IDAPA 18 - IDAHO DEPARTMENT OF INSURANCE

18.01.54 - RULE TO IMPLEMENT THE NAIC MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS MODEL ACT

DOCKET NO. 18-0154-1601

NOTICE OF RULEMAKING - 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 41-4409, 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 September 21, 2016.

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 AND STATEMENT OF PURPOSE: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

The existing rule is proposed to be amended to require all Medicare Supplement (aka Medigap) carriers to offer coverage to pre-65 Medicare eligible individuals; clarify the requirement to account for interest in projections; require experience and rate increases to be pooled among all plans offered by a company; and clarify rating/ underwriting factors that can be used and when (e.g. smoking and pre-65).

Twenty-five states now require insurance companies to sell Medigap to all ages enrolled in Part B. Under age 65 Medicare beneficiaries have limited options for payment of Medicare deductible and co-payments. We seek to expand Medicare beneficiaries' options.

The NAIC Medicare Supplement Guidance Manual states: "Interest must be considered in calculating the anticipated lifetime and future loss ratios, otherwise loss ratios will be overstated." Yet, carriers have not included interest because our rule does not state it is required.

In reviewing rate increases, the department has requested that rate increases be applied equally to all of a carrier's plans, rather than varying the increases based on the more variable experience of specific plans. This keeps the premiums more representative of the benefit differences, rather than reflecting the morbidity of the enrollees of specific plans. The proposed changes will require that approach for future rate increases.

Current rule disallows gender and geographic area as rating factors, but other factors are not clearly allowed/ disallowed during open enrollment or outside of open enrollment, other than disallowing broad terms of "health status, claims experience, receipt of health care, or medical condition."

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: N/A

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 6, 2016 Idaho Administrative Bulletin, **Volume 16-7, page 73**.

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, OBTAINING DRAFT COPIES: For assistance on technical questions concerning this proposed rule, contact Thomas A. Donovan at (208) 334-4214, or at **tom.donovan@doi.idaho.gov**.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the attention of the undersigned and must be delivered either by hard copy or via email to the same email address for questions set forth above on or before Wednesday, September 28, 2016.

DATED this 5th Day of August, 2016.

Dean L. Cameron, Director
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THE FOLLOWING IS THE PROPOSED TEXT OF DOCKET NO. 18-0154-1601
(Only Those Sections With Amendments Are Shown.)

026. OPEN ENROLLMENT.

01. Offer of Coverage. ( )

a. An issuer shall not deny or condition the issuance or effectiveness of any Medicare supplement policy or certificate available for sale in this state, nor discriminate in the pricing of a policy or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant in the case of an application for a policy or certificate that is submitted prior to or during the six (6) month period beginning with: ( )

i. ~~t~~The first day of the first month in which an individual is both sixty-five (65) years of age or older and is enrolled for benefits under Medicare Part B. ( )

ii. January 1, 2018 or the first day of the first month of Medicare Part B eligibility due to disability or end stage renal disease, whichever is later, for an individual that is both under sixty-five (65) years of age and enrolled for benefits under Medicare Part B; or ( )

iii. The first day of the first month after the individual receives written notice of retroactive enrollment under Medicare Part B due to a retroactive eligibility decision made by the Social Security Administration. ( )

b. Each Medicare supplement policy and certificate currently available from an issuer shall be made available to all applicants who qualify under ~~*this Subsection*~~ Paragraph 026.01.a. without regard to age. ~~*(3-29-10)*~~ ( )

02. Treatment of Preexisting Conditions. ( )

a. If an applicant qualifies under Subsection 026.01 and submits an application during the time period referenced in Subsection 026.01 and, as of the date of application, has had a continuous period of creditable coverage of at least six (6) months, the issuer shall not exclude benefits based on a preexisting condition. (3-29-10)

b. If the applicant qualifies under Subsection 026.01 and submits an application during the time period referenced in Subsection 026.01 and, as of the date of application, has had a continuous period of creditable coverage that is less than six (6) months, the issuer shall reduce the period of any preexisting condition exclusion by