

**State of California
Office of Administrative Law**

In re:
California Health Benefit Exchange

**NOTICE OF APPROVAL OF EMERGENCY
REGULATORY ACTION**

Regulatory Action:

Title 10, California Code of Regulations

**Government Code Sections 11346.1 and
11349.6**

Adopt sections:

Amend sections: 6408, 6410, 6472, 6474,
6476, 6478, 6482, 6484,
6486, 6492, 6494, 6496,
6504, 6602, 6606, 6618

OAL Matter Number: 2026-0928-03

Repeal sections:

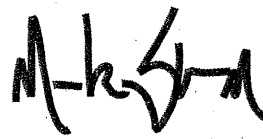
OAL Matter Type: Emergency Readopt (EE)

This California Health Benefit Exchange emergency readoption action pursuant to Government Code section 11346.1(h) amends eligibility, enrollment, and appeals processes for the Individual Exchange to align with changes in federal law and guidance and to establish a process to automatically enroll a consumer in a Qualified Health Plan when moving to a different coverage area. This emergency is deemed pursuant to Government Code section 100504(a)(6). The readoption amends definitions and other provisions to align with recent changes in federal law.

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

This emergency action is effective on 10/8/2026 and will expire on 12/18/2029. The Certificate of Compliance for this action is due no later than 12/17/2029.

Date: October 8, 2026



Digitally signed by
Mark Storm
Date: 2025.10.08
15:21:51 -07'00'

**Mark Storm
Senior Attorney**

**For: Kenneth J. Pogue
Director**

**Original: Jessica Altman, Executive
Director
Copy: Jameson Mitchell**

NOTICE PUBLICATION/REGULATORY SUBMISSION

STD. 400 (REV. 10/2019)

EMERGENCY

For use by Secretary of State only

OAL FILE NUMBERS	NOTICE FILE NUMBER Z-	REGULATORY ACTION NUMBER	EMERGENCY NUMBER 2026-0928-03EE
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For use by Office of Administrative Law (OAL) only

OFFICE OF ADMIN. LAW
2026 SEP 28 PM 4:47

ENDORSED - FILED

in the office of the Secretary of State
of the State of CaliforniaOCT 08 2026
NG 3:34 pm

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 ☐ Notice re Proposed Regulatory Action ☐ Other		4. AGENCY CONTACT PERSON		TELEPHONE NUMBER	FAX NUMBER (Optional)
OAL USE ONLY		ACTION ON PROPOSED NOTICE ☐ Approved as Submitted ☐ Approved as Modified ☐ Disapproved/Withdrawn		NOTICE REGISTER NUMBER	PUBLICATION DATE

B. SUBMISSION OF REGULATIONS (Complete when submitting regulations)

1a. SUBJECT OF REGULATION(S) Eligibility, Enrollment, and Appeals Process for the Individual Exchange		1b. ALL PREVIOUS RELATED OAL REGULATORY ACTION NUMBER(S) 2025-1202-02 EE, 2024-1204-01 E	
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.) TITLE(S) 10		ADOPT AMEND REPEAL 6408, 6410, 6472, 6474, 6476, 6478, 6482, 6484, 6486, 6492, 6494, 6496, 6504, 6602, 6606, 6618	

PER AGENCY
REQUEST
MS

3. TYPE OF FILING			
☐ Regular Rulemaking (Gov. Code §11346)	☐ 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.	☒ Emergency Readopt (Gov. Code, §11346.1(h))	☐ Changes Without Regulatory Effect (Cal. Code Regs., title 1, §100)
☐ Resubmittal of disapproved or withdrawn nonemergency filing (Gov. Code §§11349.3, 11349.4)		☐ File & Print	☐ Print Only
☐ Emergency (Gov. Code, §11346.1(b))	☐ Resubmittal of disapproved or withdrawn emergency filing (Gov. Code, §11346.1)	☐ Other (Specify) _____	
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) N/A			
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	
☐ Other (Specify) _____		☐ State Fire Marshal	

7. CONTACT PERSON Jameson Mitchell	TELEPHONE NUMBER (916) 954-3372	FAX NUMBER (Optional)	E-MAIL ADDRESS (Optional) jameson.mitchell@covered.ca.gov
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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
Jessica Altman
Digitally signed by Jessica Altman
Date: 2026.09.21 13:25:28 -0700DATE
9/21/26TYPED NAME AND TITLE OF SIGNATORY
Jessica Altman, Executive Director

For use by Office of Administrative Law (OAL) only

ENDORSED APPROVED

OCT 08 2026

Office of Administrative Law

California Code of Regulations

Title 10. Investment

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

Article 2. Abbreviations and Definitions

§ 6408. Abbreviations.

The following abbreviations shall apply to this chapter:

ACO	Accountable Care Organization
APTC	Advance Payments of Premium Tax Credit
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CalHEERS	California Healthcare Eligibility, Enrollment, and Retention System
CCR	California Code of Regulations
CCSB	Covered California for Small Business
CEC	Certified Enrollment Counselor
CFR	Code of Federal Regulations
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
CSR	Cost-Sharing Reduction
DHCS	Department of Health Care Services
DHS	U.S. Department of Homeland Security
EPO	Exclusive Provider Organization
FPL	Federal Poverty Level

FQHC	Federally-Qualified Health Center
HDHP	High Deductible Health Plan
HEDIS	Health Effectiveness Data and Information Set
HHS	U.S. Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104-191)
HMO	Health Maintenance Organization
HSA	Health Savings Account
IAP	Insurance Affordability Program
IPA	Independent Practice Association
IRC	Internal Revenue Code of 1986
IRS	Internal Revenue Services
LEP	Limited English Proficient
MAGI	Modified Adjusted Gross Income
MEC	Minimum Essential Coverage
PBE	Certified Plan-Based Enroller
PBEE	Certified Plan-Based Enrollment Entity
POS	Point of Service
QDP	Qualified Dental Plan
QHP	Qualified Health Plan
SHOP	Small Business Health Options Program
SSA	Social Security Administration

SSN	Social Security Number
TIN	Taxpayer Identification Number
USC	United States Code

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

§ 6410. Definitions.

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

“Advance Payments of Premium Tax Credit” (APTC) means payment of the tax credits authorized by Section 36B of IRC (26 USC § 36B) and implementing regulations, which are provided on an advance basis to an eligible individual enrolled in a QHP through an Exchange in accordance with Section 1412 of the Affordable Care Act.

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

“Annual Open Enrollment Period” means the period each year during which a qualified individual may enroll or change coverage in a QHP through the Exchange, as specified in Section 6502 of Article 5 of this chapter, Sections 1399.848(b) and 1399.849(c) of the Health and Safety Code, and Sections 10965.3(c) and 10965.4(b) of the Insurance Code.

“Applicable Children's Health Insurance Program (CHIP) MAGI-based Income Standard” means the applicable income standard as defined at 42 CFR Section 457.310(b)(1) (November 30, 2016), hereby incorporated by reference, as applied

under the State plan adopted in accordance with title XXI of the Social Security Act, or waiver of such plan and as certified by the State CHIP Agency in accordance with 42 CFR Section 457.348(d) (November 30, 2016), hereby incorporated by reference, for determining eligibility for child health assistance and enrollment in a separate child health program.

“Applicable Medi-Cal Modified Adjusted Gross Income (MAGI)-based Income Standard” means the same standard as “applicable modified adjusted gross income standard,” as defined in 42 CFR Section 435.911(b) (November 30, 2016), hereby incorporated by reference, and as specified in Sections 14005.60 and 14005.64 of the Welfare and Institutions Code.

“Applicant” means:

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

- (1) Enrollment in a QHP through the Exchange; or
- (2) Medi-Cal and CHIP.

(b) For SHOP (CCSB):

- (1) An employer who is seeking eligibility to purchase coverage through the SHOP Exchange but is not seeking to enroll in that coverage for themselves.
- (2) An employer, employee, or former employee seeking eligibility for enrollment in a QHP through the SHOP for themselves, and, if the qualified employer offers dependent

coverage through the SHOP, seeking eligibility to enroll their dependents in a QHP through the SHOP.

“Application Filer” means an applicant; an adult who is in the applicant's household, as defined in 42 CFR Section 435.603(f) (November 30, 2016), hereby incorporated by reference, or family, as defined in 26 USC Section 36B(d) and 26 CFR Section 1.36B-1(d) (December 19, 2016), hereby incorporated by reference; an authorized representative; or if the applicant is a minor or incapacitated, someone acting responsibly for an applicant; excluding those individuals seeking eligibility for an exemption from the shared responsibility payment.

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

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

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

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

“California Healthcare Eligibility, Enrollment, and Retention System” (CalHEERS) means the California Healthcare Eligibility, Enrollment, and Retention System, created pursuant to Government Code Sections 100502 and 100503, as well as 42 USC Section 18031, to enable enrollees and prospective enrollees of QHPs to obtain

standardized comparative information on the QHPs as well as apply for eligibility, enrollment, and reenrollment in the Exchange.

“Cancellation of Enrollment” means specific type of termination action that ends a qualified individual's enrollment on or before the coverage effective date resulting in enrollment through the Exchange never having been effective with the QHP.

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

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

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

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

“Certified Insurance Agent” means an agent certified by the Exchange to transact in the individual and Small Business Health Options Program (SHOP) Exchanges.

“Certified Plan-Based Enroller” (PBE) means an individual who provides Enrollment Assistance to Consumers, as defined in Section 6700(c) of Article 9 of this chapter, in

the Individual Exchange through a Certified Plan-Based Enroller Program. Such an individual may be:

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

(b) An Issuer Application Assister as defined in 45 CFR Section 155.20 (December 22, 2016), hereby incorporated by reference, provided that the issuer application assister is not employed or contracted by a PBEE to sell, solicit, or negotiate health insurance coverage licensed by the California Department of Insurance.

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

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

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

“COBRA” and “COBRA Continuation Coverage” have the meanings provided for in 45 CFR Section 144.103 (December 22, 2016), hereby incorporated by reference.

“COBRA Continuation Coverage” includes coverage under a similar State program.

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

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

“Day” means a calendar day unless a business day is specified.

“Dental Exclusive Provider Organization” (DEPO) means a managed care plan where services are covered if provided through doctors, specialists, and hospitals in the plan's network (except in an emergency).

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

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

“Dependent” means:

(a) In the Individual Exchange:

(1) For purposes of eligibility determination for APTC and CSR, a dependent as defined in Section 152 of IRC (26 USC § 152) and the regulations thereunder.

(2) For purposes of enrollment in a QHP, including enrollment during a special enrollment period specified in Section 6504 of Article 5 of this chapter, a dependent as defined in Section 1399.845(b) of the Health and Safety Code and in Section 10965(b) of the Insurance Code, referring to the spouse or registered domestic partner, or child until attainment of age 26 (as defined in subdivisions (n) and (o) of Section 599.500 of Title 2 of the CCR) unless the child is disabled (as defined in subdivision (p) of Section 599.500 of Title 2 of the CCR and as specified in Section 1373(d) of the Health and Safety Code), of a qualified individual or enrollee. For a plan year beginning on or after January 1, 2023, for purposes of enrollment in a QHP, except for enrollment in a QDP, dependent shall also mean a parent or stepparent of a qualified individual or enrollee, as specified in Section 1374.1(a) of the Health and Safety Code and Section 10278.1(a) of the Insurance Code.

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

“Domestic Partner” means:

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

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

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

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

“Eligible Noncitizen” means an “eligible alien,” as defined in Section 36B(e)(2)(B) of IRC (26 USC § 36B(e)(2)(B)).

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

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

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

“Enrollee” means a person who is enrolled in a QHP. It also means the dependent of a qualified employee enrolled in a QHP through the SHOP, and any other person who is enrolled in a QHP through the SHOP, consistent with applicable law and the terms of the group health plan. If at least one employee enrolls in a QHP through the SHOP, “enrollee” also means a business owner enrolled in a QHP through the SHOP, or the dependent of a business owner enrolled in a QHP through the SHOP.

“Essential Community Providers” means providers that serve predominantly low-income, medically underserved individuals, as defined in 45 CFR Section 156.235 (December 22, 2016), hereby incorporated by reference.

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

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

“Exclusive Provider Organization” (EPO) means a health insurance issuer's or carrier's insurance policy that limits coverage to health care services provided by a network of providers who are contracted with the issuer or carrier.

“Executive Director” means the Executive Director of the Exchange.

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

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

“Geographic Service Area” or “Service Area” means an area as defined in Section 1345(k) of the Health and Safety Code.

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

“Group Dental Plan” means a plan certified by the Exchange for offer in the small group marketplace that provides the pediatric dental benefits required in Health and Safety Code Section 1367.005(a)(5) and Insurance Code Section 10122.27(a)(5), and also includes coverage for certain benefits for adult enrollees and is available to qualified employers meeting the requirements of Section 6522(a)(5)(B) of Article 6 of this chapter.

“Group Participation Rate” means the minimum percentage of all eligible individuals or employees of an employer that must be enrolled.

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

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

“Health Maintenance Organization” (HMO) means an organization as defined in Section 1373.10(b) of the Health and Safety Code.

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

“High deductible health plan” (HDHP) has the same meaning as the term is defined in Section 223(c)(2) of IRC (26 USC § 223(c)(2)).

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

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

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

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

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

“Initial Open Enrollment Period” means the initial period in which Qualified Individuals may enroll in QHPs, from October 1, 2013 to March 31, 2014, subject to 45 CFR Section 155.410(b), (April 18, 2017), hereby incorporated by reference, Section

1399.849(c)(1) of the Health and Safety Code, and Section 10965.3(c)(1) of the Insurance Code.

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

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

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

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

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

“Lawfully Present” means a non-citizen individual as defined in 45 CFR Section 155.20 (August 26, 2025), hereby incorporated by reference.

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

“Minimum Essential Coverage” (MEC) means coverage as defined in Section 5000A(f) of IRC (26 USC § 5000A(f)) and in 26 CFR Section 1.36B-2(c) (July 26, 2017), hereby incorporated by reference.

“Minimum Value” when used to describe coverage in an eligible employer-sponsored plan, means that the plan meets the requirements with respect to coverage of the total

allowed costs of benefits set forth in Section 36B(c)(2)(C)(ii) of IRC (26 USC § 36B(c)(2)(C)(ii)) and in 26 CFR Section 1.36B-6 (December 18, 2015), hereby incorporated by reference.

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

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

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

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

“Plan Year” means:

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

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

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

“Preferred Provider Organization” (PPO) means a health insurance issuer's or carrier's insurance policy that offers covered health care services provided by a network of

providers who are contracted with the issuer or carrier ("in-network") and providers who are not part of the provider network ("out-of-network").

"Premium Payment Due Date" means:

(a) For purposes of the initial premium or binder payment for qualified individuals who are enrolled in a QHP by the Exchange in accordance with Section 100503.4 of the Government Code, a date no earlier than the last day of the first month of coverage.

(b) For purposes of the initial premium or binder payment for qualified individuals other than those specified under paragraph (a), and for purposes of the premium payment for the subsequent months of coverage, a date no earlier than the last day of the month prior to the prospective coverage month, and no later than the last day of the prospective coverage month.

"QHP Issuer" means a licensed health care service plan or insurer who has been selected and certified by the Exchange to be offered to Qualified Individuals and Qualified Employers purchasing health insurance coverage through the Exchange. For purposes of Section 6498(l), licensed health care service plans or insurers that are subsidiaries of the same parent company are considered to be the same QHP issuer.

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

"Qualified Employee" means any employee or former employee of a qualified employer who has been offered health insurance coverage by such qualified employer through the SHOP for themselves and, if the qualified employer offers dependent coverage through the SHOP, for their dependents.

“Qualified Employer” has the same meaning as the term is defined in 42 USC Section 18032(f)(2) and 45 CFR Section 155.710 (February 27, 2015), hereby incorporated by reference.

“Qualified Health Plan” (QHP) has the same meaning as the term is defined in Patient Protection and Affordable Care Act Section 1301 (42 USC § 18021) and Government Code Section 100501(g) and includes QDP.

“Qualified Individual” means an individual who has been determined eligible to enroll through the Exchange in a QHP in the individual market.

“Qualifying Coverage in an Eligible Employer-Sponsored Plan” means coverage in an eligible employer-sponsored plan that meets the affordability and minimum value standards specified in Section 36B(c)(2)(C) of IRC (26 USC § 36B(c)(2)(C)) and in 26 CFR Sections 1.36B-2(c)(3) and 1.36B-6.

“Rating Region” means the geographic regions for purposes of rating defined in Sections 1357.512(a)(2)(A) and 1399.855(a)(2)(A) of the Health and Safety Code and Sections 10753.14(a)(2)(A) and 10965.9(a)(2)(A) of the Insurance Code.

“Reasonably Compatible” has the same meaning as the term is defined in 45 CFR Section 155.300(d) (July 15, 2013), hereby incorporated by reference, providing that information the Exchange obtained through electronic data sources, information provided by the applicant, or other information in the records of the Exchange shall be considered to be reasonably compatible with an applicant's attestation if the difference or discrepancy does not impact the applicant's eligibility, including the amount of APTC or the category of CSR.

“Reconciliation” means coordination of premium tax credit with advance payments of premium tax credit (APTC), as described in Section 36B(f) of IRC (26 USC § 36B(f)) and 26 CFR Section 1.36B-4(a) (July 26, 2017), hereby incorporated by reference.

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

“Reinstatement of Enrollment” means a correction of an erroneous termination of coverage or cancellation of enrollment action and results in restoration of an enrollment with no break in coverage.

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

“SHOP” means a Small Business Health Options Program operated by the Exchange through which a qualified employer can provide its employees and their dependents with access to one or more QHPs. The SHOP also does business as and may be referred to as “Covered California for Small Business” or “CCSB.”

“SHOP Application Filer” means an applicant, an authorized representative, an agent or broker of the employer, or an employer filing for its employees where not prohibited by law.

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

“Small Employer” means an employer as defined in Section 1357.500(k)(3) of the Health and Safety Code and in Section 10753(q)(3) of the Insurance Code.

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

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

“State Health Insurance Regulator” or “State Health Insurance Regulators” means the Department of Managed Health Care and the Department of Insurance.

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

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

(b) If married (within the meaning of 26 CFR Section 1.7703-1 (January 16, 1997), hereby incorporated by reference), to file a joint tax return for the benefit year, unless the tax filer satisfies one of the exceptions specified in 26 CFR Section 1.36B-2(b)(2)(ii)-(v);

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

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

“Tax Household” means the tax filer and any individuals who are claimed as

dependents on the tax filer's federal income tax return. A tax household may include a spouse and/or dependents.

"Termination of Coverage" or "Termination of Enrollment" means an action taken after a coverage effective date that ends an enrollee's coverage through the Exchange for a date after the original coverage effective date, resulting in a period during which the individual was enrolled in coverage through the Exchange.

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

Note: Authority cited: Sections 100502, 100503, 100503.4, 100504 and 100505, Government Code. Reference: Sections 100501, 100502, 100503, 100503.4 and 100505, Government Code; Sections 1345, 1357.500, 1357.512, 1367.005, 1367.008, 1367.009, 1373, 1373.10, 1374.1, 1399.845, 1399.848, 1399.849 and 1399.855, Health and Safety Code; Sections 10112.27, 10112.295, 10112.297, 10122.27, 10278.1, 10753, 10753.14, 10965, 10965.3, 10965.4 and 10965.9, Insurance Code; 26 USC Sections 36B, 151, 152, 223, 414, 5000A, 6011, 6012 and 9832; 42 USC Sections 300gg-91, 9902, 18021, 18022, 18024, 18031 and 18032; 42 CFR Sections 435.603, 435.911, 457.310 and 457.348; 45 CFR Sections 144.103, 152.2, 155.20, 155.300, 155.305, 155.410, 155.415, 155.430, 155.700, 155.705, 155.710, 155.725, 156.235 and

156.1230; and 26 CFR Sections 1.36B-1, 1.36B-2, 1.36B-4, 1.36B-6, 1.5000A-1(d) and 1.7703-1.

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

Exchange

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

(a) An applicant who is seeking enrollment in a QHP that is not a catastrophic plan shall meet the requirements of this section, except for the requirements specified in subdivision (f) of this section, regardless of the applicant's eligibility for APTC or CSR.

For purposes of this section, an applicant includes all individuals listed on the application who are seeking enrollment in a QHP through the Exchange. An applicant who is seeking enrollment in a catastrophic QHP shall also meet the requirements specified in subdivision (f) of this section. An applicant who is seeking enrollment in a QDP shall also meet the requirements specified in subdivision (g) of this section.

(b) An applicant who has a SSN shall provide their SSN to the Exchange.

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

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

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

(1) For an individual who is age 21 and over, is not living in an institution as defined in 42 CFR Section 435.403(b) (March 23, 2012), hereby incorporated by reference, is

capable of indicating intent, and is not receiving Supplemental Security Income/State Supplemental Program payments as defined in Title 22, Division 3, Section 50095 of CCR, the service area of the Exchange of the individual is the service areas of the Exchange in which the individual is living and:

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

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

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

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

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

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

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

(A) Except as specified in subdivision (e)(4)(B) of this section, if all of the members of a tax household are not within the same Exchange service area, in accordance with the

applicable standards in subdivisions (e)(1), (2), and (3) of this section, any member of the tax household may enroll in a QHP through any of the Exchanges for which one of the tax filers meets the residency standard.

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

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

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

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

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

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

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

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

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

(g) The eligibility standards specified in this subdivision shall only apply to the eligibility determination for enrollment in a QDP through the Exchange. The Exchange shall determine an applicant eligible for enrollment in a QDP if the applicant meets both of the following requirements:

(1) At least one adult in the applicant's family who is enrolled in a non-catastrophic QHP through the Exchange is enrolled in the QDP. The family may continue enrollment in the QDP even if the adult later ceases enrollment in the non-catastrophic QHP through the Exchange.

(2) To enroll one child in a family in a QDP, all children in the family under 19 years of age shall also enroll in the same QDP.

Note: Authority cited: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; 26 USC Section 5000A; 42 CFR Section 435.403; 45 CFR Section 155.305.

§ 6474. Eligibility Requirements for APTC and CSR.

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

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

(c) Eligibility for APTC.

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

(A) Tax filer is an “applicable taxpayer” as defined in section 36B(c)(1) of IRC (26 USC § 36B(c)(1)) and 26 CFR Section 1.36B-2(b) for the benefit year for which coverage is requested; and

(B) ~~One or more applicants for whom the tax filer expects to claim a personal exemption deduction on their tax return for the benefit year, including the tax filer and their spouse who is expected to be a member of the tax filer’s family within the meaning of 26 CFR Section 1.36B-1(d) for the benefit year:~~

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

2. Is not eligible for MEC for the full calendar month for which APTC would be paid, with the exception of coverage in the individual market, in accordance with section

36B(c)(2)(B) and (C) of IRC (26 USC § 36B(c)(2)(B), (C)) and 26 CFR Section 1.36B-2(a)(2) and (c); and

3. Is enrolled in a QHP that is neither a catastrophic plan nor a QDP through the Exchange; and

4. For plan years beginning on or after January 1, 2027, is a U.S. citizen, U.S. national, or an eligible noncitizen as defined in Section 6410 of Article 2 of this chapter.

(2) For plan years beginning before January 1, 2026, a non-citizen tax filer who is lawfully present and ineligible for Medi-Cal by reason of immigration status, and is not

otherwise eligible for APTC under subdivision (c)(1) of this section, shall be eligible for APTC if:

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

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

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

(3) For plan years beginning on or after January 1, 2028, tax filer shall not be eligible for APTC if:

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

(B) The tax filer or the tax filer's spouse did not:

1. Comply with the requirement to file an income tax return for that year, as required by sections 6011 and 6012 of IRC (26 USC §§ 6011, 6012) and implementing regulations;
and

2. Reconcile APTC for that period.

(4) If the tax filer does not meet the tax filing requirements specified in subdivision (c)(3) of this section, the Exchange shall send a notification to the tax filer, consistent with the standards set forth in Section 6454 and the standards applicable to the protection of Federal Tax Information, that informs the tax filer that the Exchange has determined that the tax filer or the tax filer's spouse, if the tax filer is married, has failed to file and reconcile and of the need to file and reconcile, and notifies the tax filer of the risk of being determined ineligible for APTC if they fail to file and reconcile immediately. The Exchange determines an applicant's or enrollee's eligibility for APTC:

(A) When an applicant or application filer submits a completed application during an open enrollment period or special enrollment period, as specified in Section 6470 and Sections 6502 and 6504, as applicable;

(B) When an enrollee reports a change during a benefit year or the Exchange obtains information through periodic data matching, as specified in Section 6496; and

(C) As part of the annual redetermination and renewal process, as specified in Section 6498.

~~(3)~~(5) The APTC amount shall be calculated in accordance with section 36B of IRC (26 USC § 36B), 26 CFR Section 1.36B-3 (July 26, 2017), hereby incorporated by reference, and subdivision (c)(7) of this section.

~~(4)~~(6) An application filer shall provide the SSN of a tax filer who is not an applicant only if an applicant attests that the tax filer has a SSN and filed a tax return for the year for which tax data would be used to verify household income and family size.

~~(5)~~(7) The APTC amount for an enrollee who is enrolled in a policy for less than the full coverage month, including when the enrollee is enrolled in multiple policies within a month, each lasting less than the full coverage month, shall equal the product of:

(A) The APTC amount for one month of coverage divided by the number of days in the month; and

(B) The number of days for which coverage is being provided in the month described in paragraph (7)(A) of this subdivision.

(d) Eligibility for CSR.

(1) An applicant shall be eligible for CSR if the applicant:

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

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

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

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

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

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

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

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

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

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

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

(A) Not eligible for CSR;

(B) Section 6494(a)(3) and (4)-Special CSR eligibility standards and process for Indians regardless of income;

(C) Subdivision (d)(3)(C) of this section;

(D) Subdivision (d)(3)(B) of this section;

(E) Subdivision (d)(3)(A) of this section; or

(F) Section 6494(a)(1) and (2)-Special CSR eligibility standards and process for Indians with household incomes under 300 percent of FPL.

Note: Authority cited: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; 26 USC Sections 36B, 6011 and 6012; 26 CFR Sections 1.36B-1, 1.36B-2, 1.36B-3; and 45 CFR Sections 155.305 and 155.340.

§ 6476. Eligibility Determination Process.

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

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

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

(d) The following special rules relate to APTC.

(1) An enrollee may accept less than the full amount of APTC for which they are determined eligible.

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

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

(B) If married (within the meaning of 26 CFR Section 1.7703-1), they will file a joint tax return for the benefit year, unless they satisfy one of the exceptions specified in 26 CFR Section 1.36B-2(b)(2)(ii)-(v);

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

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

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

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

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

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

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

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

(i) The Exchange shall notify an employer that an employee has been determined eligible for APTC and has enrolled in a QHP through the Exchange within 30 days from the date of the determination that the employee is eligible for APTC and is enrolled in a QHP through the Exchange. Such notice shall:

(1) Identify the employee;

(2) Indicate that the employee has been determined eligible for APTC and has enrolled in a QHP through the Exchange;

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

(4) Notify the employer of the right to appeal the determination; and

(5) Inform the employer that discrimination against an employee who has been determined eligible for APTC and has enrolled in a QHP through the Exchange is prohibited under the ACA and the employees who are retaliated against may file a complaint with the Occupational Safety and Health Administration of the United States Department of Labor (OSHA), as specified in 29 USC Section 218c and 29 CFR Sections 1984.102 (November 16, 2012), hereby incorporated by reference and 1984.103 (November 16, 2012), hereby incorporated by reference.

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

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

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

Note: Authority cited: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; 26 USC Sections 4980H, 6011 and 6012; 29 USC

Section 218c; 26 CFR Sections 1.36B-2 and 1.7703-1; 29 CFR Sections 1984.102 and 1984.102; and 45 CFR Section 155.310.

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

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

(b) Verification of SSN.

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

(2) If the Exchange is unable to verify an individual's SSN through the SSA, or the SSA indicates that the individual is deceased, the Exchange shall follow the procedures specified in Section 6492, except that the Exchange shall provide the individual with a period of 95 days from the date of the notice described in Section 6492(a)(2)(A) for the applicant to provide satisfactory documentary evidence or resolve the inconsistency with the SSA. If the Exchange determines on a case-by-case basis that the individual has demonstrated that they did not receive the notice within five days from the date of the notice, the individual shall have 90 days from the date on which they received the notice to provide satisfactory documentary evidence to the Exchange or resolve the inconsistency with the SSA.

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

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

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

(3) For an applicant who attests to citizenship, status as a national, or lawful presence, and for whom the Exchange cannot verify such attestation through the SSA or the DHS, the Exchange shall follow the inconsistencies procedures specified in Section 6492, except that the Exchange shall provide the applicant with a period of 95 days from the date of the notice described in Section 6492(a)(2)(A) for the applicant to provide satisfactory documentary evidence or resolve the inconsistency with the SSA or the DHS, as applicable. If the Exchange determines on a case-by-case basis that the individual has demonstrated that they did not receive the notice within five days from the date of the notice, the individual shall have 90 days from the date on which they received the notice to provide satisfactory documentary evidence to the Exchange or resolve the inconsistency with the SSA or the DHS, as applicable.

(d) Verification of residency.

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

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

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

(e) Verification of incarceration status.

(1) Except as provided in subdivision (e)(2) of this section, the Exchange shall accept an applicant's attestation that they are not currently incarcerated without further verification.

(2) If an applicant's attestation is not reasonably compatible with other information provided by the applicant or in the records of the Exchange, the Exchange shall follow the inconsistencies procedures specified in Section 6492.

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

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

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

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

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

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

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

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

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

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

(b) For all individuals whose income is counted in calculating a tax filer's household income, in accordance with Section 36B(d)(2) of IRC (26 USC § 36B(d)(2)) and 26 CFR Section 1.36B-1(e), or an applicant's household income, calculated in accordance with 42 CFR Section 435.603(d), and for whom the Exchange has a SSN, the Exchange shall:

(1) Request tax return data regarding MAGI and family size from the Secretary of the Treasury and data regarding Social Security benefits described in 26 CFR Section

1.36B-1(e)(2)(iii) from the Commissioner of Social Security by transmitting identifying information specified by HHS to HHS; and

(2) Proceed in accordance with the procedures specified in Section 6492(a)(1) if the identifying information for one or more individuals does not match a tax record on file with the IRS that may be disclosed in accordance with Section 6103(l)(21) of IRC (26 USC § 6103(l)(21)) and its accompanying regulations.

(c) For all individuals whose income is counted in calculating a tax filer's household income, in accordance with Section 36B(d)(2) of IRC (26 USC § 36B(d)(2)) and 26 CFR Section 1.36B-1(e), or an applicant's household income, calculated in accordance with 42 CFR Section 435.603(d), the Exchange shall request data regarding MAGI-based income in accordance with 42 CFR Section 435.948(a) (March 23, 2012), hereby incorporated by reference.

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

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

(2) If an applicant attests that the information described in subdivision (b)(1) of this section represents an accurate projection of a tax filer's family size for the benefit year for which coverage is requested, the tax filer's eligibility for APTC and CSR shall be determined based on the family size data in subdivision (b)(1) of this section.

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

(A) The data described in subdivision (b)(1) of this section is unavailable; or

(B) The applicant attests that a change in family size has occurred, or is reasonably expected to occur, and so the data described in subdivision (b)(1) of this section does not represent an accurate projection of the tax filer's family size for the benefit year for which coverage is requested.

(4) If the Exchange finds that an applicant's attestation of a tax filer's family size is not reasonably compatible with other information provided by the application filer for the family or in the records of the Exchange, with the exception of the data described in subdivision (b)(1) of this section, the applicant's attestation shall be verified using data obtained through other electronic data sources. If such data sources are unavailable or information in such data sources is not reasonably compatible with the applicant's attestation, the applicant shall provide additional documentation requested by the Exchange to support the attestation, in accordance with Section 6492.

(5) The Exchange shall verify that neither APTC nor CSR is being provided on behalf of an individual using information obtained by transmitting to HHS identifying information specified by HHS.

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

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

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

(3) If an applicant's attestation indicates that the information described in subdivision (e)(1) of this section represents an accurate projection of the tax filer's household

income for the benefit year for which coverage is requested, the tax filer's eligibility for APTC and CSR shall be determined based on the household income data in subdivision (e)(1) of this section.

(4) If the data described in subdivision (b)(1) of this section is unavailable, or an applicant attests that a change in household income has occurred, or is reasonably expected to occur, and so it does not represent an accurate projection of the tax filer's household income for the benefit year for which coverage is requested:

(A) The applicant shall attest to the tax filer's projected household income for the benefit year for which coverage is requested; and

(B) The applicant's attestation of the tax filer's projected household income shall be verified in accordance with the process specified in Sections 6484 and 6486.

(5) Notwithstanding any other verification requirements specified in this section and in Sections 6484 and 6486 to the contrary, when the Exchange requests tax return and family size data from the Secretary of Treasury as described in subdivision (b)(1) of this section but no such data is returned for an applicant, the Exchange shall accept that applicant's attestation of income and family size without further verification.

(f) For plan years beginning on or after January 1, 2027, an applicant's eligible noncitizen status shall be verified in accordance with the following procedures.

(1) For an applicant who has information or documentation of immigration status that can be verified through the Department of Homeland Security's Systematic Alien Verification for Entitlements (SAVE) program, and who attests to having an eligible noncitizen immigration status as defined in Section 6410 of Article 2 of this chapter, the

Exchange shall transmit information from the applicant or document to the Department of Homeland Security for verification.

(2) For an applicant who attests to having an eligible noncitizen status as defined in Section 6410 of Article 2 of this chapter, and for whom the Exchange cannot verify such attestation through the Department of Homeland Security, the Exchange shall follow the inconsistency procedures specified in Section 6492(a)(1) through (4).

(3) If, at the conclusion of the 95-day period specified in Section 6492(a)(2)(B), the Exchange remains unable to verify the applicant's attestation, the Exchange shall:

(A) Determine the applicant ineligible for APTC and CSR;

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

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

Note: Authority cited: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; 26 USC Sections 36B and 6103~~(4)(21)~~; 26 CFR Section 1.36B-1; 42 CFR Sections 435.603 and 435.948; 45 CFR Section 155.320.

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

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

(1) An applicant attests, in accordance with Section 6482(e)(2), that a tax filer's annual household income has increased, or is reasonably expected to increase, from the

income described in Section 6482(e)(1) for the benefit year for which the applicant(s) in the tax filer's family are requesting coverage; and

(2) The Exchange has not verified the applicant's MAGI-based income to be within the applicable Medi-Cal or CHIP MAGI-based income standard, in accordance with the process specified in Medicaid regulations at 42 CFR Sections 435.945 (November 30, 2016), hereby incorporated by reference, 435.948 (March 23, 2012), hereby incorporated by reference, and 435.952 (November 30, 2016), hereby incorporated by reference, and CHIP regulations at 42 CFR Section 457.380 (November 30, 2016), hereby incorporated by reference.

(b) If data available to the Exchange regarding the MAGI-based income in accordance with Section 6482(c) indicate that a tax filer's projected annual household income is above the tax filer's attestation by more than the income threshold specified in subdivision (f) of this section, the Exchange shall follow the inconsistency procedures specified in Section 6492(a)(1) through (4).

(c) If other information provided by the application filer indicates that a tax filer's projected annual household income is above the tax filer's attestation by more than the income threshold specified in subdivision (f) of this section, the Exchange shall utilize data available to the Exchange regarding the MAGI-based income in accordance with Section 6482(c) to verify the attestation. If such data is unavailable or not reasonably compatible with the applicant's attestation, the Exchange shall follow the inconsistency procedures specified in Section 6492(a)(1) through (4).

(d) If, at the conclusion of the 95-day period specified in Section 6492(a)(2)(B), the Exchange remains unable to verify the applicant's attestation, the Exchange shall:

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

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

(3) Implement such determination in accordance with the effective dates specified in Section 6496(j) through (l).

(e) If, at the conclusion of the 95-day period specified in Section 6492(a)(2)(B), the Exchange remains unable to verify the applicant's attestation and the information described in Section 6482(e)(1) is unavailable, the Exchange shall:

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

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

(3) Discontinue any APTC and CSR in accordance with the effective dates specified in Section 6496(j) through (l).

(f) The income threshold shall be 50 percent or \$12,000 (whichever is greater).

Note: Authority cited: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; 26 USC Section 36B(b)(3)(A); 42 CFR Sections 435.945, 435.948, 435.952 and 457.380; and 45 CFR Section 155.320.

**§ 6486. Alternate Verification Process for ~~APTC and CSR Eligibility Determination~~
for Decreases Changes in Annual Household Income or if Tax Return Data is
Unavailable Related to APTC and CSR Eligibility Determination.**

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

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

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

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

(4) One of the following conditions is met:

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

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

(C) The applicant attests that a change in circumstances has occurred, or is reasonably expected to occur, and so the tax filer's annual household income has decreased, or is reasonably expected to decrease, from the income obtained from the data sources described in Section 6482(b)(1) for the benefit year for which the applicants in the tax filer's family are requesting coverage;

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

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

(b) If a tax filer qualifies for an alternate verification process based on the requirements specified in subdivision (a) of this section and the applicant's attestation to projected annual household income, as described in Section 6482(e)(2), is below the annual household income computed in accordance with Section 6482(e)(1) by no more than ~~the income threshold specified in Section 6484(f)~~ ten percent, the applicant's attestation shall be accepted without further verification.

(c) If a tax filer qualifies for an alternate verification process based on the requirements specified in subdivision (a) of this section and the applicant's attestation to projected annual household income, as described in Section 6482(e)(2), is below the annual household income computed in accordance with Section 6482(e)(1) by more than the income threshold specified in Section 6484(f), or if the data described in Section 6482(b)(1) is unavailable, the Exchange shall verify the applicant's attestation of the tax filer's projected annual household income in accordance with the following procedures:

(1) The Exchange shall use:

(A) Annualized data from the MAGI-based income sources, as specified in Section 6482(c); and

(B) Other HHS-approved electronic data sources.

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

(3) If electronic data are unavailable or the applicant's attestation to projected annual household income, as described in Section 6482(e)(2), is below the annual household income computed using data sources described in subdivision (c)(1) of this section by more than the income threshold specified in Section 6484(f), the Exchange shall follow procedures specified in Section 6492(a)(1) through (4).

(4) Except as specified in subdivision (c)(5) of this section, the Exchange shall accept the applicant's attestation without further verification if:

(A) The applicant's attestation to projected annual household income, as described in Section 6482(e)(2), indicates that a tax filer's annual household income has increased, or is reasonably expected to increase, from the data described in subdivision (c)(1) of this section for the benefit year for which the applicant(s) in the tax filer's family are requesting coverage; and

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

(5) The Exchange shall follow the inconsistency procedures specified in Section 6492(a)(1) through (4) if the Exchange finds that the applicant's attestation of a tax

filer's annual household income is not reasonably compatible with other information provided by the application filer.

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

(A) The applicant has not responded to a request for additional information from the Exchange following the 95-day period specified in Section 6492(a)(2)(B); and

(B) The data sources specified in Section 6482(b)(1) and (c) indicate that the applicant is eligible for full-scope Medi-Cal or CHIP.

(7) If, at the conclusion of the 95-day period specified in Section 6492(a)(2)(B), the Exchange remains unable to verify the applicant's attestation, the Exchange shall:

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

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

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

(8) If, at the conclusion of the 95-day period specified in Section 6492(a)(2)(B), the Exchange remains unable to verify the applicant's attestation for the tax filer and the information described in Section 6482(e)(1) is unavailable, the Exchange shall:

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

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

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

Note: Authority cited: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; 26 USC Sections 36B and 6103; 42 CFR Sections 435.945, 435.948, 435.952 and 457.380; and 45 CFR Section 155.320.

§ 6492. Inconsistencies.

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

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

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

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

(B) Provide the applicant or enrollee with a period of 95 days from the date of the notice described in subdivision (a)(2)(A) of this section to either present satisfactory documentary evidence through the channels available for the submission of an application, as described in Section 6470(j), except by telephone, or otherwise resolve the inconsistency.

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

(4) During the periods described in subdivisions (a)(1) and (a)(2)(B) of this section, shall:

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

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

(C) Clear the inconsistencies for which the Exchange receives satisfactory documentary evidence from the applicant or the enrollee. For income inconsistencies, the Exchange shall clear the inconsistency if the income shown on the documents provided by the applicant or enrollee is within 10% of the applicant's or enrollee's attestation.

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

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

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

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

(7) The Exchange shall extend the period described in subdivision (a)(2)(B) of this section by a period of 60 days for an applicant or enrollee with an income inconsistency who is required to present satisfactory documentary evidence to verify household income.

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

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

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

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

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

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

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

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

(1) An Indian applicant shall be eligible for CSR if the applicant:

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

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

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

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

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

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

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

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

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

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

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

(B) Shall not reduce the payment to any such entity for the item or service specified in subdivision (a)(3)(B) by the amount of any cost-sharing that would be due from the Indian but for subdivision (A).

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

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

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

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

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

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

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

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

Note: Authority cited: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; 26 USC Section 36B; 26 CFR Section 1.36B-1; and 45 CFR Section 155.350.

§ 6496. Eligibility Redetermination During a Benefit Year.

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

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

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

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

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

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

(g) The Exchange shall examine available data sources at least twice in a calendar year to identify the following changes of circumstances:

(1) Death; and

(2) For an enrollee on whose behalf APTC or CSR are being provided, eligibility determination for or enrollment in:

(A) Medi-Cal or CHIP;

(B) Medicare; or

(C) Multiple overlapping QHPs through the Exchange.

(h) If the Exchange verifies updated information reported by an enrollee, the Exchange shall:

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

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

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

(i) If the Exchange identifies updated information through the data matching specified in subdivision (g) of this section regarding death or eligibility for or enrollment in Medicare, Medi-Cal, CHIP, or multiple overlapping QHPs, the Exchange shall:

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

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

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

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

(A) The enrollee has not directed the Exchange to terminate their coverage under such circumstances, in which case the Exchange shall terminate the enrollee's coverage in accordance with Section 6506(a)(2) and (d)(3); and

(B) The enrollee has not been determined to be deceased, in which case the Exchange shall terminate the enrollee's coverage in accordance with Section 6506(d)(10).

(j) The Exchange shall implement changes resulting from an appeal decision, on the date specified in the appeal decision or consistent with the effective dates specified in Section 6618(c)(1) of Article 7 of this chapter.

(k) Except as specified in subdivision (j) or (l) of this section, the Exchange shall implement changes on the first day of the month following the month of the notice of eligibility redetermination described in subdivision (h)(2) of this section.

(l) The Exchange shall implement a change associated with the events described in Section 6504(h)(1), (2), (3), (4), (5), (6), and (7) on the coverage effective dates described in Section 6504(h)(1), (2), (3), (4), (5), (6), and (7) respectively.

(m) When an eligibility redetermination in accordance with this section results in a change in the amount of APTC for the benefit year, the Exchange shall recalculate the amount of APTC in such a manner as to:

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

(2) If the recalculated APTC amount is less than zero, set the APTC provided on the tax filer's behalf to zero.

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

(o) When an eligibility redetermination in accordance with this section results in a change in the enrollee's rating region, as defined in Section 6410, or if the enrollee has moved out of the service area of the QHP, the enrollee remains eligible for enrollment in

a QHP through the Exchange, and the enrollee does not terminate coverage, including termination of coverage in connection with voluntarily selecting a different QHP in accordance with Section 6506, the Exchange shall proceed in accordance with the following process:

- (1) The enrollee shall be enrolled in the same QHP as the enrollee's current QHP, unless the enrollee's current QHP is not available.
- (2) If the enrollee is not eligible for the same level of CSR as the enrollee's current level of CSR, they shall be enrolled in a silver-tier QHP offered by the same QHP issuer at the CSR level for which the enrollee is eligible. If the enrollee is not eligible for any level of CSR, they shall be enrolled in a standard silver-tier QHP offered by the same QHP issuer without CSR.
- (3) If the enrollee's current QHP is not available and the current QHP is a HDHP as defined in Section 6410, the enrollee shall be enrolled in the lowest cost HDHP offered by the same QHP issuer at the same metal tier, as determined by the Exchange on a case-by-case basis. If there is no HDHP available, the enrollee shall be enrolled in the lowest cost QHP that is not a HDHP offered by the same QHP issuer at the same metal tier, as determined by the Exchange on a case-by-case basis.
- (4) If the enrollee's current QHP is not available and the current QHP is not a HDHP, the enrollee shall be enrolled in the lowest cost QHP that is not a HDHP offered by the same QHP issuer at the same metal tier, as determined by the Exchange on a case-by-case basis.
- (5) If the issuer of the QHP in which the enrollee is currently enrolled is no longer available, the enrollee shall be enrolled in the lowest cost QHP that is most similar to

the enrollee's current QHP offered by a different QHP issuer that is available to the enrollee through the Exchange at the same metal tier and in accordance with the same hierarchy specified in subdivision (o)(3) through (4) of this section, as determined by the Exchange on a case-by-case basis.

(6) If the enrollee who is currently enrolled in a QHP as a dependent attains the age of 26 before the effectuation date of the new QHP, the enrollee shall be enrolled in their own individual QHP through the Exchange in accordance with the process specified in subdivision (o)(1) through (5) of this section.

(7) Notwithstanding the process specified in subdivision (o)(1) through (6) of this section, a federally recognized American Indian or Alaska Native enrollee who is currently enrolled in a zero cost sharing QHP shall be enrolled in the lowest cost zero cost sharing QHP that offers the same benefits and provider network offered by the same QHP issuer. If the issuer of the QHP in which the enrollee is currently enrolled is no longer available, the enrollee shall be enrolled in the lowest cost zero cost sharing QHP offered by a different QHP issuer that is available to the enrollee through the Exchange, as determined by the Exchange on a case-by-case basis.

(p) The Exchange shall implement the process specified in subdivision (o) of this section no later than October 1, 2025.

Note: Authority cited: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; 26 USC Section 36B; 26 CFR Section 1.36B-3; and 45 CFR Section 155.330.

§ 6504. Special Enrollment Periods.

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

(1) A qualified individual or their dependent either:

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

1. Except as provided in subdivision (a)(1)(A)2 of this section, the last day the qualified individual or their dependent would have coverage under their previous plan or coverage;

2. If loss of MEC occurs due to a QHP decertification, the date of the notice of decertification as described in 45 CFR Section 155.1080(e)(2) (May 29, 2012), hereby incorporated by reference;

(B) Is enrolled in any non-calendar year group health plan or individual health insurance coverage, including both grandfathered and non-grandfathered health plans that expired or will expire, even if the qualified individual or their dependent has the option to renew such coverage. The date of the loss of coverage shall be the last day of the plan or policy year;

(C) Loses Medi-Cal coverage for pregnancy-related services, as described under Section 1902(a)(10)(A)(i)(IV) and (a)(10)(A)(ii)(IX) of the Social Security Act (42 USC 1396a(a)(10)(A)(i)(IV), (a)(10)(A)(ii)(IX)) and Section 14005.18 of the Welfare and Institutions Code or loses access to healthcare services through coverage provided to a pregnant woman's unborn child, based on the definition of a child in 42 CFR Section 457.10, (November 30, 2016), hereby incorporated by reference. The date of the loss of

coverage shall be the last day the consumer would have pregnancy-related coverage or access to healthcare services through unborn child coverage; or

(D) Loses Medi-Cal coverage for medically needy, as described under Section

1902(a)(10)(C) of the Social Security Act and Section 14005.21 of the Welfare and

Institutions Code, only once per calendar year. The date of the loss of coverage shall be the last day the consumer would have medically needy coverage.

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

(3) An enrollee loses a dependent or is no longer considered a dependent through divorce, legal separation, or dissolution of domestic partnership as defined by State law in the State in which the divorce, legal separation, or dissolution of domestic partnership occurs, or if the enrollee, or their dependent, dies.

(4) A qualified individual, or their dependent, becomes newly eligible for enrollment in a QHP through the Exchange because they newly meet the requirements specified in Section 6472(c) or (d).

(5) A qualified individual's, or their 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, its instrumentalities, a QHP issuer, or a non-Exchange entity providing enrollment assistance or conducting enrollment activities. 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.

(6) An enrollee, or their dependent, adequately demonstrates to the Exchange, as determined by the Exchange on a case-by-case basis, that the QHP in which they are enrolled substantially violated a material provision of its contract in relation to the enrollee.

(7) An enrollee, or their dependent enrolled in the same QHP, is determined newly eligible or ineligible for APTC or has a change in eligibility for CSR.

(8) A qualified individual, or their dependent, who is enrolled in an eligible employer-sponsored plan is determined newly eligible for APTC because such individual is ineligible for qualifying coverage in an eligible employer-sponsored plan in accordance with 26 CFR Section 1.36B-2(c)(3), including as a result of their employer discontinuing or changing available coverage within the next 60 days, provided that such individual is allowed to terminate existing coverage.

(9) A qualified individual or enrollee, or their dependent, gains access to new QHPs as a result of a permanent move.

(10) A qualified individual who:

(A) Gains or maintains status as an Indian, as defined in Section 6410 of Article 2 of this chapter, may enroll in a QHP or change from one QHP to another one time per month;

or

(B) Is or becomes a dependent of an Indian, as defined in Section 6410 of Article 2 of this chapter, and is enrolled or is enrolling in a QHP through the Exchange on the same application as the Indian, may change from one QHP to another one time per month, at the same time as the Indian.

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

(A) If an individual receives a certificate of exemption for hardship based on the eligibility standards described in 45 CFR Section 155.605(d)(1) (April 17, 2018), hereby incorporated by reference, or the eligibility standards described in Section 6914 of Article 13 of this chapter for a month or months during the coverage year, and based on the circumstances of the hardship attested to, they are no longer eligible for a hardship exemption within a coverage year but outside of an open enrollment period described in Section 6502, the individual and their dependents shall be eligible for a special enrollment period if otherwise eligible for enrollment in a QHP.

(B) If an individual with a certificate of exemption reports a change regarding the eligibility standards for an exemption, as required under 45 CFR Section 155.620(b) (July 1, 2013), hereby incorporated by reference, or under Section 6920 of Article 13 of this chapter and the change resulting from a redetermination is implemented, the certificate provided for the month in which the redetermination occurs, and for prior months, remains effective. If the individual is no longer eligible for an exemption, the individual and their dependents shall be eligible for a special enrollment period if otherwise eligible for enrollment in a QHP.

(C) If an enrollee provides satisfactory documentary evidence to verify their eligibility for an IAP or enrollment in a QHP through the Exchange within 30 days following their termination of Exchange enrollment due to a failure to verify such status within the 95-

day period specified in Section 6492(a)(2)(B), the enrollee shall be eligible for a special enrollment period if otherwise eligible for enrollment in a QHP.

(D) If a qualified individual or enrollee, or their dependent, experiences a fire, flood, or other natural or human-caused disaster that results in the declaration of state of emergency in California, the individual shall be eligible for a special enrollment period if otherwise eligible for enrollment in a QHP. The date of the triggering event shall be the date of the declaration of state of emergency.

(E) In case of a national public health emergency or a pandemic that results in a declaration of a state of emergency at the state or national level, a qualified individual or enrollee, or their dependent, shall be eligible for a special enrollment period if otherwise eligible for enrollment in a QHP. This triggering event shall be ongoing throughout the state of emergency.

(12) A qualified individual or enrollee is a victim of domestic abuse or spousal abandonment, as specified in 26 CFR Section 1.36B-2 (b)(2)(ii) through (v), or a dependent or unmarried victim within a household, is enrolled in MEC, and seeks to enroll in coverage separate from the perpetrator of the abuse or abandonment. A dependent of a victim of domestic abuse or spousal abandonment who is on the same application as the victim may enroll in coverage at the same time as the victim.

(13) A qualified individual, or their dependent:

(A) Applies for coverage on the Exchange during the annual open enrollment period or due to a qualifying event, is assessed by the Exchange as potentially eligible for Medi-Cal or CHIP, and is determined ineligible for Medi-Cal or CHIP by the State Medi-Cal or

CHIP agency either after open enrollment period has ended or more than 60 days after the qualifying event; or

(B) Applies for coverage at the State Medi-Cal or CHIP agency during the annual open enrollment period and is determined ineligible for Medi-Cal or CHIP after open enrollment period has ended.

(14) The qualified individual's or enrollee's, or their dependent's, enrollment through the Exchange was influenced by a material error related to plan benefits, service area, cost-sharing, or premium. A material error is one that is likely to have influenced a qualified individual's, enrollee's, or their dependent's enrollment in a QHP, as determined by the Exchange on a case-by-case basis.

(15) The qualified individual, enrollee, or dependent newly gains access to an individual coverage HRA, as defined in 45 CFR Section 146.123(b) (August 19, 2019), hereby incorporated by reference, or is newly provided a qualified small employer health reimbursement arrangement (QSEHRA), as defined in Section 9831(d)(2) of the Internal Revenue Code. The date of this triggering event shall be the first day on which coverage for the qualified individual, enrollee, or dependent under the individual coverage HRA can take effect, or the first day on which coverage under the QSEHRA takes effect. An individual, enrollee, or dependent shall qualify for this special enrollment period regardless of whether they were previously offered or enrolled in an individual coverage HRA or previously provided a QSEHRA, so long as the individual, enrollee, or dependent is not enrolled in the individual coverage HRA or covered by the QSEHRA on the day immediately prior to the triggering event.

(16) The qualified individual or their dependent is enrolled in COBRA continuation coverage for which an employer is paying all or part of the premiums, or for which a government entity is providing subsidies, and the employer completely ceases its contributions to the qualified individual's or dependent's COBRA continuation coverage or government subsidies completely cease. The date of this event shall be the last day of the period for which COBRA continuation coverage is paid for or subsidized, in whole or in part, by an employer or government entity.

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

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

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

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

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

(B) Loss of eligibility for coverage through Medicare, Medi-Cal, or other government-sponsored health care programs, other than programs specified as not MEC under 26 CFR Section 1.5000A-2(b)(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 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 plan no longer offers any benefits to the class of similarly situated individuals that includes the individual.

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

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

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

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

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

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

(1) Failure to pay premiums on a timely basis, including COBRA premiums prior to exhaustion of COBRA coverage, except for circumstances in which an employer completely ceases its contributions to COBRA continuation coverage or government subsidies of COBRA continuation coverage completely cease as described in subdivision (a)(16) of this section; or

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

(d) A qualified individual or an enrollee shall attest under penalty of perjury that they meet at least one of the triggering events specified in subdivision (a) of this section. The Exchange shall inform the qualified individual or the enrollee that pursuant to 45 CFR Section 155.285, (September 6, 2016), hereby incorporated by reference, HHS may impose civil money penalties of:

(1) Up to \$25,000 on the qualified individual or the enrollee who fails to provide the correct information requested by the Exchange, subject to the exception specified in

subdivision (e)(4) of this section, due to their negligence or disregard of the federal or State rules or regulations related to the Exchange with negligence and disregard defined as they are in section 6662 of IRC (26 USC § 6662), as follows:

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

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

(2) Up to \$250,000 on the qualified individual or the enrollee who:

(A) Knowingly and willfully provides false or fraudulent information requested by the Exchange, where knowingly and willfully means intentionally providing information that the person knows to be false or fraudulent; or

(B) Knowingly and willfully uses or discloses information in violation of Section 1411(g) of the Affordable Care Act (42 USC § 18081(g)), where knowingly and willfully means intentionally using or disclosing information in violation of Section 1411(g).

(e) The Exchange shall accept the qualified individual's or the enrollee's attestation provided in accordance with subdivision (d) of this section, subject to the following statistically valid random sampling verification process:

(1) The Exchange may select a statistically valid random sample of the qualified individuals or the enrollees who, in accordance with subdivision (d) of this section, have attested that they met at least one of the triggering events specified in subdivision (a) of this section and request, in writing, that they provide documentation as proof of the triggering event to which they attested or for which they qualify.

(2) The qualified individual or the enrollee shall provide the requested document(s) within 30 days from the date of the Exchange's written request, as specified in subdivision (e)(1) of this section, to the Exchange for verification. The Exchange may extend this period if the Exchange determines on a case-by-case basis that the qualified individual or the enrollee has demonstrated that they have made a good-faith effort but was unable to obtain the requested documentation during the 30-day time period.

(3) Except as specified in subdivision (e)(4) of this section, if the qualified individual or the enrollee fails to submit the requested document(s) by the end of the time period specified in subdivision (e)(2) of this section or the Exchange is unable to verify the provided document(s), the Exchange shall:

(A) Determine the qualified individual or the enrollee ineligible for any special enrollment period;

(B) Notify the qualified individual or the enrollee regarding the determination and their appeals rights, in accordance with the requirements specified in Section 6476(h); and

(C) Implement such eligibility determination in accordance with the dates specified in Section 6496(j) and (k), as applicable.

(4) The Exchange shall provide an exception, on a case-by-case basis, to accept a qualified individual's or an enrollee's attestation as to their triggering event which cannot otherwise be verified and their explanation of circumstances as to why they do not have documentation if:

(A) The qualified individual or the enrollee does not have the requested documentation with which to prove a triggering event through the process described in subdivision

(e)(1) through (3) of this section because such documentation does not exist or is not reasonably available;

(B) The Exchange is unable to otherwise verify the triggering event for the qualified individual or the enrollee; and

(C) The qualified individual or the enrollee provides the Exchange with a signed written statement of their attestation under penalty of perjury as to the triggering event and the explanation of circumstances as to why they do not have the documentation.

(5) The sampling described in this subdivision shall not be based on the qualified individual's or the enrollee's claims costs, diagnosis code, or demographic information. For purposes of this subdivision (e)(5), demographic information does not include geographic factors.

(f) Except as provided in subdivision (f)(1), (2), (3), (4), (5), (6), (7), and (8) of this section, a qualified individual, enrollee, or their dependent shall have 60 days from the date of a triggering event to select a QHP.

(1) Except as provided in subdivision (f)(6) of this section, a qualified individual or their dependent who loses coverage, as described in subdivision (a)(1) of this section shall have 60 days before and after the date of the loss of coverage to select a QHP.

(2) A qualified individual who is enrolled in an eligible employer-sponsored plan and will lose eligibility for qualifying coverage in an eligible employer-sponsored plan within the next 60 days, as described in subdivision (a)(8) of this section, shall have 60 days before and after the loss of eligibility for qualifying coverage in an eligible employer-sponsored plan to select a QHP.

(3) A qualified individual, enrollee, or their dependent who is described in subdivision (a)(15) of this section shall have 60 days before the triggering event to select a QHP, unless the HRA or QSEHRA was not required to provide the notice setting forth its terms to such individual or enrollee at least 90 days before the beginning of the plan year, as specified in 45 CFR Section 146.123(c)(6), 26 CFR Section 54.9802-4(c)(6) (August 19, 2019), hereby incorporated by reference, and 29 CFR Section 2590.702-2(c)(6) (August 19, 2019), hereby incorporated by reference, or Section 9831(d)(4) of the Internal Revenue Code, as applicable, in which case the qualified individual, enrollee, or their dependent shall have 60 days before or after the triggering event to select a QHP.

(4) A qualified individual or their dependent who is described in subdivision (a)(16) of this section shall have 60 days before and after the date of the triggering event to select a QHP.

(5) If a qualified individual, enrollee, or their dependent did not receive timely notice of an event that triggers eligibility for a special enrollment period under this section, and otherwise was reasonably unaware that a triggering event described in subdivision (a) of this section occurred, the Exchange shall allow the qualified individual, enrollee, or when applicable, their dependent to select a new plan within 60 days of the date that they knew, or reasonably should have known, of the occurrence of the triggering event.

(6) Beginning January 1, 2024, a qualified individual or their dependent who loses Medical or CHIP coverage shall have 90 days after the date of the loss of coverage to select a QHP.

(7) Beginning January 1, 2025, the following individuals shall have 60 days before and after the triggering event to select a QHP:

(A) A qualified individual or their dependent who becomes newly eligible for enrollment in a QHP through the Exchange because they newly meet the requirements specified in Section 6472(d) as described in subdivision (a)(4) of this section.

(B) A qualified individual or their dependent who gains access to new QHPs as a result of a permanent move as described in subdivision (a)(9) of this section.

(g) Except as specified in subdivision (h) of this section, the regular coverage effective date for a special enrollment period shall be the first day of the month following plan selection.

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

(1) In the case of birth, adoption, placement for adoption, or placement in foster care, the coverage shall be effective either:

(A) On the date of birth, adoption, placement for adoption, or placement in foster care; or

(B) On the first day of the month following birth, adoption, placement for adoption, or placement in foster care; or

(C) On the first day of the month following plan selection, at the option of the qualified individual or the enrollee.

(2) In the case where a qualified individual, or their dependent, loses coverage as described in subdivisions (a)(1) and (a)(8) of this section, or is enrolled in COBRA continuation coverage and employer contributions to or government subsidies of this

coverage completely cease as described in subdivision (a)(16) of this section, the coverage and APTC and CSR, if applicable, shall be effective:

(A) On the first day of the month following the loss of coverage or the date of the triggering event if the plan selection is made on or before the date of the loss of coverage or the triggering event;

(B) On the first day of the month following plan selection if the plan selection is made after the date of the loss of coverage or the triggering event; or

(C) Beginning January 1, 2025, at the option of the qualified individual or the enrollee, on the first day of the month in which the loss of coverage or the triggering event occurs if the plan selection is made on or before the last day of the month prior to the month of the loss of coverage or the triggering event.

(3) Beginning January 1, 2025, in the case of a qualified individual or their dependent who becomes newly eligible for enrollment in a QHP through the Exchange because they newly meet the requirements specified in Section 6472(d), as described in subdivision (a)(4) of this section, or gains access to new QHPs as a result of a permanent move, as described in subdivision (a)(9) of this section, the coverage and APTC and CSR, if applicable, shall be effective:

(A) On the first day of the month following the date of the triggering event if the plan selection is made on or before the date of the event; or

(B) On the first day of the month following plan selection if the plan selection is made after the date of the triggering event.

(4) In the case of a qualified individual or enrollee eligible for a special enrollment period described in subdivisions (a)(5), (a)(6), (a)(11), (a)(13), or (a)(14) of this section, the

coverage shall be effective on an appropriate date, including a retroactive date, determined by the Exchange on a case-by-case basis based on the circumstances of the special enrollment period.

(5) In the case of a court order described in subdivision (a)(2) of this section, the coverage shall be effective either:

(A) On the date the court order is effective; or

(B) On the first day of the month following plan selection, at the option of the qualified individual or the enrollee.

(6) If a qualified individual, enrollee, or dependent newly gains access to an individual coverage HRA or is newly provided a QSEHRA, each as described in subdivision (a)(15) of this section, and if the plan selection is made before the day of the triggering event, the coverage shall be effective on the first day of the month following the date of the triggering event or, if the triggering event is on the first day of a month, on the date of the triggering event. If the plan selection is made on or after the day of the triggering event, the coverage shall be effective on the first day of the month following plan selection.

(7) At the option of a qualified individual, enrollee, or their dependent who is eligible to select a plan during a period provided for under subdivision (f)(5) of this section, the Exchange shall provide the earliest effective date that would have been available under subdivisions (g) and (h) of this section, based on the applicable triggering event under subdivisions (a) of this section.

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

(1) The individual makes their initial premium payment, reduced by the APTC amount they are determined eligible for by the Exchange, by the premium payment due date, as defined in Section 6410 of Article 2 of this chapter. In cases of retroactive enrollment dates, the initial premium shall consist of the premium due for all months of retroactive coverage through the first month of coverage following the plan selection date. If only partial premium for less than all months of retroactive coverage is paid, only prospective coverage shall be effectuated, in accordance with the regular coverage effective date specified in subdivision (g) of this section; and

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

(j) Notwithstanding the standards of this section, APTC and CSR shall adhere to the effective dates specified in subdivisions (j) through (l) of Section 6496.

(k) For purposes of this section, references to eligibility for APTC refer to being eligible for such advance payments in an amount greater than zero dollars per month.

References to ineligibility for APTC refer to being ineligible for such payments or being eligible for such payments but being eligible for a maximum of zero dollars per month of such payments.

(l) For purposes of this section, all tax household members shall be eligible for a special enrollment period, if otherwise eligible for enrollment in a QHP, if one household member experiences a triggering event.

Note: Authority cited: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; Section 1399.849, Health and Safety Code; Section 10965.3, Insurance Code; Sections 14005.18 and 14005.21, Welfare and Institutions Code; 26 USC Sections 36B(b)(3)(A), 6662 and 9831(d)(4); 42 USC Sections 1396a

and 18081; 26 CFR Sections 1.36B-2, 1.5000A-2, and 54.9802-4; 29 CFR Section 2590.702-2; 42 CFR Section 457.10; and 45 CFR Sections 146.123, 155.285, 155.420, 155.605, 155.620 and 155.1080.

Article 7. Appeals Process for the Individual Exchange

§ 6602. General Eligibility Appeals Requirements.

(a) In accordance with Section 6510 of Article 5 and Section 6922 of Article 13, an applicant or enrollee, or application filer shall have the right to appeal:

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

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

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

(C) A determination of eligibility for an enrollment period, made in accordance with Section 6476(c) of Article 5 of this chapter;

(2) An eligibility determination or redetermination for the State financial assistance, including the amount of the State advance premium assistance subsidy or the level of the State enhanced cost-sharing reduction, made in accordance with Title 25 (commencing with Section 100800) of the Government Code and Article 5 of this chapter.

(3) An eligibility determination or redetermination for a hardship or religious conscious exemption made in accordance with Article 13 of this chapter;

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

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

(b) The Exchange appeals entity shall conduct all eligibility appeals, including appeals of an eligibility determination for a hardship or religious conscious exemption made in accordance with Article 13 of this chapter.

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

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

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

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

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

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

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

(h) When an appellant seeks review of an adverse MAGI Medi-Cal or CHIP determination made by the Exchange, the appeals entity shall transmit the eligibility determination and all information provided as part of the appeal via secure electronic interface, within three business days from the date the appeal request is received to DHCS, as applicable, unless the appeal request is for an expedited appeal, in which case, the appeals entity shall follow the procedure provided in Section 6616.

(i) For any eligibility appeal decisions issued by the appeals entity on or after January 1, 2024, the appellant may request, within 14 days of the date of the decision, an administrative review of the decision by the CMS Administrator, in accordance with the process specified in 45 CFR Section 155.505(g)(1) (April 27, 2023), hereby incorporated by reference.

(j) The appeals entity shall:

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

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

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

Note: Authority cited: Sections 100504, 100506.1 and 100506.3, Government Code.

Reference: Sections 100503 and 100506, Government Code; and 45 CFR Sections 155.260, 155.270, 155.505, 155.510 and 155.605.

§ 6606. Appeal Requests.

(a) The Exchange and the appeals entity shall:

(1) Accept appeal requests submitted through any of the following channels, in accordance with Section 6470(j) of Article 5 of this chapter:

(A) The Exchange's Internet Web site;

(B) Telephone;

(C) Facsimile;

(D) Mail; or

(E) In person.

(2) Assist the applicant or enrollee in making the appeal request; and

(3) Not limit or interfere with the applicant's or enrollee's right to make an appeal request.

(b) The appeals entity shall consider an appeal request valid for purposes of this Article, as specified in Section 6602(c), if it is submitted in accordance with the requirements of subdivisions (c) and (d) of this section and Section 6602(a).

(c) The Exchange and the appeals entity shall allow an applicant or enrollee to request an appeal within 90 days of the date of the notice of eligibility determination, unless the appeals entity determines, in accordance with Section 6602(c), that there is good cause, as defined in Section 10951 of the Welfare and Institution Code, for filing the appeals request beyond the 90-day period. No filing timeline shall be extended for good

cause for more than 180 days after the date of the notice of eligibility determination. For purposes of this subdivision, if the last day of the filing period falls on a Saturday, Sunday, or holiday, as defined in Government Code Section 6700, the filing period shall be extended to the next business day, in accordance with Government Code Section 6707.

(d) If the appellant disagrees with the appeal decision of the Exchange appeals entity, they may make an appeal request to HHS within 30 days of the date of the Exchange appeals entity's appeal decision or notice of denial of a request to vacate a dismissal.

(e) Upon receipt of an appeal request pursuant to subdivisions (c) or (g) of this section, which has been determined to be valid in accordance with Section 6602(c), the appeals entity shall:

(1) Within five business days from the date on which the valid appeal request is received, send written acknowledgment to the appellant of the receipt of their valid appeal request, including but not limited to:

(A) Information regarding the appellant's opportunity for informal resolution prior to the hearing pursuant to Section 6612;

(B) Information regarding the appellant's eligibility pending appeal pursuant to Section 6608; and

(C) An explanation that any APTC paid on behalf of the tax filer pending appeal is subject to reconciliation under Section 36B(f) of IRC (26 U.S.C. § 36B(f)) and 26 CFR Section 1.36B-4.

(2) Except as provided in Section 6618(b)(2), within three business days from the date on which the valid appeal request is received, transmit via secure electronic interface

notice of the appeal request and, if applicable, instructions to provide eligibility pending appeal pursuant to Section 6608, to the Exchange and to the DHCS, as applicable; and

(3) Confirm receipt of the records transferred by the Exchange pursuant to subdivision (g) of this section within two business days of the receipt of the records.

(f) Upon receipt of an appeal request that is determined not valid because it fails to meet the requirements of this section or Section 6602(a), unless the appeals entity determines that there is good cause for such a failure, in accordance with Section 6602(c), the appeals entity shall:

(1) Within five business days from the date on which the appeal request is received, send written notice to the appellant informing him or her:

(A) That the appellant's appeal request has not been accepted;

(B) About the nature of the defect in the appeal request; and

(C) That, if the defect specified in subdivision (f)(1)(B) of this section is curable, the appellant may cure the defect and resubmit the appeal request, in accordance with subdivision (a) of this section, within 30 calendar days from the date on which the invalid appeal request is received; and

(2) Treat as valid, in accordance with Section 6602(c), an amended appeal request that meets the requirements of this section and of Section 6602(a).

(g) Upon receipt of an appeal request pursuant to subdivision (c) of this section, or upon receipt of the notice under subdivision (e)(2) of this section, the Exchange shall transmit via secure electronic interface to the appeals entity:

(1) The appeal request, if the appeal request was initially made to the Exchange; and

(2) The appellant's eligibility record.

(h) Upon receipt of the notice of an appeal request made to HHS, pursuant to subdivision (d) of this section, the Exchange appeals entity shall, within three business days from the date on which the appeal request is received, transmit via secure electronic interface the appellant's appeal record, including the appellant's eligibility record as received from the Exchange, to the HHS appeals entity.

Note: Authority cited: Section 100504, Government Code. Reference: Sections 6700, 6707, 100503 and 100506, Government Code; Section 10951, Welfare and Institution Code; 26 USC Section 36B; and 26 CFR Section 1.36B-4; and 45 CFR Section 155.520.

§ 6618. Appeal Decisions.

(a) Appeal decisions shall:

- (1) Be based exclusively on the information and evidence specified in Section 6614(e) and the eligibility requirements under Article 5 of this chapter;
- (2) State the decision, including a plain language description of the effect of the decision on the appellant's eligibility;
- (3) Include a summary of the facts relevant to the appeal;
- (4) Identify the legal basis, including the regulations that support the decision;
- (5) State the effective date of the decision, if applicable; and
- (6) Explain the appellant's right to pursue the appeal before the HHS appeals entity, including the applicable timeframe and instructions to file, if the appellant remains dissatisfied with the eligibility determination;
- (7) Indicate that the decision of the Exchange appeals entity is final, unless the appellant pursues the appeal before the HHS appeals entity; and

(8) Provide information about judicial review available to the appellant pursuant to Section 1094.5 of the California Code of Civil Procedure.

(b) The appeals entity shall:

(1) Issue a written appeal decision to the appellant within 90 days of the date on which a valid appeal request is received;

(2) If an appeal request submitted under Section 6616 is determined by the appeals entity to meet the criteria for an expedited appeal, issue the appeal decision as expeditiously as possible, but no later than five business days after the hearing, unless the appellant agrees to delay to submit additional documents for the appeals record; and

(3) Provide the appeal decision and instructions to cease the appellant's pended eligibility, if applicable, via secure electronic interface, to the Exchange or the DHCS, as applicable.

(c) Upon receiving the appeal decision described in subdivision (b) of this section, the Exchange shall promptly, but no later than 30 days from the date of the appeal decision:

(1) Implement the appeal decision effective, at the option of the appellant:

(A) Prospectively, on the first day of the month following the date of the appeal decision or consistent with the effective dates specified in Section 6496(j) through (l) of Article 5 of this chapter, as applicable; or

(B) Retroactively, to the coverage effective date the appellant did receive or would have received if the appellant had enrolled in coverage under the incorrect eligibility determination that is the subject of the appeal.

(2) Redetermine the eligibility of household members who have not appealed their own eligibility determinations but whose eligibility may be affected by the appeal decision, in accordance with the standards specified in Section 6472 and 6474 of Article 5 of this chapter.

Note: Authority cited: Section 100504, Government Code. Reference: Section 1094.5, Code of Civil Procedure; Sections 100503 and 100506, Government Code; and 45 CFR Section 155.545.

This content is from the eCFR and is authoritative but unofficial.

Title 45 — Public Welfare

Subtitle A — Department of Health and Human Services

Subchapter B — Requirements Relating to Health Care Access

Part 155 — Exchange Establishment Standards and Other Related Standards Under the Affordable Care Act

Subpart A — General Provisions.

Source: 77 FR 18444, Mar. 27, 2012, unless otherwise noted.

Authority: 42 U.S.C. 18021-18024, 18031-18033, 18041-18042, 18051, 18054, 18071, and 18081-18083.

Source: 77 FR 11718, Feb. 27, 2012, unless otherwise noted.

§ 155.20 Definitions.

The following definitions apply to this part:

Advance payments of the premium tax credit means payment of the tax credit authorized by 26 U.S.C. 36B and its implementing regulations, which are provided on an advance basis to an eligible individual enrolled in a QHP through an Exchange in accordance with section 1412 of the Affordable Care Act.

Affordable Care Act means the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152).

Agent or broker means a person or entity licensed by the State as an agent, broker or insurance producer.

Agent or broker direct enrollment technology provider means a type of web-broker business entity that is not a licensed agent or broker under State law and has been engaged or created by, or is owned by an agent or broker, to provide technology services to facilitate participation in direct enrollment under §§ 155.220(c)(3) and 155.221.

Annual open enrollment period means the period each year during which a qualified individual may enroll or change coverage in a QHP through the Exchange.

Applicant means:

- (1) An individual who is seeking eligibility for him or herself through an application submitted to the Exchange, excluding those individuals seeking eligibility for an exemption from the individual shared responsibility payment pursuant to subpart G of this part, or transmitted to the Exchange by an agency administering an insurance affordability program for at least one of the following:
 - (i) Enrollment in a QHP through the Exchange; or
 - (ii) Medicaid, CHIP, and the BHP, if applicable.
- (2) For SHOP:
 - (i) An employer seeking eligibility to purchase coverage through the SHOP; or
 - (ii) An employer, employee, or a former employee seeking eligibility for enrollment in a QHP through the SHOP for himself or herself and, if the qualified employer offers dependent coverage through the SHOP, seeking eligibility to enroll his or her dependents in a QHP through the SHOP.

Application filer means an applicant, an adult who is in the applicant's household, as defined in 42 CFR 435.603(f), or family, as defined in 26 CFR 1.36B-1(d), an authorized representative of an applicant, or if the applicant is a minor or incapacitated, someone acting responsibly for an applicant, excluding those individuals seeking eligibility for an exemption from the individual shared responsibility payment pursuant to subpart G of this part.

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

Catastrophic plan means a health plan described in section 1302(e) of the Affordable Care Act.

Code means the Internal Revenue Code of 1986.

Cost sharing means any expenditure required by or on behalf of an enrollee with respect to essential health benefits; such term includes deductibles, coinsurance, copayments, or similar charges, but excludes premiums, balance billing amounts for non-network providers, and spending for non-covered services.

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

Direct enrollment entity means an entity that an Exchange permits to assist consumers with direct enrollment in qualified health plans offered through the Exchange in a manner considered to be through the Exchange as authorized by § 155.220(c)(3), § 155.221, or § 156.1230 of this subchapter.

Direct enrollment entity application assister means an employee, contractor, or agent of a direct enrollment entity who is not licensed as an agent, broker, or producer under State law and who assists individuals in the individual market with applying for a determination or redetermination of eligibility for coverage through the Exchange or for insurance affordability programs.

Educated health care consumer has the meaning given the term in section 1304(e) of the Affordable Care Act.

Eligible employer-sponsored plan has the meaning given the term in section 5000A(f)(2) of the Code.

Employee has the meaning given to the term in section 2791 of the PHS Act.

Employer has the meaning given to the term in section 2791 of the PHS Act, except that such term includes employers with one or more employees. All persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Code are treated as one employer.

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

Enrollee means a qualified individual or qualified employee enrolled in a QHP. Enrollee also means the dependent of a qualified employee enrolled in a QHP through the SHOP, and any other person who is enrolled in a QHP through the SHOP, consistent with applicable law and the terms of the group health plan. Provided that at least one employee enrolls in a QHP through the SHOP, enrollee also means a business owner enrolled in a QHP through the SHOP, or the dependent of a business owner enrolled in a QHP through the SHOP.

Exchange means a governmental agency or non-profit entity that meets the applicable standards of this part and makes QHPs available to qualified individuals and/or qualified employers. Unless otherwise identified, this term includes an Exchange serving the individual market for qualified individuals and a SHOP serving the small group market for qualified employers, regardless of whether the Exchange is established and operated by a State (including a regional Exchange or subsidiary Exchange) or by HHS.

Exchange Blueprint means information submitted by a State, an Exchange, or a regional Exchange that sets forth how an Exchange established by a State or a regional Exchange meets the Exchange approval standards established in § 155.105(b) and demonstrates operational readiness of an Exchange as described in § 155.105(c)(2).

Exchange service area means the area in which the Exchange is certified to operate, in accordance with the standards specified in subpart B of this part.

Federal platform agreement means an agreement between a State Exchange and HHS under which a State Exchange agrees to rely on the Federal platform to carry out select Exchange functions.

Federally-facilitated Exchange means an Exchange established and operated within a State by the Secretary under section 1321(c)(1) of the Affordable Care Act.

Federally-facilitated SHOP means a Small Business Health Options Program established and operated within a State by the Secretary under section 1321(c)(1) of the Affordable Care Act.

Full-time employee has the meaning given in section 4980H (c)(4) of the Code effective for plan years beginning on or after January 1, 2016, except for operations of a Federally-facilitated SHOP for which it is effective for plan years beginning on or after January 1, 2014 and in connection with open enrollment activities beginning October 1, 2013.

Grandfathered health plan has the meaning given the term in § 147.140.

Group health plan has the meaning given to the term in § 144.103.

Health insurance issuer or issuer has the meaning given to the term in § 144.103.

Health insurance coverage has the meaning given to the term in § 144.103.

Health plan has the meaning given to the term in section 1301(b)(1) of the Affordable Care Act.

Individual market has the meaning given the term in section 1304(a)(2) of the Affordable Care Act.

Initial open enrollment period means the period during which a qualified individual may enroll in coverage through the Exchange for coverage during the 2014 benefit year.

Issuer application assister means an employee, contractor, or agent of a QHP issuer who is not licensed as an agent, broker, or producer under State law and who assists individuals in the individual market with applying for a determination or redetermination of eligibility for coverage through the Exchange or for insurance affordability programs.

Large employer means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 51 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year. In the case of an employer that was not in existence throughout the preceding calendar year, the determination of whether the employer is a large employer is based on the average number of employees that it is reasonably expected the employer will employ on business days in the current calendar year. A State may elect to define large employer by substituting "101 employees" for "51 employees." The number of employees must be determined using the method set forth in section 4980H(c)(2) of the Code.

Lawfully present means a noncitizen who—

- (1) Is a qualified noncitizen as defined at 42 CFR 435.4;

- (2) Is in a valid nonimmigrant status, as defined in 8 U.S.C. 1101(a)(15) or otherwise under the immigration laws (as defined in 8 U.S.C. 1101(a)(17));
- (3) Is paroled into the United States in accordance with 8 U.S.C. 1182(d)(5) for less than 1 year, except for a noncitizen paroled for prosecution, for deferred inspection or pending removal proceedings;
- (4) Is granted temporary resident status in accordance with 8 U.S.C. 1160 or 1255a;
- (5) Is granted Temporary Protected Status (TPS) in accordance with 8 U.S.C. 1254a;
- (6) Is granted employment authorization under 8 CFR 274a.12(c);
- (7) Is a Family Unity beneficiary in accordance with section 301 of Pub. L. 101-649 as amended; or section 1504 of the LIFE Act Amendments of 2000, title XV of H.R. 5666, enacted by reference in Pub. L. 106-554 (see section 1504 of App. D to Pub. L. 106-554);
- (8) Is covered by Deferred Enforced Departure (DED) in accordance with a decision made by the President;
- (9) Is granted deferred action, including but not limited to individuals granted deferred action under 8 CFR 236.22;
- (10) Has a pending application for adjustment of status;
- (11)
 - (i) Has a pending application for asylum under 8 U.S.C. 1158, for withholding of removal under 8 U.S.C. 1231(b)(3)(A), or for protection under the regulations implementing the Convention Against Torture; and
 - (ii) Is under the age of 14;
- (12) Has been granted withholding of removal under the regulations implementing the Convention Against Torture; or
- (13) Has a pending or approved petition for Special Immigrant Juvenile classification as described in 8 U.S.C. 1101(a)(27)(J).

Minimum essential coverage has the meaning given in section 5000A(f) of the Code.

Navigator means a private or public entity or individual that is qualified, and licensed, if appropriate, to engage in the activities and meet the standards described in § 155.210.

Plan year means a consecutive 12 month period during which a health plan provides coverage for health benefits. A plan year may be a calendar year or otherwise.

Plain language has the meaning given to the term in section 1311(e)(3)(B) of the Affordable Care Act.

Qualified employee means any employee or former employee of a qualified employer who has been offered health insurance coverage by such qualified employer through the SHOP for himself or herself and, if the qualified employer offers dependent coverage through the SHOP, for his or her dependents.

Qualified employer means a small employer that elects to make, at a minimum, all full-time employees of such employer eligible for one or more QHPs in the small group market offered through a SHOP. Beginning in 2017, if a State allows large employers to purchase coverage through the SHOP, the term "qualified employer" shall include a large employer that elects to make all full-time employees of such employer eligible for one or more QHPs in the large group market offered through the SHOP.

Qualified health plan or QHP means a health plan that has in effect a certification that it meets the standards described in subpart C of part 156 issued or recognized by each Exchange through which such plan is offered in accordance with the process described in subpart K of part 155.

Qualified health plan issuer or QHP issuer means a health insurance issuer that offers a QHP in accordance with a certification from an Exchange.

Qualified health plan issuer direct enrollment technology provider means a business entity that provides technology services or provides access to an information technology platform to QHP issuers to facilitate participation in direct enrollment under § 155.221 or § 156.1230, including a web-broker that provides services as a direct enrollment technology provider to QHP issuers. A QHP issuer direct enrollment technology provider that provides technology services or provides access to an information technology platform to a QHP issuer will be a downstream or delegated entity of the QHP issuer that participates or applies to participate as a direct enrollment entity.

Qualified individual means, with respect to an Exchange, an individual who has been determined eligible to enroll through the Exchange in a QHP in the individual market.

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

Small employer means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least one but not more than 50 employees on business days during the preceding calendar year and who employs at least one employee on the first day of the plan year. In the case of an employer that was not in existence throughout the preceding calendar year, the determination of whether the employer is a small employer is based on the average number of employees that it is reasonably expected the employer will employ on business days in the current calendar year. A State may elect to define small employer by substituting "100 employees" for "50 employees." The number of employees must be determined using the method set forth in section 4980H(c)(2) of the Code.

Small group market has the meaning given to the term in section 1304(a)(3) of the Affordable Care Act.

Special enrollment period means a period during which a qualified individual or enrollee who experiences certain qualifying events may enroll in, or change enrollment in, a QHP through the Exchange outside of the initial and annual open enrollment periods.

Standardized option means a QHP offered for sale through an individual market Exchange that either—

- (1) Has a standardized cost-sharing structure specified by HHS in rulemaking; or
- (2) Has a standardized cost-sharing structure specified by HHS in rulemaking that is modified only to the extent necessary to align with high deductible health plan requirements under section 223 of the Internal Revenue Code of 1986, as amended, or the applicable annual limitation on cost sharing and HHS actuarial value requirements.

State means each of the 50 States and the District of Columbia.

Web-broker means an individual agent or broker, group of agents or brokers, or business entity registered with an Exchange under § 155.220(d)(1) that develops and hosts a non-Exchange website that interfaces with an Exchange to assist consumers with direct enrollment in QHPs offered through the Exchange as described in § 155.220(c)(3) or § 155.221. The term also includes an agent or broker direct enrollment technology provider.

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