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.

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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

the aggregate of the period of creditable coverage applicable to the applicant as of the enrollment date. The Secretary of Health and Human Services shall specify the manner of the reduction under this Subsection. (3-29-10)

c. Except as provided in ~~*Subsection*~~ Paragraphs 026.0~~1~~2.a. and b., and Sections 027 and 038, ~~*Subsection 026.01*~~ nothing in this rule shall ~~*not*~~ be construed as preventing the exclusion of benefits under a policy, during the first six (6) months, based on a preexisting condition for which the policyholder or certificateholder received treatment or was otherwise diagnosed during the six (6) months before the coverage became effective. ~~*(3-29-10)*~~( )

03. Discrimination in Pricing. An issuer shall not discriminate in the pricing of a Medicare supplement policy or certificate issued pursuant to Subsection 026.01, except on the basis of the following criteria: ( )

a. Issue age; and ( )

b. Smoking or tobacco use. ( )

027. GUARANTEED ISSUE FOR ELIGIBLE PERSONS.

01. Guaranteed Issue. (4-5-00)

a. Eligible persons are those individuals described in Subsection 027.02 who seek to enroll under the policy during the period specified in Subsection 027.03, and who submit evidence of the date of termination or disenrollment or Medicare Part D enrollment with the application for a Medicare supplement policy. (3-29-10)

b. With respect to eligible persons, an issuer shall not deny or condition the issuance or effectiveness of a Medicare supplement policy described in Subsection 027.05 that is offered and is available for issuance to new enrollees by the issuer, shall not discriminate in the pricing of such a Medicare supplement policy because of health status, claims experience, receipt of health care, or medical condition, and shall not impose an exclusion of benefits based on a preexisting condition under such a Medicare supplement policy. (3-29-10)

02. Eligible Persons. An eligible person is an individual described here in any part of Subsection 027.02: (3-29-10)

a. The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare; and the plan terminates, or the plan ceases to provide all such supplemental health benefits to the individual; or the individual is enrolled under an employee welfare benefits plan that is primary to Medicare and the plan terminates or the plan ceases to provide all health benefits to the individual because the individual leaves the plan; (4-5-00)

b. The individual is enrolled with a Medicare Advantage organization under a Medicare Advantage plan under Part C of Medicare, and any of the following circumstances apply, or the individual is sixty-five (65) years of age or older and is enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provider under Section 1894 of the Social Security Act, and there are circumstances similar to those described below that would permit discontinuance of the individual's enrollment with such provider if such individual were enrolled in a Medicare Advantage plan: (4-11-06)

i. The certification of the organization or plan under this part has been terminated; (4-11-06)

ii. The organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides; (4-11-06)

iii. The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the Secretary of Health and Human Services, but not including termination of the individual's enrollment on the basis described in Section 1851(g)(3)(B) of the federal Social Security Act (where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under Section 1856), or the plan is terminated for all individuals within a residence

area; (4-11-06)

iv. The individual demonstrates, in accordance with guidelines established by the Secretary of Health and Human Services: (3-29-10)

(a) That the organization offering the plan substantially violated a material provision of the organization's contract under this part in relation to the individual, including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards; or (3-29-10)

(b) The organization, or agent, or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual; or (3-29-10)

(c) The individual meets such other exceptional conditions as the Secretary may provide. (3-29-10)

c. The individual is enrolled with: (4-5-00)

i. An eligible organization under a contract under Section 1876 of the Social Security Act (Medicare cost); (5-3-03)

ii. A similar organization operating under demonstration project authority, effective for periods before April 1, 1999; (4-5-00)

iii. An organization under an agreement under Section 1833(a)(1)(A) of the Social Security Act (health care prepayment plan); or (5-3-03)

iv. An organization under a Medicare Select policy; and (4-5-00)

d. The enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under Paragraph 027.02.b. (3-29-10)

e. The individual is enrolled under a Medicare supplement policy and the enrollment ceases because: (4-5-00)

i. Of the insolvency of the issuer or bankruptcy of the non-issuer organization; or (4-5-00)

ii. Of other involuntary termination of coverage or enrollment under the policy; (4-5-00)

iii. The issuer of the policy substantially violated a material provision of the policy; or (4-5-00)

iv. The issuer, or an agent or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual. (4-5-00)

f. The individual was enrolled under a Medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any Medicare Advantage organization under a Medicare Advantage plan under Part C of Medicare, any eligible organization under a contract under Section 1876 of the Social Security Act (Medicare cost), any similar organization operating under demonstration project authority, any PACE provider under Section 1894 of the Social Security Act, or a Medicare Select policy; and (4-11-06)

g. The subsequent enrollment under Paragraph 027.02.f. is terminated by the enrollee during any period within the first twelve (12) months of such subsequent enrollment (during which the enrollee is permitted to terminate such subsequent enrollment under Section 1851(e) of the federal Social Security Act); or (3-29-10)

h. The individual, upon first becoming eligible for benefits under Part A of Medicare at age sixty-five (65), enrolls in a Medicare Advantage plan under Part C of Medicare, or with a PACE provider under Section 1894 of the Social Security Act, and disenrolls from the plan or program by not later than twelve (12) months after the effective date of enrollment. (4-11-06)

i. The individual enrolls in a Medicare Part D plan during the initial enrollment period and at the time of enrollment in Part D, was enrolled under Medicare supplement policy that covers outpatient prescription drugs and the individual terminates enrollment in the Medicare supplement policy and submits evidence of enrollment in Medicare Part D along with the application for a policy described in Paragraph 027.05.e. (3-29-10)

03. Guaranteed Issue Time Periods. (5-3-03)

a. In the case of an individual described in Paragraph 027.02.a., the guaranteed issue period begins on the later of the date the individual receives a notice of termination or cessation of all supplemental health benefits (or, if a notice is not received, notice that a claim has been denied because of a termination or cessation); or the date that the applicable coverage terminates or ceases; and ends sixty-three (63) days thereafter; (3-29-10)

b. In the case of an individual described in Paragraphs 027.02.b., 027.02.c., 027.02.f., or 027.02.h., whose enrollment is terminated involuntarily, the guaranteed issue period begins on the date that the individual receives a notice of termination and ends sixty-three (63) days after the date the applicable coverage is terminated; (3-29-10)

c. In the case of an individual described in Paragraph 027.02.e., the guaranteed issue period begins on the earlier of: (3-29-10)

i. The date that the individual receives a notice of termination, a notice of the issuer's bankruptcy or insolvency, or other such similar notice if any; and (5-3-03)

ii. The date that the applicable coverage is terminated, and ends on the date that is sixty-three (63) days after the date the coverage is terminated; (5-3-03)

d. In the case of an individual described in Paragraph 027.02.b. and Subparagraph 027.02.e.iii., and Subparagraph 027.02.e.iv., Paragraph 027.02.f., or 027.02.h., who disenrolls voluntarily, the guaranteed issue period begins on the date that is sixty (60) days before the effective date of the disenrollment and ends on the date that is sixty-three (63) days after the effective date; and (3-29-10)

e. In the case of an individual described in Paragraph 027.02.i., the guaranteed issue period begins on the date the individual receives notice pursuant to Section 1882(v)(2)(B) of the Social Security Act from the Medicare supplement issuer during the sixty-day (60) period immediately preceding the initial Part D enrollment period and ends on the date that is sixty-three (63) days after the effective date of the individual's coverage under Medicare Part D; and (3-29-10)

f. In the case of an individual described in Subsection 027.02 but not described in the preceding provisions of Subsection 027.03, the guaranteed issue period begins on the effective date of disenrollment and ends on the date that is sixty-three (63) days after the effective date. (3-29-10)

04. Extended Medigap Access for Interrupted Trial Periods. (5-3-03)

a. In the case of an individual described in Paragraph 027.02.f. (or deemed to be so described, pursuant to this Paragraph) whose enrollment with an organization or provider described in Paragraph 027.02.f. is involuntarily terminated within the first twelve (12) months of enrollment, and who, without an intervening enrollment, enrolls with another such organization or provider, the subsequent enrollment shall be deemed to be an initial enrollment described in Paragraph 027.02.f.; (3-29-10)

b. In the case of an individual described in Paragraph 027.02.h. (or deemed to be so described, pursuant to this Paragraph) whose enrollment with a plan or in a program described in Paragraph 027.02.h. is involuntarily terminated within the first twelve (12) months of enrollment, and who, without an intervening enrollment, enrolls in another such plan or program, the subsequent enrollment shall be deemed to be an initial enrollment described in Paragraph 027.02.h.; and (3-29-10)

c. For purposes of Paragraphs 027.02.f. and 027.02.h., no enrollment of an individual with an

organization or provider described in Paragraph 027.02.f. or with a plan or in a program described in Paragraph 027.02.h. may be deemed to be an initial enrollment under this Paragraph after the two-year period beginning on the date on which the individual first enrolled with such an organization, provider, plan or program. (3-29-10)

05. Products to Which Eligible Persons are Entitled. The Medicare supplement policy to which eligible persons are entitled under: (4-11-06)

a. Paragraphs 027.02.a. through 027.02.e. is a Medicare supplement policy which has a benefit package classified as Plan A, B, C, or F (including F with a high deductible), K or L offered by any issuer. (3-29-10)

b. Subject to Paragraph 027.05.c., Paragraph 027.02.g. is the same Medicare supplement policy in which the individual was most recently previously enrolled, if available from the same issuer, or, if not so available, a policy described in Paragraph 027.05.a. (3-29-10)

c. After December 31, 2005, if the individual was most recently enrolled in a Medicare supplement policy with an outpatient prescription drug benefit, a Medicare supplement policy described in Subsection 027.05 is: (3-29-10)

i. The policy available from the same issuer but modified to remove outpatient prescription drug coverage; or (4-11-06)

ii. At the election of the policyholder, an A, B, C, F (including F with a high deductible), K or L policy that is offered by any issuer; (4-11-06)

d. Paragraph 027.02.h. shall include any Medicare supplement policy offered by any issuer. (3-29-10)

e. Paragraph 027.02.i. is a Medicare supplement policy that has a benefit package classified as Plan A, B, C, F (including F with a high deductible), K, or L and that is offered and is available for issuance to new enrollees by the same issuer that issued the individual's Medicare supplement policy with outpatient prescription drug coverage. (3-29-10)

06. Notification Provisions. (4-5-00)

a. At the time of an event described in Subsection 027.02 of this rule because of which an individual loses coverage or benefits due to the termination of a contract or agreement, policy, or plan, the organization that terminates the contract or agreement, the issuer terminating the policy, or the administrator of the plan being terminated, respectively, shall notify the individual of his or her rights under this Section, and of the obligations of issuers of Medicare supplement policies under Subsection 027.01. Such notice shall be communicated contemporaneously with the notification of termination. (3-29-10)

b. At the time of an event described in Subsection 027.02 because of which an individual ceases enrollment under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment, the issuer offering the policy, or the administrator of the plan, respectively, shall notify the individual of his or her rights under this Section, and of the obligations of issuers of Medicare supplement policies under Subsection 027.01. Such notice shall be communicated within ten (10) working days of the issuer receiving notification of disenrollment. (3-29-10)

07. Discrimination in Pricing. With respect to eligible persons, an issuer shall not discriminate in the pricing of a Medicare supplement policy or certificate issued pursuant to Subsection 027.01, except on the basis of the following criteria: ( )

a. Issue age; and ( )

b. Smoking or tobacco use. ( )

(BREAK IN CONTINUITY OF SECTIONS)

029. LOSS RATIO STANDARDS AND REFUND OR CREDIT OF PREMIUM.

01. Loss Ratio Standards. (4-5-00)

a. A Medicare supplement policy form or certificate form shall not be delivered or issued for delivery unless the policy form or certificate form can be expected, as estimated for the entire period for which rates are computed to provide coverage, to return to policyholders and certificateholders in the form of aggregate benefits (not including anticipated refunds or credits) provided under the policy form or certificate form. (4-5-00)

i. At least seventy-five percent (75%) of the aggregate amount of premiums earned in the case of group policies; or (4-5-00)

ii. At least sixty-five percent (65%) of the aggregate amount of premiums earned in the case of individual policies; (4-5-00)

b. Calculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a managed care organization on a service rather than reimbursement basis and earned premiums for the period and in accordance with accepted actuarial principles and practices. Incurred health care expenses where coverage is provided by a managed care organization shall not include: (4-11-06)

i. Home office and overhead costs; (4-11-06)

ii. Advertising costs; (4-11-06)

iii. Commissions and other acquisition costs; (4-11-06)

iv. Taxes; (4-11-06)

v. Capital costs; (4-11-06)

vi. Administrative costs; and (4-11-06)

vii. Claims processing costs. (4-11-06)

c. All filings of rates and rating schedules shall demonstrate that expected claims in relation to premiums comply with the requirements of this Section when combined with actual experience to date. Filings of rate revisions shall also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards. Demonstrations shall, at a minimum, account for: ~~(3-29-10)~~( )

i. Lapse rates; ( )

ii. Medical trend and rationale for trend; ( )

iii. Assumptions regarding future premium rate revisions; and ( )

iv. Interest rates for discounting and accumulating. ( )

d. For purposes of applying Paragraphs 029.01.a. and 030.05.b., only, policies issued as a result of solicitations of individuals through the mails or by mass media advertising (including both print and broadcast advertising) shall be deemed to be individual policies. (3-29-10)

e. For policies issued prior to July 1, 1992, expected claims in relation to premiums shall meet: (4-5-00)

i. The originally filed anticipated loss ratio when combined with the actual experience since inception; (4-5-00)

ii. The appropriate loss ratio requirement from Subparagraphs 029.01.a.i. and 029.01.a.ii. when combined with actual experience beginning with July 1, 1992 to date; and (3-29-10)

iii. The appropriate loss ratio requirement from Subparagraphs 029.01.a.i. and 029.01.a.ii. over the entire future period for which the rates are computed to provide coverage. (3-29-10)

02. Refund or Credit Calculation. (4-5-00)

a. An issuer shall collect and file with the director by May 31 of each year the data contained in the applicable reporting form as defined by NAIC Model Regulation (Attachments) and accessible by the Internet website at http://www.doi.idaho.gov for each type in a standard Medicare supplement benefit plan. (4-11-06)

b. If on the basis of the experience as reported the benchmark ratio since inception (ratio one (1)) exceeds the adjusted experience ratio since inception (ratio three (3)), then a refund or credit calculation is required. The refund calculation shall be done on a statewide basis for each type in a standard Medicare supplement benefit plan. For purposes of the refund or credit calculation, experience on policies issued within the reporting year shall be excluded. (4-5-00)

c. For the purpose of Section 029, policies or certificates issued prior to July 1, 1992, the issuer shall make the refund or credit calculation separately for all individual policies (including all group policies subject to an individual loss ratio standard when issued) combined and all other group policies combined for experience after July 1, 1992. The first report shall be due by May 31, 1994. (3-29-10)

d. A refund or credit shall be made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credit exceeds a de minimis level. The refund shall include interest from the end of the calendar year to the date of the refund or credit at a rate specified by the Secretary of Health and Human Services, but in no event shall it be less than the average rate of interest for thirteen (13) week Treasury notes. A refund or credit against premiums due shall be made by September 30 following the experience year upon which the refund or credit is based. (4-5-00)

03. Annual Filing of Premium Rates. An issuer of Medicare supplement policies and certificates issued before or after the effective date of July 1, 1992, in this state shall file annually its rates, rating schedule, and supporting documentation including ratios of incurred losses to earned premiums by policy duration for approval by the director in accordance with the filing requirements and procedures prescribed by the director. The supporting documentation shall also demonstrate in accordance with actuarial standards of practice using reasonable assumptions that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. The demonstration shall exclude active life reserves. An expected third-year loss ratio which is greater than or equal to the applicable percentage shall be demonstrated for policies or certificates in force less than three (3) years. As soon as practicable, but prior to the effective date of enhancements in Medicare benefits, every issuer of Medicare supplement policies or certificates in this state shall file with the director, in accordance with the applicable filing procedures of this state: (4-5-00)

a. Appropriate premium adjustments necessary to produce loss ratios as anticipated for the current premium for the applicable policies or certificates. The supporting documents necessary to justify the adjustment shall accompany the filing. (4-5-00)

b. An issuer shall make premium adjustments necessary to produce an expected loss ratio under the policy or certificate to conform to minimum loss ratio standards for Medicare supplement policies and which are expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current premiums by the issuer for the Medicare supplement policies or certificates. No premium adjustment which would modify the loss ratio experience under the policy other than the adjustments described herein shall be made with respect to a policy at any time other than upon its renewal date or anniversary date. (4-5-00)

c. If an issuer fails to make premium adjustments acceptable to the director, the director may order

premium adjustments, refunds, or premium credits deemed necessary to achieve the loss ratio required by Section 029. (3-29-10)

d. Any appropriate riders, endorsements, or policy forms needed to accomplish the Medicare supplement policy or certificate modifications necessary to eliminate benefit duplications with Medicare. The riders, endorsements, or policy forms shall provide a clear description of the Medicare supplement benefits provided by the policy or certificate. (4-5-00)

04. Public Hearings. The director may conduct a public hearing to gather information concerning a request by an issuer for an increase in a rate for a policy form or certificate form issued before or after the effective date of July 1, 1992 if the experience of the form for the previous reporting period is not in compliance with the applicable loss ratio standard. The determination of compliance is made without consideration of any refund or credit for the reporting period. Public notice of the hearing shall be furnished in a manner deemed appropriate by the director. (4-5-00)

030. FILING AND APPROVAL OF POLICIES AND CERTIFICATES AND PREMIUM RATES.

01. Filing of Policy Forms. (3-29-10)

a. An issuer shall not deliver or issue for delivery a policy or certificate to a resident of this state unless the policy form or certificate form has been filed with and approved by the director in accordance with filing requirements and procedures prescribed by the director. (3-29-10)

b. An issuer shall file any riders or amendments to policy or certificate forms to delete outpatient prescription drug benefits as required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 only with the director in the state in which the policy or certificate was issued. (3-29-10)

02. Filing of Premium Rates. (3-29-10)

a. An issuer shall not use or change premium rates for a Medicare supplement policy or certificate unless the rates, rating schedule, and supporting documentation have been filed with and approved by the director in accordance with the filing requirements and procedures prescribed by the director. (3-29-10)

b. Except as provided in Subsection 029.03, the insured shall not receive more than one (1) rate increase in any twelve (12) month period. (3-29-10)

03. Except as provided in Paragraph 030.03.a., an issuer shall not file for approval more than one (1) form of a policy or certificate of each type for each standard Medicare supplement benefit plan. (3-29-10)

a. An issuer may offer, with the approval of the director, up to ~~*four (4)*~~ three (3) additional policy forms or certificate forms of the same type for the same standard Medicare supplement benefit plan, one (1) or each of the following cases: ~~*(4-5-00)*~~( )

i. The inclusion of new or innovative benefits; (4-5-00)

ii. The addition of either direct response or agent marketing methods; (4-5-00)

iii. The addition of either guaranteed issue or underwritten coverage; (4-5-00)

~~*iv. The offering of coverage to individuals for Medicare by reason of disability.*~~ ~~*(4-5-00)*~~

b. For the purposes of S~~*ubs*~~ection 030~~*.03*~~, "type" means an individual policy, a group policy, an individual Medicare Select policy, or a group Medicare Select policy. ~~*(3-29-10)*~~( )

04. Availability of Policy Form or Certificate. Except as provided in Paragraph 030.04.a., an issuer shall continue to make available for purchase any policy form or certificate form issued after the effective date of this rule. A policy form or certificate form shall not be considered to be available for purchase unless the issuer has

actively offered it for sale in the previous twelve (12) months. (3-29-10)

a. An issuer may discontinue the availability of a policy form or certificate form if the issuer provides to the director in writing its decision at least thirty (30) days prior to discontinuing the availability of the form of the policy or certificate. After receipt of this notice by the director, the issuer shall no longer offer for sale the policy form or certificate form in this state. (4-5-00)

b. An issuer that discontinues the availability of a policy form or certificate form pursuant to Paragraph 030.04.a. shall not file for approval a new policy form or certificate form of the same type for the same standard Medicare supplement benefit plan as the discontinued form for a period of five (5) years after the issuer provides notice to the director of the discontinuance. The period of discontinuance may be reduced if the director determines that a shorter period is appropriate. (3-29-10)

c. The sale or other transfer of Medicare supplement business to another issuer shall be considered a discontinuance for the purposes of Subsection 030.04. (3-29-10)

d. A change in the rating structure or methodology shall be considered a discontinuance under this Subsection 030.04 unless the issuer complies with the following requirements: (3-29-10)

i. The issuer provides an actuarial memorandum, in a form and manner prescribed by the director, describing the manner in which the revised rating methodology and resultant rates differ from the existing rating methodology and existing rates. (4-5-00)

ii. The issuer does not subsequently put into effect a change of rates or rating factors that would cause the percentage differential between the discontinued and subsequent rates as described in the actuarial memorandum to change. The director may approve a change to the differential which is in the public interest. (4-5-00)

05. Experience of Policy Forms. (4-5-00)

a. Except as provided in Paragraph 030.05.b., the experience of all policy forms or certificate forms of the same type in a standard Medicare supplement benefit plan shall be combined for purposes of the refund or credit calculation prescribed in Section 029. (3-29-10)

b. Forms assumed under an assumption reinsurance agreement shall not be combined with the experience of other forms for purposes of the refund or credit calculation. (4-5-00)

c. The experience of all policy forms or certificate forms for standardized Medicare supplement benefit plans of the same type shall be combined for purposes of the rate change filing. Generally, any applicable percentage increase shall be filed and applied uniformly across all standardized plans within the same type, unless doing so would violate the federal lifetime loss ratio standards for specific forms within the same type. ( )

06. Attained Age Rating Prohibited. With respect to Medicare supplement policies that conform to the Standard Benefit Plans developed by the National Association of Insurance Commissioners and adopted by the State of Idaho July 1, 1992, under IDAPA 18.01.54, "Rule to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act," sold to residents of this state and all those sold on or after January 1, 1995, it is an unfair practice and an unfair method of competition for any issuer, insurer, or licensee to use the increasing age of an insured, subscriber or participant as the basis for increasing premiums or prepayment charges for policyholders who initially purchase a policy after January 1, 1995. This rule explicitly authorizes both issue age ratings and community ratings consistent with the prohibition of attained age ratings and allows companies to resubmit for approval issue age ratings previously rejected. (3-29-10)

07. Rating by Area and Gender Prohibited. With respect to Medicare supplement policies that conform to the Standard Benefit Plans developed by the National Association of Insurance Commissioners and adopted by the State of Idaho, July 1, 1992, under IDAPA 18.01.54, "Rule to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act," sold to residents of this State and all those sold on or after January 1, 1999, it is an unfair practice and an unfair method of competition for any issuee, issuer, or licensee to use area or gender for rating purpose. (3-29-10)

08. Other Rating Requirements. With respect to Medicare supplement policies that conform to the Standard Benefit Plans under this rule, sold to residents of this State on or after January 1, 2018: ( )

a. Any rate adjustments will be uniform between 1990 Standardized and 2010 Standardized plans throughout the lifetime of the policies, unless doing so would violate the federal lifetime loss ratio standards for specific forms within the same type. ( )

b. No discount or underwriting factor of less than 1.0 will be available to policies issued outside of open enrollment, per Section 026, or guaranteed issue, per Section 027, unless the greatest discount or lowest underwriting factor is automatically applied to all policies issued under open enrollment and guaranteed issue. ( )

c. For issue-ages sixty-five (65) and greater, the filed rate for any given age must not exceed the rate for any higher issue-age, similarly rated individual. ( )

d. For issue-ages sixty-four (64) or less, the premium shall not exceed one hundred fifty percent (150%) of the premium for an issue-age sixty-five (65), similarly rated individual, while the individual's attained age is less than sixty-five (65). Upon attaining age sixty-five (65), a policyholder with an issue-age less than sixty-five (65) shall be charged the same premium rate as an issue-age sixty-five (65), similarly rated individual. ( )

e. For any given age, the rating by the issuer shall not differentiate on the basis of the reason for eligibility for Medicare Part B. ( )