June 13, 2014

ADVANCE NOTICE OF READOPTION OF EMERGENCY REGULATIONS

This notice is sent in accordance with Government Code Section 11346.1(a)(2), which requires that State of California agencies give a five working day advance notice of intent to file emergency regulations with the Office of Administrative Law (OAL). The California Health Benefit Exchange ("Exchange") intends to file a request for readoption of the Emergency Rulemaking package with the Office of Administrative Law (OAL) that establishes the eligibility and enrollment process and the appeals process for the individual Exchange. As required by subdivisions (a)(2) and (b)(2) of Government Code Section 11346.1, this notice appends the following: (1) the specific language of the proposed regulation to readopt Sections 6408, 6410, 6450, 6452, 6454, 6470, 6472, 6474, 6476, 6478, 6480, 6482, 6484, 6486, 6490, 6492, 6494, 6496, 6498, 6500, 6502, 6504, 6506, 6508, 6510, 6600, 6602, 6604, 6606, 6608, 6610, 6612, 6614, 6616, 6618, and 6620 of Chapter 12, Title 10 of California Code of Regulations; and (2) the Finding of Emergency, including specific facts demonstrating the need for immediate action, the authority and reference citations, the informative digest and policy statement overview, attached reports, and required determinations.

The Exchange plans to file the request for readoption of the Emergency Rulemaking package with OAL at least five working days from the date of this notice. If you would like to make comments on the Finding of Emergency or the proposed regulations (also enclosed), they must be received by both the Exchange and the Office of Administrative Law within five calendar days of the Exchange's filing at OAL. Responding to these comments is strictly at the Exchange's discretion.

Comments should be sent simultaneously to:

California Health Benefit Exchange
Attn: Bahara Hosseini
1601 Exposition Blvd.
Sacramento, CA 95815

Office of Administrative Law
300 Capitol Mall, Suite 1250
Sacramento, CA 95814

BOARD MEMBERS Diana S. Dooley, Chair Kimberly Belshé Paul Fearer Susan Kennedy Robert Ross, MD EXEC DIRECTOR Peter V. Lee

Upon filing, OAL will have ten (10) calendar days within which to review and make a decision on the proposed emergency rule. If approved, OAL will file the regulations with the Secretary of State, and the emergency regulations will become effective for ninety (90) days. Please note that this advance notice and comment period is not intended to replace the public's ability to comment once the emergency regulations are approved. The Exchange will hold a public hearing and 45-day comment period during the subsequent certification period following the effective date of the emergency regulations.

You may also review the proposed regulatory language and Finding of Emergency on the Exchange's website at the following address: http://www.healthexchange.ca.gov.

If you have any questions concerning this Advance Notice, please contact Bahara Hosseini at (916) 228-8486.

FINDING OF EMERGENCY

The Director of the California Health Benefit Exchange finds that an emergency exists and that this proposed emergency regulation is necessary to address a situation that calls for immediate action to avoid serious harm to the public peace, health, safety or general welfare.

This emergency rulemaking was previously approved by OAL on April 1, 2014 and will expire on July 1, 2014. The Exchange now seeks a readoption with the following changes:

Changes Made to Article 2 Section 6410:

- The formatting of this section was changed for clarity and readability purposes.
- Definition of the "Accountable Care Organization" (ACO) was changed to align with the definition that Centers for Medicare and Medicaid Services (CMS) provides for this term.
- Additional citations to State law were added to the definition of "Affordable Care Act" (ACA), "Annual Open Enrollment Period," and "Applicable Medi-Cal Modified Adjusted Gross Income (MAGI)-based Income Standard".
- Definition of "Benefit Plan Requirements" was removed from the definitions section because there is no reference to this term in the text of the Exchange regulations in Chapter 12.
- Definition of "Carrier" was added because this term is typically used in State law, while federal law generally uses the term "Issuer" for the same concept. This term was added to the definitions section to harmonize State and federal law and to minimize confusion about possible use of both terms.
- Additional citations to State law were added to the definition of "Catastrophic Plan."
- Additional citation to State law was added to the definition of "Child."
- Definition of "Consumer Assessment of Healthcare Providers and Systems" (CAHPS) was revised for clarity and accuracy purposes.
- Definition of "Cost-share" or "Cost-sharing" was revised to add the phrase "if applicable" after the phrase "balance-billing amounts for non-network providers" for clarity purposes because balance-billed charges are not applicable to HMO enrollees in California.
- A technical, formatting change was made to definition of "Dental Exclusive Provider Organization" (DEPO).
- Definition of "Dental Health Maintenance Organization" (DHMO) was revised to add the word "network" after the dental plan at the end of the definition for clarity and accuracy purposes.

- A citation to State law in the definition of “Dependent” in the Individual market was revised for clarity and accuracy purposes.
- Definition of “Educated Health Care Consumer” was removed from the definitions section because there is no reference to this term in the text of the Exchange regulations in Chapter 12.
- Definition of “Enrollee” was changed to align with State law.
- Definition of “Evidence-Based Medicine” was changed for clarity and accuracy purposes.
- Definition of “Geographic Service Area” was revised to add the term “Service Area,” which has the same meaning, and to add a reference to State law adopting the definition under State law.
- Definition of “Grandfathered Health Plan” was removed from the definitions section because there is no reference to this term in the text of the Exchange regulations in Chapter 12.
- Definition of “Group Health Plan” was removed from the definitions section because there is no reference to this term in the text of the Exchange regulations in Chapter 12.
- Definition of “Health Insurance Issuer” was revised to include “Carrier” as having the same meaning.
- Definition of “Health Maintenance Organization” (HMO) was revised to add a reference to State law adopting the definition under State law.
- A citation to the federal law was added to the definition of “Health plan.”
- Definition of “Incarcerated” was added to the definitions section to provide clarity and align with federal law.
- Technical, formatting changes were made to definition of “Indian” and “Indian Tribe.”
- A citation to the federal law was added to the definition of “Individual Market.”
- Definition of “Ineligible Bidder” was removed from the definitions section because there is no reference to this term in the text of the Exchange regulations in Chapter 12.
- Citations to State law were added to definition of “Initial Open Enrollment Period” for align with State law as well as federal law.
- A technical revision was made to the definition of “Internet Web Portal” for accuracy purposes.
- Additional citations to State law were added to the definition of “Level of Coverage.”
- Additional citations to State law were added to the definition of “Medi-Cal Managed Care Plan” (MMCP).

- Definitions for “Network or Provider Network” and “Provider or Network Provider” were removed as these terms are already defined in State law and are commonly known.
- Definition of “Part-time Eligible Employee” was revised to add “per week” after the work hours for clarity purposes.
- Definitions of “Patient-Centered Medical Home,” “Plan Year,” and “Plain Language” were revised to provide more clarity and accuracy.
- Definition of “Preferred Provider Organization” (PPO) was changed to align with State law.
- Definition of “Qualified Health Plan” (QHP) was revised to include a Standalone Dental Plan, consistent with the federal rules.
- Definition of “Quality Assurance” was revised to remove Standalone Dental Plan from the definition because that term has been added to the definition of QHP.
- Additional citations to State law were added to the definition of “Rating Region.”
- Citation to federal regulations was added to the definition of “Reasonably Compatible.”
- Definition of “Self-only Coverage” was revised to align with State law.
- Additional citations to State law were added to the definition of “Special Enrollment Period.”
- Definition of “Standardized QHP Benefit Design(s)” was removed from the definitions section because there is no reference to this term in the text of the Exchange regulations in Chapter 12.
- Definition of “Telemedicine” was revised to add the term “Telehealth,” which has the same meaning, and to add citation to State law.
- Definition of “Two-Tiered Network” was removed from the definitions section because there is no reference to this term in the text of the Exchange regulations in Chapter 12.
- Additional citations were added to the Reference section of the Authority and Reference for the definitions section.

<u>Changes Made to Article 4</u>:

- Sections 6450 and 6452:
  - Technical and formatting changes were made for clarity and accuracy purposes.
- Section 6454:
  - Subdivision (c) was revised to add “at least annually” for the frequency of reevaluation of the Exchange notices for clarity purposes since the federal rules do not specify how frequent the Exchange must reevaluate notices.

Changes Made to Article 5:

- Sections 6470:
  - Subdivision (c)(25) was revised to clarify that if the applicant is a tax dependent, the applicant must not be required to provide information regarding citizenship, status as a national, or immigration status, for the non-applicant primary tax filer.
  - Subdivision (f) was revised to replace the word “pediatric” with “standalone” for dental plans.
- Section 6474:
  - Subdivisions (a) and (c)(1)(B)1 of were revised to clarify that the individuals applying for APTC and CSR are not required to meet the eligibility requirements for enrollment in a catastrophic QHP.
- Section 6476:
  - Subdivision (f) was revised to clarify that an applicant’s eligibility will be determined within 10 calendar days from the date the Exchange receives the applicant’s “complete” paper application.
  - Subdivision (j) was revised to align with the federal regulations in 45 CFR § 155.310(j).
- Section 6478:
  - A minor formatting change was made to subdivision (f)(2).
- Section 6482:
  - A cross-reference in subdivision (c) was revised to align with the federal regulations.
- Section 6484:
  - Subdivision (b) was revised to add the word “available” for clarity purposes.
- Section 6492:
  - Subdivision (a)(5)(C) was removed to align with the federal regulations in 45 CFR § 155.315(f)(5).
- Section 6496:
  - Formatting changes were made to subdivisions (e), (h), (i), and (j).
  - Subdivision (g) was revised to align with the federal regulations in 45 CFR § 155.330(d)(1).
  - Subdivision (m) was revised to align with the federal regulations.
- Section 6498:
  - Subdivisions (b) through (d) were revised to align with the federal regulations.
- Section 6500:

- Subdivision (f)(2)(D) was revised to correct a minor grammatical error.
- Formatting changes were made to subdivisions (g)(5) and (6).

- Section 6502:
  - Subdivision (c)(2) was added for clarity purposes.
  - Subdivision (c)(1) was revised for clarity purposes.
  - Subdivision (d) was revised to align the annual open enrollment period with the federal and State law.
  - Subdivisions (e) and (f) were revised to align with the federal rules.
- Section 6504:
  - Subdivision (a)(1) was revised to align with the federal rules.
  - Subdivision (a)(7) was revised to add the word “qualified” for consistency purposes and to align with the federal rules. Additionally, the last sentence was removed because it is provided for in subdivision (f)(2) of this section.
  - Subdivision (a)(12) was added to align with the State law.
  - A cross reference in the first sentence of subdivision (b) was corrected.
  - Subdivisions (b)(3) and (c) were revised to align with federal rules.
  - Subdivision (d) was revised to add the provisions of the federal regulation regarding imposition of civil penalties for providing false or fraudulent information to the Exchange.
  - Minor grammatical changes were made to subdivision (e).
  - Subdivision (f) was revised to align with the federal rules.
  - Subdivision (h)(1) was revised to provide a prospective coverage effective date in the case of birth, adoption, placement for adoption, or placement in foster care, consistent with the federal rules.
  - Subdivision (h)(2) and (3) were revised to align with the federal rules.
- Section 6506:
  - Subdivision (d)(1) was revised for clarity purposes and to align with the federal rules.
  - Subdivision (d)(2)(D) was revised by removing the last sentence of paragraph (D) to align with the federal rules.
  - Subdivision (d)(3) and (6) were revised to align with the federal rules.
  - Subdivision (e)(1) was revised and subdivision (e)(3) was added to align with the federal rules.
- Section 6510:
  - Additional citation to federal regulations was added to the reference section of the authority and reference.

Changes Made to Article 7:

- Section 6600:
  - Formatting changes made to the definitions section.
  - Additional citation to federal regulations was added to the reference section of the authority and reference.
- Section 6606:
  - Minor grammatical, formatting changes were made.
- Section 6610:
  - Subdivision (a)(1)(D) was added to align with the federal rules.
- Section 6618:
  - Subdivision (b)(2) was revised to make a technical correction.

The Exchange intends to make these emergency regulations permanent and has proceeded with diligence to comply with the requirements in Government Code § 11346.1(e), and has made substantial progress in that regard. For example, the Exchange continues to develop an Initial Statement of Reasons for the permanent rulemaking. The Exchange is also working to refine the full economic impact statement and the fiscal impact statement and will submit the completed Form 399 for review by the Department of Finance when complete. Given the size of this emergency rulemaking package and the fact that it has been determined a major regulation package by the Department of Finance, the Exchange cannot seek a permanent rulemaking at this time in order to allow for meaningful public participation, including allowing for a full 45-day comment period and public hearing, as well as allowing for a 30 working day review by OAL.

This Finding of Emergency hereby incorporates by reference all documents in the previously approved rulemaking file under file number 2014-0321-04EE.

DEEMED EMERGENCY

The Exchange may "Adopt rules and regulations, as necessary. Until January 1, 2016, any necessary rules and regulations may be adopted as emergency regulations in accordance with the Administrative Procedures Act. The adoption of these regulations shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare." (Gov. Code, § 100504(a)(6)).

AUTHORITY AND REFERENCE

Authority: Government Code Sections 100502, 100503, 100504, and 100505.
Reference: Government Code Sections 6700, 6707, 100500, 100501, 100502, 100503, 100504, 100505 and 100506; Health and Safety Code Sections 1345, 1357.500, 1357.512, 1367.005, 1367.008, 1367.009, 1373.10, 1374.60, 1399.845, and 1399.849;

Insurance Code Sections 10112.27, 10112.295, 10112.297, 10192.10, 10753, 10753.14, 10965.3, and ; Family Code Sections 297 and 299.2; Welfare and Institution Code Sections 10951, 10952.51, 4005.60, 14005.64, and 14093.07; 8 USA Section 1101; 25 USC Section 450b; 26 USC Sections 36B, 151, 152, 223, 5000A, 6011, 6012, and 9832; 42 USC Sections 300, 300gg-91, 1396d, 8032, 9902, 18021, 18022, 18024, 18031, and 18032; 26 CFR Sections 1.36B-1 through 1.36B-4, 1.5000A-1 through 1.5000A-3, and 1.7703-1; 42 CFR Sections 435.603, 435.911, 435.1200, 457.310, 457.348, ; 45 CFR Sections 144.103 and 152.2; 45 CFR Part 155; 45 CFR Sections 156.20, 156.260, 156.265, 156.270, 156.1230, and 156.1240; 2 CCR Section 599.500; 10 CCR 2699.6000.

INFORMATIVE DIGEST/POLICY STATEMENT OVERVIEW

Documents to be incorporated by reference:

None

Summary of Existing Laws

Under the federal Patient and Protection and Affordable Care Act (ACA), each state is required, by January 1, 2014, to establish an American Health Benefit Exchange that makes available qualified health plans to qualified individuals and small employers. Existing state law, the California Patient Protection and Affordable Care Act, established the California Health Benefit Exchange within state government. (Gov. Code, § 100500 et seq.) The Exchange is required to establish the criteria and process for eligibility determination, enrollment, and disenrollment of enrollees and potential enrollees in the Exchange. (Gov. Code, § 100503(a).) The Exchange is required to establish an appeals process for prospective and current enrollees of the Exchange that complies with all requirements of the federal act. (Gov. Code, § 100506.)

The proposed regulations will establish the Exchange's policies and procedures for eligibility determination and redetermination, enrollment in qualified health plans, termination of coverage through the Exchange, and appeals process in the individual market. The proposed regulations will provide the public with clear standards and eligibility requirements to qualify for federal tax subsidies through the Exchange. Additionally, the proposed regulations will provide the standards and requirements for the qualified health plan issuers regarding enrollment of qualified individuals in the qualified health plans and termination of coverage for qualified individual through the Exchange. The proposed regulations will further provide the public with clear guidelines to request and receive a fair hearing.

These proposed regulations will benefit the public by providing clear guidelines to access care through enrollment in qualified health plans and to take advantage of the federal tax subsidies for the purchase of affordable, quality health insurance for themselves and their families through the Exchange. These regulations will also

benefit the public by providing them an opportunity to exercise their right to due process.

After an evaluation of current regulations, the Exchange has determined that these proposed regulations are not inconsistent or incompatible with any existing regulations.

JUSTIFICATION FOR DUPLICATION

These proposed regulations were developed with significant stakeholder engagement to implement and clarify the mandates of the ACA and the requirements of the federal regulations. These regulations duplicate texts from the U.S. Department of Health and Human Services' (HHS) regulations in 45 C.F.R. Part 155 related to the Exchange establishment standards and other related standards under the ACA and 45 C.F.R. Part 156 related to the health insurance issuer standards under the ACA, including standards related to the Exchanges.

MATTERS PRESCRIBED BY STATUTE APPLICABLE TO THE AGENCY OR TO ANY SPECIFIC REGULATION OR CLASS OF REGULATIONS

None.

LOCAL MANDATE

The Executive Director of the California Health Benefit Exchange has determined that this proposed regulatory action does not impose a mandate on local agencies or school districts.

FISCAL IMPACT ESTIMATES

This proposal does not impose costs on any local agency or school district for which reimbursement would be required pursuant to Part 7 (commencing with Section 17500) of Division 4 of the Government Code. This proposal does not impose other nondiscretionary cost or savings on local agencies.

COSTS OR SAVINGS TO STATE AGENCIES AND TO FEDERAL FUNDING

The proposal results in additional costs to the California Health Benefit Exchange, which is currently funded by federal grant money and will become financially self-sustaining in 2015. The proposal does not result in any costs or savings to any other state agency.

California Code of Regulations

Title 10. Investment

Chapter 12. California Health Benefit Exchange (§ 6400 et seq.)

Readopt Article 2:

Article 2. Abbreviations and Definitions

§ 6408. Abbreviations.

The following abbreviations shall apply to this chapter:

ACO	Accountable Care Organization
APTC	Advance Payments of Premium Tax Credit
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CalHEERS	California Healthcare Eligibility, Enrollment, and Retention System
CCR	California Code of Regulations
CEC	Certified Enrollment Counselor
CFR	Code of Federal Regulations
CHIP	Children's Health Insurance Program
CSR	Cost-Sharing Reduction
DHCS	Department of Health Care Services
DHS	U.S. Department of Homeland Security
EPO	Exclusive Provider Organization
FPL	Federal Poverty Level
FQHC	Federally-Qualified Health Center
HEDIS	Health Effectiveness Data and Information Set
HHS	U.S. Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104–191)
HMO	Health Maintenance Organization
HSA	Health Savings Account
IAP	Insurance Affordability Program
IPA	Independent Practice Association
IRC	Internal Revenue Code of 1986

IRS	Internal Revenue Services
LEP	Limited English Proficient
MAGI	Modified Adjusted Gross Income
MEC	Minimum Essential Coverage
MMCP	Medi-Cal Managed Care Plan
PBE	Certified Plan-Based Enroller
PBEE	Certified Plan-Based Enrollment Entity
POS	Point of Service
QHP	Qualified Health Plan
SHOP	Small Business Health Options Program
SSA	Social Security Administration
SSN	Social Security Number
TIN	Taxpayer Identification Number
USC	United States Code

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100501, 100502, and 100503, Government Code; 45 CFR Sections 155.20 and 155.300.

§ 6410. Definitions.

As used in this chapter, the following terms shall mean:

"340B Entity" means a "covered entity" as defined in Public Health Service Act Section 340B(a)(4) (42 USC § 256b(a)(4)).

"Accountable Care Organization" (ACO) means a group of health care providers who come together voluntarily to give coordinated care to patients and who receive payment tied to the achievement of health care quality goals and outcomes which result in cost savings~~a voluntary group of physicians, hospitals, and other health care providers that are willing to assume responsibility and some financial risk for the care of a clearly defined patient population attributed to them on the basis of patients' use of primary care services~~. ~~Characteristics of an ACO may include robust use of electronic health record infrastructure, defined quality metrics including outcomes, shared savings formulas affecting reimbursement, coordinated care requirements, or pay for performance reimbursement components.~~

"Alternate Benefit Plan Design" means a QHP proposed benefit plan design which features different cost-sharing requirements than the Exchange's Standardized Qualified Health Plan Designs.

"Advance Payments of Premium Tax Credit" (APTC) means payment of the tax credits authorized by Section 36B of IRC (26 USC § 36B) and implementing regulations, which are

provided on an advance basis to an eligible individual enrolled in a QHP through an Exchange in accordance with Section 1412 of the Affordable Care Act.

"Affordable Care Act" (ACA) means the federal Patient Protection and Affordable Care Act of 2010 (Pub.L. 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Pub.L. 111-152), and any amendments to, or regulations or guidance issued under, those acts, as defined in Government Code 100501(d).

"Annual Open Enrollment Period" means the period each year during which a qualified individual may enroll or change coverage in a QHP through the Exchange, as specified in Section 6502 of Article 5 of this chapter, Section 1399.849(c)(1) of the Health and Safety Code, and Section 10965.3(c)(1) of the Insurance Code.

"Applicable Children's Health Insurance Program (CHIP) MAGI–based Income Standard" means the applicable income standard as defined at 42 CFR Section 457.310(b)(1), as applied under the State plan adopted in accordance with title XXI of the Social Security Act, or waiver of such plan and as certified by the State CHIP Agency in accordance with 42 CFR Section 457.348(d), for determining eligibility for child health assistance and enrollment in a separate child health program.

"Applicable Medi-Cal Modified Adjusted Gross Income (MAGI)-based Income Standard" means the same standard as "applicable modified adjusted gross income standard," as defined ~~at~~ in 42 CFR Section 435.911(b), ~~as applied under the State plan adopted in accordance with title XIX of the Social Security Act, or waiver of such plan,~~ and as specified in Sections 14005.60 and 14005.64 of the Welfare and Institutions Code~~certified by the DHCS in accordance with 42 CFR Section 435.1200(b)(2) for determining eligibility for Medi-Cal~~.

"Applicant" means:

(a) An individual who is seeking eligibility for coverage for himself or herself through an application submitted to the Exchange~~,~~ (excluding those individuals seeking eligibility for an exemption from the shared responsibility payment)~~,~~ or transmitted to the Exchange by an agency administering an insurance affordability program for at least one of the following:

(1) Enrollment in a QHP through the Exchange; or

(2) Medi-Cal and CHIP.

(b) An employer or employee seeking eligibility for enrollment in a QHP through the SHOP, where applicable.

"Application Filer" means an applicant; an adult who is in the applicant's household, as defined in 42 CFR Section 435.603(f), or family, as defined in 26 USC Section 36B(d) and 26 CFR Section 1.36B-1(d); an authorized representative; or if the applicant is a minor or incapacitated, someone acting responsibly for an applicant; excluding those individuals seeking eligibility for an exemption from the shared responsibility payment.

"Authorized Representative" means any person or entity that has been designated, in writing, by the applicant to act on his/her behalf or individuals who have appropriate power of attorney or legal conservatorship.

~~Benefit Plan Requirements: Coverage that provides for all of the following as specified under 45 CFR Section 156.20:~~

~~(a) The essential health benefits as described in Section 1302(b) of the Affordable Care Act;~~

~~(b) Cost-sharing limits as described in Section 1302(c) of the Affordable Care Act; and~~

~~(c) A bronze, silver, gold, or platinum level of coverage as described in Section 1302(d) of the Affordable Care Act, or is a catastrophic plan as described in Section 1302(e) of the Affordable Care Act.~~

"Benefit Year" means a calendar year for which a health plan provides coverage for health benefits.

"Bidder" means a Health Insurance Issuer seeking to enter into a Qualified Health Plan contract.

"Board" means the executive board that governs the California Health Benefit Exchange, established by Government Code Section 100500.

"California Health Benefit Exchange" or the "Exchange" means the entity established pursuant to Government Code Section 100500. The Exchange also does business as and may be referred to as "Covered California."

"California Healthcare Eligibility, Enrollment, and Retention System" (CalHEERS) means the California Healthcare Eligibility, Enrollment, and Retention System, created pursuant to Government Code Sections 100502 and 100503, as well as 42 USC Section 18031, to enable enrollees and prospective enrollees of QHPs to obtain standardized comparative information on the QHPs as well as apply for eligibility, enrollment, and reenrollment in the Exchange.

"Captive Agent" means an insurance agent who is currently licensed in good standing by the California Department of Insurance to sell, solicit, and negotiate health insurance coverage and has a current and exclusive appointment with a single Issuer and may receive compensation on a salary or commission basis as an agent only from that Issuer.

"Carrier" means either a private health insurer holding a valid outstanding certificate of authority from the Insurance Commissioner or a health care service plan, as defined under subdivision (f) of Section 1345 of the Health and Safety Code, licensed by the Department of Managed Health Care.

"Catastrophic Plan" means a health plan described in Section 1302(e) of the Affordable Care Act, Section 1367.008(c)(1) of the Health and Safety Code, and Section 10112.295(c)(1) of the Insurance Code.

"Certified Enrollment Counselor" (CEC) means an individual as defined in Section 6650 of Article 8 of this chapter.

"Certified Insurance Agent" means an agent as defined in Section 6800 of Article 10 of this chapter.

"Certified Plan-Based Enroller" (PBE) means an individual who provides Enrollment Assistance to Consumers, as defined in Section 6700 of Article 9 of this chapter, in the Individual Exchange through a Certified Plan-Based Enroller Program. Such an individual may be:

(a) A Captive Agent of a QHP issuer; or

(b) An Issuer Application Assister as defined in 45 CFR Section 155.20, provided that the issuer application assister is not employed or contracted by a PBEE to sell, solicit, or negotiate health insurance coverage licensed by the California Department of Insurance.

"Certified Plan-Based Enrollment Entity" (PBEE) means a QHP Issuer registered through the Exchange to provide Enrollment Assistance, as defined in Section 6700 of Article 9 of this chapter, to Consumers, as defined in Section 6700 of Article 9 of this chapter, in the Individual Exchange through a Certified Plan-Based Enroller Program sponsored by the Entity. A PBEE shall be registered by the Exchange only if it meets all of the training and certification requirements specified in Section 6706 of Article 9 of this chapter.

"Certified Plan-Based Enroller Program" (PBE Program) means the Program whereby a PBEE may provide Enrollment Assistance to Consumers in the Individual Exchange in a manner considered to be through the Exchange.

"Certified QHP" means any QHP that is selected by the Exchange and has entered into a contract with the Exchange for the provision of health insurance coverage for enrollees who purchase health insurance coverage through the Individual and/or Small Business Health Options Program (SHOP) Exchanges.

"Child" means a person as defined in Sections 1357.500(a) and 1399.845(a) of the Health and Safety Code and in Section 10753(d) of the Insurance Code.

"Consumer Assessment of Healthcare Providers and Systems" (CAHPS) means an ~~multi-year~~ initiative of the Agency for Healthcare Research and Quality (AHRQ) to assess ~~support and promote the assessment of~~ consumers' experiences with health care. CAHPS develops surveys that are taken by hospitals, health plans, and home health agencies and are designed to measure patient experience with these entities.

"Cost-share" or "Cost-sharing" means any expenditure required by or on behalf of an enrollee with respect to receipt of Essential Health Benefits; such term includes deductibles, coinsurance, copayments, or similar charges, but excludes premiums, balance-billing amounts for non-network providers, if applicable, and spending for non-covered services.

"Cost-Sharing Reduction" (CSR) means reductions in cost-sharing for an eligible individual enrolled in a silver level plan in the Exchange or for an individual who is an Indian enrolled in a QHP in the Exchange.

"Day" means a calendar day unless a business day is specified.

"Dental Exclusive Provider Organization" (DEPO) means a managed care plan where services are covered ~~only~~ if ~~you go to~~ provided through doctors, specialists, ~~or~~ and hospitals in the plan's network (except in an emergency).

"Dental Health Maintenance Organization" (DHMO) means a type of dental plan product that delivers dental services by requiring assignment to a primary dental care provider who is paid a capitated fee for providing all required dental services to the enrollee unless specialty care is needed. DHMOs require referral to specialty dental providers. These products do not include coverage of services provided by dental care providers outside the dental plan network.

"Dental Preferred Provider Organization" (DPPO) means a type of dental plan product that delivers dental services to members through a network of contracted dental care providers and includes limited coverage of out-of-network services.

"Dependent" means:

(a) In the Individual Exchange:

(1) For purposes of eligibility determination for APTC and CSR, a dependent as defined in Section 152 of IRC (26 USC § 152) and the regulations thereunder. For purposes of eligibility determinations for enrollment in a QHP without requesting APTC or CSR, "dependent" also includes domestic partners.

(2) For purposes of enrollment in a QHP, including enrollment during a special enrollment period specified in Section 6504 of Article 5 of this chapter, a dependent as defined in Section ~~1357.500(b)~~ 1399.845(b) of the Health and Safety Code and in Section 10753(e) of the Insurance Code, referring to the spouse or registered domestic partner, or child until attainment of age 26 (as defined in subdivisions (n) and (o) of Section 599.500 of Title 2 of the CCR) unless the child is disabled (as defined in ~~Section 22775 of the Government Code and~~ subdivision~~s (n) to~~ (p)~~, inclusive,~~ of Section 599.500 of Title 2 of the~~ California Code of Regulations~~ CCR), of a qualified individual or enrollee.

(b) In the SHOP Exchange, a dependent as defined in Section 1357.500(b) of the Health and Safety Code and in Section 10753(e) of the Insurance Code and also includes a non-registered domestic partner who meets the requirements established by the qualified employer for non-registered domestic partners and who is approved by the QHP issuer for coverage in the SHOP Exchange.

"Domestic Partner" means:

(a) For purposes of the Individual Exchange, a person as defined in Sections 297 and 299.2 of the Family Code.

(b) For purposes of the SHOP, a person who has established a domestic partnership as described in Sections 297 and 299.2 of the Family Code and also includes a person that has not established a domestic partnership pursuant to Sections 297 and 299.2 of the Family Code, but who meets the requirements established by his or her employer for non-registered domestic partners and who is approved by the QHP issuer for coverage in the SHOP Exchange.

~~Educated Health Care Consumer: An individual as defined in Section 1304(e) of the Affordable Care Act (42 USC § 18024(e)).~~

"Eligible Employee" means an employee as defined in Section 1357.500(c) of the Health and Safety Code and in Section 10753(f) of the Insurance Code.

"Eligible Employer-Sponsored Plan" means a plan as defined in Section 5000A(f)(2) of IRC (26 USC § 5000A(f)(2)).

"Employee" means an individual as defined in Section 2791 of the Public Health Service Act (42 USC § 300gg-91).

"Employer" means a person as defined in Section 2791 of the Public Health Service Act (42 USC § 300gg-91), except that such term includes employers with one or more employees. All persons treated as a single employer under subsection (b), (c), or (m) of Section 414 of IRC (26 USC § 414) are treated as one employer.

"Employer Contributions" means any financial contributions towards an employer sponsored health plan, or other eligible employer-sponsored benefit made by the employer including those made by salary reduction agreement that is excluded from gross income.

"Enrollee" means a person who is ~~qualified individual or qualified employee~~ enrolled in a QHP and who is a recipient of services from the QHP.

"Essential Community Providers" means providers that serve predominantly low-income, medically underserved individuals, as defined in 45 CFR Section 156.235.

"Essential Health Benefits" means the benefits listed in 42 USC Section 18022, Health and Safety Code Section 1367.005, and Insurance Code Section 10112.27.

"Evidence-Based Medicine" means patient care that combines the expertise of health practitioners with the best available research to ensure quality, effectiveness, and safety~~the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients~~.

"Exchange Evaluation Team" means the team selected by the Exchange to conduct the QHP bid response evaluation by consensus and assess whether the response is responsive and may proceed to the evaluation of the response.

"Exchange Service Area" means the entire geographic area of the State of California.

"Exclusive Provider Organization" (EPO) means an Exclusive Provider Organization, as defined in California Code of Regulations, Title 10, Section 2699.6000(r).

"Executive Director" means the Executive Director of the Exchange.

"Federally Qualified Health Center" (FQHC) has the same meaning as the term is defined in Section 1905(l)(2)(B) of the Social Security Act (42 USC § 1396d(l)(2)(B)).

"Federal Poverty Level" (FPL) means the most recently published federal poverty level, updated periodically in the Federal Register by the Secretary of Health and Human Services pursuant to 42 USC Section 9902(2), as of the first day of the annual open enrollment period for coverage in a QHP through the Exchange, as specified in Section 6502 of Article 5 of this chapter.

"Full-time employee" means a permanent employee with a normal workweek of an average of 30 hours per week over the course of a month.

"Geographic Service Area" or "Service Area" means an ~~defined geographic~~ area ~~within the State of California that a proposed QHP proposes to serve and is approved by the applicable State Health Insurance Regulator to serve~~ as defined in Section 1345(k) of the Health and Safety Code.

~~Grandfathered Health Plan: A health plan as defined in 45 CFR Section 147.140.~~

"Group Contribution Rule" means the requirement that a qualified employer pays a specified percentage or fixed dollar amount of the premiums for coverage of eligible employees.

~~Group Health Plan: A group health plan within the meaning of 45 CFR Section 146.145(a).~~

"Group Participation Rule" means the requirement relating to the minimum number of participants that must be enrolled in relation to a specified percentage or number of employees of an employer, as specified in 45 CFR Section 155.700(b).

"Health Insurance Coverage" means coverage as defined in 45 CFR Section 144.103.

"Health Insurance Issuer" has the same meaning as the term is defined in 42 USC Section 300gg-91 and 45 CFR Section 144.103. Also referred to as "Carrier," "Health Issuer," or "Issuer."

"Health Maintenance Organization" (HMO) means an organization as defined in ~~42 USC~~ Section ~~300(e)~~ 1373.10(b) of the Health and Safety Code~~a Health Care Service Plan (as that term is defined in Health and Safety Code Section 1345) holding a current license from and in good~~

~~standing with the California Department of Managed Health Care~~ .

"Health plan" means a plan as defined in Section 1301(b)(1) of the Affordable Care Act (42 USC § 18021(b)(1)).

"Health Effectiveness Data and Information Set" (HEDIS) means a set of managed care performance measures developed and maintained by the National Committee for Quality Assurance.

"Health Savings Account" (HSA) has the same meaning as the term is defined in 26 USC Section 223.

"Incarcerated" means confined, after the disposition of charges, in a jail, prison, or similar penal institution or correctional facility.

"Independent Practice Association" (IPA) means an IPA is a legal entity organized and directed by physicians in private practice to negotiate contracts with Health Insurance Issuers on their behalf.

"Indian" has the same meaning as the term is defined in Section 4(d) of the Indian Self-Determination and Education Assistance Act (Pub.L. 93-638; 25 USC § 450b(d)), ~~means~~ referring to a person who is a member of an Indian tribe.

"Indian Tribe" has the same meaning as the term is defined in Section 4(e) of the Indian Self-Determination and Education Assistance Act (Pub.L. 93-638; 25 USC § 450b(e)), ~~means~~ referring to any Indian tribe, band, nation, or other organized group or community, including any Alaska Native village or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act (85 Stat. 688) [43 USC § 1601 et seq.], which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

"Individual and Small Business Health Options Program (SHOP) Exchange" means the program administered by the Exchange pursuant to the Government Code Section 100500 et seq. (2010 Cal. Stat. 655 (AB 1602) and 2010 Cal. Stat. 659 (SB 900)), 42 USC Section 18031(b) of the federal Patient Protection Affordable Care Act and other applicable laws to furnish and to pay for health insurance plans for Qualified Individuals and Qualified Employers.

"Individual Market" means a market as defined in Section 1304(a)(2) of the Affordable Care Act (42 USC § 18024 (a)(2)).

~~Ineligible Bidder: A prospective Bidder who is not in good standing with the applicable State Health Insurance Regulator, or does not meet the qualifications for consideration as a Qualified Health Plan under this Chapter, or has not provided complete responses or conforming responses to the QHP solicitation.~~

"Initial Open Enrollment Period" means the initial period in which Qualified Individuals may enroll in QHPs, from October 1, 2013 to March 31, 2014, subject to 45 CFR Section 155.410(b), Section 1399.849(c)(1) of the Health and Safety Code, and Section 10965.3(c)(1) of the Insurance Code.

"Insurance Affordability Program" (IAP) means a program that is one of the following:

(a) The Medi-Cal program under title XIX of the federal Social Security Act (42 USC § 1396 et seq.).

(b) The State children's health insurance program (CHIP) under title XXI of the federal Social Security Act (42 USC § 1397aa et seq.).

(c) A program that makes available to qualified individuals coverage in a QHP through the Exchange with APTC established under Section 36B of the Internal Revenue Code (26 USC § 36B).

(d) A program that makes available coverage in a QHP through the Exchange with CSR established under section 1402 of the Affordable Care Act.

"Internet Web Portal" means the Web portal made available through a link on the Exchange's ~~website~~ Web site, www.healthexchange.ca.gov, through which the Exchange will make the Solicitation available electronically~~ and which can be accessed directly at https://www.proposaltech.com/app.php/ login~~.

"Lawfully Present" means a non-citizen individual as defined in 45 CFR Section 152.2.

"Level of Coverage" means one of four standardized actuarial values and the catastrophic level of coverage as defined in 42 USC Section 18022(d)~~ and (e)~~, Sections 1367.008 and 1367.009 of the Health and Safety Code, and Sections 10112.295 and 10112.297 of the Insurance Code, and the catastrophic level of coverage as defined in 42 USC Section 18022(e), Section 1367.008(c)(1) of the Health and Safety Code, and Section 10112.295(c)(1) of the Insurance Code.

~~"MAGI-based income" means income as defined in 42 CFR Section 435.603(e).~~

"Medical Group" means a group of physicians and other health care providers who have organized themselves to provide services to a defined patient population or contract with a Health Issuer or hospital.

"Medi-Cal Managed Care Plan" (MMCP) means a person or an entity contracting with DHCS to provide health care services to enrolled Medi-Cal beneficiaries, as specified in Section 14093.07(b) ~~under Chapter 7, commencing with Section 14000, or Chapter 8, commencing with Section 14200, of Division 9, Part 3,~~ of the Welfare and Institutions Code.

"Minimum Essential Coverage" (MEC) means coverage as defined in Section 5000A(f) of IRC (26 USC § 5000A(f)) and in 26 CFR Section 1.36B-2(c).

"Minimum Value," when used to describe coverage in an eligible employer-sponsored plan, means that the plan meets the requirements with respect to coverage of the total allowed costs of benefits set forth in Section 36B(c)(2)(C)(ii) of IRC (26 USC § 36B(c)(2)(C)(ii)) and in 26 CFR Section 1.36B-2(c)(3)(vi).

"Modified Adjusted Gross Income" (MAGI) means income as defined in Section 36B(d)(2)(B) of IRC (26 USC § 36B(d)(2)(B)) and in 26 CFR Section 1.36B-1(e)(2).

"Modified Adjusted Gross Income (MAGI)-based income" means income as defined in 42 CFR Section 435.603(e) for purposes of determining eligibility for Medi-Cal.

~~"Network or Provider Network" means the collection of providers who have entered into contracts with a Health Insurance Issuer. These contracts govern payment and other terms of the business relationship between the Health Insurance Issuer and the Providers. Provider Networks are integral to an Issuer's proposed QHPs.~~

"Non-citizen" means an individual who is not a citizen or national of the United States, in accordance with Section 101(a)(3) of the Immigration and Nationality Act (8 USA § 1101(a)(3)).

"Part-time Eligible Employee" means a permanent employee who works at least 20 hours per week but not more than 29 hours per week and who otherwise meets the definition of an eligible employee except for the number of hours worked.

"Patient-Centered Medical Home" means a ~~team-based model of care led by a personal physician who provides continuous and coordinated care throughout a patient's lifetime to maximize health outcomes~~ model of care that relies on the following principles: (1) the personal physician leads a team that is collectively responsible for the patient's ongoing care; (2) the physician is responsible for the whole person in all stages of life; (3) care is coordinated or integrated; (4) quality and safety are hallmarks of a medical home; (5) enhanced access to care is available through all systems; and (6) payment appropriately recognizes the added value to the patient.

"Plan Year" means: ~~a consecutive 12-month period during which a health plan provides coverage for health benefits. A plan year may be~~

(a) For purposes of the Individual Exchange, a calendar year ~~or otherwise~~.

(b) For purposes of the SHOP, a period of time as defined in 45 CFR Section 144.103.

"Plain Language" means language that the intended audience, including individuals with limited English proficiency, can readily understand and use because that language is concise, well-organized, uses simple vocabulary, avoids excessive acronyms and technical language, and follows other best practices of plain language writing.

"Point of Service" (POS) means a model of health care coverage as defined in Health and Safety Code Section 1374.60.

"Preferred Provider Organization" (PPO) has the same meaning as the term is defined in Section 10192.10(a)(10) of the Insurance Code~~means a network of medical doctors, hospitals, and other health care providers who have contracted with a Health Insurance Issuer to provide health care at reduced rates to the Issuer's insureds or enrollees~~.

"Premium Payment Due Date" means a date no earlier than the fourth remaining business day of the month prior to the month in which coverage becomes effective.

~~"Provider or Network Provider" means an appropriately credentialed or licensed individual, facility, agency, institution, organization or other entity that has a written agreement with a proposed QHP Bidder for the delivery of health care services.~~

"QHP Issuer" means a licensed health care service plan or insurer who has been selected and certified by the Exchange to be offered to Qualified Individuals and Qualified Employers purchasing health insurance coverage through the Exchange.

"Qualified Employee" means an individual who is employed by a qualified employer and has been offered health insurance coverage by such qualified employer through the SHOP.

"Qualified Employer" has the same meaning as the term is defined in 42 USC Section 8032(f)(2) and 45 CFR Section 155.710.

"Qualified Health Plan" (QHP) has the same meaning as the term is defined in Patient Protection and Affordable Care Act Section 1301 (42 USC § 18021) and Government Code Section 100501(f), and includes a Standalone Dental Plan. ~~If a Standalone Dental Plan is offered through the Exchange, another health plan offered through the Exchange shall not fail to be treated as a QHP solely because the plan does not offer coverage of benefits offered through the standalone plan under 42 USC Section 18022(b)(1)(J).~~

"Qualified Health Plan Solicitation or Solicitation" means the California Health Benefit Exchange 2012-2013 Initial Qualified Health Plan Solicitation to Health Issuers and Invitation to Respond, as amended December 28, 2012.

"Qualified Individual" means an individual who meets the requirements of 42 USC Section 18032(f)(1) and 45 CFR Section 155.305(a).

"Qualifying Coverage in an Eligible Employer-Sponsored Plan" means coverage in an eligible employer-sponsored plan that meets the affordability and minimum value standards specified in Section 36B(c)(2)(C) of IRC (26 USC § 36B(c)(2)(C)) and in 26 CFR Section 1.36B-2(c)(3).

"Quality Assurance" means processes used by proposed QHPs ~~and Standalone Dental Plans~~ to monitor and improve the quality of care provided to enrollees.

"Rating Region" means the geographic regions for purposes of rating defined in Sections 1357.512 and 1599.855 of the Health and Safety Code ~~Section 1357.512~~ and Sections 10753.14 and 10965.9 of the Insurance Code ~~Section 10753.14~~.

"Reasonably Compatible" ~~means~~ has the same meaning as the term is defined in 45 CFR Section 155.300(d), providing that information the Exchange obtained through electronic data sources, information provided by the applicant, or other information in the records of the Exchange shall be considered to be reasonably compatible with an applicant's attestation if the difference or discrepancy does not impact the applicant's eligibility ~~of the applicant~~, including the amount of APTC or the category of CSR.

"Reference Plan" means a QHP that is selected by an employer, which is used by the SHOP to determine the contribution amount the employer will be making towards its employees' premiums.

"Self-only Coverage" means a health care service plan contract or an insurance policy that covers one individual.

"SHOP" means a Small Business Health Options Program operated by the Exchange through which a qualified employer can provide its employees and their dependents with access to one or more QHPs.

"SHOP Plan Year" means a 12-month period beginning with the Qualified Employer's effective date of coverage.

"Small Employer" means an employer as defined in Section 1357.500(k) of the Health and Safety Code and in Section 10753(q) of the Insurance Code.

"Small Group Market" means a group market as defined in Section 1304(a)(3) of the Affordable Care Act.

"Special Enrollment Period" means a period during which a qualified individual or enrollee who experiences certain qualifying events, as specified in Section 6504(a) of Article 5 of this chapter, Section 1399.849(d) of the Health and Safety Code, and Section 10965.3(d) of the Insurance Code, may enroll in, or change enrollment in, a QHP through the Exchange outside of the initial and annual open enrollment periods.

"Solicitation Official" means the Exchange's single point of contact for the Solicitation.

"Standalone Dental Plan" means a plan providing limited scope dental benefits as defined in 26 USC Section 9832(c)(2)(A), including the pediatric dental benefits meeting the requirements of 42 USC Section 18022(b)(1)(J).

~~Standardized QHP Benefit Design(s): Benefit plan designs that the Board determines to be standard pursuant to Government Code Section 100504(c), as described in Solicitation Section~~

~~II.B.1.~~

"State Health Insurance Regulator" or "State Health Insurance Regulators" means the Department of Managed Health Care and California Department of Insurance.

"State Mandates" means health care benefits that must be covered, in accordance with California statutes.

"Tax Filer" means an individual, or a married couple, who attests that he, she, or the couple expects:

(a) To file an income tax return for the benefit year, in accordance with Sections 6011 and 6012 of IRC (26 USC §§ 6011, 6012), and implementing regulations;

(b) If married (within the meaning of 26 CFR § 1.7703-1), to file a joint tax return for the benefit year;

(c) That no other taxpayer will be able to claim him, her, or the couple as a tax dependent for the benefit year; and

(d) That he, she, or the couple expects to claim a personal exemption deduction under Section 151 of IRC (26 USC § 151) on his or her tax return for one or more applicants, who may or may not include himself or herself and his or her spouse.

"Telemedicine" or "Telehealth" has the same meaning as the term is defined in Section 1374.13 of the Health and Safety Code, Section 10123.85 of the Insurance Code, and Section 2290.5 of the Business and Professions Code~~means the ability of physicians and patients to connect via technology other than through virtual interactive physician/patient capabilities, especially enabling rural and out-of-area patients to be seen by specialists remotely~~.

"TIN" means an identification number used by the IRS in the administration of tax laws. It is issued either by the SSA or by the IRS. TINs include SSN, Employer Identification Number (EIN), Individual Taxpayer Identification Number (ITIN), Taxpayer Identification Number for Pending U.S. Adoptions (ATIN), and Preparer Taxpayer Identification Number (PTIN). A SSN is issued by the SSA whereas all other TINs are issued by the IRS.

~~Two-Tiered Network: A benefit design with two in-network benefit levels. Standard plan cost-share is applied to most cost-effective network with higher cost-share allowed for more expensive in-network choice. Actuarial value is based on likely overall use of tiered networks.~~

NOTE: Authority: Sections 100502, 100503, 100504, and 100505, Government Code. Reference: Sections 100501, 100502, 100503, and 100505, Government Code; Section 10753, Insurance Code; 45 CFR Sections 155.20, 155.300, 155.415, 155.430, 155.700, 155.705, 155.710, 155.725, and 156.1230; 26 CFR Section 1.5000A-1(d).

Article 4. General Provisions.

Readopt Section 6450

§ 6450. Meaning of Words.

Words in this chapter shall have their usual meaning unless the context or a definition clearly indicates a different meaning. "Shall" ~~means~~ is used in the mandatory sense. "May" ~~means~~ is used in the permissive sense. "Should" ~~means suggested or recommended~~ is used to indicate suggestion or recommendation.

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100501, 100502, and 100503, Government Code.

Readopt Section 6452

§ 6452. Accessibility and Readability Standards.

(a) All applications, including the single, streamlined application described in Section 6470 of Article 5 of this chapter, forms, notices, and correspondence provided to the applicants and enrollees by the Exchange and QHP issuers shall conform to the standards outlined in subdivisions (b) and (c) of this section. This section shall not be interpreted as limiting the application of existing State laws and regulations regarding accessibility and readability standards, if any, that apply to the QHP issuers.

(b) Information shall be provided to applicants and enrollees in plain language, as defined in Section 6410 of Article 2 of this chapter, and to the extent administratively feasible, all written correspondence shall also:

(1) Be formatted and written in such a way that it can be understood at the ninth~~sixth~~-grade level and, if possible, at ~~no more than~~ the ~~ninth~~sixth-grade level ~~of readability~~;

~~(2) Contain technical language that can be understood at the ninth-grade level;~~

~~(3)~~(2) Be in print no smaller than 12 point-equivalent font; and

~~(4)~~(3) ~~Not c~~Contain no language that minimizes or contradicts the information being provided.

(c) Information shall be provided to applicants and enrollees in a manner that is accessible and timely to:

(1) Individuals living with disabilities through the provision of auxiliary aids and services at no cost to the individual, including accessible ~~websites~~ Web sites, in accordance with the Americans with Disabilities Act and Section 504 of the Rehabilitation Act.

(2) Individuals who are limited English proficient through the provision of language services at no cost to the individual, including:

(A) Oral interpretation or written translation~~s~~; and

(B) Taglines in non-English languages indicating the availability of language services.

(3) Inform individuals of the availability of the services described in subdivisions (~~b~~c)(1) and (2) of this section and how to access such services.

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; 45 CFR Section 155.205.

Readopt Section 6454

§ 6454. General Standards for Exchange Notices.

(a) Any notice of action required to be sent by the Exchange to individuals or employers shall be written and include:

(1) An explanation of the action reflected in the notice, including the effective date of the action;

(2) Any factual bases upon which the decision was made;

(3) Citations to, or identification of, the relevant regulations supporting the action;

(4) Contact information for available customer service resources, including local legal aid and welfare rights offices; and

(5) An explanation of appeal rights.

(b) All Exchange notices shall conform to the accessibility and readability standards specified in Section 6452.

(c) The Exchange shall, at least annually, reevaluate the appropriateness and usability of all notices.

(d) The individual market Exchange shall provide required notices either through standard mail, or if an individual elects, electronically, provided that the requirements for electronic notices in 42 CFR Section 435.918 are met, except that the individual market Exchange shall not be

required to implement the process specified in 42 CFR Section 435.918(b)(1) for eligibility determinations for enrollment in a QHP through the Exchange and IAPs that are effective before January 1, 2015.

(e) The SHOP shall provide required notices either through standard mail, or if an employer or employee elects, electronically, provided that the requirements for electronic notices in 42 CFR Section 435.918(b)(2) through (5) are met for the employer or employee.

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; 45 CFR Section 155.230.

Readopt Article 5

Article 5. Application, Eligibility, and Enrollment Process for the Individual Exchange

§ 6470. Application.

(a) A single, streamlined application shall be used to determine eligibility and to collect information necessary for enrollment in an IAP, including:

(1) Medi-Cal,
(2) CHIP,
(3) APTC, and
(4) CSR.

(b) To apply for any of the programs listed in subdivision (a) of this section, an applicant or an application filer shall submit all information, documentation, and declarations required on the single, streamlined application, as specified in subdivisions (c), (d), and (e) of this section, and shall sign and date the application.

(c) An applicant or an application filer shall provide the following information on the single, streamlined application:

(1) The applicant's full name (first, middle, if applicable, and last).

(2) The applicant's date of birth.

(3) The home and mailing address, if different from home address, for the applicant and for all persons for whom application is being made, the applicant's county of residence and telephone number(s). For an applicant who does not have a home address, only a mailing address shall be provided.

(4) The applicant's SSN, if one has been issued to the applicant, and if the applicant does

not have a SSN, the reason for not having one. The applicant's TIN, if one has been issued to the applicant in lieu of a SSN.

(5) The applicant's gender.

(6) The applicant's marital status.

(7) The applicant's status as a U.S. Citizen or U.S. National, or the applicant's immigration status, if the applicant is not a U.S. Citizen or U.S. National and attests to having satisfactory immigration status.

(8) The applicant's employment status.

(9) Sources, amount, and payment frequency of the applicant's gross income including tax-exempt income, such as foreign earned income, income from interest that the applicant receives or accrues during the taxable year, and income from Social Security benefits, but excluding income from child support payments, veteran's payments, and Supplemental Security Income/State Supplementary Payment (SSI/SSP). If self-employed, the type of work, and the amount of net income.

(10) The applicant's expected annual household income from all sources.

(11) The number of members in the applicant's household.

(12) Whether the applicant is an American Indian or Alaska Native, and if so:

(A) Name and state of the tribe;

(B) Whether the applicant has ever received a service from the Indian Health Service, a tribal health program, or an urban Indian health program or through a referral from one of these programs, and if not, whether he or she is eligible to receive such services; and

(C) The sources, amount, and frequency of payment for any income the applicant receives due to his or her status as American Indian or Alaska Native, if applicable.

(13) The applicant's expected type and amount of any tax deductions, including but not limited to student loan interest deduction, tuition and fees, educator expenses, IRA contribution, moving expenses, penalty on early withdrawal of savings, health savings account deduction, alimony paid, and domestic production activities deduction.

(14) Whether the applicant currently has MEC through an employer-sponsored plan, as defined in Section 5000A(f)(2) of IRC (26 USC § 5000A(f)(2)), and if so, the amount of monthly premium the applicant pays for self-only coverage through his or her employer and whether it meets the minimum value standards, as defined in Section 6410 of Article 2 of this chapter.

(15) Whether the applicant currently has MEC through any government sponsored programs,

as defined in Section 5000A(f)(1)(A) of IRC (26 USC § 5000A(f)(1)(A)).

(16) Whether the applicant has any physical, mental, emotional, or developmental disability.

(17) Whether the applicant needs help with long-term care or home and community-based services.

(18) Pregnancy status, if applicable, and if pregnant, the number of babies expected and the expected delivery date.

(19) The applicant's preferred written and spoken language.

(20) The applicant's preferred method of communication, including telephone, mail, and email, and if email has been selected, the applicant's email address.

(21) Whether the applicant is 18 to 20 years old and a full-time student.

(22) Whether the applicant is 18 to 26 years old and lived in foster care on his or her 18th birthday or whether the applicant was in foster care and enrolled in Medicaid in any state.

(23) Whether the applicant is temporarily living out of state.

(24) Whether the applicant intends to file a federal income tax return for the year for which he or she is requesting coverage, and if so, the applicant's expected tax-filing status.

(25) Whether the applicant is a primary tax filer or a tax dependent, and if a tax dependent, the information in subdivision(c)(1) through (13) of this section, except for the information in subdivision (c)(7) regarding citizenship, status as a national, or immigration status, for the primary tax filer.

(26) For each person for whom the applicant is applying for coverage:

(A) The relationship of each person to the applicant; and

(B) The information in subdivision(c)(1) through (25) of this section.

(27) Whether the applicant designates an authorized representative, and if so, the authorized representative's name and address, and the applicant's signature authorizing the designated representative to act on the applicant's behalf for the application, eligibility and enrollment, and appeals process, if applicable.

(d) An applicant or an application filer shall indicate that he or she understands his or her rights and responsibilities by providing, on the single, streamlined application, a declaration that:

(1) The information the applicant provides on the application is true and accurate to the best of his or her knowledge, and that the applicant may be subject to a penalty if he or she does not tell the truth.

(2) The applicant understands that the information he or she provides on the application shall be only used for purposes of eligibility determination and enrollment for all the individuals listed on the application.

(3) The applicant understands that information he or she provides on the application shall be kept private in accordance with the applicable federal and State privacy and security laws and that the Exchange shares such information with other federal and State agencies in order to verify the information and to make an eligibility determination for the applicant and for any other person(s) for whom he or she has requested coverage on the application, if applicable.

(4) The applicant understands that to be eligible for Medi-Cal, the applicant is required to apply for other income or benefits to which he or she, or any member(s) of his or her household, is entitled, including: pensions, government benefits, retirement income, veterans' benefits, annuities, disability benefits, Social Security benefits (also called OASDI or Old Age, Survivors, and Disability Insurance), and unemployment benefits. However, such income or benefits do not include public assistance benefits, such as CalWORKs or CalFresh.

(5) The applicant understands that he or she is required to report any changes to the information provided on the application to the Exchange.

(6) The applicant understands that the Exchange shall not discriminate against the applicant or anyone on the application because of race, color, national origin, religion, age, sex, sexual orientation, marital status, veteran's status, or disability.

(7) The applicant understands that, except for purposes of applying for Medi-Cal, the applicant and any other person(s) the applicant has included in the application shall not be confined, after the disposition of charges (judgment), in a jail, prison, or similar penal institution or correctional facility.

(8) If the applicant or any other persons the applicant has included in the application qualifies for Medi-Cal, the applicant understands that if Medi-Cal pays for a medical expense, any money the applicant, or any other person(s) included in the application, receives from other health insurance, legal settlements, or judgments covering that medical expense shall be used to repay Medi-Cal until the medical expense is paid in full.

(9) The applicant understands that he or she shall have the right to appeal any action or inaction taken by the Exchange and shall receive assistance from the Exchange regarding how to file an appeal.

(10) The applicant understands that any changes in his or her information or information of any member(s) in the applicant's household may affect the eligibility of other members of the household.

(e) An applicant or an application filer shall declare under penalty of perjury that he or she:

(1) Understood all questions on the application, and gave true and correct answers to the best of his or her personal knowledge, and where he or she did not know the answer personally, he or she made every effort to confirm the answer with someone who did know the answer;

(2) Knows that if he or she does not tell the truth on the application, there may be a civil or criminal penalty for perjury that may include up to four years in jail, pursuant to California Penal Code Section 126;

(3) Knows that the information provided on the application shall be only used for purposes of eligibility determination and enrollment for all the individuals listed on the application who are requesting coverage, and that the Exchange shall keep such information private in accordance with the applicable federal and State privacy and security laws;

(4) Agrees to notify the Exchange if any information in the application for any person applying for health insurance changes, which may affect the person's eligibility; and

(5) Understands that if he or she selects a health plan in the application and is determined eligible by the Exchange to enroll in his or her selected plan:

(A) By signing the application and making timely payment of the initial premium, if applicable, he or she is entering into a contract with the issuer of that plan; and

(B) The applicant or responsible party signing the application is at least 18 years of age or an emancipated minor, and mentally competent to sign a contract.

(f) If an applicant or an application filer selects a health insurance plan or a standalone ~~pediatric~~ dental plan, as applicable, in the application:

(1) He or she shall provide:

(A) The name of the applicant and each family member who is enrolling in a plan; and

(B) The plan information, including plan name, metal tier, metal number, coverage level and plan type, as applicable; and

(2) All individuals, responsible parties, or authorized representatives, age 18 or older who are selecting and enrolling into a health insurance plan shall agree to, sign, and date the agreement for binding arbitration, as set forth below:

(A) For an Exchange Plan: "I understand that every participating health plan has its own rules for resolving disputes or claims, including, but not limited to, any claim asserted by me, my enrolled dependents, heirs, or authorized representatives against a health plan, any contracted health care providers, administrators, or other associated parties, about the membership in the health plan, the coverage for, or the

delivery of, services or items, medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), or premises liability. I understand that, if I select a health plan that requires binding arbitration to resolve disputes, I accept, and agree to, the use of binding arbitration to resolve disputes or claims (except for Small Claims Court cases and claims that cannot be subject to binding arbitration under governing law) and give up my right to a jury trial and cannot have the dispute decided in court, except as applicable law provides for judicial review of arbitration proceedings. I understand that the full arbitration provision for each participating health plan, if they have one, is in the health plan's coverage document, which is available online at CoveredCA.com for my review, or, I can call Covered California at 1-800-300-1506 (TTY: 1-888-889-4500) for more information."

(B) For a Kaiser Medi-Cal health plan: "I have read the plan description. I understand that Kaiser requires the use of binding neutral arbitration to resolve certain disputes. This includes disputes about whether the right medical treatment was provided (called medical malpractice) and other disputes relating to benefits or the delivery of services, including whether any medical services provided were unnecessary or unauthorized, or were improperly, negligently, or incompetently rendered. If I pick Kaiser as my Medi-Cal health plan, I give up my constitutional right to a jury or court trial for those certain disputes. I also agree to use binding neutral arbitration to resolve those certain disputes. I do not give up my right to a state hearing of any issue, which is subject to the state hearing process."

(g) The Exchange may request on the application that the applicant authorizes the Exchange to obtain updated tax return information, as described in Section 6498(c), for up to five years to conduct an annual redetermination, provided that the Exchange inform the applicant that he or she shall have the option to:

(1) Decline to authorize the Exchange to obtain updated tax return information; or

(2) Discontinue, change, or renew his or her authorization at any time.

(h) If a CEC, PBE, or a Certified Insurance Agent assists an applicant or an application filer in completing the application, he or she shall:

(1) Provide his or her name;

(2) Provide his or her certification or license number, if applicable;

(3) Provide the name of the entity with which he or she is affiliated;

(4) Certify that he or she assisted the applicant complete the application free of charge;

(5) Certify that he or she provided true and correct answers to all questions on the application to the best of his or her knowledge and explained to the applicant in plain language, and the applicant understood, the risk of providing inaccurate or false information; and

(6) Date and sign the application.

(i) To apply for an eligibility determination and enrollment in a QHP through the Exchange without requesting any APTC or CSR, an applicant or an application filer shall, for the applicant and each person for whom the applicant is applying for coverage, submit all information, documentation, and declarations required in:

(1) Subdivision (c)(1), (2), (3), (4), (5), (6), (7), (12)(A), (19), (20), (26)(A), and (27) of this section;

(2) Subdivision (d)(1), (2), (3), (5), (6), (7), (9), and (10) of this section;

(3) Subdivision (e) of this section;

(4) Subdivision (f)(1) and (2)(A) of this section; and

(5) Subdivision (h) of this section.

(j) An applicant or an application filer may file an application through one of the following channels:

(1) The Exchange's Internet Web ~~Site~~site;
(2) Telephone;
(3) Facsimile;
(4) Mail; or
(5) In person.

(k) The Exchange shall accept an application from an applicant or application filer and make an eligibility determination for an applicant seeking an eligibility determination at any point in time during the year.

(l) If an applicant or application filer submits an incomplete application that does not include sufficient information for the Exchange to conduct an eligibility determination for enrollment in a QHP through the Exchange or for an IAP, if applicable, the Exchange shall proceed as follows:

(1) The Exchange shall provide notice to the applicant indicating that information necessary to complete an eligibility determination is missing, specifying the missing information, and providing instructions on how to provide the missing information;

(2) The Exchange shall provide the applicant with a period of 90 calendar days from the date of the notice described in subdivision (l)(1) of this section, or until the end of an enrollment period, whichever date is earlier, to provide the information needed to complete the application to the Exchange. In no event, shall this period be less than 30 calendar days from the date of the notice described in subdivision (l)(1) of this section.

(3) During the period specified in subdivision (l)(2) of this section, the Exchange shall not proceed with the applicant's eligibility determination or provide APTC or CSR, unless the applicant or application filer has provided sufficient information to determine the applicant's eligibility for enrollment in a QHP through the Exchange, in which case the Exchange shall make such a determination for enrollment in a QHP.

(4) If the applicant fails to provide the requested information within the period specified in subdivision (l)(2) of this section, the Exchange shall provide notice of denial to the applicant, including notice of appeals rights in accordance with Section 6604 of Article 7 of this chapter.

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; 45 CFR Sections 155.310, 155.405.

§ 6472. Eligibility Requirements for Enrollment in a QHP through the Exchange.

(a) An applicant who is seeking enrollment in a QHP that is not a catastrophic plan shall meet the requirements of this section, except for the requirements specified in subdivision (f) of this section, regardless of the applicant's eligibility for APTC or CSR. For purposes of this section, an applicant includes all individuals listed on the application who are seeking enrollment in a QHP through the Exchange. An applicant who is seeking enrollment in a catastrophic QHP shall also meet the requirements specified in subdivision (f) of this section.

(b) An applicant who has a SSN shall provide his or her SSN to the Exchange.

(c) An applicant shall be a citizen or national of the United States, or a non-citizen who is lawfully present in the United States, and is reasonably expected to be a citizen, national, or a non-citizen who is lawfully present for the entire period for which enrollment is sought.

(d) An applicant shall not be incarcerated, other than incarceration pending the disposition of charges (judgment).

(e) An applicant shall meet one of the following applicable residency standards:

(1) For an individual who is age 21 and over, is not living in an institution as defined in 42 CFR Section 435.403(b), is capable of indicating intent, and is not receiving Supplemental Security Income/State Supplemental Program payments as defined in Title 22, Division 3, Section 50095 of CCR, the service area of the Exchange of the individual is the service areas of the Exchange in which he or she is living and:

(A) Intends to reside, including without a fixed address; or

(B) Has entered with a job commitment or is seeking employment (whether or not currently employed).

(2) For an individual who is under the age of 21, is not living in an institution as defined in in 42 CFR Section 435.403(b), is not eligible for Medi-Cal based on receipt of assistance under title IV–E of the Social Security Act, is not emancipated, and is not receiving Supplemental Security Income/State Supplementary Payment (SSI/SSP) as defined in Title 22, Division 3, Section 50095 of CCR, the Exchange service area of the individual is:

(A) The service area of the Exchange in which he or she resides, including without a fixed address; or

(B) The service area of the Exchange of a parent or caretaker, established in accordance with subdivision (e)(1) of this section, with whom the individual resides.

(3) For an individual who is not described in subdivisions (e)(1) or (2) of this section, the Exchange shall apply the residency requirements described in 42 CFR Section 435.403 with respect to the service area of the Exchange.

(4) Special rule for tax households with members in multiple Exchange service areas.

(A) Except as specified in subdivision (e)(4)(B) of this section, if all of the members of a tax household are not within the same Exchange service area, in accordance with the applicable standards in subdivisions (e)(1), (2), and (3) of this section, any member of the tax household may enroll in a QHP through any of the Exchanges for which one of the tax filers meets the residency standard.

(B) If both spouses in a tax household enroll in a QHP through the same Exchange, a tax dependent may choose to enroll in a QHP either through that Exchange or through the Exchange that services the area in which the dependent meets a residency standard described in subdivisions (e)(1), (2), or (3) of this section.

(5) The Exchange shall not deny or terminate an individual's eligibility for enrollment in a QHP through the Exchange if the individual meets the standards in subdivision (e)(1)–(4) of this section but for a temporary absence from the service area of the Exchange and intends to return when the purpose of the absence has been accomplished.

(f) The eligibility standards specified in this subdivision shall only apply to the eligibility determination for enrollment through the Exchange in a QHP that is a catastrophic plan, as defined in Section 1302(e) of the Affordable Care Act.

(1) The Exchange shall determine an applicant eligible for enrollment in a catastrophic QHP through the Exchange if the applicant:

(A) Has not attained the age of 30 before the beginning of the plan year; or

(B) Has a certification in effect for any plan year that the applicant is exempt from the requirement to maintain MEC under section 5000A of IRC (26 USC § 5000A) by reason of:

1. Section 5000A(e)(1) of IRC (26 USC § 5000A(e)(1)) relating to individuals without affordable coverage; or

2. Section 5000A(e)(5) of IRC (26 USC § 5000A(e)(5)) relating to individuals with hardships.

(2) APTC shall not be available to support enrollment in a catastrophic QHP through the Exchange.

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; 45 CFR Section 155.305.

§ 6474. Eligibility Requirements for APTC and CSR.

(a) Those individuals who apply to receive APTC and CSR shall meet the eligibility requirements of this section in addition to the requirements of Section 6472, except for the requirements specified in Section 6472(f) relating to enrollment in a catastrophic QHP.

(b) For purposes of this section, household income has the meaning given the term in Section 36B(d)(2) of IRC (26 USC § 36B(d)(2)) and in 26 CFR Section 1.36B-1(e).

(c) Eligibility for APTC.

(1) A tax filer shall be eligible for APTC if:

(A) Tax filer is expected to have a household income of greater than or equal to 100 percent but not more than 400 percent of the FPL for the benefit year for which coverage is requested; and

(B) One or more applicants for whom the tax filer expects to claim a personal exemption deduction on his or her tax return for the benefit year, including the tax filer and his or her spouse:

1. Meets the requirements for eligibility for enrollment in a QHP that is not a catastrophic plan through the Exchange, as specified in subdivisions (a) through (e) of Section 6472;

2. Is not eligible for MEC, with the exception of coverage in the individual market, in accordance with section 36B(c)(2)(B) and (C) of IRC (26 USC § 36B(c)(2)(B), (C)) and 26 CFR Section 1.36B-2(a)(2) and (c); and

3. Is enrolled in a QHP that is not a catastrophic plan through the Exchange.

(2) A non-citizen tax filer who is lawfully present and ineligible for Medi-Cal by reason of immigration status, and is not otherwise eligible for APTC under subdivision (c)(1) of this section, shall be eligible for APTC if:

(A) Tax filer meets the requirements specified in subdivision (c)(1) of this section, except for subdivision (c)(1)(A);

(B) Tax filer is expected to have a household income of less than 100 percent of the FPL for the benefit year for which coverage is requested; and

(C) One or more applicants for whom the tax filer expects to claim a personal exemption deduction on his or her tax return for the benefit year, including the tax filer and his or her spouse, is a non-citizen who is lawfully present and ineligible for Medi-Cal by reason of immigration status, in accordance with section 36B(c)(1)(B) of IRC (26 USC § 36B(c)(1)(B)) and in 26 CFR Section 1.36B-2(b)(5).

(3) Tax filer shall not be eligible for APTC if:

(A) HHS notifies the Exchange, as part of the verification process described in Sections 6482 through 6486, that APTC was made on behalf of the tax filer (or either spouse if the tax filer is a married couple) for a year for which tax data would be used to verify household income and family size in accordance with Section 6482(d) and (e);

(B) Tax filer (or his or her spouse) did not comply with the requirement to file an income tax return for that year, as required by Sections 6011 and 6012 of IRC (26 USC §§ 6011, 6012) and implementing regulations; and

(C) The APTC was not reconciled for that period.

(4) The APTC amount shall be calculated in accordance with section 36B of IRC (26 USC § 36B) and 26 CFR Section 1.36B-3.

(5) An application filer shall provide the SSN of a tax filer who is not an applicant only if an applicant attests that the tax filer has a SSN and filed a tax return for the year for which tax data would be used to verify household income and family size.

(d) Eligibility for CSR.

(1) An applicant shall be eligible for CSR if he or she:

(A) Meets the eligibility requirements for enrollment in a QHP through the Exchange, as specified in Section 6472;

(B) Meets the requirements for APTC, as specified in subdivision (c) of this section; and

(C) Is expected to have a household income that does not exceed 250 percent of the FPL for the benefit year for which coverage is requested.

(2) The Exchange may only provide CSR to an enrollee who is not an Indian if he or she is enrolled through the Exchange in a silver-level QHP, as defined by section 1302(d)(1)(B) of the Affordable Care Act.

(3) The Exchange shall use the following eligibility categories for CSR when making eligibility determinations under this section:

(A) An individual who is expected to have a household income:

1. Greater than or equal to 100 percent of the FPL and less than or equal to 150 percent of the FPL for the benefit year for which coverage is requested, or

2. Less than 100 percent of the FPL for the benefit year for which coverage is requested, if he or she is eligible for APTC under subdivision (c)(2) of this section;

(B) An individual is expected to have a household income greater than 150 percent of the FPL and less than or equal to 200 percent of the FPL for the benefit year for which coverage is requested; or

(C) An individual who is expected to have a household income greater than 200 percent of the FPL and less than or equal to 250 percent of the FPL for the benefit year for which coverage is requested.

(4) If an enrollment in a QHP under a single family policy covers two or more individuals, the Exchange shall deem the individuals under such family policy to be collectively eligible only for the last category of eligibility listed below for which all the individuals covered by the family policy would be eligible:

(A) Not eligible for CSR;
(B) Section 6494(a)(3) and (4) – Special CSR eligibility standards and process for Indians regardless of income;
(C) Subdivision (d)(3)(C) of this section;
(D) Subdivision (d)(3)(B) of this section;
(E) Subdivision (d)(3)(A) of this section; or
(F) Section 6494(a)(1) and (2) – Special CSR eligibility standards and process for Indians with household incomes under 300 percent of FPL.

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; 45 CFR Section 155.305.

§ 6476. Eligibility Determination Process

(a) An applicant may request an eligibility determination only for enrollment in a QHP through the Exchange.

(b) An applicant's request for an eligibility determination for an IAP shall be deemed a request for all IAPs.

(c) The Exchange shall determine an applicant eligible for an enrollment period if he or she meets the criteria for an enrollment period, as specified in Sections 6502 and 6504.

(d) The following special rules relate to APTC.

(1) An enrollee may accept less than the full amount of APTC for which he or she is determined eligible.

(2) To be determined eligible for APTC, a tax filer shall make the following attestations as applicable:

(A) He or she will file an income tax return for the benefit year, in accordance with Sections 6011 and 6012 of IRC (26 USC §§ 6011, 6012) and implementing regulations;

(B) If married (within the meaning of 26 CFR 1.7703–1), he or she will file a joint tax return for the benefit year;

(C) No other taxpayer will be able to claim him or her as a tax dependent for the benefit year; and

(D) He or she will claim a personal exemption deduction on his or her tax return for the applicants identified as members of his or her family, including the tax filer and his or her spouse, in accordance with Section 6482(d).

(e) If the Exchange determines an applicant eligible for Medi-Cal or CHIP, the Exchange shall notify and transmit to DHCS, within three business days from the date of the eligibility determination, all information that is necessary for DHCS to provide the applicant with coverage.

(f) An applicant's eligibility shall be determined within 10 calendar days from the date the Exchange receives the applicant's complete paper application, as specified in Section 6470. This timeline does not apply to the eligibility determinations for applications submitted online, which occur real time, if administratively feasible.

(g) Upon making an eligibility determination, the Exchange shall implement the eligibility determination under this section for enrollment in a QHP through the Exchange, APTC, and CSR as follows:

(1) For an initial eligibility determination, in accordance with the dates specified in Section 6502(c) and (f) and Section 6504(g) and (h), as applicable; or

(2) For a redetermination, in accordance with the dates specified in Section 6496(k) through (n) and Section 6498(l), as applicable.

(h) The Exchange shall provide written notice to an applicant of any eligibility determination made in accordance with this article within five business days from the date of the eligibility determination.

(i) The Exchange shall notify an employer that an employee has been determined eligible for APTC and CSR upon determination that an employee is eligible for APTC and CSR. Such notice shall:

(1) Identify the employee;

(2) Indicate that the employee has been determined eligible for APTC and CSR;

(3) Indicate that, if the employer has 50 or more full-time employees, the employer may be liable for the tax penalty assessed under Section 4980H of IRC (26 USC § 4980H); and

(4) Notify the employer of the right to appeal the determination.

(j) If an applicant who is determined eligible for enrollment in a QHP does not select a QHP within his or her enrollment periods, as specified in Sections 6502 and 6504, or is not eligible for an enrollment period, and seeks a new enrollment period prior to the date on which his or her eligibility is redetermined in accordance with Section 6498:

(1) The applicant shall attest as to whether information affecting his or her eligibility has changed since his or her most recent eligibility determination before determining his or her eligibility for a special enrollment period; and

(2) Any changes the applicant reports shall be processed in accordance with the procedures specified in Section 6496.

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; 45 CFR Section 155.310.

§ 6478. Verification Process Related to Eligibility Requirements for Enrollment in a QHP through the Exchange.

(a) The Exchange shall verify or obtain information as provided in this section to determine whether an applicant meets the eligibility requirements specified in Section 6472 relating to the eligibility requirements for enrollment in a QHP through the Exchange.

(b) Verification of SSN.

(1) For any individual who provides his or her SSN to the Exchange, the Exchange shall transmit the SSN and other identifying information to HHS, which will submit it to the SSA.

(2) If the Exchange is unable to verify an individual's SSN through the SSA, or the SSA indicates that the individual is deceased, the Exchange shall follow the procedures specified in Section 6492, except that the Exchange shall provide the individual with a

period of 90 days from the date on which the notice described in Section 6492(a)(2)(A) is received for the applicant to provide satisfactory documentary evidence or resolve the inconsistency with the SSA. The date on which the notice is received means five days after the date on the notice, unless the Exchange determines on a case-by-case basis that the individual has demonstrated that he or she did not receive the notice within the five-day period.

(c) Verification of citizenship, status as a national, or lawful presence.

(1) For an applicant who attests to citizenship and has a SSN, the Exchange shall transmit the applicant's SSN and other identifying information to HHS, which will submit it to the SSA.

(2) For an applicant who has documentation that can be verified through the DHS and who attests to lawful presence, or who attests to citizenship and for whom the Exchange cannot substantiate a claim of citizenship through the SSA, the Exchange shall transmit information from the applicant's documentation and other identifying information to HHS, which will submit necessary information to the DHS for verification.

(3) For an applicant who attests to citizenship, status as a national, or lawful presence, and for whom the Exchange cannot verify such attestation through the SSA or the DHS, the Exchange shall follow the inconsistencies procedures specified in Section 6492, except that the Exchange shall provide the applicant with a period of 90 days from the date on which the notice described in Section 6492 (a)(2)(A) is received for the applicant to provide satisfactory documentary evidence or resolve the inconsistency with the SSA or the DHS, as applicable. The date on which the notice is received means five days after the date on the notice, unless the Exchange determines on a case-by-case basis that the individual has demonstrated that he or she did not receive the notice within the five-day period.

(d) Verification of residency.

(1) Except as provided in subdivisions (d)(2) and (3) of this section, the Exchange shall accept an applicant's attestation that he or she meets the residency standards of Section 6472(e) without further verification.

(2) If information provided by an applicant regarding residency is not reasonably compatible with other information provided by the individual or in the records of the Exchange, the Exchange shall examine information in HHS-approved data sources that are available to the Exchange.

(3) If the information in data sources specified in subdivision (d)(2) of this section is not reasonably compatible with the information provided by the applicant, the Exchange shall follow the procedures specified in Section 6492. Evidence of immigration status may not be used to determine that an applicant is not a resident of the Exchange service area.

(e) Verification of incarceration status.

(1) The Exchange shall verify an applicant's attestation that he or she meets the requirements of 6472(d) by:

(A) Relying on any HHS-approved electronic data sources that are available to the Exchange; or

(B) Except as provided in subdivision (e)(2) of this section, if a HHS-approved data source is unavailable, accepting the applicant's attestation without further verification.

(2) If an applicant's attestation is not reasonably compatible with information from HHS-approved data sources described in subdivision (e)(1)(A) of this section or other information provided by the applicant or in the records of the Exchange, the Exchange shall follow the inconsistencies procedures specified in Section 6492.

(f) Verification related to eligibility for enrollment through the Exchange in a QHP that is a catastrophic plan.

(1) The Exchange shall verify an applicant's attestation that he or she meets the requirements of 6472(f) by:

(A) Verifying the applicant's attestation of age as follows:

1. Except as provided in subdivision (f)(1)(A)2 of this section, the Exchange shall accept the applicant's attestation of age without further verification.

2. If information regarding age is not reasonably compatible with other information provided by the individual or in the records of the Exchange, the Exchange shall examine information in HHS-approved data sources that are available to the Exchange.

(B) Verifying that an applicant has received a certificate of exemption as described in Section 6472(f)(1)(B).

(2) ~~To the extent that~~ If the Exchange is unable to verify the information required to determine eligibility for enrollment through the Exchange in a QHP that is a catastrophic plan as described in subdivision (f)(1) of this section, the Exchange shall follow the procedures specified in Section 6492, except for Section 6492(a)(4).

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; 45 CFR Section 155.315.

§ 6480. Verification of Eligibility for MEC other than through an Eligible Employer-Sponsored Plan Related to Eligibility Determination for APTC and CSR.

(a) The Exchange shall verify whether an applicant is eligible for MEC other than through an eligible employer-sponsored plan, Medi-Cal, or CHIP, using information obtained from the HHS.

(b) The Exchange shall verify whether an applicant has already been determined eligible for coverage through Medi-Cal or CHIP, using information obtained from the DHCS.

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100502, 100503, and 100504, Government Code; 45 CFR Section 155.320.

§ 6482. Verification of Family Size and Household Income Related to Eligibility Determination for APTC and CSR.

(a) For purposes of this section, "family size" and "household income" have the meanings given the terms in Section 36B(d)(1) and (2) of IRC (26 USC § 36B(d)(1), (2)) and in 26 CFR Section 1.36B-1(d), (e).

(b) For all individuals whose income is counted in calculating a tax filer's household income, in accordance with Section 36B(d)(2) of IRC (26 USC § 36B(d)(2)) and 26 CFR Section 1.36B-1(e), or an applicant's household income, calculated in accordance with 42 CFR Section 435.603(d), and for whom the Exchange has a SSN, the Exchange shall request tax return data regarding MAGI and family size from the Secretary of the Treasury and data regarding Social security benefits described in 26 CFR Section 1.36B–1(e)(2)(iii) from the Commissioner of Social Security by transmitting identifying information specified by HHS to HHS.

(c) If the identifying information for one or more individuals does not match a tax record on file with the IRS, the Exchange shall proceed in accordance with the procedures specified in Section 6492(a)(1).

(d) An applicant's family size shall be verified in accordance with the following procedures.

(1) An applicant shall attest to the individuals that comprise a tax filer's family for APTC and CSR.

(2) If an applicant attests that the information described in subdivision (b) of this section represents an accurate projection of a tax filer's family size for the benefit year for which coverage is requested, the tax filer's eligibility for APTC and CSR shall be determined based on the family size data in subdivision (b) of this section.

(3) Except as specified in subdivision (d)(4) of this section, the tax filer's family size for APTC and CSR shall be verified by accepting an applicant's attestation without further verification if:

(A) The data described in subdivision (b) of this section is unavailable; or

(B) The applicant attests that a change in family size has occurred, or is reasonably expected to occur, and so the data described in subdivision (b) of this section does not represent an accurate projection of the tax filer's family size for the benefit year for which coverage is requested.

(4) If the Exchange finds that an applicant's attestation of a tax filer's family size is not reasonably compatible with other information provided by the application filer for the family or in the records of the Exchange, with the exception of the data described in subdivision (b) of this section, the applicant's attestation shall be verified using data obtained through other electronic data sources. If such data sources are unavailable or information in such data sources is not reasonably compatible with the applicant's attestation, the applicant shall provide additional documentation requested by the Exchange to support the attestation, in accordance with Section 6492.

(e) An applicant’s annual household income shall be verified in accordance with the following procedures.

(1) The annual household income of the family described in subdivision (d)(1) shall be computed based on the tax return data described in subdivision (b) of this section.

(2) An applicant shall attest to a tax filer's projected annual household income.

(3) If an applicant's attestation indicates that the information described in subdivision (e)(1) of this section represents an accurate projection of the tax filer's household income for the benefit year for which coverage is requested, the tax filer's eligibility for APTC and CSR shall be determined based on the household income data in subdivision (e)(1) of this section.

(4) If the data described in subdivision (b) of this section is unavailable, or an applicant attests that a change in household income has occurred, or is reasonably expected to occur, and so it does not represent an accurate projection of the tax filer's household income for the benefit year for which coverage is requested, the applicant shall attest to

the tax filer's projected household income for the benefit year for which coverage is requested.

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; 45 CFR Section 155.320.

§ 6484. Verification Process for Increases in Household Income Related to Eligibility Determination for APTC and CSR.

(a) Except as provided in subdivisions (b) and (c) of this section, the Exchange shall accept the applicant's attestation regarding the tax filer's annual household income without further verification if:

(1) An applicant attests, in accordance with Section 6482(e)(2), that a tax filer's annual household income has increased, or is reasonably expected to increase, from the income described in Section 6482(e)(1) for the benefit year for which the applicant(s) in the tax filer's family are requesting coverage; and

(2) The Exchange has verified, in accordance with the process specified in Medicaid regulations at 42 CFR Sections 435.945, 435.948, and 435.952 and CHIP regulations at 42 CFR Section 457.380, that the applicant's MAGI-based income is not within the applicable Medi-Cal or CHIP MAGI–based income standard.

(b) If the Exchange finds that an applicant's attestation of a tax filer's projected annual household income is not reasonably compatible with other information provided by the application filer or available to the Exchange, the applicant's attestation shall be verified using data the Exchange obtained through available electronic data sources.

(c) If the data sources described in subdivision (b) of this section are unavailable or information in such data sources is not reasonably compatible with the applicant's attestation, the applicant shall provide additional documentation requested by the Exchange to support the attestation, in accordance with Section 6492.

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; 45 CFR Section 155.320.

§ 6486. Alternate Verification Process for APTC and CSR Eligibility Determination for Decreases in Annual Household Income or If Tax Return Data Is Unavailable.

(a) A tax filer's annual household income shall be determined based on the alternate verification procedures described in subdivisions (b) and (c) of this section if:

(1) An applicant attests to projected annual household income in accordance with Section 6482(e)(2);

(2) The tax filer does not meet the criteria specified in Section 6484;

(3) The Exchange has verified, in accordance with the process specified in Medicaid regulations at 42 CFR Sections 435.945, 435.948, and 435.952 and CHIP regulations at 42 CFR Section 457.380, that the MAGI–based income of the applicants in the tax filer's family is not within the applicable Medi-Cal or CHIP standard; and

(4) One of the following conditions is met:

(A) The IRS does not have tax return data that may be disclosed under Section 6103(l)(21) of IRC (26 USC § 6102(l)(21)) for the tax filer that is at least as recent as the calendar year two years prior to the calendar year for which APTC and CSR would be effective;

(B) The applicant attests that the tax filer's applicable family size has changed, or is reasonably expected to change (or the members of the tax filer's family have changed, or are reasonably expected to change), for the benefit year for which the applicants in his or her family are requesting coverage;

(C) The applicant attests that a change in circumstances has occurred, or is reasonably expected to occur, and so the tax filer's annual household income has decreased, or is reasonably expected to decrease, from the income obtained from the data sources described in Section 6482(b) for the benefit year for which the applicants in his or her family are requesting coverage;

(D) The applicant attests that the tax filer's filing status has changed, or is reasonably expected to change, for the benefit year for which the applicants in his or her family are requesting coverage; or

(E) An applicant in the tax filer's family has filed an application for unemployment benefits.

(b) If a tax filer qualifies for an alternate verification process based on the requirements specified in subdivision (a) of this section and the applicant's attestation to projected annual household income, as described in Section 6482(e)(2), is no more than ten percent below the annual household income computed in accordance with Section 6482(e)(1), the applicant's attestation shall be accepted without further verification.

(c) If a tax filer qualifies for an alternate verification process based on the requirements specified in subdivision (a) of this section and the applicant's attestation to projected annual household income, as described in Section 6482(e)(2), is greater than ten percent below the annual household income computed in accordance with Section 6482(e)(1), or if the tax data described in Section 6482(b) is unavailable:

(1) The applicant's attestation of the tax filer's projected annual household income for the tax filer shall be verified by:

(A) Using annualized data from the MAGI-based income sources specified in 42 CFR Section 435.948(a);

(B) Using other HHS-approved electronic data sources; or

(C) Following the procedures specified in Section 6492(a)(1) through (4) if electronic data are unavailable or do not support an applicant's attestation;

(2) The applicant shall not be eligible for APTC or CSR if:

(A) An applicant has not responded to a request for additional information from the Exchange following the 90-day period described in subdivision (c)(1)(C) of this section; and

(B) The data sources specified in Section 6482(b) and in 42 CFR Section 435.948(a) indicate that an applicant in the tax filer's family is eligible for Medi-Cal or CHIP, other than the restricted Medi-Cal coverage of pregnancy-related services specified in 26 CFR Section 1.5000A-2(b)(1)(ii)(C).

(3) If, at the conclusion of the period specified in subdivision (c)(1)(C) of this section, the Exchange remains unable to verify the applicant's attestation, the Exchange shall:

(A) Determine the applicant's eligibility based on the information described in Section 6482(e)(1);

(B) Notify the applicant of such determination in accordance with the notice requirements specified in Section 6476(h); and

(C) Implement such determination in accordance with the effective dates specified in Section 6496(k) through (n).

(4) If, at the conclusion of the period specified in subdivision (c)(1)(C) of this section, the Exchange remains unable to verify the applicant's attestation for the tax filer and the information described in Section 6482(e)(1) is unavailable, the Exchange shall:

(A) Determine the tax filer ineligible for APTC and CSR;

(B) Notify the applicant of such determination in accordance with the notice requirements specified in Section 6476(h); and

(C) Discontinue any APTC and CSR in accordance with the effective dates specified in Section 6496(k) through (n).

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; 45 CFR Section 155.320.

§ 6490. Verifications of Enrollment in an Eligible Employer-Sponsored Plan and Eligibility for Qualifying Coverage in an Eligible Employer-Sponsored Plan Related to Eligibility Determination for APTC and CSR.

(a) Except as specified in subdivision (f) of this section, the Exchange shall verify whether an applicant reasonably expects to be enrolled in an eligible employer-sponsored plan or is eligible for qualifying coverage in an eligible employer-sponsored plan for the benefit year for which coverage is requested.

(b) The Exchange shall obtain:

(1) Data about enrollment in and eligibility for an eligible employer-sponsored plan from any HHS-approved electronic data sources that are available to the Exchange;

(2) Any available data regarding enrollment in employer-sponsored coverage or eligibility for qualifying coverage in an eligible employer-sponsored plan based on federal employment by transmitting to HHS identifying information specified by HHS to provide the necessary verification using data obtained by HHS; and

(3) Any available data from SHOP.

(c) Except as specified in subdivision (d) of this section, the Exchange shall accept an applicant's attestation regarding the verification specified in subdivision (a) of this section without further verification.

(d) Except as specified in subdivision (e) of this section, if an applicant's attestation is not reasonably compatible with the information obtained by the Exchange as specified in subdivisions (b)(1) through (3) of this section, other information provided by the application filer, or other information in the records of the Exchange, the Exchange shall follow the procedures specified in Section 6492.

(e) For eligibility determinations for APTC and CSR that are effective before January 1, 2015, if the Exchange does not have any of the information specified in subdivisions (b)(1) through (3) of this section for an applicant, the Exchange shall accept an applicant's attestation regarding enrollment in an eligible employer-sponsored plan and eligibility for qualifying coverage in an eligible employer-sponsored plan for the benefit year for which coverage is requested without further verification.

(f) For eligibility determinations for APTC and CSR that are effective on or after January 1, 2015, the Exchange shall:

(1) Rely on a verification process performed by HHS for verification of enrollment, and eligibility for qualifying coverage, in an eligible employer-sponsored plan;

(2) Send the notices described in Section 6476(h) and (i); and

(3) Provide all relevant application information to HHS through a secure, electronic interface, promptly and without undue delay.

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; 45 CFR Section 155.320.

§ 6492. Inconsistencies.

(a) Except as otherwise specified in this Article, for an applicant whose attestations are inconsistent with the data obtained by the Exchange from available data sources, or for whom the Exchange cannot verify information required to determine eligibility for enrollment in a QHP, or for APTC and CSR, including when electronic data is required in accordance with this section but data for individuals relevant to the eligibility determination are not included in such data sources or when electronic data from IRS, DHS, or SSA is required but it is not reasonably expected that data sources will be available within one day of the initial request to the data source, the Exchange:

(1) Shall make a reasonable effort to identify and address the causes of such inconsistency, including through typographical or other clerical errors, by contacting the application filer to confirm the accuracy of the information submitted by the application filer;

(2) If unable to resolve the inconsistency through the process described in subdivision (a)(1) of this section, shall:

(A) Provide notice to the applicant regarding the inconsistency; and

(B) Provide the applicant with a period of 90 days from the date on which the notice described in subdivision (a)(2)(A) of this section is sent to the applicant to either present satisfactory documentary evidence through the channels available for the submission of an application, as described in Section 6470(j), except by telephone, or otherwise resolve the inconsistency.

(3) May extend the period described in subdivision (a)(2)(B) of this section for an applicant if the Exchange determines on a case-by-case basis that the applicant has demonstrated that he or she has made a good-faith effort to obtain the required documentation during the period.

(4) During the period described in subdivision (a)(2)(B) of this section, shall:

(A) Proceed with all other elements of eligibility determination using the applicant's attestation, and provide eligibility for enrollment in a QHP if an applicant is otherwise qualified; and

(B) Ensure that APTC and CSR are provided within this period on behalf of an applicant who is otherwise qualified for such payments and reductions, as described in Section 6474, provided that the tax filer attests to the Exchange that he or she understands that any APTC paid on his or her behalf are subject to reconciliation.

(5) If, after the period described in subdivision (a)(2)(B) of this section, the Exchange remains unable to verify the attestation, shall:

(A) Determine the applicant's eligibility based on the information available from the data sources specified in Sections 6478 through 6492, unless such applicant qualifies for the exception provided under subdivision (b) of this section; and

(B) Notify the applicant of such determination in accordance with the notice requirements specified in Section 6476(h), including notice that the Exchange is unable to verify the attestation.~~; and~~

~~(C) Effectuate the determination specified in subdivision (a)(5)(A) of this section no earlier than 10 days after and no later than 30 days after the date on which the notice in subdivision (a)(5)(A) of this section is sent.~~

(6) When electronic data to support the verifications specified in Section 6478(d) or Section 6480 is required but it is not reasonably expected that data sources will be available within one day of the initial request to the data source, the Exchange shall accept the applicant’s attestation regarding the factor of eligibility for which the unavailable data source is relevant.

(b) The Exchange shall provide an exception, on a case-by-case basis, to accept an applicant's attestation as to the information which cannot otherwise be verified and the applicant's explanation of circumstances as to why the applicant does not have documentation if:

(1) An applicant does not have documentation with which to resolve the inconsistency through the process described in subdivision (a)(2) of this section because such documentation does not exist or is not reasonably available;

(2) The Exchange is unable to otherwise resolve the inconsistency for the applicant; and

(3) The inconsistency is not related to citizenship or immigration status.

(c) An applicant shall not be required to provide information beyond the minimum necessary to support the eligibility and enrollment processes of the Exchange, Medi-Cal, and CHIP.

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100502, 100503, and 100504, Government Code; 45 CFR Section 155.315.

§ 6494. Special Eligibility Standards and Verification Process for Indians.

(a) An Indian applicant's eligibility for CSR shall be determined based on the following procedures.

(1) An Indian applicant shall be eligible for CSR if he or she:

(A) Meets the eligibility requirements specified in Sections 6472 and 6474(c);

(B) Is expected to have a household income, as defined in section 36B(d)(2) of IRC (26 USC § 36B(d)(2)) and in 26 CFR Section 1.36B-1(e), that does not exceed 300 percent of the FPL for the benefit year for which coverage is requested; and

(C) Is enrolled in a QHP through the Exchange.

(2) If an Indian applicant meets the eligibility requirements of subdivision (a)(1):

(A) Such applicant shall be treated as an eligible insured; and

(B) The QHP issuer shall eliminate any cost-sharing under the plan.

(3) Regardless of an Indian applicant's income and the requirement of Section 6476(b) to request an eligibility determination for all IAPs, such applicant shall be eligible for CSR if the individual is:

(A) Enrolled in a QHP through the Exchange; and

(B) Furnished an item or service directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or through referral under contract health services.

(4) If an Indian applicant meets the requirements of subdivision (a)(3) of this section, the QHP issuer:

(A) Shall eliminate any cost-sharing under the plan for the item or service specified in subdivision (a)(3)(B); and

(B) Shall not reduce the payment to any such entity for the item or service specified in

subdivision (a)(3)(B) by the amount of any cost-sharing that would be due from the Indian but for subdivision (A).

(b) An Indian applicant's attestation that he or she is an Indian shall be verified by:

(1) Using any relevant documentation verified in accordance with Section 6492;

(2) Relying on any HHS-approved electronic data sources that are available to the Exchange; or

(3) If HHS-approved data sources are unavailable, an individual is not represented in available data sources, or data sources are not reasonably compatible with an applicant's attestation:

(A) Following the procedures specified in Section 6492; and

(B) Verifying documentation provided by the applicant that meets the following requirements for satisfactory documentary evidence of citizenship or nationality:

1. Except as provided in subdivision (b)(3)(B)2 of this section, a document issued by a federally recognized Indian tribe evidencing membership or enrollment in, or affiliation with, such tribe (such as a tribal enrollment card or certificate of degree of Indian blood).

2. With respect to those federally recognized Indian tribes located within States having an international border whose membership includes individuals who are not citizens of the United States, such other forms of documentation (including tribal documentation, if appropriate) that HHS has determined to be satisfactory documentary evidence of citizenship or nationality.

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; 45 CFR Section 155.350.

§ 6496. Eligibility Redetermination during a Benefit Year.

(a) The Exchange shall redetermine the eligibility of an enrollee in a QHP through the Exchange during the benefit year if it receives and verifies new information reported by an enrollee or identifies updated information through the data matching described in subdivision (g) of this section.

(b) Except as specified in subdivisions (c) and (d) of this section, an enrollee, or an application filer on behalf of the enrollee, shall report any change of circumstances with respect to the eligibility standards specified in Sections 6472 and 6474 within 30 days of such change. Changes shall be reported through any of the channels available for the submission of an application, as described in Section 6470(j).

(c) An enrollee who has not requested an eligibility determination for IAPs shall not be required to report changes that affect eligibility for IAPs.

(d) An enrollee who experiences a change in income that does not impact the amount of the enrollee's APTC or the level of CSR for which he or she is eligible shall not be required to report such a change.

(e) The Exchange shall verify any reported changes ~~shall be verified~~ in accordance with the process specified in Sections 6478 through 6492 before using such information ~~shall be used~~ in an eligibility determination.

(f) The Exchange shall provide electronic notifications to an enrollee who has elected to receive electronic notifications, unless he or she has declined to receive notifications under this subdivision, regarding the requirements for reporting changes, as specified in subdivision (b) of this section, and the enrollee's opportunity not to report any changes described in subdivision (d) of this section.

(g) The Exchange shall examine available data sources on a semiannual basis to identify the following changes of circumstances:

(1) Death; and

(2) For an enrollee on whose behalf APTC or CSR are being provided~~:~~, eligibility determinations for Medicare, Medi-Cal, or CHIP.

~~(A) Household income changes; and~~

~~(B) Eligibility determinations for Medicare, Medi-Cal or CHIP.~~

(h) ~~For verification of the enrollee-reported data,~~ If the Exchange verifies updated information reported by an enrollee, the Exchange shall:

(1) Redetermine the enrollee's eligibility in accordance with the standards specified in Sections 6472 and 6474;

(2) Notify the enrollee regarding the determination, in accordance with the requirements specified in Section 6476(h); and

(3) Notify the enrollee's employer, as applicable, in accordance with the requirements specified in Section 6476(i).

(i) ~~For verification of~~ If the Exchange identifies updated information ~~that the Exchange identifies~~ through semiannual data matching regarding death, in accordance with subdivision (g)(1) of this section, or regarding any factor of eligibility not relating to income, family size, and family composition, the Exchange shall:

(1) Notify the enrollee regarding the updated information, as well as the enrollee's projected eligibility determination after considering such information;

(2) Allow an enrollee 30 days from the date of the notice described in subdivision (i)(1) to notify the Exchange that such information is inaccurate;

(3) If the enrollee responds contesting the updated information, proceed in accordance with Section 6492; and

(4) If the enrollee does not respond within the 30-day period specified in subdivision (i)(2), proceed in accordance with subdivisions (h)(1) and (2) of this section.

(j) ~~For verification of updated information that~~ If the Exchange identifies updated information through semiannual data matching regarding income, family size, and family composition, with the exception of information regarding death, the Exchange shall:

(1) Follow procedures described in subdivision (i)(1) and (2) of this section.

(2) If the enrollee responds confirming the updated information or providing more up to date information, proceed in accordance with subdivisions (h)(1) and (2) of this section.

(3) If the enrollee does not respond within the 30-day period specified in subdivision (i)(2) of this section, maintain the enrollee's existing eligibility determination without considering the updated information.

(4) If the enrollee provides more up-to-date information, proceed in accordance with subdivision (e) of this section.

(k) Except as specified in subdivisions (l) through (n) of this section, the Exchange shall implement changes:

(1) Resulting from a redetermination under this section, on the first day of the month following the date of the redetermination notice described in subdivision (h)(2) of this section;

(2) Resulting from an appeal decision, on the date specified in the appeal decision; or

(3) Affecting enrollment or premiums only, on the first day of the month following the date on which the Exchange is notified of the change.

(l) Except as specified in subdivisions (m) and (n) of this section, the Exchange shall implement a change described in subdivision (k) of this section that results in a decreased amount of APTC, or a change in the level of CSR, and for which the date of the notice of eligibility redetermination described in subdivision (h)(2) of this section, or the date specified in the appeal decision described in subdivision (k)(2) of this section, or the date on which the Exchange is notified in accordance with subdivision (k)(3) of this section is after the 15th of the month, on the first day of the month after the month specified in subdivision (k) of this section.

(m) The Exchange shall implement a change associated with the events described in Section 6504(h)(1), ~~and~~ (2), and (3) on the coverage effective dates described in Section 6504(h)(1), ~~and~~ (2), and (3), respectively.

(n) In the case of a redetermination that results in an enrollee being ineligible to continue his or her enrollment in a QHP through the Exchange:

(1) The enrollee's QHP coverage through the Exchange shall be terminated, as specified in Section 6506(b)(1); and

(2) The Exchange shall maintain the enrollee's eligibility for enrollment in a QHP without APTC and CSR until the effective dates of the termination of coverage, as specified in Section 6506(d)(3).

(o) In the case of a redetermination that results in a change in the amount of APTC for the benefit year, the Exchange shall recalculate the amount of APTC in such a manner as to:

(1) Account for any APTC already made on behalf of the tax filer for the benefit year for which information is available to the Exchange, such that the recalculated APTC amount is projected to result in total APTC for the benefit year that correspond to the tax filer's total projected APTC for the benefit year, calculated in accordance with Section 36B of IRC (26 USC § 36B) and 26 CFR Section 1.36B-3; and

(2) Ensure that the APTC provided on the tax filer's behalf is equal to or greater than zero and is calculated in accordance with Section 36B(b) of IRC (26 USC § 36B(b)) and 26 CFR 1.36B-3(d).

(p) In the case of a redetermination that results in a change in CSR, the Exchange shall determine an individual eligible for the category of CSR that corresponds to his or her expected annual household income for the benefit year, subject to the special rule for family policies set forth in Section 6474(d)(4).

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; 45 CFR Section 155.330.

§ 6498. Annual Eligibility Redetermination.

(a) Except as specified in subdivision (d) of this section, the Exchange shall redetermine the eligibility of a qualified individual on an annual basis.

(b) To conduct an annual redetermination for a qualified individual who requested an eligibility determination for IAPs in accordance with Section 6476(b), the Exchange shall have on file an active authorization from ~~a~~ the qualified individual to obtain updated tax return information described in subdivision (c) of this section. This authorization shall be for a period of no more than five years based on a single authorization, provided that an individual may:

(1) Decline to authorize the Exchange to obtain updated tax return information; or

(2) Authorize the Exchange to obtain updated tax return information ~~up to~~ for fewer than five years; and

(3) Discontinue, change, or renew his or her authorization at any time.

(c) If a qualified individual requested an eligibility determination for IAPs on the original application, in accordance with Section 6476(b), and the Exchange has an active authorization to obtain tax data as a part of the annual redetermination process, the Exchange shall request:

(1) Updated tax return information through HHS, as described in Section 6482(b);

(2) Data regarding Social Security benefits; and

(3) Data regarding MAGI-based income in accordance with the process specified in 42 CFR Section 435.948(a).

(d) If a qualified individual requested an eligibility determination for IAPs on the original application, in accordance with Section 6476(b), and the Exchange does not have an active authorization to obtain tax data as a part of the annual redetermination process, the Exchange:

(1) Shall notify the individual in accordance with the timing described in subdivision (f) of this section; ~~and~~

(2) Shall redetermine the qualified individual's eligibility only for enrollment in a QHP; and

~~(1)~~(3) Shall not proceed with ~~the~~ a redetermination ~~process described in subdivisions (e) and (g) through (m) of this section~~ for IAPs until such authorization has been obtained or the qualified individual ~~withdraws~~ continues his or her request for an eligibility determination for IAPs in accordance with Section 6476(b).

(e) The Exchange shall provide a qualified individual with an annual redetermination notice with a pre-populated form that includes:

(1) Data obtained under subdivision (c) of this section, if applicable;

(2) Data used in the individual's most recent eligibility determination; and

(3) The individual's projected eligibility determination for the following year, after considering any updated information described in subdivision (e)(1) of this section, including, if applicable, the amount of any APTC and the level of any CSR or eligibility for Medi-Cal or CHIP.

(f) For eligibility redeterminations under this section, the Exchange shall provide the annual redetermination notice, as specified in subdivision (e) of this section, and the notice of annual open enrollment period, as specified in Section 6502(e), through a single, coordinated notice.

(g) A qualified individual, or an application filer on behalf of the qualified individual, shall report to the Exchange any changes with respect to the information listed in the notice described in subdivision (e) of this section within 30 days from the date of the notice, using any of the channels available for the submission of an application, as described in Section 6470(j).

(h) The Exchange shall verify any information reported by a qualified individual under subdivision (g) of this section using the processes specified in Sections 6478 through 6492, prior to using such information to determine eligibility.

(i) A qualified individual, or an application filer on behalf of the qualified individual, shall sign and return the notice described in subdivision (e) of this section. If a qualified individual does not sign and return the notice described in subdivision (e) of this section within the 30-day period specified in subdivision (g) of this section, the Exchange shall proceed in accordance with the procedures specified in subdivision (j) of this section.

(j) After the 30-day period specified in subdivision (g) of this section has elapsed, the Exchange shall:

(1) Redetermine the qualified individual's eligibility in accordance with the standards specified in Sections 6472 and 6474 using the information provided to the individual in the notice specified in subdivision (e), as supplemented with any information reported by the individual and verified by the Exchange in accordance with subdivisions (g) and (h) of this section;

(2) Notify the qualified individual in accordance with the requirements specified in Section 6476(h); and

(3) If applicable, notify the qualified individual's employer, in accordance with the requirements specified in Section 6476(i).

(k) If a qualified individual reports a change with respect to the information provided in the notice specified in subdivision (e) of this section that the Exchange has not verified as of the end of the 30-day period specified in subdivision (g) of this section, the Exchange shall redetermine the qualified individual's eligibility after completing verification, as specified in subdivision (h) of this section.

(l) A redetermination under this section shall be effective on the first day of the coverage year following the year in which the Exchange provided the notice in subdivision (e) of this section, or in accordance with the rules specified in Section 6496(k) through (n), whichever is later.

(m) If an enrollee remains eligible for coverage in a QHP upon annual redetermination, such enrollee shall remain in the QHP selected the previous year unless he or she terminates coverage from such plan, including termination of coverage in connection with enrollment in a different QHP, in accordance with Section 6506.

(n) The Exchange shall not redetermine a qualified individual's eligibility in accordance with this section if the qualified individual's eligibility was redetermined under this section during the prior year, and the qualified individual was not enrolled in a QHP through the Exchange at the time of such redetermination, and has not enrolled in a QHP through the Exchange since such redetermination.

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; 45 CFR Section 155.335.

§ 6500. Enrollment of Qualified Individuals into QHPs.

(a) A qualified individual may enroll in a QHP (and an enrollee may change QHPs) only during, and in accordance with the coverage effective dates related to, the following periods:

(1) The initial open enrollment period, as specified in Section 6502;

(2) The annual open enrollment period, as specified in Section 6502; or

(3) A special enrollment period, as specified in Section 6504, for which the qualified individual has been determined eligible.

(b) The Exchange shall accept a QHP selection from an applicant who is determined eligible for enrollment in a QHP in accordance with Section 6472, and shall:

(1) Notify the applicant of her or his initial premium payment method options and of the requirement that the applicant's initial premium payment shall be received in full by the QHP issuer on or before the premium payment due date, as defined in Section 6410 of Article 2 of this chapter, in order for the applicant's coverage to be effectuated, as specified in Section 6502(g);

(2) Notify the QHP issuer that the individual is a qualified individual and of the applicant's selected QHP and premium payment method option;

(3) Transmit to the QHP issuer information necessary to enable the issuer to enroll the applicant within three business days from the date the Exchange obtains the information; and

(4) Transmit eligibility and enrollment information to HHS promptly and without undue delay, in a manner and timeframe as specified by HHS.

(c) The Exchange shall maintain records of all enrollments in QHPs through the Exchange.

(d) The Exchange shall reconcile enrollment information with QHP issuers and HHS no less than once a month.

(e) A QHP issuer shall accept enrollment information specified in subdivision (b) of this section consistent with the federal and State privacy and security standards specified in 45 CFR Section 155.260 and the Information Practices Act of 1977 (Cal. Civ. Code, § 1798 et seq.) and in an electronic format that is consistent with 45 CFR Section 155.270, and shall:

(1) Acknowledge receipt of enrollment information transmitted from the Exchange upon the receipt of such information;

(2) Enroll a qualified individual during the periods specified in subdivision (a) of this section;

(3) Notify a qualified individual of his or her premium payment due date;

(4) Abide by the effective dates of coverage established by the Exchange in accordance with Section 6502(c) and (f) and Section 6504(g) and (h);

(5) Notify the Exchange of the issuer’s timely receipt of a qualified individual’s initial premium payment and his or her effective date of coverage;

(6) Notify a qualified individual of his or her effective date of coverage upon the timely receipt of the individual’s initial premium payment; and

(7) Provide new enrollees an enrollment information package that is compliant with accessibility and readability standards specified in Section 6452 of Article 4 of this chapter.

(f) If an applicant requests assistance from a QHP issuer for enrollment through the Exchange,

the QHP issuer shall either:

(1) Direct the individual to file an application with the Exchange, or

(2) Ensure the applicant received an eligibility determination for coverage through the Exchange through the Exchange Internet Web site by assisting the applicant to apply for and receive an eligibility determination for coverage through the Exchange through CalHEERS, provided that the QHP issuer:

(A) Complies with the federal and State privacy and security standards specified in 45 CFR Section 155.260 and the Information Practices Act of 1977 (Cal. Civ. Code, § 1798 et seq.);

(B) Complies with the consumer assistance standards specified in 45 CFR Section 155.205(d);

(C) Informs the applicant of the availability of other QHP products offered through the Exchange and displays the Web link to, and describes how to access, the Exchange Web site; and

(D) Compl~~y~~ies with the requirements of Article 9 of this chapter.

(g) In accordance with the following premium payment process established by the Exchange, a QHP issuer shall:

(1) Accept, at a minimum, for all payments, paper checks, cashier's checks, money orders, EFT, and all general-purpose pre-paid debit cards as methods of payment and present all payment method options equally for a consumer to select their preferred payment method.

(2) Effectuate coverage upon receipt of a full initial premium payment from the applicant on or before the premium payment due date.

(3) Acknowledge receipt of qualified individuals' premium payments by transmitting to the Exchange information regarding all received payments.

(4) Initiate cancellation of enrollment if the issuer does not receive the full initial premium payment by the due date.

(5) Transmit to the Exchange the notice of cancellation of enrollment ~~N~~no earlier than the first day of the month when coverage is effectuated~~, transmit to the Exchange the notice of cancellation of enrollment~~.

(6) Send a written notice of the cancellation to the enrollee ~~W~~within five business days from

the date of cancellation of enrollment due to nonpayment of premiums~~, send a written notice of the cancellation to the enrollee~~.

(h) A QHP issuer shall reconcile enrollment and premium payment files with the Exchange no less than once a month.

(i) If individuals in the tax filers' tax households are enrolled in more than one QHP or stand-alone dental plan, and one or more APTC are to be made on behalf of a tax filer (or two tax filers covered by the same plan(s)):

(1) That portion of the APTC that is less than or equal to the aggregate adjusted monthly premiums, as defined in 26 CFR Section 1.36B-3(e), properly allocated to the essential health benefits (EHB) for the QHP policies, shall be allocated among the QHP policies as follows:

(A) The APTC shall be apportioned based on the number of enrollees covered under the QHP, weighted by the age of the enrollees, using the default uniform age rating curve established by the Secretary of HHS under 45 CFR Section 147.102(e);

(B) The portion allocated to any single QHP policy shall not exceed the portion of the QHP's adjusted monthly premium properly allocated to EHB; and

(C) If the portion of the APTC allocated to a QHP under this subdivision exceeds the portion of the same QHP's adjusted monthly premium properly allocated to EHB, the remainder shall be allocated evenly among all other QHPs in which individuals in the tax filers' tax households are enrolled.

(2) Any remaining APTC shall be allocated among the stand-alone dental policies as follows:

(A) The APTC shall be apportioned based on the number of enrollees covered under the stand-alone dental policy, weighted by the age of the enrollees, using the default uniform age rating curve established by the Secretary of HHS under 45 CFR Section 147.102(e);

(B) The portion allocated to any single stand-alone dental policy shall not exceed the portion of the stand-alone dental policy premium properly allocated to EHB; and

(C) If the portion of the APTC allocated to a stand-alone dental policy under this subdivision exceeds the portion of the same policy's premium properly allocated to EHB, the remainder shall be allocated evenly among all other stand-alone dental policies in which individuals in the tax filers' tax households are enrolled.

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; 45 CFR Sections 155.340, 155.400, 156.260, 156.265, 156.1230, and 156.1240; 26 CFR Section 1.36B-3(e).

§ 6502. Initial and Annual Open Enrollment Periods.

(a) A qualified individual may enroll in a QHP, or an enrollee may change QHPs, only during the initial open enrollment period, as specified in subdivision (b) of this section, the annual open enrollment period, as specified in subdivision (d) of this section, or a special enrollment period, as described in Section 6504, for which the qualified individual has been determined eligible.

(b) The initial open enrollment period begins October 1, 2013 and extends through March 31, 2014.

(c) Regular coverage effective dates for initial open enrollment period for a QHP selection received by the Exchange from a qualified individual:

(1) On or before December 23, 2013, shall be January 1, 2014;

(2) Between December 24, 2013 and December 31, 2013, shall be February 1, 2014;

~~(1)~~(3) Between the first and fifteenth day of the month for any month between January 2014 and March 31, 2014~~any subsequent month during the initial open enrollment period~~, shall be the first day of the following month; and

~~(2)~~(4) Between the sixteenth and last day of the month for any month between January 2014 and March 31, 2014, shall be the first day of the second following month.

(d) Annual open enrollment period for benefit years beginning on ~~or after~~ January 1, 2015 begins ~~October~~ November 15, 2014, and extends through February 15, 2015~~December 7 of the preceding calendar year~~.

(e) Beginning 2014, the Exchange shall provide a written annual open enrollment notification to each enrollee no earlier than ~~September 1~~ the first day of the month before the open enrollment period begins and no later than ~~September 30~~ the first day of the open enrollment period.

(f) ~~For a qualified individual who has made a QHP selection during the annual open enrollment period, the coverage effective date shall be the first day of the following benefit~~

~~year~~Coverage effective dates for the benefit year beginning on January 1, 2015, for a QHP selection received by the Exchange from a qualified individual:

(1) From November 15, 2014 through December 15, 2014, shall be January 1, 2015;

(2) From December 16, 2014 through January 15, 2015, shall be February 1, 2015; and

~~(1)~~(3) From January 16, 2015 through February 15, 2015, shall be March 1, 2015.

~~(f)~~(g) A qualified individual's coverage shall be effectuated in accordance with the coverage effective dates specified in subdivisions (c) and (f) of this section if:

(1) The individual makes his or her initial premium payment in full, reduced by the APTC amount he or she is determined eligible for by the Exchange, by the premium payment due date, as defined in Section 6410 of Article 2 of this chapter; and

(2) The applicable QHP issuer receives such payment on or before such due date.

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; 45 CFR Section 155.410.

§ 6504. Special Enrollment Periods.

(a) A qualified individual may enroll in a QHP, or an enrollee may change from one QHP to another, during special enrollment periods only if one of the following triggering events occurs:

(1) A qualified individual or his or her dependent either:

(A) L~~l~~oses MEC, as specified in subdivision (b) of this section. The date of the loss of MEC shall be:

1. Except as provided in subdivision (a)(1)(A)2 of this section, the last day the qualified individual or his or her dependent would have coverage under his or her previous plan or coverage~~If loss of MEC occurs due to a QHP decertification, the triggering event is the date of the notice of decertification as described in 45 CFR Section 155.1080(e)(2)~~.

2. If loss of MEC occurs due to a QHP decertification, the date of the notice of decertification as described in 45 CFR Section 155.1080(e)(2);

(B) Is enrolled in any non-calendar year health insurance policy that will expire in 2014 as described in 45 CFR Section 147.104(b)(2), even if the qualified individual or his or her dependent has the option to renew the expiring non-calendar year individual health insurance policy. The date of the loss of coverage shall be the date in 2014 of the expiration of the non-calendar year policy;

(C) Loses Medi-Cal coverage for pregnancy-related services, as described under Section 1902(a)(10)(A)(i)(IV) and (a)(10)(A)(ii)(IX) of the Social Security Act (42 USC 1396a(a)(10)(A)(i)(IV), (a)(10)(A)(ii)(IX)) and Section 14005.18 of the Welfare and Institutions Code. The date of the loss of coverage shall be the last day the consumer would have pregnancy-related coverage; or

(D) Loses Medi-Cal coverage for medically needy, as described under Section 1902(a)(10)(C) of the Social Security Act and Section 14005.21 of the Welfare and Institutions Code, only once per calendar year. The date of the loss of coverage shall be the last day the consumer would have medically needy coverage.

~~(1)~~(2) A qualified individual gains a dependent or becomes a dependent through marriage or entry into domestic partnership, birth, adoption, placement for adoption, or placement in foster care.

~~(2)~~(3) A qualified individual, or his or her dependent, who was not previously a citizen, national, or lawfully present individual gains such status.

~~(3)~~(4) A qualified individual's, or his or her dependent's, enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Exchange or HHS, or its instrumentalities as evaluated and determined by the Exchange. In such cases, the Exchange shall, on a case-by-case basis, take necessary actions to correct or eliminate the effects of such error, misrepresentation, or inaction.

~~(4)~~(5) An enrollee, or his or her dependent, adequately demonstrates to the Exchange, as determined by the Exchange on a case-by-case basis, that the QHP in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee.

~~(5)~~(6) An enrollee, or his or her dependent enrolled in the same QHP, is determined newly eligible or ineligible for APTC or has a change in eligibility for CSR.

~~(6)~~(7) A~~n~~ qualified individual, or his or her dependent, who is enrolled in an eligible employer-sponsored plan is determined newly eligible for APTC because such individual is ineligible for qualifying coverage in an eligible employer-sponsored plan in accordance with 26 CFR 1.36B–2(c)(3), including as a result of his or her employer discontinuing or changing available coverage within the next 60 days, provided that such individual is allowed to terminate existing coverage. ~~The Exchange shall permit an individual who is enrolled in an eligible employer-sponsored plan and will lose eligibility for qualifying coverage in an eligible employer-sponsored plan within the next 60 days to access this special enrollment period prior to the end of his or her existing coverage, although he or she shall not be eligible for APTC until the end of his or her coverage in an eligible employer-sponsored plan.~~

~~(7)~~(8) A qualified individual or enrollee, or his or her dependent, gains access to new QHPs as a result of a permanent move. This event shall also apply to individuals who are released from incarceration.

~~(8)~~(9) A qualified individual who is an Indian, as defined in Section 6410 of Article 2 of this chapter, may enroll in a QHP or change from one QHP to another one time per month.

~~(9)~~(10) A qualified individual or enrollee, or his or her dependent, demonstrates to the Exchange, in accordance with guidelines issued by HHS and as determined by the Exchange on a case-by-case basis, that the individual meets other exceptional circumstances. Such circumstances include, but are not limited to, the following:

(A) If an individual receives a certificate of exemption for hardship based on the eligibility standards described in 45 CFR Section 155.605(g)(1) for a month or months during the coverage year, and based on the circumstances of the hardship attested to, he or she is no longer eligible for a hardship exemption within a coverage year but outside of an open enrollment period described in Section 6502, the individual and his or her dependents shall be eligible for a special enrollment period if otherwise eligible for enrollment in a QHP.

(B) If an individual with a certificate of exemption reports a change regarding the eligibility standards for an exemption, as required under 45 CFR Section 155.620(b), and the change resulting from a redetermination is implemented, the certificate provided for the month in which the redetermination occurs, and for prior months, remains effective. If the individual is no longer eligible for an exemption, the individual and his or her dependents shall be eligible for a special enrollment period if otherwise eligible for enrollment in a QHP.

(C) If a child who has been determined ineligible for Medi-Cal and CHIP, and for whom a party other than the party who expects to claim him or her as a tax dependent is required by court order to provide health insurance coverage for the child, the child shall be eligible for a special enrollment period if otherwise eligible for enrollment in a QHP.

(11) The Exchange determines on a case-by-case basis that a qualified individual or enrollee, or his or her dependent(s) was not enrolled in QHP coverage; was not enrolled in the QHP selected by the qualified individual or enrollee; or is eligible for but is not receiving APTC or CSR as a result of misconduct on the part of a non-Exchange entity providing enrollment assistance or conducting enrollment activities. For purposes of this provision, misconduct includes, but is not limited to, the failure of the non-Exchange entity to comply with applicable standards under this title, or other applicable Federal or State laws, as determined by the Exchange.

(12) Any other triggering events listed in the Health and Safety Code Section 1399.849(d)(1) and the Insurance Code Section 10965.3(d)(1).

(b) Loss of MEC, as specified in subdivision (a)(1)(A) of this section, includes:

(1) Loss of eligibility for coverage, including but not limited to:

(A) Loss of eligibility for coverage as a result of:

1. Legal separation,
2. Divorce or dissolution of domestic partnership,
3. Cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan),
4. Death of an employee,
5. Termination of employment,
6. Reduction in the number of hours of employment, or
7. Any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing;

(B) Loss of eligibility for coverage through Medicare, Medi-Cal, or other government-sponsored health care programs, other than programs specified as not MEC under 26 CFR Section 1.5000A-2(b)(1)(ii);

(C) In the case of coverage offered through an HMO or similar program in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual);

(D) In the case of coverage offered through an HMO or similar program in the group market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual), and no other benefit package is available to the individual;

(E) A situation in which an individual incurs a claim that would meet or exceed a lifetime limit on all benefits; and

(F) A situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual.

(2) Termination of employer contributions toward the employee's or dependent's coverage that is not COBRA continuation coverage, including contributions by any current or former employer that was contributing to coverage for the employee or dependent; and

(3) Exhaustion of COBRA continuation coverage, meaning that such coverage ceases for any reason other than either failure of the individual to pay premiums on a timely basis, or for cause, such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan. An individual is considered to have exhausted COBRA continuation coverage if such coverage ceases:

(A) Due to the failure of the employer or other responsible entity to remit premiums on a timely basis;

(B) When the individual no longer resides, lives, or works in the service area of an HMO or similar program (whether or not within the choice of the individual) and there is no other COBRA continuation coverage available to the individual; or

(C) When the individual incurs a claim that would meet or exceed a lifetime limit on all benefits and there is no other COBRA continuation coverage available to the individual.

(c) Loss of ~~MEC~~coverage, as specified in subdivision (a)(1) of this section, does not include voluntary termination of coverage or loss due to:

(1) Failure to pay premiums on a timely basis, including COBRA premiums prior to exhaustion~~expiration~~ of COBRA coverage; or

(2) Termination of coverage for cause, such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with a plan.

(d) A qualified individual or an enrollee shall attest under penalty of perjury that he or she meets at least one of the triggering events specified in subdivision (a) of this section. The Exchange shall inform the qualified individual or the enrollee that pursuant to 45 CFR Section 155.285, HHS may impose civil money penalties of up to $25,000 on the qualified individual or the enrollee if he or she:

(1) Fails to provide the correct information requested by the Exchange due to his or her negligence or disregard of the federal or State rules or regulations related to the Exchange with negligence and disregard defined as they are in section 6662 of IRC (26 USC § 6662), as follows:

(A) "Negligence" includes any failure to make a reasonable attempt to provide accurate, complete, and comprehensive information; and

(B) "Disregard" includes any careless, reckless, or intentional disregard for any federal or State rules or regulations related to the Exchange;

(2) Knowingly and willfully provides false or fraudulent information requested by the Exchange, where knowing and willful means the intentional provision of information that the person knows to be false or fraudulent; or

(3) Knowing and willful use or disclosure of information in violation of Section 1411(g) of the Affordable Care Act (42 USC § 18081(g)), where knowing and willful means the intentional use or disclosure of information in violation of Section 1411(g).

~~(d)~~(e) The Exchange shall accept ~~a~~ the qualified individual's or ~~an~~ the enrollee's attestation provided in accordance with subdivision (d) of this section without further verification.

(f) Except as provided in subdivision (f)(1) and (2) of this section, a~~A~~ qualified individual or an enrollee shall have 60 days from the date of ~~one of the~~a triggering event~~s specified in subdivision (a) of this section~~ to select a QHP.

(1) A qualified individual or his or her dependent who loses coverage, as described in subdivision (a)(1) of this section shall have 60 days before and after the date of the loss of coverage to select a QHP.

~~(1)~~(2) A qualified individual who is enrolled in an eligible employer-sponsored plan and will lose eligibility for qualifying coverage in an eligible employer-sponsored plan within the next 60 days, as described in subdivision (a)(7) of this section, shall have 60 days before and after the loss of eligibility for qualifying coverage in an eligible employer-sponsored plan to select a QHP.

~~(e)~~(g) Except as specified in subdivision (h) of this section, regular coverage effective dates for a special enrollment period for a QHP selection received by the Exchange from a qualified individual:

(1) Between the first and fifteenth day of any month, shall be the first day of the following month; and

(2) Between the sixteenth and last day of any month, shall be the first day of the second following month.

~~(f)~~(h) Special coverage effective dates shall apply to the following situations.

(1) In the case of birth, adoption, placement for adoption, or placement in foster care:

(A) The coverage shall be effective either:

1. Retroactively, ~~on~~ to the date of birth, adoption, placement for adoption, or placement in foster care; or

~~1.~~2. Prospectively, on the first day of the month following the date of birth, adoption, placement for adoption, or placement in foster care, at the option of the qualified individual or the enrollee; and

(B) APTC and CSR, if applicable, are not effective until the first day of the following month, unless the birth, adoption, or placement for adoption occurs on the first day of the month.

(2) In the case of marriage or entry into domestic partnership, or in the case where a qualified individual, or his or her dependent, loses ~~MEC~~coverage, as described in

subdivisions (a)(1) and (a)(7) of this section, the coverage and APTC and CSR, if applicable, shall be effective on the first day of the month following month plan selection.

(3) In the case of a qualified individual or enrollee eligible for a special enrollment period described in subdivisions (a)(4), (a)(5), (a)(10), or (a)(11) of this section, the coverage shall be effective on an appropriate date, including a retroactive date, determined by the Exchange on a case-by-case basis based on the circumstances of the special enrollment period and in accordance with guidelines issued by HHS. Such date shall be either:

(A) The date of the event that triggered the special enrollment period under subdivisions (a)(4), (a)(5), (a)(10), or (a)(11) of this section; or

(B) In accordance with the regular effective dates specified in subdivision (g) of this section.

(g)(i) A qualified individual's coverage shall be effectuated in accordance with the coverage effective dates specified in subdivisions (g) and (h) of this section if:

(1) The individual makes his or her initial premium payment in full, reduced by the APTC amount he or she is determined eligible for by the Exchange, by the premium payment due date, as defined in Section 6410 of Article 2 of this chapter; and

(2) The applicable QHP issuer receives such payment on or before such due date.

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; 45 CFR Section 155.420.

§ 6506. Termination of Coverage in a QHP.

(a) An enrollee may terminate his or her coverage in a QHP, including as a result of the enrollee obtaining other MEC, with at least a 14-day notice to the Exchange.

(b) The Exchange may initiate termination of an enrollee's coverage in a QHP, and shall permit a QHP issuer to terminate such coverage, provided that the issuer makes reasonable accommodations for all individuals with disabilities (as defined by the Americans with Disabilities Act) before terminating coverage for such individuals, under the following circumstances:

(1) The enrollee is no longer eligible for coverage in a QHP through the Exchange;

(2) The enrollee fails to pay premiums for coverage, as specified in subdivision (c) of this section, and:

(A) The three-month grace period required for individuals receiving APTC specified in subdivision (c)(2) of this section has been exhausted, as described in subdivision (c)(4) of this section; or

(B) Any other grace period required under the State law not described in subdivision (b)(2)(A) of this section has been exhausted;

(3) The enrollee's coverage is rescinded by the QHP issuer because the enrollee has made a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan, in accordance with 45 CFR Section 147.128;

(4) The QHP terminates or is decertified as described in 45 CFR Section 155.1080; or

(5) The enrollee changes from one QHP to another during an annual open enrollment period or special enrollment period in accordance with Sections 6502 and 6504.

(c) In the case of termination of enrollee’s coverage due to non-payment of premium, as specified in subdivision (b)(2) of this section, a QHP issuer shall:

(1) Provide the enrollee, who is delinquent on premium payment, with notice of such payment delinquency;

(2) Provide a grace period of three consecutive months if an enrollee receiving APTC has previously paid at least one full month's premium during the benefit year;

(3) During the grace period specified in subdivision (c)(2) of this section:

(A) Pay all appropriate claims for services rendered to the enrollee during the first month of the grace period;

(B) Notify the Exchange and HHS of such non-payment;

(C) Notify providers that the enrollee is in the grace period; and

(D) Continue to collect APTC on behalf of the enrollee from the IRS.

(4) If an enrollee receiving APTC exhausts the three-month grace period specified in subdivision (c)(2) of this section without paying all outstanding premiums:

(A) Terminate the enrollee's coverage on the effective date described in subdivision (d)(4) of this section, provided that the QHP issuer meets the notice requirements specified in subdivision (e)(1) and (2) of this section; and

(B) Return APTC paid on behalf of such enrollee for the second and third months of the grace period.

(d) If an enrollee's coverage in a QHP is terminated for any reason, the following effective dates for termination of coverage shall apply.

(1) For purposes of this subdivision, reasonable notice is defined as 14 days ~~from~~ before the requested effective date of termination.

(2) In the case of a termination in accordance with subdivision (a) of this section, the last day of coverage shall be:

(A) The termination date specified by the enrollee, if the enrollee provides reasonable notice;

(B) Fourteen days after the termination is requested by the enrollee, if the enrollee does not provide reasonable notice;

(C) On a date on or after the date on which the termination is requested by the enrollee, subject to the determination of the enrollee's QHP issuer, if the enrollee's QHP issuer agrees to effectuate termination in fewer than 14 days, and the enrollee requests an earlier termination effective date; or

(D) If the enrollee is newly eligible for Medi-Cal or CHIP, other than the restricted Medi-Cal coverage of pregnancy-related services specified in 26 CFR Section 1.5000A-2(b)(1)(ii)(C), the day before such coverage begins. ~~For purposes of this paragraph, the enrollee's Medi-Cal or CHIP coverage shall begin no earlier than the first day of the first full calendar month beginning after the enrollee's approval for Medi-Cal or CHIP, in accordance with 26 CFR Section 1.36B-2(c)(2)(iv).~~

(3) In the case of a termination in accordance with subdivision (b)(1) of this section, the last day of QHP coverage shall be the last day of eligibility, as described in Section 6496~~(k) through~~ (n) unless the individual requests an earlier termination effective date per subdivision (a) of this section.

(4) In the case of a termination in accordance with subdivision (b)(2)(A) of this section, the last day of coverage shall be the last day of the first month of the three-month grace period.

(5) In the case of a termination in accordance with subdivision (b)(2)(B) of this section, the last day of coverage shall be consistent with existing California laws regarding grace periods.

(6) In the case of a termination in accordance with subdivision (b)(5) of this section, the last day of coverage in an enrollee's prior QHP shall be the day before the effective date of coverage in his or her new QHP, including any retroactive enrollments effectuated under Section 6504(h)(3). In cases of retroactive terminations dates, the Exchange shall ensure that appropriate actions are taken to make necessary adjustments to APTC, CSR, premiums, and claims.

(7) In the case of a termination due to the enrollee's death, the last day of coverage is the date of death.

(e) If an enrollee's coverage in a QHP is terminated in accordance with subdivision (b)(1), (2), and (3) of this section, the QHP issuer shall:

(1) Provide the enrollee with a written notice of termination of coverage that includes the termination effective date, reason for termination, and the notice of appeals right, in accordance with the requirements specified in Section 6604 of Article 7 of this chapter, within five business days from the date of the termination;

(2) Notify the Exchange of the termination effective date and reason for termination; ~~and~~

~~(2)~~(3) Abide by the termination of coverage effective dates described in subdivision (d) of this section; and

~~(3)~~(4) Maintain electronic records of termination of coverage, including audit trails and reason codes for termination, for a minimum of ten years.

(f) If an enrollee's coverage in a QHP is terminated for any reason, the Exchange shall:

(1) Send termination information to the QHP issuer within three business days from the date of the termination;

(2) Send termination information to HHS promptly and without undue delay, in the manner and timeframe specified by HHS; and

(3) Retain records of termination of coverage in order to facilitate audit functions.

(g) The Exchange shall provide an opportunity at the time of plan selection for an enrollee to choose to remain enrolled in a QHP if he or she becomes eligible for other MEC and the enrollee does not request termination in accordance with subdivision (a) of this section. If an enrollee does not choose to remain enrolled in a QHP in such a situation, the Exchange shall initiate termination of his or her coverage upon completion of the redetermination process specified in Section 6496.

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; 45 CFR Sections 155.430 and 156.270.

§ 6508. Authorized Representative.

(a) The Exchange shall permit an applicant or enrollee in the individual or small group market, subject to applicable privacy and security requirements, to designate an individual or organization to act on his or her behalf in applying for an eligibility determination or redetermination and in carrying out other ongoing communications with the Exchange.

(b) Designation of an authorized representative shall be in a written document signed by the applicant or enrollee, or through another legally binding format subject to applicable authentication and data security standards, as required by 45 CFR Section 155.270. If submitted, legal documentation of authority to act on behalf of an applicant or enrollee under State law, such as a court order establishing legal guardianship or a power of attorney, shall serve in the place of the applicant's or enrollee's signature.

(c) The authorized representative shall agree to maintain, or be legally bound to maintain, the confidentiality of any information regarding the applicant or enrollee provided by the Exchange.

(d) The authorized representative shall be responsible for fulfilling all responsibilities encompassed within the scope of the authorized representation, as described in subdivision (f) of this section, to the same extent as the applicant or enrollee he or she represents.

(e) The Exchange shall permit an applicant or enrollee to designate an authorized representative at the time of application or at other times and through methods described in Section 6470(j).

(f) The Exchange shall permit an applicant or enrollee to authorize his or her representative to:

(1) Sign an application on the applicant's or enrollee's behalf;

(2) Submit an update or respond to a redetermination for the applicant or enrollee in accordance with Sections 6496 and 6498;

(3) Receive copies of the applicant's or enrollee's notices and other communications from the Exchange; and

(4) Act on behalf of the applicant or enrollee in all other matters with the Exchange.

(g) The Exchange shall:

(1) Permit an applicant or enrollee to authorize a representative to perform fewer than all of the activities described in subdivision (f) of this section; and

(2) Track the specific permissions for each authorized representative.

(h) The Exchange shall provide information both to the applicant or enrollee, and to the authorized representative, regarding the powers and duties of authorized representatives.

(i) The Exchange shall consider the designation of an authorized representative valid until:

(1) The applicant or enrollee notifies the Exchange that the representative is no longer authorized to act on his or her behalf using one of the methods available for the submission of an application, as described in Section 6470(j). The Exchange shall notify the authorized representative of such change; or

(2) The authorized representative informs the Exchange and the applicant or enrollee that he or she no longer is acting in such capacity. An authorized representative shall notify the Exchange and the applicant or enrollee on whose behalf he or she is acting when the authorized representative no longer has legal authority to act on behalf of the applicant or enrollee.

(j) An authorized representative shall comply with applicable State and federal laws concerning conflicts of interest and confidentiality of information.

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; 45 CFR Section 155.227.

§ 6510. Right to Appeal.

The Exchange shall include the notice of the right to appeal and instructions regarding how to file an appeal in accordance with Article 7 of this chapter in any eligibility determination and redetermination notice issued to the applicant in accordance with Sections 6476(h), 6496(h)(2), or 6498(j)(2).

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100503 and 100506, Government Code; 45 CFR Sections 155.355 and 155.515.

Readopt Article 7

Article 7. Appeals Process for the Individual Exchange.

§ 6600. Definitions.

In addition to the definitions in Section 6410 of Article 2 of this chapter, for purposes of this Article, the following terms shall mean:

"Appeal Record": means t~~T~~he appeal decision, all papers and requests filed in the proceeding, and, if a hearing was held, the transcript or recording of hearing testimony or an official report

containing the substance of what happened at the hearing and any exhibits introduced at the hearing.

"Appeal Request~~:~~" means a ~~A~~ clear expression, either orally or in writing, by an applicant or enrollee, to have any Exchange eligibility determinations or redeterminations reviewed by an appeals entity.

"Appeals Entity"~~:~~ means a ~~A~~ body designated to hear appeals of any Exchange eligibility determinations or redeterminations. The California Department of Social Services shall be designated as the Exchange appeals entity.

"Appellant" means~~: T~~ the applicant or enrollee who is requesting an appeal.

"De Novo Review"~~: A~~ means a review of an appeal without deference to prior decisions in the case.

"Eligibility Determination" means ~~: A~~a determination that an applicant or enrollee is eligible for an IAP, for enrollment in a QHP, or for any enrollment periods, in accordance with Sections 6472, 6474, and 6476 of Article 5 of this chapter.

"Evidentiary Hearing~~:~~" means a ~~A~~ hearing conducted where new evidence may be presented.

"Statement of Position"~~: A~~ means a writing that describes the appellant's and the Exchange's positions regarding an appeal, as specified in Section 10952.5 of the Welfare and Institution Code.

"Vacate"~~:~~ means t~~T~~o set aside or legally void a previous action.

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100503 and 100506, Government Code; 45 CFR Section 155.500.

§ 6602. General Eligibility Appeals Requirements.

(a) In accordance with Section 6510 of Article 5, an applicant or enrollee shall have the right to appeal:

(1) An eligibility determination made in accordance with Article 5 of this chapter, including:

(A) An initial determination of eligibility, including the amount of APTC and level of CSR, made in accordance with the standards specified in Sections 6472 and 6474 of Article 5 of this chapter; and

(B) A redetermination of eligibility, including the amount of APTC and level of CSR, made in accordance with Sections 6496 and 6498 of Article 5 of this chapter;

(2) An eligibility determination for an exemption made in accordance with 45 CFR Section 155.605;

(3) The Exchange's failure to provide a timely eligibility determination in accordance with Section 6476(f) of Article 5 of this chapter or failure to provide timely notice of an eligibility determination or redetermination in accordance with Sections 6476(h), 6496(h)(2), or 6498(j)(2) of Article 5 of this chapter; and

(4) A denial of a request to vacate a dismissal made by the Exchange appeals entity in accordance with Section 6610(d)(2).

(b) The Exchange appeals entity shall conduct all eligibility appeals, except for appeals of an eligibility determination for an exemption made in accordance with 45 CFR Section 155.605.

(c) For purposes of this Article, an administrative law judge designated by the appeals entity shall determine, on a case-by-case basis:

(1) The validity of all appeal requests received by the Exchange, the appeals entity, or the counties; and

(2) Whether good cause exists, including, but not limited to, good cause for an untimely appeal request and continuance.

(d) An applicant or enrollee may request an appeal of any of the actions specified in subdivision (a) of this section to HHS upon exhaustion of the Exchange appeals process.

(e) During the appeal, an appellant may represent himself or herself, or be represented by an authorized representative, as provided in Section 6508 of Article 5 of this chapter, or by legal counsel, a relative, a friend, or another spokesperson.

(f) Appeals processes established under this Article shall comply with the accessibility and readability requirements specified in Section 6452 of Article 4 of this chapter.

(g) An appellant may seek judicial review to the extent it is available by law.

(h) When an appellant seeks review of an adverse MAGI Medi-Cal or CHIP determination made by the Exchange, the appeals entity shall transmit the eligibility determination and all information provided as part of the appeal via secure electronic interface, within three business days from the date the appeal request is received to DHCS, as applicable, unless the

appeal request is for an expedited appeal, in which case, the appeals entity shall follow the procedure provided in Section 6616.

(i) The appeals entity shall:

(1) Ensure all data exchanges in the appeals process comply with the federal and State privacy and security standards specified in 45 CFR Section 155.260 and the Information Practices Act of 1977 (Cal. Civ. Code, § 1798 et seq.) and are in an electronic format consistent with 45 CFR Section 155.270; and

(2) Comply with all data sharing requests made by HHS.

(j) The Exchange shall provide the appellant with the opportunity to review his or her entire eligibility file, including all papers, requests, documents, and relevant information in the Exchange's possession at any time from the date on which an appeal request is filed to the date on which the appeal decision is issued pursuant to Section 6618.

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100503 and 100506, Government Code; 45 CFR Sections 155.505 and 155.510.

§ 6604. Notice of Appeal Procedures.

(a) The Exchange shall provide notice of appeal procedures at the time that the:

(1) Applicant submits an application; and

(2) Notice of eligibility determination and redetermination is sent in accordance with Sections 6476(h), 6496(h)(2), or 6498(j)(2) of Article 5 of this chapter.

(b) Notices described in subdivision (a) of this section shall comply with the general standards for Exchange notices specified in Section 6454 of Article 4 of this chapter and shall contain:

(1) An explanation of the applicant or enrollee's appeal rights under this Article;

(2) A description of the procedures by which the applicant or enrollee may request an appeal, including an expedited appeal;

(3) Information on the applicant's or enrollee's right to represent himself or herself, or to be represented by legal counsel or another representative;

(4) Information on how to obtain a legal aid referral or free legal help;

(5) An explanation that all hearings shall be conducted by telephone, video conference, or in person, in accordance with the California Department of Social Services' Manual of Policies and Procedures Section 22-045;

(6) An explanation of the circumstances under which the appellant's eligibility may be maintained or reinstated pending an appeal decision, as provided in Section 6608; and

(7) An explanation that an appeal decision for one household member may result in a change in eligibility for other household members and that such a change shall be handled as a redetermination of eligibility for all household members in accordance with the standards specified in Sections 6472 and 6474 of Article 5 of this chapter.

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100503 and 100506, Government Code; 45 CFR Section 155.515.

§ 6606. Appeal Requests.

(a) The Exchange and the appeals entity shall:

(1) Accept appeal requests submitted through any of the following channels, in accordance with Section 6470(j) of Article 5 of this chapter:

(A) The Exchange's Internet Web ~~Site~~site;

(B) Telephone;

(C) Facsimile;

(D) Mail; or

(E) In person.

(2) Assist the applicant or enrollee in making the appeal request; and

(3) Not limit or interfere with the applicant's or enrollee's right to make an appeal request.

(b) The appeals entity shall consider an appeal request valid for purposes of this Article, as specified in Section 6602(c), if it is submitted in accordance with the requirements of subdivisions (c) and (d) of this section and Section 6602(a).

(c) The Exchange and the appeals entity shall allow an applicant or enrollee to request an appeal within 90 days of the date of the notice of eligibility determination, unless the appeals entity determines, in accordance with Section 6602(c), that there is good cause, as defined in Section 10951 of the Welfare and Institution Code, for filing the appeals request beyond the 90-day period. No filing timeline shall be extended for good cause for more than 180 days after the date of the notice of eligibility determination. For purposes of this subdivision, if the last day of the filing period falls on a Saturday, Sunday, or holiday, as defined in Government Code Section 6700, the filing period shall be extended to the next business day, in accordance with Government Code Section 6707.

(d) If the appellant disagrees with the appeal decision of the Exchange appeals entity, he or she may make an appeal request to HHS within 30 days of the date of the Exchange appeals entity's notice of appeal decision or notice of denial of a request to vacate a dismissal.

(e) Upon receipt of an appeal request pursuant to subdivisions (c) or (g) of this section, which has been determined to be valid in accordance with Section 6602(c), the appeals entity shall:

(1) Within five business days from the date on which the valid appeal request is received, send written acknowledgment to the appellant of the receipt of his or her valid appeal request, including but not limited to:

(A) Information regarding the appellant's opportunity for informal resolution prior to the hearing pursuant to Section 6612;

(B) Information regarding the appellant's eligibility pending appeal pursuant to Section 6608; and

(C) An explanation that any APTC paid on behalf of the tax filer pending appeal is subject to reconciliation under Section 36B(f) of IRC (26 U.S.C. § 36B(f)) and 26 CFR Section 1.36B-4.

(2) Except as provided in Section 6618(b)(2), within three business days from the date on which the valid appeal request is received, transmit via secure electronic interface notice of the appeal request and, if applicable, instructions to provide eligibility pending appeal pursuant to Section 6608, to the Exchange and to the DHCS, as applicable; and

(3) Confirm receipt of the records transferred by the Exchange pursuant to subdivision (g) of this section within two business days of the receipt of the records.

(f) Upon receipt of an appeal request that is determined not valid because it fails to meet the requirements of this section or Section 6602(a), unless the appeals entity determines that there is good cause for such a failure, in accordance with Section 6602(c), the appeals entity shall:

(1) Within five business days from the date on which the appeal request is received, send written notice to the appellant informing him or her:

(A) That the appellant's appeal request has not been accepted;

(B) About the nature of the defect in the appeal request; and

(C) That, if the defect specified in subdivision (f)(1)(B) of this section is curable, the appellant may cure the defect and resubmit the appeal request, in accordance with subdivision (a) of this section, within 30 calendar days from the date on which the invalid appeal request is received; and

(2) Treat as valid, in accordance with Section 6602(c), an amended appeal request that meets the requirements of this section and of Section 6602(a).

(g) Upon receipt of an appeal request pursuant to subdivision (c) of this section, or upon receipt of the notice under subdivision (e)(2) of this section, the Exchange shall transmit via secure electronic interface to the appeals entity:

(1) The appeal request, if the appeal request was initially made to the Exchange; and

(2) The appellant's eligibility record.

(h) Upon receipt of the notice of an appeal~~s~~ request made to HHS, pursuant to subdivision (d) of this section, the Exchange appeals entity shall, within three business days from the date on which the appeal request is received, transmit via secure electronic interface the appellant's appeal record, including the appellant's eligibility record as received from the Exchange, to the HHS appeals entity.

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100503 and 100506, Government Code; 45 CFR Section 155.520.

§ 6608. Eligibility Pending Appeal.

(a) Upon receipt of a valid appeal request or notice under Section 6606(e)(2) that concerns an appeal of a redetermination under Sections 6496(h) or 6498(j) of Article 5 of this chapter, the

Exchange shall continue to consider the appellant eligible while the appeal is pending in accordance with standards set forth in subdivision (b) of this section.

(b) If the tax filer or appellant, as applicable, accepts eligibility pending an appeal and agrees to make his or her premium payments in full, reduced by the APTC amount he or she is determined eligible for by the Exchange, by the applicable payment due dates, the Exchange shall continue, or reinstate within five business days, the appellant's eligibility for enrollment in a QHP, APTC, and CSR, as applicable, in accordance with the level of eligibility immediately before the redetermination being appealed.

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100503 and 100506, Government Code; 45 CFR Section 155.525.

§ 6610. Dismissals.

(a) The appeals entity shall dismiss an appeal if the appellant:

(1) Unconditionally or conditionally withdraws the appeal request in writing prior to the hearing date, in accordance with the following procedure:

(A) Except as provided in subdivision (a)(1)(B) of this section, if the withdrawal is unconditional, the appeal request shall be immediately dismissed.

(B) If the appellant has verbally withdrawn his or her appeal request prior to the hearing, and such withdrawal is unconditional, the appeals entity shall send the appellant a written confirmation of the withdrawal within five business days from the date on which the appellant's verbal withdrawal is received. The written confirmation shall serve as the appellant's written withdrawal and the appeal shall be dismissed unless the appellant notifies the appeals entity, in writing or verbally, within 15 days of the date of the written confirmation, that the appellant has not withdrawn his or her appeal request.

(C) If the withdrawal is conditional:

1. The withdrawal shall be accompanied by an agreement signed by the appellant and by the Exchange as part of the informal resolution process specified in Section 6612;

2. Upon receipt of the signed conditional withdrawal, the hearing date, if any, shall be vacated;

3. The actions of both parties under the agreement specified in subdivision (a)(1)(C)1 of this section shall be completed within 30 calendar days of the date on the agreement; and

4. Upon the satisfactory completion of the actions of the appellant and the Exchange under the agreement specified in subdivision (a)(1)(C)1 of this section, the appeals entity shall dismiss the appeals request unless the hearing request is reinstated within the time limits set forth in Section 6606(c);

(D) Both unconditional and conditional withdrawals shall be accepted by telephone if the following requirements are met:

1. The appellant's statement and telephonic signature made under penalty of perjury shall be recorded in full; and

2. The appeals entity shall provide the appellant with a written confirmation documenting the telephonic interaction.

(2) Fails to appear at a scheduled hearing without good cause, as determined in accordance with Section 6602(c);

(3) Fails to submit a valid appeal request as specified in Section 6606(b) without good cause, as determined in accordance with Section 6602(c); or

(4) Dies while the appeal is pending, unless the appeal affects the remaining member(s) of the deceased appellant's household, or the appeal can be carried forward by a representative of the deceased appellant's estate, or by an heir of the deceased appellant if the decedent's estate is not in probate, in accordance with the California Department of Social Services' Manual of Policies and Procedures Section 22-004.4.

(b) If an appeal is dismissed under subdivision (a) of this section, the appeals entity shall provide written notice to the appellant within five business days from the date of the dismissal. The notice shall include:

(1) The reason for the dismissal;

(2) An explanation of the dismissal's effect on the appellant's eligibility; and

(3) An explanation of how the appellant may show good cause as to why the dismissal should be vacated in accordance with subdivision (d) of this section.

(c) If an appeal is dismissed under subdivision (a) of this section, the appeals entity shall, within three business days from the date of the dismissal, provide notice of the dismissal to the Exchange, and to the DHCS, as applicable, including instructions to, no earlier than five business days from the date of the dismissal:

(1) Implement the eligibility determination; and

(2) Discontinue eligibility pending appeal provided under Section 6608.

(d) The appeals entity shall:

(1) Vacate a dismissal and proceed with the appeal if the appellant makes a written request within 30 calendar days of the date of the notice of the dismissal showing good cause why the dismissal should be vacated, in accordance with Section 6602(c); and

(2) Provide written notice of the denial of a request to vacate a dismissal to the appellant within five business days from the date of such denial, if the request is denied.

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100503 and 100506, Government Code; 45 CFR Section 155.530.

§ 6612. Informal Resolution.

(a) An appellant shall have an opportunity for informal resolution prior to a hearing in accordance with the requirements of this section.

(b) Upon receipt of an appeal request, which has been determined to be valid in accordance with Section 6602(c), or upon receipt of the notice under Section 6606(e)(2), the Exchange shall contact the appellant to resolve the appeal informally and to request additional information or documentation, if applicable, prior to the hearing date.

(c) The informal resolution process shall comply with the scope of review specified in Section 6614(e).

(d) An appellant's right to a hearing shall be preserved in any case notwithstanding the outcome of the informal resolution process unless the appellant unconditionally or conditionally withdraws his or her appeal request prior to the hearing date, in accordance with the procedure set forth in Section 6610(a)(1).

(e) If the appeal advances to hearing:

(1) The appellant shall not be asked to provide duplicative information or documentation that he or she previously provided during the application or informal resolution process; and

(2) The Exchange shall:

(A) Issue a Statement of Position; and

(B) Transmit via secure electronic interface the Statement of Position and all papers, requests, and documents, including printouts from an appeal record, which the Exchange obtained during the informal resolution process to the appeals entity, the appellant, and, if applicable, the appellant's representative, at least two business days before the date of the hearing.

(f) If the appellant is satisfied with the outcome of the informal resolution process and conditionally withdraws his or her appeal request, in accordance with Section 6610(a)(1)(C), and the appeal does not advance to hearing:

(1) Within five business days from the date of the outcome of the informal resolution, the Exchange shall:

(A) Notify the appellant of:

1. The outcome of the informal resolution, including a plain language description of the effect of such outcome on the appellant's appeal and eligibility; and

2. The effective date of such outcome, if applicable; and

(B) Provide a copy of the conditional withdrawal agreement signed by the appellant, or the appellant's authorized representative, and the Exchange and instructions on how to submit his or her conditional withdrawal request to the appeals entity, in accordance with the procedure set forth in Section 6610(a)(1)(C).

(2) Within three business days from the date of the outcome of the informal resolution, the Exchange shall send notice of the informal resolution outcome to the appeals entity via secure electronic interface.

(3) If the appeal is dismissed in accordance with Section 6610, the informal resolution decision shall be final and binding.

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100503 and 100506, Government Code; 45 CFR Section 155.535.

§ 6614. Hearing Requirements.

(a) An appellant shall have an opportunity for a hearing in accordance with the requirements of this section.

(b) When a hearing is scheduled, the appeals entity shall send written notice to the appellant of the date, time, location, and format of the hearing no later than 15 days prior to the hearing date.

(c) The hearing shall be conducted:

(1) Within 90 days from the date on which a valid appeal request is received, except for the expedited appeals specified in Section 6616;

(2) After notice of the hearing, pursuant to subdivision (b) of this section;

(3) As an evidentiary hearing, consistent with subdivision (e) of this section;

(4) By an administrative law judge who has not been directly involved in the eligibility determination or any prior Exchange appeal decisions in the same matter; and

(5) By telephone, video conference, or in person, in accordance with the California Department of Social Services' Manual of Policies and Procedures Section 22-045.1.

(d) The appeals entity shall provide the appellant with the opportunity to:

(1) Review his or her appeal record, including all documents and records to be used by the appeals entity at the hearing, at least two business days before the date of the hearing as well as during the hearing;

(2) Bring witnesses to testify;

(3) Establish all relevant facts and circumstances;

(4) Present an argument without undue interference;

(5) Question or refute any testimony or evidence, including the opportunity to confront and cross-examine adverse witnesses; and

(6) Be represented by an authorized representative, legal counsel, a relative, a friend, or another spokesperson designated by the appellant.

(e) The appeals entity shall consider the information used to determine the appellant's eligibility as well as any additional relevant evidence presented during the appeal process, including at the hearing.

(f) The appeals entity shall review the appeal *de novo* and shall consider all relevant facts and evidence presented during the appeal.

(g) Postponements and continuances shall be conducted in accordance with the California Department of Social Services' Manual of Policies and Procedures Section 22-053.

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100503 and 100506, Government Code; 45 CFR Section 155.535.

§ 6616. Expedited Appeals.

(a) Pursuant to 45 CFR Section 155.540(a) , the appeals entity shall establish and maintain an expedited appeals process for an appellant to request an expedited process where there is an immediate need for health services because a standard appeal could jeopardize the appellant's life or health or ability to attain, maintain, or regain maximum function.

(b) If the appeals entity denies a request for an expedited appeal, it shall:

(1) Conduct the appeal under the standard appeals process and issue the appeal decision in accordance with Section 6618(b)(1); and

(2) Inform the appellant, within three business days from the date of the denial of a request for an expedited appeal, through electronic or verbal notification, if possible, of the denial and, if notification is verbal, follow up with the appellant by written notice within five business days of the denial, unless a shorter timeframe is established by HHS. The written notice of the denial shall include:

(A) The reason for the denial;

(B) An explanation that the appeal will be conducted under the standard appeals process; and

(C) An explanation of the appellant's rights under the standard appeals process.

(c) If the appeals entity grants a request for an expedited appeal, it shall:

(1) Ensure a hearing date is set on an expedited basis;

(2) Provide the appellant with written notice within 10 calendar days from the date on which the appellant's request for an expedited appeal is granted, unless a shorter timeframe is established by HHS:

(A) That his or her request for an expedited appeal is granted; and

(B) Of the date, time, and type of the hearing; and

(3) Within three business days from the date on which the appellant's request for an expedited appeal is granted, provide notice via secure electronic interface to the Exchange and to the DHCS, as applicable, specifying that the appellant's request for an expedited appeal is granted and a hearing will be set on an expedited basis.

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100503 and 100506, Government Code; 45 CFR Section 155.540.

§ 6618. Appeal Decisions.

(a) Appeal decisions shall:

(1) Be based exclusively on the information and evidence specified in Section 6614(e) and the eligibility requirements under Article 5 of this chapter;

(2) State the decision, including a plain language description of the effect of the decision on the appellant's eligibility;

(3) Include a summary of the facts relevant to the appeal;

(4) Identify the legal basis, including the regulations that support the decision;

(5) State the effective date of the decision, if applicable; and

(6) Explain the appellant's right to pursue the appeal before the HHS appeals entity, including the applicable timeframe and instructions to file, if the appellant remains dissatisfied with the eligibility determination;

(7) Indicate that the decision of the Exchange appeals entity is final, unless the appellant pursues the appeal before the HHS appeals entity; and

(8) Provide information about judicial review available to the appellant pursuant to Section 1094.5 of the California Code of Civil Procedure.

(b) The appeals entity shall:

(1) Issue written notice of the appeal decision to the appellant within 90 days of the date on which a valid appeal request is received;

(2) If an appeal request submitted under Section 6616 is determined by the appeals entity to meet the criteria for an expedited appeal, issue the notice of the appeal decision as expeditiously as reasonably possible, but no later than five business days from the date of the record closure, unless a shorter timeframe is established by HHS; and

(3) Provide notice of the appeal decision and instructions to cease the appellant's pended eligibility, if applicable, via secure electronic interface, to the Exchange or the DHCS, as applicable.

(c) Upon receiving the notice described in subdivision (b) of this section, the Exchange shall promptly:

(1) Implement the appeal decision effective:

(A) Prospectively, on the first day of the month following the date of the notice of appeal decision, or consistent with Section 6496(l), if applicable; or

(B) Retroactively, to the date the incorrect eligibility determination was made, at the option of the appellant; and

(2) Redetermine the eligibility of household members who have not appealed their own eligibility determinations but whose eligibility may be affected by the appeal decision, in accordance with the standards specified in Section 6472 and 6474 of Article 5 of this chapter.

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100503 and 100506, Government Code; 45 CFR Section 155.545.

§ 6620. Appeal Record.

(a) Subject to the requirements of all applicable federal and State laws regarding privacy, confidentiality, disclosure, and personally identifiable information, the appeals entity shall make the appeal record accessible to the appellant for at least five years after the date of the written notice of the appeal decision as specified in Section 6618(b)(1).

(b) The appeals entity shall provide public access to all appeal decisions, subject to all applicable federal and State laws regarding privacy, confidentiality, disclosure, and personally identifiable information.

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100503 and 100506, Government Code; 45 CFR Section 155.550.

STATE OF CALIFORNIA — DEPARTMENT OF FINANCE

ECONOMIC AND FISCAL IMPACT STATEMENT

(REGULATIONS AND ORDERS)

STD. 399 (REV. 12/2008)

See SAM Section 6601 - 6616 for Instructions and Code Citations

DEPARTMENT NAME	CONTACT PERSON	TELEPHONE NUMBER
Covered California	Bahara Hosseini	916-228-8486
DESCRIPTIVE TITLE FROM NOTICE REGISTER OR FORM 400		NOTICE FILE NUMBER
Eligibility and Enrollment Process Regulations		Z

ECONOMIC IMPACT STATEMENT

A. ESTIMATED PRIVATE SECTOR COST IMPACTS (Include calculations and assumptions in the rulemaking record.)

1. Check the appropriate box(es) below to indicate whether this regulation:

- ☐ a. Impacts businesses and/or employees
- ☐ b. Impacts small businesses
- ☐ c. Impacts jobs or occupations
- ☐ d. Impacts California competitiveness
- ☐ e. Imposes reporting requirements
- ☐ f. Imposes prescriptive instead of performance
- ☐ g. Impacts individuals
- ☐ h. None of the above (Explain below. Complete the Fiscal Impact Statement as appropriate.)

h. (cont.) _____

(If any box in Items 1 a through g is checked, complete this Economic Impact Statement.)

2. Enter the total number of businesses impacted: _____ Describe the types of businesses (Include nonprofits.): _____

Enter the number or percentage of total businesses impacted that are small businesses: _____

3. Enter the number of businesses that will be created: _____ eliminated: _____

Explain: _____

4. Indicate the geographic extent of impacts: ☐ Statewide ☐ Local or regional (List areas.): _____

5. Enter the number of jobs created: _____ or eliminated: _____ Describe the types of jobs or occupations impacted: _____

6. Will the regulation affect the ability of California businesses to compete with other states by making it more costly to produce goods or services here?

☐ Yes ☐ No If yes, explain briefly: _____

B. ESTIMATED COSTS (Include calculations and assumptions in the rulemaking record.)

1. What are the total statewide dollar costs that businesses and individuals may incur to comply with this regulation over its lifetime? $ _____

a. Initial costs for a small business: $ _____ Annual ongoing costs: $ _____ Years: _____

b. Initial costs for a typical business: $ _____ Annual ongoing costs: $ _____ Years: _____

c. Initial costs for an individual: $ _____ Annual ongoing costs: $ _____ Years: _____

d. Describe other economic costs that may occur: _____

2. If multiple industries are impacted, enter the share of total costs for each industry: _____

3. If the regulation imposes reporting requirements, enter the annual costs a typical business may incur to comply with these requirements. (Include the dollar costs to do programming, record keeping, reporting, and other paperwork, whether or not the paperwork must be submitted.): $ _____

4. Will this regulation directly impact housing costs? ☐ Yes ☐ No If yes, enter the annual dollar cost per housing unit: _____ and the number of units: _____

5. Are there comparable Federal regulations? ☐ Yes ☐ No Explain the need for State regulation given the existence or absence of Federal regulations: _____

Enter any additional costs to businesses and/or individuals that may be due to State - Federal differences: $ _____

C. ESTIMATED BENEFITS (Estimation of the dollar value of benefits is not specifically required by rulemaking law, but encouraged.)

1. Briefly summarize the benefits that may result from this regulation and who will benefit: _____

2. Are the benefits the result of : ☐ specific statutory requirements, or ☐ goals developed by the agency based on broad statutory authority?

Explain: _____

3. What are the total statewide benefits from this regulation over its lifetime? $ _____

D. ALTERNATIVES TO THE REGULATION (Include calculations and assumptions in the rulemaking record. Estimation of the dollar value of benefits is not specifically required by rulemaking law, but encouraged.)

1. List alternatives considered and describe them below. If no alternatives were considered, explain why not: _____

2. Summarize the total statewide costs and benefits from this regulation and each alternative considered:

Regulation:	Benefit: $ _____	Cost: $ _____
Alternative 1:	Benefit: $ _____	Cost: $ _____
Alternative 2:	Benefit: $ _____	Cost: $ _____

3. Briefly discuss any quantification issues that are relevant to a comparison of estimated costs and benefits for this regulation or alternatives: _____

4. Rulemaking law requires agencies to consider performance standards as an alternative, if a regulation mandates the use of specific technologies or equipment, or prescribes specific actions or procedures. Were performance standards considered to lower compliance costs? ☐ Yes ☐ No

Explain: _____

E. MAJOR REGULATIONS (Include calculations and assumptions in the rulemaking record.) Cal/EPA boards, offices, and departments are subject to the following additional requirements per Health and Safety Code section 57005.

1. Will the estimated costs of this regulation to California business enterprises exceed $10 million ? ☐ Yes ☐ No (If No, skip the rest of this section.)

2. Briefly describe each equally as an effective alternative, or combination of alternatives, for which a cost-effectiveness analysis was performed:

   Alternative 1: _____

   Alternative 2: _____

3. For the regulation, and each alternative just described, enter the estimated total cost and overall cost-effectiveness ratio:

Regulation:	$ _____	Cost-effectiveness ratio: $ _____
Alternative 1:	$ _____	Cost-effectiveness ratio: $ _____
Alternative 2:	$ _____	Cost-effectiveness ratio: $ _____

FISCAL IMPACT STATEMENT

A. FISCAL EFFECT ON LOCAL GOVERNMENT (Indicate appropriate boxes1 through 6 and attach calculations and assumptions of fiscal impact for the current year and two subsequent Fiscal Years.)

☐ 1. Additional expenditures of approximately $ _____ in the current State Fiscal Year which are reimbursable by the State pursuant to Section 6 of Article XIII B of the California Constitution and Sections 17500 et seq. of the Government Code. Funding for this reimbursement:

   ☐ a. is provided in _____, Budget Act of _____ or Chapter _____, Statutes of _____

   ☐ b. will be requested in the _____ (FISCAL YEAR) Governor's Budget for appropriation in Budget Act of _____

☐ 2. Additional expenditures of approximately $ _____ in the current State Fiscal Year which are not reimbursable by the State pursuant to Section 6 of Article XIII B of the California Constitution and Sections 17500 et seq. of the Government Code because this regulation:

   ☐ a. implements the Federal mandate contained in _____

   ☐ b. implements the court mandate set forth by the _____

   court in the case of _____ vs. _____

   ☐ c. implements a mandate of the people of this State expressed in their approval of Proposition No. _____ at the _____ (DATE) election;

   ☐ d. is issued only in response to a specific request from the _____

   _____, which is/are the only local entity(s) affected;

   ☐ e. will be fully financed from the _____ (FEES, REVENUE, ETC.) authorized by Section

   _____ of the _____ Code;

   ☐ f. provides for savings to each affected unit of local government which will, at a minimum, offset any additional costs to each such unit;

   ☐ g. creates, eliminates, or changes the penalty for a new crime or infraction contained in _____

☐ 3. Savings of approximately $ _____ annually.

☐ 4. No additional costs or savings because this regulation makes only technical, non-substantive or clarifying changes to current law regulations.

ECONOMIC AND FISCAL IMPACT STATEMENT cont. (STD. 399, Rev. 12/2008)

☑ 5. No fiscal impact exists because this regulation does not affect any local entity or program.

☐ 6. Other.

B. FISCAL EFFECT ON STATE GOVERNMENT (Indicate appropriate boxes 1 through 4 and attach calculations and assumptions of fiscal impact for the current year and two subsequent Fiscal Years.)

☐ 1. Additional expenditures of approximately $ _____ in the current State Fiscal Year. It is anticipated that State agencies will:

☐ a. be able to absorb these additional costs within their existing budgets and resources.

☐ b. request an increase in the currently authorized budget level for the _____ fiscal year.

☐ 2. Savings of approximately $ _____ in the current State Fiscal Year.

☐ 3. No fiscal impact exists because this regulation does not affect any State agency or program.

☑ 4. Other. See attached.

C. FISCAL EFFECT ON FEDERAL FUNDING OF STATE PROGRAMS (Indicate appropriate boxes1 through 4 and attach calculations and assumptions of fiscal impact for the current year and two subsequent Fiscal Years.)

☐ 1. Additional expenditures of approximately $ _____ in the current State Fiscal Year.

☐ 2. Savings of of approximately $ _____ in the current State Fiscal Year.

☐ 3. No fiscal impact exists because this regulation does not affect any federally funded State agency or program.

☑ 4. Other. See attached.

FISCAL OFFICER SIGNATURE		DATE 9-11-2013
AGENCY SECRETARY [1] APPROVAL/CONCURRENCE		DATE
DEPARTMENT OF FINANCE [2] APPROVAL/CONCURRENCE	PROGRAM BUDGET MANAGER	DATE

1. *The signature attests that the agency has completed the STD.399 according to the instructions in SAM sections 6601-6616, and understands the impacts of the proposed rulemaking. State boards, offices, or department not under an Agency Secretary must have the form signed by the highest ranking official in the organization.*

2. *Finance approval and signature is required when SAM sections 6601-6616 require completion of Fiscal Impact Statement in the STD.399.*

COVERED CALIFORNIA
PROPOSED REGULATION
ELIGIBILITY AND ENROLLMENT PROCESS
STD FORM 399

ATTACHMENT A

FISCAL IMPACT STATEMENT

Section B – Fiscal Effect on State Government

4. The proposed regulation affects Covered California's (CC) Service Center employees who provide eligibility and enrollment services to the public (consumers). The regulation becomes effective immediately once the Office of Administrative Law files with the Secretary of State. As Attachment B indicates, the estimated cost impact to CC is $32.2 million in FY 2014-15, and $64.3 million each year thereafter. As CC becomes self-sustaining starting January 1, 2015, CC will adjust the participation fees, if necessary, to collect sufficient revenue to offset these costs.

Section C – Fiscal Effect on Federal Programs

4. The proposed regulation affects Covered California's Service Center employees who provide eligibility and enrollment services to the public (consumers). The regulation becomes effective immediately once the Office of Administrative Law files with the Secretary of State. As Attachment B indicates, the estimated cost impact to the federal funding (Grant) is $68.6 million in FY 2013-14 and $43.1 million in FY 2014-15.

COVERED CALIFORNIA
PROPOSED RULEMAKING
ELIGIBILITY AND ENROLLMENT (E&E) PROCESS (INDIVIDUAL)
STD 399
(whole dollars)

ATTACHMENT B

FISCAL EFFECT

Service Center

Service Center Unit - Total Projected Costs [1/]

Expenditure Category	FY 2013/14	FY 2014/15	FY 2015/16	Total
Salaries [2/]	$ 22,125,691	$ 33,630,000	$ 33,630,000	$ 89,385,690
Benefits [3/]	$ 7,522,735	$ 11,434,200	$ 11,434,200	$ 30,391,135
OE&E (prorated for partial year)				
Effective 10/1/13-12/31/13: 544 positions				
318 Program Tech III @ $12,500/position	$ 662,500			$ 662,500
226 Other Classifications @ $14,000/position	$ 527,333			$ 527,333
OE&E (prorated for partial year)				
Effective 1/1/14: 866 positions				
595 Program Tech III @ $12,500/position	$ 3,718,750	$ 7,437,500	$ 7,437,500	$ 18,593,750
271 Other Classifications @ $14,000/position	$ 1,897,000	$ 3,794,000	$ 3,794,000	$ 9,485,000
Total Costs	**$ 36,454,009**	**$ 56,295,700**	**$ 56,295,700**	**$ 149,045,408**

[1/] Costs effective 10/1/13 when open enrollment starts.
[2/] FY 2013/14 salaries for perm positions = sum (Oct 2013 - June 2014) x 0.95 to net out 5% salary savings = $23,290,201 x 0.95.
[3/] Benefits = 34% x Salaries.

Projected Costs (10/1/13-ongoing) for Service Center (related to Eligibility & Enrollment)

Expenditure Category	FY 2013/14	FY 2014/15	FY 2015/16	Total
Service Center Total Costs @ 95% [4/]	$ 34,631,308	$ 53,480,915	$ 53,480,915	$ 141,593,138
Federal Costs	***$ 34,631,308***	***$ 26,740,457***	***$ -***	***$ 61,371,766***
State Costs	***$ -***	***$ 26,740,457***	***$ 53,480,915***	***$ 80,221,372***
Sub-Total, Federal and State Costs	***$ 34,631,308***	***$ 53,480,915***	***$ 53,480,915***	***$ 141,593,138***
Administrative Costs [5/]	$ 33,937,941	$ 21,740,235	$ 10,781,901	$ 66,460,077
Federal Costs	***$ 33,937,941***	***$ 16,317,433***	***$ -***	***$ 50,255,375***
State Costs	***$ -***	***$ 5,422,802***	***$ 10,781,901***	***$ 16,204,702***
Sub-Total, Federal and State Costs	***$ 33,937,941***	***$ 21,740,235***	***$ 10,781,901***	***$ 66,460,077***
Total, Federal Costs	***$ 68,569,250***	***$ 43,057,891***	***$ -***	***$ 111,627,141***
Total, State Costs	***$ -***	***$ 32,163,259***	***$ 64,262,815***	***$ 96,426,074***
Grand Total, Federal and State Costs	**$ 68,569,250**	**$ 75,221,150**	**$ 64,262,815**	**$ 208,053,215**

[4/] The workload dedicated by the Service Center Unit solely to the eligibility and enrollment and appeals process is approximately 95% (no program input). Remaining 5% is for inquiries relating to general information, payments, etc.
[5/] Administrative costs include Service Center contracts (based on Contract Log, contracts only for Service Center (index 3100)) and IA with DSS (BCP).
Fingerprinting costs are identified in a separate rulemaking; thus, they are not included in this analysis.
Data transmission in CalHEERS is built into the system. No additional data processing (CalHEERS) costs are associated with this process.
All administrative costs are identified under the 2.0 grant (ends 12/31/14) and self-sustaining (effective 1/1/15).
Assume CC will not reimburse Health and Human Services for exemption processing (no cost impact).