



2022 Health Insurance Survey Instructions

General Information

1. 2022 Health Insurance Survey is due **5/1/2023**
2. The Health Insurance Survey covers only Idaho's residents, regardless of which state an employer is located.
3. Please complete the survey electronically online on the DOI website.
4. If reporting for a newly licensed company in Idaho, contact information should identify the individual for point of contact if the Idaho DOI has questions about the survey. Any subsequent change in contact information must be reported via e-mail to the DOI.
5. Report dollar amounts and numerical counts accurately using whole numbers.
6. Do not use commas or dollar signs.
7. Premium and claim totals should balance with the NAIC Annual Statement state page for Idaho.
8. Additional information is required for Associations and Trusts: Name, Location of Association or Trust, type of policy (major medical or non-major medical, and number of Idaho residents covered at the end of survey year.
9. Major Medical Demographic Data is intended to capture demographic data for major medical plans. Total covered lives must match total covered lives entered for ACA-compliant, grandfathered, transitional and HRP plans.

Specific health related questions on the survey should be directed to:
Healthsurvey@doi.idaho.gov. Any other questions should be directed to:

Kathy McGill: kathy.mcgill@doi.idaho.gov or (208) 334-4300

Zac Chejanovski: zac.chejanovski@doi.idaho.gov or (208) 334-4277

All surveys are subject to auditing. All premiums should reflect the NAIC annual statement. If figures do not reflect these totals, please provide an explanation of differences.

Individual/Group

Definition of Row Headings

- **ACA-Compliant** – A major medical health plan that incorporates all of the market reform requirements of the Patient Protection and Affordable Care Act (ACA), as amended by the Health Care and Education Reconciliation Act of 2010.
- **Accident or AD&D** – Coverage, singly or in combination, for death, dismemberment, or hospital and medical care caused by an accident, including accident only, travel accident, accidental death and dismemberment or blanket accident.
- **Administrative Services Contract** – Administrative services for a self-funded employer, association or other entity's health plan, in which claims are paid from the insurer's own bank account and the insurer subsequently receives reimbursement from the self-funded entity.
- **Administrative Services Only** – Administrative services for a self-funded employer, association or entity's health plan in which claims are paid from a bank account owned and funded directly by a self-funded entity or claims are paid from a bank account owned by the administrator but only after receiving funds from the self-funded entity.
- **Association** – A policy issued to an association, regardless of situated of contract or association, which covers at least one Idaho life.
- **Blanket** – Accident and sickness insurance covering groups of persons pursuant to Idaho Code §41-2006 (excluding accident only).
- **Bronze** – ACA-compliant health plan in the individual or small group market which, on average, has an actuarial value of 60%.
- **Catastrophic** - ACA-compliant health plan in the individual market which, on average, has an actuarial value of less than 60% and is only available to individuals under age 30 or who qualify for a hardship exemption.
- **Dental** –All Dental Plans.
- **Direct** – Coverage marketed by carrier and delivered to the consumer through mail, online services, or other non-traditional means.
- **Disability Income** – Loss of time coverage but does not include credit disability.
- **Enhanced Short-term Coverage** – Individual coverage that has an initial period of less than twelve months and is renewable at the option of the individual for up to 36 months.
- **Federal Government Benefit Plans** – The federal employee health benefit plan as administered by the U.S. Office of Personnel Management.
- **Franchise Disability** – Health insurance on a franchise plan pursuant to §41-2137.
- **Gold** - ACA-compliant health plan in the individual or small group market which, on average, has an actuarial value of 80%.
- **Group** – Insurance issued to an employer covering employees and any dependents including insurance offered to an employer through an association or trust.

- **Grandfathered** – Major medical health plan in effect on March 23, 2010 which has not been significantly changed since that date and is exempt from most of the market reforms of the ACA.
- **Health Benefit Plan** – Coverage for hospital, medical and surgical expenses (not supplemental coverage but may include dental and vision benefits that are offered as part of the hospital, medical and surgical coverage). Do not include hospital only, medical only or other limited benefit insurance in this line (include in the Limited Benefit line).
- **Health insurance** – Disability insurance as defined in Idaho Code §41-503.
- **High Risk Plan** – (HRP) An individual basic, standard, catastrophic A, catastrophic B or HSA compatible health benefit plan established pursuant to Idaho Code §41—5511. The individual must meet the eligibility requirement of Idaho Code §41—5511(1).
- **Hospital Indemnity** – Designed to provide, to persons insured, coverage in the form of a fixed daily benefit during periods of hospitalization resulting from a covered accident or sickness, subject to any limitations set forth in the policy. Coverage is not provided for any benefits other than the fixed daily indemnity for hospital confinement.
- **Individual** – Insurance issued to cover an individual and any dependent(s), which is not employment based, including insurance offered to an individual through an association or trust. Individual insurance includes conversions from group insurance.
- **Large Employer (101+)** – Health insurance offered, delivered, issued for delivery or renewed to an employer that is not a Small Employer or Mid-size Employer.
- **Limited Benefit** – A policy or contract other than a policy or contract covering only a specified disease or diseases that provides benefits that are less than minimum standards defined in IDAPA 18.01.30.029.01, Individual Disability and Group Supplemental Disability Insurance Minimum Standard Rule. Do not include specified disease insurance in this line (include in **Specified Disease** line). This benefit would be supplemental only to any other health benefit plan.
- **Long Term Care** – Coverage for at least twelve consecutive months for diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services, impairment, or loss of functional capacity. This line should include products providing only nursing home care, home health care, community-based care or any combination.
- **Long Term Disability.** – Replaces a portion of the policy holder's salary for an extended period of time. The specific percentage of replaced income varies with different policies.
- **Major Medical** –Health insurance policies, contracts or certificates that are issued to provide hospital and medical-surgical coverage.
- **Medicare Advantage** – (Title XVIII) Includes HMO, PPO, Fee-for-Service Plans, MSA and Medicare special needs.
- **Medicare Part D** – Coverage designed for reimbursement of prescription drug benefit under Medicare.
- **Medicare Supplement** – Coverage designed as a supplement to reimbursement under Medicare for hospital, medical or surgical expenses of a person eligible for Medicare.

- **Mid-size Employer (51-100)** – Health insurance offered, delivered, issued for delivery, or renewed to an employer that is not a Small Employer that employed an average of not more than one hundred eligible employees on the business days during the preceding calendar year, and that employs not more than one hundred eligible employees on the first day of the health insurance plan year.
- **Multiple Employer Association or Trust** – Health insurance issued to an association or trust covering employees and dependents of employer members. Health insurance issued to an association or trust covering only persons not covered by employment based insurance is to be reported in the Individual survey portion.
- **Nonrenewable Short term Coverage** – Short-term, limited-duration insurance that is not renewable, has a duration of six months or less in total, and is not an Enhanced Short-term plan.
- **Other** – Health insurance coverage that does not meet one of the above product definitions. Provide a brief description of the product on the survey. Please be as specific as possible.
- **Platinum** - ACA-compliant health plan in the individual or small group market which, on average, has an actuarial value of 90%.
- **Short Term Disability** – Replaces a portion of the policyholder’s salary for a short period—typically from three to six months following a disability. The specific percentage of replaced income varies with different policies.
- **Silver** - ACA-compliant health plan in the individual or small group market which, on average, has an actuarial value of 70%.
- **Small Employer (2-50)** – Health insurance offered, delivered, issued for delivery or renewed to an employer that employed an average of at least one but not more than fifty eligible employees on the business days during the preceding calendar year and that employs at least two but not more than fifty eligible employees on the first day of the health insurance plan year.
- **Specified Disease** – Coverage for diagnosis and treatment of a specifically named disease, such as cancer.
- **Stop Loss/Excess** – Coverage purchased by a self-funded entity (such as an employer, association, or trust) to cover hospital, medical or surgical expenses in excess of a specified amount.
- **Student Health Plan.** – Individual health insurance coverage provided pursuant to a written agreement between an institution of higher education and a health insurance issuer.
- **Transitional** – Non-grandfathered individual or small group health plan in existence on December 31, 2013, which is exempt from many of the market reforms of the ACA, and which may be extended through December 31, 2018, but may not be offered to new enrollees after 2013.
- **Trust** – A policy issued to a trustee, either situated in this state or any other state, established by 2 or more employers in the same or related industry or one or more labor unions where the trustee is the policyholder to insure employees of employers or labor unions.
- **Vision** – Stand-alone vision coverage.

Definition of Column Headings

Number of policies is the number of insurance contracts issued to employers, associations and trusts in Idaho, not the number of employees, dependents/spouses or other individuals covered under such policies.

Number of covered individuals is the number of employees, dependents and other individuals covered under group policies.

- **Allowed Under Contract** – The amount the insurer pays under the insurance contract.
- **Billed Provider Charges** – The amount that the provider billed for the services provided.
- **Direct Losses Paid** – The sum of all payments made during the reporting period for claimants under a benefit plan before reinsurance has been ceded or assumed. The term does not include home office and other overhead costs, advertising costs, commissions and other acquisition costs, taxes, capital costs, administrative costs, utilization review costs or claims processing costs.
- **Direct Premium** – All premium collected by the insurer before reinsurer premiums are deducted.
- **Earned Premium** – Earned premiums during the reporting year as reflected on NAIC annual statement, with the exception of association, trust or group blanket policies that were issued and/or situated in another state with insureds in Idaho. In those instances where premium has been reported in another state, the premium attributed to the Idaho residents should be added to what was reported in the annual statement.

For property and casualty insurance companies, earned premium and direct premium totals should balance to the Idaho State Page for the reporting year, Accident and Health lines including any employer or stop loss that is reported in the liability lines.
- **Individuals Covered End of Year** – Number of people covered under policies in force on December 31 of the reporting year including those Idahoans covered under an employer, trust, or association policy in force in another state. For example, a family policy covering two parents and two children would count as four individuals covered and an employer health plan that covers 25 employees, 20 spouses and 20 children would count as 65 individuals covered (1 policy).
- **Member Months** – The sum of the number of covered lives on a specified day of each month during the calendar year, (i.e., determine the number of covered lives on a particular day in each of the 12 months and add together).
- **New Policies Issued During the Year** – Number of policies newly issued during the reporting year not including renewed or reinstated policies.
- **New Policies Issued with agent or broker** – Number of policies newly issued during the reporting year, not including renewed or reinstated policies, in which a licensed agent or broker assisted a consumer in enrolling in a health insurance plan and received compensation from a carrier.

- **New Policies In Force End of Year** – Number of policies in force on December 31 of the reporting year. In the case of employer, trust or association health coverage, if no policies are in force in Idaho, but individuals in Idaho are covered under an employer, trust or association policy in force in another state, record the number of out of state policies covering one or more Idaho residents in force.
- **Policies Terminated During the Year** – Number of policies in force at least one day during the reporting year, but no longer in force on December 31 of the reporting year.
- **Rescissions** – Voiding of an insurance contract at date of issue by the insurer because of intentional material misrepresentation on the application for insurance. The policy is treated as never having been issued and the sum of all premiums paid plus interest, less any claims paid, is refunded.

Claim Payment Data

- **Claim** – A request for payment under an insurance contract. Count multiple requests for payment for the same health care service or supply as only one claim. Do not count a response to a request for additional clarification/information regarding an already submitted claim as another claim.
- **Clean Claim** – A claim that does not have a defect, impropriety or circumstance requiring special treatment that precludes timely payment on the claim.
- **Appealed claim** – A claim that is currently or was under review by an appeal agency as provided within the insurance contract.

Major Medical Demographic Data

- **Group Policy** – A contract of health insurance made with an employer or other entity that covers a group of persons as a single unit as the policyholder. It is not individual health coverage which is issued or delivered in Idaho for coverage, including out-of-state master policies where certificates of insurance are issued or delivered to Idaho residents.
- **Individual Policy** – A policy which provides protection to the policyholder and/or their family and which is not employment related.
- **Total # Covered Lives as of December 31st** – For the purposes of this inquiry the term covered lives includes:
 - Persons covered under a group health insurance policy evidenced by a certificate of insurance where the certificate of insurance is issued or delivered in and renewed in Idaho or issued or delivered and renewed in another state and covering Idaho residents.
 - Persons covered under an individual health insurance policy or group health insurance policy issued or delivered in Idaho or issued or delivered and renewed in another state and covering Idaho residents.

2022 Idaho Reporting Forms

See forms for Instructions and any due dates.

- Assessment Base Survey (**Due March 1**)
- Immunization Assessment Survey (**Due March 15**)
- Health Survey (**Due May 1**)
- Long-Term Care Rescission Reporting Form for State of Idaho for year 2022 (**Due March 1**)
- Form For Reporting Medicare Supplement Policies (**Due May 31**)
- Medicare Supplement Refund Calculation Form for Calendar Year 2022 (**Due May 31**)
- Long-Term Care Claims Denial Reporting Form (**Due June 30**)
- Long-Term Care Insurance Replacement and Lapse Reporting Form (**Due June 30**)
- Long-Term Care Insurance Suitability Reporting Form (**Due June 30**)