDAHO OPPORTUNITY FUND.

01. Program Intent. The Idaho Opportunity Fund provides funding for public costs incurred with the purpose to retain, expand or attract jobs, which include: (3-31-22)

a. Construction of or improvements to new or existing water, sewer, gas or electric utility systems for new or existing buildings to be used for industrial or commercial operations; (3-31-22)

b. Flood zone or environmental hazard mitigation; or (3-31-22)

c. Construction, upgrade or renovation of other infrastructure related items including, but not limited to, railroads, broadband, parking lots, roads or other public costs that are directly related to specific job creation or expansion projects. (3-31-22)

02. Review of Applications. The Director of the Department may, in his sole discretion, award Opportunity Fund grants to local governments in accordance with program guidelines. (3-31-22)

03. Matching Funds. This grant requires an allowable local match. Allowable match includes those costs which are allowable within the Opportunity Fund and are provided by the local government as cash, in-kind services, fee waivers (such as development impact fees), donation of assets, the provision of infrastructure or a combination thereof. The match must represent a material commitment from the local government that is commensurate with the local government's financial condition. The Director of the Department has the authority to approve other forms of local match or waive the local match requirements. (3-31-22)

04. Distribution of Funds and Eligible Applicants. Funds will be disbursed from the Opportunity Fund to local governments as defined in the Local Government Grant Agreement and after the local government has demonstrated that the Grantee Business has complied with the terms of the Company Performance Agreement. (3-31-22)

05. Grant Agreements. Local Government Grant Agreements will be entered into between the Department and one (1) or more local governments, and contain the provisions specified in the program guidelines. In addition, Company Performance Agreements will be entered into between one (1) or more local governments and a Grantee Business, and containing provisions outlined in the program guidelines. (3-31-22)

301. --~~349.~~ ~~(RESERVED)~~

~~350. IDAHO COMMUNITY DEVELOPMENT BLOCK GRANT (ICDBG).~~

~~01. Incorporation by Reference~~. ~~The Department of Commerce adopts and incorporates by reference the CDBG Procedures Guide, CDBG Application Handbook, the CDBG Grant Manual, 24 CFR Part 570, and the most current Annual Action Plan as rules for the administration of the Idaho Community Development Block Grant.~~ ~~(3-31-22)~~

~~02. Purpose~~. ~~The rules incorporated by reference in (01) relate to the scope and procedures for the implementation of the Idaho Community Development Block Grant Program.~~ ~~(3-31-22)~~

~~351. --~~ 999. (RESERVED)