State of California
Office of Administrative Law

In re:
California Health Benefit Exchange

Regulatory Action:

Title 10, California Code of Regulations

Adopt sections: 6520, 6522, 6524, 6528, 6530, 6532, 6534, 6536, 6538
Amend sections:
Repeal sections:

NOTICE OF APPROVAL OF EMERGENCY REGULATORY ACTION

Government Code Sections 100504, 11346.1, and 11349.6

OAL Matter Number: 2016-1116-03

OAL Matter Type: Emergency Readopt (EE)

The California Health Benefit Exchange submitted this emergency readoption action to amend nine sections adopted in title 10 of the California Code of Regulations in OAL file nos. 2013-0920-05E, 2014-0321-01EE, 2014-0620-06EE, 2014-0922-02EE, and 2016-0926-04EE. The regulations establish criteria and procedures for qualified employers and qualified employees to enroll in health coverage under the Small Business Health Options Program (SHOP), a program that is required under both federal and state law to implement the federal Patient and Protection and Affordable Care Act. The amendments modify SHOP regulations to reflect changes in state and federal laws, simplify and modify program requirements to reflect best practices in the SHOP, and clean up language for improved clarity.

OAL approves this emergency regulatory action pursuant to sections 11346.1 and 11349.6 of the Government Code.

This emergency regulatory action is effective on 11/28/2016 and will expire on 10/2/2018. The Certificate of Compliance for this action is due no later than 10/1/2018.

Date: November 28, 2016

Richard L. Smith
Richard L. Smith
Senior Attorney

For: Debra M. Cornez
Director

Original: Peter Lee
Copy: Gabriela Ventura Gonzales

STATE OF CALIFORNIA—OFFICE OF ADMINISTRATIVE LAW

NOTICE PUBLICATION/REGULATIONS SUBMISSION EMERGENCY (See instructions on reverse)

STD. 400 (REV. 01-2013)

For use by Secretary of State only

ENDORSED - FILED
in the office of the Secretary of State
of the State of California
NOV 28 2016
1:40 P.M.

OAL FILE NUMBERS	NOTICE FILE NUMBER	REGULATORY ACTION NUMBER	EMERGENCY NUMBER
	Z-		2016-1116-03EE

For use by Office of Administrative Law (OAL) only

2016 NOV 16 P 3:06
OFFICE OF ADMINISTRATIVE LAW

NOTICE | REGULATIONS

AGENCY WITH RULEMAKING AUTHORITY
California Health Benefit Exchange

AGENCY FILE NUMBER (If any)

A. PUBLICATION OF NOTICE (Complete for publication in Notice Register)

1. SUBJECT OF NOTICE	TITLE(S)	FIRST SECTION AFFECTED	2. REQUESTED PUBLICATION DATE

3. NOTICE TYPE	4. AGENCY CONTACT PERSON	TELEPHONE NUMBER	FAX NUMBER (Optional)
☐ Notice re Proposed Regulatory Action ☐ Other			

OAL USE ONLY	ACTION ON PROPOSED NOTICE	NOTICE REGISTER NUMBER	PUBLICATION DATE
	☐ Approved as Submitted ☐ Approved as Modified ☐ Disapproved/ Withdrawn		

B. SUBMISSION OF REGULATIONS (Complete when submitting regulations)

1a. SUBJECT OF REGULATION(S)
SHOP Eligibility and Enrollment Process

1b. ALL PREVIOUS RELATED OAL REGULATORY ACTION NUMBER(S)
2013-0920-05E; 2014-0321-01EE, 2014-0620-06EE;

2. SPECIFY CALIFORNIA CODE OF REGULATIONS TITLE(S) AND SECTION(S) (Including title 26, if toxics related)

SECTION(S) AFFECTED (List all section number(s) individually. Attach additional sheet if needed.)

ADOPT
6520, 6522, 6524, 6528, 6530, 6532, 6534, 6536, 6538

2014-0922-02EE
2016-0926-04EE
per agency request

AMEND
~~6520, 6522, 6524, 6526, 6528, 6530, 6532, 6534, 6536, 6538~~ per agency request

TITLE(S)
10

REPEAL

3. TYPE OF FILING

- ☐ Regular Rulemaking (Gov. Code §11346)
- ☐ Resubmittal of disapproved or withdrawn nonemergency filing (Gov. Code §§11349.3, 11349.4)
- ☐ Emergency (Gov. Code, §11346.1(b))
- ☐ Certificate of Compliance: The agency officer named below certifies that this agency complied with the provisions of Gov. Code §§11346.2-11347.3 either before the emergency regulation was adopted or within the time period required by statute.
- ☐ Resubmittal of disapproved or withdrawn emergency filing (Gov. Code, §11346.1)
- ☒ Emergency Readopt (Gov. Code, §11346.1(h))
- ☐ File & Print
- ☐ Other (Specify) _____
- ☐ Changes Without Regulatory Effect (Cal. Code Regs., title 1, §100)
- ☐ Print Only

4. ALL BEGINNING AND ENDING DATES OF AVAILABILITY OF MODIFIED REGULATIONS AND/OR MATERIAL ADDED TO THE RULEMAKING FILE (Cal. Code Regs. title 1, §44 and Gov. Code §11347.1)

5. EFFECTIVE DATE OF CHANGES (Gov. Code, §§ 11343.4, 11346.1(d); Cal. Code Regs., title 1, §100)

- ☐ Effective January 1, April 1, July 1, or October 1 (Gov. Code §11343.4(a))
- ☒ Effective on filing with Secretary of State
- ☐ §100 Changes Without Regulatory Effect
- ☐ Effective other (Specify) _____

6. CHECK IF THESE REGULATIONS REQUIRE NOTICE TO, OR REVIEW, CONSULTATION, APPROVAL OR CONCURRENCE BY, ANOTHER AGENCY OR ENTITY

- ☐ Department of Finance (Form STD. 399) (SAM §6660)
- ☐ Fair Political Practices Commission
- ☐ State Fire Marshal
- ☐ Other (Specify) _____

7. CONTACT PERSON	TELEPHONE NUMBER	FAX NUMBER (Optional)	E-MAIL ADDRESS (Optional)
Gabriela Ventura-Gonzales	916-228-8477		gabriela.ventura@covered.ca.gov

8. **I certify that the attached copy of the regulation(s) is a true and correct copy of the regulation(s) identified on this form, that the information specified on this form is true and correct, and that I am the head of the agency taking this action, or a designee of the head of the agency, and am authorized to make this certification.**

SIGNATURE OF AGENCY HEAD OR DESIGNEE — DATE: 10/31/16

TYPED NAME AND TITLE OF SIGNATORY
Peter V. Lee, Executive Director

For use by Office of Administrative Law (OAL) only

ENDORSED APPROVED
NOV 28 2016
Office of Administrative Law

Adopt Article 6, Sections 6520, 6522, 6524, 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

§ 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 (FTE) employees employed by the qualified employer, as calculated in accordance with Health and Safety Code Section 1357.500(k)(3) and Insurance Code Section 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 spouses, registered or non-registered domestic partners 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 Section 1389.8 and Insurance Code Section 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;~~

(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~~employer's plan selection for a tier of health insurance coverage or for two contiguous tiers of health insurance coverage, pursuant to 45 CFR ~~§~~Section 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 FTE employees and has a principal business address in California;

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

(3) That the business has at least one employee who is not the owner or business partner, or the spouse of the owner or business partner;

(~~1~~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;

(~~2~~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 Section 155.285 (September 6, 2016), hereby incorporated by reference;

(~~3~~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. §Section 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 of 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;

(~~12~~15) 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;

(~~13~~17) That the qualified employer understands that the attestations in this section are subject to audit by the SHOP at any time; and

(~~14~~18) 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 ~~and~~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 spouses or non-registered domestic partners, 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~~A) ~~The~~The first and last name of each spouse or non-registered domestic partner, and/or each dependent child, their 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

(~~C~~B) 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~~6) 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 Section 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 §Section 155.260 (September 6, 2016), hereby incorporated by reference, 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.

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-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. §Section 1396 et seq., or Medicare pursuant to 42 U.S.C. §Section 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~~10)(C).

(b) An employer that otherwise meets the criteria of this section except for ~~subdivision~~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 subdivision (a) of this section and makes the election described in subdivision (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.

§ 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.~~

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

(fe) 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.

(gf) 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.

(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 (MEC), 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 her 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.

(~~3~~4) A The **qualified 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;

(4~~5~~) 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;

(~~5~~6) 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 MEC as described in 26 CFR Section 1.5000A-1(b) (December 26, 2013), hereby incorporated by reference, 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

~~(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 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~~(C) Was released from incarceration, 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;

(~~14~~7) 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. Section 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 MEC;

(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~~c) 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~~d) 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~~e) Loss of ~~Minimum Essential Coverage (~~MEC~~)~~, as specified in subdivision (a~~b~~)(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)(2)(November 26, 2014), hereby incorporated by reference;

(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.

(ef) 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.

(g) 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).

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

(i) Limitation. Qualified employees will not be able to enroll unless the employer group meets any applicable minimum participation rules 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 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.~~

(2) If a qualified employer's first payment does not meet the requirements in subdivision (a)(1), 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(~~a~~b)(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~~MEC; and

(3) In the case of a qualified employee or dependent eligible for a special enrollment period as described in Section 6530(~~a~~b)(~~3~~4) and 6530(~~a~~b)(45), the coverage is effective on either

(A) The date of the event that triggered the special enrollment period under Section 6530(~~a~~b)(~~3~~4) or 6530(~~a~~b)(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 §Section 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~~.~~; and

(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 three (3) business days if an electronic notice is sent, and within five (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 three (3) business days if an electronic notice is sent, and within five (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.

45 CFR §155.285 Bases and process for imposing civil penalties for provision of false or fraudulent information to an Exchange or improper use or disclosure of information.

(a) *Grounds for imposing civil money penalties.* (1) HHS may impose civil money penalties on any person, as defined in paragraph (a)(2) of this section, if, based on credible evidence, HHS reasonably determines that a person has engaged in one or more of the following actions:

(i) Failure to provide correct information under section 1411(b) of the Affordable Care Act where such failure is attributable to negligence or disregard of any rules or regulations of the Secretary with negligence and disregard defined as they are in section 6662 of the Internal Revenue Code of 1986:

(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 rules or regulations of the Secretary.

(ii) Knowing and willful provision of false or fraudulent information required under section 1411(b) of the Affordable Care Act, where knowing and willful means the intentional provision of information that the person knows to be false or fraudulent; or

(iii) Knowing and willful use or disclosure of information in violation of section 1411(g) of the Affordable Care Act, where knowing and willful means the intentional use or disclosure of information in violation of section 1411(g). Such violations would include, but not be limited to, the following:

(A) Any use or disclosure performed which violates relevant privacy and security standards established by the Exchange pursuant to §155.260;

(B) Any other use or disclosure which has not been determined by the Secretary to be in compliance with section 1411(g)(2)(A) of the Affordable Care Act pursuant to §155.260(a); and

(C) Any other use or disclosure which is not necessary to carry out a function described in a contract with a non-Exchange entity executed pursuant to §155.260(b)(2).

(2) For purposes of this section, the term "person" is defined to include, but is not limited to, all individuals; corporations; Exchanges; Medicaid and CHIP agencies; other entities gaining access to personally identifiable information submitted to an Exchange to carry out additional functions which the Secretary has determined ensure the efficient operation of the Exchange pursuant to §155.260(a)(1); and non-Exchange entities as defined in §155.260(b) which includes agents, brokers, Web-brokers, QHP issuers, Navigators, non-Navigator assistance personnel, certified application counselors, in-person assistors, and other third party contractors.

(b) *Factors in determining the amount of civil money penalties imposed.* In determining the amount of civil money penalties, HHS may take into account factors which include, but are not limited to, the following:

(1) The nature and circumstances of the conduct including, but not limited to:

(i) The number of violations;

(ii) The severity of the violations;

(iii) The person's history with the Exchange including any prior violations that would indicate whether the violation is an isolated occurrence or represents a pattern of behavior;

(iv) The length of time of the violation;

(v) The number of individuals affected or potentially affected;

(vi) The extent to which the person received compensation or other consideration associated with the violation;

(vii) Any documentation provided in any complaint or other information, as well as any additional information provided by the individual to refute performing the violation; and

(viii) Whether other remedies or penalties have been imposed for the same conduct or occurrence.

(2) The nature of the harm resulting from, or reasonably expected to result from, the violation, including but not limited to:

(i) Whether the violation resulted in actual or potential financial harm;

(ii) Whether there was actual or potential harm to an individual's reputation;

(iii) Whether the violation hindered or could have hindered an individual's ability to obtain health insurance coverage;

(iv) [Reserved]

(v) The actual or potential impact of the provision of false or fraudulent information or of the improper use or disclosure of the information; and

(vi) Whether any person received a more favorable eligibility determination for enrollment in a QHP or insurance affordability program, such as greater advance payment of the premium tax credits or cost-sharing reductions than he or she would be eligible for if the correct information had been provided.

(3) No penalty will be imposed under paragraph (a)(1)(i) of this section if HHS determines that there was a reasonable cause for the failure to provide correct information required under section 1411(b) of the Affordable Care Act and that the person acted in good faith.

(c) *Maximum penalty.* The amount of a civil money penalty will be determined by HHS in accordance with paragraph (b) of this section.

(1) The following provisions provide maximum penalties for a single "plan year," where "plan year" has the same meaning as at §155.20:

(i) Any person who fails to provide correct information as specified in paragraph (a)(1)(i) of this section may be subject to a maximum civil money penalty of $25,000 as adjusted annually under 45 CFR part 102 for each application, as defined at paragraph (c)(1)(iii) of this section, pursuant to which a person fails to provide correct information.

(ii) Any person who knowingly and willfully provides false information as specified in paragraph (a)(1)(ii) of this section may be subject to a maximum civil money penalty of $250,000 as adjusted annually under 45 CFR part 102 for each application, as defined at paragraph (c)(1)(iii) of this section, on which a person knowingly and willfully provides false information.

(iii) For the purposes of this subsection, "application" is defined as a submission of information, whether through an online portal, over the telephone through a call center, or through a paper submission process, in which the information is provided in relation to an eligibility determination; an eligibility redetermination based on a change in an individual's circumstances; or an annual eligibility redetermination for any of the following:

(A) Enrollment in a qualified health plan;

(B) Premium tax credits or cost sharing reductions; or

(C) An exemption from the individual shared responsibility payment.

(2) Any person who knowingly or willfully uses or discloses information as specified in paragraph (a)(1)(iii) of this section may be subject to the following civil money penalty:

(i) A civil money penalty for each use or disclosure described in paragraph (a)(1)(iii) of this section of not more than $25,000 as adjusted annually under 45 CFR part 102 per use or disclosure.

(ii) For purposes of paragraph (c) of this section, a use or disclosure includes one separate use or disclosure of a single individual's personally identifiable information where the person against whom a civil money penalty may be imposed has made the use or disclosure.

(3) These penalties may be imposed in addition to any other penalties that may be prescribed by law.

(d) *Notice of intent to issue civil money penalty.* If HHS intends to impose a civil money penalty in accordance with this part, HHS will send a written notice of such intent to the person against whom it intends to impose a civil money penalty.

(1) This written notice will be either hand delivered, sent by certified mail, return receipt requested, or sent by overnight delivery service with signature upon delivery required. The written notice must include the following elements:

(i) A description of the findings of fact regarding the violations with respect to which the civil money penalty is proposed;

(ii) The basis and reasons why the findings of fact subject the person to a penalty;

(iii) Any circumstances described in paragraph (b) of this section that were considered in determining the amount of the proposed penalty;

(iv) The amount of the proposed penalty;

(v) An explanation of the person's right to a hearing under any applicable administrative hearing process;

(vi) A statement that failure to request a hearing within 60 calendar days after the date of issuance printed on the notice permits the assessment of the proposed penalty; and

(vii) Information explaining how to file a request for a hearing and the address to which the hearing request must be sent.

(2) The person may request a hearing before an ALJ on the proposed penalty by filing a request in accordance with the procedure to file an appeal specified in paragraph (f) of this section.

(e) *Failure to request a hearing.* If the person does not request a hearing within 60 calendar days of the date of issuance printed on the notice described in paragraph (d) of this section, HHS may impose the proposed civil money penalty.

(1) HHS will notify the person in writing of any penalty that has been imposed, the means by which the person may satisfy the penalty, and the date on which the penalty is due.

(2) A person has no right to appeal a penalty with respect to which the person has not timely requested a hearing in accordance with paragraph (d) of this section.

(f) *Appeal of proposed penalty.* Subject to paragraph (e)(2) of this section, any person against whom HHS proposed to impose a civil money penalty may appeal that penalty in accordance with the rules and procedures outlined at 45 CFR part 150, subpart D, excluding §§150.461, 150.463, and 150.465.

(g) *Enforcement authority*—(1) *HHS.* HHS may impose civil money penalties up to the maximum amounts specified in paragraph (d) of this section for any of the violations described in paragraph (a) of this section.

(2) *OIG.* In accordance with the rules and procedures of 42 CFR part 1003, and in place of imposition of penalties by CMS, the OIG may impose civil money penalties for violations described in paragraph (a)(1)(ii) of this section.

(h) *Settlement authority.* Nothing in this section limits the authority of HHS to settle any issue or case described in the notice furnished in accordance with §155.285(d) or to compromise on any penalty provided for in this section.

(i) *Limitations.* No action under this section will be entertained unless commenced, in accordance with §155.285(d), within 6 years from the date on which the violation occurred.

[79 FR 30346, May 27, 2014, as amended at 81 FR 61581, Sept. 6, 2016]

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45 CFR §155.260 Privacy and security of personally identifiable information.

(a) *Creation, collection, use and disclosure.* (1) Where the Exchange creates or collects personally identifiable information for the purposes of determining eligibility for enrollment in a qualified health plan; determining eligibility for other insurance affordability programs, as defined in §155.300; or determining eligibility for exemptions from the individual shared responsibility provisions in section 5000A of the Code, the Exchange may only use or disclose such personally identifiable information to the extent such information is necessary:

(i) For the Exchange to carry out the functions described in §155.200;

(ii) For the Exchange to carry out other functions not described in paragraph (a)(1)(i) of this section, which the Secretary determines to be in compliance with section 1411(g)(2)(A) of the Affordable Care Act and for which an individual provides consent for his or her information to be used or disclosed; or

(iii) For the Exchange to carry out other functions not described in paragraphs (a)(1)(i) and (ii) of this section, for which an individual provides consent for his or her information to be used or disclosed, and which the Secretary determines are in compliance with section 1411(g)(2)(A) of the Affordable Care Act under the following substantive and procedural requirements:

(A) *Substantive requirements.* The Secretary may approve other uses and disclosures of personally identifiable information created or collected as described in paragraph (a)(1) of this section that are not described in paragraphs (a)(1)(i) or (ii) of this section, provided that HHS determines that the information will be used only for the purposes of and to the extent necessary in ensuring the efficient operation of the Exchange consistent with section 1411(g)(2)(A) of the Affordable Care Act, and that the uses and disclosures are also permissible under relevant law and policy.

(B) *Procedural requirements for approval of a use or disclosure of personally identifiable information.* To seek approval for a use or disclosure of personally identifiable information created or collected as described in paragraph (a)(1) of this section that is not described in paragraphs (a)(1)(i) or (ii) of this section, the Exchange must submit the following information to HHS:

(*1*) Identity of the Exchange and appropriate contact persons;

(*2*) Detailed description of the proposed use or disclosure, which must include, but not necessarily be limited to, a listing or description of the specific information to be used or disclosed and an identification of the persons or entities that may access or receive the information;

(*3*) Description of how the use or disclosure will ensure the efficient operation of the Exchange consistent with section 1411(g)(2)(A) of the Affordable Care Act; and

(*4*) Description of how the information to be used or disclosed will be protected in compliance with privacy and security standards that meet the requirements of this section or other relevant law, as applicable.

(2) The Exchange may not create, collect, use, or disclose personally identifiable information unless the creation, collection, use, or disclosure is consistent with this section.

(3) The Exchange must establish and implement privacy and security standards that are consistent with the following principles:

(i) *Individual access.* Individuals should be provided with a simple and timely means to access and obtain their personally identifiable information in a readable form and format;

(ii) *Correction.* Individuals should be provided with a timely means to dispute the accuracy or integrity of their personally identifiable information and to have erroneous information corrected or to have a dispute documented if their requests are denied;

(iii) *Openness and transparency.* There should be openness and transparency about policies, procedures, and technologies that directly affect individuals and/or their personally identifiable

information;

(iv) *Individual choice.* Individuals should be provided a reasonable opportunity and capability to make informed decisions about the collection, use, and disclosure of their personally identifiable information;

(v) *Collection, use, and disclosure limitations.* Personally identifiable information should be created, collected, used, and/or disclosed only to the extent necessary to accomplish a specified purpose(s) and never to discriminate inappropriately;

(vi) *Data quality and integrity.* Persons and entities should take reasonable steps to ensure that personally identifiable information is complete, accurate, and up-to-date to the extent necessary for the person's or entity's intended purposes and has not been altered or destroyed in an unauthorized manner;

(vii) *Safeguards.* Personally identifiable information should be protected with reasonable operational, administrative, technical, and physical safeguards to ensure its confidentiality, integrity, and availability and to prevent unauthorized or inappropriate access, use, or disclosure; and,

(viii) *Accountability.* These principles should be implemented, and adherence assured, through appropriate monitoring and other means and methods should be in place to report and mitigate non-adherence and breaches.

(4) For the purposes of implementing the principle described in paragraph (a)(3)(vii) of this section, the Exchange must establish and implement operational, technical, administrative and physical safeguards that are consistent with any applicable laws (including this section) to ensure—

(i) The confidentiality, integrity, and availability of personally identifiable information created, collected, used, and/or disclosed by the Exchange;

(ii) Personally identifiable information is only used by or disclosed to those authorized to receive or view it;

(iii) Return information, as such term is defined by section 6103(b)(2) of the Code, is kept confidential under section 6103 of the Code;

(iv) Personally identifiable information is protected against any reasonably anticipated threats or hazards to the confidentiality, integrity, and availability of such information;

(v) Personally identifiable information is protected against any reasonably anticipated uses or disclosures of such information that are not permitted or required by law; and

(vi) Personally identifiable information is securely destroyed or disposed of in an appropriate and reasonable manner and in accordance with retention schedules;

(5) The Exchange must monitor, periodically assess, and update the security controls and related system risks to ensure the continued effectiveness of those controls.

(6) The Exchange must develop and utilize secure electronic interfaces when sharing personally identifiable information electronically.

(b) *Application to non-Exchange entities*—(1) *Non-Exchange entities.* A non-Exchange entity is any

individual or entity that:

(i) Gains access to personally identifiable information submitted to an Exchange; or

(ii) Collects, uses, or discloses personally identifiable information gathered directly from applicants, qualified individuals, or enrollees while that individual or entity is performing functions agreed to with the Exchange.

(2) Prior to any person or entity becoming a non-Exchange entity, Exchanges must execute with the person or entity a contract or agreement that includes:

(i) A description of the functions to be performed by the non-Exchange entity;

(ii) A provision(s) binding the non-Exchange entity to comply with the privacy and security standards and obligations adopted in accordance with paragraph (b)(3) of this section, and specifically listing or incorporating those privacy and security standards and obligations;

(iii) A provision requiring the non-Exchange entity to monitor, periodically assess, and update its security controls and related system risks to ensure the continued effectiveness of those controls in accordance with paragraph (a)(5) of this section;

(iv) A provision requiring the non-Exchange entity to inform the Exchange of any change in its administrative, technical, or operational environments defined as material within the contract; and

(v) A provision that requires the non-Exchange entity to bind any downstream entities to the same privacy and security standards and obligations to which the non-Exchange entity has agreed in its contract or agreement with the Exchange.

(3) When collection, use or disclosure is not otherwise required by law, the privacy and security standards to which an Exchange binds non-Exchange entities must:

(i) Be consistent with the principles and requirements listed in paragraphs (a)(1) through (6) of this section, including being at least as protective as the standards the Exchange has established and implemented for itself in compliance with paragraph (a)(3) of this section;

(ii) Comply with the requirements of paragraphs (c), (d), (f), and (g) of this section; and

(iii) Take into specific consideration:

(A) The environment in which the non-Exchange entity is operating;

(B) Whether the standards are relevant and applicable to the non-Exchange entity's duties and activities in connection with the Exchange; and

(C) Any existing legal requirements to which the non-Exchange entity is bound in relation to its administrative, technical, and operational controls and practices, including but not limited to, its existing data handling and information technology processes and protocols.

(c) *Workforce compliance.* The Exchange must ensure its workforce complies with the policies and procedures developed and implemented by the Exchange to comply with this section.

(d) *Written policies and procedures.* Policies and procedures regarding the creation collection, use,

and disclosure of personally identifiable information must, at minimum:

(1) Be in writing, and available to the Secretary of HHS upon request; and

(2) Identify applicable law governing collection, use, and disclosure of personally identifiable information.

(e) *Data sharing.* Data matching and sharing arrangements that facilitate the sharing of personally identifiable information between the Exchange and agencies administering Medicaid, CHIP or the BHP for the exchange of eligibility information must:

(1) Meet any applicable requirements described in this section;

(2) Meet any applicable requirements described in section 1413(c)(1) and (c)(2) of the Affordable Care Act;

(3) Be equal to or more stringent than the requirements for Medicaid programs under section 1942 of the Act; and

(4) For those matching agreements that meet the definition of "matching program" under 5 U.S.C. 552a(a)(8), comply with 5 U.S.C. 552a(o).

(f) *Compliance with the Code.* Return information, as defined in section 6103(b)(2) of the Code, must be kept confidential and disclosed, used, and maintained only in accordance with section 6103 of the Code.

(g) *Improper use and disclosure of information.* Any person who knowingly and willfully uses or discloses information in violation of section 1411(g) of the Affordable Care Act will be subject to a CMP of not more than $25,000 as adjusted annually under 45 CFR part 102 per person or entity, per use or disclosure, consistent with the bases and process for imposing civil penalties specified at §155.285, in addition to other penalties that may be prescribed by law.

[77 FR 18444, Mar. 27, 2012, as amended at 77 FR 31515, May 29, 2012; 79 FR 13837, Mar. 11, 2014; 79 FR 30346, May 27, 2014; 81 FR 12341, Mar. 8, 2016; 81 FR 61581, Sept. 6, 2016]

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26 CFR §1.5000A-1 Maintenance of minimum essential coverage and liability for the shared responsibility payment.

(a) *In general.* For each month during the taxable year, a nonexempt individual must have minimum essential coverage or pay the shared responsibility payment. For a month, a nonexempt individual is an individual in existence for the entire month who is not an exempt individual described in §1.5000A-3.

(b) *Coverage under minimum essential coverage*—(1) *In general.* An individual has minimum essential coverage for a month in which the individual is enrolled in and entitled to receive benefits under a program or plan identified as minimum essential coverage in §1.5000A-2 for at least one day in the month.

(2) *Special rule for United States citizens or residents residing outside the United States or residents of territories.* An individual is treated as having minimum essential coverage for a month—

(i) If the month occurs during any period described in section 911(d)(1)(A) or section 911(d)(1)(B) that is applicable to the individual; or

(ii) If, for the month, the individual is a bona fide resident of a possession of the United States (as determined under section 937(a)).

(c) *Liability for shared responsibility payment*—(1) *In general.* A taxpayer is liable for the shared responsibility payment for a month for which—

(i) The taxpayer is a nonexempt individual without minimum essential coverage; or

(ii) A nonexempt individual for whom the taxpayer is liable under paragraph (c)(2) or (c)(3) of this section does not have minimum essential coverage.

(2) *Liability for dependents*—(i) *In general.* For a month when a nonexempt individual does not have minimum essential coverage, if the nonexempt individual is a dependent (as defined in section 152) of another individual for the other individual's taxable year including that month, the other individual is liable for the shared responsibility payment attributable to the dependent's lack of coverage. An individual is a dependent of a taxpayer for a taxable year if the individual satisfies the definition of dependent under section 152, regardless of whether the taxpayer claims the individual as a dependent on a Federal income tax return for the taxable year. If an individual may be claimed as a dependent by more than one taxpayer in the same calendar year, the taxpayer who properly claims the individual as a dependent for the taxable year is liable for the shared responsibility payment attributable to the individual. If more than one taxpayer may claim an individual as a dependent in the same calendar year but no one claims the individual as a dependent, the taxpayer with priority under the rules of section 152 to claim the individual as a dependent is liable for the shared responsibility payment for the individual.

(ii) *Special rules for dependents adopted or placed in foster care during the taxable year*—(A) *Taxpayers adopting an individual.* If a taxpayer adopts a nonexempt dependent (or accepts a nonexempt dependent who is an eligible foster child as defined in section 152(f)(1)(C)) during the taxable year and is otherwise liable for the nonexempt dependent under paragraph (c)(2)(i) of this section, the taxpayer is liable under paragraph (c)(2)(i) of this section for the nonexempt dependent only for the full months in the taxable year that follow the month in which the adoption or acceptance occurs.

(B) *Taxpayers placing an individual for adoption.* If a taxpayer who is otherwise liable for a nonexempt dependent under paragraph (c)(2)(i) of this section places (or, by operation of law, must place) the nonexempt dependent for adoption or foster care during the taxable year, the taxpayer is liable under paragraph (c)(2)(i) of this section for the nonexempt dependent only for the full months in the taxable year that precede the month in which the adoption or foster care placement occurs.

(C) *Examples.* The following examples illustrate the provisions of this paragraph (c)(2)(ii). In each example the taxpayer's taxable year is a calendar year.

Example 1. Taxpayers adopting a child. (i) E and F, married individuals filing a joint return, initiate proceedings for the legal adoption of a 2-year old child, G, in January 2016. On May 15, 2016, G becomes the adopted child (within the meaning of section 152(f)(1)(B)) of E and F, and resides with them for the remainder of 2016. Prior to the adoption, G resides with H, an unmarried individual, with H providing all of G's support. For 2016 G meets all requirements under section 152 to be E and F's dependent, and not H's dependent.

(ii) Under paragraph (c)(2) of this section, E and F are not liable for a shared responsibility payment attributable to G for January through May of 2016, but are liable for a shared responsibility payment attributable to G, if any, for June through December of 2016. H is not liable for a shared responsibility payment attributable to G for any month in 2016, because G is not H's dependent for 2016 under section 152.

Example 2. Taxpayers placing a child for adoption. (i) The facts are the same as *Example 1,* except the legal adoption occurs on August 15, 2016, and, for 2016, G meets all requirements under section 152 to be H's dependent, and not E and F's dependent.

(ii) Under paragraph (c)(2) of this section, H is liable for a shared responsibility payment attributable to G, if any, for January through July of 2016, but is not liable for a shared responsibility payment attributable to G for August through December of 2016. E and F are not liable for a shared responsibility payment attributable to G for any month in 2016, because G is not E and F's dependent for 2016 under section 152.

(3) *Liability of individuals filing a joint return.* Married individuals (within the meaning of section 7703) who file a joint return for a taxable year are jointly liable for any shared responsibility payment for a month included in the taxable year.

(d) *Definitions.* The definitions in this paragraph (d) apply to this section and §§1.5000A-2 through 1.5000A-5.

(1) *Affordable Care Act. Affordable Care Act* refers to the Patient Protection and Affordable Care Act, Public Law 111-148 (124 Stat. 119 (2010)), and the Health Care and Education Reconciliation Act of 2010, Public Law 111-152 (124 Stat. 1029 (2010)), as amended.

(2) *Employee. Employee* includes former employees.

(3) *Exchange. Exchange* has the same meaning as in 45 CFR 155.20.

(4) *Family.* A taxpayer's family means the individuals for whom the taxpayer properly claims a deduction for a personal exemption under section 151 for the taxable year.

(5) *Family coverage. Family coverage* means health insurance that covers more than one individual.

(6) *Group health insurance coverage. Group health insurance coverage* has the same meaning as in section 2791(b)(4) of the Public Health Service Act (42 U.S.C. 300gg-91(b)(4)).

(7) *Group health plan. Group health plan* has the same meaning as in section 2791(a)(1) of the Public Health Service Act (42 U.S.C. 300gg-91(a)(1)).

(8) *Health insurance coverage. Health insurance coverage* has the same meaning as in section 2791(b)(1) of the Public Health Service Act (42 U.S.C. 300gg-91(b)(1)).

(9) *Health insurance issuer. Health insurance issuer* has the same meaning as in section 2791(b)(2) of the Public Health Service Act (42 U.S.C. 300gg-91(b)(2)).

(10) *Household income*—(i) *In general. Household income* means the sum of—

(A) A taxpayer's modified adjusted gross income; and

(B) The aggregate modified adjusted gross income of all other individuals who—

(*1*) Are included in the taxpayer's family under paragraph (d)(4) of this section; and

(*2*) Are required to file a Federal income tax return for the taxable year.

(ii) *Modified adjusted gross income. Modified adjusted gross income* means adjusted gross income (within the meaning of section 62) increased by—

(A) Amounts excluded from gross income under section 911; and

(B) Tax-exempt interest the taxpayer receives or accrues during the taxable year.

(11) *Individual market. Individual market* has the same meaning as in section 1304(a)(2) of the Affordable Care Act (42 U.S.C. 18024(a)(2)).

(12) *Large and small group market. Large group market* and *small group market* have the same meanings as in section 1304(a)(3) of the Affordable Care Act (42 U.S.C. 18024(a)(3)).

(13) *Month. Month* means calendar month.

(14) *Qualified health plan. Qualified health plan* has the same meaning as in section 1301(a) of the Affordable Care Act (42 U.S.C. 18021(a)).

(15) *Rating area. Rating area* has the same meaning as in §1.36B-1(n).

(16) *Self-only coverage. Self-only coverage* means health insurance that covers one individual.

(17) *Shared responsibility family. Shared responsibility family* means, for a month, all nonexempt individuals for whom the taxpayer (and the taxpayer's spouse, if the taxpayer is married and files a joint return with the spouse) is liable for the shared responsibility payment under paragraph (c) of this section.

(18) *State. State* means each of the 50 states and the District of Columbia.

[T.D. 9632, 78 FR 53655, Aug. 30, 2013, as amended at 78 FR 78255, Dec. 26, 2013]

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26 CFR §1.5000A-2 Minimum essential coverage.

(a) *In general. Minimum essential coverage* means coverage under a government-sponsored program (described in paragraph (b) of this section), an eligible employer-sponsored plan (described in paragraph (c) of this section), a plan in the individual market (described in paragraph (d) of this section), a grandfathered health plan (described in paragraph (e) of this section), or other health benefits coverage (described in paragraph (f) of this section). Minimum essential coverage does not include coverage described in paragraph (g) of this section. All terms defined in this section apply for purposes of this section and §1.5000A-1 and §§1.5000A-3 through 1.5000A-5.

(b) *Government-sponsored program*—(1) *In general.* Except as provided in paragraph (2), *government-sponsored program* means any of the following:

(i) *Medicare.* The Medicare program under part A of Title XVIII of the Social Security Act (42 U.S.C. 1395c and following sections);

(ii) *Medicaid.* The Medicaid program under Title XIX of the Social Security Act (42 U.S.C. 1396 and following sections);

(iii) *Children's Health Insurance Program.* The Children's Health Insurance Program (CHIP) under Title XXI of the Social Security Act (42 U.S.C. 1397aa and following sections);

(iv) *TRICARE.* Medical coverage under chapter 55 of Title 10, U.S.C., including coverage under the TRICARE program;

(v) *Veterans programs.* The following health care programs under chapter 17 or 18 of Title 38, U.S.C.:

(A) The medical benefits package authorized for eligible veterans under 38 U.S.C. 1710 and 38 U.S.C. 1705;

(B) The Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) authorized under 38 U.S.C. 1781; and

(C) The comprehensive health care program authorized under 38 U.S.C. 1803 and 38 U.S.C. 1821 for certain children of Vietnam Veterans and Veterans of covered service in Korea who are suffering from spina bifida.

(vi) *Peace Corp program.* A health plan under section 2504(e) of Title 22, U.S.C. (relating to Peace Corps volunteers); and

(vii) *Nonappropriated Fund Health Benefits Program.* The Nonappropriated Fund Health Benefits Program of the Department of Defense, established under section 349 of the National Defense Authorization Act for Fiscal Year 1995 (Pub. L. 103-337; 10 U.S.C. 1587 note).

(2) *Certain health care coverage not minimum essential coverage under a government-sponsored program. Government-sponsored program* does not mean any of the following:

(i) Optional coverage of family planning services under section 1902(a)(10)(A)(ii)(XXI) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(ii)(XXI));

(ii) Optional coverage of tuberculosis-related services under section 1902(a)(10)(A)(ii)(XII) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(ii)(XII));

(iii) Coverage of pregnancy-related services 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));

(iv) Coverage limited to treatment of emergency medical conditions in accordance with 8 U.S.C. 1611(b)(1)(A), as authorized by section 1903(v) of the Social Security Act (42 U.S.C. 1396b(v));

(v) Coverage for medically needy individuals under section 1902(a)(10)(C) of the Social Security Act (42 U.S.C. 1396a(a)(10)(C)) and 42 CFR 435.300 and following sections;

(vi) Coverage authorized under section 1115(a) of the Social Security Act (42 U.S.C. 1315(a));

(vii) Coverage under section 1079(a), 1086(c)(1), or 1086(d)(1) of title 10, U.S.C., that is solely limited to space available care in a facility of the uniformed services for individuals excluded from TRICARE coverage for care from private sector providers; and

(viii) Coverage under sections 1074a and 1074b of title 10, U.S.C., for an injury, illness, or disease incurred or aggravated in the line of duty for individuals who are not on active duty.

(c) *Eligible employer-sponsored plan*—(1) *In general. Eligible employer-sponsored plan* means, with respect to any employee:

(i) Group health insurance coverage offered by, or on behalf of, an employer to the employee that is—

(A) A governmental plan (within the meaning of section 2791(d)(8) of the Public Health Service Act (42 U.S.C. 300gg-91(d)(8)));

(B) Any other plan or coverage offered in the small or large group market within a State; or

(C) A grandfathered health plan (within the meaning of paragraph (e) of this section) offered in a group market; or

(ii) A self-insured group health plan under which coverage is offered by, or on behalf of, an employer to the employee.

(2) *Government-sponsored program generally not an eligible employer-sponsored plan.* Except for the program identified in paragraph (b)(1)(vii) of this section, a government-sponsored program described in paragraph (b) of this section is not an eligible employer-sponsored plan.

(d) *Plan in the individual market*—(1) *In general. Plan in the individual market* means health insurance coverage offered to individuals in the individual market within a state, other than short-term limited duration insurance within the meaning of section 2791(b)(5) of the Public Health Service Act (42 U.S.C. 300gg-91(b)(5)).

(2) *Qualified health plan offered by an Exchange.* A qualified health plan offered by an Exchange is a plan in the individual market. If a territory of the United States elects to establish an Exchange under section 1323(a)(1) and (b) of the Affordable Care Act (42 U.S.C. 18043(a)(1), (b)), a qualified health plan offered by that Exchange is a plan in the individual market.

(e) *Grandfathered health plan. Grandfathered health plan* means any group health plan or group health insurance coverage to which section 1251 of the Affordable Care Act (42 U.S.C. 18011) applies.

(f) *Other coverage that qualifies as minimum essential coverage.* Minimum essential coverage includes any plan or arrangement recognized by the Secretary of Health and Human Services, in coordination with the Secretary of the Treasury, as minimum essential coverage.

(g) *Excepted benefits not minimum essential coverage.* Minimum essential coverage does not include any coverage that consists solely of excepted benefits described in section 2791(c)(1), (c)(2), (c)(3), or (c)(4) of the Public Health Service Act (42 U.S.C. 300gg-91(c)).

[T.D. 9632, 78 FR 53655, Aug. 30, 2013, as amended at 78 FR 78255, Dec. 26, 2013; T.D. 9705, 79 FR 70469, Nov. 26, 2014]