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Submitted via stateinnovationwaivers@cms.hhs.gov

May 12, 2026

The Honorable Robert F. Kennedy, Jr., Secretary
U.S. Department of Health and Human Services
200 Independence Ave., SW
Washington, D.C. 20201

The Honorable Scott Bessent, Secretary
U.S. Department of the Treasury
1500 Pennsylvania Ave., NW
Washington, D.C. 20220

**Re: Idaho Section 1332 Waiver Application,
Covered Choice Amendment and Extension
of the Reinsurance Program**

Dear Secretaries Kennedy and Bessent:

The National Health Law Program (NHeLP) is a public interest organization working to advance access to quality health care and protect the legal rights of low-income and underserved people. We appreciate the opportunity to comment on the "Idaho 1332 State Innovation Waiver Covered Choice Amendment and Extension of Reinsurance Program" (Waiver Application). Our comments are focused on the proposed Covered Choice program, which would permit individuals with incomes between 100-138% of the Federal Poverty Level who are otherwise eligible for Medicaid expansion coverage to enroll in Qualified Health Plans (QHPs) with Premium Tax Credits (PTCs).

The Covered Choice program as described in the Waiver Application is unlawful and would harm Idahoans who are eligible for or enrolled in Medicaid. First, the state aims to

leverage the limited waiver authority under § 1332 of the Affordable Care Act (ACA) to implement changes well beyond the scope of the statute, most critically with respect to the Medicaid program. Second, the Covered Choice program fails to meet statutory guardrails related to comprehensiveness, affordability, and coverage. Finally, the state has failed to address key program implementation concerns that place Medicaid beneficiaries at significant risk of harm should they opt into the waiver. The Waiver Application is therefore inconsistent with the State Innovation Waiver program requirements set forth in § 1332 of the ACA and its implementing regulations. We urge the Departments of Health and Human Services (HHS) and Treasury (the Departments) to deny the Waiver Application.

I. The Covered Choice Proposal Exceeds the Scope of § 1332

A. Medicaid Requirements

Section 1332 of the ACA allows the Departments to waive certain requirements of the ACA at the request of a state, subject to statutory requirements including guardrails intended to ensure waivers do not diminish coverage, affordability, and comprehensiveness of health coverage in a state.¹ Waiver authority under § 1332 is limited to the sections of the ACA enumerated in that section of the statute.² It does not provide a blanket waiver authority over other sections of the ACA, nor does it permit the Secretary to waive other statutory requirements, including those that govern the Medicaid program.³

The state is undoubtedly aware that § 1332 does not grant the authority to waive Medicaid law, and the Waiver Application does not explicitly request such waivers.⁴ However, the Waiver Application aims to use § 1332 to evade its legal and financial obligations to Medicaid beneficiaries under the Medicaid Act. Idaho misleadingly frames the waiver proposal as a straightforward expansion of eligibility for subsidized Marketplace coverage. But the eligibility requirements described in the Waiver Application make it clear that Covered Choice enrollees are best understood not as QHP enrollees but as a new category of Medicaid beneficiaries, subject to Medicaid program requirements as well as the rules governing subsidized Marketplace enrollees.

¹ 42 U.S.C. § 18052, “Waiver for State Innovation” (§ 1332).

² § 1332(a)(2) lists the waivable requirements: Parts I and II of subtitle D, § 1402 of the ACA and §§ 36B, 4980H, and 5000A of the Internal Revenue Code (Code).

³ § 1332(c).

⁴ *Id.*; State of Idaho, Department of Insurance, *1332 State Innovation Waiver Covered Choice Amendment and Extension of Reinsurance Program* (Jan. 30 2026), <https://doi.idaho.gov/wp-content/uploads/info/1332Waiver/Idaho-1332-Waiver-Amendment-and-Extension-Application-1-2026.pdf> (“Waiver Application”).

Covered Choice enrollees must apply for and be found eligible for Medicaid expansion coverage under the specific household and income rules that apply to that program.⁵ Unlike any other QHP enrollees, Covered Choice enrollees would be subject to Medicaid-specific requirements including work requirements; biannual eligibility redeterminations that are otherwise unknown in the realm of private insurance coverage, which is premised on the concept of a 12-month plan year; and Medicaid estate recovery requirements.⁶ Individuals in the waiver program would be eligible to opt back into expansion Medicaid coverage without re-applying for Medicaid.⁷ In short, Covered Choice enrollees would be Medicaid beneficiaries. However, Idaho's waiver application fails to address how the Covered Choice program would adhere to Medicaid protections.

As Medicaid beneficiaries, Covered Choice enrollees have specific rights and protections that do not apply to other individuals enrolled in QHPs that cannot be waived pursuant to § 1332.⁸ These include:

- **Due Process Protections:** Medicaid applicants and beneficiaries have rights to adequate written notice and appeal rights including the right to an administrative fair hearing when benefits are denied, terminated, or reduced.⁹ These are Constitutional

⁵ See, e.g., Waiver Application at 9, 10: "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...Individuals...determined eligible for Medicaid and Covered Choice may elect QHP coverage..."

⁶ Waiver Application at 10, 13.

⁷ Covered Choice enrollees "retain the right to return to Medicaid at any time." *Id.* at 11.

⁸ § 1332(a)(5) of the ACA and its implementing regulations at 45 C.F.R. § 155.1302(a) permit states to submit a single application to the Secretary for a waiver under § 1332 and a waiver under one or more of the existing waiver processes applicable under titles XVIII, XIX, and XXI of the Social Security Act (SSA), such as a § 1115(a) demonstration waiver or other waiver applicable to Medicaid. To our knowledge, Idaho has not submitted a § 1115(a) or any other Medicaid waiver as part of its Waiver Application and the Waiver Application does not clearly address how the Covered Choice program would interact with any existing, relevant waivers. Based on the information provided in the Waiver Application, the Covered Choice program is inconsistent with the standards set forth in § 1115(a) of the SSA, including because it would not be an "experimental, pilot or demonstration project," would conflict with rather than promote the core objective of the Medicaid Act (to furnish medical assistance), and would require waivers of Medicaid requirements other than those in 42 U.S.C. § 1396a (for example, requirements related to due process protections and cost-sharing limitations). In other words, the deficiencies in the Waiver Application could not be cured with a separate § 1115(a) demonstration waiver request.

⁹ *Goldberg v. Kelly*, 397 U.S. 254 (1970); see also 42 C.F.R. § 431.205(d).

guarantees that cannot be waived by the Secretary. The Waiver Application entirely fails to address how the state would continue to uphold these due process protections for Medicaid beneficiaries who are eligible for or enrolled in Covered Choice.¹⁰

- **Cost-Sharing Protections:** Medicaid law limits cost-sharing in a number of respects for individuals who would be eligible for the Covered Choice program, including prohibiting premiums and capping out-of-pocket costs to no more than 5% of income.¹¹ By contrast, Covered Choice enrollees would be required to pay premiums and would be subject to cost-sharing under the terms of the QHP into which they are enrolled, which could exceed the statutory cap that applies to Medicaid beneficiaries.
- **Comparability, Freedom of Choice, and Statewideness:** Medicaid services must be provided in the same amount, duration, and scope to all enrollees. Beneficiaries must be permitted to choose a health care provider from among any of those participating in Medicaid and must be able to access Medicaid-covered benefits anywhere in the state.¹² By contrast, Covered Choice enrollees would be limited to the covered services, provider network, and geographic scope of the private QHP into which they are enrolled. As described in more detail below, QHP coverage is significantly less comprehensive than Medicaid coverage for expansion beneficiaries in Idaho.

The state's aims with respect to the Covered Choice program are clearly focused on short-term cost savings. While Idaho must finance 10% of the cost of coverage for Medicaid expansion enrollees absent the waiver, the cost of Covered Choice would be shouldered by the federal government through PTCs and by Covered Choice enrollees through premiums and cost-sharing. But the state cannot have it both ways. Covered Choice enrollees would be required to apply for, be found eligible for, and comply on an ongoing basis with Medicaid-specific requirements to retain access to coverage: they are Medicaid beneficiaries regardless of the label the state applies. The state does not have the authority to pick and choose the Medicaid benefits and obligations that apply to a set of beneficiaries, and it certainly cannot use § 1332 to do so.

B. ACA Requirements

The Covered Choice program would limit Covered Choice enrollees to enrolling in a Silver Plan with an actuarial value of 94%. This limitation appears to conflict with provisions of ACA for which the state has not requested a waiver, including guaranteed issue requirements that are not waiveable under § 1332.

¹⁰ Waiver Application at 9, stating that Covered Choice enrollees would be covered by "consumer protections of Title I of the ACA".

¹¹ *See, e.g.*, 42 U.S.C. § 1396o-1(b)(1)(B)(ii), (b)(2)(A); 42 C.F.R. § 447.56(f).

¹² § 42 U.S.C. § 1396a(a)(1), (a)(10)(B), (a)(23).

Section 1312(d)(3)(C) of the ACA requires that qualified individuals be permitted to enroll in any QHP. Covered Choice enrollees, however, appear to be limited to enrolling in 94% Silver plans.¹³ These beneficiaries could have valid reasons for selecting plans other than 94% Silver plans, including preferring options with lower premiums or lower out-of-pocket costs, interest in taking advantage of Health Savings Accounts, or availability of a particular provider network or drug formulary. The Waiver Application asserts that Covered Choice upholds the ACA's goals of expanded consumer choice, but does not address this apparent conflict, nor does it specifically request a waiver of the consumer choice requirements.¹⁴

A central tenet of the ACA is the requirement that a health insurance issuer that offers health insurance coverage in the individual market must accept "every ... individual in the State that applies for such coverage."¹⁵ This "guaranteed issue" provision at § 2702 of the ACA is not among those enumerated at § 1332(a)(2); therefore, the Secretary does not have the authority to waive it pursuant to a State Innovation Waiver. However, Covered Choice Enrollees who incur premium debt could be prevented from enrolling in a Marketplace plan in the future, under regulations finalized by the Department in 2025.¹⁶ Although this provision is currently stayed pending the final outcome of litigation, if it is ultimately implemented as finalized in the Marketplace Program Integrity Final Rule, individuals who enroll in Covered Choice and incur a premium debt could be barred from enrolling in Marketplace coverage offered by the same issuer in the future. This barrier, which enrollees would not face in the absence of the waiver program, violates the principle of guaranteed issue.¹⁷

II. The Waiver Application Fails to Meet Statutory Guardrails

In order for the Secretary to approve a § 1332 waiver, the Departments must determine that the waiver will provide coverage that is at least as comprehensive as the coverage provided without the waiver; provide coverage and cost-sharing protections against

¹³ See Waiver Application at 1; see also at 2 ("The individuals who opt out of Medicaid and choose a QHP with PTC, due to it being preferable for their particular circumstances, will be given a choice of all 94% actuarial value Silver QHPs available in their service area"); at 10 (listing features of Covered Choice, including "[e]xchange enrollment **only** in 94% actuarial value, reduced cost sharing QHPs") (emphasis added).

¹⁴ See, e.g., Waiver Application at 2 ("The amendment does not eliminate any option, only adds similarly comprehensive alternative coverage options"); at 17 ("The waiver adds a coverage option; it does not remove one").

¹⁵ 42 U.S.C. § 300gg-1(a); 42 C.F.R. § 147.104(a).

¹⁶ 45 C.F.R. § 147.104.

¹⁷ *City of Columbus v. Kennedy*, No. 1:25-cv-02114 (D. Md. 2025).

excessive out-of-pocket spending that are at least as affordable as without the waiver; provide coverage to at least a comparable number of residents as without the waiver; and not increase the federal deficit.¹⁸ The Waiver Application fails to meet at least three of these statutory guardrails: comprehensiveness, affordability, and coverage.

A. Comprehensiveness

The Covered Choice program would not provide coverage that is as comprehensive as Medicaid coverage. Indeed, the purpose of the waiver is to encourage Medicaid beneficiaries to opt into less-comprehensive QHP coverage.

The Waiver Application would allow Medicaid beneficiaries with incomes between 100-138% FPL to enroll in a 94% Silver QHP. QHPs must provide the 10 essential health benefits (EHB) as defined in Idaho's EHB benchmark plan.¹⁹ While EHB is a critically important floor for QHP enrollees, Covered Choice enrollees are Medicaid beneficiaries who remain eligible for much more comprehensive coverage under Idaho's Basic Alternative Benefit Plan (ABP).²⁰

Medicaid, including coverage for the adult expansion population, provides more comprehensive benefits than the benchmark plan.²¹ Medicaid beneficiaries would lose coverage of important services if they were moved into QHPs, including:

- **Early and Periodic Screening, Diagnostic, and Treatment Services:** Individuals aged 19 and 20 enrolled in Idaho's Medicaid expansion for adults receive Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services - comprehensive Medicaid benefits for individuals up to age 21 including medical, vision, hearing, and dental screening services, immunizations, laboratory tests (including lead blood tests),

¹⁸ § 1332(b)(1); Centers for Medicare & Medicaid Services (CMS), *Section 1332: State Innovation Waivers*, <https://www.cms.gov/marketplace/states/section-1332-state-innovation-waivers>.

¹⁹ 42 U.S.C. § 300gg-6; 42 U.S.C. § 18022; 45 C.F.R. § 156.100, *et seq.*; Idaho EHB Benchmark Plan, <https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/Updated-Idaho-Benchmark-Summary.pdf>.

²⁰ Idaho Department of Health & Welfare, Idaho Medicaid Health Plan Booklet, July 2025-June 2026 7-12, available at <https://publicdocuments.dhw.idaho.gov/WebLink/DocView.aspx?id=2080&dbid=0&repo=PUBLIC-DOCUMENTS>. ("Plan Booklet").

²¹ Wayne Turner, et al., National Health Law Program, *What Makes Medicaid, Medicaid? — Services* (Spring 2023), <https://healthlaw.org/resource/what-makes-medicaid-medicaid-services>.

developmental assessments, and health education.²² EPSDT treatment must include any necessary health care, diagnostic services, treatment, and other measures, described in § 1396d(a) of the Medicaid Act, to “correct or ameliorate” physical and mental illnesses and conditions, whether or not such services are covered for adults in the state’s Medicaid program.²³

By contrast, QHPs provide enrollees with a much more limited set of preventive services, including screenings and services with an A or B recommendation from the U.S. Preventive Services Task Force (USPSTF).²⁴ There is nothing comparable to Medicaid’s “correct or ameliorate” requirement in private insurance coverage.

- **Prescription Drug Coverage:** Adults enrolled in Idaho’s Medicaid expansion currently receive very generous prescription drug coverage. Idaho’s Basic ABP aligns its outpatient prescription drug benefit with that offered in its Medicaid state plan, which requires coverage of most FDA-approved drugs for medically accepted indications, as well as certain off-label uses.²⁵ Medicaid enrollees are entitled to a 72-hour emergency supply of outpatient prescription drugs, and requests for prior authorization must be addressed within 24 hours.²⁶

By contrast, QHPs provide a minimum of 1 drug per US Pharmacopeia class and category, the EHB standard.²⁷

- **Adult dental:** Idaho currently provides routine oral health services for adults enrolled in Medicaid expansion, including annual exams, twice-annual cleanings, fillings, extractions, endodontic, and periodontal services, as well as dentures.²⁸ Evidence overwhelmingly demonstrates that oral health care is a critical, essential part

²² 42 U.S.C. §§ 1396a(a)(43)(B), 1396d(r)(1) to (4). See also CMS, *EPSDT – A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents* (2014) [hereinafter EPSDT Guide], https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/epsdt_coverage_guide_82.pdf.

²³ 42 U.S.C. §§ 1396a(a)(43)(C), 1396d(r)(5); 42 C.F.R. §§ 441.50, 441.55 to 441.62.

²⁴ 45 C.F.R. § 147.130

²⁵ 42 U.S.C. §§ 1396a(a)(54), 1396r-8, 1396b(i)(10); 42 C.F.R. § 447.500 to 447.522; Idaho State Plan Amendment #24-008, 48 (Mar. 25, 2026), <https://www.medicaid.gov/medicaid/spa/downloads/ID-24-0008.pdf>; 42 U.S.C. § 1396r-8(k)(2)(A)(i); Idaho EHB Benchmark Plan, <https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/Updated-Idaho-Benchmark-Summary.pdf>.

²⁶ 42 U.S.C. § 1396r-8(d)(1)(A), 1396r-8(d)(5).

²⁷ 45 C.F.R. § 156.122(a).

²⁸ Idaho State Plan Amendment #24-008, 48 (Mar. 25, 2026), <https://www.medicaid.gov/medicaid/spa/downloads/ID-24-0008.pdf>.

of health care, prompting the World Health Organization to call for the integration of oral health services and primary care.²⁹ HHS recognized that “[o]ral health and overall health are inextricably linked.”³⁰ Notably, Idaho’s legislature restored Medicaid non-emergency adult dental coverage, which it previously cut, after a fiscal analysis showed providing adult dental would result \$2.5 million in cost savings resulting from reduced emergency department use and hospitalizations.³¹ Providing adult dental coverage in Medicaid also reduces treatment costs for conditions caused or exacerbated by lack of access to preventive oral health care, including diabetes, cardiovascular disease, pneumonia, kidney disease, and dementia.³²

By contrast, QHPs in Idaho offer no such coverage, and are unlikely to cover non-emergency adult dental services in the future. In the Notice of Benefit and Payment Parameters for 2027 proposed rule, HHS bans coverage of routine non-pediatric dental services as EHB beginning on or after January 1, 2027.³³ If the adult dental EHB ban is finalized, states would be foreclosed from adding these vital services to their benchmark plans, and would be required to defray 100% of the cost of these services if the state requires them in the future.³⁴ Idaho, and other states providing coverage to low- income adults enrolled in ACA’s Medicaid expansion, receive the 90% federal match for services.³⁵

²⁹ Kwan S Petersen, The 7th WHO Global Conference on Health Promotion-towards integration of oral health (Nairobi, Kenya 2009), *Community Dental Health* 2010; 27(Suppl 1):129–36, <https://www.cdjournal.org/issues/27-3-june-2010-supplement1/274-the-7th-who-global-conference-on-health-promotion-towards-integration-of-oralhealth-nairobi-kenya-2009?downloadarticle=download>.

³⁰ Dept. of Health and Human Svcs., *HHS Notice of Benefit and Payment Parameters for 2025; Updating Section 1332 Waiver Public Notice Procedures; Medicaid; Consumer Operated and Oriented Plan (CO-OP) Program; and Basic Health Program Proposed Rule*, 88 Fed Reg 82510 - 82655, 82597 (Nov. 23, 2023), <https://www.govinfo.gov/content/pkg/FR-2023-11-24/pdf/2023-25576.pdf>.

³¹ ID Code § 56-255 (2025); HB 465 Statement of Purpose and Fiscal Note (Jul 1, 2018), [H0465SOP.pdf](#) . See also, Betsy Russell, *Idaho House narrowly approves restoring non-emergency Medicaid dental benefits*, *Spokesman Review* (Feb. 12, 2018), [Idaho House narrowly approves restoring non-emergency Medicaid dental benefits](#) .

³² *Id.*

³³ Dept. of Health and Human Svcs., *HHS Notice of Benefit and Payment Parameters for 2027; and Basic Health Program*, 91 Fed Reg 6292 - 6486, 6482 (Feb. 11, 2026), <https://www.govinfo.gov/content/pkg/FR-2026-02-11/pdf/2026-02769.pdf> (proposing to amend 45 C.F.R. § 156.155(d)).

³⁴ 42 U.S.C. § 18031(d)(3)(B); 45 C.F.R. § 155.170 .

³⁵ 42 U.S.C. § 1396d(y)(1); 42 C.F.R. § 433.10(c)(6).

- **Long-Term Services and Supports:** Individuals enrolled in Medicaid expansion coverage in Idaho receive coverage for long-term services and supports (LTSS). For example, the Basic ABP will cover up to 100 Home Health visits without prior authorization; more can be authorized when medically necessary. The Home Health benefit in the Basic ABP is robust, including skilled nursing, aide visits, Physical Therapy (PT), Occupational Therapy (OT), and Speech-Language Pathology (SLP) services. Idaho Medicaid covers additional services for expansion enrollees “with healthcare needs that cannot be met through the Standard State Plan” through its Enhanced ABP.³⁶ Basic ABP enrollees may self-identify as medically frail at any time and initiate the process to transition to the Enhanced ABP, and they are **automatically transitioned** to the Enhanced ABP as soon as they receive **any** services in a skilled nursing facility (SNF). The Enhanced ABP covers extensive LTSS not covered under the benchmark plan, including home- and community-based services (HCBS), hospice services, more than 30 days of care in a SNF, and personal care services.³⁷

By contrast, the benchmark plan covers only up to 20 annual combined visits for outpatient PT/OT/SLP services.³⁸ Further, the Waiver Application fails to explain the process for Covered Choice enrollees to terminate QHP coverage and quickly access Medicaid LTSS. As a result, Covered Choice enrollees may face significant financial liability for the cost of LTSS that are not covered by a QHP or for inpatient care because they do not have access to LTSS that would allow them to receive care outside of an inpatient or institutional setting.

Examples of additional services that are covered by the Basic ABP but not by Idaho’s benchmark plan include non-emergency medical transport (NEMT); a preventive health assistance benefit for weight management; maternal and newborn care provided by a Licensed Midwife; and behavioral health services that are not included in the benchmark plan such as methadone maintenance for opioid use disorder, peer services, Assertive Community Treatment, and crisis intervention and mobile response.³⁹

³⁶ Idaho State Plan Amendment #19-0016, 2 (Nov. 13, 2009), <https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/ID/ID-19-0016.pdf>.

³⁷Idaho State Plan Amendment #24-0009 at 50 (March 25, 2026), <https://www.medicaid.gov/medicaid/spa/downloads/ID-24-0009.pdf> (“2026 Idaho SPA”).

³⁸ Plan Booklet at 7-12, 16; Idaho Department of Health & Welfare, Early Periodic Screening, Diagnostic and Treatment (EPSDT), <https://healthandwelfare.idaho.gov/services-programs/medicaid-health/early-periodic-screening-diagnostic-and-treatment-epsdt>; 2026 Idaho SPA, “14. Other 1937 Covered Benefits that are not Essential Health Benefits” at 35-86 (March 25, 2026), <https://www.medicaid.gov/medicaid/spa/downloads/ID-24-0009.pdf>.

³⁹ Plan Booklet at 7-12, 16; 2026 Idaho SPA at 35-86.

The state asserts that the EHB standard is the appropriate “measure of comprehensiveness” for determining whether a waiver proposal meets the statutory guardrail.⁴⁰ This interpretation ignores the plain language of the Department’s implementing regulation at 45 C.F.R. § 155.1308(f)(3)(iv)(A), which states: “To satisfy the comprehensive coverage requirement, the Secretary and the Secretary of the Treasury...must determine that the coverage under the State plan is forecasted **to be at least as comprehensive overall for residents of the State as coverage absent the waiver**” (emphasis added). In the absence of the Covered Choice program, Medicaid beneficiaries would remain in more comprehensive coverage; the intended outcome of the waiver is to shift Medicaid beneficiaries into less-comprehensive QHP coverage to achieve state cost savings. The Covered Choice proposal clearly fails to meet the requirements of the comprehensiveness guardrail at § 1332(b)(1)(A) and its implementing regulation at 45 C.F.R. § 155.1308(f)(3)(iv)(A) and must be rejected on that basis.

B. Affordability

To satisfy the affordability requirement, the Departments must determine that the coverage under a proposed waiver will be at least as affordable overall for state residents as coverage absent the waiver, based on a comparison of individuals’ expected out-of-pocket spending for health coverage and services to income.⁴¹ The Covered Choice program fails this test.

As noted above, Medicaid beneficiaries are protected by a range of cost-sharing limitations that do not apply to QHP enrollees. For Medicaid expansion enrollees who would be eligible to enroll in Covered Choice, these protections include a prohibition on monthly premiums and a cap on aggregate out-of-pocket costs to no more than 5% of family income.⁴² In Idaho, while most Medicaid services do not require cost-sharing, select outpatient Medicaid services are subject to a \$3.65 copayment, scheduled to increase to \$4.00 effective July 1, 2026.⁴³

⁴⁰ Waiver Application at 17.

⁴¹ 45 C.F.R. § 155.1308(f)(3)(iv)(B); 2022 Final Rule at 53468.

⁴² 42 C.F.R. § 447.56(f)(1). In Idaho, this limit is applied on a monthly basis. Idaho Admin. Code. 16.03.18; Idaho Department of Health & Welfare, *Medicaid Aggregate Limits on Program Premiums and Copayments for Services*, <https://publicdocuments.dhw.idaho.gov/WebLink/DocView.aspx?id=19933&dbid=0&repo=PUBLIC-DOCUMENTS>.

⁴³ Idaho Department of Health & Welfare, *Public Schedule of Premiums and Cost Sharing*, <https://publicdocuments.dhw.idaho.gov/WebLink/DocView.aspx?id=19934&dbid=0&repo=PUBLIC-DOCUMENTS>. The state notes that Idaho’s Medicaid program does not mandate cost-sharing for prescription drugs under Medicaid, but that it “intends to implement \$4.00

The Waiver Application claims that “[d]ue to the affordability protections of the ACA, [Covered Choice enrollees] are similarly not projected to pay more than 5% of their income for this QHP coverage.” This is misleading and likely inaccurate for most people. Marketplace cost-sharing subsidies reflect average spending across a population. In fact, the actual cost of QHP coverage is likely to be significantly higher than the cost of Medicaid.

First, a Medicaid beneficiary that opts to enroll in Covered Choice would be required to pay a monthly premium ranging from 2.0% to over 3.0% of their income.⁴⁴ Second, cost-sharing requirements for specific services would be set by the QHP. Individuals who use more services will face higher expenses. A comparison of two 94% Silver plans available during the 2026 Plan Year shows that Medicaid is more affordable:

Example Service (in-network)	Silver 94% 1⁴⁵	Silver 94% 2⁴⁶	Medicaid
Specialty physician	\$25 co-payment	\$25 co-payment	\$0-\$4 co-payment
Imaging	20% coinsurance	30% coinsurance	\$0
ED services for emergency condition	20% coinsurance	30% coinsurance	\$0
Prenatal care and hospital delivery	Office visit: 20% coinsurance; Delivery: Separate 20% coinsurance fees for facility and professional services	Office visit: \$0; Delivery: Separate 20% coinsurance fees for facility and professional services	\$0
Maximum Out-of-Pocket Costs for Family Coverage	\$2,800	\$3,200	5% of monthly household income

copays on preferred and \$8.00 copays on non-preferred drugs” in the future. See Waiver Application, Attachment D. See *infra* note 49 regarding changes that are not yet in effect.

⁴⁴ 26 U.S.C. § 36B(b)(3)(A).

⁴⁵ Blue Cross of Idaho, Silver Copay 4000, Summary of Benefits and Coverage, <https://www.bcidaho.com/public-sbcs>.

⁴⁶ Mountain Health Co-Op, LINK SILVER 94, Summary of Benefits and Coverage, <https://mountainhealth.coop/health-plan/link-silver-94>.

Crucially, Covered Choice enrollees would be required to enroll in a Silver 94% plan; in 2026, such plans are subject to a maximum out-of-pocket (MOOP) cost of \$3,500 for a self-only plan and \$7,000 for a non-self-only plan, increasing to \$4,000 and \$8,000, respectively, in 2027.⁴⁷ A two-person Covered Choice household earning 100% FPL in 2026 (\$21,640) could spend more than a third of its income on premiums and out-of-pocket costs before reaching the out-of-pocket maximum.⁴⁸ While Silver 94% plans can apply a MOOP less than the federal maximum, they are not required to do so, and recent changes to the Actuarial Value Calculator are likely to necessitate higher cost-sharing in the 2027 plan year.⁴⁹ Moreover, the QHP MOOP is based on projected annual income, rather than the 5% Medicaid cap based on actual family income in a given month, a particularly important distinction for people with low incomes who are more likely to experience income fluctuations throughout the year.⁵⁰

⁴⁷ 90 Fed. Reg. 27074, 27170 (Table 5—Final Reductions in Maximum Annual Limitation on Cost Sharing for PY 2026); CMS, Premium Adjustment Percentage, Maximum Annual Limitation on Cost Sharing, Reduced Maximum Annual Limitation on Cost Sharing, and Required Contribution Percentage for the 2027 Benefit Year (Jan. 29, 2026) <https://www.cms.gov/files/document/2027-papi-parameters-guidance-2026-01-29.pdf>.

⁴⁸ The Waiver Application also mischaracterizes changes to Medicaid cost-sharing requirements required under the “One Big Beautiful Bill Act” (OBBBA), effective October 1, 2028. *See* Waiver Application at 13, 19, Attachment C, stating that OBBBA requires that the state impose cost-sharing up to \$35 “per service”. However, the statute does not require cost-sharing for all services. While OBBBA directs states to impose *some* cost-sharing, each state will determine the care, items, or services subject to cost-sharing, with the exception of services that are explicitly exempt from cost-sharing under the statute, such as primary care services, mental health and substance use disorder services, and services furnished in an FQHC or RHC. States also have the discretion to determine the amount of the cost-sharing on a service-by-service basis, subject to a \$35 limit. *See* § 71120 of OBBBA. Given the \$35 cap and required exemptions, it is unlikely that the cost-sharing burden for Medicaid beneficiaries enrolled in expansion coverage would exceed that for Covered Choice enrollees. Regardless, these changes are not yet in effect, and therefore cannot be considered by the Secretary as part of the affordability analysis. *See* 86 Fed. Reg. 53412, 53459 (Sept. 27, 2021) (“2022 Final Rule”) (“The Departments **will not consider the potential impact of policy changes that are contingent on further state action**, such as state legislation that is proposed but not yet enacted that would be in effect during the timeframe for the section 1332 waiver”) (emphasis added).

⁴⁹ Jason Levitis and Sabrina Corlette, State Health and Value Strategies, *Changes to the Actuarial Value Calculator for 2027* (April 23, 2026), <https://shvs.org/changes-to-the-actuarial-value-calculator-for-2027>.

⁵⁰ *See* Idaho Admin. Code. 16.03.18; 26 C.F.R. § 1.36B-2(b)(1); Pew Charitable Trusts, *How Income Volatility Interacts With American Families’ Financial Security* (March 9,

Medicaid clearly represents a more affordable coverage option with lower out-of-pocket spending than a Silver 94% QHP. The Covered Choice program aims to reduce Medicaid enrollment by allowing Medicaid beneficiaries to opt into less affordable QHP coverage. Therefore, the Waiver Application fails the affordability guardrail under § 1332(b)(1)(B) and its implementing regulation at 45 C.F.R. § 155.1308(f)(3)(iv)(B), and must be rejected on that basis.

C. Coverage

To satisfy the coverage guardrail, the Departments must determine that the waiver proposal would provide coverage to at least a comparable number of State residents as would have coverage absent the waiver.⁵¹ The Covered Choice program fails this standard for three reasons.

First, the primary purpose of the waiver program is to encourage individuals in the Medicaid expansion population with incomes between 100-138% FPL to enroll in QHP coverage, thereby reducing the number of individuals with access to the full suite of Medicaid-covered services. In the 2022 Final Rule, HHS made it clear that a "section 1332 waiver cannot decrease ... the number of individuals with coverage that includes the services covered under the state's Medicaid or CHIP programs."⁵² In the absence of the Covered Choice program, individuals otherwise eligible for the waiver would remain covered by Medicaid. While the Waiver Application acknowledges a "high degree of uncertainty surrounding the uptake of Covered Choice," **any** uptake would result in decreased numbers of individuals with coverage that includes Medicaid-covered services.⁵³

Second, Covered Choice enrollees would not benefit from Medicaid-specific mechanisms designed to promote access to coverage, increasing the likelihood that they would experience coverage gaps. For example, newborns whose parents are enrolled in Medicaid

2017), <https://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2017/03/how-income-volatility-interacts-with-american-families-financial-security>. Idaho Medicaid beneficiaries enrolled in expansion coverage would be subject to lower cost-sharing requirements in months when their incomes are reduced, whereas Covered Choice enrollees would be subject to the same annual MOOP regardless of actual monthly income. Even if a two-person household earning the 138% FPL maximum income level for Covered Choice enrollment earned the same amount in each month, the household's Medicaid cost-sharing limit would not exceed \$124 per month.

⁵¹ 45 C.F.R § 155.1308(f)(3)(iv)(C).

⁵² 2022 Final Rule at 53465.

⁵³ Waiver Application at 14.

expansion coverage are automatically enrolled in Medicaid for their first year of life.⁵⁴ The Waiver Application does not address newborn deeming in the context of Covered Choice, but a typical QHP enrollee would be required to submit a separate application for Medicaid coverage on behalf of an eligible newborn. A Covered Choice enrollee who does not take that additional step would, potentially unknowingly, forfeit more affordable Medicaid coverage with more comprehensive benefits for their child, including EPSDT. Additionally, the Waiver Application does not adequately address how a Covered Choice enrollee would take advantage of retroactive coverage. Effective January 1, 2027, Medicaid expansion beneficiaries are eligible for a retroactive coverage period of 30 days from the date of application.⁵⁵ While the Waiver Application indicates that the State intends to implement “[e]nrollment system updates to enable one month of retroactive coverage in a QHP,” it does not specify whether coverage will be based on the date of application or a different date, such as the date of plan selection or first date of coverage. Nor does it explain how Medicaid beneficiaries would be advised regarding the cost of retroactive coverage under Medicaid (free or minimal cost-sharing) versus a QHP (premium costs and cost-sharing for any covered claims). Compared to people enrolled in Medicaid expansion coverage, which implements policies such as newborn deeming and retroactive coverage tied to the date of application, Covered Choice enrollees and members of their households are more likely to experience coverage gaps, forgo access to Medicaid-covered services, or drop coverage due to the higher costs of QHP coverage.

Third, the waiver is likely to result in decreased coverage overall, simply due to the additional red tape barriers put in place for Medicaid beneficiaries eligible for Covered Choice. As discussed in greater detail in Section III of these comments, the program’s complexity and lack of decision support will result in beneficiary confusion and churn between expansion Medicaid coverage, Covered Choice, and uninsurance. Research shows that increased friction at eligibility and enrollment increases the likelihood that an individual who is eligible for insurance coverage will instead become uninsured, losing access to health care services.⁵⁶

The Covered Choice program is designed to reduce access to Medicaid services and increases the likelihood, compared to the status quo, that individuals who are eligible for or enrolled in Medicaid coverage will become uninsured due to administrative complexity and red tape. The waiver proposal fails the coverage guardrail under § 1332(b)(1)(C) and its implementing regulation at 45 C.F.R. § 155.1308(f)(3)(iv)(C) and must be rejected on that basis.

⁵⁴ Idaho Admin. Code 16.03.01.530.

⁵⁵ Section 71112 of OBBBA.

⁵⁶ Mark Shepard and Myles Wagner, *Do Ordeals Work for Selection Markets? Evidence from Health Insurance Auto-Enrollment*, NBER Working Paper 30781 (2022), <https://doi.org/10.3386/w30781>.

III. The Covered Choice Program Would Harm Idaho Residents

In addition to the legal deficiencies described elsewhere in these comments, the Departments should reject the Waiver Application because Covered Choice as proposed would harm Idahoans who are eligible for and enrolled in Medicaid.

Research shows that people face significant barriers to informed decision-making related to health insurance enrollment. Only 4% of the U.S. population accurately understands basic health insurance terminology such as “deductible,” “premium,” and “copay”.⁵⁷ People living in poverty, those with a high school education or less, and non-white communities, all of whom are disproportionately represented among Medicaid beneficiaries, have generally lower health insurance literacy.⁵⁸ Covered Choice enrollees would be required to adhere to a patchwork of requirements across both Medicaid and the Marketplace programs, doubling the compliance burden.

The Covered Choice program introduces multiple points of friction for Medicaid beneficiaries who, in the absence of the waiver, would be enrolled in comprehensive coverage at low or no cost. If the waiver program is implemented, these beneficiaries would be required to make an array of cost and coverage choices that could result in their being enrolled in a private health plan with higher costs, less-comprehensive benefits, and increased administrative burden to remain enrolled. In the worst-case scenario, eligible individuals could become uninsured because they fail to overcome the administrative barriers to enroll or maintain coverage.

Despite these high stakes, the Waiver Application fails to demonstrate the State’s interest in or capacity to develop and implement the necessary decision supports to ensure that beneficiaries enroll in the best coverage available to them. The single example decision support tool included in the Waiver Application is a misleading, one-page chart that appears intended to mischaracterize Medicaid coverage as equivalent to, or in some cases, inferior to, QHP coverage. For example, the chart notes that both Medicaid and QHPs are required to cover the 10 EHBs and highlights a specific service type (chiropractic services)

⁵⁷ Coralys M. Colón-Morales, et al., *Informed Decision-making for Health Insurance Enrollment: Survey Study*, JMIR Formative Research (Aug. 12, 2021), <https://pmc.ncbi.nlm.nih.gov/articles/PMC8391737>.

⁵⁸ Hilary Wething, Econ. Pol’y Inst., *Work requirements for safety net programs like SNAP and Medicaid*, <https://www.epi.org/publication/snap-medicaid-work-requirements>, (Jan. 24, 2025); Kathryn A. Paez and Coretta J. Mallery, Am. Inst. for Research, *A Little Knowledge is a Dangerous Thing: Wide Gap in What People Think They Know About Health Insurance and What They Actually Know*, https://www.air.org/sites/default/files/Health%20Insurance%20Literacy%20brief_Oct%202014_amended.pdf (Oct. 2014).

in which Medicaid imposes a lower quantity limit in the Basic ABP plan than the benchmark plan. Yet, the chart fails to list numerous services that are covered under Medicaid but omitted or covered less generously under the benchmark plan, such as EPSDT, outpatient prescription drugs, LTSS, and behavioral health services. The chart does not address or compare costs, provider networks, or access to prescription drugs. It does not explain any potential differences between retroactive coverage in Medicaid versus a QHP or potential impacts on other household members, such as the lack of newborn deeming in the private insurance context. Further, it is presented in a format that is not accessible to people with disabilities or with Limited English Proficiency.⁵⁹

Potential Covered Choice enrollees should be equipped with a variety of tools that would allow them to estimate and compare total costs, provider access, formularies, and quality ratings across Medicaid and QHP options. These tools should be available in formats that are accessible for people with physical and intellectual disabilities and for people with Limited English Proficiency. Further, individuals facing a choice between Medicaid and Covered Choice enrollment should have access to real-time, individualized, in-person or virtual enrollment support from unbiased enrollment assisters who are familiar with both Medicaid and QHP coverage options, such as trained Navigators. The Waiver Application does not indicate whether or how Medicaid beneficiaries eligible for Covered Choice could access this type of enrollment assistance. Nor does the state address how it would guard against improper steering of beneficiaries into QHPs by agents and brokers who are typically paid commissions to enroll people in private insurance plans and have no financial incentive or specialized training to assist people with enrolling in Medicaid.⁶⁰

Further, although the Waiver Application repeatedly states that Covered Choice enrollees can return to Medicaid coverage at any time, it does not adequately explain the steps a beneficiary will have to take to effectuate this coverage change without experiencing a coverage gap, other than noting that an individual who loses QHP coverage due to non-payment of premiums will **not** be automatically re-enrolled in Medicaid.⁶¹ As one example of the complex interactions between private coverage and Medicaid, Covered Choice enrollees who fall behind on premiums are at risk of not only losing access to ongoing coverage but potentially to liability for claims paid during the second and third months of the QHP “grace period.”⁶² The Waiver Application provides no evidence

⁵⁹ Waiver Application, Attachment C: Side-by-side Analysis of Benefits and Services.

⁶⁰ Tara Straw, “‘Direct Enrollment’ in Marketplace Coverage Lacks Protections for Consumers, Exposes Them to Harm,” Center on Budget and Policy Priorities, March 15, 2019, <https://www.cbpp.org/research/direct-enrollment-in-marketplace-coverage-lacks-protections-for-consumers-exposes-them-to>.

⁶¹ Waiver Application at 12.

⁶² 45 C.F.R. § 156.270(d).

that the state will develop and sustain the beneficiary supports necessary to avert predictable harmful financial and medical consequences for Covered Choice enrollees.

IV. Conclusion

NHeLP supports the use of § 1332 to pursue innovative strategies for providing residents with high quality, affordable health insurance. However, we strongly object to any efforts to use State Innovation Waivers to circumvent essential provisions that Congress has placed in the ACA and the Medicaid Act to protect Medicaid beneficiaries. As demonstrated above, the Covered Choice waiver proposal is inconsistent with the standards of § 1332 and presents a significant risk of harm to Idahoans who are eligible for Medicaid. For these reasons, the Secretary must reject the Waiver Application.

We have included numerous citations to supporting research, including direct links to the research. We direct the Departments to each of the materials we have cited and made available through active links, and we request that the full text of each of the studies and articles cited, along with the full text of our comment, be considered part of the formal administrative record for purposes of the Administrative Procedure Act. If the Departments are not planning to consider these materials part of the record as we have requested here, we ask that you notify us and provide us an opportunity to submit copies of the studies and articles into the record.

Thank you for the opportunity to comment on Idaho's application. If you have further questions, please contact Geraldine Doetzer (doetzer@healthlaw.org) or Wayne Turner (turner@healthlaw.org).

Sincerely,

A handwritten signature in black ink, appearing to read 'G. Doetzer', with a stylized flourish at the end.

Geraldine M. Doetzer
Senior Attorney