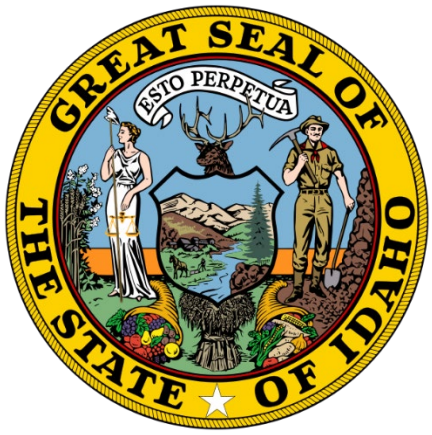

Idaho Section 1332 Waiver Application
Extension of the Reinsurance Program and Covered Choice Amendment

November 14, 2025

DRAFT

Idaho Department of Insurance

Dean Cameron, Director

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Section I – Executive Overview

Idaho respectfully submits for approval this Section 1332 State Innovation Waiver application, combining a four-year extension of the state's successful reinsurance program with an amendment that expands coverage options for Medicaid-eligible individuals at or above 100% of the federal poverty level (FPL), which will be referred to as "Covered Choice." This integrated approach will continue to reduce individual market QHP premiums by leveraging federal pass-through funding generated by Idaho's proven reinsurance program while advancing the Affordable Care Act's goals of expanded coverage and consumer choice.

Idaho's application represents a carefully structured approach to coverage innovation. The state's existing reinsurance program has exceeded initial projections, achieving 12% individual market health insurance premium reduction in 2023, 16% in 2024, 20% in 2025, and 18% in 2026 (compared to 7-12% projected). The federal savings generated through reduced Premium Tax Credit (PTC) expenditures are passed through to Idaho to pay the reinsurance program claims.

The Covered Choice amendment, mandated by Idaho House Bill 345 (2025), allows Medicaid-eligible individuals and households with income at or above 100% FPL to choose between traditional Medicaid enrollment or QHP coverage with PTC. Providing these Idahoans choice respects their individual situations and preferences while maintaining comprehensive coverage and strong consumer protections. Importantly, the federal cost impact of Covered Choice is limited to any incremental cost (compared to the federal cost of Medicaid coverage) of providing the PTC, based on the applicable percentage of household income, and not the full commercial premium. Idaho proposes to fund any incremental federal cost of the Covered Choice program to maintain overall federal deficit neutrality. With that approach, Idaho can maintain the market benefits of its reinsurance program while expanding coverage options for this "Choice" population – those who choose a QHP with PTC rather than Medicaid, based on their own evaluation of their situation and needs.

Compliance with Statutory Guardrails

Comprehensiveness

The waiver extension and amendment continue to meet the comprehensiveness guardrail as they do not reduce or modify Idaho's Essential Health Benefits (EHBs). The reinsurance program and both coverage pathways of the Covered Choice program—Medicaid and Qualified Health Plans (QHPs) through Your Health Idaho (YHI)—provide access to comprehensive coverage meeting or exceeding the EHB requirements. The amendment does not eliminate any option, only adds similarly comprehensive alternative coverage options.

Affordability

The waiver extension and amendment maintain affordability for the affected populations. The reinsurance program creates significantly more affordable QHPs than without the waiver. The Covered Choice amendment does not adjust any affordability provision of the ACA. It improves the affordability of commercial health insurance coverage for individuals who otherwise are not eligible to receive PTC due to Medicaid eligibility, while retaining the option for households to return to Medicaid at any point. Covered Choice eligible households who do not choose a QHP with PTC will continue to receive Medicaid coverage, consistent with current law.

Coverage

Idaho projects the waiver will maintain the number of residents with coverage. The reinsurance program reduces individual market QHP premiums, which may lead to households who do not qualify for PTC to purchase coverage. Covered Choice only provides access to more affordable commercial coverage options to Medicaid-eligibles over 100% FPL who may prefer it based on their individual circumstances and preferences. It therefore maintains overall enrollment among that population.

Deficit Neutrality

The integrated program design achieves federal deficit neutrality over the five-year waiver period. Federal savings from reinsurance-driven PTC reductions are the source of funding for the reinsurance program (the extension), and Idaho ensures that the Covered Choice program (the amendment) also maintains deficit neutrality by offsetting any incremental federal cost compared to Medicaid coverage.

Implementation Timeline and Federal Coordination

The amended waiver will be effective January 1, 2027, aligning both the reinsurance extension and Covered Choice for a unified five-year term through December 31, 2031. This represents an early four-year extension of the current reinsurance program (which expires December 31, 2027) to ensure seamless integration of both components.

Idaho has engaged extensively with the Centers for Medicare & Medicaid Services (CMS) and Department of the Treasury (Treasury) throughout the development process. These federal partners have provided both regulatory and technical feedback, which Idaho has addressed in this application.

Idaho Department of Insurance (IDOI) will continue to work closely with Your Health Idaho (YHI) and Idaho Department of Health and Welfare (IDHW) regarding the "Choice" population. IDHW and YHI will be coordinating and implementing needed changes regarding Covered Choice eligibility, enrollment, and monitoring with both state and federal partners where needed.

State Authority and Legislative Mandate

On March 23, 2022, Governor Little signed House Bill 611, which modified Title 41, Chapter 55 of Idaho Code. This legislation allowed the state to develop a section 1332 waiver application to submit to the Departments. Under this authority, Idaho established its risk stabilization strategy to implement the reinsurance program.

Idaho House Bill 345, enacted in 2025, established Chapter 22, Title 56, Idaho Code and provided legislative authority and direction for this waiver application amendment. The legislation requires the Idaho agencies submit necessary waivers, one of which specifically authorizes the Covered Choice program for Medicaid-eligible individuals at or above 100% FPL.

Section II – Evidence of State Authority

Idaho continues to possess authority for the reinsurance program already in place, and the Idaho Legislature provided legislative authority to pursue and implement this Section 1332 waiver amendment through Idaho House Bill 345, enacted in 2025, to provide the proposed choice to certain Medicaid-eligible individuals.

Existing Reinsurance Program Authority

The Idaho Individual High Risk Reinsurance Pool operates under authority established in Title 41, Chapter 55 of Idaho Code, which authorizes the Director of the IDOI to establish and operate reinsurance programs to stabilize the individual health insurance market. The current Section 1332 waiver, approved August 2022, operates under this ongoing authority.

Legislative Authorization of the Covered Choice Amendment

Idaho House Bill 345 (2025), signed into law March 19, 2025, establishes in Section 56-2205(1), Idaho Code that:

> *The [Idaho] department of health and welfare is authorized to and shall submit to the centers for medicare and medicaid services the following state plan amendments and*

waivers no later than July 1, 2026: [...] (b) Allow persons eligible for medicaid under section 56-267, Idaho Code, who have a modified adjusted gross income at least at or above one hundred percent (100%) of the federal poverty level to receive the advance premium tax credit to purchase a qualified health plan through the Idaho health insurance exchange established by chapter 61, title 41, Idaho Code, instead of enrolling in medicaid, except that the person may choose to enroll in medicaid instead of receiving the advance premium tax credit to purchase a qualified health plan.

The full text of Idaho House Bill 345 (2025) is included as Attachment B.

Section III – Provision(s) of the Law that the State Seeks to Waive

Idaho requests waiver of specific provisions of the Affordable Care Act necessary to implement both the reinsurance program extension and Covered Choice amendment.

For Reinsurance Program Extension

Section 1312(c)(1) of the ACA – Single Risk Pool Requirement (Individual Market)

- **Current Waiver Status**: Currently waived through December 31, 2027
- **Extension Request**: Extend waiver through December 31, 2031
- **Rationale**: No proposed change from approved waiver plan: waiver of the single risk pool requirement to the extent it would otherwise require excluding total expected state reinsurance payments when establishing the market-wide index rate, enabling carriers to consider reinsurance payments in rate development and pass premium savings to consumers

For Covered Choice Amendment

Internal Revenue Code Section 36B(c)(2) – Definition of Coverage Month

- **New Waiver Request**: Waive provisions that exclude individuals otherwise eligible for Medicaid from premium tax credit eligibility
- **Scope**: Limited to individuals who affirmatively choose QHP coverage; does not affect automatic Medicaid enrollment processes

- **Rationale**: Enable Medicaid-eligible individuals with income at or above 100% FPL to receive PTC if they choose a QHP over Medicaid enrollment

Internal Revenue Code Section 36B(f)(2) – Excess Advance Payments

- **New Waiver Request**: Waive provisions that would require PTC repayment if the tax credit allowed would have gone to zero upon filing taxes, due to a household's income resulting to be below 100% FPL
- **Scope**: Limited to individuals who affirmatively choose QHP coverage and whose income was expected to exceed 100% FPL at application
- **Rationale**: The individual remains Medicaid-eligible below 100% FPL, so allowing the PTC to be claimed does not affect the federal deficit neutrality presented in this application, and it protects "Choice" individuals from having to repay the full PTC if their income decreases during the year

Section 1402(f)(2) of the ACA – Cost-Sharing Reduction Eligibility

- **New Waiver Request**: Waive to the extent necessary to ensure individuals choosing QHP coverage have access to appropriate cost-sharing reductions
- **Scope**: Limited to individuals who affirmatively choose QHP coverage
- **Rationale**: Ensure affordability protections for low-income individuals regardless of coverage choice

These targeted waivers represent the minimum necessary to implement Idaho's integrated program while maintaining all consumer protections and federal oversight mechanisms.

Use of Pass-through Funding

The state is seeking to continue to receive federal pass-through funding to implement the state reinsurance program. The federal pass-through funds are generated by a reduction in individual market premiums, which in turn reduces the amount of federal funds expended on PTC for Idaho residents. No changes are being proposed to the federal calculation method for the pass-through funds. Idaho is proposing that any potential federal deficit increase created by the Covered Choice amendment would be offset by the state through an approved reconciliation method.

Section IV – Description of Application

Reinsurance Program Extension Component

Current Program Structure and Performance

Idaho's reinsurance program operates through the Idaho Individual High Risk Reinsurance Pool, providing reinsurance to participating insurers that is invisible to all enrollees, reducing premiums through strategic mitigation of claims of specified high-risk medical conditions. The insurer pays a monthly reinsurance premium to cede a portion of the risk of enrollees with those identified conditions. The program's plan of operations, which includes the program parameters and covered health conditions, is published on the IDOI's website. All board meetings are open to the public.

Demonstrated Performance Metrics (2023-2026)

The program's success stems from its board's authority to establish a target premium reduction annually, taking into account market conditions and available funding. All individual market QHP insurers reduce their premium rate filings by that target premium reduction. The board establishes the year's reinsurance parameters, such as the attachment point, reinsurance maximum, and claim coinsurance percentage, to produce the target premium reduction based on actuarial analysis. The board can also evaluate and change the health conditions that are ceded to the program by the participating insurers.

The reinsurance program's actual performance exceeded original expectations. The 2022 waiver application projected premium reductions of 7-12%, but actual reductions ranged from 12-20%. The larger savings are primarily due to greater state funding than originally projected. Similarly, enrollment growth exceeded projections, with 2025 enrollment reaching 122,000 compared to the original baseline projection of approximately 92,000.

Table 1. Idaho Reinsurance Program Data

Calendar Year	2023	2024	2025	2026
Premium Reduction %	12%	16%	20%	18%
Attachment Point	$50,000	$40,000	$35,000	$45,000
Coinsurance Percent	70%	75%	75%	75%
Reinsurance Cap	$665,000	$720,000	$723,750	$716,250
Claim Maximum	$1,000,000	$1,000,000	$1,000,000	$1,000,000
Insurer Premium PMPM	$341	$100	$100	$130
Individual Enrollment (on and off exchange)	92,431	108,640	122,000 *	104,000 *

Calendar Year	2023	2024	2025	2026
Aggregate Premium w/o Reinsurance	$599.1 M	$727.3 M	$893.2 M *	$847.5 M *
Aggregate Premium Savings w/Reinsurance	$71.9 M	$116.4 M	$178.64 M *	$152.5 M *
Federal Savings/ Pass-Through	$51.5 M	$97.9 M	$148.7 M *	$107.2 M *
State Funded	$18.7 M	$33.5 M	$36.6 M *	$45.3 M *
Reinsurance Payments	$94.4 M	$139.8 M	$192.9 M *	$160.9 M *

* 2025 and 2026 enrollment and total dollars are estimates.

Idaho's reinsurance program has consistently met all four statutory guardrails required under 42 U.S.C. § 18052(b)(1). See Section V for additional discussion of how the program meets each guardrail.

Operational Excellence

Idaho's reinsurance program operates with minimal administrative burden, leveraging existing carrier reporting mechanisms and established governance structures. The program's board includes the Director of the IDOI, representatives of insurers, insurance producers, consumer advocates, and state legislators, ensuring comprehensive stakeholder representation and accountability.

Extension Parameters and Projections

The four-year extension (2028-2031) will maintain the current program's fundamental structure while preserving flexibility for parameter adjustments based on market evolution and funding availability. Projected premium impact modeling indicates continued reductions averaging 10% compared to the without-waiver baseline.

Key Extension Elements

- Continuation of invisible-to-consumer reinsurance model to reduce gross premiums
- Preservation of conditions-based approach
- Annual parameter adjustment authority responding to market conditions
- Maintenance of existing governance and operational structures
- Continued state funding

Covered Choice Amendment Component

Eligible Population and Framework

The Covered Choice program applies to Idaho residents eligible for Medicaid under Section 56-267, Idaho Code, with modified adjusted gross household income at or above 100% FPL. These individuals will be presented with a clear choice during the eligibility determination process:

Option 1 - Traditional Medicaid Enrollment

- Standard Medicaid benefits with minimal cost-sharing
- Continuation of existing Medicaid protections and services
- Access to Idaho's Medicaid provider network

Option 2 - QHP Coverage with PTC

- Reduced net premium through PTC, which is based on the applicable percentage of household income and the available second lowest-cost Silver QHP (SLCSP)
- Selection from 94% actuarial value Silver QHPs offered through YHI by up to eight participating insurers, depending on the county
- All consumer protections of Title I of the ACA, including income-based cost-share reductions and non-discriminatory benefit designs
- Access to a choice of commercial provider networks

Consumer Protection and Decision Support

Section V of this application demonstrates specifically how the Covered Choice amendment meets the four waiver guardrails. Idaho has carefully considered and is proposing several program design components that go further than required by the guardrails, to ensure Idahoans are able to make informed decisions between their coverage options.

Idaho will implement additional consumer protection mechanisms ensuring informed choice without coercion or adverse selection, including:

- Decision support tools
- Coverage flexibility
- No wrong door policy
- Exchange enrollment directed to reduced cost sharing QHPs

Decision Support Tools

IDHW and YHI will develop consumer decision support tools presenting information such as:

- Potential monthly premium costs after PTC application
- Annual deductibles and out-of-pocket maximums
- Provider network composition and accessibility
- Prescription drug formulary coverage
- Additional benefits and services

See Attachment C for an example of a coverage comparison decision support tool.

Coverage Flexibility

The "Choice" individuals (those who have chosen a QHP rather than Medicaid) retain the right to return to Medicaid at any time by cancelling their QHP and contacting Medicaid, and the individuals may change QHP coverage selection during:

- New Medicaid eligibility
- Annual open enrollment period
- Qualifying life events, as defined by federal regulations

No Wrong Door Policy

Regardless of initial application point (*e.g.* YHI, IDHW, or community assisters), individuals receive consistent information and support for coverage decisions.

Cost Sharing Protections

Medicaid participants may currently be charged a copay of $3.65 per visit for certain outpatient services. The copay is anticipated to increase to $4.00 per visit on July 1, 2026. This change is consistent with Idaho House Bill 345 (2025), which requires IDHW to apply Medicaid participant cost-sharing "that is at least to the levels developed by other states and up to the maximum charged by other states." See Attachment D for additional details. Public Law 119-21, Section 71120 requires that before October 1, 2028, state Medicaid programs institute cost-sharing of up to $35 per service for adults in expansion population with incomes over 100% FPL, with households not paying more than 5% of their income, applied on a quarterly or monthly basis.

The "Choice" population are provided all the consumer protections of Title I of the ACA, which include the strongest cost sharing reduction (CSR) of 94% actuarial value Silver QHPs, rather than the standard 70% actuarial value Silver QHPs. The 94% CSR plans typically include copays between $0 and $10 per medical service or generic drug prescription, a deductible between $0 and

$100, and additional mandated consumer protections to ensure affordability and non-discriminatory benefit design. To ensure that "Choice" households benefit from all Title I of the ACA consumer protections, YHI will implement a system change to limit their QHP selection to only the 94% CSR plans, rather than also showing the Bronze, Gold, and Platinum QHPs that have higher cost sharing.

Applicability of Public Law 119-21 Redeterminations for Expansion Population

The following provisions of H.R. 1, which became Public Law 119-21, will be applied to the expansion population, regardless of enrollment in Medicaid or a QHP with PTC.

- Section 71107: Eligibility Redeterminations. States must redetermine expansion population every 6 months. Certain individuals, such as those eligible due to disability, those over age 65, and tribal members are exempt and will be redetermined every 12 months.
- Section 71112: Retroactive Coverage. Limits retroactive coverage to 1 month for adults in expansion population and 2 months for other Medicaid eligibility groups and CHIP.
- Section 71119: Required Medicaid Community Engagement for Certain Recipients (Work Requirements). Requires Able Bodied Adults Without Dependents (ABAWDs) aged 19 to 64 in expansion population or "Choice" population receiving PTC to complete 80 hours a month of work, education, community or a combination to retain eligibility for benefits. See Attachment E of this application for exceptions.
- Section 71120: Cost Sharing Requirements of Some Expansion Individuals. Requires cost sharing for adults in expansion population with incomes over 100% FPL. Cost sharing between $0 to $35 per service, with households not paying more than 5% of their income, applied on a quarterly or monthly basis. Exempts cost sharing for primary, prenatal and pediatric services, emergency care (except for non-emergency care use of the emergency room), behavioral health services, and services provided by Federally Qualified Health Centers (FQHCs) and rural health clinics.

Integration with Public Law 119-21 Community Engagement Requirements

Idaho's Covered Choice implementation maintains full integration with Public Law 119-21 community engagement requirements. Individuals cannot circumvent the requirements by selecting QHP coverage over Medicaid.

- IDHW maintains oversight for community engagement compliance across both coverage pathways
- Work/community engagement hours tracked through integrated reporting systems

- Exemptions (medically frail, caregivers, students) applied consistently regardless of coverage choice
- Non-compliance penalties enforced uniformly across both coverage options

IDHW will accomplish this through:

- Data sharing protocols between IDHW and YHI ensure comprehensive compliance monitoring
- Monthly reconciliation processes verify engagement hours across coverage types
- Consumer notifications clearly communicate that requirements apply regardless of coverage selection

Federal Cost Structure and Budget Impact

The amended waiver, which includes the current reinsurance program and the Covered Choice program as proposed, will maintain federal deficit neutrality, consistent with the waiver guardrails. Idaho's pass-through funding, which is currently utilized by the waiver reinsurance program, will continue to be determined as is currently done.

The Covered Choice deficit neutrality is achieved by annually calculating any incremental federal cost per "Choice" household, as measured across both the direct federal PTC cost increases and the direct federal Medicaid cost decreases, and Idaho remitting a payment for the total incremental federal cost to CMS or Treasury through an approved reconciliation method. If there is incremental federal *savings* per "Choice" household, then the Covered Choice program will have met federal deficit neutrality and the payment amount will be $0. The included actuarial analysis and certification projects that no payment will be needed, given current assumptions.

Any net federal cost for the "Choice" population may have some impact on the reinsurance program's premium reduction. The size of that impact is heavily dependent on two factors: (1) the net federal cost PMPM, and (2) the number of Idahoans who utilize Covered Choice. The actuarial analysis includes sensitivity testing regarding this uptake and its expected impacts, if any, to the reinsurance program's QHP premium reductions. The program's board would account for any such impact when annually setting the reinsurance parameters.

Due to the high degree of uncertainty surrounding the uptake of Covered Choice, Idaho proposes that any total incremental federal cost for Covered Choice be retrospectively determined, after actual uptake is known. This retrospective approach is consistent with the intent of the deficit neutrality guardrail by prioritizing the accuracy of the payment calculation, given the uncertainty of the program's uptake. For ease of administration, if a payment is needed for the Covered Choice program to meet federal deficit neutrality for a given year, Idaho proposes that the Covered Choice

payment be reconciled by applying it as an offset to the pass-through funding amount calculated for the subsequent calendar year.

For example, the calendar year 2027 pass-through funding would be prospectively determined, as it is now. The 2027 "Choice" population incremental federal cost (or savings) amount would be retrospectively determined (after the end of a calendar year) based on actual lives who opted out of Medicaid and enrolled in a QHP with PTC. The calendar year 2028 pass-through funding would again be prospectively determined based on the actual individual market QHP premium reduction and anticipated enrollments, with a pass-through funding payment offset equal to any incremental federal cost of the 2027 "Choice" population. Each subsequent year would be similarly reconciled.

While Idaho believes that the proposed reconciliation method provides the most accurate method to ensure federal deficit neutrality, particularly given the uncertainties of initial program uptake, the state remains open to alternative approaches to the reconciliation process that may prove more operationally efficient for CMS and Treasury while achieving the same accuracy.

Implementation of Systems and Infrastructure

YHI Exchange Modifications

- Enhanced consumer interface with decision support tools
- Integration with Idaho Medicaid for seamless enrollment regardless of choice
- Eligibility determination system updates to support Idahoan's informed decision to decline Medicaid and choose PTC
- Enrollment system updates to enable one month of retroactive coverage in a QHP
- Shopping system updates to present only the 94% actuarial value Cost-Sharing Reduction (CSR) Silver QHPs for "Choice" population
- Administering a special enrollment period for individuals newly eligible for Medicaid and Covered Choice who elect PTC over Medicaid
- "Choice" eligibility reconciliation process with IDHW

Tax Administration Coordination

- YHI issues Form 1095-A for households who choose QHP coverage
- Clear consumer education on tax implications and reconciliation requirements
- Coordination with IRS for appropriate tax credit administration

Integrated Program Monitoring and Adjustment Framework

Idaho commits to meet all waiver reporting requirements of CMS or Treasury. Idaho will also perform comprehensive monitoring and evaluation of both waiver components, including:

- Reinsurance program covered lives and premium impact
- "Choice" population by income level and coverage selection
- Demographic analysis of "Choice" population
- Federal pass-through funding utilization
- Budget neutrality tracking against projections
- Premium trends in individual and small group markets

Idaho maintains authority to adjust either program's parameters within approved waiver terms to ensure continued compliance with statutory guardrails and budget neutrality requirements. Potential adjustments include:

- Reinsurance attachment points and coinsurance rates
- Covered high risk medical conditions
- Consumer education and outreach strategies
- Decision support tool enhancements
- Administrative process improvements

Section V – Program Outcomes and 1332 Guardrails

Idaho engaged Milliman, Inc. to perform actuarial and economic analyses related to this waiver application. The actuarial and economic analyses and certifications support Idaho's proposed waiver extension and amendment meeting all four of the section 1332 guardrails. Those analyses and certifications are included as Attachment A.

Idaho proposes no changes to the reinsurance program with this waiver extension, therefore the program will continue to meet all section 1332 guardrails as demonstrated in the initial application. Idaho's Covered Choice program will similarly meet each of the four section 1332 guardrails as demonstrated herein.

Comprehensive Coverage Assessment – Section 1332(b)(1)(A)

As required under section 1332(b)(1)(A) of the ACA (the comprehensive coverage requirement), any approved waiver will provide coverage that is at least as comprehensive *overall* as the coverage defined in section 1302(b) of the ACA and 45 CFR 156.110, known as the Essential

Health Benefits (EHBs). In accordance with 45 CFR 155.1308, the coverage under the waiver should be forecasted to be at least as comprehensive ***overall*** for State residents as coverage absent the waiver.

The reinsurance program reimburses insurers for high-cost claims without modifying plan designs or EHBs. All individual market plans continue to meet the same coverage requirements, and therefore the reinsurance program extension will allow for plans that are as comprehensive as without the waiver.

The proposed Covered Choice program similarly does not modify or reduce EHB, nor does it remove any eligibility or access to Medicaid coverage. Therefore, the proposed waiver amendment also meets the comprehensive coverage requirement.

Covered Choice Comprehensive Coverage Assessment

Both Medicaid and QHPs provide comprehensive coverage that meets or exceeds Essential Health Benefits requirements as defined in section 1302(b) of the ACA and 45 CFR 156.110.

Medicaid Coverage Components

- All ten EHB categories with no annual or lifetime limits
- Additional non-EHB benefits including non-emergency transportation, enhanced behavioral health services, and comprehensive adult dental coverage

QHP Coverage Components

- All ten EHB categories with no annual or lifetime limits
- Insurers can choose to include non-EHB benefits, but it is not required
- Standardized actuarial value designations and non-discrimination coverage rules

Individual's Choice to Maximize Coverage with Covered Choice

While there are distinctions between Medicaid and QHP coverage, both offer comprehensive coverage as defined in section 1302(b) of the ACA by covering at least all EHBs. Providing households with access to additional coverage choices does not reduce the comprehensiveness of their coverage; it empowers households to choose the coverage that works best for their specific needs.

Affordability Protection Mechanisms – Section 1332(b)(1)(B)

As required under section 1332(b)(1)(B) of the ACA (the affordability requirement), any approved waiver will provide coverage and cost sharing protections against excessive out-of-pocket spending that are at least as affordable as the provisions of Title I of the ACA would provide. In accordance with 45 C.F.R 155.1308, the coverage under the waiver should be forecasted to be at least as affordable ***overall*** for State residents as coverage absent the waiver.

The reinsurance program reimburses insurers for a portion of certain high-cost claims, and it requires insurers to reduce the gross premium they charge enrollees by the expected premium savings. By decreasing individual market premiums and not affecting the other ACA Title 1 protections, such as protections against excessive out-of-pocket costs, the reinsurance program extension significantly improves the affordability of QHPs compared to without the waiver.

The proposed Covered Choice program similarly does not modify or reduce any ACA Title 1 protections, nor does it remove any eligibility or access to Medicaid coverage. Therefore, the proposed waiver amendment also meets the affordability requirement.

Premium Contribution Limits

This waiver extension plus amendment improves affordability *overall* through reduced QHP premiums (reinsurance program) for all individual market enrollees and by maintaining the Title I of the ACA protections, including premium contributions and cost sharing, for those that opt out of Medicaid to purchase a QHP (Covered Choice program). In other words, in addition to the waiver extension plus amendment improving affordability overall by significantly reducing individual market premiums, which meets the affordability guardrail, the Covered Choice program further ensures that *every eligible individual* obtains all protections against excessive out-of-pocket spending that Title I of the ACA provides.

At or Above 100% FPL Population Choosing QHPs

- Premium contribution capped at the applicable indexed % of household income through PTC, which is deemed affordable for that household by federal statute
- Only the 94% actuarial value CSR Silver QHPs are offered, which provide strong affordability protections regarding out-of-pocket expenses
- Affordability is maintained even if a household's income drops below 100% FPL during the calendar year, by retaining the household's PTC eligibility

Impact on Remaining QHP Population

- Reinsurance program reduces gross premiums for all QHP enrollees and net premiums for all QHP enrollees who choose a QHP other than the SLCSP
- PTC recipients benefit from lower benchmark premiums, reducing federal and individual costs when not enrolling in the SLCSP
- Unsubsidized enrollees benefit from the reinsurance program's full premium reduction

Choice and Overall Market Affordability

Similar to the comprehensiveness guardrail, providing households access to additional coverage choices does not reduce the affordability of their coverage; it empowers households to choose the coverage that works best for their specific needs. Every individual and household who would be eligible for Medicaid coverage without the proposed waiver amendment will continue to have that same option to maintain Medicaid coverage, with no change to its affordability. The "Choice" population also benefits from the strong affordability provisions of the ACA, including PTC and CSR. Overall, the affordability of Idaho's individual health insurance market is greatly improved by the combined reinsurance and Covered Choice programs, while offering households more options for coverage that meets their specific needs.

Scope of Coverage Maintenance – Section 1332(b)(1)(C)

As required under section 1332(b)(1)(C) of the Affordable Care Act (the scope of coverage requirement), any approved waiver will provide coverage to at least a comparable number of residents as the provisions of Title I of the ACA would otherwise provide. For each year the section 1332 waiver will be in effect, Idaho forecasts at least a comparable number of residents will have healthcare coverage than would have had absent the waiver.

The primary mechanism for any increased coverage numbers is the improved affordability of unsubsidized QHPs in the individual health insurance market due to the reinsurance program's premium reduction. The Covered Choice program does not eliminate or change the comprehensiveness or affordability of Medicaid or QHP coverage, and it is therefore projected to have no additional impact on the scope of coverage.

Federal Deficit Neutrality Demonstration – Section 1332(b)(1)(D)

As prohibited under section 1332(b)(1)(D) of the ACA (the federal deficit requirement), an approved waiver will not increase the federal deficit. As demonstrated in the initial waiver application and this extension application, Idaho's reinsurance program reduces federal PTC costs

by reducing individual market QHP premiums. The calculated reduction in federal PTC costs is passed through to Idaho and utilized by the reinsurance program to further reduce premiums. The reduced individual market premiums are expected to lead to higher enrollment of individuals who do not qualify for PTC; however, such enrollees do not impact federal PTC costs and therefore do not increase the federal deficit.

If there is determined to be any incremental federal cost attributable to the "Choice" population during any year of the waiver's operation, Idaho will maintain federal deficit neutrality by offsetting the incremental federal cost to CMS or Treasury through an approved reconciliation method. The included actuarial analysis and certification projects that no such offset will be needed, given current assumptions.

Demonstration Approach

To demonstrate compliance with this guardrail, the attached actuarial and economic analyses evaluated the following scenarios:

1. Baseline/Without-Waiver Scenario

- No reinsurance program
- No Covered Choice provisions
- Status quo for Expansion populations
- Standard marketplace with full premium costs and standard PTC

2. With Approved Waiver Extension Only Scenario (Reinsurance Only)

- Reinsurance program extension without Covered Choice
- Continue gross premium reductions
- Pass-through funding used only for the reinsurance program
- Status quo for Expansion Medicaid-eligible populations

3. With Approved Waiver Extension and Amendment Scenario (Both)

- Reinsurance extension *AND* Covered Choice amendment approved
- Allow 100%+ FPL Medicaid-eligible individuals to choose a QHP with PTC
- Use net pass-through funding for reinsurance and any Covered Choice offset
- Integrated program achieving overall deficit neutrality and other guardrails

Analysis by Population Cohort

The federal deficit neutrality of Covered Choice is dependent on the changes to five key Medicaid-eligible cohorts at or above 100% FPL, each requiring specific analysis:

- Cohort 1 - Currently enrolled in Medicaid and remaining: no cost impact, due to no change in coverage
- Cohort 2 – Currently enrolled in Medicaid but not meeting Public Law 119-21 community engagement requirements
- Cohort 3 – Currently not enrolled in Medicaid and not choosing any coverage
- Cohort 4 – Currently enrolled in Medicaid and choosing QHP with PTC
- Cohort 5 – Currently not enrolled in Medicaid and choosing QHP with PTC

Under the waiver scenario, the cohorts are projected to affect the federal deficit as follows:

- Cohorts 1, 2, and 3 are projected to have no federal deficit impact. Their costs are unchanged by Covered Choice.
- Cohort 4 could increase the federal deficit only during any year where the cost to provide PTC exceeds the per-enrollee federal share of the cost of Medicaid coverage.
- Cohort 5 is projected to increase the federal deficit equal to the full PTC.

Section VI – Public Notice and Input

Idaho has ensured that stakeholder engagement is clearly communicated with sufficient notice, accessible, and responsive. Stakeholders have many different opportunities to engage with and comment on all aspects of this waiver application. By taking a multi-pronged approach to engaging and updating the public, Idaho has ensured stakeholders have multiple ways to provide input on the waiver extension.

Tribal Consultation

Idaho will conduct meaningful tribal consultation with the five federally recognized tribes within the state:

- Coeur d'Alene Tribe
- Kootenai Tribe of Idaho
- Nez Perce Tribe
- Shoshone-Bannock Tribes
- Shoshone-Paiute Tribes

Consultation Process

- Initial notification: November 14, 2025
- Formal consultation meetings, if requested: November 17 – December 5, 2025
- Written comment period: November 14 - December 22, 2025
- Response to tribal input: Incorporated in final application

Key Discussion Topics

- Impact on tribal members' coverage options
- Coordination with Indian Health Service
- Preservation of tribal premium sponsorship programs
- Network adequacy in tribal service areas

State Public Comment Process

Public Notice Requirements

Idaho will exceed minimum federal requirements with 3 public hearings throughout the state and a public comment period of more than 30 days:

- Draft application posting: November 14, 2025
- Public comment period: November 14 - December 22, 2025
- Public hearings: November 21, 2025, December 5, 2025, and December 10, 2025

Public Hearing Structure

- Virtual and in-person options at each of the three meetings, ensuring statewide accessibility
- Real-time Spanish interpretation and ASL services available upon request
- Recorded sessions available for later viewing
- Written comment submission through multiple channels

Stakeholder Engagement

Targeted outreach to key stakeholder groups including:

- Consumer advocacy organizations
- Insurance carriers and associations
- Healthcare provider organizations
- Employer groups and chambers of commerce

- Community health centers and safety net providers

Section VII – Timeline for Implementation

With approval of the waiver, Idaho will be able to continue the reinsurance program and provide additional options to the Covered Choice program eligible population. The timeline to extend the reinsurance program and implement the Covered Choice program is as follows:

2025: Drafting and Public Comment Process

Q3 2025

- September: Draft application development, engage actuarial resources
- October 1: Submit Letter of Intent to CMS

Q4 2025

- November 14: Publish draft application and begin public comment
- November 19: Tribal consultation meetings
- November 21: First public hearing, Boise
- December 5: Second public hearing, Coeur d'Alene
- December 10: Third public hearing, Idaho Falls
- December 22: Close public comment period

2026: Submission, Federal Review and Approval Process

Q1 2026

- January: Incorporate public input and finalize application
- January x: Submit final application to CMS and Treasury
- February-March: 45-day preliminary completeness review

Q2-Q3 2026

- April 1: Begin 180-day federal review period
- April 15-May 15: 30-day federal public comment period
- June-August: Federal review and state responses to questions
- September 30: Target federal approval date

Q4 2026

- October: YHI system updated and implemented for open enrollment
- October: Consumer education campaign launch

2027: Program Launch

January 1, 2027

- Covered Choice provisions operational
- Enhanced consumer support services active

Ongoing Monitoring and Reporting

- Enrollment tracking during initial implementation
- Stakeholder coordination calls
- Federal reporting on enrollment and budget impact

Attachment A: Actuarial and Economic Analyses and Certifications

MILLIMAN REPORT

Section 1332 Waiver Amendment Actuarial Certification and Economic Analyses

Prepared for the State of Idaho, Department of Insurance

November 14, 2025

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Milliman


Milliman

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Executive Summary

Milliman, Inc. (Milliman) has been engaged by the State of Idaho, Department of Insurance (IDOI) to provide actuarial and consulting services related to its operation of the Idaho High Risk Reinsurance Pool (reinsurance program) under an existing Section 1332 waiver that was approved by the Centers for Medicare & Medicaid Services (CMS) on August 16, 2022 for an effective period from January 1, 2023 to December 31, 2027.[1] The State is seeking an extension of the reinsurance program under the waiver through December 31, 2031, and is also requesting an amendment to the Section 1332 waiver to implement Covered Choice effective January 1, 2027. Covered Choice would allow an individual with income of at least 100% of the federal poverty level (FPL) who is eligible for Medicaid expansion coverage the option to alternatively purchase individual market coverage in Your Health Idaho and receive a federal premium tax credit (PTC).

This report provides the required actuarial analysis, certification, and economic analyses supporting the State's determination that the reinsurance program extension and Covered Choice amendment meet the requirements for a Section 1332 waiver. The information contained in this report is consistent with CMS requirements for Section 1332 waiver extension and amendment applications.[2]

Note, the assumptions contained in this report are based on laws and available regulations as of November 7, 2025. Legislative or regulatory changes impacting either the individual health insurance market, including the calculation of PTC value, or Medicaid may have material impacts on the estimates provided in this report. We have estimated federal pass-through funding under the Section 1332 waiver amendment consistent with the State's proposed pass-through calculation in its application. The values presented in this report are estimates and actual values are certain to vary by an unknown degree.

1332 waiver guardrails

For the State's waiver application to meet the federal requirements for a 1332 waiver, it must meet the following standards:

- *Scope of Coverage*: The 1332 waiver must provide health insurance to *at least* as many people as would be projected under the status-quo ACA (without waiver).
- *Affordability*: The 1332 waiver must provide coverage and cost sharing protections against excessive out-of-pocket spending that are at least as affordable as would be projected without the waiver.
- *Comprehensiveness*: The 1332 waiver must provide coverage at least as comprehensive (as defined by the ACA's essential health benefits) as would be projected without the waiver.
- *Deficit Neutrality*: The 1332 waiver must be deficit neutral to the federal government as would be projected without the waiver.

It should be emphasized that these requirements are in relation to scope of coverage, affordability, comprehensiveness, and deficit neutrality without the waiver. For example, a 1332 waiver is not required to result in more insured individuals relative to a period before its implementation. Rather, it must be estimated to ensure at least as many insured individuals are covered during the projection period relative to if the 1332 waiver was not implemented.

Our analysis indicates that Idaho's 1332 waiver meets the federal requirements cited above. The reinsurance program's operation through December 31, 2031, is anticipated to be consistent with the program approved by CMS in calendar year (CY) 2022. Covered Choice will offer an additional health insurance coverage option to certain Idahoans eligible for Medicaid expansion, but it does not make any changes to Medicaid in relation to eligibility requirements or available benefits in the absence of the Covered Choice amendment. We do not estimate any incremental federal cost increase from the Covered Choice program, as the federal PTC cost for Covered Choice is estimated to be less than the federal Medicaid expansion cost.

The remainder of the report provides the requested information in the CMS 1332 Waiver Checklist for a waiver extension and amendment.

[1] https://www.cms.gov/files/document/1332-id-approval-letter-stcs.pdf

[2] https://www.cms.gov/files/document/checklist-section-1332-waivers-final.pdf

Background

Milliman was engaged by IDOI to support a Section 1332 waiver extension for its reinsurance program and amendment for the Covered Choice program. This section provides background on the reinsurance program, Covered Choice amendment, and the actuarial and economic analyses requested by CMS.

APPROVED SECTION 1332 WAIVER FOR REINSURANCE PROGRAM

On August 16, 2022, the State of Idaho received CMS approval to implement a state reinsurance program (Idaho Individual High Risk Reinsurance Pool (Reinsurance Pool)) for plan years 2023 through 2027 (January 1, 2023 through December 31, 2027).[3] From the Section 1332 waiver, Idaho receives federal pass-through funding as a result of the reinsurance program reducing market premiums and corresponding federal premium tax credit expenditures. The specific premium rate reduction achieved by the reinsurance program is determined by the Reinsurance Pool's board on an annual basis based on available funding for the program. The State is seeking an extension of the reinsurance program through December 31, 2031.

COVERED CHOICE WAIVER AMENDMENT

Idaho House Bill 345 (HB 345), enacted in 2025, allows persons Medicaid-eligible under the Medicaid expansion population eligibility group, who have modified adjusted gross income of at least 100% FPL, the option of receiving federal premium tax credits (PTCs) to purchase a qualified health plan (QHP) through Your Health Idaho, the state exchange.[4] Covered Choice would become effective January 1, 2027. The State is not seeking federal pass-through funding for the Covered Choice amendment and proposes that any incremental cost (the net cost of additional federal premium tax credits less federal Medicaid savings) is offset by a reduction in federal pass-through funding generated by the reinsurance program.

CMS REQUESTED INFORMATION FOR REINSURANCE EXTENSION AND COVERED CHOICE AMENDMENT

The Centers for Medicare & Medicaid Services (CMS) has requested the State's Section 1332 waiver extension for the reinsurance program and Covered Choice amendment include the following information, consistent with the *Checklists for Section 1332 State Innovation Waiver Applications*[5]:

- Brief, updated economic and actuarial analyses that include updated projections and assumptions for the 4-year reinsurance program extension period.
- Identification of any significant policy changes impacting the assumption used to create the original budget projections in the initial Section 1332 waiver application.
- For the 5-year period beginning on January 1, 2027 (coinciding with implementation of Covered Choice and 4 year extension of the reinsurance program), actuarial and economic analyses that include for both without-waiver baseline scenarios and with-waiver scenarios the following information:
    - Total exchange enrollment
        - Subsidized (i.e., premium tax credit) enrollment on the exchange
        - Unsubsidized enrollment on the exchange
    - Off-exchange enrollment
    - Statewide average second-lowest cost silver plan (SLCSP) premiums (aggregate and per member per month (PMPM))
    - Statewide average gross and net premiums (aggregate and PMPM)
    - Premium tax credits (aggregate and PMPM)

[3] https://www.cms.gov/files/document/1332-id-approval-letter-stcs.pdf

[4] https://legislature.idaho.gov/sessioninfo/billbookmark/?yr=2025&bn=H0345

[5] https://www.cms.gov/files/document/checklist-section-1332-waivers-final.pdf

  - State funding for the waiver plan
  - State reinsurance reimbursements
  - Pass-through funding (e.g., federal PTC savings, net any offsets)

- For the amendment, similar to an initial waiver application, the analyses must also identify the impact of the amendment on the statutory guardrails and include both summary and detailed explanations and projections of the impact on the no waiver (baseline), the existing waiver, and the waiver amendment scenarios using data from recent experience. These analyses must also include an explanation of the estimated impact, if any, of the section 1332 waiver amendment on pass-through funding. In addition, the analyses must include the assumptions used to develop the projections. To support this analyses request, CMS requested the following scenarios be modeled:

  Scenario 1: Baseline, no reinsurance and no Covered Choice program (while reflecting current law)

  Scenario 2: With reinsurance program only (similar to the analysis submitted with the initial waiver, accounting for any state or federal law changes, changes to market, and updated projections and assumptions)

  Scenario 3: With waiver amendment (both reinsurance and Covered Choice programs)

The appendices of this report provide the requested CMS information for calendar years 2027 through 2031.

Appendix 1 provides estimated individual market ACA-compliant enrollment for each coverage year, with enrollment separately illustrated for the subsidized exchange, unsubsidized exchange, and off exchange populations.

Appendix 2 provides aggregate gross premium, gross premium PMPM, aggregate net premiums, and net premium PMPMs for the exchange and off exchange populations for the three modeled scenarios. To isolate the impacts of Covered Choice for Scenario 3, we have separately illustrated the premium information for the Covered Choice population with income between 100% and 138% FPL. In addition, Appendix 2 provides the statewide average SLCSP premium on an aggregate and PMPM basis.

Appendix 3 summarizes estimated exchange enrollment, PTC PMPM, and aggregate PTC for the Covered Choice and other exchange populations. In addition, estimated total reinsurance program funding, federal pass-through funding, and state-based reinsurance program funding are illustrated. Appendix 3 also illustrates estimated Covered Choice federal Medicaid savings (assuming a 90% federal medical assistance percentage (FMAP)), offsets to pass-through funding generated by the reinsurance attributable to Covered Choice, and ultimate estimated net pass-through funding estimated to be received by the State.

Note, Scenario 3 (reinsurance and Covered Choice) assumes a 20% Covered Choice take-up rate among eligible Medicaid expansion enrollees. Based on discussions with IDOI and Idaho Department of Health and Welfare (IDHW), this is a high take-up scenario. Our low take-up scenario for Covered Choice assumes a 0% take-up rate (based on zero out-of-pocket premium requirement to enroll in Medicaid coverage relative to net premiums equivalent to approximately 2% to 3% of household income with Covered Choice), which would result in market impact identical with Scenario 2.

The remainder of this report describes our assessment of how the State's Section 1332 waiver reinsurance program extension and Covered Choice amendment meets the statutory guardrails for a Section 1332 waiver. We have organized the report around the four statutory guardrails for Section 1332 waivers (Comprehensiveness, Scope of Coverage, Affordability, and Federal Deficit Neutrality), followed by a methodology section that describes key assumptions used in modeling individual market changes under the Section 1332 waiver, as well as Medicaid cost savings under Covered Choice.

The modeling results illustrated in this report and appendices are based on the State's proposed methodology for the federal pass-through calculation under the reinsurance extension and Covered Choice amendment as described in the extension and amendment request provided to CMS. The modeling results are not appropriate and will need to be updated to the extent the finalized pass-through calculation methodology differs from these assumptions.

Comprehensiveness

As required under 45 CFR 155.1308(f)(3)(iv)(A), a state's proposed 1332 waiver must provide coverage that is at least as comprehensive as the coverage defined in Section 1302(b) of the ACA. As described in CMS-9936-N, comprehensiveness refers to the scope of benefits provided by the coverage as measured by the extent to which coverage meets the requirements for essential health benefits (EHBs). Consistent with the initial 1332 waiver application, the reinsurance program makes no changes to EHB requirements in the individual market, fulfilling the comprehensiveness requirements of 45 CFR 155.1308(f)(4)(iv)(A). In addition, Covered Choice also does not make any changes to covered benefits in Medicaid or the individual market. While there are differences in covered benefits between Medicaid and EHBs, Covered Choice enrollees will have the option of either set of benefits, both of which are equal to or greater than EHB coverage in the non-waiver scenario.

Scope of Coverage

As required under 45 CFR 155.1308(f)(3)(iv)(C), a State's proposed waiver must provide coverage to at least a comparable number of its residents as the provisions of Title I of the ACA. Under Idaho's 1332 waiver reinsurance program (both Scenarios 2 and 3), we estimate the number of Idahoans with health insurance coverage will increase by approximately 1,000 persons per year relative to without the waiver (as illustrated in Appendix 1).[6] This is attributable to the assumption that the reinsurance program will reduce market premiums by approximately 10% each year during the CY 2027 through CY 2031 projection period. The additional enrollment is estimated to occur among non-subsidized populations (individuals not qualifying for premium assistance who will realize the full premium reduction from the reinsurance program) both on and off the exchange.

While ultimate enrollment in the individual market through Covered Choice is uncertain, we estimate that Covered Choice will not decrease overall health insurance enrollment. Although we assume that the individuals electing to use Covered Choice would most likely be otherwise enrolled in the Medicaid expansion population, it is possible some individuals may use Covered Choice to purchase subsidized individual market coverage that would have otherwise remained uninsured.

To support our assessment that the reinsurance extension and Covered Choice amendment meet the scope of coverage guardrail, Appendix 1 illustrates individual market enrollment among PTC-eligible and unsubsidized populations both on and off the exchange from CY 2026 through CY 2031 for the baseline, reinsurance only, and reinsurance and Covered Choice scenarios. In addition, differences between the first and second and first and third scenarios are illustrated.

Affordability

For the non-group market, the reinsurance program is estimated to reduce gross premium rates by approximately 10% (relative to without the waiver) over the CY 2027 to CY 2031 projection period. Note, for CY 2026, the reinsurance program is estimated to reduce premium rates by 18%[7], which is illustrated in Scenarios 2 and 3. The IDOI requires insurers to include the pre-determined impact of the reinsurance program in rate filings. Therefore, there is no variation in reinsurance impacts by carrier or plan. As a result of the reinsurance program, we estimate the ACA-compliant risk pool's average morbidity will improve because of higher insurance take-up rates among the population that has income above 400% FPL.

Under the ACA's premium assistance program (which assumes enhanced premium subsidies sunset effective December 31, 2025), qualifying households with income between 100% and 400% FPL (who do not qualify for Medicaid) have out-of-pocket premium expenses capped to a specified percent of income. To a large degree, we estimate most individuals that would receive premium assistance without the waiver will also receive premium assistance under the reinsurance program.

- For most of these individuals, the premium savings accrue to the federal government, as it reduces the amount of premium assistance necessary to ensure the out-of-pocket cost of coverage does not exceed the maximum specified by the ACA.

[6] The enrollment impact assumption was supported by an analysis of Section 1332 waiver impacts included in this report: https://www.soa.org/49617d/globalassets/assets/files/resources/research-report/2025/aca-at-15.pdf.

[7] https://doi.idaho.gov/wp-content/uploads/Health/ADDENDUM-1-2026-IDAHO-STANDARDS-FOR-QHP-and-QDP-5-22-25.pdf

- It is possible that some young adults and other persons with income approaching 400% FPL receiving premium assistance without the waiver will see out-of-pocket premiums fall below the maximum specified by the ACA under the reinsurance program. In these cases, only partial premium savings accrue to the federal government, while the consumer also directly benefits from the premium reduction.
- It is also possible that individuals purchasing a QHP with premium rates below the SLCSP (typically bronze-level coverage), will experience small net premium increases because of the reinsurance program compressing the dollar differential between their plan selection and the SLCSP.

For households not eligible for premium assistance, the full amount of premium rate reduction will be realized under the reinsurance program, with the federal government not accruing any savings. The reinsurance program is not estimated to impact premium rates for employer-sponsored insurance, nor change affordability for public programs such as Medicaid and Medicare. The above premium and net premium rate impacts are consistent with assumptions and modeling associated with the State's initial Section 1332 waiver application.

The Covered Choice program is estimated to have minimal impacts to individual market premiums. Under Scenario 3 (which is the high take-up scenario for Covered Choice), Covered Choice enrollment represents less than 4% of estimated total individual market enrollment. Because Covered Choice enrollees will only be eligible to enroll in silver-level QHP coverage (and receive the 94% cost-sharing reduction (CSR) plan), insurers would theoretically[8] need to incrementally increase CSR-loading on silver QHP coverage[9]. However, the impact of the reinsurance program (assumed 10% premium reduction from CY 2027 through CY 2031), would maintain premium rates that are more affordable relative to if the reinsurance program did not exist.

Covered Choice does not make any changes to Medicaid expansion coverage, which is assumed to not have any premium requirements and have cost sharing as described in Appendix C of the State's reinsurance extension and Covered Choice amendment request. While QHP coverage has additional premium and cost sharing requirements relative to Medicaid expansion coverage, it is entirely the consumer's choice to opt-out of Medicaid expansion and purchase QHP coverage with a federal PTC. This scenario is comparable with non-Covered Choice consumers electing to purchase more expensive QHP coverage relative to the lowest cost plans offered in Your Health Idaho.

To support our assessment that the reinsurance extension and Covered Choice amendment meets the affordability guardrail, Appendix 2 and Appendix 3 illustrates the following information for the CY 2026 baseline year and CY 2027 through CY 2031 projection years for the three modeled scenarios by individual market segments:

- Aggregate gross premiums
- Gross premium PMPM
- Aggregate net premiums
- Net premium PMPM
- Aggregate PTC
- PTC PMPM
- Aggregate statewide SLCSP premium
- Statewide SLCSP premium PMPM

Deficit Neutrality

A 1332 waiver application must demonstrate it will not increase the federal deficit. The reinsurance program during the CY 2027 through CY 2031 projection period is anticipated to be funded through a combination of state-based funding (premium tax revenue) and federal pass-through amounts. Premium tax revenue in CY 2026 to support the reinsurance program is estimated to be approximately $23 million. Note, in CY 2026, the reinsurance program is funded through additional assets beyond premium tax revenue, allowing a 18% premium rate reduction to be supported. It is assumed that beginning in 2027, these additional assets will have been drawn down and premium tax revenue will be the only available state-based revenue source to support the reinsurance program.

The reinsurance program will continue to operate as a condition-based reinsurance program, with insurers receiving payment for enrollees meeting specific clinical criteria.

[8] Given Covered Choice enrollment is estimated to represent a minimal portion of overall exchange enrollment, we have not made any explicit adjustment for changes in CSR loading.

[9] https://doi.idaho.gov/wp-content/uploads/Health/2026-Idaho-ACA-HBP-and-QDP-Standards.pdf

The clinical criteria and reinsurance plan design will be established prior to the beginning of each coverage year to target the projected total reinsurance program funding available for the upcoming year.

By reducing non-group premiums, the reinsurance program is estimated to continue to result in federal savings on premium assistance provided through YHI for the population qualifying for federal PTCs. As indicated in the State's Section 1332 waiver amendment request for Covered Choice, Idaho proposes to reduce pass-through funding generated by the reinsurance program based on incremental federal cost attributable to Covered Choice enrollment. The incremental cost is based on the following retrospective calculation after the calendar year is completed:

- The additional cost of federal PTCs for the Covered Choice population,
- Less federal per capita Medicaid expenditures for the similarly situated Medicaid expansion population with household income greater than or equal to 100% FPL, multiplied by the number of Covered Choice enrollees.

Figure 1 illustrates the modeling of this calculation for calendar years 2027 through 2031. As shown by Figure 1, Covered Choice is estimated to result in federal savings of approximately $8 million to $10 million each year, as the estimated cost of federal PTCs is approximately 25% less than the federal portion of Medicaid expansion coverage (based on an assumed federal medical assistance percentage (FMAP) rate of 90%). Because federal cost savings are estimated to be generated by Covered Choice, there are no projected offsets required to the pass-through funding generated by the reinsurance program. Additional discussion on the methodology for estimating federal PTC expenditures and Medicaid expansion costs is provided later in this report.

FIGURE 1: COVERED CHOICE ENROLLMENT AND COST PROJECTIONS

Covered Choice Assuming 20% Election Rate	CY 2027	CY 2028	CY 2029	CY 2030	CY 2031
Estimated Enrollment	3,400	3,500	3,500	3,600	3,600
Aggregate Gross Premiums ($ Millions)	$ 25.7	$ 27.3	$ 28.8	$ 30.4	$ 32.0
Aggregate Premium Tax Credits ($ Millions)	$ 24.0	$ 25.5	$ 26.9	$ 28.5	$ 30.0
Aggregate Net Premiums ($ Millions)	$ 1.7	$ 1.7	$ 1.8	$ 1.9	$ 2.0
Gross Premium PMPM	$ 621.38	$ 648.72	$ 675.31	$ 703.00	$ 731.83
Premium Tax Credit PMPM	581.05	607.18	632.39	658.84	686.39
Net Premium PMPM	40.33	41.54	42.93	44.16	45.43
Medicaid Federal Savings ($ Millions)	$ 32.1	$ 33.9	$ 35.7	$ 37.6	$ 39.6
Medicaid Federal Savings PMPM	$ 776.08	$ 806.49	$ 838.11	$ 870.97	$ 905.11
PTC and Medicaid Federal Savings PMPM Percent Difference	(25.1%)	(24.7%)	(24.5%)	(24.4%)	(24.2%)
PTC and Medicaid Federal Savings Expenditure Difference ($ Millions)	**($ 8.1)**	**($ 8.4)**	**($ 8.8)**	**($ 9.2)**	**($ 9.6)**
Covered Choice Offset to Pass-Through Funding	$ 0.0	$ 0.0	$ 0.0	$ 0.0	$ 0.0

Notes:
1. Assumptions are consistent with the Section 1332 Waiver Amendment Actuarial Certification and Economic Analysis Draft Report shared on November 3, 2025.
2. Covered Choice enrollees are assumed to select the second lowest cost silver plan (SLCSP).
3. Covered Choice enrollment demographics based on the October 2025 Medicaid expansion census. Covered Choice take-up rates are assumed to be uniform by household income, age, rating area, and household size and vary relative to other exchange enrollees in the 100% to 138% FPL cohort.
4. Federal Medicaid expansion cost savings per Covered Choice enrollee are estimated to be approximately 25% greater than the per capita PTC received by the enrollee. Therefore, based on the State's proposed pass-through methodology, there are no offsets to pass-through funding generated by the reinsurance program as federal deficit neutrality is maintained.

Figure 2 provides additional discussion around the incremental federal deficit impact of Covered Choice based on different potential consumer behavior in reaction to the implementation of Covered Choice.

FIGURE 2: COVERED CHOICE ENROLLMENT AND COST PROJECTIONS

POTENTIAL ENROLLEE CHORTS	COHORT DESCRIPTION	FEDERAL DEFICIT IMPACT FROM COVERED CHOICE
Cohort 1	Currently enrolled in Medicaid and remaining	No cost impact as enrollee remains in Medicaid expansion
Cohort 2	Currently enrolled in Medicaid but not meeting Public Law 119-21 community engagement requirements	No cost impact as enrollee would be disenrolled from Medicaid and not eligible for Covered Choice
Cohort 3	Currently not enrolled in Medicaid and not choosing any coverage	No cost impact, as neither Medicaid or PTC costs are incurred
Cohort 4	Currently enrolled in Medicaid and choosing QHP with PTC	Incremental federal cost based on difference between federal PTC and 90% FMAP Medicaid Expansion expenditures
Cohort 5	Currently not enrolled in Medicaid and choosing QHP with PTC	Incremental cost from federal PTC

Modeling Methodologies

The following sections provide a detailed description of the model process for the reinsurance program extension and Covered Choice amendment.

REINSURANCE PROGRAM PROJECTIONS

This section describes the methodology used to model the impact of the State's reinsurance program under the Section 1332 waiver. While key assumptions have been adjusted based on updated data sources, the general methodology for modeling the impacts of the reinsurance program on individual market enrollment, premiums, and PTC expenditures is consistent with initial waiver application.

BASE DATA

IDOI provided Milliman with March 2025 seriatim exchange census data that included for each enrollee the following information: age, FPL percentage, carrier, plan selection, net premium, and premium subsidy. In addition, estimated off-exchange enrollment was also provided for the first quarter of 2025. IDOI provided CY 2026 premium information for each qualified health plan that will be offered in Your Health Idaho by age and rating area.

ADJUSTMENTS FOR THE END OF ENHANCED PREMIUM SUBSIDIES

The IDOI and Idaho Reinsurance Pool had previously engaged Milliman to estimate CY 2026 ACA compliant enrollment and claims expense to support the determination of the reinsurance program parameters and premium rate impact for CY 2026. As of March 2025, approximately 115,000 Idahoans were enrolled in Your Health Idaho, consistent with CMS data published on state-level exchange enrollment during the first 5 months of CY 2025.[10] An additional 8,100 Idahoans were estimated to be purchasing ACA-compliant coverage off-exchange based on a carrier survey conducted by IDOI.

[10] https://www.cms.gov/files/document/first-five-months-effectuated-enrollment-tables.xlsx

With the enhanced premium subsidies scheduled to sunset on December 31, 2025[11], it is assumed that some degree of disenrollment from Your Health Idaho will occur in CY 2026 because of higher out-of-pocket premium requirements for many enrollees. Based on discussions with the Idaho Reinsurance Pool board, we assumed 104,000 Idahoans would purchase coverage in the ACA-compliant individual market (approximately a 15.5% decrease from enrollment levels observed in the first quarter of CY 2025), with approximately 96,000 Idahoans projected to purchase coverage through Your Health Idaho in CY 2026. We have assumed disenrollments will be isolated to individuals previously purchasing coverage through Your Health Idaho.

Note, we have not assumed any further disenrollments from Your Health Idaho attributable to market integrity provisions in the 2025 Marketplace Integrity and Affordability final rule[12] or H.R. 1, which became Public Law 119-21 (P.L. 119-21)[13]. Based on our review of exchange enrollment changes among state and federal-exchange states in the last several years, we believe the market integrity rules are likely to have much more material impacts in states using the federal exchange.[14]

Using the CY 2026 premium information provided by IDOI, we mapped the CY 2026 premium rates to each exchange enrollee using CY 2025 plan selections. In cases when the CY 2025 plan was not offered in CY 2026, we mapped the CY 2026 premium of a similar plan of the same carrier to the exchange enrollee. We have assumed that carriers developed premium rates that inherently reflected market acuity changes expected to occur from estimated market enrollment decreases from CY 2025 to CY 2026.

Note, there is significant uncertainty regarding market enrollment changes in CY 2026 attributable to levels of federal premium assistance reverting to pre-2021 levels. These changes include overall market enrollment, but also enrollment across different income cohorts, carriers, and metallic plan levels.

ASSUMPTIONS USED IN CY 2027 THROUGH CY 2031 PROJECTIONS

Using the CY 2026 individual market enrollment estimates as a baseline, enrollment, premiums, premium tax credits, and enrollee household income were projected through CY 2031 using the following assumptions:

Enrollment: Individual market enrollment was assumed to be consistent with Idaho's forecasted under 65 population growth as published by the Idaho Department of Labor.[15] The under 65 population is forecasted to increase on an annual basis by 1.2% to 1.3% during the CY 2027 through CY 2031 projection period.

Premium trend: CY 2026 premiums were trended using the CMS National Health Expenditure forecast for 'Private Health Insurance spending per enrollee ($) (excluding Medigap)'. Annual premium trends during the CY 2027 through CY 2031 projection period varied between 4.1% and 5.0%.[16]

Premium tax credit percentages: Premium tax credit percentages were based on CY 2026 values published by the Internal Revenue Service.[17] For CY 2027 through CY 2031, premium tax credit percentages were indexed based on forecasted changes in the excess per capita premium growth over the rate of per capita personal income growth using the CMS National Health Expenditure forecast.[18]

Household income: Household income, as measured by FPL, was assumed to remain consistent with the March 2025 census data. FPL was assumed to be indexed in each calendar year based on changes in the Consumer Price Index (CPI-U). We utilized CPI-U projections from the CMS National Health Expenditure forecast, which projected annual CPI-U growth rates of 2.4% to 2.6% during the projection period.[19]

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[11] For additional background on the enhanced premium subsidies, please see https://www.milliman.com/en/insight/quantifying-value-aca-premium-subsidy-expire-2026.

[12] https://www.cms.gov/newsroom/fact-sheets/2025-marketplace-integrity-and-affordability-final-rule

[13] https://www.congress.gov/bill/119th-congress/house-bill/1

[14] https://www.milliman.com/en/insight/benchmarking-state-insurance-medicaid-since-covid-19

[15] https://lmi.idaho.gov/data-tools/population-projections/

[16] https://www.cms.gov/files/zip/nhe-projections-tables.zip

[17] https://www.irs.gov/pub/irs-drop/rp-25-25.pdf

[18] https://www.cms.gov/files/zip/nhe-projections-tables.zip

[19] https://www.cms.gov/files/zip/nhe-projections-tables.zip

PTC / Advanced Premium Tax Credit (APTC) Reconciliation Factor: In estimating federal pass-through funding generated by the reinsurance program for each calendar year, we calculated the projected difference in PTCs between Scenario 1 (without reinsurance) and Scenario 2 (with reinsurance) and then applied a 97.7% PTC / APTC adjustment factor consistent with Idaho's CY 2025 federal pass-through calculation.[20]

COVERED CHOICE MEDICAID SAVINGS PROJECTIONS

The following section describes the methodology used to estimate state and federal Medicaid savings as the result of Covered Choice.

BASE DATA

IDHW provided Milliman with the following data and information for use in the Section 1332 waiver's actuarial certification and economic analyses:

- Medicaid expansion enrollment projections through June 2029 as of its September 2025 forecast.
- Medicaid expansion per member per month cost projections for state fiscal years 2026 through 2028 based on IDHW's September 2025 forecast.
    - The PMPM projections included offsets for the collection of pharmacy rebates.
    - We confirmed with IDHW that the September 2025 forecast did not reflect any impacts from P.L. 119-21.
- IDHW indicated that 21.2% of the Medicaid expansion population had income between 100% and 138% FPL (the population eligible for Covered Choice) as of October 2025.

PROJECTIONS THROUGH DECEMBER 2031 WITHOUT P.L. 119-21 IMPACTS

We applied the following assumptions, which were reviewed and approved by IDOI and IDHW, to project the IDHW enrollment and PMPM forecasts through December 2031, specific to the Medicaid expansion population with income between 100% and 138% FPL:

- Enrollment and PMPM projections were extended through December 2031 based on IDHW's trend assumptions in the last 12 months of its enrollment and PMPM forecasts.
    - Medicaid expansion enrollment was estimated to increase by approximately 1.3% annually..
    - Medicaid expansion PMPM costs were projected to increase by approximately 3.9% on an annualized basis.
- We assumed that 21.2% of the Medicaid expansion population during each projection month would have income between 100% and 138% FPL.
    - Prior to P.L. 119-21 or Covered Choice impacts, this resulted in an estimated 20,100 Medicaid expansion enrollees with income between 100% and 138% FPL as of January 2027, increasing to approximately 21,600 by December 2031.
- We assumed the Medicaid expansion population with income between 100% and 138% FPL has healthcare costs 15% lower than the composite Medicaid expansion population.
    - By virtue of having household income at or above 100% FPL (based on the 2025 FPL, this represents income of $15,650 for a single household and $32,150 for a 4-person household[21]), we believe it reasonable to assume the Medicaid expansion population with income between 100% and 138% is more likely to be employed and have fewer health barriers that would limit employment opportunities relative to the Medicaid expansion population with income less than 100% FPL.

[20] https://www.cms.gov/files/document/1332-key-components-2025-pass-throughv1.xlsx

[21] https://aspe.hhs.gov/sites/default/files/documents/dd73d4f00d8a819d10b2fdb70d254f7b/detailed-guidelines-2025.pdf

- We recommend IDHW conduct a claim costs analysis of its Medicaid expansion population to determine the historical claim costs relativities between the two income cohorts. It is certain that actual cost relativities will differ from the relativity assumed in modeling..

PROJECTIONS THROUGH DECEMBER 2031 WITH P.L. 119-21 IMPACTS

P.L. 119-21 introduces several significant changes to the Medicaid program. For the Medicaid expansion population, community engagement and more frequent eligibility redetermination requirements beginning on January 1, 2027 are estimated to have material impact to Medicaid enrollment by the Congressional Budget Office (CBO).

- Community engagement: P.L. 119-21 requires state implementation of community engagement requirements for Medicaid expansion populations by January 1, 2027 (with delays permissible until January 1, 2029, if the secretary of the Department of Health and Human Services determines that a "good faith" effort is being made toward implementation).[22]
    - The CBO estimates 4.8 million able-bodied adults will lose Medicaid coverage as the result of not meeting community engagement requirements.[23] This is relative to CBO-forecasted national Medicaid expansion enrollment without P.L. 119-21 impacts of approximately 14 million.[24]
    - P.L. 119-21 also requires Medicaid expansion eligibility redeterminations every 6 months (instead of typically 12 months).[25] The CBO estimated 2.2 million individuals will become uninsured because of this provision.[26]

While the CBO estimated these two provisions would reduce Medicaid expansion enrollment by more than 40% (including interaction between the two policies), the estimates are not specific to the population with income between 100% and 138% FPL. As stated above, by virtue of having income at or above 100% FPL, we believe the Expansion population that will be eligible for Covered Choice is more likely to be employed at least 80 hours a month and thus meeting the community engagement requirements under P.L. 119-21. Note, in addition to having employment at least 80 hours a month. P.L. 119-21's community engagement requirements have a number of exemptions (a sample includes medically frail individuals, individuals with a substance disorder, individuals with a serious or complex medical condition) and other compliance activities (a sample includes individuals enrolled in an educational program at least half-time, monthly income that is not less than the minimum wage multiplied by 80 hours, and community service of not less than 80 hours per month).[27] While the community engagement requirements may have less impact on the Expansion population with household income of at least 100% FPL, the requirement for six month Expansion population eligibility redeterminations may have a larger enrollment impact on this income cohort than the overall Expansion population. Household income fluctuations may result in some members being identified with income above 138% FPL and thus being rendered ineligible for Medicaid.

Based on the CBO estimates and considering P.L. 119-21's allowable exemption and compliance activities, we have assumed Medicaid expansion enrollment within the 100% to 138% FPL cohort will be reduced by 15% or approximately 3,000 individuals (20,100 to 17,100) on January 1, 2027.[28] Note, this is a high-level estimate based on actuarial judgment.

The scope of our engagement with IDOI did not include a detailed review of Medicaid expansion members' health conditions, employment status, or family situation which may better inform this assumption.

[22] https://www.milliman.com/en/insight/benchmarking-state-insurance-medicaid-since-covid-19

[23] https://www.cbo.gov/system/files/2025-06/Arrington-Guthrie-Letter-Medicaid.pdf

[24] https://www.cbo.gov/system/files/2024-06/51301-2024-06-medicaid.xlsx

[25] https://www.milliman.com/en/insight/benchmarking-state-insurance-medicaid-since-covid-19

[26] https://www.cbo.gov/system/files/2025-06/Arrington-Guthrie-Letter-Medicaid.pdf

[27] https://www.milliman.com/en/insight/benchmarking-state-insurance-medicaid-since-covid-19

[28] Note, enrollment is estimated to be reduced by 15% for each month through December 2031 relative to enrollment projections without Public Law 119-21impacts.

At the time of this report, CMS has also not released regulations concerning the community engagement provisions under P.L. 119-21 which may also influence ultimate Medicaid expansion enrollment levels. While IDHW has reviewed this assumption and believes it is a reasonable estimate of P.L. 119-21 impacts to Medicaid expansion enrollment for the Covered Choice income cohort, a more comprehensive analysis may result in enrollment estimates that differ from those assumed in this report.

We have also assumed that individuals disenrolled from Medicaid expansion because of P.L. 119-21 will be healthier and less expensive than the residual population that remains enrolled in Medicaid expansion (or selects to enroll in Your Health Idaho through Covered Choice).

- As stated above P.L. 119-21 exempts individuals who are medically frail or have serious or complex medical conditions from the community engagement requirements. In addition, we anticipate that adverse selection dynamics will result in individuals with pre-existing healthcare conditions maintaining better compliance with community engagement documentation requirements relative to individuals without any pre-existing health needs.
- Based on relative morbidity during the PHE unwinding process, we estimate the individuals disenrolled from Medicaid expansion (and are not eligible for Covered Choice) have a relative cost 30% less than the residual population that remains enrolled within the 100% to 138% FPL income cohort.
- This results in the PMPM cost for the Medicaid expansion 100% to 138% FPL income cohort increasing by approximately 5% because of P.L. 119-21.

As stated above, the scope of our engagement with IDOI did not include a detailed review of Medicaid expansion members' health conditions, historical benefit expenses, employment status, or family situation which may better inform this assumption. While IDHW has reviewed this assumption and believes it is a reasonable estimate of P.L. 119-21 impacts to Medicaid expansion PMPM cost for the Covered Choice income cohort, a more comprehensive analysis may result in PMPM estimates that differ from those assumed in this report.

COVERED CHOICE TAKE-UP AND RELATIVE COSTS

The ultimate number of eligible individuals electing to use Covered Choice is highly uncertain. Based on the methodology described above, Figure 2 summarizes the estimated number of individuals that will be eligible for Covered Choice (and otherwise enrolled in Medicaid expansion) from CY 2027 to CY 2031 in Idaho's Medicaid expansion population as well as CY 2026 baseline enrollment. We have assumed average healthcare costs of individuals electing to use Covered Choice will be consistent with PMPM costs from the residual (i.e. after P.L. 119-21 effects) Medicaid expansion population with income between 100% and 138% FPL. Therefore, the Medicaid Expansion PMPM values illustrated for CY 2027 through CY 2031 represent the estimated monthly Medicaid savings (state and federal) from individuals using Covered Choice.

Figure 3 illustrates low and high enrollment scenarios for Covered Choice. The low enrollment scenario assumes no enrollment in Covered Choice (consistent with Scenario 2). Medicaid expansion enrollment does not require out-of-pocket premiums. Through Covered Choice, individuals with income between 100% and 133% FPL are estimated to have out-of-pocket premiums for the silver benchmark plan of approximately 2.1% of household income, with out-of-pocket premiums between 3.2% and 3.5% of household income for enrollees with income between 133% and 138% FPL. It is possible the premium requirement for Covered Choice will result in minimal Covered Choice enrollment take-up. Because of the out-of-pocket premium differentials between Medicaid and exchange coverage, the high enrollment scenario is limited to a 20% Covered Choice take-up rate. The estimated federal savings for each calendar year is calculated by taking the Medicaid Expansion PMPM, multiplying it by the 90% federal medical assistance percentage (FMAP) rate, multiplying it by estimated Covered Choice enrollment, and finally multiplying it by 12 months.

FIGURE 3: COVERED CHOICE ENROLLMENT AND COST PROJECTIONS

	2027	2028	2029	2030	2031
100% to 138% FPL Medicaid Expansion Enrollment	17,200	17,500	17,700	18,000	18,200
Medicaid Expansion PMPM (State and Federal)	$ 862.00	$ 895.79	$ 930.91	$ 967.41	$ 1,005.34
Covered Choice (Low Enrollment)	-	-	-	-	-
Covered Choice Federal Savings ($ Millions)	$ 0.0	$ 0.0	$ 0.0	$ 0.0	$ 0.0
Covered Choice (High Enrollment)	3,400	3,500	3,500	3,600	3,600
Covered Choice Federal Savings ($ Millions)	$ 32.1	$ 33.9	$ 35.7	$ 37.6	$ 39.6

Notes:

1. Medicaid expansion enrollment estimates for 100% to 138% FPL income cohort prior to Covered Choice elections.
2. Federal savings estimates assume 90% federal medical assistance percentage (FMAP) for Expansion population.
3. Medicaid PMPM values include offsets from collected pharmacy rebates.
4. Values are rounded.

It is our understanding that individuals who are ineligible for Medicaid expansion will also not be eligible for Covered Choice (specifically, individuals failing to meet P.L. 119-21's community engagement requirements and do not have an exemption will be ineligible for Covered Choice). However, it is possible that an individual may purchase exchange coverage through Covered Choice that would not otherwise have enrolled in the Medicaid expansion program. However, because of the additional premium requirements associated with Covered Choice, we believe this is likely to represent a small number of enrollees. The modeling estimates shown in this report assume the State of Idaho implements and operates Covered Choice as described in this report. To the extent there are operational differences, the estimates in this report will need to be updated.

COVERED CHOICE IMPACT TO FEDERAL DEFICIT NEUTRALITY

While there is considerable uncertainty regarding ultimate Covered Choice take-up, the State of Idaho has agreed to have federal pass-through amounts generated by the reinsurance program reduced by the incremental federal cost of Covered Choice. Specifically, in the amendment request, the State indicates:

The Covered Choice program as proposed will maintain the neutral impact to the federal deficit, consistent with the waiver guardrails, as measured across both the direct federal PTC cost increases and the direct federal Medicaid cost decreases. Idaho achieves that by accepting a lower federal pass-through funding equal to any incremental federal cost per Choice household. The incremental federal cost per Choice household is less than the full PTC after accounting for the federal cost savings to Medicaid.

Because the State is agreeing to accept the financial risk associated with the incremental federal cost difference between Medicaid expansion and premium tax credits for the Covered Choice population, federal deficit neutrality can be assured under the State's Section 1332 waiver amendment request.

Limitations and Data Reliance

Milliman has developed certain models to estimate the values included in this report. The intent of the models was to estimate impacts on insurance market enrollment, premiums, and federal expenditures under a Section 1332 waiver. We have reviewed the models, including their inputs, calculations, and outputs for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOP).

The models rely on data and information as input to the models. We have relied upon certain data and information provided by State of Idaho, Department of Health & Welfare (IDHW) and Department of Insurance (IDOI), as well as publicly available data published by federal agencies for this purpose and accepted it without audit. To the extent that the data and information provided is not accurate, or is not complete, the values provided in this report may likewise be inaccurate or incomplete.

Milliman's data and information reliance includes:

- IDHW Medicaid enrollment forecast as of September 2025
- IDHW Medicaid Expansion expenditure forecast as of September 2025
- IDHW Medicaid Expansion census as of October 2025
- Idaho population forecasts available at https://lmi.idaho.gov/data-tools/population-projections/
- March 2025 Your Health Idaho census provided by IDOI
- CY 2026 individual market premium rates by rating area provided by IDOI
- Carrier enrollment survey data for off-exchange enrollment in first quarter 2025 provided by IDOI
- Congressional Budget Office projections of Medicaid expansion enrollment including impacts from P.L. 119-21
- Proposed pass-through calculation methodology as described by IDOI in its Section 1332 waiver amendment application
- CMS National Health Expenditure Projections including selected economic indicators, health insurance enrollment, and health insurance premiums

If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete. Furthermore, actual enrollment, individual market premium, federal PTC, and Medicaid expenditures can vary from projected amounts due to a multitude of reasons, including economic changes, regulatory or legislative changes, consumer behavior, healthcare trends, and population changes. The values in this report are based on current laws and regulations as of November 7, 2025. Specifically, changes to the federal PTC structure or methodology will have material impact on the values presented in this report.

The results presented are based upon a set of assumptions, as described above. If actual results differ from the underlying assumptions, actual enrollment and financial results are certain to differ from those presented in this presentation.

We are members of the American Academy of Actuaries and meet the qualification standards to perform projections of this type.

This analysis has been prepared for the use of the Idaho Individual High Risk Reinsurance Pool Board and the Idaho Department of Insurance. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. Milliman recommends any third-party recipient be aided by its own actuary or other qualified professional when reviewing the Milliman work product.

The consultants who worked on this assignment are actuaries. Milliman's advice is not intended to be a substitute for qualified tax, legal, or accounting counsel.

Idaho Department of Insurance
Section 1332 Waiver
Reinsurance Program Extension and Covered Choice Amendment
Actuarial Certification

I, Paul R. Houchens, am a Principal and Consulting Actuary with the firm of Milliman, Inc. I am a Member of the American Academy of Actuaries and a Fellow of the Society of Actuaries. I meet the qualification standards established by the American Academy of Actuaries and have followed the standards of practice established by the Actuarial Standards Board. I have been employed by the State of Idaho, Department of Insurance to perform an actuarial analysis and certification regarding the state's extension of a reinsurance program for the individual health insurance market under a Section 1332 State Relief and Empowerment Waiver, and the introduction of the Covered Choice program for the Medicaid expansion population with income between 100% and 138% of the federal poverty level. I am generally familiar with the federal requirements for Section 1332 waiver proposals, commercial health insurance rating rules, Medicaid eligibility, insurance exchanges, the Affordable Care Act's premium assistance structure, rules surrounding individual shared responsibility payments, and other components of the Affordable Care Act relevant to this Section 1332 State Relief and Empowerment Waiver proposal.

As required under 45 CFR 155.1308 (f)(4)(i), this certification provides documentation that my actuarial analyses support the State of Idaho's finding that the amended 1332 waiver complies with the following requirements for Section 1332 waivers as defined under 45 CFR 155.1308 (f)(3)(iv)(a)-(c):

- The proposal will provide coverage to at least a comparable number of the state's residents as would be provided absent the waiver;
- the proposal will provide coverage and cost-sharing protections against excessive out-of-pocket spending that are at least as affordable for the state's residents as would be provided absent the waiver; and,
- the proposal will provide access to coverage that is at least as comprehensive for the state's residents as would be provided absent the waiver.

The assumptions and methodology used in the development of the actuarial certification have been documented in my report provided to the State of Idaho. The actuarial certification provided with this report is for the period from January 1, 2027 through December 31, 2031. To the extent state or federal regulations or legislation are modified through the end of the waiver period, it may be necessary for this actuarial certification and corresponding analyses to be amended.

The actuarial analyses presented with this certification are based on a projection of future events. Actual experience may be expected to vary from the experience assumed in the analyses.

In developing the actuarial certification, I have relied upon data and information provided by the State of Idaho agencies, and publicly available federal government data sets and reports. I have relied upon these third parties for audit of the data. However, I did review the data for reasonableness and consistency.

Paul R. Houchens, FSA
Member, American Academy of Actuaries

November 14, 2025
Date

Appendix 1

APPENDIX 1

IDAHO DEPARTMENT OF INSURANCE

SECTION 1332 WAIVER - REINSURANCE AND COVERED CHOICE

ESTIMATED ENROLLMENT IMPACTS FROM REINSURANCE EXTENSION AND COVERED CHOICE AMENDMENT

SCENARIO 1: WITHOUT WAIVER

ENROLLMENT CATEGORY	CY 2026	CY 2027	CY 2028	CY 2029	CY 2030	CY 2031
PTC Exchange Enrollment	76,000	77,000	78,000	79,100	80,000	81,000
Unsubsidized Exchange Enrollment	19,200	19,500	19,700	20,000	20,200	20,400
Total Exchange Enrollment	**95,300**	**96,500**	**97,800**	**99,000**	**100,200**	**101,400**
Off Exchange Enrollment	7,800	7,900	8,100	8,200	8,300	8,400
Total ACA Compliant Enrollment	**103,100**	**104,500**	**105,800**	**107,200**	**108,500**	**109,800**

SCENARIO 2: REINSURANCE EXTENSION ONLY

ENROLLMENT CATEGORY	CY 2026	CY 2027	CY 2028	CY 2029	CY 2030	CY 2031
PTC Exchange Enrollment	76,000	76,900	78,000	79,000	80,000	80,900
Unsubsidized Exchange Enrollment	19,800	20,200	20,400	20,700	20,900	21,100
Total Exchange Enrollment	**95,900**	**97,100**	**98,400**	**99,600**	**100,800**	**102,100**
Off Exchange Enrollment	8,100	8,200	8,300	8,400	8,500	8,600
Total ACA Compliant Enrollment	**103,900**	**105,300**	**106,700**	**108,100**	**109,400**	**110,700**

SCENARIO 3: REINSURANCE EXTENSION AND COVERED CHOICE AMENDMENT

ENROLLMENT CATEGORY	CY 2026	CY 2027	CY 2028	CY 2029	CY 2030	CY 2031
PTC Exchange Enrollment	76,000	80,400	81,500	82,500	83,600	84,600
Unsubsidized Exchange Enrollment	19,800	20,200	20,400	20,700	20,900	21,100
Total Exchange Enrollment	**95,900**	**100,600**	**101,900**	**103,200**	**104,400**	**105,700**
Off Exchange Enrollment	8,100	8,200	8,300	8,400	8,500	8,600
Total ACA Compliant Enrollment	**103,900**	**108,700**	**110,200**	**111,600**	**113,000**	**114,300**

IMPACT FROM REINSURANCE PROGRAM ONLY

ENROLLMENT CATEGORY	CY 2026	CY 2027	CY 2028	CY 2029	CY 2030	CY 2031
PTC Exchange Enrollment	-	(100)	(100)	(100)	(100)	(100)
Unsubsidized Exchange Enrollment	600	700	700	700	700	700
Total Exchange Enrollment	**600**	**600**	**600**	**600**	**600**	**600**
Off Exchange Enrollment	200	200	200	300	300	300
Total ACA Compliant Enrollment	**800**	**800**	**900**	**900**	**900**	**900**

IMPACT FROM REINSURANCE PROGRAM AND COVERED CHOICE

ENROLLMENT CATEGORY	CY 2026	CY 2027	CY 2028	CY 2029	CY 2030	CY 2031
PTC Exchange Enrollment	-	3,300	3,400	3,500	3,500	3,600
Unsubsidized Exchange Enrollment	600	700	700	700	700	700
Total Exchange Enrollment	**600**	**4,000**	**4,100**	**4,200**	**4,200**	**4,300**
Off Exchange Enrollment	200	200	200	300	300	300
Total ACA Compliant Enrollment	**800**	**4,300**	**4,400**	**4,400**	**4,500**	**4,500**

Notes

1. Values have been rounded to the nearest hundred.
2. It is estimated that the reinsurance program impact will result in a minimal number of consumers changing from having minimal PTCs to being unsubsidized as a result of the benchmark premium reduction.

Appendix 2

APPENDIX 2

IDAHO DEPARTMENT OF INSURANCE

SECTION 1332 WAIVER - REINSURANCE AND COVERED CHOICE

ESTIMATED GROSS PREMIUM AND NET PREMIUM EXPENDITURES ($ MILLIONS) AND PMPM: CY 2026 THROUGH CY 2031

SCENARIO 1: WITHOUT WAIVER

100% to 138% FPL EXCHANGE	CY 2026	CY 2027	CY 2028	CY 2029	CY 2030	CY 2031
Non-Covered Choice Aggregate Gross Premiums	$ 19.9	$ 21.1	$ 22.4	$ 23.6	$ 24.8	$ 26.2
Covered Choice Aggregate Gross Premiums	$ 0.0	$ 0.0	$ 0.0	$ 0.0	$ 0.0	$ 0.0
Total 100% to 138% FPL Aggregate Gross Premiums	$ 19.9	$ 21.1	$ 22.4	$ 23.6	$ 24.8	$ 26.2
Non-Covered Choice Gross Premium PMPM	$ 704.58	$ 740.05	$ 772.60	$ 804.59	$ 837.77	$ 872.45
Covered Choice Gross Premium PMPM	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00
Composite 100% to 138% FPL Gross Premium PMPM	$ 704.58	$ 740.05	$ 772.60	$ 804.59	$ 837.77	$ 872.45
Non-Covered Choice Aggregate Net Premiums	$ 2.6	$ 2.7	$ 2.9	$ 3.0	$ 3.2	$ 3.4
Covered Choice Aggregate Net Premiums	$ 0.0	$ 0.0	$ 0.0	$ 0.0	$ 0.0	$ 0.0
Total 100% to 138% FPL Aggregate Net Premiums	**$ 2.6**	**$ 2.7**	**$ 2.9**	**$ 3.0**	**$ 3.2**	**$ 3.4**
Non-Covered Choice Net Premium PMPM	$ 91.61	$ 95.92	$ 99.87	$ 103.71	$ 107.66	$ 111.77
Covered Choice Net Premium PMPM	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00
Total Aggregate 100% to 138% Net Premium PMPM	**$ 91.61**	**$ 95.92**	**$ 99.87**	**$ 103.71**	**$ 107.66**	**$ 111.77**

OTHER FPL EXCHANGE	CY 2026	CY 2027	CY 2028	CY 2029	CY 2030	CY 2031
Non-Covered Choice Aggregate Gross Premiums	$ 752.2	$ 800.4	$ 846.4	$ 892.9	$ 940.9	$ 991.6
Non-Covered Choice Gross Premium PMPM	$ 674.64	$ 708.61	$ 739.77	$ 770.40	$ 802.17	$ 835.38
Non-Covered Choice Aggregate Net Premiums	$ 292.0	$ 309.4	$ 325.8	$ 342.2	$ 358.9	$ 376.4
Non-Covered Choice Net Premium PMPM	$ 261.91	$ 273.92	$ 284.77	$ 295.24	$ 305.98	$ 317.08

TOTAL EXCHANGE	CY 2026	CY 2027	CY 2028	CY 2029	CY 2030	CY 2031
Total Aggregate Gross Premiums	$ 772.1	$ 821.5	$ 868.8	$ 916.5	$ 965.8	$ 1,017.8
Total Aggregate Net Premiums	$ 294.6	$ 312.1	$ 328.7	$ 345.2	$ 362.1	$ 379.7
Total Composite Gross Premium PMPM	$ 675.38	$ 709.38	$ 740.58	$ 771.25	$ 803.05	$ 836.29
Total Composite Net Premiums PMPM	$ 257.71	$ 269.53	$ 280.21	$ 290.52	$ 301.08	$ 312.01

TOTAL OFF EXCHANGE	CY 2026	CY 2027	CY 2028	CY 2029	CY 2030	CY 2031
Total Aggregate Gross Premiums	$ 77.7	$ 82.6	$ 87.4	$ 92.2	$ 97.1	$ 102.3
Total Composite Gross Premium PMPM	$ 825.08	$ 866.33	$ 904.45	$ 941.54	$ 980.14	$ 1,020.32

TOTAL ACA COMPLIANT	CY 2026	CY 2027	CY 2028	CY 2029	CY 2030	CY 2031
Total Aggregate Gross Premiums	$ 849.8	$ 904.1	$ 956.2	$ 1,008.7	$ 1,062.8	$ 1,120.1
Total Composite Gross Premium PMPM	$ 686.77	$ 721.33	$ 753.05	$ 784.21	$ 816.53	$ 850.30
Statewide Average SLCSP Premium PMPM[2]	$ 680.04	$ 714.25	$ 745.65	$ 776.51	$ 808.47	$ 841.93
Statewide Aggregate SLCSP Premiums	$ 620.6	$ 660.3	$ 698.3	$ 736.7	$ 776.3	$ 818.1

Notes

1. Aggregate Gross and Net Premiums illustrated in $ millions.
2. Statewide Average SLCSP Premium PMPM limited to PTC eligible enrollees.
3. Note, exchange enrollment values for all income cohorts include individuals who do not qualify for federal PTCs.

APPENDIX 2

IDAHO DEPARTMENT OF INSURANCE

SECTION 1332 WAIVER - REINSURANCE AND COVERED CHOICE

ESTIMATED GROSS PREMIUM AND NET PREMIUM EXPENDITURES ($ MILLIONS) AND PMPM: CY 2026 THROUGH CY 2031

SCENARIO 2: REINSURANCE EXTENSION ONLY

100% to 138% FPL EXCHANGE	CY 2026	CY 2027	CY 2028	CY 2029	CY 2030	CY 2031
Non-Covered Choice Aggregate Gross Premiums	$ 16.3	$ 19.0	$ 20.1	$ 21.2	$ 22.4	$ 23.6
Covered Choice Aggregate Gross Premiums	$ 0.0	$ 0.0	$ 0.0	$ 0.0	$ 0.0	$ 0.0
Total 100% to 138% FPL Aggregate Gross Premiums	$ 16.3	$ 19.0	$ 20.1	$ 21.2	$ 22.4	$ 23.6
Non-Covered Choice Gross Premium PMPM	$ 577.60	$ 665.87	$ 695.16	$ 723.94	$ 753.80	$ 785.00
Covered Choice Gross Premium PMPM	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00
Composite 100% to 138% FPL Gross Premium PMPM	$ 577.60	$ 665.87	$ 695.16	$ 723.94	$ 753.80	$ 785.00
Non-Covered Choice Aggregate Net Premiums	$ 2.3	$ 2.6	$ 2.7	$ 2.8	$ 3.0	$ 3.1
Covered Choice Aggregate Net Premiums	$ 0.0	$ 0.0	$ 0.0	$ 0.0	$ 0.0	$ 0.0
Total 100% to 138% FPL Aggregate Net Premiums	**$ 2.3**	**$ 2.6**	**$ 2.7**	**$ 2.8**	**$ 3.0**	**$ 3.1**
Non-Covered Choice Net Premium PMPM	$ 80.41	$ 89.72	$ 93.40	$ 96.96	$ 100.64	$ 104.45
Covered Choice Net Premium PMPM	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00
Total Aggregate 100% to 138% Net Premium PMPM	**$ 80.41**	**$ 89.72**	**$ 93.40**	**$ 96.96**	**$ 100.64**	**$ 104.45**

OTHER FPL EXCHANGE	CY 2026	CY 2027	CY 2028	CY 2029	CY 2030	CY 2031
Non-Covered Choice Aggregate Gross Premiums	$ 620.9	$ 725.0	$ 766.8	$ 808.9	$ 852.4	$ 898.3
Non-Covered Choice Gross Premium PMPM	$ 553.31	$ 637.87	$ 665.92	$ 693.50	$ 722.09	$ 751.99
Non-Covered Choice Aggregate Net Premiums	$ 267.1	$ 296.9	$ 312.6	$ 328.2	$ 344.1	$ 360.8
Non-Covered Choice Net Premium PMPM	**$ 238.02**	**$ 261.20**	**$ 271.49**	**$ 281.40**	**$ 291.54**	**$ 302.03**

TOTAL EXCHANGE	CY 2026	CY 2027	CY 2028	CY 2029	CY 2030	CY 2031
Total Aggregate Gross Premiums	$ 637.2	$ 744.1	$ 786.9	$ 830.1	$ 874.8	$ 921.9
Total Aggregate Net Premiums	$ 269.3	$ 299.5	$ 315.3	$ 331.1	$ 347.1	$ 363.9
Total Composite Gross Premium PMPM	$ 553.91	$ 638.55	$ 666.64	$ 694.24	$ 722.87	$ 752.80
Total Composite Net Premiums PMPM	$ 234.15	$ 256.99	$ 267.11	$ 276.87	$ 286.86	$ 297.18

TOTAL OFF EXCHANGE	CY 2026	CY 2027	CY 2028	CY 2029	CY 2030	CY 2031
Total Aggregate Gross Premiums	$ 65.7	$ 76.7	$ 81.1	$ 85.5	$ 90.1	$ 94.9
Total Composite Gross Premium PMPM	$ 676.57	$ 779.70	$ 814.01	$ 847.38	$ 882.12	$ 918.29

TOTAL ACA COMPLIANT	CY 2026	CY 2027	CY 2028	CY 2029	CY 2030	CY 2031
Total Aggregate Gross Premiums	$ 702.8	$ 820.8	$ 868.0	$ 915.7	$ 964.8	$ 1,016.8
Total Composite Gross Premium PMPM	$ 563.46	$ 649.54	$ 678.11	$ 706.16	$ 735.27	$ 765.68
Statewide Average SLCSP Premium PMPM[2]	$ 557.63	$ 643.11	$ 671.31	$ 699.08	$ 727.87	$ 757.97
Statewide Aggregate SLCSP Premiums	$ 508.9	$ 593.7	$ 628.1	$ 662.6	$ 698.3	$ 736.0

Notes

1. Aggregate Gross and Net Premiums illustrated in $ millions.
2. Statewide Average SLCSP Premium PMPM limited to PTC eligible enrollees.
3. Note, exchange enrollment values for all income cohorts include individuals who do not qualify for federal PTCs.

APPENDIX 2

IDAHO DEPARTMENT OF INSURANCE

SECTION 1332 WAIVER - REINSURANCE AND COVERED CHOICE

ESTIMATED GROSS PREMIUM AND NET PREMIUM EXPENDITURES ($ MILLIONS) AND PMPM: CY 2026 THROUGH CY 2031

SCENARIO 3: REINSURANCE EXTENSION AND COVERED CHOICE AMENDMENT

100% to 138% FPL EXCHANGE	CY 2026	CY 2027	CY 2028	CY 2029	CY 2030	CY 2031
Non-Covered Choice Aggregate Gross Premiums	$ 16.3	$ 19.0	$ 20.1	$ 21.2	$ 22.4	$ 23.6
Covered Choice Aggregate Gross Premiums	$ 0.0	$ 25.7	$ 27.3	$ 28.8	$ 30.4	$ 32.0
Total 100% to 138% FPL Aggregate Gross Premiums	$ 16.3	$ 44.7	$ 47.4	$ 50.0	$ 52.7	$ 55.6
Non-Covered Choice Gross Premium PMPM	$ 577.60	$ 665.87	$ 695.16	$ 723.94	$ 753.80	$ 785.00
Covered Choice Gross Premium PMPM	$ 0.00	$ 621.38	$ 648.72	$ 675.31	$ 703.00	$ 731.83
Composite 100% to 138% FPL Gross Premium PMPM	$ 577.60	$ 639.57	$ 667.67	$ 695.15	$ 723.70	$ 753.47
Non-Covered Choice Aggregate Net Premiums	$ 2.3	$ 2.6	$ 2.7	$ 2.8	$ 3.0	$ 3.1
Covered Choice Aggregate Net Premiums	$ 0.0	$ 1.7	$ 1.7	$ 1.8	$ 1.9	$ 2.0
Total 100% to 138% FPL Aggregate Net Premiums	**$ 2.3**	**$ 4.2**	**$ 4.5**	**$ 4.7**	**$ 4.9**	**$ 5.1**
Non-Covered Choice Net Premium PMPM	$ 80.41	$ 89.72	$ 93.40	$ 96.96	$ 100.64	$ 104.45
Covered Choice Net Premium PMPM	$ 0.00	$ 40.33	$ 41.54	$ 42.93	$ 44.16	$ 45.43
Total Aggregate 100% to 138% Net Premium PMPM	**$ 80.41**	**$ 60.53**	**$ 62.71**	**$ 64.97**	**$ 67.18**	**$ 69.46**

OTHER FPL EXCHANGE	CY 2026	CY 2027	CY 2028	CY 2029	CY 2030	CY 2031
Non-Covered Choice Aggregate Gross Premiums	$ 620.9	$ 725.0	$ 766.8	$ 808.9	$ 852.4	$ 898.3
Non-Covered Choice Gross Premium PMPM	$ 553.31	$ 637.87	$ 665.92	$ 693.50	$ 722.09	$ 751.99
Non-Covered Choice Aggregate Net Premiums	$ 267.1	$ 296.9	$ 312.6	$ 328.2	$ 344.1	$ 360.8
Non-Covered Choice Net Premium PMPM	**$ 238.02**	**$ 261.20**	**$ 271.49**	**$ 281.40**	**$ 291.54**	**$ 302.03**

TOTAL EXCHANGE	CY 2026	CY 2027	CY 2028	CY 2029	CY 2030	CY 2031
Total Aggregate Gross Premiums	$ 637.2	$ 769.8	$ 814.2	$ 858.9	$ 905.1	$ 953.9
Total Aggregate Net Premiums	$ 269.3	$ 301.1	$ 317.0	$ 332.9	$ 349.0	$ 365.9
Total Composite Gross Premium PMPM	$ 553.91	$ 637.97	$ 666.02	$ 693.59	$ 722.19	$ 752.07
Total Composite Net Premiums PMPM	$ 234.15	$ 249.57	$ 259.36	$ 268.82	$ 278.49	$ 288.49

TOTAL OFF EXCHANGE	CY 2026	CY 2027	CY 2028	CY 2029	CY 2030	CY 2031
Total Aggregate Gross Premiums	$ 65.7	$ 76.7	$ 81.1	$ 85.5	$ 90.1	$ 94.9
Total Composite Gross Premium PMPM	$ 676.57	$ 779.70	$ 814.01	$ 847.38	$ 882.12	$ 918.29

TOTAL ACA COMPLIANT	CY 2026	CY 2027	CY 2028	CY 2029	CY 2030	CY 2031
Total Aggregate Gross Premiums	$ 702.8	$ 846.5	$ 895.2	$ 944.4	$ 995.2	$ 1,048.8
Total Composite Gross Premium PMPM	$ 563.46	$ 648.65	$ 677.17	$ 705.18	$ 734.24	$ 764.60
Statewide Average SLCSP Premium PMPM[2]	$ 626.64	$ 719.01	$ 750.33	$ 781.27	$ 813.32	$ 846.87
Statewide Aggregate SLCSP Premiums	$ 571.9	$ 693.5	$ 733.5	$ 773.8	$ 815.4	$ 859.4

Notes

1. Aggregate Gross and Net Premiums illustrated in $ millions.
2. Statewide Average SLCSP Premium PMPM limited to PTC eligible enrollees.
3. Note, exchange enrollment values for all income cohorts include individuals who do not qualify for federal PTCs.
4. Covered Choice enrollees are assumed to select the SLCSP.

Appendix 3

APPENDIX 3

IDAHO DEPARTMENT OF INSURANCE

SECTION 1332 WAIVER - REINSURANCE AND COVERED CHOICE

ESTIMATED PREMIUM TAX CREDIT ENROLLMENT, PMPM, AND EXPENDITURES ($ MILLIONS): CY 2026 THROUGH CY 2031

SCENARIO 1: WITHOUT WAIVER

100% to 138% FPL	CY 2026	CY 2027	CY 2028	CY 2029	CY 2030	CY 2031
Non-Covered Choice PTC Enrollment	2,200	2,300	2,300	2,300	2,400	2,400
Covered Choice PTC Enrollment	-	-	-	-	-	-
Total 100% to 138% FPL Enrollment	2,200	2,300	2,300	2,300	2,400	2,400
Non-Covered Choice PTC PMPM	$ 643.35	$ 676.05	$ 706.07	$ 735.62	$ 766.30	$ 798.39
Covered Choice PTC PMPM	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00
Composite 100% to 138% FPL PTC PMPM	$ 643.35	$ 676.05	$ 706.07	$ 735.62	$ 766.30	$ 798.39
Non-Covered Choice Aggregate PTC	$ 17.3	$ 18.4	$ 19.5	$ 20.5	$ 21.7	$ 22.8
Covered Choice Aggregate PTC	$ 0.0	$ 0.0	$ 0.0	$ 0.0	$ 0.0	$ 0.0
Total Aggregate 100% to 138% PTC	**$ 17.3**	**$ 18.4**	**$ 19.5**	**$ 20.5**	**$ 21.7**	**$ 22.8**

OTHER FPL	CY 2026	CY 2027	CY 2028	CY 2029	CY 2030	CY 2031
Non-Covered Choice PTC Enrollment	73,800	74,800	75,700	76,700	77,700	78,600
Non-Covered Choice PTC PMPM	$ 519.57	$ 547.19	$ 572.74	$ 598.11	$ 624.54	$ 652.36
Non-Covered Choice Aggregate PTC	**$ 460.2**	**$ 491.0**	**$ 520.6**	**$ 550.7**	**$ 582.0**	**$ 615.2**

TOTAL EXCHANGE	CY 2026	CY 2027	CY 2028	CY 2029	CY 2030	CY 2031
Total PTC Enrollment	76,000	77,000	78,000	79,100	80,000	81,000
Composite Exchange PTC PMPM	$ 523.21	$ 550.98	$ 576.67	$ 602.15	$ 628.72	$ 656.66
Total Aggregate PTC	**$ 477.5**	**$ 509.4**	**$ 540.1**	**$ 571.3**	**$ 603.7**	**$ 638.1**

Notes

1. Aggregate PTC illustrated in $ millions.
2. Enrollment limited to PTC eligible enrollees.

APPENDIX 3

IDAHO DEPARTMENT OF INSURANCE

SECTION 1332 WAIVER - REINSURANCE AND COVERED CHOICE

ESTIMATED PREMIUM TAX CREDIT ENROLLMENT, PMPM, AND EXPENDITURES ($ MILLIONS): CY 2026 THROUGH CY 2031

SCENARIO 2: REINSURANCE EXTENSION ONLY

100% to 138% FPL	CY 2026	CY 2027	CY 2028	CY 2029	CY 2030	CY 2031
Non-Covered Choice PTC Enrollment	2,200	2,300	2,300	2,300	2,400	2,400
Covered Choice PTC Enrollment	-	-	-	-	-	-
Total 100% to 138% FPL Enrollment	2,200	2,300	2,300	2,300	2,400	2,400
Non-Covered Choice PTC PMPM	$ 522.60	$ 605.59	$ 632.51	$ 659.02	$ 686.54	$ 715.33
Covered Choice PTC PMPM	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00
Composite 100% to 138% FPL PTC PMPM	$ 522.60	$ 605.59	$ 632.51	$ 659.02	$ 686.54	$ 715.33
Non-Covered Choice Aggregate PTC	$ 14.0	$ 16.5	$ 17.4	$ 18.4	$ 19.4	$ 20.5
Covered Choice Aggregate PTC	$ 0.0	$ 0.0	$ 0.0	$ 0.0	$ 0.0	$ 0.0
Total Aggregate 100% to 138% PTC	**$ 14.0**	**$ 16.5**	**$ 17.4**	**$ 18.4**	**$ 19.4**	**$ 20.5**

OTHER FPL	CY 2026	CY 2027	CY 2028	CY 2029	CY 2030	CY 2031
Non-Covered Choice PTC Enrollment	73,800	74,700	75,700	76,700	77,600	78,500
Non-Covered Choice PTC PMPM	$ 399.43	$ 477.85	$ 500.19	$ 522.51	$ 545.79	$ 570.32
Non-Covered Choice Aggregate PTC	**$ 353.8**	**$ 428.1**	**$ 454.2**	**$ 480.7**	**$ 508.2**	**$ 537.5**

TOTAL EXCHANGE	CY 2026	CY 2027	CY 2028	CY 2029	CY 2030	CY 2031
Total PTC Enrollment	76,000	76,900	78,000	79,000	80,000	80,900
Composite Exchange PTC PMPM	$ 403.05	$ 481.62	$ 504.08	$ 526.53	$ 549.93	$ 574.59
Total Aggregate PTC	**$ 367.8**	**$ 444.6**	**$ 471.6**	**$ 499.1**	**$ 527.6**	**$ 558.0**

REINSURANCE PROGRAM FUNDING	CY 2026	CY 2027	CY 2028	CY 2029	CY 2030	CY 2031
Total Reinsurance Program Funding	$ 154.3	$ 91.2	$ 96.4	$ 101.7	$ 107.2	$ 113.0
Estimated Federal Pass-through Funding[3]	$ 107.1	$ 63.3	$ 66.9	$ 70.5	$ 74.3	$ 78.3
State-Based Reinsurance Program Funding[4]	$ 47.2	$ 27.9	$ 29.6	$ 31.2	$ 32.9	$ 34.7

Notes

1. Aggregate PTC and Reinsurance Program Funding illustrated in $ millions.

2. Enrollment limited to PTC eligible enrollees.

3. Estimated Federal Pass-through Funding from the reinsurance program is calculated based on the following formula:
(Total Aggregate PTC without Reinsurance - Total Aggregate PTC with Reinsurance) x (PTC / APTC Reconciliation Factor).
The PTC / APTC reconciliation factor is 97.7% based on the value applied in Idaho's CY 2025 pass-through calculation.
See https://www.cms.gov/files/document/1332-key-components-2025-pass-throughv1.xlsx for additional information.

4. The state-based reinsurance program funding requirement is calculated based on the estimated total reinsurance program funding, less estimated federal pass-through funding. As stated in the report, state premium tax revenue is the assumed state funding source for the reinsurance program.

APPENDIX 3

IDAHO DEPARTMENT OF INSURANCE

SECTION 1332 WAIVER - REINSURANCE AND COVERED CHOICE

ESTIMATED PREMIUM TAX CREDIT ENROLLMENT, PMPM, AND EXPENDITURES ($ MILLIONS): CY 2026 THROUGH CY 2031

SCENARIO 3: REINSURANCE EXTENSION AND COVERED CHOICE AMENDMENT

100% to 138% FPL	CY 2026	CY 2027	CY 2028	CY 2029	CY 2030	CY 2031
Non-Covered Choice PTC Enrollment	2,200	2,300	2,300	2,300	2,400	2,400
Covered Choice PTC Enrollment	-	3,400	3,500	3,500	3,600	3,600
Total 100% to 138% FPL Enrollment	2,200	5,700	5,800	5,900	6,000	6,000
Non-Covered Choice PTC PMPM	$ 522.60	$ 605.59	$ 632.51	$ 659.02	$ 686.54	$ 715.33
Covered Choice PTC PMPM	$ 0.00	$ 581.05	$ 607.18	$ 632.39	$ 658.84	$ 686.39
Composite 100% to 138% FPL PTC PMPM	$ 522.60	$ 590.79	$ 617.22	$ 642.93	$ 669.79	$ 697.83
Non-Covered Choice Aggregate PTC	$ 14.0	$ 16.5	$ 17.4	$ 18.4	$ 19.4	$ 20.5
Covered Choice Aggregate PTC	$ 0.0	$ 24.0	$ 25.5	$ 26.9	$ 28.5	$ 30.0
Total Aggregate 100% to 138% PTC	**$ 14.0**	**$ 40.5**	**$ 42.9**	**$ 45.3**	**$ 47.9**	**$ 50.5**

OTHER FPL	CY 2026	CY 2027	CY 2028	CY 2029	CY 2030	CY 2031
Non-Covered Choice PTC Enrollment	73,800	74,700	75,700	76,700	77,600	78,500
Non-Covered Choice PTC PMPM	$ 399.43	$ 477.85	$ 500.19	$ 522.51	$ 545.79	$ 570.32
Non-Covered Choice Aggregate PTC	**$ 353.8**	**$ 428.1**	**$ 454.2**	**$ 480.7**	**$ 508.2**	**$ 537.5**

TOTAL EXCHANGE	CY 2026	CY 2027	CY 2028	CY 2029	CY 2030	CY 2031
Total PTC Enrollment	76,000	80,400	81,500	82,500	83,600	84,600
Composite Exchange PTC PMPM	$ 403.05	$ 485.88	$ 508.51	$ 531.08	$ 554.63	$ 579.41
Total Aggregate PTC	**$ 367.8**	**$ 468.6**	**$ 497.1**	**$ 526.0**	**$ 556.1**	**$ 588.0**

REINSURANCE PROGRAM FUNDING	CY 2026	CY 2027	CY 2028	CY 2029	CY 2030	CY 2031
Total Reinsurance Program Funding	$ 154.3	$ 91.2	$ 96.4	$ 101.7	$ 107.2	$ 113.0
Estimated Federal Pass-through Funding	$ 107.1	$ 63.3	$ 66.9	$ 70.5	$ 74.3	$ 78.3
State-Based Reinsurance Program Funding	$ 47.2	$ 27.9	$ 29.6	$ 31.2	$ 32.9	$ 34.7
Covered Choice Medicaid Federal Savings[4]	n/a	$ 32.1	$ 33.9	$ 35.7	$ 37.6	$ 39.6
Covered Choice Offset to Pass-Through Funding[5]	n/a	$ 0.0	$ 0.0	$ 0.0	$ 0.0	$ 0.0
Net Federal Pass-through Funding[6]	n/a	$ 63.3	$ 66.9	$ 70.5	$ 74.3	$ 78.3

Notes

1. Aggregate PTC and Reinsurance Program Funding illustrated in $ millions.
2. Enrollment limited to PTC eligible enrollees.

3. Covered Choice enrollment demographics based on the October 2025 Medicaid expansion census. Covered Choice enrollees are assumed to select the second lowest cost silver plan (SLCSP) at a 20% election rate (high scenario) and are assumed to be uniform by household income, age, rating area, and household size and vary relative to other exchange enrollees in the 100% to 138% FPL cohort.

4. Federal Medicaid expansion cost savings per Covered Choice enrollee are estimated to be approximately 25% greater than the per capita PTC received by the enrollee. Therefore, based on the State's proposed pass-through methodology, there are no offsets to pass-through funding generated by the reinsurance program as federal deficit neutrality is maintained.

5. The Covered Choice Offset to Pass-Through Funding is calculated based on the following formula: Maximum ($0, Covered Choice Aggregate PTC - Covered Choice Medicaid Federal Savings). Additional detail is contained in Figure 1 of the report.

6. Net federal pass-through funding is calculated based on the following formula: Estimated Federal Pass-through Funding (Reinsurance Program Funding) - Covered Choice Offset to Pass-Through Funding.

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Attachment B: Authorizing Legislation

LEGISLATURE OF THE STATE OF IDAHO

Sixty-sixth Legislature Second Regular Session - 2022

IN THE HOUSE OF REPRESENTATIVES

HOUSE BILL NO. 611

BY BUSINESS COMMITTEE

AN ACT

RELATING TO INSURANCE; AMENDING SECTION 41-5504, IDAHO CODE, TO SPECIFY REQUIREMENTS FOR CERTAIN REINSURANCE CLAIMS; AND DECLARING AN EMERGENCY AND PROVIDING AN EFFECTIVE DATE.

Be It Enacted by the Legislature of the State of Idaho:

SECTION 1. That Section 41-5504, Idaho Code, be, and the same is hereby amended to read as follows:

41-5504. POWERS AND AUTHORITY. (1) The pool shall have the general powers and authority granted under the laws of this state to insurance companies and managed care organizations licensed to transact business, except the power to issue health benefit plans directly to individuals. In addition thereto, the pool shall have the specific authority to:

(a) Enter into contracts as are necessary or proper to carry out the provisions and purposes of this chapter, including the authority, with the approval of the director, to enter into contracts with similar programs of other states for the joint performance of common functions or with persons or other organizations for the performance of administrative functions;

(b) Sue or be sued, including taking any legal actions necessary or proper to recover any assessments and penalties for, on behalf of, or against the pool or any carrier;

(c) Define the high risk medical conditions for which reinsurance will be provided, and to issue reinsurance policies, in accordance with the requirements of this chapter;

(d) Establish rules, conditions and procedures for reinsuring risks under the pool;

(e) Establish actuarial functions as appropriate for the operation of the pool;

(f) Assess carriers in accordance with the provisions of section 41-5508, Idaho Code, and make advance interim assessments of carriers as may be reasonable and necessary for organizational and interim operating expenses. Any interim assessments shall be credited as offsets against any regular assessments due following the close of the fiscal year;

(g) Appoint appropriate legal, actuarial and other committees as necessary to provide technical assistance in the operation of the pool, policy and other contract design, and any other function within the authority of the pool;

(h) Borrow money to effect the purposes of the pool. Any notes or other evidence of indebtedness of the pool not in default shall be legal investments for carriers and may be carried as admitted assets;

(i) Establish rules, policies and procedures as may be necessary or convenient for the implementation of this chapter and the operation of the pool.

(2) Neither the board nor its employees shall be liable for any obligations of the pool. No member or employee of the board shall be liable, and no cause of action of any nature may arise against them, for any act or omission related to the performance of their powers and duties under this chapter, unless such act or omission constitutes willful or wanton misconduct. The board may provide for indemnification of, and legal representation for, its members and employees.

(3) No participation of a reinsuring carrier in the pool, no establishment of rates, forms or procedures, and no other joint or collective action required under the provisions of this chapter shall be grounds for any legal action, criminal or civil liability, or penalty against the pool or any of its reinsuring carriers either jointly or separately.

(4) The pool shall have no authority to provide reinsurance for any claims incurred after December 31, 2022, unless the following conditions are met:

(a) The state develops an application for a waiver for state innovation pursuant to 42 U.S.C. 18052 of the federal patient protection and affordable care act that facilitates the resumption of operations of the pool in a manner that minimizes the loss of federal funding to support the affordability of health insurance in the state;

(b) After proper public comment periods and consultation with interested parties, including the pool board, and the approval of the governor, the waiver application is submitted to the secretary of the United States department of health and human services and to the secretary of the United States department of the treasury; and

(c) The waiver application is approved.

(5) The director shall have the authority as necessary or proper to develop, apply for, and upon approval implement an innovation waiver under 42 U.S.C. 18052 of the federal patient protection and affordable care act, including authorizing the pool to perform activities necessary for its implementation.

SECTION 2. An emergency existing therefor, which emergency is hereby declared to exist, this act shall be in full force and effect on and after July 1, 2022.

LEGISLATURE OF THE STATE OF IDAHO

Sixty-eighth Legislature First Regular Session - 2025

IN THE HOUSE OF REPRESENTATIVES

HOUSE BILL NO. 345

BY HEALTH AND WELFARE COMMITTEE

AN ACT

RELATING TO LEGISLATIVE APPROVAL FOR MEDICAID STATE PLAN AMENDMENTS AND WAIVERS; REPEALING SECTION 56-270, IDAHO CODE, AS ENACTED BY SECTION 1, CHAPTER 288, LAWS OF 2024, RELATING TO LEGISLATIVE APPROVAL OF WAIVERS AND STATE PLAN AMENDMENTS; AMENDING TITLE 56, IDAHO CODE, BY THE ADDITION OF A NEW CHAPTER 22, TITLE 56, IDAHO CODE, TO PROVIDE THAT LEGISLATIVE APPROVAL IS REQUIRED FOR CERTAIN STATE PLAN AMENDMENTS AND WAIVERS, TO PROVIDE LEGISLATIVE APPROVAL FOR A STATE PLAN AMENDMENT REGARDING RURAL EMERGENCY HOSPITAL DESIGNATION, TO PROVIDE LEGISLATIVE APPROVAL FOR A STATE PLAN AMENDMENT REGARDING MEDICAID COST-SHARING, TO PROVIDE LEGISLATIVE APPROVAL FOR STATE PLAN AMENDMENTS AND WAIVERS REGARDING COMPREHENSIVE MEDICAID MANAGED CARE, TO PROVIDE LEGISLATIVE APPROVAL FOR STATE PLAN AMENDMENTS AND WAIVERS REGARDING MEDICAID EXPANSION LIMITS, TO PROVIDE LEGISLATIVE APPROVAL FOR A STATE PLAN AMENDMENT REGARDING PRACTICE AUTHORITY PROTECTION, AND TO PROVIDE LEGISLATIVE APPROVAL FOR A STATE PLAN AMENDMENT REGARDING SITE NEUTRAL PAYMENTS; REPEALING SECTION 56-253, IDAHO CODE, RELATING TO POWERS AND DUTIES OF THE DIRECTOR; AMENDING SECTION 56-263, IDAHO CODE, TO REMOVE OBSOLETE LANGUAGE AND TO PROVIDE THAT THE DEPARTMENT OF HEALTH AND WELFARE SHALL DISCONTINUE CERTAIN CONTRACTING AND REIMBURSEMENT; AMENDING SECTION 56-265, IDAHO CODE, TO PROVIDE THAT FEDERALLY QUALIFIED HEALTH CENTERS SHALL BE EXEMPT FROM FINANCIAL RISK IN CERTAIN PAYMENT ARRANGEMENTS; AMENDING SECTION 56-267, IDAHO CODE, TO REVISE PROVISIONS REGARDING ELIGIBILITY EXPANSION; AMENDING SECTION 56-1403, IDAHO CODE, TO REVISE PROVISIONS REGARDING THE HOSPITAL ASSESSMENT FUND; AMENDING SECTION 56-1404, IDAHO CODE, TO REVISE PROVISIONS REGARDING THE UPPER PAYMENT LIMIT ASSESSMENT RATE; PROVIDING THAT CERTAIN ADMINISTRATIVE RULES CONTAINED IN IDAPA 16.03.17 SHALL BE NULL, VOID, AND OF NO FORCE AND EFFECT; PROVIDING THAT CERTAIN ADMINISTRATIVE RULES CONTAINED IN IDAPA 16.03.18 SHALL BE NULL, VOID, AND OF NO FORCE AND EFFECT; PROVIDING THAT CERTAIN ADMINISTRATIVE RULES CONTAINED IN IDAPA 16.03.09 SHALL BE NULL, VOID, AND OF NO FORCE AND EFFECT; PROVIDING THAT CERTAIN ADMINISTRATIVE RULES CONTAINED IN IDAPA 16.03.10 SHALL BE NULL, VOID, AND OF NO FORCE AND EFFECT; AND DECLARING AN EMERGENCY.

Be It Enacted by the Legislature of the State of Idaho:

SECTION 1. That Section 56-270, Idaho Code, as enacted by Section 1, Chapter 288, Laws of 2024, be, and the same is hereby repealed.

SECTION 2. That Title 56, Idaho Code, be, and the same is hereby amended by the addition thereto of a NEW CHAPTER, to be known and designated as Chapter 22, Title 56, Idaho Code, and to read as follows:

CHAPTER 22

LEGISLATIVE APPROVAL FOR MEDICAID STATE PLAN AMENDMENTS AND WAIVERS

56-2201. LEGISLATIVE APPROVAL REQUIRED. Notwithstanding any provision of law to the contrary, the state department of health and welfare shall not seek or implement a medicaid state plan amendment or a waiver pursuant to section 1115 or 1915 of the social security act that would expand coverage to any additional individuals or class of individuals or would increase any net cost to the state without first obtaining approval from the legislature. Such approval must be provided in statute and, to be effective, must be listed in this chapter. The provisions of this section shall not affect any state plan amendment or waiver program previously authorized by statute or already implemented as of July 1, 2025. The provisions of this section shall not apply to any medicaid state plan amendment or waiver program that does not expand coverage to any individuals or class of individuals and does not increase any net cost to the state. The department of health and welfare shall provide regular updates to the medicaid legislative review panel on a schedule determined by the cochairs and shall seek input from the medicaid legislative review panel to design any waivers submitted to the centers for medicare and medicaid services on behalf of the state.

56-2202. LEGISLATIVE APPROVAL -- RURAL EMERGENCY HOSPITAL DESIGNATION AND REIMBURSEMENT. The department of health and welfare is authorized to and shall submit a state plan amendment to the centers for medicare and medicaid services allowing the recognition and reimbursement of medicaid services provided by a rural emergency hospital. For the purposes of this section, "rural emergency hospital" has the same meaning as provided in 42 U.S.C. 1395x(kkk)(2).

56-2203. LEGISLATIVE APPROVAL -- MEDICAID COST-SHARING. (1) The department of health and welfare is authorized to and shall submit a state plan amendment to the centers for medicare and medicaid services to include participant cost-sharing as a condition of participation in a medical assistance program, to the extent allowed under federal law, that is at least to the levels developed by other states and up to the maximum charged by other states.

(2) The department of health and welfare shall:

(a) Take such actions as are necessary to implement the provisions of this section;

(b) Begin the application process for federal approval of the state plan amendment required by this section no later than July 1, 2026; and

(c) Continue any existing cost-sharing under the medicaid state plan in effect at the time of the passage of this act until supplanted by the new state plan amendment required by this section.

56-2204. LEGISLATIVE APPROVAL -- COMPREHENSIVE MEDICAID MANAGED CARE. (1) The department of health and welfare is authorized to and shall submit to the centers for medicare and medicaid services all state plan and waiver authorities required to implement a plan for comprehensive medicaid managed care.

(2) The department of health and welfare shall:

(a) Take such actions as are necessary to implement the provisions of this section;
(b) Submit the application for federal approval of the state plan amendments and waivers required by this section no later than July 1, 2026;
(c) Continue any existing managed care under the medicaid state plan and its waivers in effect at the time of the passage of this act until supplanted by the new comprehensive managed care plan required under this section;
(d) Undertake cost containment strategies, such as bidding multi-year contracts with predetermined inflationary adjustments or withholding a percentage of capitation if managed care organizations do not meet these cost containment targets; and
(e) Engage medicaid providers and participants in the substance and design of a comprehensive managed care plan.

56-2205. LEGISLATIVE APPROVAL -- MEDICAID EXPANSION LIMITS. (1) The department of health and welfare is authorized to and shall submit to the centers for medicare and medicaid services the following state plan amendments and waivers no later than July 1, 2026:
(a) Work-requirements for able-bodied adults enrolled in medicaid in which no individual shall be eligible to participate in the medicaid program pursuant to section 56-267, Idaho Code, unless the individual is:
(i) Working twenty (20) hours or more per week, averaged monthly;
(ii) Participating in and complying with the requirements of a work program twenty (20) hours or more per week, as determined by the department;
(iii) Volunteering twenty (20) hours or more per week, as determined by the department;
(iv) Meeting any combination of working and participating in a work program for a total of twenty (20) hours or more per week, as determined by the department; or
(v) Participating and complying with the requirements of a workfare program, unless the individual is:
1. Younger than nineteen (19) years of age;
2. Older than sixty-four (64) years of age;
3. Medically classified as physically or mentally unfit for employment;
4. Pregnant;
5. A parent or caretaker responsible for the care of a dependent child younger than six (6) years of age;
6. A parent or caretaker personally providing the care for a dependent with a serious medical condition or with a disability, as determined by the department;
7. Receiving unemployment compensation and complying with the work requirements as part of the federal-state unemployment compensation system;
8. Participating in a drug addiction or alcohol treatment and rehabilitation program; or

9. Enrolled at least part-time in a college, university, or vocational education program.

(b) Allow persons eligible for medicaid under section 56-267, Idaho Code, who have a modified adjusted gross income at least at or above one hundred percent (100%) of the federal poverty level to receive the advance premium tax credit to purchase a qualified health plan through the Idaho health insurance exchange established by chapter 61, title 41, Idaho Code, instead of enrolling in medicaid, except that the person may choose to enroll in medicaid instead of receiving the advance premium tax credit to purchase a qualified health plan.

(c) Implement the following changes to eligibility determination:

(i) Suspend requirements to renew eligibility automatically based on available information and pre-populated forms; and

(ii) Implement biannual redetermination for persons eligible for medicaid under section 56-267, Idaho Code.

(d) Implement the following changes to benefits:

(i) No funds shall be used to fulfill any contract or commercial transaction with any health care provider or health care facility under the terms of which such health care provider or health care facility agrees to provide services prohibited under section 18-1506C, Idaho Code; and

(ii) No funds shall be used to fulfill any gender reassignment procedures, including treatment and surgery for any resident eighteen (18) years of age or older.

(2) An individual is exempt from the provisions of any state plan amendment or waiver pursuant to this section if the individual is an American Indian or Alaska native who is eligible for services through the Indian health service or through a tribal program pursuant to the Indian self-determination and education assistance act or the Indian health care improvement act.

56-2206. LEGISLATIVE APPROVAL -- PRACTICE AUTHORITY PROTECTION. The department of health and welfare is authorized to and shall submit a state plan amendment to the centers for medicare and medicaid services by July 1, 2025, allowing for practice authority protection to the extent permitted by state law.

56-2207. LEGISLATIVE APPROVAL -- SITE-NEUTRAL PAYMENTS. The department of health and welfare is authorized to seek and shall submit a state plan amendment by July 1, 2026, that sets reimbursement rates for hospital-acquired physician practices at the same rate as physician-owned medical practices for all equivalent outpatient health services where the service is not dependent on the hospital facility's associated technologies and in the absence of any evidence-based rationale. The department shall except critical access hospitals and rural emergency hospitals to the extent allowable.

SECTION 3. That Section 56-253, Idaho Code, be, and the same is hereby repealed.

SECTION 4. That Section 56-263, Idaho Code, be, and the same is hereby amended to read as follows:

56-263. MEDICAID MANAGED CARE PLAN. ~~(1) The department shall present to the legislature on the first day of the second session of the sixty-first Idaho legislature a plan for medicaid managed care with focus on high-cost populations, including but not limited to:~~

~~(a) Dual eligibles; and~~

~~(b) High-risk pregnancies.~~

~~(2) The medicaid managed care plan shall include but not be limited to the following elements:~~

~~(a) Improved coordination of care through primary care medical homes.~~

~~(b) Approaches that improve coordination and provide case management for high-risk, high-cost disabled adults and children that reduce costs and improve health outcomes, including mandatory enrollment in special needs plans, and that consider other managed care approaches.~~

~~(c) Managed care contracts to pay for behavioral health benefits as described in executive order no. 2011-01 and in any implementing legislation. At a minimum, the system should include independent, standardized, statewide assessment and evidence-based benefits provided by businesses that meet national accreditation standards.~~

~~(d) The elimination of duplicative practices that result in unnecessary utilization and costs.~~

~~(e) Contracts based on gain-sharing, risk-sharing or a capitated basis.~~

~~(f) Medical home development with focus on populations with chronic disease using a tiered case management fee.~~

~~(3) The department shall seek federal approval or a waiver to require that a medicaid participant who has a medical home as required in section 56-255(5)(b), Idaho Code, and who seeks family planning services or supplies from a provider outside the participant's medical home, must have a referral to such outside provider. The provisions of this subsection shall apply to medicaid participants upon such approval or the granting of such a waiver.~~

~~(4)~~ (1) The department shall seek approval as soon as practicable but no later than July 1, 2027, from the centers for medicare and medicaid services for directed payments to qualifying ~~hospitals~~ entities participating in the Idaho behavioral health plan or any comprehensive managed care plan in accordance with 42 CFR 438~~.~~, with thirty percent (30%) of the directed payments being utilized for general fund medicaid needs. Such funds shall be continuously appropriated.

~~(5)~~ (2) Subject to written approval by the centers for medicare and medicaid services, the department shall make directed payments to qualifying hospitals participating in medicaid managed care programs in an amount not to exceed the maximum allowable payment authorized by federal regulations.

~~(6)~~ (3) Qualifying behavioral health hospitals assessed pursuant to this section for the Idaho behavioral health plan are exempt from assessment pursuant to section 56-1404, Idaho Code.

(4) The department shall discontinue contracting and reimbursing as part of the healthy connections value care program through value care organizations and the healthy connections primary care case management program by January 1, 2026.

SECTION 5. That Section 56-265, Idaho Code, be, and the same is hereby amended to read as follows:

56-265. PROVIDER PAYMENT. (1) Where there is an equivalent, the payment to medicaid providers:

(a) May be up to but shall not exceed one hundred percent (100%) of the current medicare rate for primary care procedure codes as defined by the centers for medicare and medicaid services; and

(b) Shall be ninety percent (90%) of the current medicare rate for all other procedure codes.

(2) Where there is no medicare equivalent, the payment rate to medicaid providers shall be prescribed by rule.

(3) Notwithstanding any other provision of this chapter, if the services are provided by a private, freestanding mental health hospital facility that is an institution for mental disease as defined in 42 U.S.C. 1396d(i), the department shall reimburse for inpatient services at a rate not to exceed ninety-one percent (91%) of the current medicare rate within federally allowed reimbursement under the medicaid program. The reimbursement provided for in this subsection shall be effective until July 1, 2021.

(4) The department shall, through the annual budget process, include a line-item request for adjustments to provider rates. All changes to provider payment rates shall be subject to approval of the legislature by appropriation.

(5) Notwithstanding any other provision of this chapter, the department may enter into agreements with providers to pay for services based on their value in terms of measurable health care quality and positive impacts to participant health.

(a) Any such agreement shall be designed to be cost-neutral or cost-saving compared to other payment methodologies.

(b) The department is authorized to pursue waiver agreements with the federal government as needed to support value-based payment arrangements, up to and including fully capitated provider-based managed care.

(c) Beginning with the 2024 performance period and for all future performance periods thereafter, federally qualified health centers and any organization owned and controlled by a federally qualified health center shall be exempt from any financial risk in value-based payment agreements created pursuant to this section.

(6) Medicaid reimbursement for critical access, out-of-state, and state-owned hospitals shall be as follows:

(a) In-state, critical access hospitals as designated according to 42 U.S.C. 1395i-4(c)(2)(B) shall be reimbursed at one hundred one percent (101%) of cost;

(b) Out-of-state hospitals shall be reimbursed at eighty-seven percent (87%) of cost;

(c) State-owned hospitals shall be reimbursed at one hundred percent (100%) of cost; and

(d) Out-of-state hospital institutions for mental disease as defined in 42 U.S.C. 1396d(i) shall be reimbursed at a per diem equivalent to ninety-five percent (95%) of cost.

(7) The department shall equitably reduce net reimbursements for all hospital services, including in-state institutions for mental disease but excluding all hospitals and institutions described in subsection (6) of this section, by amounts targeted to reduce general fund needs for hospital

payments by three million one hundred thousand dollars ($3,100,000) in state fiscal year 2020 and eight million seven hundred twenty thousand dollars ($8,720,000) in state fiscal year 2021.

(8) The department shall work with all Idaho hospitals, including institutions for mental disease as defined in 42 U.S.C. 1396d(i), to establish value-based payment methods for inpatient and outpatient hospital services to replace existing cost-based reimbursement methods for in-state hospitals, other than those hospitals and institutions described in subsection (6) of this section, effective July 1, 2021. Budgets for hospital payments shall be subject to prospective legislative approval.

(9) The department shall work with Idaho hospitals to establish a quality payment program for inpatient and outpatient adjustment payments described in section 56-1406, Idaho Code. Inpatient and outpatient adjustment payments shall be subject to increase or reduction based on hospital service quality measures established by the department in consultation with Idaho hospitals.

SECTION 6. That Section 56-267, Idaho Code, be, and the same is hereby amended to read as follows:

56-267. MEDICAID ELIGIBILITY EXPANSION. (1) Notwithstanding any provision of law or federal waiver to the contrary, the state shall amend its state plan to expand medicaid eligibility to include those persons under sixty-five (65) years of age whose modified adjusted gross income is one hundred thirty-three percent (133%) of the federal poverty level or below and who are not otherwise eligible for any other coverage under the state plan, in accordance with sections 1902(a)(10)(A)(i)(VIII) and 1902(e)(14) of the social security act.

(2) No later than ninety (90) days after approval of this act, the department shall submit any necessary state plan amendments to the United States department of health and human services, centers for medicare and medicaid services to implement the provisions of this section. The department is required and authorized to take all actions necessary to implement the provisions of this section as soon as practicable.

(3) Eligibility for medicaid as described in this section shall not be delayed if the centers for medicare and medicaid services fail to approve any waivers of the state plan for which the department applies, nor shall such eligibility be delayed while the department is considering or negotiating any waivers to the state plan. The department shall not implement any waiver that would result in a reduction in federal financial participation for persons identified in subsection (1) of this section below the ninety percent (90%) commitment described in section 1905(y) of the social security act.

(4) If section 1905(y) of the social security act is held unlawful or unconstitutional by the United States supreme court, then the legislature shall declare this section to be null, void, and of no force and effect.

(5) If federal financial participation for persons identified in subsection (1) of this section is reduced below the ninety percent (90%) commitment described in section 1905(y) of the social security act, then the senate and house of representatives health and welfare committees shall, as soon as practicable, review the effects of such reduction and make a recommendation to the legislature as to whether medicaid eligibility expansion should

remain in effect. The review and recommendation described in this subsection shall be conducted by the date of adjournment of the regular legislative session following the date of reduction in federal financial participation. Notwithstanding any other provision of law to the contrary, if the reduction in federal financial participation occurs outside of a state legislative session, the department shall take any action necessary to offset the increase in state funding, including but not limited to reductions in provider payment rates or elimination of optional benefits. Such actions shall be taken until such time as the state legislature may convene and determine a proper course of action.

~~(6) The department:~~

~~(a) Shall place all persons participating in medicaid pursuant to this section in a care management program authorized under section 56-265(5), Idaho Code, or in another managed care program to improve the quality of their care, to the extent possible; and~~

~~(b) Is authorized to seek any federal approval necessary to implement the provisions of this subsection.~~

~~(7) No later than January 31 in the 2023 legislative session, the senate and house of representatives health and welfare committees shall review all fiscal, health, and other impacts of medicaid eligibility expansion pursuant to this section and shall make a recommendation to the legislature as to whether such expansion should remain in effect.~~

SECTION 7. That Section 56-1403, Idaho Code, be, and the same is hereby amended to read as follows:

56-1403. HOSPITAL ASSESSMENT FUND ESTABLISHED. (1) There is hereby created in the office of the state treasurer a dedicated fund to be known as the hospital assessment fund, hereinafter "fund," to be administered by the department of health and welfare, hereinafter "department." The state treasurer shall invest idle moneys in the fund and any interest received on those investments shall be returned to the fund. All moneys in the fund are continuously appropriated to the department for the purposes specified in this chapter.

(2) Moneys in the fund shall consist of:

(a) All moneys collected or received by the department from private hospital assessments required by this chapter;

(b) All federal matching funds received by the department as a result of expenditures made by the department that are attributable to moneys deposited in the fund;

(c) Any interest or penalties levied in conjunction with the administration of this chapter; and

(d) Any appropriations, federal funds, donations, gifts or moneys from any other sources.

(3) The fund is created for the purpose of receiving moneys in accordance with this section and section 56-1404, Idaho Code. Moneys in the fund shall be distributed by the department ~~subject to appropriation~~ for the following purposes only:

(a) Payments to private hospitals as required under Idaho's medical assistance program as set forth in sections 56-209b through 56-209d, Idaho Code;

(b) Reimbursement of moneys collected by the department from private hospitals through error or mistake in performing the activities authorized under Idaho's medical assistance program;
(c) Payments of administrative expenses incurred by the department or its agent in performing the activities authorized by this chapter;
(d) Payments made to the federal government to repay excess payments made to private hospitals from the fund if the assessment plan is deemed out of compliance and after the state has appealed the findings. Hospitals shall refund the payments in question to the assessment fund. The state in turn shall return funds to both the federal government and hospital providers in the same proportion as the original financing. Individual hospitals shall be reimbursed based on the proportion of the individual hospital's assessment to the total assessment paid by all private hospitals. If a hospital is unable to refund payments, the state shall develop a payment plan and deduct moneys from future medicaid payments;
(e) Transfers to any other fund in the state treasury, provided such transfers shall not exceed the amount transferred previously from that other fund into the hospital assessment fund;
(f) Making refunds to hospitals pursuant to section 56-1410, Idaho Code; and
(g) Offsetting general funding needed to support Idaho medicaid.

SECTION 8. That Section 56-1404, Idaho Code, be, and the same is hereby amended to read as follows:

56-1404. ASSESSMENTS. (1) All private hospitals, except those exempted under section 56-1408, Idaho Code, shall make payments to the fund in accordance with this chapter. Subject to section 56-1410, Idaho Code, an annual assessment on both inpatient and outpatient services is determined for each qualifying hospital for each state fiscal year in an amount calculated by multiplying the rate, as set forth in subsections (2)(c) and (3)(b) of this section, by the assessment base, as set forth in subsection (5) of this section.
(2)(a) The department shall calculate the private hospital upper payment limit gap for both inpatient and outpatient services. The upper payment limit gap is the difference between the maximum allowable payments eligible for federal match, less medicaid payments not financed using hospital assessment funds. The upper payment limit gap shall be calculated separately for hospital inpatient and outpatient services. Medicaid disproportionate share payments shall be excluded from the calculation.
(b) Idaho medicaid will start work toward approval by the centers for medicare and medicaid services (CMS) of an updated upper payment limit calculation methodology no later than July 1, 2022. This change is needed due to the change reflected in section 56-265, Idaho Code, in reimbursement from retrospective cost settlements to prospective payment systems.
(c) The department shall calculate the upper payment limit assessment rate for each state fiscal year to be the percentage that, when multi-

plied by the assessment base as defined in subsection (5) of this section, equals the upper payment limit payment.

(d) Beginning July 1, 2022, or upon approval by CMS, whichever is later, the assessment rate referenced in paragraph (c) of this subsection will increase to the amount needed to attain an increased supplemental upper payment limit payment. This payment amount is subject to CMS approval of the updated upper payment limit methodology described in paragraph (a) of this subsection and ~~legislative appropriation~~ shall be continuously appropriated.

(e) Beginning July 1, 2023, an additional amount will be assessed at thirty percent (30%) of the upper payment limit payment to be utilized for general fund medicaid needs.

(f) If CMS does not approve the updated upper payment limit methodology described in paragraph (b) of this subsection, then the additional assessment described in paragraph (e) of this subsection shall not be implemented.

(g) The assessment described in paragraph (e) of this subsection shall be assessed only if the upper payment limit payment is greater than the total assessment.

(3)(a) The department shall calculate the disproportionate share allotment amount to be paid to private in-state hospitals.

(b) The department shall calculate the disproportionate share assessment rate for private in-state hospitals to be the percentage that, when multiplied by the assessment base as defined in subsection (5) of this section, equals the amount of state funding necessary to pay the private in-state hospital disproportionate share allotment determined in paragraph (a) of this subsection.

(4) For private in-state hospitals, the assessments calculated pursuant to subsections (2) and (3) of this section shall not be greater than the federal limit as referenced in 42 CFR 433.68 of the assessment base as defined in subsection (5) of this section.

(5) The assessment base shall be the hospital's net patient revenue for the applicable period. Net patient revenue, beginning with state fiscal year 2023, shall be determined using each hospital's fiscal year 2021 medicare cost report on file with the department, without regard to any subsequent adjustments or changes to such data. If the 2021 cost report has not been filed, the prior year's cost report will be used. Net patient revenue for each state fiscal year thereafter shall be determined in the same manner using a rolling yearly schedule for each hospital's fiscal year medicare cost report.

SECTION 9. The rules contained in IDAPA 16.03.17, Department of Health and Welfare, relating to Medicare/Medicaid Coordinated Plan Benefits, shall be null, void, and of no force and effect on and after July 1, 2025.

SECTION 10. The rules contained in IDAPA 16.03.18, Department of Health and Welfare, relating to Medicaid Cost-Sharing, shall be null, void, and of no force and effect on and after July 1, 2025.

SECTION 11. The rules contained in IDAPA 16.03.09, Department of Health and Welfare, relating to Medicaid Basic Plan Benefits, shall be null, void, and of no force and effect on and after July 1, 2025.

SECTION 12. The rules contained in IDAPA 16.03.10, Department of Health and Welfare, relating to Medicaid Enhanced Plan Benefits, shall be null, void, and of no force and effect on and after July 1, 2025.

SECTION 13. An emergency existing therefor, which emergency is hereby declared to exist, this act shall be in full force and effect on and after its passage and approval.

Attachment C: Side-by-side Analysis of Benefits and Services

Category	Medicaid	QHPs
Essential Health Benefits (EHBs)	Covers all 10 ACA-required EHBs plus additional benefits, including vision, dental, and therapy services beyond EHB scope.	Covers all 10 ACA-required EHBs: ambulatory care, emergency services, hospitalization, pregnancy/ maternity/ newborn care, mental health/ substance use disorder, prescription drugs, rehabilitative/ habilitative services, laboratory services, preventive/ wellness care, and pediatric oral and vision care. Adult dental and vision coverage are generally not included but are available for a separate premium.
Eligibility & Enrollment	Eligibility based on income, disability, or qualifying health condition. PTC is not applicable.	Enrollment determined by income and other factors; PTC available for eligible individuals.
Opting Out	Requires informed choice to opt out of Medicaid coverage.	Not applicable. Enrollment in plans is optional.
Provider Choice	Medicaid participants have the right to choose any provider accepting Medicaid under federal law (Social Security Act § 1902(a)(23)). If a provider does not accept Medicaid, participants may pay out-of-pocket.	Plans typically have a network of providers. Participants can access out-of-network providers but may face higher cost-sharing.
Covered Populations	Includes pregnant individuals, children under EPSDT, people with disabilities or chronic conditions, and other qualifying groups.	Individuals and families until age 65.
Pregnancy and Childbirth Coverage	Comprehensive maternity and newborn care covered, including pregnancies beginning prior to coverage start.	Pregnancy and childbirth covered as EHBs from the first day of coverage.

Category	Medicaid	QHPs
Mental Health and Substance Use Disorder	Comprehensive coverage including treatment and inpatient services for mental health and substance use disorders. Parity protections apply to Medicaid MCOs and CHIP.	Covered as EHBs with federal parity protections. No denials or higher costs for pre-existing conditions.
Preventive Services Coverage	Preventive care with limited or no cost sharing; covering adults and children.	Preventive services covered at no cost when provided by in-network providers for adults and children.
Pre-Existing Conditions & Enrollment Protections	Medicaid and CHIP cannot deny or charge more based on pre-existing conditions.	Plans cannot deny coverage or charge more for pre-existing conditions. Coverage begins immediately for pregnancy and other conditions. Special Enrollment Periods are available for qualifying life events (birth or adoption, etc.).
Additional Benefits	Includes vision, dental, therapy, and specialized medical management programs.	Other benefits, including dental and vision, vary by plan.
Cost Sharing (Copays, Premiums)	Limited cost sharing; some populations and services exempt. May include deductibles and out-of-pocket limits.	Cost sharing varies by plan. Out-of-network care generally incurs higher copays and coinsurance.
Vision and Dental Coverage	Vision and dental coverage often included beyond pediatric EHBs; adult coverage varies by Medicaid program.	Pediatric vision and dental included as EHBs. Adult dental and vision coverage may be included but are not required. Dental plans are available separately or bundled with health plans with corresponding premiums and cost-sharing.
Therapy Services (OT, PT, SLP)	Covered up to age 21 with dollar limits, including Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services.	Therapy services covered with limits and cost-sharing.
Long-Term & Institutional Care	Nursing home care, in-home care, and institutional care covered for eligible	Generally not covered or very limited coverage.

Category	Medicaid	QHPs
	individuals based on health or disability criteria.	
Emergency Care Access	Emergency services must be provided at the nearest capable hospital regardless of network status; no additional cost-sharing for out-of-network emergency care.	Emergency services covered at the nearest capable facility with no additional cost-sharing for out-of-network emergency care.

Medicaid offers comprehensive coverage that includes all EHBs plus additional services such as vision, dental, and therapy, with broad provider choice and limited cost-sharing, especially for vulnerable populations such as pregnant individuals, children, and people with disabilities. QHPs cover all ACA EHBs with structured provider networks and variable cost-sharing, including premiums and deductibles. Both Medicaid and QHPs protect individuals with pre-existing conditions and guarantee access to emergency care without additional cost-sharing regardless of network status.

Attachment D: Cost Sharing under Medicaid

Medicaid participants may be charged a copay per visit for certain outpatient services of $3.65, which may increase to $4.00 effective July 1, 2026:

1. Accessing hospital emergency room services for non-emergency medical conditions;
2. Accessing emergency transportation services for non-emergency medical conditions;
3. Chiropractic services;
4. Optometric services;
5. Outpatient hospital services;
6. Podiatry services;
7. Physical therapy;
8. Speech therapy;
9. Occupational therapy; and
10. Physician office visits, unless the visit is for:
    a. A preventive wellness exam, immunizations, or family planning, or
    b. Urgent care provided at a clinic billing as an urgent care facility.

The following participants are exempt from copays:

1. A child under the age of nineteen (19) with family income less than or equal to 133% FPL;
2. An individual age of nineteen (19) or older with family income less than or equal to 100% FPL except for participants eligible for the Adult Group otherwise known as Medicaid Expansion;
3. A pregnant or post-partum individual when the services provided are related to the pregnancy;
4. An inpatient in a hospital, nursing facility, intermediate care facility for persons with intellectual disabilities (ICF/ID), or other medical institution;
5. An adult participant who receives services provided under a 1915(c) waiver;
6. A participant who has other health care coverage that is the primary payor for the services provided;
7. A participant receiving hospice care;
8. A child in foster care receiving aid or assistance under Title IV, Part B of the Social Security Act;
9. A participant receiving adoption or foster care assistance under Title IV, Part E of the Social Security Act, or those in continued care regardless of age; and
10. A participant eligible under the breast and cervical cancer eligibility group.

Attachment E: Applicability of Public Law 119-21 Community Engagement

Public Law 119-21, Sec 71119 - Medicaid Community Engagement for Certain Recipients (Work Requirements)

Requires Able Bodied Adults Without Dependents (ABAWDs) aged 19 to 64 in expansion or Covered Choice waiver program equivalents with MEC to complete 80 hours a month of work, education, community or a combination to retain eligibility for benefits.

Exemptions include:

- pregnant women,
- under 19 or over 64,
- former foster care youth under 26,
- tribal members and Alaska natives,
- veterans with rated disabilities,
- medically frail individuals,
- participants of substance use treatment programs,
- individuals compliant with TANF and SNAP work requirements,
- parents/caregivers of children 13 years of age and under or someone with a disability,
- incarcerated individuals and those released within the past 90 days, and
- family caregivers defined in RAISE family caregiver act.

Public Law 119-21 and Idaho House Bill 345 (2025) both exempt Medicaid participants from community engagement if they participate in SNAP or TANF community engagement programs.

Public Law 119-21 also allows exemptions for counties with high unemployment, allows for short-term hardship waiver, and 30-day grace period to come into compliance when noncompliance is identified.

Attachment F: Notice of Public Comment Period

State of Idaho
DEPARTMENT OF INSURANCE

BRAD LITTLE
Governor

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DEAN L. CAMERON
Director

November 14, 2025

Idaho Department of Insurance Section 1332 State Innovation Waiver Notice of Public Hearings and Public Comment Period

The Idaho Department of Insurance (the Department) gives public notice of intent to apply for a four-year extension of its Section 1332 State Innovation Waiver, as well as intent to submit an amendment. The Department opens a public comment period on November 14, 2025. The comment period will close on December 22, 2025. All comments can be directed to the addressed contact below.

On October 1, 2025, the Department submitted this intent to the Centers for Medicare and Medicaid Services (CMS) and to the United States Department of the Treasury for an extension and amendment of Idaho's currently approved Section 1332 State Innovation waiver. The purpose of the waiver is to increase the affordability of individual health insurance in Idaho through a reinsurance program, and to expand coverage options for Medicaid-eligible individuals at or above 100% of the federal poverty level (FPL), through a new program referred to as "Covered Choice." This integrated waiver approach will continue to reduce individual market QHP premiums by leveraging federal pass-through funding generated by Idaho's proven reinsurance program while advancing the Affordable Care Act's goals of expanded coverage and consumer choice. The proposed effective date for the waiver is January 1, 2027.

The waiver's reinsurance program will continue to be implemented primarily by the Idaho Individual High Risk Reinsurance Pool ("the Pool"). Enrollees in individual coverage who are diagnosed with certain specified medical conditions are ceded to the Pool by the health insurer. The health insurer then pays a monthly premium to the Pool for that reinsurance. The program mitigates a portion of high-cost medical claims within the individual market, helping to stabilize and reduce the individual market health insurance premiums. The approval of this 1332 waiver extension is projected to reduce premiums by 10% in 2027 and onward, compared to premiums without the waiver in place.

Idaho House Bill 345, enacted in 2025, provides legislative authority and direction for this Section 1332 waiver amendment. The legislation requires that Idaho agencies submit necessary waivers, one of which authorizes establishing a new program to provide commercial coverage options to certain Medicaid-eligible individuals. This legislation allows individuals eligible for Medicaid under section 56-267, Idaho Code, who have a modified adjusted gross income at or above one hundred percent (100%) of the federal poverty level to receive the advance premium tax credit

(APTC) to purchase a Qualified Health Plan through the Idaho health insurance exchange, Your Health Idaho. This amendment does not force anyone to purchase a Qualified Health Plan, and instead it only adds a coverage option for those households. Individuals may still choose to enroll in Medicaid.

The Department's comprehensive public notice, Tribal notice, and the waiver application are available on the Department website at https://doi.idaho.gov/information/public/reinsurance-waiver/. The Department is seeking public comment through public hearings, the interactive form available on the website, via fax, via email or traditional mail as indicated below. Public hearings will be held at the following locations:

Boise Hearing
Location: 450 W. State Street, Boise, ID 83702, Conference Room 9A
Date/Time: November 21, 2025 at 1:00PM MT
Virtual Meeting Link: Click here to access the meeting link.
Meeting ID: 219 581 190 520 3
Passcode: BP7ZQ7kY

Coeur d'Alene Hearing
Location: 1120 Ironwood Drive, Coeur d'Alene, ID 83814, Conference Room 1120
Date/Time: December 5, 2025 at 9:00AM PT/10:00AM MT
Virtual Meeting Link: Click here to access the meeting link.
Meeting ID: 241 718 692 991 5
Passcode: Pw6JJ763

Idaho Falls Hearing
Location: 150 Shoup Avenue, Idaho Falls, ID 83402, Conference Room – 2nd Floor
Date/Time: December 10, 2025 at 12:00PM MT
Virtual Meeting Link: Click here to access the meeting link.
Meeting ID: 257 954 651 173 9
Passcode: dG64f8fd

Interested parties may also request hard copies of the waiver packet or submit comments via email or traditional USPS mail to:

Idaho Department of Insurance
ATTN: Shannon Hohl
Market Oversight Bureau Chief
P.O. Box 83720, Boise, ID 83720-0043
Email to: DOI.Reform@doi.idaho.gov

Public Comments will be accepted until December 22, 2025.

Attachment G: Records of Public Testimony

[ATTACHMENT TO BE FINALIZED PRIOR TO CMS SUBMISSION AFTER CLOSE OF PUBLIC COMMENT PERIOD.]

Attachment H: Tribal Consultation Communications

[ATTACHMENT TO BE FINALIZED PRIOR TO CMS SUBMISSION AFTER CLOSE OF PUBLIC COMMENT PERIOD.]

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

November 14, 2025

Via Email

Dear Tribal Representative:

The Idaho Department of Insurance (the Department) gives public notice of intent to apply for a four-year extension of its Section 1332 State Innovation Waiver, as well as intent to submit an amendment. The Department opens a public comment period on November 14, 2025. The comment period will close on December 22, 2025. All comments can be directed to the addressed contact below.

On October 1, 2025, the Department submitted this intent to the Centers for Medicare and Medicaid Services (CMS) and to the United States Department of the Treasury for an extension and amendment of Idaho's currently approved Section 1332 State Innovation waiver. The purpose of the waiver is to increase the affordability of individual health insurance in Idaho through a reinsurance program, and to expand coverage options for Medicaid-eligible individuals at or above 100% of the federal poverty level (FPL), through a new program referred to as "Covered Choice." This integrated waiver approach will continue to reduce individual market QHP premiums by leveraging federal pass-through funding generated by Idaho's proven reinsurance program while advancing the Affordable Care Act's goals of expanded coverage and consumer choice. The proposed effective date for the waiver is January 1, 2027.

Department staff intend to share initial information about the proposed waiver extension and amendment and process with Tribal Representatives during the November 19, 2025, Idaho Tribes/Idaho Medicaid Quarterly Meeting. This letter is intended to provide further information and invite you to provide comments on the application.

The proposed 1332 waiver does not affect the provision of tribal health care services or the benefits of any health insurance policies that tribal members may be enrolled in. There is no impact to Indian Health Services, the Federal Health Program for American Indians, and Alaska Natives. The proposed 1332 waiver, if approved by CMS, will reduce health insurance premiums for any Native Americans who buy on Idaho's individual market. The waiver is also expected to help reduce uncompensated care costs for providers by helping more people afford insurance coverage.

The waiver's reinsurance program will continue to be implemented primarily by the Idaho Individual High Risk Reinsurance Pool ("the Pool"). Enrollees in individual coverage who are diagnosed with certain specified medical conditions are ceded to the Pool by the health insurer.

The health insurer then pays a monthly premium to the Pool for that reinsurance. The program mitigates a portion of high-cost medical claims within the individual market, helping to stabilize and reduce the individual market health insurance premiums. The approval of this 1332 waiver extension is projected to reduce premiums by 10% in 2027 and onward, compared to premiums without the waiver in place.

Idaho House Bill 345, enacted in 2025, provides legislative authority and direction for this Section 1332 waiver amendment. The legislation requires that Idaho agencies submit necessary waivers, one of which authorizes establishing a new program to provide commercial coverage options to certain Medicaid-eligible individuals. This legislation allows individuals eligible for Medicaid under section 56-267, Idaho Code, who have a modified adjusted gross income at or above one hundred percent (100%) of the federal poverty level to receive the advance premium tax credit (APTC) to purchase a Qualified Health Plan through the Idaho health insurance exchange, Your Health Idaho. This amendment does not force anyone to purchase a Qualified Health Plan, and instead it only adds a coverage option for those households. Individuals may still choose to enroll in Medicaid.

The Department's comprehensive public notice, Tribal notice and the waiver application are available on our website at https://doi.idaho.gov/information/public/reinsurance-waiver/. The Department is seeking public comment through public hearings, the interactive form available on the website, via fax, via email or traditional mail as indicated below. Public hearings will be held at the following locations:

Boise Hearing
Location: 450 W. State Street, Boise, ID 83702, Conference Room 9A
Date/Time: November 21, 2025 at 1:00PM MT
Virtual Meeting Link: Click here to access the meeting link.
Meeting ID: 219 581 190 520 3
Passcode: BP7ZQ7kY

Coeur d'Alene Hearing
Location: 1120 Ironwood Drive, Coeur d'Alene, ID 83814, Conference Room 1120
Date/Time: December 5, 2025 at 10:00AM MT
Virtual Meeting Link: Click here to access the meeting link.
Meeting ID: 241 718 692 991 5
Passcode: Pw6JJ763

Idaho Falls Hearing
Location: 150 Shoup Avenue, Idaho Falls, ID 83402, Conference Room – 2nd Floor
Date/Time: December 10, 2025 at 12:00PM MT
Virtual Meeting Link: Click here to access the meeting link.
Meeting ID: 257 954 651 173 9
Passcode: dG64f8fd

We would be happy to respond to any questions you may have about this proposed waiver application. If you would like to arrange a virtual meeting to discuss the proposal, please contact Shannon Hohl, Market Oversight Bureau Chief via email Shannon.Hohl@doi.idaho.gov, or via phone 208-334-4315. We would appreciate any written comments you may have by December 22, 2025.

Sincerely,

/s/

Weston Trexler
Deputy Director
Idaho Department of Insurance