November 20, 2025

ADVANCE NOTICE OF ADOPTION OF EMERGENCY REGULATIONS

This notice is sent in accordance with Government Code Section 11346.1(a)(2), which requires that State of California agencies give a five working day advance notice of intent to file emergency regulations with the Office of Administrative Law (OAL). The California Health Benefit Exchange ("Exchange") intends to file a request for adoption of the Emergency Rulemaking package with the Office of Administrative Law (OAL) that amends the regulations for the eligibility and enrollment and appeals process for the individual Exchange. As required by subdivisions (a)(2) and (b)(2) of Government Code Section 11346.1, this notice appends the following: (1) the specific language of the proposed regulation to amend Sections 6410, 6474, 6484, 6492, 6504, and 6602 of Chapter 12, Title 10 of California Code of Regulations; and (2) the Finding of Emergency, including specific facts demonstrating the need for immediate action, the authority and reference citations, the informative digest and policy statement overview, attached reports, and required determinations.

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

Comments should be sent simultaneously to:

Jameson Mitchell
Regulations Analyst
California Health Benefit Exchange
1601 Exposition Blvd.
Sacramento, CA 95815

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

Comments may also be submitted by facsimile (FAX) at 916-228-4468 or by e-mail to regulations@covered.ca.gov.

Upon filing, OAL will have ten (10) calendar days within which to review and make a decision on the proposed emergency rule. If approved, OAL will file the regulations with the Secretary of State, and the emergency regulations will become effective on the day

BOARD MEMBERS Kim Johnson, Chair Mayra Alvarez Craig Cornett Jerry Fleming Sumi Sousa EXEC. DIR. Jessica Altman

of filing. These regulations will remain in effect until five years from the date of their initial adoption upon OAL's approval, or until revised by the Board pursuant to Government Code Section 100504(a)(6). Please note that this advance notice and comment period is not intended to replace the public's ability to comment during the subsequent certification period of the permanent rulemaking process. The Exchange will hold a public hearing and 45-day comment period after it has published notice to make these regulations permanent.

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

www.healthexchange.ca.gov/regulations.

If you have any questions concerning this advance notice, please contact Jameson Mitchell at (916) 954-3372.

FINDING OF EMERGENCY

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

This rulemaking was adopted by OAL on July 24, 2024, upon completion of the certification period of the permanent rulemaking process. This emergency rulemaking was previously approved by OAL on December 16, 2024 (2024-1204-01E). The Exchange now seeks a readoption to allow for the necessary and immediate incorporation of conforming amendments to recent changes in federal regulations, and other amendments for eligibility and enrollment to these rules. In seeking this readoption, the Exchange is acting in accordance with Government Code §100504 which permits emergency regulations to be adopted and in effect for five years, allowing for the reconciliation process between state and federal law to occur rapidly and regularly, as may be warranted.

The Exchange is proposing to modify these regulations through its emergency rulemaking authority to establish, implement, simplify, and modify program requirements to align and comply with the recent federal changes, including CMS's Marketplace Integrity and Affordability Final Rule, the recent court decision temporarily blocking some of the rule's provisions (*City of Columbus v. Kennedy*, No. 25-cv-2114-BAH (D. Md.)), and H.R. 1 (The One Big Beautiful Bill Act). Therefore, these regulations are necessary for public health and general welfare.

DEEMED EMERGENCY

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

The Exchange may "adopt rules and regulations, as necessary. Until January 1, 2030, any necessary rules and regulations, except those implementing Section 1043, may be adopted as emergency regulations in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2). The adoption of emergency regulations pursuant to this section shall be deemed to be an emergency and necessary for the immediate preservation of public peace, health and safety, or general welfare. Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2, including subdivisions (e) and (h) of Section 11346.1, an emergency regulation adopted pursuant to this section shall be repealed by operation of law unless the adoption, amendment, or repeal of the regulation is promulgated by the board pursuant to Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code within five years of the initial adoption of the emergency regulation. A rule or regulation adopted pursuant to this section shall be discussed by the board during at least one properly noticed board meeting before the board meeting at which the board adopts the rule or regulation.

Notwithstanding subdivision (h) of Section 11346.1, until January 1, 2035, the Office of Administrative Law may approve more than two readoptions of an emergency regulation adopted pursuant to this section. The amendments made to this paragraph by the act that added this subparagraph also shall apply to any regulation adopted pursuant to this section before January 1, 2025."

CHANGES MADE TO THE REGULATIONS

The Exchange has reviewed and refined the proposed emergency regulations to streamline the process and improve clarity. The changes for this adoption are as follows:

Changes Made to Article 2:

- Section 6410:
  - Updated the date of 45 CFR Section 155.20 that is incorporated by reference for the definition of "Lawfully Present" to refer to the updated federal regulation that excludes Deferred Action for Childhood Arrivals (DACA) recipients from the definition of lawfully present effective August 25, 2025. This is necessary for clarity purposes and to comply with the recently revised federal regulations.

Changes Made to Article 5:

- Section 6474:
  - Revised subdivision (c)(2) to clarify that the APTC eligibility for lawfully present individuals under 100% FPL who are ineligible for Medi-Cal due to their immigration status ends on December 31, 2025, per H.R. 1. This is necessary for clarity purposes and to comply with the federal law.
  - Removed paragraphs (3) and (6) of subdivisions (c) related to the failure to reconcile (FTR) process and its notice requirements per the *City of Columbus v. Kennedy* decision blocking enforcement of this process. This is necessary for clarity purposes and to comply with the court ruling.
- Section 6484:
  - Revised subdivision (c) to correct a typo.
- Section 6492:
  - Removed subdivision (a)(7) related to the automatic 60-day extension of the reasonable opportunity period for individuals with income inconsistencies to submit documentation or resolve the issue, per the Marketplace Integrity and Affordability Final Rule. This is necessary for clarity purposes and to comply with the federal regulations in 45 CFR Section 155.315(f).
- Section 6504:
  - Removed subdivision (a)(17) related to the low-income (at or below 150% FPL) special enrollment period (SEP) triggering event, per the Marketplace Integrity and Affordability Final Rule. This is necessary for clarity purposes and to comply with the federal regulation in 45 CFR Section 155.420(d)(16).

Changes Made to Article 7:

- Section 6602:
  - Revised subdivision (a) to specify that an "application filer" shall have the right to appeal in addition to the applicants and enrollees. This is necessary for clarity

purposes and to comply with the federal regulation in 45 CFR Section 155.505(b).

Text proposed to be added is displayed in underline type font. Text proposed to be deleted is displayed in ~~strikethrough~~ type font.

The Exchange intends to make permanent these proposed regulations within five years in accordance with the Government Code, Section 100504, subdivision (a)(6).

AUTHORITY AND REFERENCE

Authority: Government Code Sections 100502, 100503, 100503.4, 100504, and 100505.
Reference: Government Code Sections 100502, 100503, 100503.4, and 100506.1; 45 CFR Sections 155.20, 155.315, 155.420, and 155.505.

DOCUMENTS RELIED UPON

None.

INFORMATIVE DIGEST/POLICY STATEMENT OVERVIEW

Documents to be incorporated by reference:

45 CFR Section 155.20 as amended in 90 FR 27220 (August 26, 2025).

Summary of Existing Laws

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

The proposed regulations will amend the regulations regarding the Exchange's policies and procedures for eligibility determination and enrollment in qualified health plans in the individual market. The proposed regulations will provide the public with clear standards and eligibility requirements for eligibility determination during the benefit year and renewal through the Exchange. Additionally, the proposed regulations will provide the standards and requirements for the qualified health plan issuers regarding enrollment of qualified individuals in the qualified health plans through the Exchange.

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

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

JUSTIFICATION FOR DUPLICATION

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

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

None.

LOCAL MANDATE

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

FISCAL IMPACT ESTIMATES

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

COSTS OR SAVINGS TO STATE AGENCIES AND TO FEDERAL FUNDING

There will be no costs or savings in federal funding to the state. The proposal results in additional costs to the California Health Benefit Exchange, which is currently financially self-sustaining and is not funded by federal grant money. The proposal does not result in any costs or savings to any other state agency.

California Code of Regulations

Title 10. Investment

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

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; 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) and1399.849(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)).

“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

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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.

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“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.

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“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.

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“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~~November 1, 2024~~), 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 §

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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”).

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“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.

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“Qualified Employer” has the same meaning as the term is defined in 42 USC Section 8032(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.

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“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.

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“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.

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

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Article 4. General Provisions

§ 6450. Meaning of Words.

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

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

§ 6452. Accessibility and Readability Standards.

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

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

(1) Be formatted and written in such a way that it can be understood at the ninth-grade level and, if possible, at the sixth-grade level;

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

(3) Contain no language that minimizes or contradicts the information being provided.

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

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

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

(A) Oral interpretation, including telephonic interpreter services in at least 150 languages;

(B) Written translations; and

(C) Taglines in non-English languages indicating the availability of language services in at least the top 15 languages spoken by the limited English proficient population in California.

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

(d) Information shall be provided to applicants and enrollees in a manner that is compliant with the nondiscrimination requirements under Section 11135 of the Government Code and Section 1557 of the ACA (42 USC § 18116) and its implementing regulations under Part 92 of Title 45 of Code of Federal Regulations (45 CFR Part 92) (May 18, 2016), hereby incorporated by reference.

Note: Authority cited: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; 42 USC Section 18116; 45 CFR Part 92; 45 CFR Section 155.205.

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§ 6454. General Standards for Exchange Notices.

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

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

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

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

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

(5) An explanation of appeal rights, as specified in Section 6604(b) of Article 7 of this chapter.

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

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

(d) The individual market Exchange shall provide required notices either through standard mail, or if an individual elects, electronically, provided that the requirements for electronic notices in 42 CFR Section 435.918 (July 15, 2013), hereby incorporated by reference, are met, except that the individual market Exchange shall not be required to implement the process specified in 42 CFR Section 435.918(b)(1) for eligibility determinations for enrollment in a QHP through the Exchange and IAPs that are effective before January 1, 2015.

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(e) Unless otherwise required by federal or State law, the SHOP shall provide required notices electronically, or if an employer or employee elects, through standard mail. If notices are provided electronically, the SHOP shall comply with the requirements for electronic notices in 42 CFR Section 435.918(b)(2) through (5) for the employer or employee.

(f) In the event that the individual market Exchange or SHOP is unable to send select required notices electronically due to technical limitations, it may instead send these notices through standard mail, even if an election has been made to receive such notices electronically.

Note: Authority cited: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; 42 CFR Section 435.918 and 45 CFR Section 155.230.

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

§ 6470. Application.

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

(1) Enrollment in a QHP,

(2) Medi-Cal,

(3) CHIP,

(4) APTC, and

(5) CSR.

(b) To apply for any of the programs listed in subdivision (a) of this section, an applicant or an application filer, or their Certified Enrollment Counselor (CEC), as defined in

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Section 6650 of Article 8 of this chapter, Certified Application Counselor (CAC), as defined in Section 6850(a)(2) of Article 11 of this chapter, Medi-Cal Managed Care Plan Enroller, as defined in Section 6900(a)(3) of Article 12 of this chapter, Plan-Based Enroller (PBE), as defined in Section 6410 of Article 2 of this chapter, or Certified Insurance Agent, as defined in Section 6410 of Article 2 of this chapter, shall submit all information, documentation, and declarations required on the single, streamlined application, as specified in subdivisions (c), (d), and (e) of this section, and shall sign and date the application. CECs, CACs, Medi-Cal Managed Care Plan Enrollers, PBEs, and Certified Insurance Agents must obtain the applicant's consent before signing and submitting the application. Before a CEC, PBE, or Certified Insurance Agent can submit the application, they shall comply with the requirements specified in subdivision (h) of this section.

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

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

(2) The applicant's date of birth.

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

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

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(5) The applicant's gender.

(6) The applicant's marital status.

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

(8) The applicant's employment status.

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

(10) The applicant's expected annual household income from all sources, as specified in subdivision (c)(9) of this section.

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

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

(A) Name and state of the tribe;

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

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

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(13) The applicant's expected type and amount of the tax deductions that the applicant is allowed to deduct from their taxable gross income when calculating the applicant's adjusted gross income on their federal income tax return.

(14) Whether the applicant is eligible for or enrolled in MEC through an employer-sponsored plan, as defined in Section 5000A(f)(2) of IRC (26 USC § 5000A(f)(2)), and if so, the amount of monthly premium the applicant must pay for self-only coverage, and family coverage if applicable, through their employer and whether it meets the minimum value standards, as defined in Section 6410 of Article 2 of this chapter.

(15) Whether the applicant currently has MEC through any government sponsored programs, as defined in Section 5000A(f)(1)(A) of IRC (26 USC § 5000A(f)(1)(A)).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(d) An applicant or an application filer shall declare under penalty of perjury that they:

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

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

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

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

(5) Understand that if they received premium tax credits for health coverage through the Exchange during the previous benefit year, they must have filed or will file a federal tax return for that benefit year.

(e) An applicant or an application filer shall indicate that they understand their rights and responsibilities by providing, on the single, streamlined application, a declaration that:

(1) The information the applicant provides on the application is true and accurate to the best of their knowledge, and that the applicant may be subject to a penalty if they do not tell the truth.

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

(3) The applicant understands that information they provide on the application shall be kept private in accordance with the applicable federal and State privacy and security laws and that the Exchange shares such information with other federal and State agencies in order to verify the information and to make an eligibility determination for

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the applicant and for any other person(s) for whom they have requested coverage on the application, if applicable.

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

(5) The applicant understands that they are required to report any changes to the information provided on the application to the Exchange.

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

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

(8) If the applicant or any other persons the applicant has included in the application qualifies for Medi-Cal, the applicant understands that if Medi-Cal pays for a medical expense, any money the applicant, or any other person(s) included in the application, receives from other health insurance, legal settlements, or judgments covering that

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medical expense shall be used to repay Medi-Cal until the medical expense is paid in full.

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

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

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

(1) They shall provide:

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

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

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

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

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

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

(g) The Exchange may request on the application that the applicant authorizes the Exchange to obtain updated tax return information, as described in Section 6498(b), for

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up to five years to conduct an annual redetermination, provided that the Exchange inform the applicant that they shall have the option to:

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

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

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

(1) Provide their name;

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

(3) Provide the name of the entity with which they are affiliated;

(4) Certify that they assisted the applicant complete the application free of charge;

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

(6) Date and sign the application.

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

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

(2) Subdivision (d) of this section;

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

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

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(5) Subdivision (h) of this section.

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

(1) The Exchange's Internet Web site;

(2) Telephone;

(3) Facsimile;

(4) Mail; or

(5) In person.

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

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

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

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

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

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

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

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

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

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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

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(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.

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(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.

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

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

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

(2) For plan years beginning before January 1, 2026, A~~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) 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 spouse, if the tax filer is a married couple, for two consecutive years 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:~~

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~~1. Comply with the requirement to file an income tax return for that year and for the previous 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)~~(3) 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.

~~(5)~~(4) 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.

~~(6) Notwithstanding the requirements in subdivision (c)(3) of this section, if 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 spouse, if the tax filer is a married couple, for one year for which tax data would be used to verify household income and family size in accordance with Section 6482(d) and (e); and the tax filer or the tax filer's spouse did not comply with the requirement to file an income tax return for that year, as required by Sections 6011 and 6012 of IRC (26 USC §§ 6011, 6012) and implementing regulations, and reconcile APTC for that period ("file and reconcile"), the Exchange shall send a notification to the tax filer, consistent with the standards applicable to the protection of Federal Tax Information as required by Section 6103 of IRC (26 USC § 6103) and described in IRS Publication 1075 Tax Information Security Guidelines For Federal, State, and Local Agencies, 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~~

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~~married, has failed to file and reconcile, and educate the tax filer of the need to file and reconcile or risk being determined ineligible for APTC if they fail to file and reconcile for a second consecutive tax year.~~

~~(7)~~(5) 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:

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(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.

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

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(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 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

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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

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(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 CFR Sections 1.36B-2 and 1.7703-1; 29 CFR Sections 1984.102 and 1984.102; 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

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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.

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(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.

(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

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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; 45 CFR Section 155.315.

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

(a) The Exchange shall verify whether an applicant is eligible for MEC other than through an eligible employer-sponsored plan, Medi-Cal, or CHIP, using information obtained by transmitting identifying information specified by HHS to HHS for verification purposes.

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

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

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

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

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

(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.

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(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.

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(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

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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.

Note: Authority cited: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; 26 USC Section 6103(l)(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

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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 ~~are~~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

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Section 6496(j) through (l).

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

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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; 45 CFR Section 155.320.

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

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

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

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

(3) The Exchange has 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

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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), 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:

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(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

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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;

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(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; 42 CFR Sections 435.945, 435.948, 435.952 and 457.380; 45 CFR Section 155.320.

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

(a) The Exchange shall verify whether an applicant reasonably expects to be enrolled in an eligible employer-sponsored plan or is eligible for qualifying coverage in an eligible employer-sponsored plan for the benefit year for which coverage is requested.

(b) The Exchange shall obtain:

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

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

(3) Any available data from SHOP.

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

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

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

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(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.

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(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:

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(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; 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.

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(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

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(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 CFR Section 1.36B-1; 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).

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(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:

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(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).

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(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).

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(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

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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.

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

§ 6498. Annual Eligibility Redetermination.

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

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

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

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

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

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

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

(2) Data regarding Social Security benefits, as described in Section 6482(b); and

(3) Income data from available State data sources, such as Franchise Tax Board and Employment Development Department.

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

(1) Shall notify the individual at least 30 days prior to the date of the notice of annual redetermination described in subdivision (f) of this section. This notice shall include an explanation that unless the individual authorizes the Exchange to obtain their updated tax return information to redetermine the individual's eligibility for coverage effective January first of the following benefit year:

(A) The individual’s APTC and CSR will end on the last day of the current benefit year; and

(B) The individual’s coverage in a QHP will be renewed for the following benefit year, in accordance with the process specified in subdivision (l) of this section, without APTC and CSR;

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

(3) Shall not proceed with a redetermination for IAPs until such authorization has been obtained or the qualified individual continues their request for an eligibility determination for IAPs in accordance with Section 6476(b).

(e) The Exchange shall provide an annual redetermination notice in accordance with the following process:

(1) For all qualified individuals who are not currently enrolled in a QHP through the Exchange, the notice shall include at least:

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(A) A description of the annual redetermination and renewal process;

(B) The requirement to report changes to information affecting eligibility, as specified in Section 6496(b);

(C) The instructions on how to report a change to the Exchange; and

(D) The open enrollment date and the last day on which a plan selection may be made for coverage effective on January first of the following benefit year to avoid any coverage gap.

(2) For all current enrollees who have requested an eligibility determination for IAPs for the current benefit year, the notice shall include at least:

(A) All the information specified in subdivision (e)(1) of this section;

(B) An explanation that the premiums for the QHPs and the amount of APTC and the level of CSR, for which the enrollee may be eligible, may change each benefit year;

(C) A description of the reconciliation process for APTC;

(D) Data used in the enrollee's most recent eligibility determination and the amount of monthly APTC and the level of CSR the enrollee has been receiving during the current benefit year;

(E) An explanation that if the enrollee does not complete the Exchange's renewal process to obtain an updated eligibility determination by December 15 of the current benefit year for coverage effective January first of the following benefit year, the Exchange will redetermine the enrollee's eligibility and renew the enrollee's coverage for the following benefit year, in accordance with the process specified in subdivision (l) of this section, using information obtained from the electronic data sources specified in

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subdivision (c) of this section and the most recent information the enrollee provided to the Exchange; and

(F) An explanation that in order to obtain the most accurate eligibility determination from the Exchange, including APTC that may increase or decrease, or to change their QHP, the enrollee shall contact the Exchange and update their information, as required under subdivision (g) of this section, or make a plan selection by the end of the open enrollment period.

(3) For all current enrollees who have not requested an eligibility determination for IAPs for the current benefit year, the notice shall include at least:

(A) All the information specified in subdivision (e)(1) of this section;

(B) An explanation that the premiums for the QHPs may change each benefit year;

(C) An explanation that unless the enrollee completes the Exchange's renewal process to obtain an updated eligibility determination by December 15 of the current benefit year for coverage effective January first of the following benefit year, the Exchange will redetermine the enrollee's eligibility and renew the enrollee's coverage for the following benefit year, in accordance with the process specified in subdivision (l) of this section, using the most recent information the enrollee provided to the Exchange; and

(D) An explanation that in order to obtain the most accurate eligibility determination from the Exchange or to change their QHP, the enrollee shall contact the Exchange and update their information, as required under subdivision (g) of this section or make a plan selection by the end of the open enrollment period.

(f) For eligibility redeterminations under this section, the Exchange shall provide the annual redetermination notice, as specified in subdivision (e) of this section, and the

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notice of annual open enrollment period, as specified in Section 6502(e), through a single, coordinated notice.

(g) Except as specified in Section 6496(c), an enrollee, a qualified individual, or an application filer on behalf of the qualified individual, shall report to the Exchange any changes with respect to the eligibility standards specified in Sections 6472 and 6474 within 30 days of such change, using any of the channels available for the submission of an application, as described in Section 6470(j).

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

(i) A current enrollee or a qualified individual who has selected a QHP through the Exchange during the current benefit year but their coverage has not been effectuated, shall complete the Exchange's renewal process, as specified in subdivision (i)(1) of this section, within 30 days from the date of the notice described in subdivision (e) of this section.

(1) To complete the Exchange's renewal process, the enrollee or the qualified individual shall:

(A) Check their application information for accuracy, and make any changes to the application information, as required under subdivision (g) of this section;

(B) If any changes made, provide a reason for the change and the date of the change;

(C) Declare under penalty of perjury that the enrollee or the qualified individual:

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1. Understands that they must report any changes to the information on the application that may affect their eligibility for enrollment in a QHP or for APTC and CSR, if applicable, to the Exchange within 30 days of such change;

2. Understands that if they, or someone in their household, have health insurance through Medi-Cal, they must report any changes to information on the application to their county social services office within 10 days of such change;

3. Provided true answers and correct information to the best of their knowledge during the renewal process;

4. Knows that if they do not tell the truth, there may be a civil or criminal penalty for perjury that may include up to four years in jail, pursuant to California Penal Code Section 126;

5. Understands that if they received premium tax credits for health coverage through the Exchange during the previous benefit year, they must have filed or will file a federal tax return for that benefit year;

6. Understands that, unless they have already provided authorization for the Exchange to use electronic data sources to obtain their updated tax return information to conduct the annual redetermination for all IAPs, except for Medi-Cal or CHIP, they are giving the Exchange authorization to obtain updated tax return information to provide him or her with an updated eligibility determination for the following benefit year; and

7. Understands that they must provide their electronic signature and PIN to complete the Exchange's renewal process for enrollment in a QHP or for APTC and CSR, if applicable;

(D) Provide their electronic signature and PIN;

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(E) Submit any reported changes and the signed declarations, through any of the channels specified in subdivision (i)(2) of this section, to obtain an updated eligibility determination for the following benefit year; and

(F) If eligible to enroll in a QHP, make a plan selection for the following benefit year.

(2) The enrollee or the qualified individual may complete the renewal process described in subdivision (i)(1) of this section through the channels available for the submission of an application, as described in Section 6470(j), except mail and facsimile.

(3) The enrollee or the qualified individual may seek assistance from a CEC, PBE, or a Certified Insurance Agent to complete the renewal process described in subdivision (i)(1) of this section.

(4) If the enrollee or the qualified individual does not complete the Exchange's renewal process specified in subdivision (i)(1) of this section within 30 days from the date of the notice described in subdivision (e) of this section, the Exchange shall proceed in accordance with the process specified in subdivision (j) of this section.

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

(1) Redetermine the enrollee's or the qualified individual's eligibility in accordance with the standards specified in Sections 6472 and 6474 using information obtained from the electronic data sources specified in subdivision (c) of this section and the most recent information the individual provided to the Exchange and renew the enrollee's coverage for the following benefit year, in accordance with the process specified in subdivision (l) of this section;

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

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

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

(l) If an enrollee remains eligible for enrollment in a QHP through the Exchange upon annual redetermination, 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

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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 enrollee who is currently enrolled in a catastrophic QHP attains the age of 30 before the beginning of the following benefit year, the enrollee shall be enrolled in the lowest cost bronze-tier QHP that is not a HDHP offered by the same QHP issuer.

(6) Notwithstanding the process specified in subdivision (l)(1) through (5) of this section, an enrollee whose household income is at or below 250 percent of the FPL and who upon annual redetermination is determined eligible for CSR, in accordance with Section 6474(d), shall be enrolled as follows:

(A) An enrollee who is currently enrolled in a bronze-tier QHP shall be enrolled in a silver-tier QHP with the same provider network as the enrollee’s current QHP offered by the same QHP issuer if the silver-tier QHP has a $0.00 net monthly premium.

(B) An enrollee who is currently enrolled in a gold-tier or platinum-tier QHP shall be enrolled in a silver-tier QHP with the same or higher actuarial value and the same provider network as the enrollee’s current QHP offered by the same QHP issuer if the silver-tier QHP has the same or lower net monthly premium.

(7) 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

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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 (l)(3) through (6) of this section, as determined by the Exchange on a case-by-case basis.

(8) If the enrollee who is currently enrolled in a QHP as a dependent attains the age of 26 before the beginning of the following benefit year, the enrollee shall be enrolled in their own individual QHP through the Exchange in accordance with the process specified in subdivision (l)(1) through (7) of this section.

(9) Notwithstanding the process specified in subdivision (l)(1) through (8) 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.

(10) Notwithstanding the process specified in subdivision (l)(1) through (9) of this section, if the enrollee's current QDP is not available, the enrollee shall be enrolled in the lowest cost QDP that is most similar to the enrollee's current QDP offered by the same or different QDP issuer that is available to the enrollee through the Exchange, as determined by the Exchange on a case-by-case basis.

(m) The Exchange shall not redetermine a qualified individual's eligibility in accordance with this section if the qualified individual's eligibility was redetermined under this

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section during the prior year, and the qualified individual was not enrolled in a QHP through the Exchange at the time of such redetermination and has not enrolled in a QHP through the Exchange since such redetermination.

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

§ 6500. Enrollment of Qualified Individuals into QHPs.

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

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

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

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

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

(1) Notify the applicant of her or his initial premium payment method options and of the requirement that the applicant's initial premium payment shall be received by the QHP issuer on or before the premium payment due date, as defined in Section 6410 of Article 2 of this chapter, in order for the applicant's coverage to be effectuated, as specified in Sections 6502(g) and 6504(i);

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

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

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

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

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

(e) A QHP issuer shall accept enrollment information specified in subdivision (b) of this section consistent with the federal and State privacy and security standards specified in 45 CFR Section 155.260 (September 6, 2016), hereby incorporated by reference, and the Information Practices Act of 1977 (Cal. Civ. Code, § 1798 et seq.) and in an electronic format that is consistent with 45 CFR Section 155.270 (August 30, 2013), hereby incorporated by reference, and shall:

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

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

(3) Notify a qualified individual of their premium payment due date;

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

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(5) Notify the Exchange of the issuer's timely receipt of a qualified individual's initial premium payment and their effective date of coverage;

(6) Notify a qualified individual of their effective date of coverage upon the timely receipt of the individual's initial premium payment; and

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

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

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

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

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

(B) Complies with the consumer assistance standards specified in 45 CFR Section 155.205(d) (December 22, 2016), hereby incorporated by reference;

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

(D) Complies with the requirements of Article 9 of this chapter.

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

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

(2) Effectuate coverage upon receipt of an initial premium payment from the applicant on or before the premium payment due date. 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 Section 6504(g).

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

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

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

(6) Send a written notice of the cancellation to the enrollee within five business days from the date of cancellation of enrollment due to nonpayment of premiums.

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

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(i) The premium for coverage lasting less than one month shall equal the product of:

(1) The premium for one month of coverage divided by the number of days in the month; and

(2) The number of days for which coverage is being provided in the month described in subdivision (i)(1) of this section.

(j) If individuals in the tax filers' tax households are enrolled in more than one QHP, and one or more APTC are to be made on behalf of a tax filer (or two tax filers covered by the same plan(s)), that portion of the APTC that is less than or equal to the aggregate adjusted monthly premiums, as defined in 26 CFR Section 1.36B-3(e), properly allocated to the essential health benefits (EHB) for the QHP policies, shall be allocated among the QHP policies as follows:

(1) The APTC shall be apportioned based on the number of enrollees covered under the QHP, weighted by the age of the enrollees, using the default uniform age rating curve established by the Secretary of HHS under 45 CFR Section 147.102(e) (April 17, 2018), hereby incorporated by reference;

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

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

(k) In accordance with Section 100503.4 of the Government Code, the Exchange shall:

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(1) Automatically enroll qualified individuals, whose Medi-Cal or CHIP coverage is being discontinued, in the lowest-cost silver QHP available or any other appropriate QHP, as specified in subdivision (a) of Section 100503.4 of the Government Code, before the termination date of their Medi-Cal or CHIP coverage;

(2) Provide a written notice to the qualified individuals who are automatically enrolled in a QHP in accordance with subdivision (d) of Section 100503.4 of the Government Code;

(3) Ensure that the QHP coverage is effective on the first day of the month following the qualified individual's loss of Medi-Cal or CHIP coverage with no gap in coverage;

(4) Require the qualified individuals who are automatically enrolled in a QHP with $0 monthly premium to actively opt in and accept the enrollment; and

(5) Allow the qualified individuals, whose Medi-Cal or CHIP coverage is being discontinued, to opt out of the automatic enrollment through the Exchange.

Note: Authority cited: Section 100504, Government Code. Reference: Sections 100502, 100503, and 100503.4, Government Code; 45 CFR Sections 147.102, 155.205, 155.240, 155.270, 155.340, 155.400, 156.260, 156.265, 156.1230, and 156.1240; 26 CFR Section 1.36B-3(e).

§ 6502. Initial and Annual Open Enrollment Periods.

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

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

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

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

(2) On or between December 24, 2013 and December 31, 2013, shall be February 1, 2014;

(3) On or between the first and fifteenth day of the month for any month between January 2014 and March 31, 2014, shall be the first day of the following month; and

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

(d) Annual open enrollment period for benefit years beginning:

(1) On January 1, 2015 begins on November 15, 2014 and extends through February 15, 2015.

(2) On or after January 1, 2016 through December 31, 2018 begins on November 1, of the calendar year preceding the benefit year, and extends through January 31 of the benefit year.

(3) On or after January 1, 2019 begins on November 1 and extends through December 15 of the calendar year preceding the benefit year.

(4) On or after January 1, 2023 begins on November 1 of the calendar year preceding the benefit year, and extends through January 31 of the benefit year.

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

(f) Coverage effective dates are as follows:

(1) For the benefit year beginning on January 1, 2015, for a QHP selection received by the Exchange from a qualified individual:

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

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

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

(2) For the benefit year beginning on or after January 1, 2016, for a QHP selection received by the Exchange from a qualified individual:

(A) On or before December 15 of the calendar year preceding the benefit year, shall be January 1;

(B) From December 16 of the calendar year preceding the benefit year through January 15 of the benefit year, shall be February 1; and

(C) From January 16 through January 31 of the benefit year, shall be March 1.

(3) For the benefit year beginning on or after January 1, 2023, for a QHP selection received by the Exchange from a qualified individual:

(A) From November 1 through December 31 of the calendar year preceding the benefit year, shall be no later than January 1 of the benefit year; and

(B) From January 1 through January 31 of the benefit year, shall be no later than February 1 of the benefit year.

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

(1) The individual makes 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; and

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

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

§ 6504. Special Enrollment Periods.

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

(1) A qualified individual or 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

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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.

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(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.

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(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.

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(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.

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(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

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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) The qualified individual, enrollee, or dependent, who is eligible for APTC and whose expected household income is at or below 150 percent of the FPL may enroll in a QHP or change from one QHP to another one time per month.~~

~~(18)~~(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).

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(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

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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:

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(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:

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(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

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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.

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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.

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(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 Medi-Cal 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.

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(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;

(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.

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(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

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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.

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(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; 26 USC Sections 36B(b)(3)(A) and 9831(d)(4); 26 CFR Sections 1.36B-2, 1.5000A-2, and 54.9802-4; 29 CFR Section 2590.702-2; 42 CFR Section 457.10; 45 CFR Sections 146.123, 155.420, 155.605, 155.620 and 155.1080.

§ 6506. Termination of Coverage in a QHP.

(a) Enrollee-initiated terminations shall be conducted in accordance with the following process:

(1) An enrollee may terminate their coverage in a QHP through the Exchange, including as a result of the enrollee obtaining other MEC, by notifying the Exchange or the QHP issuer.

(2) An enrollee may choose to remain enrolled in a QHP at the time of plan selection if they become eligible for other MEC and the enrollee does not request termination in accordance with subdivision (a)(1) of this section. If the enrollee does not choose to remain enrolled in a QHP in such a situation, the Exchange shall initiate termination of

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their enrollment in the QHP upon completion of the redetermination process specified in Section 6496.

(3) An individual, including an enrollee's authorized representative, shall be permitted to report the death of an enrollee to the Exchange for purposes of initiating termination of the enrollee's coverage in accordance with the following requirements:

(A) The individual shall be at least 18 years old.

(B) If the individual reporting the death is the application filer, the enrollee's authorized representative, or anyone in the household of the deceased who was included in the initial application, they shall be permitted to initiate termination of the deceased's coverage.

(C) If the individual reporting the death is not the application filer, the enrollee's authorized representative, or anyone in the household of the deceased who was included in the initial application, they shall submit satisfactory documentation of death to the Exchange before they can initiate termination of the deceased's coverage. Satisfactory documentation may include a copy of a death certificate, obituary, medical record, power of attorney, proof of executor, or proof of estate. The documentation or an attached cover note shall provide the following information:

1. Full name of the deceased;

2. Date of birth of the deceased;

3. The Exchange application ID or case number (if known) of the deceased;

4. Social Security Number (if known) of the deceased; and

5. Contact information for the person submitting the documentation, including full name, address, and phone number.

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(4) The Exchange shall permit an enrollee to retroactively terminate or cancel their coverage or enrollment in a QHP if the enrollee demonstrates to the Exchange that:

(A) They attempted to terminate their coverage or enrollment in a QHP and experienced a technical error that did not allow the enrollee to terminate their coverage or enrollment through the Exchange, and requests retroactive termination within 60 days after the enrollee discovered the technical error;

(B) Their enrollment in a QHP through the Exchange was unintentional, inadvertent, or erroneous and was the result of the error or misconduct 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. Such enrollee must request cancellation within 60 days of discovering the unintentional, inadvertent, or erroneous enrollment. 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; or

(C) The enrollee was enrolled in a QHP without their knowledge or consent by any third party, including third parties who have no connection with the Exchange, and requests cancellation within 60 days of discovering of the enrollment.

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

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

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

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

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

(3) The enrollee's coverage is rescinded by the QHP issuer because the enrollee has made a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan, in accordance with Section 1389.21 of the Health and Safety Code and Section 10384.17 of the Insurance Code, after the QHP issuer demonstrates to the Exchange that the rescission is appropriate due to the enrollee's fraudulent claim or intentional misrepresentation of a material fact;

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

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

(6) The enrollee was enrolled in a QHP without their knowledge or consent by a third party, including by a third party with no connection with the Exchange.

(7) Any other reason for termination of coverage described in 45 CFR Section 147.106 (December 22, 2016), hereby incorporated by reference.

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

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

(2) Provide a grace period of three consecutive months for an enrollee who, when first failing to timely pay premiums, is receiving APTC;

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

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

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

(C) Continue to collect APTC on behalf of the enrollee from the IRS; and

(D) Comply with any other applicable State laws and regulations relating to the grace period specified in subdivision (c)(2) of this section; and

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

(A) Terminate the enrollee's coverage on the effective date described in subdivision (d)(6) of this section, provided that the QHP issuer meets the notice requirements specified in subdivision (e)(1) and (2) of this section; and

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

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

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

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(2) Changes in eligibility for APTC and CSR, including terminations, shall adhere to the effective dates specified in subdivisions (j) through (l) of Section 6496.

(3) In the case of a termination in accordance with subdivision (a)(1) through (3) of this section, the last day of coverage shall be:

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

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

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

(D) If the enrollee is newly eligible for full-scope Medi-Cal or CHIP, the last day of the month during which the enrollee is determined eligible for full-scope Medi-Cal or CHIP; or

(E) The retroactive termination date requested by the enrollee, if specified by applicable State laws.

(4) In the case of a retroactive termination in accordance with subdivision (a)(4) of this section, the following termination dates apply:

(A) For a termination in accordance with subdivision (a)(4)(A) of this section, the termination date shall be no sooner than 14 days after the date that the enrollee can demonstrate they contacted the Exchange to terminate their coverage or enrollment through the Exchange, unless the QHP issuer agrees to an earlier effective date as set forth in paragraph (d)(3)(C) of this section.

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(B) For a termination or cancellation in accordance with subdivision (a)(4)(B) or (C) of this section, the cancellation or termination date shall be the original coverage effective date or a later date, as determined appropriate by the Exchange on a case-by-case basis, based on the circumstances of the cancellation or termination.

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

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

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

(8) In the case of a termination in accordance with subdivision (b)(5) of this section, the last day of coverage in an enrollee's prior QHP shall be the day before the effective date of coverage in their new QHP, including any retroactive enrollments effectuated under Section 6504(h)(4) when an enrollee is granted a special enrollment period to change QHPs with a retroactive coverage effective date.

(9) In the case of a cancellation of enrollment in accordance with subdivision (b)(6) of this section, the Exchange may cancel the enrollee's enrollment upon its determination that the enrollment was performed without the enrollee's knowledge or consent. The cancellation date shall be the original coverage effective date.

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

(11) In cases of retroactive termination dates, the Exchange shall ensure that:

(A) The enrollee receives the APTC and CSR for which they are determined eligible;

(B) The enrollee is refunded any premiums owed to the enrollee by the QHP issuer after the retroactive termination date;

(C) If the enrollee enrolls in a new QHP:

1. The enrollee's premium and cost sharing are adjusted to reflect the enrollee's obligations under the new QHP; and

2. Consistent with 45 CFR Section 156.425(b) (February 27, 2015), hereby incorporated by reference, in the case of a change in the level of CSR (or a QHP without CSR) under the same QHP issuer during a benefit year, any cost sharing paid by the enrollee under the previous level of CSR (or a QHP without CSR) for that benefit year is taken into account in the new level of CSR for purposes of calculating cost sharing based on aggregate spending by the individual, such as for deductibles or for the annual limitations on cost sharing.

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

(1) Provide the enrollee, within five business days from the date of the termination, with a written notice of termination of coverage that includes:

(A) The termination effective date;

(B) The reason for termination; and

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(C) The notice of appeals right, in accordance with the requirements specified in Section 6604 of Article 7 of this chapter.

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

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

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

(f) If an enrollee's coverage in a QHP is terminated for any reason other than terminations pursuant to subdivision (b)(2) and (3) of this section, the Exchange shall:

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

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

(3) Retain records of termination of coverage for a minimum of ten years in order to facilitate audit functions.

Note: Authority cited: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; Section 1389.21, Health and Safety Code; Section 10384.17, Insurance Code; 45 CFR Sections 147.106, 147.128, 155.430 155.1080, 156.270 and 156.425.

§ 6508. Authorized Representative.

(a) The Exchange shall permit an applicant or enrollee in the individual or small group market, subject to applicable privacy and security requirements, to designate an individual or organization to act on their behalf in applying for an eligibility determination

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or redetermination and in carrying out other ongoing communications with the Exchange.

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

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

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

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

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

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

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

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

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

(g) The Exchange shall:

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

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

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

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

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

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

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

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Note: Authority cited: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; 45 CFR Sections 155.227 and 155.270.

§ 6510. Right to Appeal.

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

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

Article 7. Appeals Process for the Individual Exchange

§ 6600. Definitions.

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

“Appeal Record” means the appeal decision, all papers and requests filed in the proceeding, and, if a hearing was held, the transcript or recording of hearing testimony or an official report containing the substance of what happened at the hearing and any exhibits introduced at the hearing.

“Appeal Request” means a clear expression, either orally or in writing, by an applicant, enrollee, employer, or employee to have any Exchange eligibility determinations or redeterminations reviewed by an appeals entity.

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

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“Appellant” means the applicant or enrollee who is requesting an appeal.

“De Novo Review” means a review of an appeal without deference to prior decisions in the case.

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

“Evidentiary Hearing” means a hearing conducted where new evidence may be presented.

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

“Vacate” means to set aside or legally void a previous action.

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

§ 6602. General Eligibility Appeals Requirements.

(a) In accordance with Section 6510 of Article 5 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;

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(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:

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(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

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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; 45 CFR Sections 155.260, 155.270, 155.505, 155.510, 155.605.

§ 6604. Notice of Appeal Procedures.

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

(1) Applicant submits an application; and

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

(b) Notices described in subdivision (a) of this section shall comply with the general standards for Exchange notices specified in Section 6454 of Article 4 of this chapter and shall contain:

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(1) An explanation of the applicant or enrollee's appeal rights under this Article;

(2) A description of the procedures by which the applicant or enrollee may request an appeal, including an expedited appeal;

(3) Information on the applicant's or enrollee's right to represent themselves, or to be represented by legal counsel or another representative;

(4) Information on how to obtain a legal aid referral or free legal help;

(5) An explanation that all hearings shall be conducted by telephone, video conference, or in person, in accordance with the California Department of Social Services' Manual of Policies and Procedures Section 22-045;

(6) An explanation of the circumstances under which the appellant's eligibility may be maintained or reinstated pending an appeal decision, as provided in Section 6608; and

(7) An explanation that an appeal decision for one household member may result in a change in eligibility for other household members and that such a change shall be handled as a redetermination of eligibility for all household members in accordance with the standards specified in Sections 6472 and 6474 of Article 5 of this chapter.

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

§ 6606. Appeal Requests.

(a) The Exchange and the appeals entity shall:

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

(A) The Exchange's Internet Web site;

(B) Telephone;

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(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.

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(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:

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(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 100503 and 100506, Government Code; 26 CFR Section 1.36B-4 and 45 CFR Section 155.520.

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§ 6608. Eligibility Pending Appeal.

(a) Upon receipt of a valid appeal request or notice under Section 6606(e)(2) that concerns an appeal of a redetermination under Sections 6496(h) or 6498(j) of Article 5 of this chapter or an appeal of an erroneous termination of enrollment, the Exchange shall continue to consider the appellant eligible while the appeal is pending in accordance with standards set forth in subdivision (b) of this section.

(b) If the tax filer or appellant, as applicable, accepts eligibility pending an appeal and agrees to make their premium payments, reduced by the APTC amount they are determined eligible for by the Exchange, by the applicable payment due dates, the Exchange shall continue the appellant's eligibility for enrollment in a QHP, APTC, and CSR, as applicable, in accordance with the level of eligibility immediately before the redetermination being appealed.

Note: Authority cited: Section 100504, Government Code. Reference: Sections 100503 and 100506, Government Code; 26 CFR Section 1.36B-4; 45 CFR Section 155.525.

§ 6610. Dismissals.

(a) The appeals entity shall dismiss an appeal if the appellant:

(1) Unconditionally or conditionally withdraws the appeal request in writing prior to the hearing date, in accordance with the following procedure:

(A) Except as provided in subdivision (a)(1)(B) of this section, if the withdrawal is unconditional, the appeal request shall be immediately dismissed.

(B) If the appellant has verbally withdrawn their appeal request prior to the hearing, and such withdrawal is unconditional, the following process shall apply:

1. The appeals entity shall send the appellant a written confirmation of the withdrawal within five business days from the date on which the appellant's verbal withdrawal

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request is received by the appeals entity. The written confirmation shall serve as the appellant's written withdrawal and the appeal shall be dismissed unless the appellant notifies the appeals entity, in writing or verbally, within 15 days of the date of the written confirmation, that the appellant has not withdrawn their appeal request.

2. If the appellant makes the verbal unconditional withdrawal request to the Exchange, the Exchange shall notify the appeals entity of the appellant's verbal unconditional withdrawal request within three business days from the date of the request.

(C) If the withdrawal is conditional:

1. The withdrawal shall be accompanied by an agreement signed by the appellant and by the Exchange as part of the informal resolution process specified in Section 6612;

2. Upon receipt of the signed conditional withdrawal, the hearing date, if any, shall be vacated;

3. The actions of both parties under the agreement specified in subdivision (a)(1)(C)1 of this section shall be completed within 30 calendar days of the date on the agreement; and

4. Upon the satisfactory completion of the actions of the appellant and the Exchange under the agreement specified in subdivision (a)(1)(C)1 of this section, the appeals entity shall dismiss the appeals request unless the hearing request is reinstated within the time limits set forth in Section 6606(c);

(D) Both unconditional and conditional withdrawals shall be accepted by telephone if the following requirements are met:

1. The appellant's statement and telephonic signature made under penalty of perjury shall be recorded in full; and

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2. The appeals entity shall provide the appellant with a written confirmation documenting the telephonic interaction.

(2) Fails to appear at a scheduled hearing without good cause, as determined in accordance with Section 6602(c);

(3) Fails to submit a valid appeal request as specified in Section 6606(b) without good cause, as determined in accordance with Section 6602(c); or

(4) Dies while the appeal is pending, unless the appeal affects the remaining member(s) of the deceased appellant's household, or the appeal can be carried forward by a representative of the deceased appellant's estate, or by an heir of the deceased appellant if the decedent's estate is not in probate, in accordance with the California Department of Social Services' Manual of Policies and Procedures Section 22-004.4.

(b) If an appeal is dismissed under subdivision (a) of this section, the appeals entity shall provide written notice to the appellant within five business days from the date of the dismissal. The notice shall include:

(1) The reason for the dismissal;

(2) An explanation of the dismissal's effect on the appellant's eligibility; and

(3) An explanation of how the appellant may show good cause as to why the dismissal should be vacated in accordance with subdivision (d) of this section.

(c) If an appeal is dismissed under subdivision (a) of this section, the appeals entity shall, within three business days from the date of the dismissal, provide notice of the dismissal to the Exchange, and to the DHCS, as applicable, including instructions to, no earlier than five business days from the date of the dismissal:

(1) Implement the eligibility determination; and

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(2) Discontinue eligibility pending appeal provided under Section 6608.

(d) The appeals entity shall:

(1) Vacate a dismissal and proceed with the appeal if the appellant makes a written request within 30 calendar days of the date of the notice of the dismissal showing good cause why the dismissal should be vacated, in accordance with Section 6602(c); and

(2) Provide written notice of the denial of a request to vacate a dismissal to the appellant within five business days from the date of such denial, if the request is denied.

Note: Authority cited: Section 100504, Government Code. Reference: Sections 100503 and 100506, Government Code; 45 CFR Section 155.530.

§ 6612. Informal Resolution.

(a) An appellant shall have an opportunity for informal resolution prior to a hearing in accordance with the requirements of this section.

(b) Upon receipt of an appeal request, which has been determined to be valid in accordance with Section 6602(c), or upon receipt of the notice under Section 6606(e)(2), the Exchange shall contact the appellant to resolve the appeal informally and to request additional information or documentation, if applicable, prior to the hearing date.

(c) The informal resolution process shall comply with the scope of review specified in Section 6614(e).

(d) An appellant's right to a hearing shall be preserved in any case notwithstanding the outcome of the informal resolution process unless the appellant unconditionally or conditionally withdraws their appeal request prior to the hearing date, in accordance with the procedure set forth in Section 6610(a)(1).

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(e) If the appeal advances to hearing:

(1) The appellant shall not be asked to provide duplicative information or documentation that they previously provided during the application or informal resolution process; and

(2) The Exchange shall:

(A) Issue a Statement of Position; and

(B) Transmit via secure electronic interface the Statement of Position and all papers, requests, and documents, including printouts from an appeal record, which the Exchange obtained during the informal resolution process to the appeals entity, the appellant, and, if applicable, the appellant's representative, at least two business days before the date of the hearing.

(f) If the appellant is satisfied with the outcome of the informal resolution process and conditionally withdraws their appeal request, in accordance with Section 6610(a)(1)(C), and the appeal does not advance to hearing:

(1) Within five business days from the date of the outcome of the informal resolution, the Exchange shall:

(A) Notify the appellant of:

1. The outcome of the informal resolution, including a plain language description of the effect of such outcome on the appellant's appeal and eligibility; and

2. The effective date of such outcome, if applicable; and

(B) Provide a copy of the conditional withdrawal agreement signed by the appellant, or the appellant's authorized representative, and the Exchange and instructions on how to submit their conditional withdrawal request to the appeals entity, in accordance with the procedure set forth in Section 6610(a)(1)(C).

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(2) Within three business days from the date of the outcome of the informal resolution, the Exchange shall send notice of the informal resolution outcome to the appeals entity via secure electronic interface.

(3) If the appeal is dismissed in accordance with Section 6610, the informal resolution decision shall be final and binding.

Note: Authority cited: Section 100504, Government Code. Reference: Sections 100503 and 100506, Government Code; 45 CFR Section 155.535.

§ 6614. Hearing Requirements.

(a) An appellant shall have an opportunity for a hearing in accordance with the requirements of this section.

(b) When a hearing is scheduled, the appeals entity shall send written notice to the appellant and the appellant's authorized representative, if any, of the date, time, location, and format of the hearing no later than 15 days prior to the hearing date unless:

(1) The appellant requests an earlier hearing date; or

(2) A hearing date sooner than 15 days is necessary to process an expedited appeal, as described in Section 6616(a), and the appeals entity has contacted the appellant to schedule a hearing on a mutually agreed upon date, time, and location or format.

(c) The hearing shall be conducted:

(1) Within 90 days from the date on which a valid appeal request is received, except for the expedited appeals specified in Section 6616;

(2) After notice of the hearing, pursuant to subdivision (b) of this section;

(3) As an evidentiary hearing, consistent with subdivision (e) of this section;

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(4) By an administrative law judge who has not been directly involved in the eligibility determination or any prior Exchange appeal decisions in the same matter; and

(5) By telephone, video conference, or in person, in accordance with the California Department of Social Services' Manual of Policies and Procedures Section 22-045.1.

(d) The appeals entity shall provide the appellant with the opportunity to:

(1) Review their appeal record, including all documents and records to be used by the appeals entity at the hearing, at least two business days before the date of the hearing as well as during the hearing;

(2) Bring witnesses to testify;

(3) Establish all relevant facts and circumstances;

(4) Present an argument without undue interference;

(5) Question or refute any testimony or evidence, including the opportunity to confront and cross-examine adverse witnesses; and

(6) Be represented by an authorized representative, legal counsel, a relative, a friend, or another spokesperson designated by the appellant.

(e) The appeals entity shall consider the information used to determine the appellant's eligibility as well as any additional relevant evidence presented during the appeal process, including at the hearing.

(f) The appeals entity shall review the appeal *de novo* and shall consider all relevant facts and evidence presented during the appeal.

(g) Postponements and continuances shall be conducted in accordance with the California Department of Social Services' Manual of Policies and Procedures Section 22-053.

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Note: Authority cited: Section 100504, Government Code. Reference: Sections 100503 and 100506, Government Code; 45 CFR Section 155.535.

§ 6616. Expedited Appeals.

(a) Pursuant to 45 CFR Section 155.540(a) (December 22, 2016), hereby incorporated by reference, the appeals entity shall establish and maintain an expedited appeals process for an appellant to request an expedited process where there is an immediate need for health services because a standard appeal could jeopardize the appellant's life or health or ability to attain, maintain, or regain maximum function.

(b) If the appeals entity denies a request for an expedited appeal, it shall:

(1) Conduct the appeal under the standard appeals process and issue the appeal decision in accordance with Section 6618(b)(1); and

(2) Inform the appellant, within three business days from the date of the denial of a request for an expedited appeal, through electronic or verbal notification, if possible, of the denial and, if notification is verbal, follow up with the appellant by written notice within five business days of the denial. The written notice of the denial shall include:

(A) The reason for the denial;

(B) An explanation that the appeal will be conducted under the standard appeals process; and

(C) An explanation of the appellant's rights under the standard appeals process.

(c) If the appeals entity grants a request for an expedited appeal, it shall:

(1) Provide the appellant with written notice within three business days from the date on which the appellant's request for an expedited appeal is granted:

(A) That their request for an expedited appeal is granted; and

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(B) Of the date, time, and type of the hearing;

(2) Ensure a hearing date is set within 10 calendar days from the date on which the appellant's request for an expedited appeal is granted; and

(3) Within three business days from the date on which the appellant's request for an expedited appeal is granted, provide notice via secure electronic interface to the Exchange and to the DHCS, as applicable, specifying that the appellant's request for an expedited appeal is granted and a hearing will be set on an expedited basis.

Note: Authority cited: Section 100504, Government Code. Reference: Sections 100503 and 100506, Government Code; 45 CFR Section 155.540.

§ 6618. Appeal Decisions.

(a) Appeal decisions shall:

(1) Be based exclusively on the information and evidence specified in Section 6614(e) and the eligibility requirements under Article 5 of this chapter;

(2) State the decision, including a plain language description of the effect of the decision on the appellant's eligibility;

(3) Include a summary of the facts relevant to the appeal;

(4) Identify the legal basis, including the regulations that support the decision;

(5) State the effective date of the decision, if applicable; and

(6) Explain the appellant's right to pursue the appeal before the HHS appeals entity, including the applicable timeframe and instructions to file, if the appellant remains dissatisfied with the eligibility determination;

(7) Indicate that the decision of the Exchange appeals entity is final, unless the appellant pursues the appeal before the HHS appeals entity; and

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(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.

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(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: Sections 100503 and 100506, Government Code; 45 CFR Section 155.545.

§ 6620. Appeal Record.

(a) Subject to the requirements of all applicable federal and State laws regarding privacy, confidentiality, disclosure, and personally identifiable information, the appeals entity shall make the appeal record accessible to the appellant for at least five years after the date of the written appeal decision as specified in Section 6618(b)(1).

(b) The appeals entity shall provide public access to all appeal decisions, subject to all applicable federal and State laws regarding privacy, confidentiality, disclosure, and personally identifiable information.

Note: Authority cited: Section 100504, Government Code. Reference: Sections 100503 and 100506, Government Code; 45 CFR Section 155.550.

§ 6622. Employer Appeals Process.

(a) The provisions of this section apply to employer appeals processes through which an employer may, in response to a notice under Section 6476(i) of Article 5 of this chapter, appeal a determination that the employer does not provide MEC through an employer-sponsored plan or that the employer does provide such coverage but it is not affordable coverage with respect to an employee or employee's dependent who is an enrollee receiving APTC through the Exchange.

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(b) An employer who seeks an appeal pursuant to paragraph (a) of this section shall request such an appeal directly to HHS in accordance with the process specified in 45 CFR Section 155.555 (December 22, 2016), hereby incorporated by reference, and the process established by HHS.

(c) After receiving an appeal decision that affects the enrollee's eligibility, the Exchange shall, within 30 days from the date on which the Exchange receives the decision, notify the enrollee of the requirement to report changes in eligibility, as described in Section 6496(b) of Article 5 of this chapter.

Note: Authority cited: Section 100504, Government Code. Reference: Sections 100503 and 100506, Government Code; 45 CFR Section 155.555.

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Displaying title 45, up to date as of 10/03/2025. Title 45 was last amended 10/01/2025.

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.

§ 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;

(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).

(14) An individual with deferred action under the Department of Homeland Security's Deferred Action for Childhood Arrivals process, as described at 8 CFR 236.22, shall not be considered to be lawfully present as described in any of the above categories in paragraphs (1) through (13) of this definition.

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.

Preponderance of the evidence means proof by evidence that, compared with evidence opposing it, leads to the conclusion that the fact at issue is more likely true than not.

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.

[77 FR 18444, Mar. 27, 2012, as amended at 78 FR 15532, Mar. 11, 2013; 78 FR 39523, July 1, 2013; 78 FR 42313, July 15, 2013; 78 FR 54134, Aug. 30, 2013; 80 FR 10864, Feb. 27, 2015; 81 FR 12336, Mar. 8, 2016; 81 FR 94175, Dec. 22, 2016; 84 FR 17562, Apr. 25, 2019; 86 FR 24288, May 5, 2021; 89 FR 39436, May 8, 2024; 90 FR 27220, June 25, 2025]

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STATE OF CALIFORNIA — DEPARTMENT OF FINANCE

ECONOMIC AND FISCAL IMPACT STATEMENT (REGULATIONS AND ORDERS)

STD. 399 (Rev. 10/2019)

ECONOMIC IMPACT STATEMENT

DEPARTMENT NAME	CONTACT PERSON	EMAIL ADDRESS	TELEPHONE NUMBER
California Health Benefit Exchange	Haley Bohnert	Haley.Bohnert@covered.ca.gov	916-228-8717

DESCRIPTIVE TITLE FROM NOTICE REGISTER OR FORM 400	NOTICE FILE NUMBER
Individual Market Eligibility and Enrollment Emergency Regulations (2025)	Z

A. ESTIMATED PRIVATE SECTOR COST IMPACTS *Include calculations and assumptions in the rulemaking record.*

1. Check the appropriate box(es) below to indicate whether this regulation:

- ☐ a. Impacts business and/or employees
- ☐ b. Impacts small businesses
- ☐ c. Impacts jobs or occupations
- ☐ d. Impacts California competitiveness
- ☐ e. Imposes reporting requirements
- ☐ f. Imposes prescriptive instead of performance
- ☒ g. Impacts individuals
- ☐ h. None of the above (Explain below):

If any box in Items 1 a through g is checked, complete this Economic Impact Statement.
If box in Item 1.h. is checked, complete the Fiscal Impact Statement as appropriate.

2. The California Health Benefit Exchange (Agency/Department) estimates that the economic impact of this regulation (which includes the fiscal impact) is:

- ☒ Below $10 million
- ☐ Between $10 and $25 million
- ☐ Between $25 and $50 million
- ☐ Over $50 million *[If the economic impact is over $50 million, agencies are required to submit a Standardized Regulatory Impact Assessment as specified in Government Code Section 11346.3(c)]*

3. Enter the total number of businesses impacted: None

Describe the types of businesses (Include nonprofits): See Attachment A, Response A.3.1

Enter the number or percentage of total businesses impacted that are small businesses: See A.3.2.

4. Enter the number of businesses that will be created: 0 eliminated: 0

Explain: See Attachment A, Response A.4.

5. Indicate the geographic extent of impacts: ☒ Statewide

☐ Local or regional (List areas):

6. Enter the number of jobs created: 0 and eliminated: 0

Describe the types of jobs or occupations impacted: See Attachment A, Response A.6.

7. Will the regulation affect the ability of California businesses to compete with other states by making it more costly to produce goods or services here? ☐ YES ☒ NO

If YES, explain briefly: N/A

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ECONOMIC IMPACT STATEMENT (CONTINUED)

B. ESTIMATED COSTS *Include calculations and assumptions in the rulemaking record.*

1. What are the total statewide dollar costs that businesses and individuals may incur to comply with this regulation over its lifetime? $ _____

   a. Initial costs for a small business: $ 0 Annual ongoing costs: $ 0 Years: _____

   b. Initial costs for a typical business: $ 0 Annual ongoing costs: $ 0 Years: _____

   c. Initial costs for an individual: $ 0 Annual ongoing costs: $ 0 Years: _____

   d. Describe other economic costs that may occur: See attachment A, Response B.1.

2. If multiple industries are impacted, enter the share of total costs for each industry: Not applicable.

3. If the regulation imposes reporting requirements, enter the annual costs a typical business may incur to comply with these requirements. *Include the dollar costs to do programming, record keeping, reporting, and other paperwork, whether or not the paperwork must be submitted.* $ _____

4. Will this regulation directly impact housing costs? ☐ YES ☒ NO

   If YES, enter the annual dollar cost per housing unit: $ _____

   Number of units: _____

5. Are there comparable Federal regulations? ☒ YES ☐ NO

   Explain the need for State regulation given the existence or absence of Federal regulations: See Attachment A, Response B.5.

   Enter any additional costs to businesses and/or individuals that may be due to State - Federal differences: $ 0

C. ESTIMATED BENEFITS *Estimation of the dollar value of benefits is not specifically required by rulemaking law, but encouraged.*

1. Briefly summarize the benefits of the regulation, which may include among others, the health and welfare of California residents, worker safety and the State's environment: e Attachment A, Response C.1.

2. Are the benefits the result of: ☒ specific statutory requirements, or ☐ goals developed by the agency based on broad statutory authority?

   Explain: See Attachment A, Response C.2.

3. What are the total statewide benefits from this regulation over its lifetime? $ See Attachment A, C.3.

4. Briefly describe any expansion of businesses currently doing business within the State of California that would result from this regulation: This regulation does not result in any expansion of businesses currently operating within California, as it solely involves internal updates to Covered California's enrollment application to comply with federal requirements.

D. ALTERNATIVES TO THE REGULATION *Include calculations and assumptions in the rulemaking record. Estimation of the dollar value of benefits is not specifically required by rulemaking law, but encouraged.*

1. List alternatives considered and describe them below. If no alternatives were considered, explain why not: _____

   See Attachment A, D.1.

ECONOMIC IMPACT STATEMENT (CONTINUED)

2. Summarize the total statewide costs and benefits from this regulation and each alternative considered:

Regulation: Benefit: $ N/A Cost: $ N/A

Alternative 1: Benefit: $ N/A Cost: $ N/A

Alternative 2: Benefit: $ N/A Cost: $ N/A

3. Briefly discuss any quantification issues that are relevant to a comparison of estimated costs and benefits for this regulation or alternatives: N/A

4. Rulemaking law requires agencies to consider performance standards as an alternative, if a regulation mandates the use of specific technologies or equipment, or prescribes specific actions or procedures. Were performance standards considered to lower compliance costs? ☐ YES ☐ NO

Explain: Not applicable, as the regulations primarily focus on policy and eligibility criteria rather than mandating the use of specific technologies, equipment, or prescribing specific actions, thus aiming to streamline operations and access without imposing direct compliance costs on entities.

E. MAJOR REGULATIONS *Include calculations and assumptions in the rulemaking record.*

California Environmental Protection Agency (Cal/EPA) boards, offices and departments are required to submit the following (per Health and Safety Code section 57005). Otherwise, skip to E4.

1. Will the estimated costs of this regulation to California business enterprises **exceed $10 million**? ☐ YES ☒ NO

If YES, complete E2. and E3
If NO, skip to E4

2. Briefly describe each alternative, or combination of alternatives, for which a cost-effectiveness analysis was performed:

Alternative 1:

Alternative 2:

(Attach additional pages for other alternatives)

3. For the regulation, and each alternative just described, enter the estimated total cost and overall cost-effectiveness ratio:

Regulation: Total Cost $ Cost-effectiveness ratio: $

Alternative 1: Total Cost $ Cost-effectiveness ratio: $

Alternative 2: Total Cost $ Cost-effectiveness ratio: $

4. Will the regulation subject to OAL review have an estimated economic impact to business enterprises and individuals located in or doing business in California exceeding $50 million in any 12-month period between the date the major regulation is estimated to be filed with the Secretary of State through12 months after the major regulation is estimated to be fully implemented?

☐ YES ☒ NO

If YES, agencies are required to submit a Standardized Regulatory Impact Assessment (SRIA) as specified in Government Code Section 11346.3(c) and to include the SRIA in the Initial Statement of Reasons.

5. Briefly describe the following:

The increase or decrease of investment in the State: N/A

The incentive for innovation in products, materials or processes: N/A

The benefits of the regulations, including, but not limited to, benefits to the health, safety, and welfare of California residents, worker safety, and the state's environment and quality of life, among any other benefits identified by the agency: The regulation ensures compliance with federal requirements, supporting the health and welfare of California residents by maintaining access to affordable health insurance.

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STATE OF CALIFORNIA — DEPARTMENT OF FINANCE

ECONOMIC AND FISCAL IMPACT STATEMENT (REGULATIONS AND ORDERS)

STD. 399 (Rev. 10/2019)

FISCAL IMPACT STATEMENT

A. FISCAL EFFECT ON LOCAL GOVERNMENT *Indicate appropriate boxes 1 through 6 and attach calculations and assumptions of fiscal impact for the current year and two subsequent Fiscal Years.*

☐ 1. Additional expenditures in the current State Fiscal Year which are reimbursable by the State. (Approximate)
(Pursuant to Section 6 of Article XIII B of the California Constitution and Sections 17500 et seq. of the Government Code).

$ _____

☐ a. Funding provided in _____

Budget Act of _____ or Chapter _____ , Statutes of _____

☐ b. Funding will be requested in the Governor's Budget Act of _____

Fiscal Year: _____

☐ 2. Additional expenditures in the current State Fiscal Year which are NOT reimbursable by the State. (Approximate)
(Pursuant to Section 6 of Article XIII B of the California Constitution and Sections 17500 et seq. of the Government Code).

$ _____

Check reason(s) this regulation is not reimbursable and provide the appropriate information:

☐ a. Implements the Federal mandate contained in _____

☐ b. Implements the court mandate set forth by the _____ Court.

Case of: _____ vs. _____

☐ c. Implements a mandate of the people of this State expressed in their approval of Proposition No. _____

Date of Election: _____

☐ d. Issued only in response to a specific request from affected local entity(s).

Local entity(s) affected: _____

_____

☐ e. Will be fully financed from the fees, revenue, etc. from: _____

Authorized by Section: _____ of the _____ Code;

☐ f. Provides for savings to each affected unit of local government which will, at a minimum, offset any additional costs to each;

☐ g. Creates, eliminates, or changes the penalty for a new crime or infraction contained in _____

☐ 3. Annual Savings. (approximate)

$ _____

☐ 4. No additional costs or savings. This regulation makes only technical, non-substantive or clarifying changes to current law regulations.

☒ 5. No fiscal impact exists. This regulation does not affect any local entity or program.

☐ 6. Other. Explain _____

_____

FISCAL IMPACT STATEMENT (CONTINUED)

B. FISCAL EFFECT ON STATE GOVERNMENT *Indicate appropriate boxes 1 through 4 and attach calculations and assumptions of fiscal impact for the current year and two subsequent Fiscal Years.*

☐ 1. Additional expenditures in the current State Fiscal Year. (Approximate)

$ _____

It is anticipated that State agencies will:

☐ a. Absorb these additional costs within their existing budgets and resources.

☐ b. Increase the currently authorized budget level for the _____ Fiscal Year

☐ 2. Savings in the current State Fiscal Year. (Approximate)

$ _____

☐ 3. No fiscal impact exists. This regulation does not affect any State agency or program.

☒ 4. Other. Explain The total cost for this rulemaking package is $9,936.34, covering one-time Maintenance & Operations costs for eligibility updates related to the DACA change. All other changes used configurable system updates previously paid for in past rulemakings, with no additional costs. See Attachment A and B for details.

C. FISCAL EFFECT ON FEDERAL FUNDING OF STATE PROGRAMS *Indicate appropriate boxes 1 through 4 and attach calculations and assumptions of fiscal impact for the current year and two subsequent Fiscal Years.*

☐ 1. Additional expenditures in the current State Fiscal Year. (Approximate)

$ _____

☐ 2. Savings in the current State Fiscal Year. (Approximate)

$ _____

☒ 3. No fiscal impact exists. This regulation does not affect any federally funded State agency or program.

☐ 4. Other. Explain _____

FISCAL OFFICER SIGNATURE	DATE
DocuSigned by: Jim Watkins 4418CA7A7E36A400...	11/7/2025

The signature attests that the agency has completed the STD. 399 according to the instructions in SAM sections 6601-6616, and understands the impacts of the proposed rulemaking. State boards, offices, or departments not under an Agency Secretary must have the form signed by the highest ranking official in the organization.

AGENCY SECRETARY	DATE
Signed by: Kathleen Webb E2B6C2413D9C4F4...	11/10/2025

Finance approval and signature is required when SAM sections 6601-6616 require completion of Fiscal Impact Statement in the STD. 399.

DEPARTMENT OF FINANCE PROGRAM BUDGET MANAGER	DATE

ECONOMIC IMPACT STATEMENT *[Per SAM Section 6603]*

A. Estimated Private Sector Costs

3.1 Describe the types of businesses (including nonprofits):

The regulatory changes do not directly impact businesses, as The Exchange's enrollment application will reflect the new rules automatically. Businesses that use the enrollment application (e.g., health insurance carriers, brokers, nonprofits) will not need to make any changes or adjustments.

3.2 Enter the number or percentage of total businesses impacted that are small businesses:

The regulatory changes do not directly impact businesses, including small businesses, as The Exchange's enrollment application will automatically reflect the updated rules. Number or percentage of small businesses impacted

4. Enter the number of businesses that will be created or eliminated. Explain:

These regulatory changes are internal updates to The Exchange's enrollment application and eligibility rules to comply with federal requirements. These changes primarily impact enrollees and do not require businesses (e.g., health insurance carriers, brokers, enrollment assistance nonprofits) to make any changes to their processes or operations. As such, the changes will neither result in the creation of new businesses nor the elimination of existing businesses.

6. Describe the types of jobs or occupations impacted:

These regulatory changes are internal updates to The Exchange's enrollment application to align with federal requirements. The changes do not directly impact employment or occupations, as enrollers exclusively rely on The Exchange's system, which is automatically updated to reflect the revised rules. No jobs will be created or eliminated because of these changes.

B. Estimated Costs

1. Describe other economic costs that may occur:

The regulatory changes described involve updates to The Exchange's enrollment application and eligibility processes, which are necessary to comply with federal requirements. These changes are primarily internal to The Exchange's enrollment system and do not impose direct compliance costs on businesses or individuals, as enrollers (e.g., health insurance carriers, brokers, nonprofits) exclusively rely on The Exchange's system, which will automatically reflect the updated rules. Most changes were implemented as configurable system updates using existing functionality, resulting in no additional development or implementation costs. For example, updates related to

advanced premium tax credit (APTC) eligibility (§6474), the removal of the income inconsistency process (§6492), the elimination of the low-income special enrollment period (§6504), and appeals process updates (§6602) were completed without requiring additional resources. Similarly, correcting a typo in §6484 did not result in any costs. However, the exclusion of Deferred Action for Childhood Arrivals (DACA) recipients from "Lawfully Present" status (§6410) involved additional costs due to eligibility and enrollment update batches for impacted consumers. These one-time Maintenance & Operations costs totaled $9,936.34 in FY 2025-26 and were charged to Application Maintenance Change Request.

While no direct costs are imposed on businesses or individuals, indirect economic impacts may occur for enrollees affected by changes to APTC eligibility or special enrollment periods. For instance, individuals losing access to premium tax credits due to changes in "Lawfully Present" status or the elimination of the low-income SEP may face higher out-of-pocket costs for health insurance. These indirect impacts are driven by federal mandates and are beyond the scope of The Exchange's regulatory implementation.

Overall, the total statewide fiscal impact of implementing these regulatory changes is $9,936 in FY 2025-26, with no ongoing costs in subsequent years. It's important to note that these costs are absorbed by The Exchange's operating budget, which is funded through the California Health Trust Fund (Fund 3175). The revenue for this fund comes from participation fees collected from health and dental carriers participating in The Exchange, not from the state's General Fund.

5. Explain the need for State regulation given the existence or absence of federal regulations:

The need for state regulation by The Exchange, despite the existence of federal regulations under the Affordable Care Act (ACA), stems from the imperative to tailor the implementation of health insurance exchanges to the specific legal, operational, and consumer needs of California. State-specific regulations ensure compliance with both federal guidelines and additional mandates set forth by California law, addressing areas where federal regulations may be less detailed or silent. These regulations facilitate The Exchange's ability to adapt to legislative changes, enhance operational efficiency, and provide improved support to consumers. Furthermore, state regulations allow for customization to meet the unique health care landscape and market dynamics of California's diverse population, ensuring that the state's health benefit exchange operates effectively, efficiently, and in full alignment with the state's goals of expanding access to affordable, quality health care coverage.

C. Estimated Benefits

1. Briefly summarize the benefits of the regulation, which may include among others, the health and welfare of California residents, worker safety and the State's environment:

The proposed regulations are necessary to comply with recent federal requirements, including the Marketplace Integrity and Affordability Final Rule, H.R. 1, and the *City of Columbus v. Kennedy* court decision. These updates ensure The Exchange's eligibility and enrollment processes align with federal mandates, including changes to eligibility for Deferred Action for Childhood Arrivals (DACA) recipients and lawfully present individuals, as well as the removal of specific requirements, such as the failure-to-reconcile (FTR) process and the low-income special enrollment period (SEP).

By implementing these changes, The Exchange maintains compliance with federal law and ensures its enrollment application reflects current requirements. The updates also provide clarity and consistency in eligibility rules and appeals processes, ensuring that the Exchange continues to meet its obligations under state and federal law to provide access to affordable health insurance for California residents.

3. Are the benefits the result of specific statutory requirements, or goals developed by the agency based or broad statutory authority? Explain:

The benefits of this regulation are the result of specific statutory requirements. The changes are driven by federal mandates outlined in the Marketplace Integrity and Affordability Final Rule, H.R. 1, and the *City of Columbus v. Kennedy* court decision. These regulatory updates are necessary for The Exchange to comply with explicit federal requirements governing eligibility and enrollment processes for health insurance coverage through the Exchange. The regulation does not reflect new agency-developed goals but rather ensures alignment with federal law and adherence to the statutory authority granted to the Exchange under Government Code Section 100504(a)(6).

3. What are the total statewide benefits from this regulation over its lifetime?

The regulation ensures The Exchange's continued compliance with federal requirements, allowing the Exchange to deliver affordable health insurance to California residents. By implementing these updates, the regulation supports the long-term stability and functionality of the enrollment application, ensuring it reflects current federal policies. Over its lifetime, this regulation contributes to the Exchange's ability to provide Californians with accessible health coverage options, helping reduce uninsured rates and promoting the overall health and welfare of the state's population.

D. Alternatives to the Regulation

1. List alternatives considered and describe them below. If no alternatives were considered, explain why not:

No alternatives were considered for the proposed regulation because the changes are required to comply with specific federal mandates, including the Marketplace Integrity and Affordability Final Rule, H.R. 1, and the City of Columbus v. Kennedy court decision. As these regulations stem from binding federal requirements, The Exchange does not have discretion to adopt alternative approaches. Failure to implement these updates would result in noncompliance with federal law, which could jeopardize the Exchange's ability to operate and provide affordable health coverage to California residents.

FISCAL IMPACT STATEMENT

B. Fiscal Effect on State Government *[Per SAM Sections 6607, 6611, and 6612]*

Statement of the Mandate:

Pursuant to Government Code Section 100504(a)(6), the California Health Benefit Exchange (the Exchange) Board has the authority to adopt rules and regulations as necessary. The proposed regulations are required to comply with federal law, including the Marketplace Integrity and Affordability Final Rule, H.R. 1, and *the City of Columbus v. Kennedy* court decision. These updates ensure The Exchange operates effectively within the constraints of federal requirements and maintains alignment with state and federal laws governing eligibility and enrollment processes.

Background or Introductory Material:

The Legislature has granted The Exchange emergency rulemaking authority through January 1, 2030, allowing the organization to rapidly adopt regulations in response to federal mandates. This rulemaking package is intended to update the eligibility and enrollment regulations for the individual Exchange, ensuring compliance with new federal requirements and maintaining the functionality of The Exchange's enrollment application. The changes address issues such as eligibility for Deferred Action for Childhood Arrivals (DACA) recipients, advanced premium tax credit (APTC) eligibility, appeals rights, and special enrollment periods (SEPs) in alignment with evolving federal standards.

Key Areas of Regulatory Updates:

- Lawfully Present Eligibility (§6410): Updates the referenced federal regulation to reflect the exclusion of Deferred Action for Childhood Arrivals (DACA) recipients from "Lawfully Present" status as of August 25, 2025, per the Marketplace Integrity and Affordability Final Rule.
- Advanced Premium Tax Credit Eligibility and Failure-to-Reconcile Process (§6474): Clarifies that APTC eligibility for lawfully present individuals under 100% FPL who are ineligible for Medi-Cal due to immigration status ends on December 31, 2025, per H.R. 1. Additionally, the regulation removes the failure-to-reconcile (FTR) process and its notice requirements, per the City of Columbus v. Kennedy decision, which blocks enforcement of these provisions as of September 6, 2025.
- Correction to Subdivision (§6484): Revised subdivision (c) to correct a typographical error.
- Income Inconsistency Process (§6492): Eliminates the automatic 60-day extension of the reasonable opportunity period for individuals with income inconsistencies, per the Marketplace Integrity and Affordability Final Rule. Implemented August 31, 2025.

- Special Enrollment Period (§6504): Removes the low-income special enrollment period (SEP) for individuals at or below 150% FPL, per the Marketplace Integrity and Affordability Final Rule.
- Appeals Process (§6602): Revises general eligibility appeals requirements to add "application filer" to the list of individuals who have the right to appeal, per the 2026 Notice of Benefit and Payment Parameters.

The Exchange is a self-sustaining entity, and the costs associated with these regulatory changes are absorbed by its operating budget, funded through the California Health Trust Fund (Fund 3175). Revenues for this fund are derived from participation fees collected from carriers, ensuring these costs do not impact the state's General Fund.

Working Data:

The fiscal impact analysis is based on detailed reviews of each regulatory update, incorporating feedback from internal stakeholders, IT teams, and legal advisors. Working data includes:

- Estimates of system modification costs provided by IT and operational teams.
- Historical data on enrollment and eligibility processes to project the scope of impacted users.

For further details, see Attachment B.

Assumptions:

It is assumed that the regulatory updates will streamline operations and ensure compliance with federal mandates without imposing additional burdens on The Exchange's financial resources. System modifications rely on existing technology and resources to minimize costs.

Calculations:

The total costs associated with this rulemaking package are calculated at $9,936 for FY 2025-26, reflecting one-time Maintenance & Operations expenses related to §6410 (Lawfully Present eligibility) due to batch processing for impacted consumers. Other regulatory updates (§6474, §6484, §6492, §6504, §6602) were implemented using existing system functionality and resulted in no additional costs. For a detailed breakdown of these costs, please refer to Attachment B.

Multi-Year Projections of Operational Costs: [Per SAM Section 6615]

	FY2025/2026	*FY2026/2027*	*FY2027/2028*
Technology	$9,936	$0	$0
Total	$9,936	$0	$0

The costs reflect one-time Maintenance & Operations expenses incurred for system updates related to §6410 (Lawfully Present eligibility). Other updates utilize configurable system functionality already implemented under prior regulatory packages and result in no additional costs.

Conclusion:

The proposed regulations are designed to ensure The Exchange complies with federal mandates and maintains alignment with state and federal laws governing eligibility and enrollment processes. While the fiscal impact is minimal, totaling $9,936 in one-time costs for system updates, these expenditures are necessary to implement the required changes and avoid noncompliance. The Exchange's self-sustaining financial structure ensures that these costs are absorbed through participation fees collected from carriers, without impacting the state's General Fund. By adopting these regulations, The Exchange continues to fulfill its mission to provide accessible, affordable health insurance to Californians.

Covered California Individual Market Eligibility and Enrollment Emergency Regulations (2025)
STD 399 Attachment B

Section	Description of Change	Fiscal Impact Description	Initial Cost for FY25/26	Ongoing Costs for FY 26/27	Ongoing Costs for FY 27/28	Amount
§ 6410	**Lawfully Present eligibility:** Revise the referenced federal regulation to reflect the exclusion of Deferred Action for Childhood Arrivals (DACA) recipients from "Lawfully Present" status as of August 25, 2025, per the Marketplace Integrity and Affordability Final Rule.	These changes were implemented through a configurable system change (functionality turned off). However, additional costs were incurred to run eligibility and enrollment update batches for impacted consumers. These one-time Maintenance & Operations costs were charged to Application Maintenance Change Request and totaled $9,936.34.	$9,936	$0	$0	$9,936
§ 6474	**Advanced premium tax credits (APTC) eligibility and failure-to-reconcile (FTR) process:** Clarify that the APTC eligibility for lawfully present individuals under 100% FPL who are ineligible for Medi-Cal due to their immigration status ends on December 31, 2025, per H.R. 1. Remove the FTR process and its notice requirements, per the City of Columbus v. Kennedy decision blocking enforcement of this process. (Implemented September 6, 2025)	These changes are configurable system updates that use existing functionality already implemented and paid for under a previous regulatory package. Since no new development or implementation is required, there are no additional costs to turn these functionalities on or off.	$0	$0	$0	$0
§ 6484	Revised subdivision (c) to correct a typo.	No system updates, operational changes, or additional resources were required, and therefore there are no costs associated with this revision.	$0	$0	$0	$0
§ 6492	**Inconsistency process:** Remove the automatic 60-day extension of the reasonable opportunity period for individuals with income inconsistencies to submit documentation or resolve the issue, per the Marketplace Integrity and Affordability Final Rule. (Implemented August 31, 2025)	These changes are configurable system updates that use existing functionality already implemented and paid for under a previous regulatory package. Since no new development or implementation is required, there are no additional costs to turn these functionalities on or off.	$0	$0	$0	$0
§ 6504	**Special Enrollment Period:** Remove the low-income (at or below 150% FPL) SEP, per the Marketplace Integrity and Affordability Final Rule.	These changes are configurable system updates that use existing functionality already implemented and paid for under a previous regulatory package. Since no new development or implementation is required, there are no additional costs to turn these functionalities on or off.	$0	$0	$0	$0
§ 6602	**Appeals process:** Revise the general eligibility appeals requirements to add an "application filer" to the list of individuals who have the right to appeal, per the 2026 Notice of Benefit and Payment Parameters.	This change aligns the regulatory text with existing practice. No system updates or operational changes were required, and therefore there are no costs associated with this revision.	$0	$0	$0	$0
		Total Costs:	**$9,936**	**$0**	**$0**	**$9,936**