

Your Health Idaho Policy Manual

January 25, 2019



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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.
Agent of Record (AOR)	The person who helps enroll a consumer according to the consumer’s Exchange account.
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.
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.
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.
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.
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.
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. 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.

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 Life Change Event (LCE), 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 the 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.
Split household	A household (HH) that is allowed to split APTC onto different policies based on qualified circumstances.
State-Based Marketplace (SBM)	A market (aka, the Exchange) where individuals, families, and small businesses can <ul style="list-style-type: none">• 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

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
- A tax filer who is married and filing jointly OR single and filing single

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

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)
- Deferred action status (ineligible for APTC if granted deferred action under DACA program)

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 CFR 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)

Consumers' taxable income must be between 100% and 400% of the Federal Poverty Level to be eligible to receive 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 6: Income for APTC Calculation

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

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 on taxable income including the following:

- Wages/salaries
- Social Security retirement and Social Security disability
- Unemployment
- Self-employment
- Tips and gratuities
- Compensation for personal services
- Farm income

Non-taxable income is 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)

APTC 7: Verification of Income for a Financial Application

45 CFR 155.320 E (iii)

To receive a tax credit, YHI or the Idaho Department of Health and Welfare must use electronic interfaces to verify the applicant's self-attestation of income. If the data returned is not reasonably compatible, further documentation will be required from the applicant to verify income.

NOTE: Reasonable compatibility is a standard of measure utilized to verify that an applicant's income is between 100 percent and 400 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.

APTC 8: Determining Tax Credit Amount

26 CFR 1.36 B-1

Updated: 6/20/2017

To determine the tax credit, several factors are taken into consideration. The following are reviewed by the Idaho Department of Health and Welfare:

- Age of consumer(s) as of January 1 of the benefit year
- Household's anticipated, modified adjusted gross income
- Household size
- Number of household members eligible for APTC
- County

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

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

The Idaho Department of Health and Welfare will calculate APTC using the ages of the family members as of January 1 of the plan year.

APTC 10: Household Composition

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.

NOTE: YHI's policy is that tax dependent status automatically ends when individuals turn 24. For more details, see [APTC 12: 24-Year-Old Dependents and APTC Eligibility](#).

APTC 11: Household Plan Enrollment

Tax families must all be included in an APTC calculation, and they must enroll in a health insurance plan. Family members may be able to enroll in different plans through a manual process.

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

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.

In APTC households, when a child turns 24, at the end of their birthday month, the dependent status automatically drops. This removes the 24-year-old from the household APTC eligibility.

If the parents will continue to claim the child as a "Qualified Dependent" on their taxes, then the parent, or the family's agent, will need to contact DHW to let them know that the child should be added back into the tax filing household. The full household should be sent back to YHI with the full APTC intact.

If the parents do not want to claim the 24-year-old as a "Qualified Dependent," or the child is not eligible to be claimed as a qualified dependent, they have two options:

1. The parents can keep the non-tax-qualified child on their plan until age 26, since insurance rules state that the child may still be kept on the plan until they turn 26 years old. However, they must request that their APTC be discontinued.

OR

2. The parents can keep the plan they have for the rest of the family (with APTC) but exclude the 24-year-old. The 24-year-old could apply for a plan of his/her own (with or without APTC, depending on eligibility determination). If the 24-year-old would like to apply for APTC on their own, they would need to fill out an application through DHW. This loss of coverage would qualify them for an SEP. See [Special Enrollment Period](#).

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 CFR 155.320(b); § 36B(c)(2)(C)(i)(II) and § 1.36B-2(c)(3)(v)(C)

Updated: 1/15/2019

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 9.86% of the annual household income. Employees, and their spouse and dependents, that are offered employer-sponsored coverage that’s affordable and provides minimum value are not eligible for a premium tax credit. If someone 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 coverage reviewed for APTC eligibility.

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: 5/1/2016

When YHI re-enrolls consumers, the APTC amount is automatically set so that 100 percent is applied to the monthly premium. If a consumer prefers a different percentage applied to their monthly premium, they can log into their account to adjust it at any time, which will be effective the first of the month following the change.

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

APTC 18: Appeals

45 CFR 155.510; 45 CFR 155.335

Updated: 5/1/2016

The Idaho Department of Health and Welfare will accept appeals for determination, verification, and redetermination of tax credit or cost sharing.

Financial determination appeals are taken by phone at the Idaho Department of Health and Welfare by calling 1-877-456-1233. 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 both financial eligibility and enrollment determination to file an appeal on any issue.

APTC 19: Cutoff Date for APTC Redetermination

Information submitted for redetermination of advance premium tax credit and cost sharing reductions must be complete 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.

APTC 20: APTC and CSR Effective Date

45 CFR 155.310; 45 CFR 155.340

Updated: 4/19/2017

Consumers who are currently enrolled on the Exchange with financial assistance 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 updated application is received by YHI.

Consumers who are currently enrolled on the Exchange with no financial assistance and gain eligibility for APTC will have their new APTC amount applied to their premiums effective the date of eligibility, if received within 60 days of the eligibility start date.

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](#)).

NOTE: Policy is effective as of May 1, 2017, but updated eligibility applications on enrollments will be applied on an appeal basis only until the technology is completed.

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

Updated: 3/02/2018

YHI conducts periodic residency verification. Consumers have 30 days from the date the verification notice is sent to provide accepted documentation. Without receipt of the acceptable verification documentation, financial and enrollment eligibility is terminated after the end of 30 days to the last day of the month.

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

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: 3/20/2018

Consumers can end dental coverage without terminating health coverage.

Dependents under the age of 26:

- Consumers enrolled in a pediatric dental policy will be automatically disenrolled at the end of the month in which they turn 19.
- Consumers enrolled as dependents on a dental policy which includes adult coverage, will be automatically disenrolled at the end of the month in which they turn age 26. However, if applicable, Advanced Premium Tax Credits (APTC) will cease 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.

See also [Insurance 29: Disenrollment](#).

Dental 6: Renewals

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

Updated 10/12/2015

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

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. 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: 4/19/2017

NOTE: YHI Open Enrollment dates are determined by the Secretary of Health and Human Services.

Plan Year	Open Enrollment Period
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: 2/18/2016; 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 Split Household Groups

When a household is split into multiple enrollment groups so a single household can purchase multiple plans or multiple households can purchase a single plan, the APTC will be split between the different family members using the following formula:

APTC offset % applied to each family member = (Total household APTC / Total household premium)

To split an APTC within a household, the household must be enrolled with the same carrier.

EXAMPLE: There are three individuals in a household, broken into two coverage groups: Mom is on one policy; Dad and Child are on a second policy. The family's total APTC amount is \$700.

Actual premiums of second lowest cost silver plans chosen: \$330 Mom, \$525 Dad + Child = \$855 total

APTC offset % applied to each family member = (Total APTC: \$700 ÷ Total medical premium: \$855) = 81.87% of each person's premium that will be covered by APTC

APTC for each group: \$270.17 Mom, \$429.83 Dad + Child = \$700 total

Premium after APTC: \$59.83 Mom, \$95.17 Dad + Child = \$155 total

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: 5/1/2016

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 (excluding pregnancy)
- 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

NOTE: Pregnancy Medicaid is not considered MEC. However, loss of pregnancy-related coverage opens a Special Enrollment Period. 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

The primary tax filer for a household is the primary contact for the account.

NOTE: The primary tax filer cannot be changed if the same household composition exists pre- and post-tax filer change, unless it is a very extenuating circumstance.

Insurance 9: Maximum Age of Dependent

Idaho PST Decision 70

The maximum age of a dependent on a health insurance policy is 25 years old. When an individual turns 26, they will need to go onto 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 month of their 26th birthday.

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 Dependents 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, see [SEP 1: Qualifying Life Events for Special Enrollment Period](#), Matrix 5.3. YHI will manually split the household to process the case. See [Insurance 5: Calculating Distribution of APTC for Split Household Groups](#).

Insurance 13: Enrolling Families with Mixed CSR Status

If a family has mixed cost sharing reduction status, the family will be enrolled using the lowest common denominator CSR status, unless they request split health insurance plans.

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: 8/22/2017

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.

For plan year 2019, 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.

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.

NOTE: Consumers have 72 hours to complete and submit their APTC application in the Idalink system.

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: 3/02/2018; 8/21/2018

During Open Enrollment, if a household wants health insurance coverage to start by January 1, they must complete and submit their APTC application no later than December 15 of the prior year. They must enroll in a health insurance plan within seven days of applying for and receiving approval on their APTC application.

Coverage starts 1/1/2019 for plans selected during OE for the plan year 2019.

Insurance 28: Changing Plans during Open Enrollment

Idaho PST Decision 166, 177, and 191

Updated: 5/15/2018

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

- If an application is completed at DHW by 12/15, the consumer may enroll or change plans until 12/22 for a 1/1 policy effective date.
- If updated eligibility is received by YHI before 12/31 and the consumer is not currently enrolled, it requires Qualifying Life Event validation. See [SEP 3](#).
- If updated eligibility is received by YHI before 12/31, and a change in CSR 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.

Updates to financial eligibility outside of Open Enrollment dates follow the enrollment rules in [APTC 20](#).

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

Insurance 29: Disenrollment

Updated: 10/06/2017

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.

When a child is on a parent's health insurance policy, they are automatically disenrolled from the plan at the end of the month 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 and requests a termination of their Exchange policy, YHI will

- require documentation of group coverage,
- terminate to the last day of the month that the consumer reported, and
- retroactively terminate, 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 retro termination, YHI will

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

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.

Effective August 1, 2017, updated termination dates on enrollments are only applied through carrier or consumer appeals until the technology is completed.

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

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: 10/06/2017

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 cost-savings programs including Medicaid, CHIP, Advance Premium Tax Credit (APTC) or Cost Sharing Reductions (CSR) and is handled by the Idaho Department of Health and Welfare.
- Information is missing from your appeal request form.
- Additional clarification is required.

Overtaken

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: 7/19/2016

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.

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 155.400€(1)(iv); 45 CFR 147.104-5

Updated: 5/16/2017

A consumer with a policy (or policies) previously terminated by the carrier for non-payment of premium, who re-enrolls on the Exchange, may be required by the carrier to arrange repayment of unpaid delinquent premiums due up to 12 months prior to effectuation of the new policy. The carrier may extend the binder payment deadline while the consumer makes payments on the delinquency.

Carriers may terminate coverage for a consumer's failure to complete the repayment option with the carrier.

NOTE: Policy is approved as of May 16, 2017, but it will not be applied across carriers until the technology update is completed.

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: 6/20/2017

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 may 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.

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: 5/1/2016

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 90-day grace period for payment carries over for renewed enrollments if APTC is used to lower monthly premiums. If a delinquency exists on the account, carriers may apply any payments received to the delinquency.

Renewals 6: APTC and CSR Effective Date

45 CFR 155.310; 45 CFR 155.340

Updated: 4/19/2017

Consumers who are currently enrolled on the Exchange with financial assistance 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 updated application is received by YHI.

Consumers who are currently enrolled on the Exchange with no financial assistance and experience a change in APTC will have their updated APTC amount applied to their enrollment to match the approved effective date sent to YHI from DHW, if received within 60 days of the eligibility start date.

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 eligibility applied to their enrollment following the enrollment rule, or per any guidelines due to Special Enrollment Periods, complex cases, or appeals resolution (see [APTC 20: APTC and CSR Effective Date](#); [SEP 1: Qualifying Life Events for Special Enrollment Period](#); and [SEP 1 Matrix 4 Change in Financial Eligibility](#)).

NOTE: Policy is effective as of May 1, 2017, but updated eligibility applications on enrollments will be applied on an appeal basis only until the technology is completed.

Renewals 7: Carrier Terminations during Renewal Period

45 CFR 155.310; 45 CFR 155.340

9/19/2017

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: 5/15/2018

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	<p>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. *</p> <p>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.</p>	Yes	MEC	Up to 60 days before event, through 60 days after event	<p>1st day of month following loss of coverage, if plan enrollment is completed before 1st day of month.</p> <p>If loss of coverage is reported after the event, effective date is the 1st of month following plan enrollment.</p>	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	<p>Loss of MEC:</p> <p>1) Loss of subscriber (divorce, incarceration, or moves out of state)</p> <p>2) Loss of employer coverage (must be MEC)</p> <p>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)</p> <p>4) Cancelled exemption</p> <p>5) Aged out</p> <p>a. Child turns 26</p> <p>b. Child applies as separate tax household. Example: Child turns 24 and ages out of family tax household (financial plan).</p> <p>c. Person turns 31 and becomes ineligible for catastrophic plan.</p> <p>6) Loss of other coverage (TriCare, Peace Corps, or Medicaid, etc.)</p> <p>7) Released from incarceration</p> <p>8) Exhaustion or loss of employer contribution to COBRA enrollment</p> <p>9) Exhaustion of Public Employee Retirement System of Idaho (PERSI) sick-leave funds applied to qualified PERSI funded insurance</p>	Yes	MEC	Up to 60 days before event through 60 days after event	<p>If plan enrollment is completed prior to last day of the month, the 1st day of following month</p> <p>If plan enrollment is completed after last day of the month, the 1st of month after month following plan enrollment date.</p>	<p>45 CFR 155.420(b)(2)(ii); 45 CFR 155.420(d)(1)(i); 45 CFR 155.420(c)(2)(ii);</p> <p>COBRA Overview and QSERHRA Assistance and Special Enrollment Period (SEP) Overview on https://www.cms.gov</p>
Loss of MEC	1.3	<p>Loss of MEC Due to Death of Subscriber:</p> <p>Consumer has loss of MEC due to death of subscriber in other application.</p>	Yes	MEC	60 days from QLE (Loss of MEC)	Enrollment is terminated retroactive to 1 day after the date of death.	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
Loss of MEC	1.4	Loss of MEC Due to Voluntary Termination: Subscriber chooses to terminate existing plan. Policy ends.* * 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" LCE") 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)
Loss of MEC	1.8	Loss of SHIP (Student Health Insurance Program): Consumer needs coverage due to enrollment in an Idaho university.* * One-time SEP offered in 2015.	Yes	SHIP	Up to 60 days before the loss of SHIP through 60 days after loss of SHIP	1 st day of month following plan enrollment	Idaho SBM PST Log 169

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	1.9	Loss of employer contribution to COBRA enrollment	Yes	COBRA	Up to 60 days before the event through 60 days after the event	1 st day of month following plan enrollment	45 CFR 155.420(d)(1)(i)
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 LCE."	Yes	YHI	60 days from dependent's QLE	1 st day of month following plan enrollment	45 CFR 155.330 (f)(1)(iii); 45 CFR 155.420 (d)
Change in Household Size	2.2	Birth, Adoption, or Court-Appointed Ward	Yes	No	60 days from date of QLE	Retroactively to date of event OR The 1 st 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. 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 crosswalked 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

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	2.3	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	1 st 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
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	1 st 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	1 st day of month following plan enrollment	45 CFR 155.420 (d)(2); 45 CFR 155.420(b)(2)(ii)
			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).				

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	2.7	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)
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	1 st day of the month following plan enrollment	45 CFR 155.420 (d)(7); 45 CFR 155.420 (b)(2)(iv)
			* A permanent move qualifies only if a qualified individual or consumer and their dependents become eligible for different QHPs as a result of a rating area change OR if the move is from outside the state. 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.	No	YHI	N/A	APTC will be applied the 1 st day of the month following the receipt of the DHW 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)

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	4.2	<p>APTC Amount Change: Exchange-enrolled household with no previous APTC becomes eligible for APTC (no CSR).</p> <p>*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.</p>	Yes	YHI	60 days from date of QLE	<p>Coverage effective date will follow the 1st of the month enrollment rules, if a plan change is completed.</p> <p>Updated APTC will be applied the 1st day of the month following the receipt of the DHW approved application or applied retroactively up to 60 days.*</p> <p>*Carriers must retain accumulations if consumers change APTC amount but retain the same policy. (See APTC 20.)</p>	45 CFR 155.330(f)(1)(i); 45 CFR 155.420 (d) (6); 45 CFR 156.425(b)
Change in Financial Eligibility	4.3	<p>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.</p> <p>*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 update is completed.</p>	Yes	YHI	60 days from date of QLE	<p>Coverage effective date will follow the 1st of the month enrollment rules if a plan change is completed.</p> <p>Updated CSR will be applied the 1st day of the month following the receipt of the DHW approved application.*</p> <p>*Carriers must retain accumulations if consumers change APTC amount but retain the same policy. (See APTC 20.)</p> <p>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)."</p>	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
Change in Financial Eligibility	4.4	<p>Income Change: Subscriber reports a change in income.*</p> <p>* 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.)</p>	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)

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	4.5	Newly Eligible or Ineligible for APTC: Consumer with existing MEC (can be on/off Exchange) becomes newly eligible or ineligible for APTC.	Yes	Varies	60 days from QLE	Coverage effective date will follow the 1 st of the month enrollment rules if an enrollment or plan change is completed. Updated APTC will be applied the 1 st day of the month following the receipt of the DHW 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 8/31/2016, Idaho is a non-Medicaid expansion state.	Yes	No	60 days from QLE	Coverage effective date will follow the 1 st 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 1 st day of the month following the receipt of the DHW 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.
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 consumer selects and enrolls in a plan within SEP timeframe, they may request to cancel the enrollment within 10 days of coverage effective date. However, the consumer may not change plans. Consumer has closed SEP with plan selection per YHI Policy Manual, SEP 3. However, 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: 18.01.30.101.01.k
Exceptions/Other	5.3	Split Household 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).	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 1 st requested policy (e.g., Jan 1 if tried to apply during OEP) 2. Allow consumers to choose to follow standard rule: Enrollment before 15 th , then 1 st day of following month; otherwise, 1 st day of second following month	Idaho SBM PST Log 170
Exceptions/Other	5.4	QHP Materially Violated Contract: Consumer or Exchange identifies error in consumer contract.	Case by case basis* * Handled through appeals process	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)

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	6.1	Exceptional Circumstances: Due to extenuating circumstances, consumer needs to choose a new plan (unable to pay previous premiums due to extreme circumstances, natural disaster, or domestic violence, 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.*	If plan enrollment prior to 15 th , then 1st of following month If plan enrollment after 15 th , then 1 st of month after month following report date	Idaho SBM PST Decision ID#167
			* If only primary or only dependent has A/I status, that individual follows the split household LCE.				
Change in Eligibility Status	6.3	Date of Birth Change: Consumer sees incorrect birth date and updates it.	No*	N/A	Anytime	1 st 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	If plan enrollment is completed prior to 15 th of the month, the 1 st of following month; or, if plan enrollment is completed after 15 th of the month, the 1 st of month after month following plan enrollment date	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	If plan enrollment is completed prior to 15 th of the month, the 1 st of following month; or, if plan enrollment is completed after 15 th of the month, the 1 st of month after month following plan enrollment date	45 CFR 155.420(d)(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 Eligibility Status	6.6	Loss of Legal Presence: Consumer loses legal presence.	No*	N/A	N/A	1 st 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 (LCE “Loss of Dependent”). If a subscriber is disenrolled, the household follows the SEP Matrix #1.7 (LCE “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	1 st day of month following plan enrollment date (if guidelines are met) YHI requires previous Exchange enrollment in last month of previous plan year and 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 DHW 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 with DHW, following IRS clearance.	26 CFR 1.36B-4; Idaho SBM PST Decision #244
			*Enrollees who have lost tax credit due to FTR will be automatically updated when YHI receives updated application from DHW. Consumers who have cancelled coverage due to FTR may be eligible for SEP.				

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

- Voluntarily dropping coverage
- 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, 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.

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.

SEP 9: Student Losing SHIP

College and university students in Idaho who are losing their student health insurance coverage (SHIP) will be granted a Special Enrollment Period. To receive the Special Enrollment Period, students will need to have a certificate of credible coverage, the previous year's school transcripts and a letter from the university informing them of the loss of coverage. This is a one-time Special Enrollment Period for the 2015-2016 academic year.

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: 5/15/2018

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)	<p>BOTH</p> <ul style="list-style-type: none"> • Marriage certificate <p>OR</p> <p>Copy of court order, decree, or petition for name change</p> <p>OR</p> <p>Domestic legal document</p> <p>OR</p> <p>Validation on Idaho Repository</p> <p>AND (if reporting marriage)</p> <ul style="list-style-type: none"> • Proof of coverage is required for at least one partner for at least one of the previous 60 days prior to the marriage (after June 19, 2017, per Market Stabilization Rule, 4/13/2017). The plan cannot be terminated for non-payment or voluntarily terminated. Any COBRA benefits must demonstrate that eligibility has been exhausted.
Death of primary tax filer/subscriber	<p>Death certificate</p> <p>OR</p> <p>Signed affidavit</p> <p>OR</p> <p>Obituary</p>
Change in dependents	<p>Birth certificate</p> <p>OR</p> <p>Court order (indicating the addition or removal of dependent(s) and the effective date)</p>
Change in address	<p>Combination of documentation:</p> <ul style="list-style-type: none"> • 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 <p>AND</p> <ul style="list-style-type: none"> • Valid Idaho Driver’s license, state-issued identification, or U.S. passport <p>OR</p> <ul style="list-style-type: none"> • Idaho Voter Registration Card

	<p>AND</p> <ul style="list-style-type: none"> • Proof of previous address and current address, including two of the following documents dated within 60 days of the change in address: <ul style="list-style-type: none"> ○ 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
Change in American Indian status	<p>Certificate of Degree of Indian Blood or Alaska Native Blood from the Bureau of Indian Affairs</p> <p>OR</p> <p>Tribal Membership</p>
<p>Loss of Minimal Essential Coverage (MEC)</p> <p><i>*Coverage may not have been terminated for non-payment. COBRA benefits must demonstrate that eligibility has been exhausted or employer contribution has expired.</i></p>	<p>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).</p> <p>OR</p> <p>Termination letter from a government provider (i.e., Medicaid)</p> <p>OR</p> <p>Screenshot of current enrollment from carrier's website or portal AND a non-editable letter (PDF) from the previous employer confirming loss of coverage</p>
<p>Loss of Minimum Essential Coverage (MEC) due to exhaustion of employer contribution to COBRA enrollment (prior to end of COBRA eligibility)</p>	<p>COBRA notice of termination of employer contribution to enrollment</p> <p>OR</p> <p>Employer letter of exhaustion of contribution to COBRA enrollment</p>
<p>Loss of Minimum Essential Coverage (MEC) due to exhaustion of sick leave retirement funds for PERSI coverage</p>	<p>Dated letter of fund exhaustion from PERSI (sent three months prior to exhaustion of funds)</p>
Change in citizenship or immigration status	<p>Use the government interfaces (SSI) to validate</p>

Change in APTC eligibility, if previously ineligible for Medicaid, in a non-Medicaid expansion state, OR change in CSR eligibility	SEP Verification Form
Exceptional circumstances	Examples: <ul style="list-style-type: none">• Called to active military duty in another country: Official military evidence is required.• Medicaid conditions such as coma: Letter from the physician is required.• Technical difficulty: YHI approved documentation is required.

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