



November 7, 2016

ADVANCE NOTICE OF RE-ADOPTION 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 advance notice at least five working days of their intent to file emergency regulations with the Office of Administrative Law (OAL). The California Health Benefit Exchange (“Exchange”) intends to file a re-adoption of an Emergency Rulemaking package with the Office of Administrative Law (OAL) that establishes the Exchange’s policies and procedures for eligibility determination and redetermination, enrollment in qualified health plans, and termination of coverage through the Small Business Health Options Program (SHOP) Exchange (AKA “Covered California for Small Business”). 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 regulations and (2) the Finding of Emergency, including specific facts demonstrating the need for immediate action, authority and reference citations, informative digest and policy statement overview, any reports, and required determinations.

The Exchange plans to file 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. Response to these comments is strictly at the Exchange’s discretion.

Comments should be sent simultaneously to:

California Health Benefit Exchange
Attn: Gabriela Ventura Gonzales
1601 Exposition Blvd
Sacramento, CA 95815

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

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 two years. 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 after it has published Notice to make these regulations permanent.

You may also view the proposed regulatory language and Finding of Emergency on the Exchange's website at the following address:

<http://hbex.coveredca.com/regulations/>

If you have any questions concerning this Advance Notice, please contact Gabriela Ventura Gonzales at (916) 228-8477.

FINDING OF EMERGENCY

The Director of the California Health Benefit Exchange (Covered California) 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 adopted by OAL on September 30, 2013; readopted on April 1, June 30, October 2, 2014, and September 30, 2016. The current emergency regulations are in effect until September 30, 2018; however, the Exchange now seeks an additional readoption to allow for the necessary and immediate incorporation of conforming amendments, and other amendments, to these rules. In seeking this readoption the Exchange is acting in accordance with Government Code § 100504 which permits emergency regulations to be adopted and in effect for five years, allowing for the reconciliation process between state and federal law to occur rapidly and regularly, as may be warranted. Specifically, the Exchange is proposing to modify these regulations to reflect changes in state and federal authorizing laws, simplify and modify program requirements to reflect best practices in the small business exchange, and clean up language throughout for improved clarity and understanding.

While the Exchange is seeking an emergency readoption at this time, the Exchange is simultaneously proceeding with diligence to comply with the requirements in Government Code § 11346.1(e), and has made substantial progress in furtherance of a future permanent rulemaking action. The Exchange has drafted the Initial Statement of Reasons for the permanent rulemaking. The Exchange has also completed a revised Form 399, and recently submitted this document as part of the emergency rulemaking readoption package on September 30, 2016. As part of its efforts to continuously evaluate the economic impact of the SHOP, the Exchange concluded a months long collaboration with the Department of Finance (DOF) to determine whether the SHOP comprised a major regulation. The analysis concluded that the proposed action is not a major regulation based on its economic impact.

This Finding of Emergency hereby incorporates by reference all documents in the original rulemaking file, which is file number 2013-0920-05 E.

DEEMED EMERGENCY

The necessity of this regulation to be adopted immediately as a deemed emergency has been declared by the Legislature in Government Code Section 100504 (a)(6) which grants the Exchange with emergency rule making authority:

The Exchange may “Adopt rules and regulations, as necessary. Until January 1, 2017, any necessary rules and regulations may be adopted as emergency regulations in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2). Until January 1, 2019, any necessary

rules and regulations to implement the eligibility, enrollment, and appeals processes for the individual and small business exchanges, changes to the small business exchange, or any act in effect that amends this title that is operative on or before December 31, 2016, may be adopted as emergency regulations in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2). The adoption of emergency regulations pursuant to this section shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare. Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2, including subdivisions (e) and (h) of Section 11346.1, any emergency regulation adopted pursuant to this section shall be repealed by operation of law unless the adoption, amendment, or repeal of the regulation is promulgated by the board pursuant to Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code within five years of the initial adoption of the emergency regulation.” Government Code § 100504(a)(6).

Additionally the Exchange may seek more than two readoptions pursuant to this emergency rulemaking authority:

“Notwithstanding subdivision (h) of Section 11346.1, until January 1, 2017, the Office of Administrative Law may approve more than two readoptions of an emergency regulation adopted pursuant to this section.” Id.

AUTHORITY AND REFERENCE

Authority: Government Code Section 100504.

Reference: Government Code Sections 100502, 100503, and 100504; 45 C.F.R. §§ 155 and 156.

INFORMATIVE DIGEST/POLICY STATEMENT OVERVIEW

Documents to be incorporated by reference:

45 CFR 156.140(b) (February 25, 2013); 45 CFR 155.1080 (May 29, 2012).

Summary of Existing Laws

Under the federal Patient and Protection and Affordable Care Act (PPACA), 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 a Small Business Health Options Program (SHOP) (AKA “Covered California for Small Business”). Gov. Code § 100502(m). The Exchange is further required to establish the criteria and process for eligibility determination, enrollment, and disenrollment of

enrollees and potential enrollees in the Exchange's Small Business Health Options Program. Gov. Code § 100503(a).

The proposed regulations will establish the Exchange's policies and procedures for eligibility determination and redetermination, enrollment in qualified health plans, and termination of coverage through the SHOP Exchange. The proposed regulations will provide the small employer and employees with clear standards and eligibility requirements to qualify for and sign up for health insurance coverage through the SHOP Exchange. The proposed regulations will also provide the standards and requirements for the qualified health plan issuers regarding enrollment of qualified employers and employees in the qualified health plans and termination of coverage for qualified employers and employees through the SHOP Exchange.

These proposed regulations will benefit the public by providing clear guidelines to access care through enrollment in qualified health plans and for small employers to take advantage of the federal small business tax credit, which is only available to those small employers offering health insurance coverage to its employees through the SHOP Exchange.

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

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 became financially self-sustaining in 2016. The proposal does not result in any costs or savings to any other state agency.

Adopt Article 6, Sections 6520, 6522, 6524, 6526, 6528, 6530, 6532, 6534, 6536, and 6538, which new regulation text is underlined and deleted text is shown in strikethrough:

ARTICLE 6. APPLICATION, ELIGIBILITY, AND ENROLLMENT IN THE SHOP EXCHANGE
10 CCR § 6520

§ 6520. Employer and Employee Application Requirements.

(a) A qualified employer who is eligible to purchase coverage from a Qualified Health Plan (QHP) for its qualified employees through the Small Business Health Options Program (SHOP) pursuant to Section 6522, may apply to participate in the SHOP by submitting the following information to the SHOP:

(1) General employer information: business legal name and whether the employer is doing business under a fictitious name, Federal ~~employer identification number, State employer identification number~~Employer Identification Number, State Employer Identification Number, organization type (private, nonprofit, government, church/church affiliated), ~~primary business~~principal business address, mailing address, and billing address;

(2) The number of qualified employees enrolling in SHOP and the total number of Full-Time and Full-Time Equivalent employees employed by the qualified employer, as calculated in accordance with Health and Safety Code § 1357.500(k)(3) and Insurance Code § 10965.3(q)(3);

~~(3) The United States Department of Labor Standard Industrial Code of the qualified employer;~~

(3) Whether you have employed 20 or more employees for 20 or more weeks in the current or preceding calendar year;

(4) Whether the qualified employer is offering dependent health insurance coverage, ~~including whether the qualified employer is offering coverage for~~ for spouse, registered or non-registered domestic partners~~partner and/or dependent children~~;

(5) The qualified employer's desired health insurance coverage effective date;

(6) Whether the qualified employer is subject to COBRA or Cal-COBRA continuation coverage regulations;

(7) The name, ~~and~~ primary phone number, and email address for the primary contact for the qualified employer and the preferred method of communication;

(8) Whether the qualified employer used an insurance agent and if so, the agent's name, general agency name (if applicable), CA insurance license number, and whether the agent is an insurance agent certified by Covered California. If the qualified employer uses an insurance agent, the qualified employer must have that agent certify that he or she understands he or she may be subject to a civil penalty for providing false information under Health and Safety Code § 1389.8 and Insurance Code § 10119.3.

~~(9) Information about the qualified employer's qualified employees, including each qualified employee's taxpayer identification number, full name, date of birth, home address, telephone number, the qualified employee's number of dependents, if the qualified employer offers dependent coverage, including spouse, partner, child dependents under the age of 21 and the number of child dependents from 21 to 25 years of age, if applicable, the COBRA or Cal-COBRA continuation coverage designation, start date of the continuation coverage, if any, and the remaining months of eligibility for continuation coverage for enrollees that are not qualified employees or their dependents;~~

~~(10)(9) Information about the qualified employer's qualified employees, in the employee application in subdivision (d);~~

(10) The employer's offer of health insurance coverage, which includes:

(A) The employer's contribution rate to each of its qualified employee's Qualified Health Plan (QHP) premiums pursuant to Section 6522(a)(5)(A);

(B) The employer's health premium contribution rate for employees and their dependents for spouse or non-registered domestic partner, or dependent children coverage, if applicable; and

(B_C) The employer's plan selection for a tier of health insurance coverage or for two contiguous tiers of health insurance coverage, pursuant to 45 CFR § 156.140(b) (bronze, silver, gold, or platinum) (February 25, 2013), hereby incorporated by reference, and the reference plan;

(b) To participate in the SHOP, an employer must attest to the following:

(1) That the business has 100 or fewer full time or full-time equivalent (FTE) employees and has a principal business address in California;

(2) All qualified full-time employees of this business will be offered SHOP coverage;

(3) This business has at least one employee who isn't the owner or business partner, or the spouse of the owner or business partner;

(4) That the employer is signing the application under penalty of perjury, which means all information contained in the qualified employer application is true and correct to the best of the qualified employer's knowledge;

(5) That the employer knows that he or she may be subject to penalties under federal law if he or she intentionally provides false or untrue information pursuant to 45 CFR 155.285;

(6) That the employer knows that the information will only be used to determine eligibility and facilitate enrollment for health coverage and will otherwise be kept private as required by federal and state law;

~~(47)~~ That any waiting period established by the qualified employer complies with 42 U.S.C. § 300gg-7 and applicable state law, including Section 10198.7 of the California Insurance Code and Section 1357.51 of the California Health and Safety Code, and all qualified employees have complied with the qualified employer's waiting period;

~~(58)~~ That the employer has the consent from every qualified employee listed on the application to include their personally identifiable information such as ~~dates~~dates of ~~birth~~birth, addresses ~~and, social security numbers or tax identification numbers, phone numbers, and email addresses~~;

~~(69)~~ That the employer understands that discrimination is prohibited on the basis of race, color, national origin, religion, sex, age, sexual orientation, marital status, gender identity, veteran status, disability, or any other type of discrimination prohibited in the Health and Safety Code and Insurance Code;

~~(710)~~ That the qualified employer understands that the SHOP will not consider the qualified employer approved for health insurance coverage until the SHOP has received the qualified employer's first month health premium payment, which shall be no less than 85 percent of the total amount due;

~~(811)~~ That the qualified employer agrees to continue to make the total required monthly health premium payments by the due date, and which at no time shall be less than 85 percent of the total amount due each month, including any premium amounts past due, to maintain eligibility for coverage in the SHOP;

~~(912)~~ That the qualified employer agrees to inform its qualified employees of the availability of health insurance coverage and that those declining coverage must wait until the next open enrollment period, pursuant to Section 6528, to sign up for coverage, unless that employee experiences an event that would entitle him or her to a special enrollment period pursuant to Section 6530;

~~(1013)~~ That the qualified employer understands that once coverage in a QHP is approved by the SHOP, changes to the coverage cannot be implemented until the qualified employer's annual election of coverage period pursuant to Section 6526, except to the extent the qualified employer exercises the right to change coverage with the same issuer within the first 30 days of the effective date of coverage pursuant to Health and Safety Code 1357.504(d) and Insurance Code Section 10753.06.5(d);

~~(1114)~~ That the qualified employer understands that health insurance coverage through the SHOP is subject to the applicable terms and conditions of the QHP issuer contract or policy and applicable state law, which will determine the procedures, exclusions and limitations relating to the coverage and will govern in the event of any conflict with SHOP or QHP issuer benefits comparison, summary or other description of the coverage;

~~(1215)~~ That the qualified employer understands that once employer and employee information is transmitted to the selected QHPs, the qualified employer's coverage effective dates cannot be changed nor can the qualified employer terminate coverage until after the first month of coverage;

(16) That the qualified employer agrees to inform its qualified employees of the availability of child and family dental plans and that qualified employees may choose to enroll only in a dental plan even if the qualified employee does not choose to enroll in a QHP;

~~(1317)~~ That the qualified employer understands that the attestations in this section are subject to audit by the SHOP at any time; and

~~(1418)~~ That the qualified employer agrees to maintain compliance with the attestations in this section in order to continue eligibility for coverage through the SHOP.

(c) A qualified employer must provide the SHOP with its most recent Quarterly Contribution Return and Report of Wages (Form DE-9C), as filed with the California Employment Development Division, on which the qualified employer must identify on the face of the form whether each employee listed on the DE-9C is a full-time employee, part-time eligible employee, ineligible employee and whether the employee is still employed by the qualified employer. If there is not sufficient space on the face of the Form DE-9C for the qualified employer to add the required information, the qualified employer may attach additional sheets of paper to the Form DE-9C as necessary. A qualified employer must provide the SHOP with additional or other documents in the following circumstances:

(1) For a qualified employer who is a sole proprietor in business less than three (3) months, a California business license or Fictitious Business Name Filing and a DE-9C or payroll records for 30 days;

(2) For a qualified employer who is a sole proprietor who is in business three (3) months or more, a DE-9C. If the owner is not listed as earning wages on the DE-9C and wishes to enroll for coverage, a current IRS Form 1040 Schedule C Profit or Loss From Business (Sole Proprietorship) or, if a Form 1040 Schedule C is not available, a California business license or Fictitious Business Name filing may be substituted;

(3) For a qualified employer who is a corporation in business less than three (3) months, Articles of Incorporation, filed and stamped by the Secretary of State, and a Statement of Information or corporate meeting minutes listing all officers' names and a DE-9C or payroll records for 30 days;

(4) For a qualified employer who is a corporation in business three (3) months or more, a DE-9C, and, if officers who are not listed on DE-9C enroll for coverage, a Statement of Information;

(5) For a qualified employer who is a partnership in business less than three (3) months, a Partnership Agreement, a Federal Tax Identification appointment letter, and a DE-9C or payroll records for 30 days;

(6) For a qualified employer who is a partnership in business three (3) months or more, a DE-9C and a current IRS Form 1065 Schedule K-1, if the partners are not listed on DE-9C and want to enroll for coverage. If an IRS Form 1065 Schedule K-1 is not yet available, the Partnership Agreement and the Federal Tax Identification appointment letter can be substituted;

(7) For a qualified employer who is a limited partnership in business less than three (3) months, a Partnership Agreement, a Federal Tax Identification appointment letter, and a DE-9C or payroll records for 30 days;

(8) For a qualified employer who is a limited partnership in business three (3) months or more, a DE-9C. If General Partners are not listed on DE-9C and wish to enroll in coverage, then a current IRS Form 1065 Schedule K-1. If an IRS Form 1065 Schedule K-1 is not available, the Partnership Agreement and a Federal Tax Identification appointment letter can be substituted. Limited partners are not eligible for coverage unless they appear on a DE-9C;

(9) For a qualified employer who is a limited liability partnership in business less than three (3) months, a Partnership Agreement or a Federal Tax Identification appointment letter, and a DE-9C or payroll records for 30 days;

(10) For a qualified employer who is a limited liability partnership in business three (3) months or more, a DE-9C. If partners are not listed on the DE-9C and wish to enroll in coverage, then a current IRS Form 1065 Schedule K-1. If the IRS Form 1065 Schedule K-1 is not yet available, the Partnership Agreement and the Federal Tax Identification appointment letter can be substituted;

(11) For a qualified employer who is a limited liability company in business less than three (3) months, Articles of Organization with the Operating Agreement or the Statement of Information and a DE-9C or payroll records for 30 days; and

(12) For a qualified employer who is a limited liability company in business three (3) months or more, a DE-9C. If managing members are not listed as earning wages on the DE-9C and wish to enroll for coverage, a current IRS Form 1065 Schedule K-1 for a partnership or IRS Form 1040 Schedule C for a sole proprietorship. If an IRS Form 1065 Schedule K-1 is not yet available, a Statement of Information or Articles of Organization with the Operating Agreement may be substituted.

(13) For a qualified employer who was previously insured outside of the SHOP, the SHOP may waive or alter any additional documentation submission requirements in Section 6520(c)(1 – 12), if as determined by the SHOP on a case-by-case basis, the proof of coverage is sufficient to satisfy these requirements.

(d) To participate in the SHOP, a qualified employee must submit the following information to the SHOP:

(1) The employer's business name, principal business address, and business phone number ~~of the employee's employer~~;

(2) The qualified ~~employee's~~ employee's first and last name, taxpayer identification number, Taxpayer Identification Number, date of birth, home address, mailing addresses, phone number, address (if different from home address), and whether telephone number;

(3) Whether the employee is applying for Cal-COBRA or COBRA coverage; ~~and, if so, the~~

(A) The effective date of that coverage, the qualifying event that triggered that coverage (if applicable), and the date of the qualifying event (and, if applicable);

~~(3) If the qualified employer is offering coverage for dependents and the employee elects to offer his or her dependents coverage, the marital or domestic partnership status of the qualified employee;~~

(B) The start date of any prior Cal-COBRA or COBRA continuation coverage; and

(C) The remaining months of eligibility for continuation coverage.

(4) If the qualified employer is offering coverage for dependents and the employee elects to offer his or her dependents coverage, the marital or domestic partnership status of the qualified employee;

(5) If the qualified employer is offering coverage for spouse or non-registered domestic partner, and/or dependent children and the employee elects to offer his or her dependents coverage, then information about the qualified employee's dependents, spouse or non-registered partner, and/or dependent children, which includes:

(A) The number of dependents applying for health insurance coverage;

(B) ~~The~~ Spouse or non-registered domestic partner and/or each dependent child's first and last name, relationship of the dependents to the qualified employee;

(C) Each dependent's name, SSN or taxpayer identification number, date of birth, age, gender, home address, and mailing addresses; address (if different from home address); and

(D) Whether the qualified employee would like to enroll a dependent who is a disabled child pursuant to Section 599.500 of Title 2 of the California Code of Regulations; and

(5) The name of the QHP and dental plan, if applicable, selected by the qualified employee and dependents.

(e) To participate in the SHOP, a qualified employee must do all of the following:

(1) Agree to mandatory arbitration if the QHP selected by the employee requires arbitration, which would require the employee and his or her dependents to arbitrate all claims relating to his or her QHP;

(2) Disclose whether the employee used an insurance agent and, if so, the agent's name, general agency name (if applicable), and whether the agent is an insurance agent certified by Covered California. If the employee uses an insurance agent, the employee must have that agent certify that he or she understands he or she may be subject to a civil penalty for providing false information under Health and Safety Code 1389.8 and Insurance Code 10119.3.

(3) ~~That the employee is signing~~Sign the application under penalty of perjury, ~~which means that~~ all information contained in the employee application is true and correct to the best of the employee's knowledge.

(4) ~~That~~Acknowledge that the employee ~~knows~~understands that he or she may be subject to penalties under federal law if he or she intentionally provides false or untrue information pursuant to 45 CFR 155.285.

(f) If a qualified employee declines coverage, the employee must state other sources of coverage, if any.

(g) The SHOP must keep all information received pursuant to this section private in accordance with applicable federal and state privacy and security laws pursuant to 45 CFR § 155.260 and the Information Practices Act of 1977 (Cal. Civ. Code, commencing with Section 1798). The SHOP may not provide to the qualified employer any information collected on the employee application with respect to the qualified employees or dependents of qualified employees, other than the name, address, birth date, and plan selection of the spouse or dependent. The SHOP may only share information from an employee application with the QHP or employer that is strictly necessary for the purposes of eligibility and enrollment. Information obtained by the SHOP pursuant to this section may not be used for purposes other than eligibility determinations and enrollment in health coverage through the SHOP.

(h) Employer and employee applications must be received within 5 business days

Note: Authority: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; and 45 CFR Sections 155.705, 155.715, 155.730 and 156.285.

§ 6522. Eligibility Requirements for Enrollment in the ~~Shop~~SHOP.

(a) An employer is a qualified employer and eligible to participate in the SHOP if such employer:

(1) Is a small employer as defined in Section 6410;

(2) Elects to offer all eligible employees coverage in a QHP through the SHOP;

(3) Either ~~has~~—

(A) Has its principal business address in California and offers coverage to all its ~~full-~~Full-Time employees through the SHOP in California or

(B) offers coverage to each eligible employee through the SHOP serving that employee's primary worksite;

_____ (4) Meets the following minimum participation rules:

(A) A minimum of 70 percent of eligible employees of the qualified employer must enroll in health insurance coverage through the SHOP. However, if the qualified employer pays 100 percent of the qualified employees' QHP premiums or the qualified employer only employs one to three eligible employees, then all eligible employees of the qualified employer must enroll in health insurance coverage through the SHOP.

(B) A qualified employee who waives coverage because that qualified employee is enrolled in coverage through another employer, an employee's union, Medicaid pursuant to 42 U.S.C. § 1396 et seq., or Medicare pursuant to 42 U.S.C. § 1395 et seq., is not counted in calculating compliance with the group participation rules above.

(5) Meets the following group contribution rule:

(A) A qualified employer must contribute to each of its qualified employees' QHP premiums, a minimum of 50 percent of the lowest cost premium for employee-only coverage in the level of coverage selected by the qualified employer pursuant to Section 6520(a)(~~10~~)(B)(C).

(b) An employer that otherwise meets the criteria of this section except for ~~subdivisions~~ subdivisions (a)(4) and (a)(5)(A) of this section shall be a qualified employer, but may only elect to offer coverage to its employees during the period specified in Section 6526(b).

(c) A qualified employer who ceases to be a small employer solely by reason of an increase in the number of employees of such employer shall continue to be eligible for the SHOP until the qualified employer otherwise fails to meet the eligibility criteria of this section or elects to no longer purchase coverage for qualified employees through the SHOP.

(d) All qualified employees are eligible to select a QHP through the SHOP.

~~(e) The dependents of~~ (e) The spouse or non-registered domestic partner and or dependent children of the qualified employees, if offered health insurance coverage by the qualified employer, are eligible to select a QHP through the SHOP.

~~(f) If an employer meets the criteria in paragraph (a) of this section and makes the election described in (a)(3)(B) of this section, a SHOP shall allow the employer to offer coverage to those employees whose primary worksite is in the SHOP's service area.~~

~~(g) A qualified employer shall immediately notify the SHOP of any change to the principal business location; if the new principal business address is in a different geographic rating area in California the SHOP shall only apply a new geographic rating factor upon renewal.~~

Note: Authority: Section 100504, Government Code. Reference: Sections 100502 and 10503, Government Code; and 45 CFR Sections 147.104, 155.705, 155.710, 155.715 and 155.720.

§ 6524. Verification Process for Enrollment in the ~~Shop~~SHOP.

(a) Verification of Eligibility

(1) The SHOP shall verify or obtain information as provided in this section to determine whether an employer, employee or dependent meets the eligibility requirements specified in Section 6522 prior to allowing an employer to offer health insurance coverage to its employees or a qualified employee to select a QHP through the SHOP.

(2) For purposes of verifying employee eligibility, the SHOP must:

(A) Verify that the employee has been identified by the qualified employer as an employee being offered health insurance coverage by the qualified employer;

(B) Accept the information attested to by the employee under Section 6520 unless the information is inconsistent with the qualified employer-provided information; and

(C) Collect only the minimum information necessary for verification of eligibility and enrollment in accordance with the eligibility requirements in Section 6522.

(b) Inconsistencies

(1) When the information submitted to the SHOP by an employer, or an agent or authorized representative on behalf of the employer, is inconsistent with the eligibility requirements in Section 6522, the SHOP must:

(A) Make a reasonable effort to identify and address the causes of such inconsistency, including through typographical or other clerical errors;

(B) Provide written notice to the employer of the inconsistency; and

(C) Provide the employer with a period of 30 days from the date on which the notice described in subdivision (b)(1)(B) of this section is sent to the employer to either present satisfactory documentary evidence to support the employer's application or resolve the inconsistency.

(D) If, after the 30-day period described in subdivision (b)(1)(C) of this section, the SHOP has not received satisfactory documentary evidence to support the employer's application or resolve the inconsistency, the SHOP must provide written notice to the employer of its denial of eligibility in accordance with subdivision (c) of this section and of the employer's right to appeal such determination pursuant to Section 6542(c).

(2) When the information submitted to the SHOP by an employee is inconsistent with the information provided by the employee's employer, the SHOP must:

(A) Make a reasonable effort to identify and address the causes of such inconsistency, including through typographical or other clerical errors;

(B) Provide written notice to the employee of the inability to substantiate his or her employee status and;

(C) Provide the employee with a period of 30 days from the date on which the notice described in subdivision (b)(2)(B) of this section is sent to the employee to either present satisfactory documentary evidence to support the employee's application or resolve the inconsistency.

(D) If, after the 30-day period described in subdivision (b)(2)(C) of this section, the SHOP has not received satisfactory documentary evidence to support the ~~employee's~~ application or resolve the inconsistency, the SHOP must provide written notice to the employee of its denial of eligibility in accordance with subdivision (d) of this section.

(c) Notification of Employer Eligibility

(1) The SHOP must provide written notice to an employer applying to participate in the SHOP whether the employer is eligible in accordance with Section 6522 and the ~~employer's~~ right to appeal such determination pursuant to Section 6542(c).

(d) Notification of Employee Eligibility

(1) The SHOP must provide written notice to an employee seeking to enroll in a QHP offered through the SHOP of the determination by the SHOP whether the employee is eligible in accordance with Section 6522(d) and the employee's right to appeal such eligibility determination pursuant to Section 6542(c).

Note: Authority: Section 100504, Government Code. Reference: Sections 100502 and 10503, Government Code; and 45 CFR Sections 155.715 and 155.720.

§ 6526. Qualified Employer Election of Coverage Periods.

(a) Subject to subdivision (b) of this section, a qualified employer who is not already participating in the SHOP may elect to offer health insurance coverage through the SHOP for its qualified employees at any time during the calendar year by submitting the information required in Section 6520.

(b) If a qualified employer fails to meet the minimum participation or the group contribution requirements in Section 6522(a)(4) and (5), but satisfies the remaining eligibility criteria in Section 6522, the qualified employer may only elect to offer health insurance coverage through SHOP for its qualified employees in an annual enrollment period from November 15th through December 15th of each year.

(c) A qualified ~~employer's~~ plan year is a 12-month period beginning on the coverage effective date for its qualified employees as described in Section 6536. All qualified employees of a qualified employer will have the same plan year as their qualified employer.

(d) A qualified employer may only change its offer of health insurance coverage to its qualified employees, as described in Section 6520(a)(10), during the qualified employer's annual election period. The qualified employer's annual election period is at least 10 days, beginning on the day the SHOP sends written notice of the annual employer election period, which the SHOP must send at least 30 days prior to the completion of the employer's plan year.

Note: Authority: Section 100504, Government Code. Reference: Sections 100502 and 10503, Government Code; and 45 CFR Sections 147.104, 155.705, 155.720, 155.725 and 156.285.

§ 6528. Initial and Annual Enrollment Periods for Qualified Employees.

(a) A qualified employee may enroll in a QHP or change his or her QHP only during the initial employee open enrollment period and annual employee open enrollment period described in this section or during a special enrollment period as described in Section 6530.

(b) Subject to subdivision (e) of this section, a qualified employee's initial employee open enrollment period begins the day his or her employer submits all of the information required in Section 6520 and the SHOP has determined that the employer is a qualified employer.

(c) Subject to subdivision (e) of this section, the annual employee open enrollment period begins the day after his or her qualified employer's annual election period has ended.

~~(d) For employees of a qualified employer described in Section 6526(b), the initial and annual employee open enrollment period is December 15th through January 15th of each year.~~

~~(e)~~ The initial and annual employee open enrollment period is at least 20 days.

~~(f)~~ Beginning January 1, 2014, the SHOP shall provide to qualified employers ~~for distribution to all qualified employees~~, a written annual employee open enrollment period notification for each qualified employee 60 days prior to the employee's annual open enrollment period.

~~(g)~~ If a qualified employee does not enroll in a different QHP during his or her annual employee open enrollment period, that qualified employee will remain in the QHP selected in the previous year unless:

(1) The qualified employee terminates his or her coverage from the QHP in accordance with Section 6538(b), or

(2) The QHP is no longer available to the qualified employee.

~~(h)~~ (g) Notwithstanding subdivision(f)(2), if the qualified employee's current QHP is not available, the qualified employee shall be enrolled in a QHP offered by the same QHP issuer at the same metal tier that is the most similar to the qualified employee's current QHP, as determined by the SHOP on a case-by-case basis.

(h) An employee who becomes a qualified employee outside of the initial employee open enrollment period, the annual employee open enrollment period, or a special enrollment period shall have a 30-day period to enroll in a QHP beginning on the first day the employee becomes a qualified employee.

(i) For an employer with changes to report to the initial employer application information in Section 6520(a)(3) the employer shall notify the SHOP of the updated employee counts.

Note: Authority: Section 100504, Government Code. Reference: Sections 100502 and 10503, Government Code; and 45 CFR Sections 147.104, 155.720, 155.725 and 156.285.

§ 6530. Special Enrollment Periods for Qualified Employees and Dependents.

(a) The SHOP must provide special enrollment periods consistent with this section, during which certain qualified employees or a dependent of a qualified employee may enroll in QHPs and QDPs and enrollees may change QHPs.

(b) A qualified employee may enroll in a QHP or change QHPs during special enrollment periods outside of the initial and annual open enrollment periods in the following situations:

(1) A qualified employee, or his or her dependent ~~loses, either:~~

(A) Loses Minimum Essential Coverage, as specified in subdivision (d) of this section. The date of the loss of MEC shall be:

(1) The date of the last day the qualified employee, or his or her dependent, would have coverage under his or previous plan or coverage; or

(2) If a 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) Loses pregnancy-related coverage described under section 1902(a)(10)(A)(i)(IV) and (a)(10)(A)(ii)(IX) of the Social Security Act (42 U.S.C. 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 is the last day the consumer would have pregnancy-related coverage; or

(C) Loses Medi-Cal coverage for the 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 is the last day the consumer would have medically needy coverage;

(2) A qualified employee gains a dependent or becomes a dependent through marriage or entry into domestic partnership, birth, adoption, placement for adoption, or placement in foster care, or through a child support order or other court order;

(3) The enrollee loses a dependent or is no longer considered a dependent through divorce or legal separation as defined by State law in the State in which the divorce or legal separation occurs, or if the enrollee, or his or her dependent, dies.

~~(34) A~~The qualified ~~employee's~~employee'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, misconduct, or inaction of an officer, employee, or agent of the Exchange or HHS ~~or~~its instrumentalities, or a non-Exchange entity providing enrollment assistance or conducting enrollment activities, as evaluated and determined by the Exchange. In such cases, the Exchange shall take necessary actions to correct or eliminate the effects of such error, misrepresentation, ~~or inaction~~inaction, or misconduct. For purposes of this provision, misconduct, as determined by the Exchange, includes the failure to comply with applicable standards under this title, or other applicable Federal or State laws;

~~(45) An enrollee~~qualified employee, 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 ~~qualified employee~~enrollee;

~~(56) A qualified employee~~ or enrollee, or his or her dependent, gains access to new QHPs as a result of a permanent move and either—

(A) Had minimum essential coverage as described in 26 CFR 1.5000(A)-1(b) for one or more days during the 60 days preceding the permanent move; or

(B) Was living outside of the United States or in a United States territory at the time of the permanent move; or

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~~(6) An Indian, as defined by Section 4 of the Indian Health Care Improvement Act (25 U.S.C. § 1603(c)), may enroll in a QHP or change from one QHP~~(C) Was to another one time per month;

~~(7) A qualified employee loses eligibility for coverage under a Medicaid plan under title XIX of the Social Security Act or a State child health plan under title XXI of the Social Security Act;~~

~~(8) A qualified employee or dependent becomes eligible for assistance, with respect to health insurance coverage under a SHOP, under a Medicaid plan or a State child health plan (including any waiver or demonstration project conducted under or in relation to such a plan);~~

~~(9) An individual is mandated to be covered as a dependent pursuant to a valid state or federal court order;~~

~~(10) An individual has been released from incarceration;~~

~~(11) A qualified employee or dependent was receiving services from a contracting provider under another health benefit plan, as defined in Section 1399.845(f) of the Health and Safety Code or Section 10965(f) of the Insurance Code, for one of the conditions described in Section 1373.96(c) of the Health and Safety Code and that provider is no longer participating in the health benefit plan;~~

~~(12) A qualified employee or dependent demonstrates to the Exchange, with respect to health benefit plans offered through the Exchange, or to the applicable regulator, with respect to health benefit plans offered outside the Exchange, that he or she did not enroll in a health benefit plan during the immediately preceding enrollment period available to the employee or dependent because he or she was misinformed that he or she was covered under Minimum Essential Coverage;~~

~~(13) A qualified employee or dependent or is a member of the reserve forces of the United States military returning from active duty or a member of the California National Guard returning from active duty service under Title 32 of the United States Code;~~

~~(147) A qualified employee or dependent who is an Indian, as defined by Section 4 of the Indian Health Care Improvement Act (25 U.S.C. § 1603(c)), may enroll in a QHP or change from one QHP to another one time per month;~~

~~(8) A qualified employee, or her 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 circumstances:~~

~~(A) 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;~~

~~(B) A qualified employee or dependent was receiving services from a contracting provider under another health benefit plan, as defined in Section 1399.845(f) of the Health and Safety Code or Section 10965(f) of the Insurance Code, for one of the conditions described in Section 1373.96(c) of the Health and Safety Code and that provider is no longer participating in the health benefit plan;~~

~~(C) A qualified employee or dependent demonstrates to the Exchange, with respect to health benefit plans offered through the Exchange, or to the applicable regulator, with~~

respect benefit plan during the immediately preceding enrollment period available to the employee or dependent because he or she was misinformed that he or she was covered under Minimum Essential Coverage;

(9) A qualified employee or his or her dependent loses eligibility for coverage under a Medi-Cal plan under title XIX of the Social Security Act or a State child health plan under title XXI of the Social Security Act;

(10) A qualified employee or his or her dependent becomes eligible for assistance, with respect to health insurance coverage under a SHOP, under a Medi-Cal plan (including any waiver or demonstration project conducted under or in relation to such a plan).

~~(b)~~ A qualified employee, or his or her dependent, who experiences one of the situations described in subdivision (a) of this section has ~~60~~:

(1) 30 days from the date of the event described ~~in paragraphs (b)(1)-(8) of~~ that subdivision to select a QHP through the SHOP.

(2) 60 days from the date of the event described in paragraphs (b)(9) and (b)(10) of that subdivision to select a QHP through the SHOP.

~~(c)~~ A dependent of a qualified employee is not eligible for a special enrollment period if the qualified employer does not extend the offer of health insurance coverage to dependents.

~~(d)~~ Loss of Minimum Essential Coverage (MEC), as specified in subdivision ~~(a)~~(1) of this section, includes:

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

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

1. Legal separation;
2. Divorce;
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; and

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, Medicaid, 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 health insurance 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; and

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

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

(3) Exhaustion of COBRA or Cal-COBRA continuation health insurance coverage, meaning that such coverage ceases for any reason other than a reason specified in subdivision (d)(4) of this section. 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, but not of the employee or dependent receiving COBRA benefits, to remit premiums on a timely basis;
~~or~~

(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 the individual

(4) Loss of MEC, as specified in subdivision (a**b**)(1) of this section, does not include termination or loss due to:

(A) The employee's or dependent's failure to pay premiums on a timely basis, including COBRA premiums prior to expiration of COBRA coverage; or

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

(e) If requested by a QHP or SHOP, an employee or a dependent of an employee who experiences a triggering event that gives rise to a special enrollment period pursuant to this section must provide verification of the triggering event to SHOP for review.

(f) A qualified employee or his or her dependent may enroll in a QDP during a special enrollment period outside of the initial and annual open enrollment periods in the following situations:

(1) Loss of eligibility for dental insurance coverage. Loss of eligibility for dental insurance coverage shall be consistent with any of following situations specified in subdivisions (e)(1)-(3) of this section. The date of the loss of dental coverage shall be the date of the last day the qualified employee, or his or her dependent, would have coverage under his or her previous plan or coverage.

(2) Loss of eligibility for dental insurance coverage does not include termination or loss of dental insurance coverage due to any of the situations specified in subdivisions (e)(4)(A)-(B).

(g) The effective dates of coverage are determined using the provisions of Section 6534.

(h) Limitation. Qualified employees will not be able to enroll unless the employer group meets any applicable minimum participation rate implemented under Section 6522(a)(4).

Note: Authority: Section 100504, Government Code. Reference: Sections 100502 and 10503, Government Code; 26 CFR Section 54.9801-2, 45 CFR Sections 147.104, 155.420, 155.725 and 156.285; Sections 1357.503 and 1399.849, Health and Safety Code; and Sections 10753.05 and 10753.063.5, Insurance Code.

§ 6532. Employer Payment of Premiums.

(a) Upon completion of the initial employee open enrollment period by all of the qualified employees of a qualified employer, the SHOP will send an invoice to the qualified employer for the total premium amount due for all of that qualified employer's qualified employees.

(1) A qualified ~~employer's~~employer's first ~~full~~premium payment shall be no less than 85 percent of the total amount due for effectuation and must be delivered to the SHOP or postmarked by the due date indicated on the invoice.

(2) If a qualified employer's first ~~full~~ payment ~~is not delivered to the SHOP or postmarked by the due date on the invoice, the SHOP will cancel the application of that qualified employer and the applications of that employer's qualified employees.~~

~~(b) Once coverage is effective, the SHOP will send invoices to qualified employers on the 15th of the month, or the following business day if the 15th falls on a weekend or holiday, for health insurance coverage for the following month. Payment must be delivered to the SHOP or postmarked by the last day of the invoicing month.~~

~~(c) If a qualified employer makes a payment for less than the full amount due, the payment will be allocated first to the coverage providing health benefits and then to coverage providing dental benefits, if any.~~

~~(d) In any month after a qualified employer has paid its initial month's premium in full, if a qualified employer does not pay its premium pursuant to meet the requirements in subdivision (b) of this section, the SHOP will, on the day following the due date of the invoice, mail a notice of delinquency to the qualified employer that shows the past due balance, informs the qualified employer of any applicable grace period pursuant to Section 10273.4(a)(1) of the California Insurance Code and Section 1365(a)(1) of the California Health and Safety Code, and of the qualified employer's right to appeal.~~

~~Note: Authority: Section 100504, Government Code. Reference: Sections 100502 and 10503, Government Code; and 45 CFR Sections 155.705, 155.720 and 156.285.~~

~~§ 6532. Employer Payment of Premiums.~~

~~(a) Upon completion of the initial employee open enrollment period by all of the qualified employees of a qualified employer, the SHOP will send an invoice to the qualified employer for the premium amount due for all of that qualified employer's qualified employees.~~

~~(1) A qualified employer's first full payment must be delivered to the SHOP or postmarked by the due date indicated on the invoice.~~

~~(2) If a qualified employer's first full payment is not delivered to the SHOP or postmarked by the due date on the invoice, the SHOP will cancel the application of that qualified employer and the applications of that employer's qualified employees.~~

~~(b) Once coverage is effective, the SHOP will send invoices to qualified employers on the 15th of the month, or the following business day if the 15th falls on a weekend or holiday, for health insurance coverage for the following month. Payment must be delivered to the SHOP or postmarked by the last day of the invoicing month.~~

~~(1) A qualified employer's monthly premium payment must be delivered to the SHOP or postmarked by the last day of the invoicing month.~~

~~(2) After the first invoice, the qualified employer must make a monthly premium payment of no less than 85 percent of the total balance due, including any amounts past due, by the due date on the invoice.~~

(c) If a qualified employer makes a payment for less than the full amount due, the payment will be allocated ~~first to the coverage providing~~ by the total percentage paid across all amounts due for health benefits and ~~then to coverage providing~~ dental benefits, if any.

(d) In any month after a qualified employer has paid its initial month's premium ~~in full~~, if a qualified employer does not pay its premium pursuant to subdivision (b) of this section, the SHOP will, on the day following the due date of the invoice, mail a notice of delinquency to the qualified employer that shows the past due balance, informs the qualified employer of any applicable grace period pursuant to Section 10273.4(a)(1) of the California Insurance Code and Section 1365(a)(1) of the California Health and Safety Code, the effective date of termination if payment is not received during this grace period, and of the qualified employer's right to appeal.

(e) In any month after a qualified employer has paid its initial month's premium, if a qualified employer does not pay its premium pursuant to subdivision (b), the SHOP may apply a late penalty fee pursuant to the terms in the Covered California group supplement agreement with the employer.

(f) If a qualified employer makes a premium payment via check that is returned unpaid for any reason the SHOP shall apply a \$25.00 insufficient funds fee.

Note: Authority: Section 100504, Government Code. Reference: Sections 100502 and 10503, Government Code; and 45 CFR Sections 155.705, 155.720 and 156.285.

§ 6534. Coverage Effective Dates for Special Enrollment Periods.

(a) Except as specified in subdivision (b) of this section, coverage effective dates for special enrollment periods for a QHP or QDP selection received by the Exchange from a qualified employee:

(1) Shall be no later than the first day of the following month for applications received between the first and fifteenth day of any month, or

(2) Shall be no later than the first day of the second following month for applications received between the sixteenth and last day of any month.

(b) 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, coverage is effective for that enrollee on the date of birth, adoption, placement for adoption, or placement in foster care, or on the first day of the following month if requested by the enrollee;

(2) In the case of marriage, domestic partnership or where a qualified employee loses Minimum Essential Coverage, as described in Section 6530(~~ab~~)(1), coverage is effective for that qualified employee or dependent on the first day of the month following the date of the marriage, domestic partnership, or loss of Minimum Essential Coverage; and

(3) In the case of a qualified employee or dependent eligible for a special enrollment period as described in Section 6530(ab)(34) and 6530(ab)(45), the coverage is effective on either

(A) The date of the event that triggered the special enrollment period under Section 6530(ab)(34) or 6530(ab)(45), or

(B) In accordance with subdivision (a) of this section, whichever is the least financially burdensome on the enrollee, as determined by the Exchange.

Note: Authority: Section 100504, Government Code. Reference: Sections 100502 and 10503, Government Code; and 45 CFR Sections 155.725 and 156.285.

§ 6536. Coverage Effective Dates for Qualified Employees.

(a) If the ~~full~~-premium payment from a qualified employer is made pursuant to Section 6520(b)(10) for all of its qualified employees and their dependents who selected coverage and is delivered to the SHOP or postmarked by the last calendar day of the month, the effective dates of coverage for qualified employees and dependents who selected QHPs during the initial employee open enrollment shall be the first day of the following month.

(b) The effective date of coverage for a qualified employee who selected a QHP during the employee's annual open enrollment period shall be the first day of the following plan year if the qualified employer has elected to offer coverage during its annual election of coverage period pursuant to Section 6526(d).

(c) The effective date of coverage for a qualified employee described in Section 6528(h) shall be the first day of the month following the month in which the employee became a qualified employee.

Note: Authority: Section 100504, Government Code. Reference: Sections 100502 and 10503, Government Code; and 45 CFR Sections 155.720, 155.725 and 156.285.

§ 6538. Disenrollment and Termination.

(a) A qualified employer may terminate coverage during the plan year for its qualified employees and their dependents at the end of each month with at least a 30-day notice to the SHOP, as fully set forth in subdivision (e) of this section. If a qualified employer terminates coverage through the SHOP, the SHOP must:

(1) Ensure that each QHP terminates the coverage of the qualified employer's qualified employees enrolled in the QHP through the SHOP; and

(2) Send a notice to each of the qualified employer's qualified employees enrolled in a QHP through the SHOP prior to the effective date of termination specified in subdivision (e) of this section. Such notification must provide information about other potential sources of coverage, including access to individual market coverage through the Exchange.

(b) A qualified employer must request that the SHOP or QHP terminate the coverage of a qualified employee or dependent upon receiving written request by the qualified employee.

(c) The SHOP may initiate termination of a qualified employee's coverage in a QHP or a dependent's coverage in a QHP, and shall permit a QHP issuer to terminate such coverage provided that the QHP issuer makes reasonable accommodations for all individuals with disabilities (as defined by the Americans with Disabilities Act) and complies with any and all requirements for cancellations, rescissions, and nonrenewals pursuant to Health and Safety Code section 1365 and Insurance Code section 10273.4 and relevant state regulations before terminating coverage for such individuals, under the following circumstances:

- (1) The qualified employee or dependent is no longer eligible for coverage in a QHP;
- (2) The qualified employer fails to pay premiums for coverage, as specified in Section 6532 and any applicable grace period has been exhausted;
- (3) The qualified employee's or the qualified employee's dependent coverage is rescinded by the QHP issuer in compliance with Health and Safety Code Section 1389.21 or California Insurance Code Section 10384.17;
- (4) The QHP terminates or is decertified as described in 45 CFR § 155.1080 (May 29, 2012), hereby incorporated by reference; except for those eligible for enrollment in a similar plan as determined by the SHOP, on a case-by-case basis, pursuant to Section 6528(g);
- (5) The qualified employee changes from one QHP to another QHP during an annual employee open enrollment period or special enrollment period in accordance with Sections 6528 and 6530;
- (6) Upon the death of the qualified employee or a dependent of a qualified employee;
- (7) The qualified employee chooses not to remain enrolled in the QHP at open enrollment;
- (8) The qualified employee is no longer an employee or a dependent; and
- (9) The qualified employee is newly eligible for Medi-Cal or CHIP, but only if the qualified employee or dependent requests coverage to be terminated.
- (10) The qualified employer is ineligible to participate in the SHOP because it has lost its eligibility pursuant to Section 6522.

(d) If a QHP issuer terminates coverage pursuant to subdivision (c)(2) and (4) of this section, the QHP issuer must comply with Section 10273.4 of the California Insurance Code and Section 1365 of the California Health and Safety Code, and relevant state regulations.

(e) Effective Dates of Termination

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

(A) The end of the month in which the qualified employer provided notice of termination, if the qualified employer provides at least a 30-day notice to the SHOP; or

(B) If the qualified employer does not provide at least a 30-day notice to the SHOP, the last day of the month following the month in which the qualified employer gave notice of termination.

(2) In the case of a termination in accordance with subdivision (b) of this section, the effective date of termination shall be 14 days after the date of the request or the date requested by the qualified employee, whichever is later, or upon agreement between the QHP and the qualified employee.

(3) In the case of a termination in accordance with subdivision (c)(1) of this section, the last day of coverage shall be the last day of the month in which the qualified employee's eligibility or the eligibility of a qualified employee's dependent ceased.

(4) In the case of a termination in accordance with subdivision (c)(2) of this section, the last day of coverage shall be consistent with the grace periods in Section 10273.4 of the California Insurance Code and Section 1365 of the California Health and Safety Code, and relevant state regulations.

(5) In the case of a termination in accordance with subdivision (c)(3) of this section, the last day of coverage shall be the day prior to the day the fraud or misrepresentation occurred.

(6) In the case of a termination in accordance with subdivision (c)(4) of this section, the last day of coverage shall be the day before the QHP was decertified or terminated, or the day on which the issuer has met the requirements in Health and Safety Code 1365(a)(5) and (6) or Insurance Code 10273.4(d) or (e), whichever is later.

(7) In the case of a termination in accordance with subdivision (c)(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.

(8) In the case of a termination in accordance with subdivision (c)(6) of this section, the last day of coverage shall be the date of death.

(9) In the case of a termination in accordance with subdivision (c)(7) of this section, the last day of coverage shall be the last day of the qualified employer's plan year.

(10) In the case of a termination in accordance with subdivision (c)(8) of this section, the last day of coverage shall be the last day of the month in which the employee or dependent ceased being an employee or dependent.

(11) In the case of a termination in accordance with subdivision (c)(9), the effective date of termination of coverage shall be the day before such other coverage begins.

(f) If a qualified employee's coverage or the coverage of a qualified employee's dependent is terminated pursuant to subdivision (b) of this section, the SHOP shall promptly provide the qualified employee or qualified employee's dependent with a notice of termination of coverage that includes the termination effective date and reason for termination.

(g) Notice of termination:

(1) Except as provided in subdivision (g)(3) of this section, if any enrollee's coverage or enrollment through the SHOP is terminated due to non-payment of premiums or due to a loss of the enrollee's eligibility to participate in the SHOP, including where an enrollee loses his or her eligibility because a qualified employer has lost its eligibility, the SHOP must notify the enrollee of the termination. Such notice must include the termination effective date and reason for termination, and must be sent within 3 business days if an electronic notice is sent, and within 5 business days if a mailed hard copy notice is sent.

(2) Except as provided in subdivision (g)(3) of this section, if an employer group's coverage or enrollment through the SHOP is terminated due to non-payment of premiums or, where applicable, due to a loss of the qualified employer's eligibility to offer coverage through the SHOP, the SHOP must notify the employer of the termination. Such notice must include the termination effective date and reason for termination, and must be sent within 3 business days if an electronic notice is sent, and within 5 business days if a mailed hard copy notice is sent.

(3) Where State law requires a QHP issuer to send the notices described in subdivisions (g)(1) and (g)(2) of this section, a SHOP is not required to send such notices.

(4) When a primary subscriber and his or her dependents live at the same address, a separate termination notice need not be sent to each dependent at that address, provided that the notice sent to each primary subscriber at that address contains all required information about the termination for the primary subscriber and his or her dependents at that address.

Note: Authority: Section 100504, Government Code. Reference: Sections 100502 and 10503, Government Code; and 45 CFR Sections 155.720, 155.725, 155.735 and 156.285.

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 Covered California	CONTACT PERSON Brandon Ross	TELEPHONE NUMBER 916-228-8281
DESCRIPTIVE TITLE FROM NOTICE REGISTER OR FORM 400 SHOP Eligibility and Enrollment Process		NOTICE FILE NUMBER 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: _____

ECONOMIC AND FISCAL IMPACT STATEMENT cont. (STD. 399, Rev. 12/2008)

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.

ECONOMIC AND FISCAL IMPACT STATEMENT cont. (STD. 399, Rev. 12/2008)

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 boxes 1 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 _____ Governor's Budget for appropriation in Budget Act of _____
(FISCAL YEAR)

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 _____
election; (DATE)

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 _____ authorized by Section
(FEES, REVENUE, ETC.)
_____ 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)

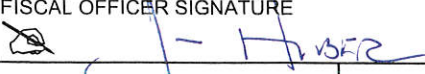

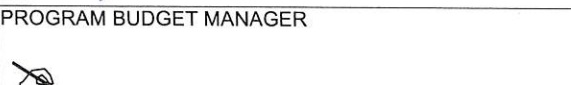

5. No fiscal impact exists because this regulation does not affect any local entity or program.
6. Other.

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 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.
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 9/26/2013	
AGENCY SECRETARY ¹ APPROVAL/CONCURRENCE 	PROGRAM BUDGET MANAGER 	DATE 9/12/13
DEPARTMENT OF FINANCE ² APPROVAL/CONCURRENCE 		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.*

FISCAL IMPACT STATEMENT

Section B – Fiscal Effect on State Government

4. Covered California (CC) contracted with an external vendor to administer the SHOP eligibility and enrollment program. As Attachment B indicates, the estimated cost impact to CC is \$4.8 million in FY 2014-15, and \$9.3 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. Covered California (CC) contracted with an external vendor to administer the SHOP eligibility and enrollment program. 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 \$6.8 million in FY 2013-14 and \$5.8 million in FY 2014-15.

COVERED CALIFORNIA
SHOP ELIGIBILITY & ENROLLMENT
EMERGENCY RULEMAKING
FISCAL ANALYSIS

ATTACHMENT B

FY 2013-14	MONTHLY x 3		MONTHLY x 4			FY 2013-14 TOTAL	
	MONTHLY	CY 2013 OCT-DEC	MONTHLY	CY 2014 JAN-APR	MAY		JUN
BASE OPERATIONS	\$ 600,000	\$ 1,800,000	\$ 600,000	\$ 2,400,000	\$ 600,000	\$ 600,000	\$ 5,400,000
PMPM FEE CALCULATION							
ENROLLMENT EST (ORIGINAL)			28,800		52,800		76,800
ENROLLMENT EST (REVISED) @ 50%			14,400		26,400		38,400
PMPM RATE PAY TO CONTRACTOR			\$ 14.70		\$ 9.00		\$ 9.00
PMPM FEE (REV EST x PMPM RATE)			\$ 211,680	\$ 846,720	\$ 237,600	\$ 345,600	\$ 1,429,920
						State Costs	\$ -
						Federal Costs	\$ 6,829,920
			TOTAL COSTS (BASE OPERATIONS + PMPM FEE)				\$ 6,829,920

FY 2014-15	MONTHLY x 5		MONTHLY x 6			FY 2014-15 TOTAL	
	MONTHLY	CY 2014 JUL-NOV	DEC	MONTHLY	CY 2015 JAN-JUN		
BASE OPERATIONS	\$ 600,000	\$ 3,000,000	\$ 600,000	\$ 550,000	\$ 3,300,000	\$ 6,900,000	
PMPM FEE CALCULATION							
ENROLLMENT EST (ORIGINAL)	76,800		96,000	96,000			
ENROLLMENT EST (REVISED) @ 50%	38,400		48,000	48,000			
PMPM RATE PAY TO CONTRACTOR	\$ 9.00		\$ 9.00	\$ 5.15			
PMPM FEE (REV EST x PMPM RATE)	\$ 345,600	\$ 1,728,000	\$ 432,000	\$ 247,200	\$ 1,483,200	\$ 3,643,200	\$ 3,643,200
						State Costs (effective 1/1/15)	\$ 4,783,200
						Federal Costs	\$ 5,760,000
			TOTAL COSTS (BASE OPERATIONS + PMPM FEE)				\$ 10,543,200

FY 2015-16	MONTHLY x 6		MONTHLY x 6		FY 2015-16 TOTAL	
	MONTHLY	JUL-DEC	MONTHLY	JAN-JUN		
BASE OPERATIONS	\$ 550,000	\$ 3,300,000	\$ 550,000	\$ 3,300,000	\$ 6,600,000	
PMPM FEE CALCULATION						
ENROLLMENT EST (ORIGINAL)	96,000		96,000			
ENROLLMENT EST (REVISED) @ 50%	48,000		48,000			
PMPM RATE PAY TO CONTRACTOR	\$ 5.15		\$ 4.35			
PMPM FEE (REV EST x PMPM RATE)	\$ 247,200	\$ 1,483,200	\$ 208,800	\$ 1,252,800	\$ 2,736,000	
					State Costs	\$ 9,336,000
					Federal Costs	\$ -
			TOTAL COSTS (BASE OPERATIONS + PMPM FEE)			\$ 9,336,000

SUMMARY	FY 2013-14	FY 2014-15	FY 2015-16
State Costs (effective 1/1/15)	\$ -	\$ 4,783,200	\$ 9,336,000
Federal Costs	\$ 6,829,920	\$ 5,760,000	\$ -
GRAND TOTAL COSTS	\$ 6,829,920	\$ 10,543,200	\$ 9,336,000

Notes:

1. Revised Enrollment Estimates assume 50% less than originally anticipated.
2. Cost for Base Operations and PMPM Fee based on provisions in the contract.
3. Calculations do not include Bonus Payments.