State of Idaho
DEPARTMENT OF INSURANCE

BRAD LITTLE
Governor

700 West State Street, 3rd Floor
P.O. Box 83720
Boise, Idaho 83720-0043
Phone 208-334-4250
Fax 208-334-4398

Website: https://doi.idaho.gov

DEAN L. CAMERON
Director

March 12, 2025

2026 IDAHO STANDARDS FOR AFFORDABLE CARE ACT COMPLIANT INDIVIDUAL AND SMALL GROUP HEALTH BENEFIT PLANS AND QUALIFIED DENTAL PLANS

The Idaho Department of Insurance (DOI) is providing the following guidelines for carriers who intend to sell health benefit plans complying with the Affordable Care Act (ACA) in Idaho's individual or small group markets, and dental carriers wishing to participate in the Idaho Health Insurance Exchange, Your Health Idaho (YHI). This includes (1) individual and small group health benefit plans seeking exchange certification, known as Qualified Health Plans (QHPs); (2) ACA-compliant individual and small group health benefit plans not seeking exchange certification (non-QHPs); and (3) stand-alone dental plans seeking exchange certification, known as Qualified Dental Plans (QDPs).

The standards set forth in this document may be revised if changes to federal guidance require such revisions to Idaho standards.

Certain requirements addressed in this notice may apply only to plans intended to be sold through YHI. There are many other requirements that are not directly addressed in this notice, and DOI expects the carriers to be aware of, and to comply with, those additional requirements.

DOI will review the information that carriers submit and, from the plans seeking certification, recommend QHPs to YHI for certification. These guidelines provide the criteria DOI will use when performing reviews and ultimately making recommendations for certification. The guidelines align with the regulatory requirements of title 41, chapters 21, 22, 47, 52, 61, Idaho Code, and 45 C.F.R. Parts 155 and 156.

DOI or YHI will provide additional guidance as needed. Please contact William Coon (208-334-4300 / william.coon@doi.idaho.gov) or carriers@yourhealthidaho.org with questions or comments.

Items of Note

There may be legislative and rule changes that impact HBPs and QDPs; this document does not cover such changes so carriers should track potential changes and consult with the DOI as needed. Changes and items of note in this document that carriers should pay particular attention to are:

- Carriers in the individual and group markets may not apply premium payments made for new enrollment towards outstanding debt due to failure to pay premiums for previous coverage in the same or a different plan, as per the federal guidance, doing so conflicts with the guaranteed availability provision.
- Carriers should continue to submit alternative rate tables reflecting:
    - Silver plan rates without the Cost-Sharing Reduction (CSR) load,
    - Rates with the CSR load, but without the High-Risk Pool savings.
- Renewal notices must be sent out 60 days prior to the date of renewal, and discontinuation notices must be sent out 90 days prior to the termination date of the discontinued plan.
- For the 2026 policy year, carriers must meet specific time and distance network adequacy standards. See Section 3.2, Network Adequacy, for how carriers will demonstrate compliance.
- All plans, including dental plans, must have a network associated with them. Per CMS rule, plans identified as "Indemnity" are not allowed to be sold through the exchange.
- Carriers should use the template validation tools provided by CMS prior to submission. Errors should be corrected, or justification should be provided as Supporting Documentation in the binder.
- Carriers have a responsibility to ensure that all information in the form filing, rate filing, and the binder are kept consistent and up to date. If changes are made to the rate filing, the binder must be updated at the same time.

Contents

Section One: Filing, Review, and Certification Process 4
1. Timeline 4
2. Filing Expectations 5
3. Summary of Benefits and Coverage 6
4. Variable Language in Forms 7
5. Rate Information Considerations 7
6. Transparency 8
Section Two: Health Benefit Plan Requirements 8
1. Fair Health Insurance Premiums 8
2. Service Area 9
3. Discriminatory Marketing and Benefit Design 9
4. Minimum Participation and Contribution Rates on Small Group Renewals 11
5. Coverage Appeals 11
6. Discontinued Plans 12
Section Three: QHP and QDP Certification Standards 12
1. Licensure and Good Standing 13
2. Network Adequacy 13
2.2 Time and Distance Standards 14
3. Essential Community Providers 15
4. Accreditation (not applicable to QDPs) 16
5. Patient Safety Standards (not applicable to QDPs) 17
6. Quality Reporting and Quality Improvement Strategy (not applicable to QDPs) 17
7. QHP Agreement 18
8. Prescription Drug Coverage (not applicable to QDPs) 18
9. Meaningful Difference (not applicable to QDPs) 19
10. Third Party Payment of Premiums and Cost Sharing 19
11. Cost Sharing Reduction Plan Variation Reviews (not applicable to QDPs) 20
12. Oversight of Agents/Brokers (Producers) 20
13. Idaho's Small Employer Health Options Program 20
14. Meaningful Access 21
15. Provider Directory 21
16. QDP Considerations 21
17. Tribal Relations and Support 22
Appendix A - Timeline 24
Appendix B – Rate Increase Justification Template ("Part II") 25
Appendix C – Sample Exhibit Testing Plan Adjusted Index Rate Ratios 26
Appendix D – Provider/Facility Maximum Time and Maximum Distance Requirements 27
Appendix E – County Designations 29

Section One: Filing, Review, and Certification Process

Individual and Small Group health benefit plans, both QHPs and non-QHPs, as well as QDPs, follow the same timeline for the review process. Only QHPs and QDPs participate in the certification process.

1. Timeline

The preliminary timeline for the 2026 plan year review and certification process is shown in Appendix A. The dates are approximate and subject to change. DOI will revise and redistribute Appendix A upon any decision to modify a date.

Letters of intent to offer QHPs or QDPs must be submitted by new and returning carriers. The letter should contain information on the service area (entire state or specified counties) to be covered, market types (individual and/or small group) and number of plans, including metal level and plan type (PPO, POS, etc.). Carriers may update the information in their letter if plans change between submission of the letter and SERFF filings.

If a carrier will be discontinuing plans currently offered in the individual or small group market, the letter must provide the HIOS/plan IDs and names of the plans to be discontinued, the plans to which the affected consumers will be cross walked, the counties in which the plans will be discontinued, the number of affected consumers per the most recently available data, and the percentage of the applicable market that will be discontinued. If a carrier proposes to discontinue more than 15% of its individual or small group market, the Department's permission must be obtained. See Section 2.6 Discontinued Plans for further information on discontinuations.

Carriers may submit their rates, forms, or templates as early as SERFF makes the functionality available but no later than the dates shown in Appendix A. In the case that SERFF is not ready to accept binder filings by the specified due dates, carriers will still be expected to submit their forms and rates through standard (non-binder) filings. DOI will expect carriers to complete their application by submitting the remaining components in a binder within one week of the SERFF binder functionality becoming available.

In compliance with 45 C.F.R. § 154.220, DOI expects each carrier to submit the uniform rate review template (URRT), actuarial memorandum, and the rate increase justification to Centers for Medicare & Medicaid Services (CMS) on the same date the carrier submits the rate change filing to DOI through SERFF. The carrier has the responsibility to maintain both filings up-to-date throughout the review process. The rate increase justification, following the Appendix B template, must be submitted to DOI for each health benefit plan rate filing even if the increase is below the federal threshold.

DOI will post proposed rate increases on the DOI website no later than the dates specified in Appendix A. Consumers will be able to submit comments to DOI through the website.

Carrier plan preview is expected to be available on the YHI website through the plan management module on the date shown in Appendix A. DOI will transfer the QHP data from

SERFF to the YHI plan management module. The carriers will be able to view plan data in the plan preview environment concurrent with DOI's review of the QHP submissions. DOI will work with carriers to resolve objections and transfer updated SERFF data to the plan management module for plan preview in a timely manner. Carriers should attempt to bundle corrections identified through plan preview into periodic requests and submit the requests to make corrections to DOI through email or SERFF.

DOI will allow carriers to make approved corrections to filings through SERFF until the date shown in Appendix A. DOI plans to present the final certification recommendations concerning QHPs and QDPs to the YHI Board of Directors based on the finalized information provided by the carriers by the date shown in Appendix A. YHI expects to send out certification notices shortly after the approval.

Concerning advertising of QHPs and QDPs, advertising materials should be submitted only after the plan's form filing has been given a disposition of "filed" in order to avoid having to update the advertising materials if form filing documents need to be changed. If advertising of QHPs/QDPs begins before the plans have been certified by YHI, advertising materials must contain a disclaimer that the plans have not yet been certified. Any exclusions, exceptions, reductions and limitations must be listed in accordance with IDAPA 18.04.03 and specifically IDAPA 18.04.03.013.02.

No later than the first day of open enrollment, DOI will post all final rate increases on DOI's website.

After open enrollment, DOI will allow a carrier to adjust its small group quarterly index rates, which affect the rates of all of the carrier's small group plans by a similar percentage, as long as the rate adjustment is filed with the DOI at least 105 days prior to the effective date. The rate adjustment needs to be justified by submitting an updated URRT, actuarial memorandum, and the rate template as part of the rate filing. The carrier should also request the DOI reopen the corresponding binder to replace the binder's rate template once the rate filing is accepted and closed. DOI will not allow rate adjustments to individual health plans during the calendar year.

2. Filing Expectations

For Idaho, the QHP/QDP application for certification refers to a carrier submitting all QHP/QDP related forms, rate manuals, templates, and other requested documents to DOI through SERFF. There is no separate application to complete. Non-QHPs must submit much of the same information, as outlined below.

Carriers must ensure that plan specifics do not vary between form and binder filings. For example, the cost sharing information contained in the Summary of Benefits and Coverage (SBC) must match that which is provided in the Plans and Benefits template.

Carriers should submit all forms for each product in a single filing. The forms of multiple products should be grouped into a single filing if all forms fall under the specified "Type of Insurance" (TOI). Carriers currently selling plans can submit changes, other than changes to cost

sharing amounts, to the forms as an amendment. Any forms pertaining to new plans must be submitted without amendments. Carriers must not reuse plan IDs from any previous plan year unless the market, metal level and plan type are identical.

There must be only one rate filing per carrier per market (individual medical, small group medical, individual dental and small group dental). Supporting documents for rate filings should be in PDF or Excel format.

Carriers should submit no more than one binder per carrier per market. The binder should include the following XML templates:

- Plan and Benefits
- Prescription Drug
- Network
- Service Area
- Essential Community Provider / Network Adequacy
- Rate Data
- Rating Business Rules

The binder's supporting documentation at a minimum should include:

- Time and Distance Reporting (see 2.2 Time and Distance)
- Statement of detailed attestation responses for SBM issuers
- Part I: Unified Rate Review Template (*Excel and XML versions*)
- Part II: written description justifying the rate increase (see Appendix B, n/a to QDPs)
- Part III: actuarial memorandum and certification (unredacted)
- Plan ID Crosswalk Template (*Excel and XML versions*)
- Idaho Filing Submission Documentation Information on Filing - DOI Website
- Network Narrative and Access Plan (QHP/QDP only)
- Issuer URL Template
- Compliance plan and organizational chart (QHPs/QDPs only)
- Idaho-specific attestations (QHPs/QDPs only)
- Quality Improvement Strategy implementation plan (QHPs only)
- QDP actuarial value certification (QDPs only)
- QDP description of EHB allocation method (QDPs only)
- Justifications for any potential deficiencies (as needed)

3. Summary of Benefits and Coverage

Carriers must include on the SERFF form schedule, a schedule of benefits and the federally mandated Summary of Benefits and Coverage (SBC) corresponding to each Standard Component ID plus variant code included in the carrier's SERFF medical plan binder(s). Carriers are permitted to submit the SBCs up to two weeks after the binder submission, provided that carriers notify DOI of the delay.

The schedule of benefits and SBCs should not include variable language for benefits. DOI requests that carriers include the plan's ID plus variant code on corresponding schedule of benefits and SBCs, to facilitate review. Carriers can file SBCs without a form number printed within the document, but there must be a form number attached to each SBC within SERFF. The DOI will accept a generic form number (such as SBC2026) to be assigned to each SBC within SERFF.

4. Variable Language in Forms

Policy forms (including SBCs) should not include variable language unless such language is approved by DOI prior to submission. Variable language that the DOI may allow would generally not affect the benefits or cost sharing. The DOI will allow variable language in the following contexts without prior approval:

- Religious exemption for a specific benefit
- Benefits exclusive to eligible tribal members
- Employer choice to offer coverage to spouses, dependents, or domestic partners
- Employer group number
- Employer name
- Internal plan/product identifier

5. Rate Information Considerations

The carrier must maintain consistent submissions of the URRT, actuarial memorandum, and the rate increase justification in both the Idaho and CMS filing systems. Rates must continue to account for the impact of the 1332 Reinsurance Waiver. As Supporting Documentation, please include rate tables without the savings from the 1332 Waiver. DOI supports a carrier providing additional rate development details to DOI through an Idaho-specific addendum to the actuarial memorandum. Being Idaho-specific, the addendum would not need to be submitted to CMS, thereby limiting the potential for federal disclosure of proprietary data.

While CMS requires the rate increase justification only for increases above a threshold, DOI requires carriers to submit the justification for *all* rate filings. In order to improve transparency and clarity, DOI is providing a template as Appendix B that carriers should utilize when developing their written description justifying any rate increase. The explanation needs to be a consumer-friendly narrative that describes the relevant URRT data, the assumptions used to develop the rate increase, and an explanation of the most significant factors causing the rate change. DOI will ask carriers to revise any explanations that are missing the information contained in the template.

Within the rate filing, carriers must delineate their broker commission schedules for the upcoming calendar year. The schedules must not distinguish between special enrollments or open enrollments or any other factor that could be related to health status such as metal level, age, family size, etc. As commissions are a key component of the rate development, changes to the schedules for individual and small group health benefit plans should largely align with the

calendar year rate setting process. Commission schedule changes must be submitted to the DOI for review at least 90 days prior to implementation and may not be accepted without clear justification as to why the change cannot be postponed until the next calendar year.

6. Transparency

Per Idaho Code § 74-107(1) and DOI Bulletin 95-2, DOI generally considers as proprietary or "trade secret" any rating information that is flagged as confidential within a filing. While flagging a document within a filing as confidential does not conclusively resolve the question, it assists DOI in its identification of confidential, proprietary information or trade secrets. Consistent with Idaho Code and historical practices, DOI will not treat form filings as confidential.

QHP carriers are required to submit specified information to YHI, CMS and DOI in a timely and accurate manner as required by 45 C.F.R. § 156.220, which implements § 1311(e)(3) of the Affordable Care Act.

Section Two: Health Benefit Plan Requirements

The following requirements apply to all health benefit plans in the individual and small group markets, which include both QHPs and non-QHPs (ACA-compliant plans only offered off-exchange).

1. Fair Health Insurance Premiums

Idaho Code § 41-4706 and § 41-5206, as well as federal regulation at 45 C.F.R. § 147.102 provide health insurance premium standards that all plans must follow. These standards include the following:

- Rates for a particular plan may vary only by rating area, age (not more than 3:1 for ages above 20), and tobacco use (not more than 1.5:1);
- The uniform age rating curve must be utilized;
- Premiums for coverage of more than one individual must be determined by summing the premiums for each individual covered, with a maximum of three premiums for covered children under age 21;
- Small group composite rating be in accordance with the methodology specified for Idaho on the DOI website.
- Rating area factors should only reflect differences in the cost of delivery, not differences in morbidity; and
- Differences in the rates between plans reflect objective differences in plan design and not differences in morbidity or selection.

DOI will review each rate filing against these criteria. To evaluate if the plan adjusted index rate differences reflect only objective differences in plan design, DOI has established specific criteria that should not be exceeded. For the set of plans within the same plan type (Managed Care or

PPO) and network, the difference in plan adjusted index rates – considering only the portion attributable to Essential Health Benefits and assuming CSR payments – should not exceed:

- Within the same metal: difference in metal actuarial value (AV) × 115%,
- Silver to bronze Midpoint rates: difference in metal AV midpoints × 115%,
- Gold to bronze Midpoint rates: difference in metal AV midpoints × 125%,
- Platinum to bronze Midpoint rates: difference in metal AV midpoints × 140%.

The test for rate differences between metal levels relies on a rate midpoint and a metal AV midpoint. The rate midpoint is calculated for this purpose as the average of the lowest and highest plan adjusted index rates within a metal level. The metal AV midpoint is calculated for this purpose as the average of the metal AVs for the lowest and highest plan adjusted index rate plans within a metal level. Extended bronze plans should be included as additional bronze plans in this testing. Carriers should provide an exhibit in the rate filing that demonstrates compliance with these ratios. Appendix C has an example of such a demonstration.

The actuarial memorandum or addendum to the memorandum should include a comparison table indicating what the carrier's silver rates would be at a given age if cost sharing reduction payments were made, how the offsetting rate load is justified, and what the final silver rates are after accounting for the anticipated lack of the payments. The rates for non-silver plans must not vary between the two scenarios. If at some point prior to open enrollment the cost sharing reduction payments are restored, carriers will be required to submit modified rate templates containing the non-loaded silver rates already communicated within the rate filing.

2. Service Area

Consistent with regulations at 45 C.F.R. § 155.1055(a), each service area of a QHP must cover a minimum geographic area that is at least the entire geographic area of a county. The service area of a QHP must be established without regard to racial, ethnic, language, or health status-related factors as specified under § 2705(a) of the Public Health Service (PHS) Act, or other factors that exclude specific high utilizing, high cost or medically-underserved populations.

DOI will apply the same criteria to the service areas of non-QHPs in the interest of fairness in the marketplace. Carriers that submit new service areas that include partial counties or carriers that wish to modify their current service areas must include justification that explains the need and describes how the service area meets the regulatory standards listed above.

3. Discriminatory Marketing and Benefit Design

The regulation at 45 C.F.R. § 156.200(e) provides consumer protections against discrimination that apply to all QHPs. 45 C.F.R. § 156.225(a) requires that in order to have a plan certified as a QHP, a carrier must comply with all applicable state laws on health plan marketing by health insurance carriers. In addition, 45 C.F.R. § 156.225(b) states that a QHP carrier must not employ marketing practices that will have the effect of discouraging the enrollment of individuals with significant health needs in QHPs. DOI will apply the same criteria to non-QHPs in the interest of

fairness in the marketplace. YHI and DOI recommend that all marketing materials distributed to enrollees or potential enrollees include the notice language suggested by CMS.

DOI, with the assistance of YHI, will monitor consumer complaints regarding a carrier's marketing activities and complaints concerning an agent's, broker's, or web-broker's conduct. Determinations of discrimination may result in a QHP decertification and potentially additional enforcement action against the carrier, agent, broker, or web-broker.

Regarding discriminatory benefit designs, 45 C.F.R. § 156.125(a) states that an issuer does not provide Essential Health Benefits (EHB) if its benefit design, or the implementation of its benefit design, discriminates based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions. The Office for Civil Rights' final rule on the matter is entitled "Nondiscrimination in Health Programs and Activities" (81 Federal Register 31375). Carriers should review the rule, along with https://www.hhs.gov/civil-rights for additional information.

For purposes of QHP certification, carriers will attest to compliance with the non-discrimination standards. DOI will apply an outlier analysis on benefit cost sharing (similar to the outlier tests explained in the CMS Letter to Issuers). DOI may require changes to certain cost sharing provisions that potentially discourage the enrollment of individuals with significant health needs or specific conditions. DOI will consider an unusually large number of drugs subject to prior authorization and/or step therapy requirements, as well as unusually high-cost sharing requirements in a particular category and class to be potentially discriminatory. Finally, DOI will review the "explanations" and "exclusions" applicable to benefits for discriminatory language.

Under Idaho Code, the allowable network types for health benefit plans are managed care or preferred provider organization. Carriers should designate managed care plans as "HMO" or "POS" in the federal templates, as the federal templates do not include a "managed care" designation. Idaho law does not recognize "EPO" or "Exclusive Provider Organizations." Therefore, such designation or label, even if only for marketing purposes, will not be accepted. All major medical plans must not exceed 50% member coinsurance for in-network care, and non-managed care (e.g., PPO) plans must not exceed 50% member coinsurance on covered services received out-of-network. Managed care plans must provide substantive coverage of out-of-network services (see § 41-3905(3), Idaho Code); DOI will continue to consider health plans with out-of-network member coinsurance that exceeds 60% to be out of compliance with that standard.

Out-of-network deductibles and out-of-network out-of-pocket limits must similarly not be excessive. DOI will consider out-of-network deductibles in excess of twice the federal in-network annual limitation to be excessive, and DOI will consider out-of-network out-of-pocket limits in excess of ten times the federal in-network annual limitation to be excessive. The federal maximum annual limitation on cost sharing for 2026 is $10,150 for self-only coverage and $20,300 for other than self-only coverage.

With regard to Expanded Bronze plans, the DOI will review in order to determine that these plans either meet the requirements to be a high deductible health plan within the meaning of 26 U.S.C. 223(c)(2) or that the plan pays for at least one major service before the deductible with reasonable cost sharing. The DOI will consider either 50% coinsurance or the copay amounts displayed below as the maximum amount be paid by the member that constitutes "reasonable cost sharing" for a specific major service:

Primary Care Visits	$60.00
Specialist Visits	$80.00
Emergency Department Services	$400.00
Inpatient Hospital Services	$500.00 per day
Generic Drugs	$10.00
Preferred Brand Drugs	$100.00
Specialty Drugs	$250.00

If a carrier cannot meet those copay maximums for at least one major service in designing an Expanded Bronze plan, the carrier should inform DOI of the justification as to how their Expanded Bronze plan design still meets the federal requirements.

4. Minimum Participation and Contribution Rates on Small Group Renewals

The guaranteed availability regulation at 45 C.F.R. § 147.104(b)(1) requires that a small employer be allowed to purchase coverage from November 15 through December 15, even if the employer cannot meet the carrier's minimum participation or contribution requirements. YHI and DOI have determined it would impose undue burden on employers and their employees for carriers to non-renew coverage under the exception to guaranteed renewability for failure to meet minimum participation or contribution rates and then re-enroll employers under guaranteed availability during this period. Therefore, carriers offering small group plans must not enforce minimum participation or contribution requirements for renewals of policies purchased between November 15 and December 15.

5. Coverage Appeals

QHPs and non-QHPs are required to meet the standards for internal claims and appeals and external review established at 45 C.F.R. § 147.136, which require an effective process for internal claims appeals and external review. DOI will also review all applicable policy forms for compliance with title 41, chapter 59, Idaho Code and IDAPA 18.04.01.

6. Discontinued Plans

Any discontinuation of an individual or small group health benefit plan must be executed in compliance with § 41-4707(1)(g), Idaho Code, for small employer plans, or § 41-5207(1)(e), Idaho Code, for individual plans. Without prior authorization by DOI, a carrier cannot discontinue (1) a health benefit plan that has been in use for less than thirty-six consecutive months, or (2) more than fifteen percent of a line of business within a twelve-month period.

When applying the federal discontinuation criteria at 45 C.F.R § 147.106, the federal definitions at 45 C.F.R § 144.103 of *plan* and *product* apply. As explained in those definitions, a *plan* consists of a certain package of health insurance benefits with a particular cost sharing structure, provider network, and service area; and a *product* comprises all a carrier's plans with the same package of health insurance benefits and with a particular network type (such as preferred provider organization), within the product's service area (defined as the combined service area of all plans constituting that product).

A carrier may make certain changes to a product without being considered a new product. The changes must meet the criteria of a uniform modification of coverage, as provided at 45 C.F.R. §§ 146.152(f), 147.106(e), 148.122(g). The carrier requesting a uniform modification must demonstrate to DOI that:

- The product is offered by the same health insurance issuer.
- The product is offered as the same product network type.
- The product continues to cover at least a majority of the same service area.
- Within the product, each plan must have the same cost sharing structure as before the modification, except for any variation in cost sharing solely related to changes in cost and utilization of medical care, or to maintain the same metal tier; and
- The product provides the same covered benefits, except for changes that cumulatively impact any plan-adjusted index rate within the allowable variation of 2 percentage points.

In order to assist DOI with the evaluation of changes to a plan's cost sharing structure, each carrier making cost sharing changes to a plan must submit with the binder an exhibit showing how each cost sharing change (for both in-network and out-of-network) meets at least one of the two permitted conditions: "solely related to changes in cost and utilization of medical care" or "to maintain the same metal tier." Cost sharing changes beyond those two conditions will need DOI approval to be considered the same plan or product.

Upon discontinuing a particular health benefit plan, carriers must comply with the requirements of Idaho Code and federal rule cited above as well as 45 C.F.R. § 156.270.

Section Three: QHP and QDP Certification Standards

YHI will rely upon DOI to review potential QHPs and QDPs for compliance with the regulatory and other requirements and to recommend QHPs/QDPs to be certified and available for sale

through YHI. The standards and processes do not differ between first-time certifications and re-certifications; therefore, in this document we refer to both situations when discussing certification. This section provides the criteria set by YHI in order to meet certain regulatory requirements for QHPs/QDPs pursuant to 45 C.F.R. Parts 155 and 156. DOI will evaluate QHP/QDP applications against these criteria.

1. Licensure and Good Standing

Consistent with 45 C.F.R. § 156.200(b)(4), each carrier offering QHPs/QDPs must be licensed and in good standing in each state in which it applies for the applicable market, product type, and service area. Carriers must attest that they meet this standard as part of the signed Attestations Document, which carriers can access through SERFF. DOI's Company Activities Bureau maintains the records associated with this requirement. Carriers are therefore not required to submit any supporting documentation of licensure and good standing in Idaho.

2. Network Adequacy

Pursuant to 45 C.F.R. § 156.230(a)(2), carriers offering QHPs/QDPs that have a provider network must maintain a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance use disorder services, to assure that all services will be accessible to enrollees without unreasonable delay.

Carriers seeking certification of QHPs/QDPs in Idaho are required to attest that the networks meet this standard. Additionally, carriers must demonstrate that each network associated with QHPs meets or exceeds the Health Plan network adequacy related accreditation standard of the National Committee for Quality Assurance (NCQA), the Accreditation Association for Ambulatory Health Care (AAAHC) or URAC. Carriers can demonstrate that they meet one of the accreditation standards by providing proof of accreditation or by providing a network access plan showing how the standards are met.

As part of a medical QHP application, carriers must submit detailed network provider data using the EHB/Network Adequacy template. This includes information about the participating physicians, facilities, and pharmacies, including the location and specialty when applicable.

As supporting documentation to that data, the carrier must provide a network narrative that describes the approach to developing or selecting each network and how the carrier evaluates the availability and accessibility of care. This narrative must include the standards used by the carrier to determine whether each network contains a sufficient number of in-network providers and facilities that are accessible to prospective plan members, as well as the carrier's methodology for measuring whether standards are met. Additionally, the narrative should distinguish between any narrow and broad networks, provide high-level network composition and provider adequacy criteria, describe monitoring and care coordination efforts, and explain the in-network and out-of-network referral policy. The narrative must explain how the carrier meets Idaho's any willing provider laws (see Idaho Code §§ 41-2872 and 41-3927) for each network, including who decides the terms and conditions of participation and who providers

should contact to obtain the requirements to participate. YHI and DOI will review the data and narratives and may request additional information or justification if inadequate.

QDP carriers and any carrier with non-accredited medical QHPs should complete and attach the Network Adequacy Cover Sheet and an accompanying Network Access Plan which demonstrates that each plan meets 45 C.F.R. § 156.230(a)(2), as it applies to QDPs. The following sections of the Cover Sheet apply to QDPs: standards for network composition (excluding references to mental health and substance abuse providers), ongoing monitoring process, plan for addressing needs of special populations, member communication methods, and continuity of care plan (in the event of provider contract termination or corporate insolvency).

The Department will continue to support flexibility in the provision of services through telehealth, to the extent allowed by federal law and consistent with state guidance.

2.2 Time and Distance Standards

Starting with the 2026 plan year, carriers will need to meet network adequacy time and distance standards. The Department is adopting the minimum standards required by CMS. The CMS templates found in the binder will be used by the Department to determine compliance with the standards. Carriers should carefully review the instructions provided by CMS for each of the templates and validate all templates prior to submission. The network adequacy template should list no more than 10 unique address locations for any one individual practitioner NPI or facility provider NPI.

To offer QHPs or QDPs in a given county, a carrier's network must include providers and facilities within the time and distance standards indicated in Appendix D for at least 90% of the county's population. Appendix E lists the size designation for each Idaho county. The distance will be based on population data taken from the 2020 census. Carriers will provide their own report to the Department indicating if they have met the standard. The report will contain at a minimum the following information.

- Network Name
- County
- Population designation for that county
- Specialty Code
- Percentage of members meeting the distance requirements.
- Column indicating if the 90% standard is met or not met.
- Justification for any deficiencies identified in the report

Any deficiencies will necessitate the carrier submit a narrative explaining the causes and steps taken to remedy those deficiencies. Additionally, carriers will need to answer the following questions regarding any deficiencies:

- What sources are used to monitor new providers entering the service area?
- How often do you monitor your sources for new providers entering the service area?

- Do you hold QHP enrollees of this plan responsible for only in-network cost sharing for out-of-network care received when you do not meet the network adequacy standards for network/county/specialty combinations?
- What is the number of QHP enrollee complaints received regarding network adequacy during the prior plan year?

See the following CMS Q&A for further details on how time and distance standards are calculated and measured:
https://www.qhpcertification.cms.gov/s/Network%20Adequacy%20FAQs

How are the network adequacy time and distance standards calculated and measured?

- CMS uses industry-standard technology to calculate estimated driving time and distance between Marketplace-eligible consumers (see FAQ describing the target QHP Population Sample File) and servicing provider locations. Street addresses for consumers (based on census data sampling) and providers are assigned latitude and longitude geocodes. Once those coordinates are created, estimated driving time and distance are calculated between consumers and providers. Time is calculated using the estimated distance and applying a driving speed based on the geographic area, and distance is measured by determining the estimated driving distance between the geocodes and the average number of Marketplace-eligible consumers in the designated geographic areas. Finally, the results are compared against the time and distance metric standards for the respective provider specialty type and county designation type to determine if the standard is met.

3. Essential Community Providers

45 C.F.R. § 156.235 establishes requirements for the inclusion of Essential Community Providers (ECPs) in QHP and QDP provider networks and provides an alternate standard for carriers that provide a majority of covered services through physicians employed by the carrier or a single contracted medical group.

DOI will require a minimum thirty-five percent (35%) participation standard, in accordance with the draft federal guidance.

To meet the ECP standard for YHI, a carrier must demonstrate that it:

- Contracts with at least (35%) of available ECPs in each plan's service area to participate in the provider network.
- Contracts with at least 35% of available Federally Qualified Health Centers and 35% of available Family Planning Providers.
- Offers contracts in good faith to all available Indian health providers in the service area, to include the Indian Health Service, Indian Tribes, Tribal organizations, and urban Indian organizations, with the terms and conditions referenced in the model QHP Addendum for Indian health providers developed by CMS; and

- Offers contracts in good faith to at least one ECP in each ECP category (includes Federally Qualified Health Centers, Ryan White Providers, Family Planning Providers, Indian Health Providers, Hospitals, Mental Health Facilities, Substance Use Disorder Treatment Centers and Other ECP Providers) in each county in the service area, where an ECP in that category is available and provides services that are covered by the plan.

If a carrier's network does not satisfy the 35% ECP standard described above, the carrier is required to include as part of its application a satisfactory narrative justification. The justification must describe how the carrier's provider network, as currently designed, provides an adequate level of service for low-income and medically underserved enrollees and how the carrier plans to increase ECP participation in the carrier's provider network in future years, as necessary.

If carriers include, in their Essential Community Provider/Network Adequacy Template, any provider with whom a contract has not been finalized as of the date of submission of the binder, the Network Narrative and Access Plan must identify all such providers and contain a summary of actions being taken to secure the contract and an estimate of when the contract is expected to be finalized.

To assist carriers in identifying these providers, CMS published a non-exhaustive list of available ECPs based on data maintained by CMS and other federal agencies. Carriers should use this CMS-developed list to calculate their satisfaction of the 35% ECP standard. Carriers must use the federally designed ECP template to report participating ECPs to DOI. Carriers may not write in ECPs not on the CMS-developed list for consideration. Only one ECP is permitted per physical address.

QDPs have the same standard, except for the requirement to offer contracts to at least one ECP in each category. If the QDP network does not meet the 35% ECP standard or does not offer contracts in good faith to all Indian health providers in the service area, the carrier must submit a satisfactory narrative justification.

4. Accreditation (not applicable to QDPs)

Requirements at 45 C.F.R. § 155.1045(b) establish the timeline by which QHP carriers offering coverage in a FFM must be accredited. Pursuant to 45 C.F.R. § 156.275 YHI adopted the same phased approach to the accreditation requirement.

Carriers without YHI-certified QHPs that do not have an existing commercial, Medicaid, or Exchange health plan accreditation granted by a recognized accrediting entity (NCQA, AAAHC, or URAC) for Idaho must schedule a review for accreditation from a recognized accrediting entity. The carrier must submit an attestation that they have scheduled a review for accreditation as supporting documentation, which should reference the accrediting entity and the anticipated review date.

Carriers with YHI-certified QHPs must provide their accreditation information to DOI using the SERFF's company accreditation entries. Alternatively, a carrier must have Idaho specific commercial or Medicaid health plan accreditation granted by a recognized accrediting entity.

The administrative policies and procedures underlying that accreditation must be the same or similar to the administrative policies and procedures used in connection with the QHPs.

5. Patient Safety Standards (not applicable to QDPs)

Regulatory requirements at 45 C.F.R. § 156.1110 outline how carriers can demonstrate compliance with the patient safety standards. QHP carriers that contract with a hospital with more than 50 beds are to verify that the hospital, as defined in § 1861(e) of the Social Security Act (SSA), is Medicare-certified or has been issued a Medicaid-only CMS Certification Number (CCN) and is subject to the Medicare Hospital Condition of Participation requirements for:

- A quality assessment and performance improvement program as specified in 42 C.F.R. § 482.21; and
- Discharge planning as specified in 42 C.F.R. § 482.43.

In addition, carriers are required to collect and maintain documentation of the CCNs from their applicable network hospitals.

As part of the application, YHI will require carriers (other than QDP carriers) to demonstrate compliance with these patient safety standards as part of the QHP application with an attestation that they have collected and are maintaining the required documentation from their network hospitals.

6. Quality Reporting and Quality Improvement Strategy (not applicable to QDPs)

QHP carriers are required to comply with requirements related to quality reporting for QHPs offered on Marketplaces through implementation of the Quality Reporting Standards (QRS) and the QHP Enrollee Survey. QHP carriers will be required to attest that they comply with these requirements as part of certification process.

YHI will publicly display QHP quality rating information during the shopping experience to help consumers compare QHPs. QHP carriers may include QRS and QHP Enrollee Survey results in marketing materials.

CMS anticipates issuing technical guidance on an annual basis that will detail requirements for the QRS and QHP Enrollee Survey including the standards related to data collection, validation and submission, as well as the minimum enrollment and other participation criteria. The Qualified Health Plan Enrollee Experience Survey: Technical Specifications for 2025 may be found here.

A Quality Improvement Strategy (QIS) is a requirement for both individual and Small Employer Health Options Program (SHOP) carriers. A QIS is a payment structure that provides increased reimbursement or other market-based incentives for improving health outcomes of plan enrollees. A QIS must also include:

- Activities for improving health outcomes;
- Activities to prevent hospital readmissions;

- Activities to improve patient safety and reduce medical errors;
- Activities for wellness and health promotion; and
- Activities to reduce health and health care disparities.

Carriers meeting the applicable minimum enrollment threshold as defined by CMS must implement one or more QIS that applies to all of their QHPs; a QIS does not have to address the needs of all enrollees.

Carriers must submit with their QHP application a QIS Implementation Plan and a progress report form. DOI will review the QIS plan as part of the certification process. The submission should follow the format provided by CMS for the FFM.

7. QHP Agreement

Carriers offering QHPs /QDPs in YHI will be required to sign an agreement with YHI as part of the plan year certification process. The agreement must be signed prior to the date specified in Appendix A to be eligible for certification. The agreement will cover all of the QHPs/QDPs offered by a carrier at the Health Insurance Oversight System (HIOS) Issuer ID level and must be signed by an officer of the carrier who has legal authority to contractually bind the QHP/QDP carrier.

8. Prescription Drug Coverage (not applicable to QDPs)

Regulations at 45 C.F.R. § 156.122 establish that a health plan that provides EHB must cover at least the greater of (1) one drug in every United States Pharmacopeial Convention (USP) category and class or (2) the same number of prescription drugs in each USP category and class as the EHB benchmark plan. The CMS website lists the EHB benchmark prescription drug category and class counts for Idaho.

DOI will use the federal prescription drug template to collect and review compliance with this standard. The drug template allows carriers to demonstrate that a plan's formulary is sufficiently broad to meet the Idaho benchmark formulary drug count by USP category and class. Carriers are to provide reasonable justification for any deficiencies in drug lists compared to the Idaho benchmark.

QHP carriers must also verify their pharmacy and therapeutics committee meets the various requirements of 45 C.F.R. § 156.122(a)(3). Pursuant to 45 C.F.R. 156.122(e), carriers must allow enrollees to access prescription drug benefits at in-network retail pharmacies except in the specific cases enumerated in that section.

As part of the QHP application, carriers must provide a URL to their formulary and provide information regarding their formulary to consumers, pursuant to 45 C.F.R. § 147.200(a)(2)(i)(K). YHI expects the URL link to direct consumers to an up-to-date formulary from which they can view the list of covered drugs along with the corresponding tiers and cost sharing applicable to the QHP of interest, as required by 45 C.F.R. 156.122(d)(1). The URL provided to YHI as part of the QHP application should link directly to the formulary, such that consumers do not have to

log on, enter a policy number or otherwise navigate the carrier's website before locating it. If a carrier has multiple formularies, it should be clear to consumers which directory applies to the selected QHP. While the drugs covered only under a plan's medical benefit can be used in demonstrating compliance with the Idaho benchmark drug count, carriers are not required to include those drugs on the formulary that is accessible to consumers.

YHI and DOI encourage carriers to closely monitor requests for non-formulary medications and utilize this information, along with market factors, when reviewing medications for formulary coverage, especially regarding new drugs that enter the pharmacy market. Requests during at least the first thirty (30) days of coverage for medications requiring prior authorization or step therapy should be reviewed promptly with the goal of limiting disruptions in ongoing treatment for new enrollees. YHI recommends carriers ensure their exceptions and appeals processes for prescription drugs meet the requirements of 45 C.F.R. § 156.122(c) and do not result in treatment delays. YHI will consider stricter guidelines if the needs of enrollees are not being met in a timely manner.

9. Meaningful Difference (not applicable to QDPs)

YHI will continue to apply the same standards as last year. The meaningful difference criteria are applied to each carrier's QHPs matching a subgroup of the same plan type, metal level, and overlapping service areas. DOI may not recommend certification of a carrier's plan, and YHI may not certify a carrier's plan, if within a subgroup, plans do not differ from each other by at least one of the following criteria:

- Different network;
- Different cost sharing tier levels;
- $800 or more difference in both individual and family in-network deductibles; and
- Difference in covered benefits.

DOI may ask carriers with plans identified as potentially not meaningfully different to modify or withdraw one or more of the identified plans to meet this requirement. Alternatively, DOI will review a carrier's justification to how the identified plans are meaningfully different and add to meaningful consumer choice.

10. Third Party Payment of Premiums and Cost Sharing

Carriers of individual market QHPs/QDPs are required under 45 C.F.R. § 156.1250 to accept third party premium and cost sharing payments made on behalf of enrollees by the Ryan White HIV/AIDS Program; Indian tribes, tribal organizations, and urban Indian organizations; and other federal, state, and local government programs. Payments from grantees or sub-grantees of the allowed third party payers must also be accepted. Violations of 45 C.F.R. § 156.1250 may result in the decertification of corresponding QHPs.

45 C.F.R. § 156.130(h) allows, but does not require, QHP issuers to count drug manufacturer coupons towards the annual limitation on cost sharing for specific prescription drugs, regardless

of whether a generic drug is available. Idaho carriers were provided guidance on treatment of third-party payments in DOI Bulletin 16-04, which is still in effect. That bulletin, among other things, requires carriers to apply payments from third parties that are meet certain criteria, including not being "financially interested," toward deductibles and out-of-pocket maximums as if the insured made the payment directly. Payments from other third-party payers, including drug manufacturers, need not apply toward an enrollee's deductible or out-of-pocket maximum, regardless of the availability of a generic drug equivalent. Such application continues to be consistent with the intent of deductibles and out-of-pocket maximums to equitably require and reflect only amounts truly paid by an enrollee or a non-financially interested party on behalf of the enrollee.

11. Cost Sharing Reduction Plan Variation Reviews (not applicable to QDPs)

Regulations at 45 C.F.R. § 156.420 generally require QHP carriers to submit three plan variations for each silver level QHP in the individual market as well as zero and limited cost sharing plan variations for all QHPs in the individual market. YHI expects QHP applications to comply with 45 C.F.R. part 156, subpart E.

12. Oversight of Agents/Brokers (Producers)

All agreements between QHP issuers and downstream or delegated entities (to include agents, brokers and third-party administrators) must include language stating that the exchange and DOI have the authority to request and receive records related to the QHP issuer's compliance with federal standards related to the exchange.

YHI and DOI will not allow agents and brokers (licensed as producers) to use "YHI," "Your Health Idaho," "Marketplace," or "Exchange" in the names of their businesses or names of their websites. Agents and brokers should also be careful in representations that might tend to mislead or confuse consumers. As required by 45 C.F.R. § 155.220(c)(3), if a producer assists a qualified individual with QHP selection through the agent, broker, or web-broker's website, a standardized disclaimer must be prominently displayed on each page to indicate that the site is not Your Health Idaho, the Idaho Health Insurance Exchange, and it must also include a link to the YHI website. Failure to comply with the preceding may result in the loss of an agent or broker's Exchange certification and may constitute a violation of Idaho Code §§ 41-1016(1)(h) or 41-1321, resulting in a potential administrative action against the producer that could affect the producer's license.

13. Idaho's Small Employer Health Options Program

Idaho will continue the state-based SHOP through YHI. YHI will provide carriers with the details needed to allow small employers access to the federal tax credit through Idaho's SHOP.

Regarding the definition of a small employer in the Idaho small group market, the definitions of "eligible employee" and "small employer" found in Idaho Code §§ 41-4703(13) and 41-4703(28) are not categorically preempted by federal regulations. Therefore, there is no change in the size or employee counting method in Idaho's small group market as a whole.

Note that, however, for purposes of SHOP enrollment and the Small Business Tax Credit, group size is determined using the federal full-time equivalent (FTE) method of counting employees. Under the FTE method, sole proprietors and their spouses or other family members are not counted as employees. Therefore, although a small employer consisting of only a business owner and spouse who is an eligible employee or business partner are eligible to enroll in a small group plan, the group may not be able to enroll through the SHOP or qualify for the Small Business Tax Credit.

14. Meaningful Access

Pursuant to 45 C.F.R. §§ 155.205(c), 155.230(b), and 156.250, QHP/QDP carriers must ensure meaningful access by limited-English proficient (LEP) speakers and by individuals with disabilities. Carriers should review the above referenced regulatory requirements and other details provided by CMS.

15. Provider Directory

Pursuant to 45 C.F.R. § 156.230(b), YHI requires QHPs to make their provider directories available for publication online by providing the URL link as part of the QHP Application and by having the directory openly accessible from the carrier's website. The URL that carriers provide to YHI as part of the QHP application should link directly to an up-to-date provider directory corresponding to the selected QHP. Consumers should not have to log on, enter a policy number, or otherwise navigate the carrier's website in order to view the directory. If a carrier has multiple provider directories, it should be clear to consumers which directory applies to the QHP of interest. Further, YHI expects the directory to include location, contact information, specialty, medical group, and any institutional affiliations for each provider, and whether the provider is accepting new patients. YHI encourages carriers to include languages spoken, provider credentials, and whether the provider is an Indian health provider.

Carriers should submit a PDF of their provider directory as supporting documentation with each form filing in SERFF. While carriers are not required to submit updates to the provider directory to DOI during the year, carriers should update the directory available through their website at least monthly to be considered current. In the case of provider directory changes that have a substantial negative impact to consumers, DOI expects carriers to notify DOI of the changes by submitting a new directory and a description of the impact to consumers.

16. QDP Considerations

The annual limitation on cost sharing for the pediatric dental EHB offered by QDPs remains unchanged – it is not to exceed $450.00 for one child and $900.00 for two or more children. Carriers submitting QDPs to YHI for certification are expected to meet the applicable standards. As federal regulations no longer mandate QDPs to meet specific actuarial values, DOI will no longer require carriers offering these plans to demonstrate that a plan meets either the 70% (low) actuarial value or the 85% (high) actuarial value. Carriers of QDPs still must submit the actuarial value of each plan as certified by a member of the American Academy of Actuaries.

QDPs that are not to be sold through YHI cannot be "exchange-certified." The DOI Bulletin 14-02 provides the process in Idaho for carriers to be reasonably assured that individuals and employers are made aware of their option to purchase a QDP that covers the pediatric dental EHB. Individuals and employers are then able to choose from among QDPs that are sold through YHI and dental plans that are not sold through YHI to find the plan that best meets their needs.

Per CMS rule, all dental plans must have a network to be sold on the exchange. Plans that are identified as "Indemnity" will not be certified for the exchange.

17. Tribal Relations and Support

The Affordable Care Act (ACA) at Subtitle K, section 2901, of Title II includes Protections for American Indian and Alaska Natives (AI/AN), which extends special benefits and protections to AI/AN, including limits on cost sharing and clarifies payer of last resort requirements for health programs operated by the Indian Health Service (IHS), Indian tribes, tribal organizations and urban Indian organizations.

In coordination with the leadership of the five federally recognized tribes in Idaho, YHI developed a tribal consultation policy that outlines YHI's commitment to achieving culturally appropriate interactions between YHI and Indian Tribes and greater access to the services that will be provided by the YHI Insurance Exchange for AI/AN. Among the goals of the policy are to:

- Maximize participation by AI/AN in QHPs offered by YHI
- Assure that AI/AN receive the benefits and protections provided under federal law
- Assure that AI/AN can choose to receive their health care from the Indian Health Services, a tribally-operated program, or an urban Indian program

As noted in the Essential Community Providers section above, YHI strongly encourages QHP carriers to engage with Indian health care providers, through which a significant portion of American Indians access care. When offering contracts in good faith, YHI recommends QHPs include considerations for culturally specific terms. To promote contracting between carriers and Indian health care providers, YHI expects carriers to offer contracts to Indian health care providers and use the CMS Model QHP Addendum for Indian Health Care Providers.

Per the Cost Sharing Reduction Plan Variation Reviews section above, QHPs in the individual market are required to offer two plan variations specifically for tribal communities: the zero cost sharing and the limited cost sharing plan variations, as defined at 45 CFR § 156.420(b).

The ACA also allows members of federally recognized tribes to purchase and enroll in Exchange individual or SHOP health insurance coverage monthly rather than just during the annual open enrollment period. QHPs must accept and support tribal members in accordance with this special enrollment option.

Regulations at 45 C.F.R. § 155.240(b) provide YHI with flexibility to permit Indian tribes, tribal organizations, and urban Indian organizations to pay QHP premiums—including aggregated

payment—on behalf of members who are qualified individuals, subject to terms and conditions determined by YHI. During YHI consultations with tribal governments, tribal leaders indicated the importance of tribes having the ability to pay premiums on behalf of their members. Since YHI does not collect premiums from individuals, YHI has determined it will rely on the carriers to work directly with each of the five federally recognized tribes to enable tribal premium sponsorship, as required at 45 C.F.R § 156.1250.

Appendix A - Timeline

The dates are approximate, subject to change, and occur during 2025.

Carriers to notify DOI of their intent to offer 2026 QHPs	March 24
QHP forms filings due in SERFF	May 26
QHP rates and binder filings due in SERFF; YHI to provide 2026 carrier participation agreement	June 2
Carrier plan preview begins	July 7
Final day for carriers to submit rate filing corrections in SERFF	July 16
Proposed rate increases posted on DOI website	August 1
Signed carrier participation agreement due to YHI	August 4
DOI to provide final QHP recommendations to YHI	September 19
QHP certification notices provided	September 22
All final rate increases posted on DOI website	October 1
2026 Open Enrollment Start	October 15
2026 Open Enrollment End	December 15

Appendix B – Rate Increase Justification Template ("Part II")

[Company Name]
Preliminary Rate Increase Justification for 2026
[Individual/Small Group] Health Benefit Plans

Rate Change

[In narrative form, provide the percentage rate change overall for the market and the number of individuals impacted. Also provide the percentage rate changes for any major groupings that differ from the overall, for example, by metal level, network, or geographic area. If the percentages here do not match the percentages in the URRT, the differences must be explained.]

Most Significant Factors

The rate change described above is driven by the following factors:

- [Most significant factor description]: [Most significant factor percentage]
- [2nd most significant factor description]: [2nd most significant factor percentage]
- [3rd most significant factor description]: [3rd most significant factor percentage]
- [4th most significant factor description]: [4th most significant factor percentage]
- [etc.]

[Explanation of factors. Any minor factors can be grouped together into an "other" factor, which is then explained here. The sum of the factor percentages should match the overall rate change listed in the first section.]

Financial Experience

[Include a narrative explanation of the financial experience utilized in the URRT. This section must show the total paid claims after subtracting CSR reimbursements and total premium including APTC payments. All amounts should be based on best estimates of incurred, aligning with data used in URRT, or describe how they differ.]

Key Assumptions

The annual cost trends used in developing the 2026 rates:

- Medical: [percentage]
- Drug: [percentage]
- [Other]: [percentage]

[Explanation of trends]

The 2026 rates are made up of the following components:

- Claims: [percentage]
- Administrative costs: [percentage]
- Federal taxes and fees: [percentage]
- State taxes and fees: [percentage]
- Commissions: [percentage]
- Contribution to surplus, profit, and risk margin: [percentage]

[Explanation of percentages, which should add up to 100%.]

Appendix C – Sample Exhibit Testing Plan Adjusted Index Rate Ratios

All Plans Offered in a Given Network

HIOS Plan ID	Plan Type	Metal Level	Metal AV	Plan Name	Plan Adjusted Index Rate	Plan Rank For Testing
12345ID0010001	PPO	Bronze	60.0%	Plan 1 - PPO	$244.00	
12345ID0010002	PPO	Bronze	60.6%	Plan 2 - PPO	$247.00	High Bronze
12345ID0010003	PPO	Bronze	61.5%	Plan 3 - PPO	$228.00	Low Bronze
12345ID0010004	PPO	Silver	68.1%	Plan 4 - PPO	$272.00	
12345ID0010005	PPO	Silver	68.5%	Plan 5 - PPO	$261.00	Low Silver
12345ID0010006	PPO	Silver	71.9%	Plan 6 - PPO	$299.00	High Silver
12345ID0010007	PPO	Gold	81.5%	Plan 7 - PPO	$379.00	Only Gold
12345ID0050051	HMO	Bronze	59.0%	Plan 51 - HMO	$210.00	Low Bronze
12345ID0050052	HMO	Bronze	61.4%	Plan 52 - HMO	$229.00	High Bronze
12345ID0050053	HMO	Silver	68.6%	Plan 53 - HMO	$250.00	Low Silver
12345ID0050054	HMO	Silver	71.0%	Plan 54 - HMO	$283.00	High Silver
12345ID0050055	HMO	Silver	70.5%	Plan 55 - HMO	$278.00	
12345ID0050056	HMO	Gold	79.0%	Plan 56 - HMO	$323.00	Low Gold
12345ID0050057	HMO	Gold	80.5%	Plan 57 - HMO	$361.00	High Gold

Plan Adjusted Index Rate Ratios Compared to Maximum Allowable

PPO	Plan Adjusted Index Rate			Metal Actuarial Value			Rate / AV	Maximum
	High	Low	Ratio	High	Low	Ratio	Ratios	Allowable
Bronze/Bronze	$247.00	$228.00	1.083	60.6%	61.5%	0.985	**1.099**	1.15
Silver/Silver	$299.00	$261.00	1.146	71.9%	68.5%	1.050	**1.091**	1.15
Gold/Gold	$379.00	$379.00	1.000	81.5%	81.5%	1.000	**1.000**	1.15
	Plan Adjusted Index Rate			**Metal Actuarial Value**				
	Higher Metal Midpoint	Bronze Midpoint	Ratio	Higher Metal Midpoint	Bronze Midpoint	Ratio	Rate / AV Ratios	Maximum Allowable
Silver/Bronze	$280.00	$237.50	1.179	70.2%	61.1%	1.150	**1.025**	1.15
Gold/Bronze	$379.00	$237.50	1.596	81.5%	61.1%	1.335	**1.195**	1.25

HMO	Plan Adjusted Index Rate			Metal Actuarial Value			Rate / AV	Maximum
	High	Low	Ratio	High	Low	Ratio	Ratios	Allowable
Bronze/Bronze	$229.00	$210.00	1.090	61.4%	59.0%	1.041	**1.048**	1.15
Silver/Silver	$283.00	$250.00	1.132	71.0%	68.6%	1.035	**1.094**	1.15
Gold/Gold	$361.00	$323.00	1.118	80.5%	79.0%	1.019	**1.097**	1.15
	Plan Adjusted Index Rate			**Metal Actuarial Value**				
	Higher Metal Midpoint	Bronze Midpoint	Ratio	Higher Metal Midpoint	Bronze Midpoint	Ratio	Rate / AV Ratios	Maximum Allowable
Silver/Bronze	$266.50	$219.50	1.214	69.8%	60.2%	1.159	**1.047**	1.15
Gold/Bronze	$342.00	$219.50	1.558	79.8%	60.2%	1.325	**1.176**	1.25

Appendix D – Provider/Facility Maximum Time and Maximum Distance Requirements

Provider Specialty	Large		Metro		Micro		Rural		CEAC	
	Time	Dist.	Time	Dist.	Time	Dist.	Time	Dist.	Time	Dist.
Allergy and Immunology	30	15	45	30	80	60	90	75	125	110
Cardiology	20	10	30	20	50	35	75	60	95	85
Cardiothoracic Surgery	30	15	60	40	100	75	110	90	145	130
Chiropractor	30	15	45	30	80	60	90	75	125	110
Dental	30	15	45	30	80	60	90	75	125	110
Dermatology	20	10	45	30	60	45	75	60	110	100
Emergency Medicine	20	10	45	30	80	60	75	60	110	100
Endocrinology	30	15	60	40	100	75	110	90	145	130
ENT/Otolaryngology	30	15	45	30	80	60	90	75	125	110
Gastroenterology	20	10	45	30	60	45	75	60	110	100
General Surgery	20	10	30	20	50	35	75	60	95	85
Gynecology, OB/GYN	10	5	15	10	30	20	40	30	70	60
Infectious Diseases	30	15	60	40	100	75	110	90	145	130
Nephrology	30	15	45	30	80	60	90	75	125	110
Neurology	20	10	45	30	60	45	75	60	110	100
Neurosurgery	30	15	60	40	100	75	110	90	145	130
Occupational Therapy	20	10	45	30	80	60	75	60	110	100
Oncology–Medical, Surgical	20	10	45	30	60	45	75	60	110	100
Oncology–Radiation	30	15	60	40	100	75	110	90	145	130
Ophthalmology	20	10	30	20	50	35	75	60	95	85
Orthopedic Surgery	20	10	30	20	50	35	75	60	95	85
Outpatient Clinical Behavioral Health (licensed, accredited, or certified professionals)	10	5	15	10	30	20	40	30	70	60
Physical Medicine and Rehabilitation	30	15	45	30	80	60	90	75	125	110
Physical Therapy	20	10	45	30	80	60	75	60	110	100
Plastic Surgery	30	15	60	40	100	75	110	90	145	130
Podiatry	20	10	45	30	60	45	75	60	110	100
Primary Care–Adult	10	5	15	10	30	20	40	30	70	60
Primary Care–Pediatric	10	5	15	10	30	20	40	30	70	60

Provider Specialty	Large		Metro		Micro		Rural		CEAC	
	Time	Dist.	Time	Dist.	Time	Dist.	Time	Dist.	Time	Dist.
Psychiatry	20	10	45	30	60	45	75	60	110	100
Pulmonology	20	10	45	30	60	45	75	60	110	100
Rheumatology	30	15	60	40	100	75	110	90	145	130
Speech Therapy	20	10	45	30	80	60	75	60	110	100
Urology	20	10	45	30	60	45	75	60	110	100
Vascular Surgery	30	15	60	40	100	75	110	90	145	130
Allergy and Immunology	30	15	45	30	80	60	90	75	125	110

Facility Type	Large		Metro		Micro		Rural		CEAC	
	Time	Dist.	Time	Dist.	Time	Dist.	Time	Dist.	Time	Dist.
Acute Inpatient Hospitals (must have Emergency services available 24/7)	20	10	45	30	80	60	75	60	110	100
Cardiac Catheterization Services	30	15	60	40	160	120	145	120	155	140
Cardiac Surgery Program	30	15	60	40	160	120	145	120	155	140
Critical Care Services–Intensive Care Units (ICUs)	20	10	45	30	160	120	145	120	155	140
Diagnostic Radiology (freestanding; hospital outpatient; ambulatory health facilities with Diagnostic Radiology)	20	10	45	30	80	60	75	60	110	100
Inpatient or Residential Behavioral Health Facility Services	30	15	70	45	100	75	90	75	155	140
Mammography	20	10	45	30	80	60	75	60	110	100
Outpatient Infusion/ Chemotherapy	20	10	45	30	80	60	75	60	110	100
Skilled Nursing Facilities	20	10	45	30	80	60	75	60	95	85
Surgical Services (outpatient or ASC)	20	10	45	30	80	60	75	60	110	100
Urgent Care	20	10	45	30	80	60	75	60	110	100

Dental	Large		Metro		Micro		Rural		CEAC	
	Time	Dist.	Time	Dist.	Time	Dist.	Time	Dist.	Time	Dist.
Dental	30	15	45	30	80	60	90	75	125	110

Appendix E – County Designations

COUNTY, STATE	COUNTY DESIGNATION
Ada, ID	Metro
Adams, ID	CEAC
Bannock, ID	Micro
Bear Lake, ID	CEAC
Benewah, ID	Rural
Bingham, ID	Micro
Blaine, ID	CEAC
Boise, ID	CEAC
Bonner, ID	Micro
Bonneville, ID	Micro
Boundary, ID	Rural
Butte, ID	CEAC
Camas, ID	CEAC
Canyon, ID	Metro
Caribou, ID	CEAC
Cassia, ID	Rural
Clark, ID	CEAC
Clearwater, ID	CEAC
Custer, ID	CEAC
Elmore, ID	CEAC
Franklin, ID	Rural
Fremont, ID	CEAC

COUNTY, STATE	COUNTY DESIGNATION
Gem, ID	Rural
Gooding, ID	Rural
Idaho, ID	CEAC
Jefferson, ID	Rural
Jerome, ID	Rural
Kootenai, ID	Metro
Latah, ID	Rural
Lemhi, ID	CEAC
Lewis, ID	CEAC
Lincoln, ID	CEAC
Madison, ID	Metro
Minidoka, ID	Rural
Nez Perce, ID	Micro
Oneida, ID	CEAC
Owyhee, ID	CEAC
Payette, ID	Micro
Power, ID	CEAC
Shoshone, ID	CEAC
Teton, ID	Rural
Twin Falls, ID	Micro
Valley, ID	CEAC
Washington, ID	CEAC