Your Health Idaho

Policy Manual

July 17, 2025

Your Health Idaho complies with applicable federal civil rights laws pertaining to eligibility determination and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Your Health Idaho does not exclude people or treat them differently because of their race, color, national origin, age, disability, or sex.

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Overview

Objectives

This document accomplishes the following:

- It provides important information about YHI policy requirements.
- It serves as a tool for the proper handling of YHI consumer cases.

NOTE: The YHI Policy Manual is updated regularly to reflect federal, state, and local regulations. It is also updated to improve consumer experience on the Exchange.

Important Definitions

Advance Premium Tax Credit (APTC)	The Affordable Care Act (ACA) allows individuals to qualify for a tax credit, based on income level and household size, to lower the cost of their monthly premium for insurance plans sold on Your Health Idaho.
Affordable Care Act (ACA)	A federal health care reform law enacted in March 2010. The law was enacted in two parts: The Patient Protection and Affordable Care Act. It was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name "Affordable Care Act" is used to refer to the final, amended version of the law.
Authorized representative	An individual chosen by the consumer to act on their behalf with the Idaho Department of Health and Welfare (often a family member or another trusted person). Some authorized representatives might have legal authority to act on the consumer's behalf.
Benefit year	A calendar year for which a health plan provides coverage for health benefits.
Binder payment	A binder payment is the consumer's portion of the initial (or first) premium payment on a new policy that is necessary for coverage to become effective.
Centers for Medicare and Medicaid Services (CMS)	The federal agency that runs the Medicare, Medicaid, and Children's Health Insurance Programs, and the federally facilitated marketplace.
Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)	A law passed by the U.S. Congress that, among other things, mandates an insurance program which gives some employees the ability to continue health insurance coverage after leaving employment.
Code of Federal Regulations (CFR)	The Code of Federal Regulations (CFR) is the codification of the general and permanent rules and regulations (sometimes called administrative law), published in the Federal Register by the executive departments and agencies of the federal government of the United States.

Consumer Connector	The person or agency who helps consumers with eligibility applications and/or enrollment processes, as designated on the consumer's Exchange account. This includes Agents of Record (AOR) or Enrollment Counselors (EC). Also called Connectors.
Cost sharing	The share of costs covered by insurance that an individual pays out of their own pocket. This term generally includes deductibles, coinsurance and copayments, or similar charges, but it doesn't include premiums, balance billing amounts for non-network providers, or the cost of non-covered services.
Cost Sharing Reductions (CSR)	A discount that lowers the out-of-pocket expense for health coverage. It's available for individuals/families that earn up to 250 percent of Federal Poverty Level, or for American Indians up to 300 percent. See cost sharing.
Crosswalked plan	A mapping of plan enrollment from one year to the next, used for renewal purposes. For example, a 2018 plan to the 2019 plan that is either the same or most appropriate and similar if the same plan isn't available.
Custom grouping (previously 'split household')	A household that is allowed to split APTC onto different policies based on qualified circumstances.
Dependent	Dependents are typically children or spouses/partners of insured individuals. When individuals buy health insurance, they usually have the choice to buy a plan that covers their spouse, partner, or children. Some plans may allow other individuals in their care to be covered under the plan. See also qualified dependent.
DMI (Data Matching Inconsistency)	Your Health Idaho is required to use a consumer's self-reported information when determining their eligibility for marketplace coverage and the advance premium tax credit. Our system automatically verifies consumer information against official data sources to determine its accuracy. The verification process occurs whenever a consumer applies, and annually, during redetermination and early summer. When the system returns a condition inconsistent with the information provided in the application this is known as a Data Matching Inconsistency.
Employer contributions	Any financial contribution toward an employer-sponsored health plan, or other eligible employer-sponsored benefit made by the employer, including those made by salary reduction agreement that is excluded from gross income.
Enhanced Short-Term Plans	An individual health benefit plan that:

	(a) Has an initial period of less than twelve (12) months and is renewable at the option of the individual for up to the number of months established by rules issued pursuant to section 41-5214, Idaho Code; and (b) Otherwise meets the standards established by rules issued pursuant to section 41-5214, Idaho Code.
Enrollee	A person enrolled in a QHP or off-Exchange plan (see also qualified individual).
Essential Health Benefits (EHBs)	Healthcare service categories that must be covered by Qualified Health Plans and certain plans starting in 2014. Essential Health Benefits must include items and services within each of the following general categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.
Failure to Reconcile (FTR)	The failure of a tax-paying individual to submit IRS Form 8962 to report the amount of advance tax credit used versus the tax credit for which the individual qualifies based on the actual income for that year.
Federal Poverty Level (FPL)	A measure of income level issued annually by the Department of Health and Human Services. Federal Poverty Levels are used to determine your eligibility for certain programs and benefits.
Grandmothered plan	Plans that are not fully ACA-compliant that were purchased between March 23, 2010—when the ACA was signed into law—and October 1, 2013. (In some states, policies purchased through December 31, 2013, are considered grandmothered.)
Grandfathered plan	Coverage provided by a group health plan, or group or individual health insurance issuer, with an individual who was enrolled on March 23, 2010.
Group health plan	An employee benefit plan that provides medical care (including items and services paid for as medical care) to employees (including both current and former employees) or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise.
Health insurance coverage	Benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or HMO contract offered by a health insurance issuer. Health insurance coverage includes group health insurance coverage, individual health insurance coverage, and short-term, limited-duration insurance.
Health plan categories (also known as “metal plan levels”)	Plans sold on an Exchange/marketplace are primarily separated into three Health Plan Categories (also known as metallic levels)—Bronze,

	Silver, or Gold—based on the percentage the plan pays of the average overall cost of providing essential health benefits to members.
Health Reimbursement Arrangement (HRA)	Health Reimbursement Arrangements or HRAs are employer-funded, account-based group health plans offered by employers that reimburse employees (and potentially their household) for their medical expenses. Employees are reimbursed tax-free for qualified medical expenses up to a fixed dollar amount per year.
Health Savings Account (HSA)	A savings account that lets you set aside money on a pre-tax basis to pay for qualified medical expenses such as deductibles, copayments and coinsurance which helps lower overall healthcare costs.
Household (HH)	Generally considered to be the primary subscriber, their spouse (if married), and any tax dependents.
Minimum Essential Coverage (MEC)	The type of coverage an individual must have to meet the individual responsibility requirement under federal law. This includes individual market policies, some employer-sponsored coverage, Medicare, Medicaid, SHIP, TRICARE, and certain other coverage.
Minimum value standard	A health plan meets this standard if it's designed to pay at least 60% of the total cost of medical services for a standard population and provides substantial coverage of inpatient hospital services and physician services. Starting in 2014, individuals covered by employer-sponsored coverage that provides minimum value and that's affordable won't be eligible for a premium tax credit.
Open Enrollment (OE) Period	The period during which individuals who are eligible can apply for a tax credit and enroll in a Qualified Health Plan through YHI.
Policy Steering Team (PST)	A leadership group that includes representation from carriers, Idaho Department of Insurance (DOI), Your Health Idaho (YHI), YHI Consumer Connectors, and Idaho Department of Health and Welfare (DHW), which meets monthly to review and update YHI policy to comply with the CFR, State of Idaho regulations, and consumer experience needs.
Premium	The monthly dollar amount that must be paid for health insurance coverage.
Qualified Dental Plan (QDP)	A dental insurance health plan that is qualified for use on the Exchange.
Qualified dependent	A dependent that may be claimed by the primary subscriber as a member of the household to qualify for an APTC (see also dependent).
Qualified Health Plan (QHP)	An insurance plan that is certified by the Exchange/marketplace. It must provide essential health benefits, follow established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meet other requirements.
Qualified individual	A person that qualifies to enroll in health insurance through the Exchange (see also enrollee).

Qualifying Life Event (QLE)	A change in an individual's life can make them eligible for a Special Enrollment Period to enroll in health coverage. Examples of Qualifying Life Events include moving to a new state, changes in income, or changes in family size (for example, marriage, divorce, and having a baby). This may also be referred to as a Qualifying Life Event (QLE), but that does not guarantee that it is an SEP qualifier.
Reasonably compatible	The Exchange must consider consumer information obtained through electronic data sources, other information provided by the applicant, or other information in the records of the Exchange to be reasonably compatible with an applicant's attestation of their eligibility. If the difference or discrepancy of applicant information does not impact the eligibility of the applicant, including the amount of Advance Premium Tax Credit or category of Cost Sharing Reductions, then the applicant information is considered reasonably compatible.
Second Lowest Cost Silver Plan (SLCSP)	The second-lowest priced Exchange QHP in the Silver category for which a consumer is eligible. Consumers need to know their SLCSP premium to figure out their final premium tax credit (the SLCSP may not be the plan the consumer selects, but it will affect tax credit amounts). The SLCSP premium is listed on Form 1095-A.
Special Enrollment Period (SEP)	A time outside of the annual Open Enrollment Period during which an individual may sign up for, or change to, a Qualified Health Plan because of a Qualifying Life Event.
State-Based Marketplace (SBM)	A market (aka, the Exchange) where individuals, families, and small businesses can • learn about some of their health coverage options, • compare health insurance plans based on cost, benefits, and other important factors, • choose a health insurance plan, and • enroll in coverage.
Student Health Insurance Plan (SHIP)	A health insurance plan qualified to meet federal requirements for students to carry coverage.
System for Electronic Rate and Form Filing (SERFF)	A system designed with the intent to provide a cost-effective method for facilitating the submission, review, and approval of product filings between regulators and insurance companies.
Tax filer	An individual or married couple that expects to • file an income tax return for the benefit year, • file a joint tax return for the benefit year, if married, • not be claimed by any other taxpayer as a tax dependent for the benefit year, and • claim a personal exemption deduction on their tax return for one or more applicants, which might or might not include self, or self and spouse.

Advance Premium Tax Credit (APTC)

APTC 1: Who Is Eligible

45 CFR 155.305 (f)(g); 45 CFR 155.335

Updated 5/3/2023

To be eligible to receive the APTC, the consumer must meet certain requirements, including each of the following:

- A United States citizen, national, or "lawfully present"
  - Lawfully present means a non-citizen holds one of the immigration statuses that qualifies as "lawfully present." See APTC 3: What Is Considered Lawfully Present.
  - A consumer holds citizenship or a "lawfully present" status for the entire enrollment period.
- A resident of Idaho
- NOT incarcerated
- A modified, adjusted gross income between 100 percent and 400 percent of the Federal Poverty Level prior to plan year 2021 and over 100 percent from 2021 to 2025*
- A tax filer who is married and filing jointly OR single and filing single
- Not eligible for affordable employer sponsored coverage which provides minimum value
- Not eligible for government-issued minimum essential coverage including VA, Medicaid, Tri-Care, etc.

NOTE: YHI consumers have 90-days from the date of the request to provide the documents necessary for a manual verification process, if needed. See APTC 3: What Is Considered Lawfully Present.

Consumers who are eligible for employer-sponsored or government-issued minimum essential coverage (MEC) may not be eligible for financial assistance.

*Some lawfully present individuals may qualify for financial assistance outside of this income range. Additionally, Idaho Medicaid coverage was extended to 138% of FPL, effective 1/1/2020, disqualifying those between 100-138% if they are eligible for Medicaid.

APTC 2: Eligibility Verification Standards

45 CFR 155.305 (f)(1-6); 45 CFR 155.315 (a-j); 45 CFR 155.320 (a-e); 45 CFR 155.330 (a-g); 45 CFR 155.335

The Exchange follows the verification standards plan approved by CMS and maintained by the Idaho State Plan.

Forms of documentation commonly used to verify U.S. citizenship or legal status: U.S. passport or passport card, certificate of naturalization, certificate of U.S. citizenship, documented evidence issued by a federally recognized Indian tribe, U.S. birth certificate, copy of the front and back of a resident alien card, or copy of another form of documentation showing legal status

Forms of documentation commonly used to verify income: Wage stubs, tax returns, unemployment benefit statements, Schedule C or E for self-employment earnings, bank statements showing regular deposits, accountant statements, bookkeeping records, or a statement from a knowledgeable source

In addition, the following interfaces are checked to verify income: Department of Labor, Federal Tax Interface, Social Security Administration, and The Work Number.

APTC 3: What Is Considered Lawfully Present

45 CFR 155.300; 45 CFR 155.305; 26 CFR 1.36-b (2)

- Lawful Permanent Resident (LPR) (without having met the 5-year bar)
- Individual who is seeking, or has been granted, political asylum
- Refugee
- Cuban/Haitian entrant
- Paroled into the U.S.
- Conditional entrant (granted before 1980)
- Battered spouse, child, or parent
- Victim of trafficking and his/her spouse, children, siblings, or parents
- Granted withholding of deportation or withholding of removal (under immigration laws or under Convention Against Torture (CAT))
- Temporary Protected Status (TPS)
- Lawful Temporary Resident (LTR)
- Individual with non-immigrant status (includes worker visas, student visas, and citizens of Micronesia, Marshal Islands, and Palau)
- Administrative order staying removal issued by the Department of Homeland Security
- Member of federally recognized Indian tribe or American Indian born in Canada
- Resident of American Samoa
- Deferred Enforced Departure (DED)

OR

An applicant for any of these statuses:

- Adjustment to LPR status
- Temporary Protected Status (TPS) with employment authorization
- Special immigrant juvenile status
- Victim of trafficking visa
- Asylum (those who are granted employment authorization, or are under the age of 14 and have had application pended at least 180 days)
- Withholding of deportation or withholding removal (under immigration laws or under CAT)

OR

With employment authorization:

- Registry applicants
- Order of supervision
- Applicant for cancellation of removal or suspension of deportation
- Applicant for legalization under Immigration Reform and Control Act (IRCA)
- Legalization under the Legal Immigration Family Equity Act (LIFE)

APTC 4: Tax Filing Requirements

45 CFR 155. 320 (c)(B); 45 CRF 155.335

To receive a tax credit, consumer tax returns must be filed as Single, and be unmarried, or Divorced. Otherwise, they must file as Married Filing Jointly, if they are living with, or apart from, their spouse AND they are filing taxes together (with spouse).

APTC 5: Income Eligibility Limits

45 CFR 155.320(c)

Updated 5-3-2023

Until 2025 a consumers' taxable income must be above 100% of the Federal Poverty Level to be eligible to receive a tax credit. Prior to 2021 a consumer's taxable income must be between 100 and 400% of the Federal Poverty Level.

Special Income Rule: Lawfully present individuals who are ineligible for Medicaid due to immigration status may be eligible for APTC if household income is less than 100% of the Federal Poverty Level. A family can determine their APTC status by completing the application process.

APTC 6: Income for APTC Calculation

45 CFR 155.320 (c)(ii); 45 CFR 155.320 (E)(ii)(iii)

Updated:12/04/2023

Income is used to determine whether an individual or family is eligible to receive APTC, and, if they are eligible, how much APTC they receive.

Tax credits are calculated using modified adjusted gross income and include the following:

- Wages/salaries
- Social Security retirement and Social Security disability
- Unemployment
- Self-employment
- Tips and gratuities

- Compensation for personal services
- Farm income
- Capital gains
- Investment income
- Foreign-earned income
- Other taxable income (e.g., court awards, gambling prizes)
- Rental income
- Royalties
- Retirement income such as *traditional* IRA withdrawal(s)
    - Pre-tax income that is put in a traditional IRA is taxed after it has been withdrawn during retirement

Certain types of non-taxable income are not factored into APTC calculations. This income can include the following:

- Supplemental Security Income (SSI)
- Child support
- Workers' compensation
- Temporary Assistance for Needy Families (TANF)/Temporary Assistance for Families in Idaho (TAFI)
- Veteran's benefits
- Federal income tax refunds
- Insurance proceeds (accident, health, and life)
- Certain economic stimulus payments (e.g., COVID-related federal payments)
- Gifts
- Retirement income from *Roth* IRA
    - Income placed into IRA after it has already been taxed. When withdrawn during retirement the income is tax-free

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NOTE: IRA's have different impacts on MAGI and what income is counted toward an individual's financial eligibility:

Distributions from traditional IRAs count towards the MAGI.

Distributions from Roth IRAs do not count toward MAGI

APTC 7: Verification of Income for a Financial Application

45 CFR 155.320 E (iii)
Updated 5-3-2023

To receive a tax credit, YHI must use electronic interfaces to verify the applicant's self-attestation of income. If the data returned is not reasonably compatible, the following document(s) may be requested to verify income:

Annual Income:

- Form 1040 federal or state tax return
- Pay stubs
- Social Security Administration statements
- Unemployment benefits letter
- Wages and tax statement (W-2 or 1099)

Self-Employment Income:

- Form 1040 with Schedule C, F, or SE
- Form 1065 Schedule K-1 with Schedule E
- Tax return
- Bookkeeping records
- Profit and loss statement

Unearned Income:

- Annuity statement
- Statement of pension distribution from any government of private source
- Worker's compensation letter
- Prizes, settlements, awards, including court-ordered awards letter
- Proof of gifts and contributions
- Proof of inheritances in cash or property
- Proof of strike pay and other benefits from unions
- Interests and dividends income statement
- Loan statement showing loan proceeds
- Royalty income statement or 1099-MISC
- Proof of bonus/incentive payments
- Proof of severance pay
- Pay stub indicating sick pay
- Letter, deposit, or other proof of deferred compensation benefits
- Pay stub indicating substitute/assistance pay
- Pay stub indicating vacation pay
- Proof of residuals
- Letter, deposit, or other proof of travel/business reimbursement pay

NOTE: Reasonable compatibility is a standard of measure utilized to verify that an applicant's income is above 100 percent of Federal Poverty Level, which would qualify them for tax credit.

NOTE: There are two applications for consumers. A financial application is used for individuals and families who would like to apply for tax credits. A non-financial application is used for individuals or families who do not qualify for a tax credit.

Special Income Rule: Lawfully present individuals who are ineligible for Medicaid due to immigration status may be eligible for APTC if household income is less than 100% of the Federal Poverty Level. A family can determine their APTC status by completing the application process.

APTC 8: Determining Tax Credit Amount

26 CFR 1.36 B-1; 26 CFR 1.36 B-3; 26 CFR 1.36 B-4; 45 CFR 155.300

Updated: 06/24/2024

To determine the tax credit, several factors are taken into consideration. The following are reviewed:

- Age of consumer(s)
- Applicant's eligibility for other coverage
- Attestation or verification of prior APTC reconciliation with IRS
- Citizenship and immigration
- County of residence
- Household's anticipated, modified adjusted gross income
- Household size
- Name
- Number of household members eligible for APTC
- Number of remaining months in the year based on the eligibility start date
- Social Security Number (SSN) OR Individual Taxpayer Identification Number (TIN) OR Alien Registration Number to verify lawful presence
- APTC amount that has already been used in the application year

APTC tax households include all the individuals that the primary taxpayer will claim an exemption for including the following:

- Self
- Spouse
- Qualified children (up to age 24)
- Qualified dependents

When calculating APTC, eligibility will be calculated based on the remaining months in the year. Any unused APTC from prior months will be reconciled when the consumer files their taxes.

If a consumer fails to reconcile APTC by filing taxes, they will be determined ineligible for a tax credit.

In cases of divorce, the parent who claims the child as a dependent on their tax returns is the only parent who can claim the child for their APTC calculation.

NOTE: If a child is primarily living with a parent who does not claim them on their taxes, the child may be eligible for Medicaid under MAGI (Modified Adjusted Gross Income) Medicaid rules. In this case, the parent seeking APTC can claim the child in their tax household, but the child cannot be given APTC, since they are eligible for MEC through the other household.

APTC 9: Calculating Age for Household Members

Updated: 6/21/2022

YHI will calculate APTC using the ages of the family members as of the application date of the plan year.

APTC 10: Household Composition

Updated: 5/20/2025

To align with federal tax households, YHI allows the following household relationships to be considered as part of the APTC calculation: spouse, child, adopted child, stepson/stepdaughter, ward, and anyone who is in your legal custody (e.g., grandchild). Everyone in a tax household must be included in the APTC calculation.

Households with an unmarried domestic partner who are applying for cost-savings should include the domestic partner on their application if they have a child together or claim their partner as a tax dependent. If found eligible, the applicant and their domestic partner will need to enroll in separate insurance policies.

APTC 11: Household Plan Enrollment

Updated: 5/20/2025

All tax family members must be included in an APTC calculation. Family members may be able to enroll in different plans or may be required to enroll separately if the tax relationship is not applicable for enrollment on the same insurance plan.

APTC 12: 24-Year-Old Dependents and APTC Eligibility

Updated: 5/20/2025

In general, when a child turns 24, that child can no longer be claimed as a "qualified child" on a tax form, but they can be claimed as a "Qualified Dependent," assuming other IRS-defined qualification criteria is met.

Children who turn 24 can continue to be considered a "Qualified Dependent," and therefore part of an APTC household, or they can be dropped from the household APTC, depending on the family's wishes.

APTC 13: Employer-Sponsored Coverage

26 CFR 1.36 (b-2)(C)(3); 26 CFR 1.36 (b-1)(e)(2); 26 CFR 1.36(b)(3); 26 CFR 601.105; 45 CRF 155.320(b); § 36B(c)(2)(C)(i)(II) and § 1.36B-2(c)(3)(v)(C)

Updated: 11/08/2024

Employer coverage is considered affordable—as it relates to the premium tax credit—if the employee's share of the annual premium for the lowest priced, self-only plan is not greater than 8.39% of their annual household income for plan year 2024 and 9.02% for plan year 2025. If the lowest-cost plan

offered that would cover the employee and their family members costs more than 8.39% of the household income, family members may also be eligible to receive APTC, even if the plan covering only the employee is less than this percentage.

Employees, and their spouse and dependents, that are offered employer-sponsored coverage that is affordable and provides minimum value are not eligible for a premium tax credit. If a consumer thinks their employer-sponsored coverage does not meet minimum essential coverage, the minimum value standard, or affordability requirements, they may file an appeal to have their coverage reviewed for APTC eligibility.

NOTE: This affordability threshold is updated annually.

APTC 14: Applying for APTC When Enrolled in Retirement Coverage

26 CFR 1.36 B-2(c)(3)(v); 45 CFR 156.145

Updated: 8/21/2018

If someone is enrolled in retirement health insurance coverage, they can only apply for a tax credit and purchase health insurance if their current coverage does not qualify as minimum essential coverage and it is Open Enrollment.

NOTE: If coverage ends outside of the Open Enrollment period and they choose not to re-enroll, they would be eligible for a Special Enrollment Period.

For the exhaustion of PERSI retirement funds, see SEP 1, 1.2 (9).

APTC 15: Applying for APTC When You Have COBRA

26 CFR 1.36 B(c)

Updated: 3/20/2018

Idahoans who are offered Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") coverage can choose to apply for APTC instead of enrolling in COBRA.

If an individual is enrolled in COBRA coverage, they must wait until that coverage expires, employer contribution to the COBRA enrollment ceases, or until Open Enrollment before applying for APTC or enrolling on the Exchange. They will not be eligible to enroll on the Exchange or receive APTC until their COBRA coverage expires, the employer stops contributing to COBRA, or Open Enrollment allows them to voluntarily leave their COBRA policy and begin a new policy on the Exchange.

For the exhaustion of employer contributions to COBRA premiums, see SEP 1, 1.2 (8).

APTC 16: Medicare and APTC

26 CFR 1.36 (B)(c)(2)(v)

Updated: 11/21/2017

- Individuals who receive Medicare are not eligible to receive APTC.
- Individuals who receive **Medicare Part A** at a cost may drop Part A and Part B coverage, or they can choose not to enroll in Medicare at the time they become eligible (these individuals may be subject to tax penalties or Medicare penalties if they defer Medicare enrollment outside of the qualifying time).
- Individuals who receive free **Medicare Part A** cannot drop it without also dropping their retiree benefits (i.e., Social Security) and paying back all received retirement benefits and costs incurred by the Medicare program.
- Individuals over 65 years old who elect not to receive retirement benefits may be eligible for APTC.

NOTE: Medicare Part B alone is not considered minimum essential coverage. However, if someone is eligible for Part B, it is assumed they are also eligible for Part A, and they won't be eligible for APTC.

APTC 17: Tax Credit Amount for Automated Renewal

45 CFR 155.340 (f)

Updated: 6/28/2019

When YHI re-enrolls consumers, the APTC amount is automatically set so that 100% is applied to the monthly premium. If a consumer prefers a different percentage applied to their monthly premium, they can adjust it at any time in their account. The change becomes effective on the first of the month following the change.

Exchange enrollees determined eligible for Medicaid programs through DHW are not auto-renewed during the redetermination process. YHI doesn't prohibit consumers from re-enrolling without a tax credit.

APTC 18: Appeals

45 CFR 155.510; 45 CFR 155.335; 45 CR 155.525; 45 CFR 155.545(c)(1)(I); 45 CFR 155.545(c)(2)

Updated: 7/19/2022

YHI will accept appeals for determination, verification, and redetermination of APTC or cost-sharing reductions.

Appeals must be submitted to YHI following the instructions available at www.yourhealthidaho.org.

Individuals have 30 days from the date of the notice of both financial eligibility and enrollment determination to file an appeal on any issue.

If requested, YHI will maintain the current APTC and CSR eligibility while the appeal is pending. If the consumer is determined to be ineligible, changes will be made effective the first day of the month following the appeal decision.

APTC 19: Cutoff Date for APTC Redetermination

Information submitted for the redetermination of Advance Premium Tax Credit and Cost Sharing Reductions must be completed by December 15* to correspond with the application cutoff date.

NOTE: If a consumer is eligible for a Special Enrollment Period, the household APTC can be calculated or re-calculated during this time.

**In keeping with standard business practices, when a deadline falls on a Sunday, or other legal holiday, the application period is extended to include the next day that is not a holiday.*

APTC 20: APTC and CSR Effective Date

45 CFR 155.310; 45 CFR 155.340

Updated: 5/3/2023

Consumers who are currently enrolled on the Exchange and experience a change in APTC will have their updated APTC amount applied to their enrollment starting the first of the month following the date that the eligibility is determined, and the consumer confirms any required changes to the enrollment.

Consumers who are not enrolled and receive a new APTC eligibility determination, or who are currently enrolled and have a change in Cost Share Reduction, will have their new APTC and/or CSR level amount applied to their enrollment following the enrollment rule, or per any guidelines due to Special Enrollment Periods, complex cases, or appeals resolution (see Renewals 6: APTC and CSR Effective Date and SEP 1: Qualifying Life Events for Special Enrollment Period).

APTC 21: Periodic Data Matching

45 CFR 155.260(e);45 CFR 155.310(k)(2); 45 CFR 155.330

12/04/2023

YHI conducts periodic data matching to identify situations where a consumer may be inadvertently receiving both APTC and Medicaid or has lost eligibility since the enrollment was initially created.

When periodic data matching is conducted outside of the renewal process, consumers who are found to be enrolled in Medicaid or CHIP while receiving their tax credit at the time of periodic matching will have their APTC removed from their enrollment starting the first of the month after discovery.

Consumers who are found to potentially have lost QHP eligibility will be given a 90-day reasonable opportunity period to provide documentation. If they do not complete verification, they will be given a 60-day extension. If documentation is not provided, the consumer's financial eligibility will be removed on the first of the month after the 60 days expires. This excludes verification of citizenship.

APTC 22: Resolving Income Discrepancies

45 CFR 155.300(d)

12/04/2023

When a consumer self-attests income that is discrepant from their records at IRS upon initial application, or during redetermination, they will be required to provide proof of their income to keep their tax credit. Consumers will be given 90 days to complete this process. If they fail to complete verification, the consumer's financial eligibility will be removed on the first of the month after the 90 days expires.

APTC 23: Cost Sharing Reduction (CSR) Eligibility

45 CFR 155.305(g); 45 CFR 155.305(f)(2)

3/15/2022

To be eligible to receive CSR, the consumer must meet certain requirements, including the following:

- Meet eligibility requirements for APTC
- Not eligible for employer sponsored coverage which provides minimum value
- A modified, adjusted gross income between 100 percent and 250 percent of the Federal Poverty Level

Note: To utilize CSR, consumers must be enrolled in a Silver level QHP

*Some lawfully present individuals may be eligible for CSR if they fall below 100% FPL

*Alaska Natives and American Indians with recognized tribal memberships are eligible for limited cost-share regardless of other eligibility factors.

Who is Eligible	**Customer Income Level:**	**Actuarial Value:**
American Indian/Alaska Native	100%-300%FPL	No cost-sharing when accessing care from an Indian Health Service (IHS), tribal and/or urban Indian health program care provider or when getting essential health benefits through a marketplace plan (no referral needed)
American Indian/ Alaska Native	Below 100% or above 300% FPL; Below 100%FPL and/or have no reported income	No cost sharing when accessing care from an Indian Health Service (IHS), tribal and/or urban Indian health program care provider or when getting essential health benefits with a referral from one of these providers.
American Indian/ Alaska Native	N/A	No cost sharing when accessing care from an Indian Health Service (IHS), tribal and/or urban Indian health program care provider or when getting essential

		health benefits with a referral from one of these providers.
Anyone	100%-150% FPL	94%
Anyone	151% - 200% FPL	87%
Anyone	201%-250% FPL	73%
Lawfully Present Non-Citizens ineligible for Medicaid due to Immigration Status	Under 100% FPL	94%

APTC 24: APTC Special Exceptions

26 CFR 1.36B-2; 45

3/15/2022

Lawfully present immigrants who are ineligible for Medicaid based on immigration status and whose household income falls below 100% of the FPL may be eligible for APTC. These individuals must be lawfully present and must meet all APTC requirements.

Individuals who are Victims of Domestic Violence or Spousal Abandonment and are planning to file taxes under the category "Married and filing separately," are eligible to receive APTC as part of a household separate from their spouse without penalty.

Individuals who are over the age of 65, but not eligible for Medicare may be eligible for APTC. These individuals must provide documentation to demonstrate ineligibility for Medicare benefits.

Pregnant women enrolled in a QHP at time of pregnancy can choose to stay on their plan even if eligible for Medicaid, if the only factor making them Medicaid eligible is the pregnancy status.

Application

Application 1: Eligibility Verification Documents

Forms of documentation commonly used to verify U.S. citizenship or legal status: U.S. passport or passport card, certificate of naturalization, certificate of U.S. citizenship, documented evidence issued by a federally recognized Indian tribe, U.S. birth certificate, copy of the front and back of a resident alien card, or copy of another form of documentation showing legal status

Forms of documentation commonly used to verify income: Wage stubs, tax returns, unemployment benefit statements, Schedule C or E for self-employment earnings, bank statements showing regular deposits, accountant statements, bookkeeping records, or a statement from a knowledgeable source

In addition, the following interfaces are checked to verify income: Department of Labor, Federal Tax Interface, Social Security Administration, and The Work Number.

Application 2: Address

4 CFR 435.403(f)

Updated: 10/18/2016

Financial and non-financial consumers applying for health insurance coverage through YHI must provide a physical address on their application.

Consumers who lack a physical address may complete an affidavit to verify residency and determine insurance rating. The affidavit provides homeless status, and it establishes a way to communicate with the consumer.

Application 3: Periodic Residency/Citizenship Verification

45 CFR 155.305, 310, 315; YHI SEP #14

Updated: 8/18/2020

YHI conducts periodic residency verification. Consumers that are not eligible for a tax credit will have 30 days from the date the verification notice is sent to provide accepted documentation.

Without receipt of the acceptable verification documentation, the adults from the household will be disenrolled from coverage.

Consumers that are receiving a tax credit will have 90 days from the date the verification notice is sent to provide accepted documentation. If verification of residency is not received, they will be determined ineligible for the tax credit until residency can be verified.

In situations of suspected fraud, YHI notifies the Idaho Department of Insurance for investigation.

Documentation required to provide residency after YHI identifies or is notified of an address discrepancy or determines to conduct periodic verification:

- *Valid Idaho driver's license, state-issued identification, or U.S. passport (including Idaho STAR card or U.S. Passport card)*

  OR

- *Idaho Voter Registration Card*

AND

- *Utility bills (dated bills showing service within 60 days)*

AND one of the following documents dated within 60 days:

- *Student college enrollment letter from an Idaho institution*
- *Idaho automobile registration*
- *Rental agreement*
- *Home purchase agreement*
- *Property tax notice (homeowner's exemption for Idaho must be demonstrated)*
- *Home payment notice*

Dental

Dental 1: Open Enrollment

45 CFR 155.410

Dental insurance has the same Open Enrollment and special enrollment periods as health insurance.

Dental 2: Rate Codes

To determine the dental premium, count members of the household over the age of 19 and the three oldest children who are still 18 years old or younger and add their individual premium amounts together to get the household premium amount.

Dental 3: Pediatric Dental Age Limits

Anyone 18 years of age or under can enroll in a pediatric dental plan.

Dental 4: Pediatric Dental Plans

Households with dependents are not required to purchase Qualified Health Plans with embedded pediatric dental or child-only dental plans.

Dental 5: Disenrollment

Updated: 5/3/2023

Consumers can end dental coverage without terminating health coverage.

Dependents under the age of 26:

- Consumers enrolled in a dental policy that offers only pediatric benefits are automatically disenrolled at the end of the year in which they turn 19.
- Consumers enrolled as dependents on a dental policy that includes adult coverage will be automatically disenrolled at the end of the year in which they turn age 26. However, if applicable, Advance Premium Tax Credits (APTC) ceases for consumers at the end of the month in which they turn age 19. See Dental 7: APTC for loss of APTC for dental coverage at age 19.

- **NOTE**: If an individual ages out of their pediatric dental plan, they do not qualify for a Special Enrollment Period.

See also Insurance 29: Disenrollment.

Dental 6: Renewals

45 CFR 155.335 (j); 77 FR 18309, 18315

Updated 5/21/2019

Dental health insurance plans are renewed for consumers during the Open Enrollment period.

Exchange enrollees determined eligible for Medicaid programs through DHW are not auto-renewed in either medical or dental enrollments during the redetermination process. YHI doesn't prohibit consumers from re-enrolling without a tax credit.

Dental 7: APTC

45 CFR 155.1030; 45 CFR 155.340; 26 CFR 36B-3(e)

Updated 5/1/2016

Tax credits (APTC) may only be applied to pediatric dental when it is part of healthcare coverage, or to the premiums of a pediatric enrollee when enrolled in a stand-alone dental plan.. Tax credits cannot be applied toward dental coverage for consumers over the age of 19.

Insurance

Insurance 1: Open Enrollment

45 CFR 155.410; 78 FR 13405; Idaho PST Decision 132

Updated: 06/24/2024

Starting in 2023, Open enrollment will take place October 15-December 15th of each calendar year. In keeping with standard business practices, when a deadline falls on a Sunday, or other legal holiday, the enrollment period is extended to include the next day that is not a holiday.

Plan Year	Open Enrollment Period
2026	October 15, 2025 – December 15, 2025
2025	October 15, 2024 – December 15, 2024
2024	October 15, 2023- December 15, 2023
2023	October 15, 2022 – December 15, 2022
2022	November 1, 2021 – December 15, 2021
2021	November 1, 2020 -- December 15, 2020
2020	November 1, 2019 – December 16, 2019*
2019	November 1, 2018 – December 15, 2018
2018	November 1, 2017 – December 15, 2017
2017	November 1, 2016 – January 31, 2017
2016	November 1, 2015 – January 31, 2016
2015	November 15, 2014 – February 15, 2015

Insurance 2: Rating Area

Idaho PST Decision 77

Updated: 10/18/2016

Rating area is determined from the primary contact's physical address listed on the application.

NOTE: For exceptions to this policy, see Application 2: Address.

Insurance 3: Coverage Start Dates

45 CFR 155.330(f)

Updated: 8/21/2018

YHI consumers who enroll in a health insurance plan prior to the end of the current month have coverage start the first of the following month, pending carrier effectuation, unless otherwise noted in

SEP 1 (Matrix). Outside of Open Enrollment, coverage always begins the first of the month following plan enrollment unless otherwise noted in SEP 1 (Matrix).

Consumers who enroll in a health insurance plan during Open Enrollment have coverage start the first day of the plan year, pending carrier effectuation. See SEP 1: Qualifying Life Events for Special Enrollment Period for coverage start date exceptions.

See Special Enrollment Period policies for exceptions.

Insurance 4: Determining Premiums for Households with Dependents

Idaho PST Decision 78

There is no limit to the number of dependents allowed in a household. The three oldest dependents under the age of 21 are factored into the premium calculation from the date of enrollment. Any additional dependents under the age of 21 are covered under the plan at no additional charge.

Dependents over the age of 21 have separate health insurance premiums and are billed in addition to the household premium.

NOTE: Minors who are married and have children are considered adults under this calculation formula. For child-only plans, the first three children are used to calculate the premium price and the rest are covered under the plan at no additional charge.

Insurance 5: Calculating Distribution of APTC for Custom Grouping

Updated: 5/21/2019

If a household decides to enroll household members in different plans, APTC is distributed in proportion to each household member's premiums in an automated process.

Insurance 6: Splitting APTC between Health Insurance and Dental Insurance

45 CFR 155.340; 26 CFR 1.36B-3(e)

APTC must be applied to health insurance plans first. If the APTC covers the entire monthly premium amount and there is still money left, the remaining APTC can be applied to pediatric dental coverage.

Insurance 7: Minimum Essential Coverage

45 CFR 155. 420 (e)(6)

Updated: 10/09/2023

As defined earlier, minimum essential coverage (MEC) is any health insurance coverage that satisfies the individual shared responsibility payment. Any of the following plans are considered MEC:

- Any QHP sold on the Exchange (Catastrophic plans sold on the Exchange are considered MEC but are not considered eligible QHPs for application of the APTC.)
- Any employer-based plan that meets the affordability standards
- Any retiree plan and COBRA

- Any plan with grandfathered status
- Medicaid coverage
- CHIP (Children's Health Insurance Program)
- Coverage under a parent's plan, if under 24
- Self-funded health coverage offered to students through universities
- Certain types of veteran coverage
- TRICARE
- Peace Corps
- Part A Medicare
- Idaho Pregnancy Medicaid Coverage as of 2020
- YES Medicaid (When the household is less than 300% FPL)

NOTE: Grandfathered plans are considered to meet MEC requirements. (45 CFR 155.420(d)(1)(iii))

Employees who currently have health insurance plans that meet minimum essential coverage requirements are not eligible to receive a tax credit. However, they may buy a health insurance plan through the Exchange without a tax credit. See Important Definitions for MEC.

Insurance 8: Primary Contact

Primary contact for the household is the primary contact on the account. All correspondence will be directed to them.

Insurance 9: Maximum Age of Dependent

Idaho PST Decision 70; 5/17/2022

The maximum age of a dependent on a health insurance policy is 25 years old. When an individual turns 26, they must enroll in their own health insurance policy and be removed from the household policy. YHI will allow 26-year-olds to stay on the household plan through the end of the plan year of their 26th birthday and terminate their enrollment upon plan year end.

* If the household changes their plan during the year in which the individual turns 26, the dependent will be dropped from the enrollment and will be required to enroll in their own health insurance policy. **NOTE**: It is also important to know that, in general, when a child turns 24, that child can no longer be claimed as a "qualified child" on a tax form but could be claimed as a "qualified dependent," assuming other qualifications are met based on IRS rules.

Children who turn 24 can continue to be considered as a "qualified dependent," and therefore part of an APTC household, or they can be dropped from the household APTC depending on the family's wishes. For more details, see APTC_12_Dependendents_Eligibility.

Insurance 10: Adding a Dependent during Open Enrollment

Idaho PST Decision 166

If a household has effectuated their health insurance coverage during the Open Enrollment period, they are not allowed to retroactively add another dependent to their plan unless there is an adoption or birth of a child.

NOTE: Consumers can choose to go through the appeals process if they feel they have an exception.

Insurance 11: Children of Undocumented Immigrants

45 CFR 155.300, 305

YHI allows children of undocumented immigrants to apply for health insurance coverage. If undocumented immigrants have a tax filer ID and the household files taxes, and the children are citizens, the children may be eligible for APTC even though the parents are not eligible to purchase insurance through the Exchange.

Insurance 12: Unsupported Household Relationship Codes

Idaho PST Decision 43; Idaho PST Decision 86

If a health insurance carrier does not recognize an individual's relationship to the primary subscriber as a covered relationship, the household will be given the option to enroll household members on separate insurance policies. See SEP 1: Qualifying Life Events for Special Enrollment Period, Matrix 5.3. See Insurance 5: Calculating Distribution of APTC for Custom Grouping Groups.

Insurance 13: Enrolling Families with Mixed CSR Status

Updated: 5/21/2019

Families with mixed eligibilities for Cost Sharing Reductions may enroll separately to maximize the value of their benefits in most cases.

Insurance 14: Age in Medicare

45 CFR 155.305; section 1882 (d)(3) of Social Security Act; 26 CFR 1.36B-2; Idaho PST Decision 38

Updated: 11/15/2016

If a YHI consumer becomes eligible for Medicare during a benefit year in which they are enrolled in coverage through the Exchange, they will no longer be eligible for tax credits; however, their eligibility for health insurance through YHI will remain unchanged. If a consumer becomes newly eligible for Medicare during a benefit year, they cannot enroll in the Exchange. If a consumer enrolls in a **Medicare Part A** plan and notifies YHI, their health insurance policy through YHI will be canceled. In the event a consumer doesn't terminate their plan upon converting to Medicare, YHI will backdate terminations on Medicare-eligible consumers at the request of the carrier or consumer.

Conversely, if YHI learns that a consumer is eligible for **Medicare Part A**, the consumer will be notified that they are no longer eligible to receive a tax credit, but they can still maintain their enrollment. Consumers will also be informed if they can cancel their coverage and enroll in **Medicare Part A**. YHI allows Medicare-eligible individuals to purchase a full price Qualified Dental Plan from the Exchange without APTC.

Insurance 15: Dual Enrollment in Medicaid and Full Price QHP

Updated: 7/19/2016

YHI will not prevent an individual enrolled in Medicaid from purchasing a full price Qualified Health Plan from the Exchange without APTC.

Insurance 16: Plan Eligibility

Eligibility is determined based on eligibility results, not a household's application.

EXAMPLE: If a household of four applies for health insurance coverage but one person is deemed ineligible, then the other three members of the household can still enroll in health insurance.

Insurance 17: Displaying Health Insurance Plans in the System

Updated: 5/21/2019

YHI shows consumers all Qualified Health Plans (QHPs) within their county address that are reviewed by the Idaho Department of Insurance and certified by YHI. For plans effective 1/1/2018 and after, YHI uses the county associated with the primary contact address.

Carriers that sell plans on the Exchange are required to publish information about their provider directories and formulary drug lists on their website in a standardized, machine-readable format.

Insurance 18: Catastrophic Health Insurance Plans

Individuals who are under the age of 30 (even if they will turn 30 during the plan year) or who have an eligible hardship exemption number may enroll in catastrophic health insurance plans. See Tax 1: 1095 A Tax Statement.

Insurance 19: Tobacco Status

45 CFR 147.102 (a)(iv) Idaho PST Decision 85

If a YHI consumer has used tobacco products four times or more per week within the last six months, then they are considered a tobacco user. Vaping is considered tobacco use.

YHI will only allow smoking status to be determined during enrollment for the entire plan year until a subsequent enrollment is made during an SEP or OE. For appeals for application misstatements, such as smoking, carriers will validate the update with the consumer and work with YHI to update information on the Exchange.

NOTE: Participation in smoking cessation programs will not impact individual monthly premium amounts.

Insurance 20: Electronic and Telephonic Signatures

YHI and the Idaho Department of Health and Welfare will allow consumers to give their signatures either electronically or verbally over the phone for their health insurance applications.

Insurance 21: Self-Attestation for Employer-Sponsored Coverage

YHI will allow consumers to provide self-attestation on their access to employer-sponsored health insurance coverage.

NOTE: If an applicant has access to employer-sponsored coverage that meets the minimum essential coverage requirements, but claims they do not have access, they will be subject to a tax penalty.

Insurance 22: Urgent Case Resolution

Updated: 4/19/2017

YHI will resolve urgent cases within three business days upon receiving a consumer's information.

NOTE: Urgent cases are situations in which an individual has an immediate need for health services, and the standard wait period of 15 days could seriously jeopardize the individual's life, health, or ability to attain, maintain, or regain maximum function. In addition, a case is considered urgent if the process for a non-urgent case would jeopardize a potential enrollee's ability to enroll in a qualified health plan through YHI.

Insurance 23: Qualified Health Plans (QHPs) Not Accepting New Consumers

Health insurance carriers who sell plans through YHI may choose to restrict new enrollees in certain plans. However, any qualified health plan sold on the Exchange must continue to service its existing consumers.

Insurance 24: QHP Certification Outside of Standard Timeframe

YHI will only add Qualified Health Plans to the Exchange one time each year—the Exchange will not add any additional plans outside of the designated certification period, which is set by the YHI Board of Directors in coordination with the Idaho Department of Insurance.

Insurance 25: Active Application Timeframe

Once YHI consumers have completed an application in the system, it will remain active throughout the Open Enrollment period.

Insurance 26: Disenrollment by Carrier

Updated: 4/19/2017

Health insurance carriers will be allowed to disenroll consumers for non-payment, fraud, or intentional misrepresentation.

Insurance 27: Deadline for Coverage during Open Enrollment

Idaho PST Decision 179

Updated: 5/17/2022

During Open Enrollment, if a household wants health insurance coverage to start by January 1, they must complete and submit their enrollment no later than December 15* of the prior year.

Coverage starts January 1 for plans selected during OE.

* *In keeping with standard business practices, when a deadline falls on a Sunday, or other legal holiday, the application period is extended to include the next day that is not a holiday.*

Insurance 28: Changing Plans during Open Enrollment

Idaho PST Decision 166, 177, and 191

Updated: 5/17/2022

During the Open Enrollment period, a household may prospectively enroll, disenroll, or change their health insurance plan.

- During Open Enrollment (OE), a consumer may enroll or change plans until 12/15 for a 1/1 policy effective date.
- If updated eligibility is received by YHI after 12/15 and the consumer is not currently enrolled, a valid Qualifying Life Event will be required. See SEP 3.
- If a consumer is enrolled AND updated eligibility is received by YHI after 12/15, and a change in CSR has occurred or an action is required, the consumer has 60 days from the approved application to change plans with a start date following the enrollment rule (See SEP 1).

Updates to financial eligibility outside of Open Enrollment dates follow the enrollment rules in APTC 20 and APTC 10.

Special enrollment cases are reviewed individually during Open Enrollment to honor consumer coverage dates.

* *In keeping with standard business practices, when a deadline falls on a Sunday, or other legal holiday, the application period is extended to include the next day that is not a holiday.*

Insurance 29: Disenrollment

Updated: 5/3/2023

NOTE: See Insurance 3: Coverage Start Dates for coverage start dates.

A YHI consumer can voluntarily disenroll and set the date for the end of the current month, next month, or the following month. That date is always the last day of the month, unless it is death related. Disenrollment for non-payment happens at the carrier's discretion. YHI will allow authorized consumers to disenroll an enrollee due to death based on self-attestation. If a consumer requests a corresponding SEP, verification may be requested.

When a child is on a parent's health insurance policy, they are automatically disenrolled from the plan at the end of the year in which they turn 26. Dependents who turn 24 and lose their tax credit can remain on their parents' plan without APTC.

When a consumer or agent reports dual coverage for health and/or dental and requests a termination of the Exchange policy, YHI

- requires documentation of group coverage,
- terminates to the last day of the month that the consumer reported, and
- retroactively terminates, if requested and validated within 14 days of the requested termination date.

When a consumer or agent reports a move from the state and requests a retroactive termination, YHI

- terminates to the last day of the month in which the consumer reported the move.

When a consumer or agent reports retroactive approval of Medicare Part A and B and requests a termination of the Exchange policy, YHI.

- Requires documentation of Medicare Parts A and B
- Retroactively terminates up to 60 days

If a consumer reports Idaho residency to enroll on the Exchange and residency is not verified, enrollment may be canceled at the carrier's discretion.

Additionally, if a consumer fails to provide required verifications within the specified timeframe, the enrollment may be terminated to the last day of the month following the deadline.

An enrollee may end their health coverage without terminating their dental coverage.

If a consumer is determined Medicaid eligible AND YHI receives the updated application, the consumer is automatically disenrolled to the end of the month in which the application is received.
See also Dental 5: Disenrollment.

Insurance 30: Agent Certification

Updated: 6/21/2017

Agents and brokers who wish to sell health insurance through YHI must complete yearly training, including in-person training sessions, online coursework, and certification testing with passing scores. Agents are allowed three attempts to pass the test.

YHI certified agents and brokers are required to adhere to the YHI Agent Accountability Standards.

NOTE: If an agent fails the test three times, they can appeal only if a technical reason prevented them from passing on the final attempt.

Insurance 31: Appeals

Updated: 5/3/2023

Appeals for enrollment and plan eligibility will need to be submitted to Your Health Idaho following the instructions available on the www.yourhealthidaho.org website.

Individuals have 30 days from the date of the notice of enrollment determination to file an appeal.

See Advance Premium Tax Credit (APTC) for information about appealing tax credits.

Appeals Decisions Definitions

Dismissed

Consumer or agent has requested to withdraw the request. **Or**, the requested actions are already reflected on account. **Or**, the consumer failed to appear at scheduled appeal hearing without cause.

Invalid

Appeal request is not accepted due to the following possible reasons:

- Failure to submit your appeal request within 30 days from the date of your notice of eligibility determination.
- Request is not an appeal of an eligibility determination and therefore does not constitute a valid subject of appeal under applicable regulations.
- Request is not within the jurisdiction of Your Health Idaho.
- Your Health Idaho does not have responsibility for hearing your appeal. Your appeal request relates to an eligibility determination for programs administered by other agencies including Medicaid, and CHIP and is handled by the Idaho Department of Health and Welfare.
- Information is missing from your appeal request form.
- Additional clarification is required.

Overturned

Original decision has been changed based on the Code of Federal Regulations and *YHI Policy Manual*.

Upheld

Original decision has not been changed based on the Code of Federal Regulations and *YHI Policy Manual*. If a decision is upheld, the consumer has 10 days from the date of receiving the informal resolution to request a formal appeal hearing.

Insurance 32: Agent Disciplinary Action

Updated: 9/22/2015

If YHI or the Idaho Department of Health and Welfare staff observe fraudulence or unethical actions or behaviors from agents, brokers, or enrollment counselors, YHI may report their concerns to the Idaho Department of Insurance (DOI) for further investigation and possible discipline by DOI. If DOI suspends an agent's license, YHI may decertify the same individual to preclude them from selling plans on the Exchange.

Insurance 33: Reinstatement

Updated: 06/24/2024

Consumers requesting reinstatement must submit the request to their insurance carrier for a reinstatement decision, unless the reinstatement is the result of a complex case or appeals resolution.

YHI may not reinstate coverage without a documented system or agency error. Due to redetermination processes, consumers may also experience a temporary loss of financial eligibility, which may result in an enrollment termination. If loss of financial eligibility is in the same month and the consumer acts within that same month, YHI will reinstate without gap in coverage for continuous coverage. If APTC is

removed due to a DMI expiration and the DMI is resolved in the same month, YHI can reinstate APTC without a gap in financial eligibility.

Insurance 34: Eligibility to Enroll on the Exchange

45 CFR 155.305
Updated: 8/31/2016

A YHI consumer must be an Idaho resident or intend to be a resident of the state. A YHI consumer must also be one of the following:

- a citizen of the United States
- a non-citizen who is lawfully present and is reasonably expected to become a citizen or national
- a non-citizen who is lawfully present for the entire time in which enrollment is sought

A YHI consumer is neither of the following:

- incarcerated
- receiving or eligible for Medicare coverage

Insurance 35: Re-Enrollment Following Termination for Non-Payment

45 CFR 147.104 i)
Updated: 06/25/2024

A new plan selected by a consumer during an Open Enrollment or Special Enrollment Period cannot be denied by a Carrier due to a prior policy that was terminated for non-payment. Money that the consumer intended to pay toward the new plan's binder payment cannot be applied to a prior delinquency by the Carrier.

Insurance 36: Rate Calculation

Updated: 11/21/2017

YHI calculates premium rates per the effective date of the covered member; YHI does not recalculate rates per member on applications if there is only a change in CSR or if the primary subscriber leaves the plan and there are no other plan changes. Carriers may terminate coverage for a consumer's failure to complete the repayment option with the carrier.

Renewals

Renewals 1: Automatically Renewing Coverage

45 CFR 155.335; 45 CFR 156.290 (5); 45 CFR 155.430

Updated: 2/15/2022

YHI automatically renews consumer health insurance coverage for the next plan year if consumers are deemed eligible.

If a consumer is deemed conditionally eligible for the next plan year, they are renewed. The consumer might need to supply additional information, if requested, to prove eligibility. Conditionally eligible consumers may have their APTC end if they do not provide the requested additional documentation within 30 days.

YHI automatically renews consumer coverage even if they lose eligibility for a tax credit (APTC) or cost-sharing by renewing them into a corresponding plan without APTC or cost-sharing benefits.

Consumers who are no longer eligible to purchase health insurance on the Exchange are not renewed.

When an insurance carrier does not renew, or they are decertified by the Exchange at the end of the plan year, the Exchange terminates their enrollment coverage at the end of the plan year. Consumers are automatically enrolled in a crosswalked plan, as directed by the Department of Insurance.

Consumers may change coverage during Open Enrollment.

Consumers determined eligible for Medicaid programs through DHW are not auto renewed during the redetermination process. Consumers who are found to be enrolled in Medicaid, Medicare, or CHIP during periodic data matching are also not renewed during the autorenewal process. YHI does not prohibit consumers from re-enrolling without a tax credit.

NOTE: After 1/1/2022, YHI will not renew a 26-year-old dependent at the end of the plan year. The individual may create his/her own account and enroll in their own plan during Open Enrollment, or with a valid QLE.

Renewals 2: Changing Plans through Open Enrollment Period

Even if a consumer has already renewed their health insurance plan and paid for the coverage, they can still choose to change plans through the end of Open Enrollment.

Renewals 3: Changes to Cost Sharing Reduction or APTC

Even if there are changes to a consumer's Cost Sharing Reduction level or tax credit, YHI will automatically renew their coverage unless they have turned 26 and aged out of their family's qualified health plan, or they have specifically requested their health insurance coverage end with the plan year.

Renewals 4: Changing Subscriber for Child-Only Policy

If a family has a child-only health insurance policy, the subscriber will remain as the original dependent on the policy until they age out of the coverage, even if the family has a younger dependent join the policy.

Renewals 5: Carrier Use of Payment

45 CFR 155.400; 156.270

Updated: 6/21/2022

New enrollments completed during an eligible enrollment period require the first full payment to be made by the initial payment due date for coverage to become effective.

Renewed plans are considered a continuation of coverage and do not need an initial binder payment for coverage to be effective. The three-month grace period for payment carries over for renewed enrollments if APTC is used to lower monthly premiums.

Renewals 6: APTC and CSR Effective Date

45 CFR 155.310; 45 CFR 155.340

Updated: 5/3/2023

Consumers who experience a change in APTC or CSR during the annual redetermination process will have changes applied with the effective date of their new plan year coverage.

Renewals 7: Carrier Terminations during Renewal Period

45 CFR 155.310; 45 CFR 155.340

Updated: 2/15/2022

In cases in which a carrier does not communicate terminations for non-payment to YHI in a timely manner (30 days prior to the renewal date), and renewals are processed, carriers will accept the renewal as a new enrollment, subject to enrollment rules and expectations. Carriers will be able to dispute renewals that are processed within 30 days of the renewal date.

Small Business Health Options Program (SHOP)

SHOP 1: Definition

Updated: 10/20/15

YHI's Small Business Health Options Program (SHOP) is open to small businesses in Idaho with up to 50 employees. Employees are defined as working 30 hours or more per week on average.

SHOP 2: Retroactive Assignment of SHOP Identification Numbers

Idaho PST Decision

Updated: 6/21/2016

YHI will approve retroactive SHOP identification numbers to employers who have demonstrated enrollment in a SHOP-qualified plan for the previous year, but who did not complete the SHOP application process.

Special Enrollment Period

SEP 1: Qualifying Life Events for Special Enrollment Period

45 CFR 155.420

Updated: 10/09/2023

Special Enrollment Matrix

The **SEP Type** column reflects federal and YHI designations:

1. Loss of MEC
2. Change in Household Size
3. Change in Residency (with Limitations)
4. Change in Financial Eligibility
5. Exceptions/Other
6. Change in Eligibility Status

The **Exchange Enrollment Required Prior to QLE** column indicates YHI or MEC coverage, which must be ≥1 day of the previous 60 days.

Type	#	Type of Qualifying Life Event (QLE) & Scenario	QLE Merits SEP	Exchange Enrollment Required Prior to QLE	Timeframe to Report and Enroll in a Plan (SEP)	Coverage or Change Effectuates	Regulation Reference
Loss of MEC	**1.1**	**Expiration of Off-Exchange Plan:** Consumer loses coverage in any non-calendar year group health plan or individual health insurance coverage due to off-Exchange plan or coverage expiring. * Individual is eligible even if they have the option to renew their previous policy, including those enrolled on COBRA plans during group plan renewal time.	Yes	MEC	Up to 60 days before event, through 60 days after event	1st day of month following loss of coverage, if plan enrollment is completed before 1st day of month. If loss of coverage is reported after the event, effective date is the 1st of month following plan enrollment.	45 CFR 155.420(d)(1)(ii); Idaho SBM PST ID 167
			* Rule does not apply to non-MEC policies, such as hospital indemnity policies, short-term policies, or other non-MEC policies.				

Type	#	Type of Qualifying Life Event (QLE) & Scenario	QLE Merits SEP	Exchange Enrollment Required Prior to QLE	Timeframe to Report and Enroll in a Plan (SEP)	Coverage or Change Effectuates	Regulation Reference
Loss of MEC	**1.2**	**Loss of MEC:** 1) Loss of subscriber (divorce, incarceration, or moves out of state) 2) Loss of employer coverage (must be MEC) 3) Moving into the state (requires proof of coverage if moving between US states; if moving from outside the country or from US territory, no prior proof of coverage required; see SEP 14) 4) Cancelled exemption 5) Aged out a. Child turns 26 b. Child applies as separate tax household. Example: Child turns 24 and ages out of family tax household (financial plan). c. Person turns 31 and becomes ineligible for catastrophic plan. 6) Loss of other coverage (TriCare, Peace Corps, etc.) 7) Exhaustion or loss of employer contribution to COBRA enrollment 8) Exhaustion of Public Employee Retirement System of Idaho (PERSI) sick-leave funds applied to qualified PERSI funded insurance 9) Newly eligible for HRA, QSEHRA, or ICHRA through employer	Yes	MEC	Up to 60 days before event through 60 days after event	If plan enrollment is completed prior to last day of the month, the 1st day of following month If plan enrollment is completed after last day of the month, the 1st of month after month following plan enrollment date.	45 CFR 155.420(b)(2)(ii); 45 CFR 155.420(d)(1)(i); 45 CFR 155.420(c)(2)(ii); COBRA Overview and QSERHRA Assistance and Special Enrollment Period (SEP) Overview on https://www.cms.gov
Loss of MEC	**1.2 (a)**	**Loss of MEC:** Loss of Medicaid/CHIP coverage *If the consumer has a voluntary loss of Medicaid **and** qualifies for APTC they are eligible for a SEP.	Yes	MEC	Up to 60 days before event through 90 days after event	If plan enrollment is completed prior to the last day of the month, the 1st day of the following month. If plan enrollment is completed after last day of the month, the 1st of month after month following plan enrollment date.	45 CFR 155.420(c)(2)(ii); 45 CFR 155.420(d)(1)(i); 45 CFR155.420(c)(6)

Type	#	Type of Qualifying Life Event (QLE) & Scenario	QLE Merits SEP	Exchange Enrollment Required Prior to QLE	Timeframe to Report and Enroll in a Plan (SEP)	Coverage or Change Effectuates	Regulation Reference
Loss of MEC	**1.3**	**Loss of MEC Due to Death of Subscriber:** Consumer has loss of MEC due to death of subscriber in other application.	Yes	MEC	60 days from QLE (Loss of MEC)	Subscriber enrollment is terminated retroactive to the date of death.	45 CFR 155.420 (b) (3)
Loss of MEC	**1.4**	**Loss of MEC Due to Voluntary Termination:** Subscriber chooses to terminate existing plan. Policy ends * This does not apply when there is a voluntary loss of Medicaid, and the consumer qualifies for ATPC. See SEP 1.2 (a). * Subscriber is not eligible to reapply.	No	N/A	Consumer reports to Carrier / Exchange	Consumer determines desired end date: 1. End of current month 2. End of next month 3. End of third month	45 CFR 155.420(e)
Loss of MEC	**1.5**	**Loss of MEC Due to Fraud:** Subscriber performs an act, practice, or omission that constitutes fraud, or the individual makes an intentional misrepresentation of material fact, as prohibited by the terms of the plan or coverage.	No	N/A	NA	The discontinuance of coverage will have a retroactive effect to the beginning of coverage.	45 CFR 147.128(a)(2); 45 CFR 155.420(e)
Loss of MEC	**1.6**	**Loss of MEC Due to Non-Payment:** Subscriber decides not to pay.* * Dependents can appeal Exchange eligibility as "Loss of MEC" due to subscriber non-payment.	No	N/A	Carriers will report through cancellation 834s or will system-generate by Exchange	**Financial Consumers:** Termed retroactively to last day of month after last month in which premium was paid in full **Non-Financial Consumers:** Termed retroactively to end of last month premium was paid in full	45 CFR 156.270(d)(1); 45 CFR 155.420(e)
Loss of MEC	**1.7**	**Subscriber Has Gain of MEC:** Subscriber gains coverage through other means (including incarceration of subscriber) or moves out of state (gain of MEC in another state is assumed). Policy ends.* * Dependents can reapply for coverage following SEP Matrix 1.2 ("Loss of MEC" QLE") if they do not also gain MEC.	No	N/A	Up to 60 days before the event through 60 days after the event	Coverage is terminated to the last day of the month that the consumer disenrolls (and, if necessary, cancels financial eligibility). See Insurance 29.	45 CFR 155.420(c)(2)(ii)

Type	#	Type of Qualifying Life Event (QLE) & Scenario	QLE Merits SEP	Exchange Enrollment Required Prior to QLE	Timeframe to Report and Enroll in a Plan (SEP)	Coverage or Change Effectuates	Regulation Reference
Loss of MEC	**1.8**	**Loss of SHIP (Student Health Insurance Program):** Consumer needs coverage due to enrollment in an Idaho university.	Yes	SHIP	Up to 60 days before the loss of SHIP through 60 days after loss of SHIP	1st day of month following plan enrollment	Idaho SBM PST Log 169
Loss of MEC	**1.9**	**Loss of employer or government contribution to COBRA enrollment**	Yes	COBRA	Up to 60 days before the event through 60 days after the event	1st day of month following plan enrollment	45 CFR 155.420(d)(1)(i)
Loss of MEC	**1.10**	**Expiration of Idaho Enhanced Short Term Plan (ESTP) eligibility**, expiration of the plan without the option to renew, OR termination from household enrollment of ESTP due to aging off (dependent). *While ESTPs are recognized as non-MEC enrollments, YHI approves the opportunity for SEP based upon established criteria. NOTE: Policy to be effective immediately but will require manual process until technology can be updated.	Yes	ESTPs	Up to 60 days before the event through 60 days after the event	1st day of month following plan enrollment	45 CFR 155.420(d)(1)(i); Idaho SBM PST Log 8/18/2020
Change in Household Size	**2.1**	**Gain Dependent to QHP Due to QLE**: Dependent has QLE and doesn't have coverage on subscriber's policy. Dependent may or may not be an existing tax dependent on subscriber's application.* * If the HH has a change in APTC/CSR due to the gain of the dependent, follow "Change in APTC/CSR QLE."	Yes	YHI	60 days from dependent's QLE	1st day of month following plan enrollment	45 CFR 155.330 (f)(1)(iii); 45 CFR 155.420 (d)

Type	#	Type of Qualifying Life Event (QLE) & Scenario	QLE Merits SEP	Exchange Enrollment Required Prior to QLE	Timeframe to Report and Enroll in a Plan (SEP)	Coverage or Change Effectuates	Regulation Reference
Change in Household Size	**2.2**	**Birth, Adoption, or Court-Appointed Ward** * For exchange-enrolled households the dependent can be added to the same plan that the household is currently enrolled in, or the dependent can enroll in separate plan at any metal level.	Yes	No	60 days from date of QLE	Retroactively to date of event OR The 1st day of the month following plan enrollment * * For financial consumers, APTC and CSR are granted retroactively to the date of event, which is applied when the consumer reconciles their taxes except in cases of hardship. Additionally, an SEP is granted for parent(s) regardless of if child goes on CHIP or Medicaid. * Consumers who report an added dependent after Open Enrollment closes, but before the new plan year effectuates, may add the dependent on the date of the event or the first of the month following plan enrollment; additionally, they may enroll in a cross walked plan for the upcoming plan year or select a new plan for the new year in a special enrollment period.	45 CFR 155.420(b)(2)(i)(1,2); 45 CFR 155.420 (d) (2)(i); 45 CFR 155.330(g); Idaho SBM PST Log: 188; Idaho SBM PST Log:189
Change in Household Size	**2.3**	**Divorce*** *If the consumer is not enrolled on the Exchange but experiences a loss of MEC due to divorce, refer to SEP Matrix #1.2. ***Updated 9/27/16***	Yes* *Eligible enrollees must lose coverage due to the divorce.	No	60 days from the effective date on the court order	1st day of month following plan enrollment	45 CFR 155.420(d)2)(ii)
Change in Household Size	**2.4**	**Death of Dependent**	No	N/A	N/A	Dependent is removed retroactively to date of death.	45 CFR 155.420 (b) (3); 45 CFR 155.420 (d)(2)(ii); Idaho SBM PST ID 166

Type	#	Type of Qualifying Life Event (QLE) & Scenario	QLE Merits SEP	Exchange Enrollment Required Prior to QLE	Timeframe to Report and Enroll in a Plan (SEP)	Coverage or Change Effectuates	Regulation Reference
Change in Household Size	**2.5**	**Loss of Dependent (Not Death or Loss of Subscriber):** 1) Age out; 2) Incarceration of Dependent; 3) Give child up for Adoption; 4) Loss for another reason* * In some situations, dependents may qualify for loss of MEC.	No	N/A	N/A	1st day of month following QLE (date of loss)	45 CFR 155.330 (f)(1)(iii); 45 CFR 155.420 (d)(2)(ii); Idaho SBM PST ID 166
Change in Household Size	**2.6**	**Marriage*** If neither party is enrolled on the Exchange and the couple has a QLE, both can enroll; if one party is on Exchange, the subscriber can add a dependent or the couple may elect to enroll in a new plan; or, if both parties are on Exchange, parties can choose to remain on separate plans (if separate tax HH), or one party must disenroll and the other party adds the spouse to the policy. The Exchange recognizes any marriage legally enacted in a jurisdiction outside of Idaho and applies the federal definition of marriage, which includes same-sex couples.	Yes	No	60 days from QLE At least one partner in a marriage related QLE must demonstrate at least one day of coverage in 60 days prior to marriage, unless moving from out of country, per CMS guidelines (effective June 19, 2017).	1st day of month following plan enrollment	45 CFR 155.420 (d)(2); 45 CFR 155.420(b)(2)(ii)
Change in Household Size	**2.7**	**Subscriber Dies:** Subscriber dies, and policy ends on date of death.* * Dependents can reapply for coverage following SEP Matrix 1.3 ("Loss of MEC").	No	MEC	60 days from QLE	Termination is dated retroactively to the date of QLE.	45 CFR 155.420 (b) (3)

Type	#	Type of Qualifying Life Event (QLE) & Scenario	QLE Merits SEP	Exchange Enrollment Required Prior to QLE	Timeframe to Report and Enroll in a Plan (SEP)	Coverage or Change Effectuates	Regulation Reference
Change in Residency (with Limitations)	**3.1**	**Permanent Move:** Consumer has a change of physical address (within the state of Idaho) or moves into Idaho from other state or outside of country.	Yes*	MEC	60 days from QLE	1st day of the month following plan enrollment	45 CFR 155.420 (d)(7); 45 CFR 155.420 (b)(2)(iv)
			* A permanent move only qualifies if a qualified individual or consumer and their dependents become eligible for different QHPs as a result of a rating area change, if the move is from outside the state, or if the plan is unavailable in the new county. Consumers must demonstrate at least one day of coverage in 60 days prior to the move, unless moving from out of country, per CMS guidelines (effective July 11, 2016).				
Change in Residency (with Limitations)	**3.2**	**Demographic Change:** Consumer reports change in mailing address, name, or other demographic info.	No	N/A	N/A	Immediately	
Change in Financial Eligibility	**4.1**	**APTC Amount Change:** Exchange-enrolled household with existing APTC has a change in APTC amount, or it adjusts the APTC amount applied on the APTC slider. *Plan change will be limited to plans that are one metal level higher, lower, or at the same level as the current plan that they are enrolled in.	No	YHI	N/A	APTC will be applied the 1st day of the month following the receipt of the approved application.* *Carriers must retain accumulations if consumers change APTC amount but retain the same policy. (See APTC 20.)	45 CFR 155.330(f)(1)(i); 45 CFR 155.420 (d) (6); 45 CFR 156.425(b)
Change in Financial Eligibility	**4.2**	**APTC Amount Change:** Exchange-enrolled household with no previous APTC becomes eligible for APTC (no CSR).	Yes	YHI	60 days from date of QLE	Coverage effective date will follow the 1st of the month enrollment rules, if a plan change is completed. Updated APTC will be applied the 1st day of the month following the receipt of the approved application or applied retroactively up to 60 days.* *Carriers must retain accumulations if consumers change APTC amount but retain the same policy. (See APTC 20.)	45 CFR 155.330(f)(1)(i); 45 CFR 155.420 (d) (6); 45 CFR 156.425(b)

Type	#	Type of Qualifying Life Event (QLE) & Scenario	QLE Merits SEP	Exchange Enrollment Required Prior to QLE	Timeframe to Report and Enroll in a Plan (SEP)	Coverage or Change Effectuates	Regulation Reference
Change in Financial Eligibility	**4.3**	**CSR Tier Change or Change in CSR Eligibility**: Exchange-enrolled household is newly eligible or ineligible for CSR or has a change in CSR tier eligibility. *Plan change will be limited to plans that are one metal level higher, lower, or at the same level as the current plan they are enrolled in.	Yes	YHI	60 days from date of QLE	Coverage effective date will follow the 1st of the month enrollment rules if a plan change is completed. Updated CSR will be applied the 1st day of the month following the receipt of the approved application. *Carriers must retain accumulations if consumers change APTC amount but retain the same policy. (See APTC 20.)	45 CFR 155.420(d)(4); 45 CFR 155.420 (d)(6); 45 CFR 155.330(f)(3); 45 CFR 156.425(b); Idaho SBM decision
						Although 155.420(b(1) indicates that plan enrollment follows the "15-day rule," the Exchange has determined that it is best for both the Exchange and the consumer to follow the effective date that aligns with the CSR tier change as identified in 155.330(f)(3)."	
Change in Financial Eligibility	**4.4**	**Income Change**: Subscriber reports a change in income. * If consumer becomes newly eligible for APTC and was previously unenrolled, follow SEP Matrix 4.6.; or, if consumer was previously enrolled, follow SEP Matrix 4.6. If consumer has a change of CSR resulting from an income change, follow SEP Matrix 4.3 (Newly Eligible or Ineligible for APTC). (See APTC 20.)	No	N/A	N/A	N/A	45 CFR 155.330(e)(1)(i) and (ii); 45 CFR 155.330(e)(2)(i); 45 CFR 155.330 (e)(2)(ii)
	4.5		Yes	Varies	60 days from QLE		

Type	#	Type of Qualifying Life Event (QLE) & Scenario	QLE Merits SEP	Exchange Enrollment Required Prior to QLE	Timeframe to Report and Enroll in a Plan (SEP)	Coverage or Change Effectuates	Regulation Reference
Change in Financial Eligibility		**Newly Eligible or Ineligible for APTC:** Consumer with existing MEC (can be on/off Exchange) becomes newly eligible or ineligible for APTC.	*Approved QLE for tier change or eligibility is limited to silver level or lower, approved 5/16/2017 but not applicable until technology can be updated.			Coverage effective date will follow the 1st of the month enrollment rules if an enrollment or plan change is completed. Updated APTC will be applied the 1st day of the month following the receipt of the approved application or applied retroactively up to 60 days.* *Carriers must retain accumulations if consumers change APTC amount but retain the same policy. (See APTC 20.)	45 CFR 155.330(f)(3); 45 CFR 155.420 (d) (6)
Change in Financial Eligibility	**4.6**	**Newly Eligible for APTC:** Qualified individual becomes eligible, but was previously ineligible for APTC, because of a household income below 100% of the FPL and who, during the same timeframe, was ineligible for Medicaid because they were living in a non-Medicaid expansion state (based on change in income or move to different state). As of 1/1/2020, Idaho is a Medicaid expansion state and this QLE will no longer be relevant. **Special Income Rule**: Lawfully present individuals who are ineligible for Medicaid due to immigration status may be eligible for APTC if household income is less than 100% of the Federal Poverty Level. A family can determine their APTC status by completing the application process.	Yes	No	60 days from QLE *Approved QLE for tier change or eligibility is limited to silver level or lower. Policy is approved 5/16/2017 but is not applicable until the technology updated is completed.	Coverage effective date will follow the 1st of the month enrollment rules, if a plan change is completed. Timeframe to report QLE and complete SEP enrollment begins from the date of QLE (date of income increase). Updated APTC will be applied the 1st day of the month following the receipt of the approved application or applied retroactively up to 60 days.* *Carriers must retain accumulations if consumers change APTC amount but retain the same policy. (See APTC 20.)	45 CFR 155.420 (d)(6)(iv)* Verification of change in income will be required to complete SEP enrollment. See SEP #14.

Type	#	Type of Qualifying Life Event (QLE) & Scenario	QLE Merits SEP	Exchange Enrollment Required Prior to QLE	Timeframe to Report and Enroll in a Plan (SEP)	Coverage or Change Effectuates	Regulation Reference
Change in Financial Eligibility	**4.7**	***This SEP is no longer available for applications beginning after August 25, 2025.*** **Eligible for APTC:** Qualified individual is eligible for APTC, and household income falls below 150% of the FPL. * For the Advanced Premium Tax Credit, eligibility is based on the published Federal Poverty Guidelines that were in effect at the start of the plan year's open enrollment period	Yes	No	60 days from QLE	1st day of the month following plan enrollment.	45 CFR 155.420(b)(2)(vii)Change
Change in Financial Eligibility	**4.8**	**Newly Eligible for APTC:** Qualified individual becomes eligible for APTC, and has an offer of employer coverage that has been determined to be unaffordable.	Yes	No	60 days from QLE	1st day of the month following plan enrollment.	
Exceptions/Other	**5.1**	**Erroneous / Unintentional / Other Enrollment Error Made by Marketplace:** Consumer or Exchange/marketplace identifies error in consumer account.	Case by case basis – handled via appeal process	N/A	Case by case, but no more than 60 days from time error is identified	Case by case basis	45 CFR 155.420(c)(3)); 45 CFR 155.420(d)(4)

Type	#	Type of Qualifying Life Event (QLE) & Scenario	QLE Merits SEP	Exchange Enrollment Required Prior to QLE	Timeframe to Report and Enroll in a Plan (SEP)	Coverage or Change Effectuates	Regulation Reference
Exceptions/Other	**5.2**	**10-Day Lookback:** Consumer decides to cancel QHP within 10 days of coverage effective date. ("free look" period)	No	YHI	Within 10 days of plan effective date	If a consumer selects and enrolls in a plan within OE or SEP timeframe, they may request to return the enrollment within 10 days of coverage effective date. If a consumer returns the policy within the 10-day free-look period, the amount of time remaining on their enrollment period will revert to the amount of the time there was on the day the plan was purchased. E.g., if a consumer purchases a plan on day 55 of a 60-day SEP and returns it nine days later, the consumer will still have five days remaining in which to enroll in a plan (as if it were still day 55 of the SEP). If previously enrolled on the Exchange, the consumer has the option to request reinstatement into the original policy dependent on carrier approval, which YHI will request per YHI Policy Manual, Insurance #33. If carrier denies request, consumer may appeal to carrier for reinstatement request.	Idaho Insurance Code: 41-2138
Exceptions/Other	**5.3**	**Custom Grouping SEP:** 1) American Indian/Alaska Native (AI/AN) cost share is not available to partial AI/AN households, so family requests one policy with different cost sharing (same carrier required). 2) Unsupported relationships are requested to be on the same policy (e.g., mother-in-law is a dependent as defined by the IRS, but the relationship is invalid per the carrier's contract with the member). **Updated 2/17/2021: This QLE is no longer in effect due to updated	Case by case basis* * Handled through YHI appeals process	Varies	Case by case basis	One of two possibilities to be determined on a case by case basis: 1. Retro-date back to beginning of 1st requested policy (e.g., Jan 1 if tried to apply during OEP) 2. Allow consumers to choose to follow standard rule: Enrollment before 15th, then 1st day of following month; otherwise, 1st day of second following month	Idaho SBM PST Log 170

Type	#	Type of Qualifying Life Event (QLE) & Scenario	QLE Merits SEP	Exchange Enrollment Required Prior to QLE	Timeframe to Report and Enroll in a Plan (SEP)	Coverage or Change Effectuates	Regulation Reference
		technological options to enroll with custom grouping needs.					
Exceptions/Other	**5.4**	**QHP Materially Violated Contract:** Consumer or Exchange identifies error in consumer contract.	Case by case basis*	N/A	Case by case basis, but no more than 60 days from time error identified	Case by case basis	45 CFR 155.420(c)(3); 45 CFR 155.420(d)(5)
			* Handled through appeals process				
Exceptions/Other	**5.5**	**Change in Exchange Eligibility** Consumer misses OE or SEP window due to Medicaid referral processing times.	Case by case basis*	Varies	Case by case basis	1st day of the month following plan enrollment	45 CFR 155.420(d)(11)
			*Consumer will be required to provide validation documents as required under SEP #14 to validate the reported QLE OR must demonstrate they applied during OE.				
Exceptions/Other	**5.6**	**Expiration of Data Matching Inconsistency (DMI)** If the consumer was terminated by the exchange as part of the verification procedure, and then resolved the DMI after.	Yes	Yes	60 days after consumer notified of their enrollment termination	1st day of the month following plan enrollment	
Change in Eligibility Status	**6.1**	**Exceptional Circumstances:** Due to extenuating circumstances, consumer needs to choose a new plan (unable to pay previous premiums due to extreme circumstances, natural disaster, domestic violence, conflicting advertising dates regarding OE, etc.).	Case by case basis*	Varies	Case by case basis	Case by case basis	45 CFR 155.420(c)(3); 45 CFR 155.420(d)(9)
Change in Eligibility Status	**6.2**	**American Indian or Alaska Native:** Consumer is American Indian or Alaska Native and recently gains status as American Indian or Alaska Native.	Yes	No	All can have SEP once a month.*	1st day of the month following plan enrollment	
			* If only primary or only dependent has A/I status, that individual follows the custom grouping QLE.				

Type	#	Type of Qualifying Life Event (QLE) & Scenario	QLE Merits SEP	Exchange Enrollment Required Prior to QLE	Timeframe to Report and Enroll in a Plan (SEP)	Coverage or Change Effectuates	Regulation Reference
Change in Eligibility Status	**6.3**	**Date of Birth Change**: Consumer sees incorrect birth date and updates it.	No*	N/A	Anytime	1st day of month following plan enrollment date	45 CFR 155.420(d)(4)
			*If DOB change results in eligibility change for current plan, then follow loss of MEC; i.e., if consumer becomes eligible for different priced premiums or change in APTC/CSR, then they should follow those QLEs.				
Change in Eligibility Status	**6.4**	**Gains Citizenship:** Consumer gains U.S. citizenship.	Yes	No	60 days from QLE	1st day of the month following plan enrollment	45 CFR 155.420(d)(3)
Change in Eligibility Status	**6.5**	**Gain of Legal Presence:** Consumer gains legal presence.	Yes	No	60 days from QLE	1st day of the month following plan enrollment	45 CFR 155.420(d)(3)
Change in Eligibility Status	**6.6**	**Loss of Legal Presence:** Consumer loses legal presence.	No*	N/A	N/A	1st day of month following report date	
			*Consumer is disenrolled as of the date of loss of legal presence. Consumer may request earlier termination, if desired, based on voluntary termination rules. If a dependent is disenrolled, the household follows the SEP Matrix #1.5 (QLE "Loss of Dependent"). If a subscriber is disenrolled, the household follows the SEP Matrix #1.7 (QLE "Loss of Subscriber").				
Change in Eligibility Status	**6.7**	**SSN:** Consumer reports change in SSN.	No	N/A	N/A	N/A	
Change in Eligibility Status	**6.8**	**Failure to Reconcile Taxes (FTR):** Enrollee on Exchange completes tax reconciliation.	No*	N/A	60 days from notice of reconciliation approval	1st day of month following plan enrollment date (if guidelines are met) YHI requires previous Exchange enrollment in last month of previous plan year and	26 CFR 1.36B-4; Idaho SBM PST Decision #244

Type	#	Type of Qualifying Life Event (QLE) & Scenario	QLE Merits SEP	Exchange Enrollment Required Prior to QLE	Timeframe to Report and Enroll in a Plan (SEP)	Coverage or Change Effectuates	Regulation Reference
			*Enrollees who have lost tax credit due failure to reconcile for two consecutive years will need to reapply. Enrollment will not be automatically updated. Enrollees who have disenrolled coverage due to FTR will be eligible for SEP.			proof of loss of financial eligibility due to FTR process with Internal Revenue Service (IRS). Proof includes dated letter from IRS indicating clearance and updated financial application approval. Resolution of FTR within last 60 days qualifies for SEP. Exceptions are made for consumers who are new residents to Idaho, managed case by case. Enrollments following loss of eligibility due to FTR have updated financial eligibility automatically applied when confirmed, following IRS clearance.	
Change in Eligibility Status	**6.9**	**Release from Incarceration**	Yes	No	60 days from notice of release from incarceration	1st day of month following plan enrollment date (if guidelines are met)	45 CFR 155.420(d)(3); 45 CFR 155.305(aa)(2)

SEP 2: Life Events That **Do Not Trigger** a Special Enrollment Period

- Voluntarily dropping coverage. (This does not apply when there is a voluntary loss of Medicaid, and the consumer qualifies for APTC.)
- Loss of eligibility for coverage when the person was not enrolled in it (i.e., loses job, but was not in the employer's health plan)
- Income change (i.e., raise at a job)

  See SEP 1: Qualifying Life Events for Special Enrollment Period for exceptions.
- Termination from other coverage for not paying premiums or for fraud
- Death of a family member without a resulting loss of coverage
- Becoming pregnant
- Death of a dependent

SEP 3: Timeline for Reporting a Qualifying Life Event (QLE) and Obtaining Coverage

45 CFR 155.305-320; 45 CFR 155.420

Updated: 5/15/2018

Consumers have 60 days to report a QLE, validate the event, and enroll in a plan on the Exchange. If an individual knows they are losing minimum essential coverage, they can report the loss of that coverage up to 60 days in advance. Consumers seeking a first of the month effective date, who are in a pending verification status, may request an earlier effective date to be considered upon approval of the QLE. Those who do not complete validation in a timely manner may appeal to request an earlier effective date.

If an existing YHI consumer's address is updated after 60 days of the event (either through reconciliation or consumer/agent request) or a death is reported outside of the required 60-day timeframe, and the consumer made all payments with the carrier, YHI either maintains the consumer's enrollment if they are eligible for the plan, offers a crosswalk plan with the same carrier, or offers a crosswalk plan within the same plan level.

NOTE: If an individual reports multiple Qualifying Life Events at one time, the effective date of their health insurance policy is dated to the earliest effective date for the Qualifying Life Events.

Once an individual enrolls in a health insurance plan, their Special Enrollment Period closes, and they cannot change their plan until the next Open Enrollment or Qualifying Life Event occurs.

SEP 4: Mid-Month Coverage Start Date

Health insurance coverage obtained through a Special Enrollment Period will not start mid-month, except in cases of death of subscriber or birth of a dependent. In the event of death of subscriber, the coverage for the remaining dependents may begin on the day after the death. In the event of the birth of a child or court appointment of a ward, the coverage starts on the event date. Coverage always starts at the first of the month, regardless of when an individual enrolls in a plan.

SEP 5: Parents Add a New Dependent

If a family has a baby, adopts a child, is placed in foster care, or is appointed by a court as the ward for a child, they are entitled to a Special Enrollment Period, even if the child gains alternative health insurance coverage such as CHIP. The new APTC eligibility calculation will be retroactive to the date of the event in cases where the dependent is also added retroactively.

NOTE: Pregnancy does not qualify for a Special Enrollment Period. Additionally, if an individual is granted a Special Enrollment Period for a reason other than having a baby, adoption, or becoming a child ward, another dependent cannot be added to their health insurance plan.

Dependents can only be added to a health insurance plan if they have their own Qualifying Life Event.

SEP 6: Loss of Off-Exchange Health Insurance Coverage Outside of Open Enrollment

Idahoans who are enrolled in health insurance plans sold off Exchange will be granted a Special Enrollment Period if the plan they are enrolled in expires outside of YHI's Open Enrollment—even if they are given the option to renew their coverage.

NOTE: If an individual ages out of their pediatric dental plan, they do not qualify for a Special Enrollment Period.

SEP 7: Loss of a Dependent

YHI will NOT grant households a Special Enrollment Period if they lose a dependent.

SEP 8: Paying a Tax Penalty

An individual does not qualify for a Special Enrollment Period because they must pay a penalty for not having health insurance coverage when they file their taxes. Those individuals need to wait until the next Open Enrollment period or Qualifying Life Event to purchase health insurance coverage.

NOTE: As of 1/1/2019, the Shared Responsibility Payment is no longer applicable.

SEP 9: Student Losing SHIP

College and university students in Idaho who are losing their student health insurance coverage (SHIP) due to graduation, or the end of the college/university term will be granted a Special Enrollment Period. To receive the Special Enrollment Period, students will need to provide proof of SHIP coverage and a letter from the university confirming the loss of coverage due to semester completion, or graduation. Alternatively, a termination letter from the SHIP carrier accompanied by a school calendar indicating alignment with the college/university term conclusion is acceptable.

SEP 10: Domestic Violence

If an individual is granted a Special Enrollment Period due to a domestic violence situation, YHI does not require proof that domestic violence took place but takes the victim's self-attestation.

SEP 11: Consumer Takes No Action and Current Plan Unavailable

Updated: 5/1/2017

If a consumer reports a life event, their current plan might not be available to them as a result. If the consumer does not select a new plan, YHI will disenroll the consumer from their current plan when their Special Enrollment Period ends. YHI will then enroll the consumer in a crosswalk plan so health insurance coverage continues. Alternately, the consumer whose plan is no longer available due to the reported change can choose to enroll in a different plan during their Special Enrollment Period.

SEP 12: Validate Consumer Action Prior to Loss of MEC

If a consumer, or their designated agent, broker, or enrollment counselor, tries to take action prior to losing minimum essential coverage, the effective date will be backdated to the first of the month following the event that caused them to lose coverage. YHI will validate action was taken from a recording of a consumer's phone call, an affidavit provided by the agent/broker, or a ticket or support email that was received. The consumer, or their designee, must act within 60 days of the event. If action cannot be validated within 60 days of the event, coverage will start the first of the month following the notification of the loss of minimum essential coverage.

Consumers seeking a first of the month effective date, who are in a pending verification status on the last business day of the month, must notify YHI of the urgency for the effective date to be considered potentially eligible. Consumers may also appeal to adjust dates.

SEP 13: Validation of Application and Enrollment

Updated: 5/1/2017

Health insurance carriers may validate life change events and enrollment eligibility with evidence of fraud or intentional misrepresentation.

SEP 14: Validation Documents

Updated: 02/18/2025

When an individual is granted a Special Enrollment Period due to a Qualifying Life Event (QLE), they must provide appropriate documentation as outlined in the following table. This ensures consistent validation methods for carriers, consumers, and Your Health Idaho. Each QLE has its own requirements.

Qualifying Life Event	Acceptable Validation Documentation
Change in marital status (Marriage/Divorce)	**BOTH** • Marriage certificate **OR** Domestic legal document **OR** Validation on Idaho Repository **AND** • Proof of coverage is required for at least one partner for at least one of the previous 60 days prior to the marriage/divorce (after June 19, 2017, per Market Stabilization Rule, 4/13/2017). The plan cannot be termed for non-payment or voluntarily termed. Any COBRA benefits must demonstrate that eligibility has been exhausted.
Death of primary tax filer/subscriber	Death certificate **OR** Signed affidavit **OR** Obituary
Change in dependents	Birth certificate **OR** Court order or foster placement documentation (indicating the addition or removal of dependent(s) and the effective date) **OR** Other documentation containing a signed sworn statement with a signature from the healthcare provider including the same data points found on a birth certificate. Documentation must include the hospital or providers letterhead. *If currently enrolled on-Exchange, no additional verifications will be required after birth is reported, unless requested by the carrier.
Change in address	**Combination of documentation:** • Proof of coverage is required for at least one of the previous 60 days prior to the move.* • Demonstrated exhaustion of eligibility for any COBRA benefits **AND** • Valid Idaho Driver's license, state-issued identification, or U.S. passport (including Idaho STAR card or U.S. Passport card) **OR**

	• Idaho Voter Registration Card **AND** • Proof of previous address** and proof of current address, which includes **two** of the following documents dated within 60 days of the change in address: ○ Student college enrollment letter ○ Idaho automobile registration ○ Rental agreement ○ Home purchase agreement ○ Utility bills (dated bills showing previous and new addresses) ○ Property tax notice (homeowner's exemption for Idaho must be demonstrated) ○ Home payment notice ○ Offer of employment * A permanent move only qualifies if a qualified individual or consumer and their dependents become eligible for different QHPs as a result of a rating area change, if the move is from outside the state, or if the plan is unavailable in the new county. Consumers must demonstrate at least one day of coverage in the 60 days prior to the move, unless moving from out of country, per CMS guidelines (effective July 11, 2016). **If moving from outside of the country, proof of previous residency may be demonstrated with a combination of appropriately dated lease agreements or utility bills, passport or visa stamps, and airline tickets. ***If currently enrolled on-Exchange and moving within Idaho, proof of prior address will not be required, unless requested by the carrier
Change in American Indian status	Certificate of Degree of Indian Blood or Alaska Native Blood from the Bureau of Indian Affairs **OR** Tribal Membership
Loss of Minimal Essential Coverage (MEC) **Coverage may not have been terminated for non-payment. COBRA benefits must demonstrate that eligibility has been exhausted or employer contribution has expired.*	Termination letter from prior carrier; email termination notices from prior carrier that can be validated may also be accepted (including and limited to carriers participating with the Exchange). **OR** Termination letter from a government provider (i.e., Medicaid) **OR** A letter from the previous employer. The letter must state that employment status resulted in a loss of coverage and includes the insurance coverage end date, and name of the employee/individual losing coverage. **OR** A letter detailing an offer of COBRA coverage continuation from an employer or third-party benefits administrator including date of coverage and name of household members. **OR** COBRA notice of termination of employer contribution to enrollment **OR** Employer letter of exhaustion of contribution to COBRA enrollment. *If a State of Emergency is declared related to COVID-19, YHI will allow attestation-based reporting of Loss of MEC due to COVID-19. Consumers will be required to provide proof of Loss of MEC after enrollment is

	processed or risk rescission of enrollment. YHI will practice this process through thirty (30) days from the expiration of the declaration of the state of emergency.
Loss of Minimum Essential Coverage (MEC) due to exhaustion of sick leave retirement funds for PERSI coverage	Dated letter of fund exhaustion from PERSI (sent three months prior to exhaustion of funds)
Loss of SHIP	• Proof of SHIP coverage **AND** • Letter from the college/university confirming the loss of coverage due to semester completion, or graduation. Alternatively, a termination letter from the SHIP carrier accompanied by a school calendar indicating alignment with the semester conclusion is acceptable. **OR** • Termination letter from the SHIP Carrier and a school calendar showing the date coincides with semester end.
Gain of APTC due to Affordability. Loss of MEC due to employer affordability during employer open enrollment	Proof of existing Minimum Essential Coverage (MEC) from employer or insurance carrier **AND** Documentation of employer Open Enrollment demonstrating an offer of unaffordable coverage
Change in citizenship or immigration status	Use the government interfaces (SSI) to validate
Newly eligible for APTC AND previously enrolled in a Minimum Essential Coverage (MEC)	Proof of current coverage (in the last 60 days) **AND** Proof of change in income **AND** Confirmation that household is newly eligible for tax credit
Release from Incarceration	Verification of time served from incarceration facility, including dates served and date released **AND** Confirmation of conviction or disposition of charges and date approved**
Newly eligible for HRA, QSEHRA, or ICHRA through employer	Employer letter of offer of eligibility, with date (in the last 60 days)
Marketplace Exemption Cancelled	Notice from Marketplace of expired or cancelled exception or documented enrollment in a Catastrophic plan and birthdate on enrollment showing the consumer is turned aged 30 and lost eligibility.
Exceptional circumstances	Case by case review via the YHI Appeals Process

Exhaustion of eligibility for, or aging off household enrollment on, Idaho Enhanced Short-Term Plans (ESTPs)***	See documentation requirements for Loss of MEC Verification directly with carrier

*This QLE will no longer be available in Idaho after 1/1/2020 due to approved Medicaid expansion.

**See CMS guidance for additional detail around incarceration definitions: https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/Incarceration-and-the-Marketplace-FAQs-05-03-2016.pdf or https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/AB_Incarcerated-Consumers_Final.pdf

NOTE: Qualifications for incarcerations reflect adherence to Idaho Law regarding parole violation as extension of original crime and conviction, not a new event, per https://legislature.idaho.gov/statutesrules/idstat/title20/t20ch2/sect20-228/. Additionally, an individual is considered incarcerated if the individual has been convicted of a crime and is sentenced to confinement in an institution such as a correctional facility or inpatient mental health facility. An individual will also be considered incarcerated if the individual is currently an escapee from confinement or has had his or her parole and/or probation revoked and is sentenced to confinement in a correctional institution. YHI will not consider an individual incarcerated if the individual:

(1) has not been convicted of a crime,

(2) has been convicted of a crime but is not currently sentenced to confinement in an institution, or

(3) has been convicted of a crime and is sentenced to a partial, limited, or alternative form of confinement, but no government entity is required to provide the individual with medical care.

For example, an individual in one or more of the following situations would not be considered incarcerated by YHI:

- Living in the community after a sentence has been served; on probation or parole;
- or any of the following is true: no county, city, state, or federal government is required to pay for or provide for the individual's medical care;
- or serving a sentence but allowed work release, or under house arrest or home confinement, or residing in a halfway house.

***Effective 1/1/2021

SEP 15: Guaranteed Availability of Coverage

45 CFR 157.104 and 105

Updated: 5/1/2016

If a consumer's plan availability ends prior to the end of the plan year, the Exchange terminates enrollment when the plan availability ends. The consumer is granted a Special Enrollment Period due to loss of MEC, unless otherwise directed by the Department of Insurance (DOI).

Tax Reporting

Tax 1: 1095 A Tax Statement

IRS Forms and Publications

Updated: 5/1/2016

Your Health Idaho provides annual tax statements to all enrolled consumers, except for those enrolled in catastrophic or dental-only plans.

Revision History

Version	Date	Updater	Comments
1.0	2/12/2014	ACN/Gallatin	Not published
	8/14/2015	KH	First draft published
	9/22/2015	KH	
	1/20/2016	KH	
	2/2/2016	KH	
	2/18/2016	KH	Published
	5/1/2016	KH	
	5/20/2016	FN	Published
	7/2016	KC	Published
	7/20/2016	FN	
	7/26/2016	KC	
	8/3/16	KC	
	8/31/2016	FN, NF	Updated content and language for items requested during CSC training. In the SEP Matrix, re-worked content, organization, and formatting. Some basic formatting and editing made throughout manual.
	10/5/2016	FN, NF	Minor edits
	10/11/2016	FN	Published
	10/20/2016	FN	Updated content per PST.
	10/27/2016	FN	Published
	11/21/2016	FN	Published
	11/29/2016	FN	Published, revised annual percentage rates for 2017
	2/21/2017	FN	Updated SEP #1, 5.3 to remove non-tribal split households; updated SEP #14 to include additional documentation required for QLE verification.
	4/28/2017	FN, NF	Updated APTC 20; Ins 1, 22, 26; Ren 6; SEP 13 and 14, per April PST and affirmation of Marketplace Stabilization Rule (4/14/2017).
	5/1/2017	FN	Published
	5/25/2017	FN, NF	Updated APTC 21 (new), Ins 35 (new), SEP 1 (2.6 and 4.2, 3, 5, 6) per Marketplace Stabilization Rule (4/14/2017), and SEP 3 (added info).
	6/26/2017	FN, NF	Updated APTC 13, Ins 17, Ins 27, Ins 30, and Ren 1.
	7/28/2017	FN, NF	Updated Ins 29 and SEP Matrix (Divorce)
	8/28/2017	FN, NF	Updated APTC 13 and Ins 17
	9/20/2017	FN, NF	Updated Ins 29 and 31 for clarification; Added Ins 36 and Ren 7 per PST
	12/13/2017	FN, NF	Updated APTC 16 and Ins 36
	3/2/2018	FN, NF	Updated App 3; made language consistent in SEP 1 (Matrix) (‘no’, ‘NA’, ‘none’)

	4/3/2018	FN, NF	Dental 3; Insurance 18; APTC 15; SEP 1, 1.1
	4/18/2018	FN, NF	Insurance 28; SEP 1, 1.2
	5/22/2018	FN, NF	SEP 1
	8/21/2018	FN, NF	APTC 14 (add SEP 1,1.2 ref); APTC 15 (add SEP 1, 1.2 ref); Ins 3; Ins 32; SEP 1: 1.7, 6.6 (language edits)
	9/18/2018	FN, NF	Important Definitions (added "binder payment"); APTC 21 (removed); Insurance 3
	1/15/2019	FN, NF	APTC 13, updated for annual rate
	5/21/2019	FN, NF	APTC 1 (clarify language); APTC 11 (reflect 'custom grouping' technology); APTC 13 (update rate); APTC 17 (renewal process); Dental 5 (pediatric age-off process); Dental 6 (renewal process); Insurance 1 (dates); Insurance 5 (reflect 'custom grouping' technology); Insurance 7 (remove pregnancy Medicaid language); Insurance 13 (reflect 'custom grouping' technology); Insurance 17 (remove year reference); Insurance 27 (dates); Insurance 28 (dates); Insurance 29 (Medicaid disenrollment); Renewals 7 (renewal process); SEP 1, 3.1 (add county reference); SEP 1, 4.6 (remove Medicaid expansion SEP); SEP 14 (Incarceration add; Newly eligible for APTC; Medicaid expansion removal)
	8/21/2019	FN, MM	SEP 1 (1.2) moved to SEEP 1 (6.9); SEP 1 (1.3) updated to reflect subscriber; SEP 14 updated to reflect required documents for divorce and incarceration.
	9/19/2019	FN, MB, MM	APTC 1 (Medicaid Expansion); SEP 14 (Add a dependent)
	10/28/2019	FN, MB, MM	Renewals 5; SEP 5
	6/16/2020	FN, MB, MM	Annual review and update of SEP 14 (Loss of MEC, Newly eligible for APTC, Move); Removed newly eligible due to Medicaid expansion
	8/31/2020	FN, MB, MM	APTC 5,7; SEP 1, 4.6 (added explanation around 100-139%); Ins 1 (updated OE dates); SEP 1, 1.10 (new SEP approved for ESTPs); Application 3 (updated documents); Glossary references to Life Change Events updated to reflect Qualifying Life Events
	10/22/2020	FN, MM	Glossary-added ESTPs; Ins 9/Renewal 1-Max Age of Dependent and Renewal of dependent; Ins 33-

			Reinstatement requests due to gap in DHW eligibility; SEP 1, 1.10-ESTP QLE; SEP 14-loss of MEC documentation and ESTP documentation
	2/5/2021	FN, MB	Dental 5 updated; SEP 1 and 14 updated re: HRA, QSEHRA, ICHRA; formatting throughout
	2/17/2021	FN, MW	SEP 1, 5.3: removed as listed QLE
	4/20/2021	FN, MW	Updated SEP 14 updated to remove petition for name change (Marital status) all examples except appeal process (Exceptional circumstances).
	5/18/2021	MB, MM	Updated SEP 14 (spacing); SEP 1, 1.9; updated to include expiration of government contribution; APTC 13 (updated rates).
	6/15/2021	MB, MM	Glossary: Added HRA, HSA, Consumer Connector and Premium. Removed AOR; SEP 14 updated to included exceptions for existing consumers who experience a move.
	7/20/2021	MB, MM	INS 29 updated to include Dental
	8/17/2021	MB, FN, MM	INS 1 (updated OE dates); APTC13 (updated affordability threshold)
	9/21/2021	MB, FN, MM	SEP 1: 6.2, 6.4, 6.5 (updated effective dates)
	3/15/2022	MB, MM	Updated APTC 6-8;18, Renewal 1;7; INS 29; New APTC 21-24; SEP 1, 4.7
	5/17/2022	MB, FN	Updated INS #1;9;27-28
	6/21/2022	MB, FN, WW, NL	Updated Renewal #5 and APTC #9; Updated APTC #1;7;12, INS #33, Renewal #6, SEP #1 Matrix 4.1-4.3;4.5-4.6;6.8 and SEP #14 to remove DHW references
	7/19/2022	MB, SS	Updated APTC #18
	9/20/2022	MB	Updated APTC #13 and INS #25; NEW SEP #1 Matrix 5.5
	10/18/2022	MB	Updated Minimum Value Standard (Glossary), APTC #13, SEP #1 Matrix 2.2 and SEP #5
	11/15/2022	MB	Updated SEP #14; New SEP #1 Matrix 4.8
	06/21/2023	LK	Updated 1.2 to add 1.2 (a) in SEP Matrix. SEP for loss of Medicaid coverage
	10/09/2023	LK	Updated SEP 5.2 with changes to 10-day lookback
	10/09/2023	LK	SEP 14 Updated to remove plan name as a requirement for loss of MEC validation as well as COBRA letters acceptable document.

	10/09/2023	LK	APTC 13 updated for annual rate
	10/09/2023	LK	Insurance 7 updated to include Idaho Pregnancy Medicaid as a form of MEC
	10/09/2023	LK	SEP Matrix 4.1 and 4.3 note added to include plan limitation when change in APTC/CSR amounts.
	10/09/2023	LK	SEP Matrix 1.2 (a) with a note that SEP for loss of Medicaid during unwinding qualifies for SEP through 11/30/2023
	12/04/2023	LK	SEP 14 updated changing the requirement for Idaho state-issued identification to any state issued identification
	12/04/2023	LK	Insurance 29 updated adding verbiage to allow authorized consumers to self-attest when disenrolling a consumer due to death
	12/04/2023	LK	APTC 22 from PY24 NBPP updated to allow a 60-day extension if income verification isn't completed within the initial 90-days allowed.
	12/04/2023	LK	APTC 21 updated to allow a 60-day extension if verification isn't completed within the initial 90-days allowed excluding citizenship.
	12/04/2023	LK	SEP Matrix 2.2 Added verbiage due to marketplace stabilization. Plan change will be limited to plans that are one metal level higher, lower, or at the same level as the current plan they are enrolled in.
	12/04/2023	LK	APTC 6 verbiage updated. Tax credits are calculated using modified adjusted gross income
	06/24/2024	LK	SEP 4.7 language was amended to "APTC eligible" from "Newly Eligible for APTC"
	06/24/2024	LK	Insurance 29 updated to allow retroactive termination when a consumer is retroactively approved for Medicare Part A and B. This disenrollment will require documentation and retroactively terminates up to 60 days.
	06/24/2024	LK	Insurance #35 updated verbiage. A new plan selected by a consumer during an Open Enrollment or Special Enrollment Period cannot be denied by a Carrier due to a prior policy that was terminated for non-payment. Money that the consumer intended to pay toward the new plan's binder payment cannot be applied to a prior delinquency by the Carrier.

	06/24/2024	LK	APTC8 Updated to include: APTC amount that has already been used in application year
	06/24/2024	LK	SEP Matrix 5.6 updated to allow SEP for consumers that have been disenrolled due to expiration of DMI if the DMI is resolved within 60 days of the consumer being notified of their enrollment termination.
	06/24/2024	LK	Insurance 33 updated to include reinstatement for a loss of financial eligibility that is resolved in the same month it is lost
	08/20/2024	LK	SEP 1.10 updated verbiage. Expiration of Idaho Enhanced Short Term Plan (ESTP) eligibility, expiration of the plan without the option to renew, OR termination from household enrollment of ESTP due to aging off (dependent)
	08/20/2024	LK	SEP 1.2 (a) updated to allow a SEP when the consumer has voluntary loss of Medicaid and also qualifies for APTC when applying.
	08/20/2024	LK	SEP 1.4 updated with an asterisk stating *This does not apply when there is a voluntary loss of Medicaid and the consumer qualifies for APTC.
	08/20/2024	LK	SEP 2 updated stating that voluntarily dropping coverage does not apply when there is a voluntary loss of Medicaid and the consumer qualifies for APTC.
	11/08/2024	LK	APTC 13 Updated to reflect the new annual change to in the affordability threshold
	11/08/2024	LK	SEP 4.7 Added verbiage to help reduce confusion as to what Federal Poverty Guidelines are being used. For the Advanced Premium Tax Credit, eligibility is based on the published Federal Poverty Guidelines that were in effect at the start of the plan year's open enrollment period.
	11/08/202	LK	SEP 6.8 Added verbiage to policy to reduce confusion for consumers impacted by FTR. Sets

			the expectation that the consumer will need to take action with YHI after they reconcile. Enrollees who have lost tax credit due to Failure to Reconcile for two consecutive years will need to reapply. Enrollment will not be automatically updated. Consumers who have disenrolled coverage due to FTR will be eligible for SEP.
	11/08/2024	LK	Federal Regulations state that placement of a child in foster care is a qualifying life event. This update is to align policy with the regulations. Parents Add a New Dependent If a family has a baby, adopts a child, is placed in foster care, or is appointed by a court as the ward for a child, they are entitled to a Special Enrollment Period, even if the child gains alternative health insurance coverage such as CHIP.
	11/08/204	LK	SEP 14 updated validation documents to include foster placement documentation as an acceptable validation document. Change in dependents: Birth certificate OR Court order or **foster placement documentation** (indicating the addition or removal of dependent(s) and the effective date)
	02/18/2025	LK	APTC 23 updated adding *Alaska Natives and American Indians with recognized tribal memberships are eligible for limited cost share reduction regardless of other eligibility factors.
	02/18/2025	LK	Insurance 7: Added a bullet to include YES Medicaid as MEC • YES Medicaid (When the household is less than 300% FPL)
	02/18/2025	LK	APTC 24: Added section to include add a section to this section of policy that reads as follows:

			Pregnant women enrolled in a QHP at time of pregnancy can choose to stay on their plan even if eligible for Medicaid, if the only factor making them Medicaid eligible is the pregnancy status.
	02/18/2025	LK	Insurance 19: Updated to include that vaping is considered tobacco use.
	02/18/2025	LK	SEP 14: Updated to remove the requirement that the carrier's name must be on validation documentation as well as the requirement that the document is non-editable.
	5/20/25	SH	APTC 10, 11, 12: Removed reference to automatically changing tax dependent status for 24 yr old dependents. Added detail to include adding domestic partner to tax household if claimed in tax family, or if child is in the household. Updated notes that this is not a supported relationship for enrollment and could require separate enrollments. SEP 2.2 Clarified birth SEP allows baby to be added to plan or enrolled in a sperate group at any plan level. SEP Documents: Added new documents for the SEP "Exemption Cancelled."
	7/17/25	SH	Insurance 1: updated OE dates for PY26. SEP 4.7: Removes SEP for those with income beneath 150% FPL as of August 25, 2025. APTC 22:Removes automatic 60-day extension to resolve income data matching issues. Insurance 12: Removes manual requirement for custom grouping. Dental 7: Clarifies APTC can be used on pediatric stand alone dental premiums. Application 3: Clarifies residency validation process.