IDAPA 18 – IDAHO DEPARTMENT OF INSURANCE

Health & Disability Insurance

18.04.15 – Rules Governing Short-Term Health Insurance Coverage

Who does this rule apply to?
This rule applies to all enhanced short-term plans and nonrenewable short-term coverage that provide medical expense coverage.

What is the purpose of this rule?
This rule implements Title 41, Chapters 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.

What is the legal authority for the agency to promulgate this rule?
This rule implements the following statutes passed by the Idaho Legislature:

Insurance -
- 41-02, et seq., Idaho Code – The Department of Insurance
- 41-21, et seq., Idaho Code – Disability Insurance Policies
- 41-22, et seq., Idaho Code – Group and Blanket Disability Insurance
- 41-52, et seq., Idaho Code – Hospital And Professional Service Corporations

Who do I contact for more information on this rule?

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This rule chapter will be reviewed in compliance with Section 67-5292, Idaho Code, and in accordance with the 8-year rule review schedule linked here.

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000. LEGAL AUTHORITY.
Section 41-211, Section 41-4203, Section 41-4204, and Section 41-5211 Idaho Code. (4-2-26)

001. SCOPE.
This chapter implements Title 41, Chapters 21, 42, and 52, Idaho Code. (4-2-26)

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 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. (4-2-26)

04. Qualified Health Plan or QHP. A health plan certified as such by the Exchange. (3-31-22)

05. 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)

06. 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 SHORT-TERM, LIMITED-DURATION INSURANCE.
Short-term, Limited-duration Insurance is subject to the provisions of IDAPA 18.04.13, Sections 081, 082, and 101. (4-2-26)

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 twelve (12) months or longer is subject to the requirements applicable to enhanced short-term plans. (4-2-26)

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. (4-2-26)

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)

013. -- 019. (RESERVED)

020. ENROLLMENT.

01. Year-round Enrollment. A carrier will allow year-round enrollment. (4-2-26)

02. Preexisting Conditions. A preexisting condition exclusion period may be applied, subject to Section 41-5208, Idaho Code. (4-2-26)

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. 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. The carrier will provide to the policyholder timely notification of eligibility plus the notification of any offer of reissuance. (4-2-26)

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 Section 41-5206, Idaho Code. (4-2-26)

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. 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. The following covered benefits and limitations are to be provided, consistent with the Benchmark Medical Plan. (4-2-26)

a. Ambulatory (outpatient) patient services; (3-31-22)

b. Emergency services; (3-31-22)

c. Hospitalization; (3-31-22)

d. Generic prescription drugs; (4-2-26)

e. Rehabilitative and habilitative services and devices; and (4-2-26)

f. Laboratory services. (4-2-26)

02. 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)

03. 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 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. (4-2-26)

c. The annual limit is no less than one million dollars ($1,000,000) for each insured. (4-2-26)

04. Benefit Requirements. The minimum benefits imposed by Subsection 030.01 may be subject to all applicable deductibles, coinsurance and general policy exceptions and limitations. Except as allowed by Subsection 030.03, a policy will cover the usual, customary and reasonable charges, as determined consistently by the carrier or another rate agreed to between the insurer and provider, for covered services up to the annual limit. (4-2-26)

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)