Notice Published May 3, 2019

NOTICE OF PROPOSED RULEMAKING

CALIFORNIA CODE OF REGULATIONS, TITLE 10, CHAPTER 12, ARTICLE 4 ADOPT SECTION 6464

The Board of Directors for the California Health Benefit Exchange (hereinafter referred to as the "Exchange") proposes to adopt the regulation described below after considering all comments, objections, and recommendations regarding the proposed action.

PUBLIC HEARING

The Exchange has not scheduled a public hearing on this proposed action. However, the Exchange will hold a hearing if it receives a written request for a public hearing for any interested person, or his or her authorized representative, no later than 15 days before the close of the written comment period.

WRITTEN COMMENT PERIOD

Any interested person, or his or her authorized representative, may submit written comments relevant to the proposed regulatory action to the Exchange. The written comment period closes on **June 10, 2019** (45 days after the published date). The Exchange will consider only comments received at the Exchange's office by that time. Submit written comments to:

Faviola Adams
Regulations Coordinator
California Health Benefit Exchange (Covered California)
1601 Exposition Blvd.
Sacramento, CA 95815

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

AUTHORITY AND REFERENCE

Government Code section 100504, subdivision (a)(6) authorizes the Board of Directors for the Exchange to adopt rules and regulations, as necessary. The proposed regulations implement, interpret, and make specific Government Code section 100503, subdivisions (a), (h) and (s), and Centers for Medicare and Medicaid Services (CMS),

Guidance Regarding Identity Proofing for the Marketplace, Medicaid, and CHIP, and Disclosure of Certain Data Obtained through the Data Services Hub (June 11, 2013).

INFORMATIVE DIGEST/POLICY STATEMENT OVERVIEW

Summary of Existing Laws

In March 2010, President Obama signed federal health reform legislation called the Patient Protection and Affordable Care Act (ACA). It created the opportunity for each state to establish a state-based health insurance exchange to implement the ACA. California chose to operate an exchange that is commonly known as known as "Covered California." For purposes of this Notice, Covered California will be referred to as the “Exchange.” The Exchange’s mission is to increase the number of insured Californians, improve health care quality, lower costs, and reduce health disparities through an innovative, competitive marketplace that empowers consumers to choose their health plan.

State law also specifies the powers and duties of the executive board of the Exchange. Government Code section 100504, subdivision (a)(6) authorizes the Exchange’s Board of Directors to adopt rules and regulations, as necessary. The Exchange proposes this permanent rulemaking in furtherance of its rulemaking authority to implement, interpret, and make specific state and federal laws.

The Exchange is required to establish the criteria and process for eligibility determination, enrollment, and disenrollment of enrollees and potential enrollees in California, provide for the processing of applications and the enrollment and disenrollment of enrollees, and exercise all powers reasonably necessary to carry out and comply with the duties, responsibilities, and requirements of the Government Code and the ACA. (Gov. Code § 100503, subds. (a), (h) & (s)).

The Exchange currently provides rigorous system features and procedures that ensure that individuals who apply for coverage or who provide enrollment assistance are who they say they are. However, for continued use of the federal data services hub for verification of income and social security data, CMS guidance requires state exchanges to establish remote identity verification for customers who apply online and over the phone. (CMS, Guidance Regarding Identity Proofing for the Marketplace, Medicaid, and CHIP, and the Disclosure of Certain Data Obtained through the Data Services Hub (June 11, 2013), pp.1-2.) As a result, the proposed regulations will integrate the federal remote identity verification service for consumers who apply online or over the phone. These proposed regulations will provide the public with clear standards for identity verification, including the processes that will be used for paper and non-paper (i.e., electronic or telephonic) applications and the alternate process should the initial identify verification fail. These regulations allow the Exchange to continue using the federal data services hub by complying with existing federal guidance.

Currently, there are emergency regulations that establish remote identity verification procedures. Those regulations include definitions and application procedures. The Exchange is now proposing to make permanent those emergency regulations at California Code of Regulations, title 10, section 6464.

Summary of the Effect of the Proposed Regulation

The broad purpose of this proposed regulatory action is to: (1) complete Certificate of Compliance requirements for section 6464; and (2) make minor edits that ensure clarity and address stakeholder requests. The proposed regulations will make permanent the regulations in article 4 governing identity verification requirements for applicants submitting an application for health insurance through the Exchange's individual market. The proposed permanent regulations include definitions and application procedures. If approved, these regulations will assist the Exchange with the implementation of identity verification requirements on an indefinite basis.

Anticipated Benefits of the Proposed Regulation

The anticipated benefits of this proposed regulation include:

- Providing consumers with clear guidelines on how the Exchange will verify the identity for consumers who apply in either paper or non-paper formats.
- Ensuring compliance with federal requirements.
- Protecting and safeguarding California consumers from the unauthorized and illegal access to, or disclosure of, sensitive information such as federal tax information, personal health information, and personal identifying information, confidential information, or financial information contained in the information systems and devices of the Exchange, or any other information as required by federal law or guidance.

Evaluation of Inconsistency/Incompatibility with Existing State Regulations

After an evaluation of current regulations, the Exchange determined that these proposed regulations are not inconsistent or incompatible with any existing regulations. The proposed regulations do not conflict with any other regulations governing other Certified Enrollers.

Documents to be Incorporated by Reference:

45 C.F.R. § 155.205 (December 22, 2016)
45 C.F.R. § 155.225 (March 8, 2016)

Documents Relied Upon:

Centers for Medicare and Medicaid Services, Guidance Regarding Identity Proofing for the Marketplace, Medicaid, and CHIP, and the Disclosure of Certain Data Obtained through the Data Services Hub (June 11, 2013)

DISCLOSURES REGARDING THE PROPOSED ACTION

The Exchange has made the following initial determinations:

Matters Prescribed by Statute Applicable to the Agency or to Any Specific Regulation or Class of Regulations

None.

Mandate on Local Agencies and School Districts

None. The Exchange has determined that this proposed regulatory action does not impose a mandate on local agencies or school districts.

Cost to Any Local Agency or School District Which Must Be Reimbursed in Accordance with Government Code Sections 17500 Through 17630

None. 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.

Costs or Savings to any State Agencies

The proposal results in additional costs to the Exchange but will have no impact on other agencies or the State General Fund. The Exchange is currently completely funded by assessments on premiums charged by Qualified Health Plans.

Other Nondiscretionary or Savings Imposed on Local Agencies

None. This proposal does not impose other nondiscretionary costs or savings on local agencies.

Costs or Savings in Federal Funding to the State

The proposal will not result in costs or savings in federal funding to the state.

Significant Effect on Housing Costs

None.

Significant, Statewide Adverse Economic Impact Directly Affecting Business, Including the Ability of California Businesses to Compete with Businesses in Other States

None.

Results of the Economic Impact Assessment/Analysis

The Exchange concludes regarding the proposed regulations that it is:

(1) **unlikely** that the proposal will create or eliminate any jobs in the State;
(2) **unlikely** that the proposal will create or eliminate businesses within the State;
(3) **unlikely** that the proposal will impact the expansion of businesses currently doing business in California; and
(4) **likely** that the health and welfare of consumers will benefit from the proposed regulation.

Cost Impacts on a Representative Private Person or Business

The Exchange is not aware of any cost impacts that a representative private person or business would necessarily incur in reasonable compliance with the proposed action.

Effect on Small Business

This proposed regulation is not expected to create or expand small business within the State of California because the proposed regulations only pertain to enrollment in individual health insurance policies.

CONSIDERATION OF ALTERNATIVES

In accordance with Government Code section 11346.5, subdivision (a)(13), the Exchange must determine that no reasonable alternative considered or that has otherwise been identified and brought to the attention of the Exchange would be more effective in carrying out the purpose for which this action is proposed, would be as effective and less burdensome to affected private persons than the proposed action, or would be more cost effective to affected private persons and equally effective in implementing the statutory policy or other provision of law. This proposed action is the most effective in effectuating the purpose of the statute and applicable federal regulations.

The Exchange invites interested persons to present statements or arguments with respect to alternatives to the proposed regulations at the scheduled hearing or during the written comment period.

CONTACT PERSONS

Inquiries concerning the proposed administrative action may be directed to:

Faviola Adams
Regulations Coordinator
California Health Benefit Exchange (Covered California)
1601 Exposition Blvd.
Sacramento, CA 95815
Telephone: (916) 228-8668

The backup contact person for inquiries concerning the proposed administrative action may be directed to:

Crystal Hirst
Attorney
California Health Benefit Exchange (Covered California)
1601 Exposition Blvd.
Sacramento, CA 95815
Telephone: (916) 228-8313

Please direct copies of the proposed text of the regulations, the Initial Statement of Reasons, the modified text of the regulations, if any, or other information upon which the rulemaking is based to Faviola Adams at the address or phone number listed above.

AVAILABILITY OF STATEMENT OF REASONS, TEXT OF PROPOSED REGULATIONS AND RULEMAKING FILE

The Exchange will have the entire rulemaking file available for inspection and copying throughout the rulemaking process at its office at the above address. As of the date of this notice is published in the Notice Register, the rulemaking file consists of this notice, the proposed text of the regulation, and the Initial Statement of Reasons. Copies may be obtained by contacting Faviola Adams at the address or phone number listed above.

AVAILABILITY OF CHANGED OR MODIFIED TEXT

After considering all timely and relevant comments, the Exchange may adopt the proposed regulations substantially as described in this notice. If the Exchange makes modifications which are sufficiently related to the originally proposed text, it will make the modified text (with the changes clearly indicated) available to the public at least 15 days before the Exchange adopts the regulations as revised. Please send requests for copies of any modified regulations to the attention of Faviola Adams at the address indicated above. The Exchange will accept written comments on the modified regulations for 15 days after the date on which they are made available.

AVAILABILITY OF THE FINAL STATEMENT OF REASONS

Upon its completion, copies of the Final Statement of Reasons may be obtained by contacting Faviola Adams at the above address.

AVAILABILITY OF DOCUMENTS ON THE INTERNET

Copies of the Notice of Proposed Rulemaking, the Initial Statement of Reasons and the text of the regulations in underline can be accessed through our website at https://hbex.coveredca.com/regulations.

May 3, 2019

INITIAL STATEMENT OF REASONS

CALIFORNIA CODE OF REGULATIONS TITLE 10 INVESTMENT

CHAPTER 12 CALIFORNIA HEALTH BENEFIT EXCHANGE

ARTICLE 4
ADOPT SECTION 6464

The Administrative Procedure Act ("APA") requires that an Initial Statement of Reasons be available to the public upon request when a permanent rulemaking action is undertaken. The following information required by the APA pertains to this particular rulemaking action:

BACKGROUND

In March 2010, President Obama signed federal health reform legislation called the Patient Protection and Affordable Care Act (ACA). It created the opportunity for each state to establish a state-based health insurance exchange to implement the ACA. California chose to operate an exchange that is commonly known as known as "Covered California." For purposes of this Notice, Covered California will be referred to as the "Exchange." The Exchange's mission is to increase the number of insured Californians, improve health care quality, lower costs, and reduce health disparities through an innovative, competitive marketplace that empowers consumers to choose their health plan.

State law also specifies the powers and duties of the executive board of the Exchange. Government Code section 100504, subdivision (a)(6) authorizes the Exchange's Board of Directors to adopt rules and regulations, as necessary. The Exchange proposes this permanent rulemaking in furtherance of its rulemaking authority to implement, interpret, and make specific state and federal laws.

The Exchange is required to establish the criteria and process for eligibility determination, enrollment, and disenrollment of enrollees and potential enrollees in California, provide for the processing of applications and the enrollment and disenrollment of enrollees, and exercise all powers reasonably necessary to carry out and comply with the duties, responsibilities, and requirements of the Government Code and the ACA. (Gov. Code § 100503, subds. (a), (h) & (s)). Furthermore, the Exchange must establish and implement operational, technical, administrative, and physical safeguards to ensure the confidentiality, integrity, and availability of personally identifiable information that is created, collected, used, or disclosed and to ensure that personally identifiable

information is used by or disclosed to only those authorized to receive or view it (45 C.F.R. § 155.260(a)(4)).

PROBLEM STATEMENT

As noted above, the Exchange is required to establish the criteria and process for eligibility determination, enrollment, and disenrollment of enrollees and potential enrollees in California, provide for the processing of applications and the enrollment and disenrollment of enrollees, and exercise all powers reasonably necessary to carry out and comply with the duties, responsibilities, and requirements of the Government Code and the ACA. (Gov. Code § 100503, subds. (a), (h) & (s)). The federal regulations require the Exchange to verify information provided by applicants and obtain information from federal and state sources to determine that an applicant is eligible for enrollment in a Qualified Health Plan (QHP) through the Exchange. (45 C.F.R. § 155.315). Applicants may consent to the use and disclosure of trusted data necessary for making an eligibility determination, including data from federal agencies, and the Exchange must establish and implement operational, technical, administrative, and physical safeguards to ensure the confidentiality, integrity, and availability of personally identifiable information that is created, collected, used, or disclosed and to ensure that personally identifiable information is used by or disclosed to only those authorized to receive or view it (45 C.F.R. § 155.260(a)(4)). To that end, the Exchange must follow federal guidelines pertaining to identity proofing to ensure that personally identifiable information is used and safeguarded appropriately.

According to the Centers for Medicare and Medicaid Services (CMS) Identity Proofing Guidance for State marketplaces, before a marketplace accepts an online or telephone application for enrollment in a QHP, it must conduct identity proofing sufficient to provide assurance that only the appropriate individual has access to restricted data. The guidance, published in June 2013, outlines the requirements for establishing the identity of customers of the state based exchanges in order to ensure the privacy of personal information including the use of a federally-sponsored service offered through the federal data services hub that provides remote identity proofing for online and phone applicants prior to their submitting applications.

These proposed regulations will provide the public with clear standards for identity verification, including the processes that will be used for paper and non-paper (i.e., electronic or telephonic) applications and the alternate process should the initial identity verification fail. These regulations allow the Exchange to continue using the federal data services hub by complying with existing federal guidance.

Currently, there are emergency regulations that establish identity verification procedures and formalize the obligations and options of individual applicants to verify their identity. Those regulations include definitions, and application procedures. The Exchange is now proposing to make permanent those emergency regulations at California Code of Regulations, title 10, section 6464.

ANTICIPATED BENEFITS

The anticipated benefits of this proposed regulation include:

- Providing consumers with clear guidelines on how the Exchange will verify the identity for consumers who apply in either paper or non-paper formats.
- Ensuring compliance with federal requirements.
- Protecting and safeguarding California consumers from the unauthorized and illegal access to, or disclosure of, sensitive information such as federal tax information, personal health information, and personal identifying information, confidential information, or financial information contained in the information systems and devices of the Exchange, or any other information as required by federal law or guidance.

PURPOSE

The purpose of this proposed regulatory action is to establish the Exchange's policies and procedures for identity verification, including the processes that will be used for paper and non-paper (i.e., electronic or telephonic) applications and the alternate process should the initial identity verification fail. These regulations allow the Exchange to continue using the federal data services hub by complying with existing federal guidance.

Detailed Discussion of the Specific Purpose, Rationale, Problems Addressed, and Necessity for Each Regulation Proposed for Adoption

Pursuant to its authorities, the Exchange proposes to permanently adopt Section 6464 of Article 4 of Title 10, Investment, Chapter 12. The detailed discussion of the specific purpose, rationale, problems addressed, and statement of reasons for this section is as follows:

Section 6464(a), in its entirety, specifies, clarifies, and defines the definitions of various terms used in these proposed regulations. This is necessary to ensure the clarity and consistency of the regulations and to avoid reader confusion as to the meaning and requirements of the regulations by providing these definitions. Adoption of these definitions is necessary so that the terms align with federal Identity Proofing Guidance. The following is a more specific, detailed discussion of the necessity for the definitions included in this section:

Defining "RIDP" is necessary to avoid confusion regarding a specialized, technical term. Any reference in the proposed regulation to RIDP means the Remote Identity Proofing service. The definition is consistent with the federal Identity Proofing Guidance.

Defining "FDSH" is necessary to avoid confusion regarding a specialized, technical term. Any reference in the proposed regulation to FDSH refers to the Federal Data Service Hub. The definition is consistent with the federal Identity Proofing Guidance.

Defining "Certified Representative" is necessary to avoid confusion regarding a specialized, technical term, and to specify that the term refers to Service Center Representative (an Exchange employee operating in a call center), Certified Enrollment Counselor as defined in section 6650, Certified Application Counselor as defined in 45 C.F.R. section 155.225, Certified Insurance Agent as defined in section 6800, and Certified Plan-Based Enroller as defined in section 6410. Consumers may seek telephonic or in-person assistance with applying for and enrolling in QHP coverage through the Exchange, which requires identity proofing. Defining Certified Representative is necessary to distinguish individuals who are authorized to assist consumers with the identity proofing process and to make clear to the public which individuals are eligible to provide such identity proofing assistance.

Section 6464(b), in its entirety, implements, clarifies, and makes specific identity verification requirements for applicants who submit paper applications. Under 45 C.F.R. § 155.405(c)(iii), the Exchange must allow applicants to submit paper applications by mail. For a paper application, the Exchange requires the applicant's signature under penalty of perjury before the Exchange processes the application. Cal. Code Regs.. tit. 10, § 6470(b), (d). The signature is sufficient to enable the Exchange to verify the applicant's identity and adjudicate the application. This is necessary to provide individual applicants with clear standards and guidelines on how to complete and submit an application for coverage through the Exchange, and to comply with the federal Identity Proofing Guidance under Q&A 10.

Section 6464(c), in its entirety, implements, clarifies, and makes specific identity verification requirements for non-paper applications and in person verification of identity. This is necessary to provide individual applicants with clear standards and guidelines on how to complete and submit an application for coverage through the Exchange, and to comply with the federal Identity Proofing Guidance under Q&As 2, 4, 5, 6, 11, and 12.

Section 6464(c)(1) clarifies that prior to initiating an application, an applicant must consent to having his or her identity verified, and outlines the ways in which the applicant can provide that consent. This is necessary to provide the public with clear guidance on when the identity proofing will occur, what questions they will be asked, and how they can provide that consent. This is also necessary to comply with the federal Identity Proofing Guidance under Q&As 2 and 4.

Section 6464(c)(2) outlines the methods an applicant may elect to verify their identity for non-paper applications and in person verification of identity. An applicant may either visually verify his or her identity by providing copies of the any of the listed proof of identity documents or remotely verify their identity by successfully completing the Federal Data Service Hub Remote Identity Proofing service process. This is necessary to provide the public with clear standards and guidelines on what documentation they may provide to complete the identity verification. This is also necessary to comply with the federal Identity Proofing Guidance under Q&As 5, 6, 11, and 12.

Section 6464(c)(3) informs the applicant that the Exchange will not accept an application if the individual is unable to satisfy the identity verification requirements. This is necessary to provide the public with clear guidelines on the consequences of failing to successfully

complete the identity verification process. This is also necessary to comply with the federal Identity Proofing Guidance under Q&As 2, 11, and 14.

Section 6464(d), in its entirety, clarifies that only the applicant is subject to identity verification requirements and not additional members of the household. Furthermore, applicants who have successfully completed identity verification may apply for health insurance for himself/herself and for members of his/her household. This is necessary to provide the applicants with clear standards regarding whom the identity verification requirements apply to and whose information they will have to provide if they are applying for coverage for multiple individuals. It is also necessary to comply with the federal Identity Proofing Guidance under Q&A 2.

Section 6464(e), in its entirety, implements and clarifies that applicants who submitted an application prior to the effective date of this section are subject to the identity verification requirements if they make a change to the Primary Contact screen. This is necessary to provide clear guidelines to the applicants regarding when they must engage in the identity verification process if they have not yet done so.

Section 6464(f), in its entirety, implements and specifies that the identity verification requirements of this section do not apply to individuals applying through Covered California for Small Business. This is necessary to clarify which Exchange applicants must complete the identity verification process.

DOCUMENTS REPLIED UPON

Centers for Medicare & Medicaid Services (CMS), *Guidance Regarding Identity Proofing for the Marketplace, Medicaid, and CHIP, and the Disclosure of Certain Data Obtained through the Data Services Hub* (June 11, 2013)

ECONOMIC IMPACT ASSESSMENT

Although the proposed action will affect Certified Entities statewide, applicants will not seek external assistance for the sole purpose of identity verification because identity verification is only required when submitting an application for enrollment. Individuals who seek external assistance will likely need help in completing the entire application, in addition to identity verification, in which case the certified enrollment entities would be entitled to compensation. There is no additional compensation provided for assistance with identity proofing. Therefore, the Exchange concludes that the economic impact, including the ability of California businesses to compete with businesses in other states, will not be significant. These provisions will have no substantial impact on the operation of these entities and thus the proposed regulation is not expected to have a significant adverse economic impact on businesses.

Creation or Elimination of Jobs within the State of California

For the reasons stated above, this proposed regulation is not expected to create or eliminate any jobs within the State of California because the proposed regulations add an additional requirement to a process that Certified Entities are already engaging in

statewide. As such, Certified Entitles will not need to create or eliminate jobs to comply with these proposed regulations.

Creation of new businesses or the elimination of existing businesses within the State of California

For the reasons stated above, the proposed regulation is not expected to create or eliminate any new business within the State of California because the proposed regulations add an additional requirement to a process that Certified Entities are already engaging in statewide. No compensation is provided for these services, so it is highly unlikely that any new businesses will be created or existing businesses will be eliminated to comply with these proposed regulations.

Expansion of businesses currently doing business within the State of California

For the reasons stated above, the proposed regulation is not expected to expand any business within the State of California because the proposed regulations add an additional requirement to a process that Certified Entities are already engaging in statewide. The same individuals and employees who are currently providing enrollment assistance will likely be completing the identity verification requirements. As such, Certified Entitles will not need to expand their businesses to comply with these proposed regulations.

Benefits of the Regulation to the Health and Welfare of California Residents, Worker Safety, and the State's Environment

The regulation has a number of benefits which are tied to the Exchange's overall mission. The Exchange is committed to improving the consumer experience in obtaining health insurance. The regulation ensures that identity proofing is used to protect the privacy of personal information, such that only the appropriate individuals have access to data to which access is restricted. A robust identity proofing process is a key piece of the comprehensive privacy and security framework that is needed when providing interactive access to an eligibility process that includes sensitive federal and state data.

ADVERSE ECONOMIC IMPACT DIRECTLY AFFECTING BUSINESS

For the reasons stated above, the Exchange has determined that these regulations will have no significant, statewide adverse economic impact directly affecting business, including the ability of California businesses to compete with businesses in other states.

CONSIDERATION OF ALTERNATIVES

No alternatives were proposed or considered which would be more effective in carrying out the purpose for which this action is proposed, would be as effective and less burdensome to affected private persons than the proposed action, or would be more cost effective to affected private persons and equally effective in effectuating the purpose of the statute.

Guidance Regarding Identity Proofing for the Marketplace, Medicaid, and CHIP, and the Disclosure of Certain Data Obtained through the Data Services Hub
June 11, 2013

We encourage states that would like to discuss the impact of these changes on design, as well as state-specific implementation approaches, to contact their CCIIO State Officer or CMCS State Operations and Technical Assistance (SOTA) lead, as applicable. We also note that we will continue to work with our federal and state partners to explore additional solutions for future years.

Q1: What is identity proofing? Why is it necessary?

A1: In the context of the Marketplace, Medicaid, and CHIP, identity proofing refers to a process through which the Marketplace, state Medicaid agency, or state CHIP agency obtains a level of assurance regarding an individual's identity that is sufficient to allow access to electronic systems that include sensitive state and federal data. Identity proofing is used throughout the public and private sector to ensure the privacy of personal information, such that only the appropriate individuals have access to data to which access is restricted. In this context, a robust identity proofing process is a key piece of the comprehensive privacy and security framework that is needed when providing interactive access to an eligibility process that includes sensitive federal and state data. Once identity proofing has been completed, the individual who has been proofed may consent to the use and disclosure of trusted data necessary for making an eligibility determination, including data from federal agencies. For the Marketplace, Medicaid, and CHIP, identity proofing will rely on an electronic process to the maximum extent possible, and may also include a combination of paper-based and in-person approaches. We also note that identity proofing as described here is distinct from the citizenship and identity verification process specified in the Deficit Reduction Act of 2005 (Pub. L. No. 109-171), although we have taken steps to ensure operational alignment where possible to ease state implementation.

Q2: Who must be identity proofed as part of an online or telephonic application for enrollment in a qualified health plan (QHP) through the Marketplace in the individual market, advance payments of the premium tax credit, cost-sharing reductions, Medicaid and CHIP?

A2: In order to submit an online or telephonic application for enrollment in a qualified health plan (QHP) through the Marketplace in the individual market, advance payments of the premium tax credit, cost-sharing reductions, Medicaid and CHIP, the adult[1] application filer must complete identity proofing sufficient to provide CMS assurance level 2. An authorized representative for an applicant who is identified on the application must complete identity proofing sufficient to provide CMS assurance level 2. Please see question 11 regarding the process for application filers who are unable to complete electronic proofing.

We will provide future guidance regarding the applicability of identity proofing to a certified application counselor, in-person assister, agent, broker, or Navigator who is identified on the application as assisting the application filer, as well as to an employee or contractor of a

[1] If the application filer is an emancipated minor, he or she will also need to complete identity proofing.

Marketplace, state Medicaid agency, or state CHIP agency who is viewing personally identifiable information from applications and federal data sources.

Q3: Who must complete identity proofing as part of an online or telephonic application for SHOP?

A3: In order to submit an online or telephonic application for SHOP, employees, as well as primary and secondary employer contacts, will need to complete identity proofing sufficient to provide CMS assurance level 2.

Q4: When must identity proofing occur?

A4: The Federally-facilitated Marketplace (FFM) will be inserting the identity proofing process before the start of the online application. An application filer must complete identity proofing prior to the disclosure of any information obtained through the Hub to the application filer. We will provide future guidance regarding the applicability of identity proofing to a certified application counselor, in-person assister, agent, broker, or Navigator who is identified on the application as assisting the application filer.

Q5: What is necessary to achieve levels of assurance 1 and 2?

A5: See the below chart for information on the processes that the FFM will use to achieve assurance levels 1 and 2. A state-based Marketplace, state Medicaid agency, or state CHIP agency may utilize different processes, to the extent that they comply with privacy and security standards.

Level of Assurance	Process
Level 1	• *Remote:* Confirmation via e-mailed link
Level 2	• *Remote:* Collection of core attributes, including name, date of birth, SSN (optional), address, phone number, and e-mail address; validation of core attributes with trusted data source; collection and validation of responses to knowledge-based questions for a share of the population. • *Delegated:* Remote or in-person proofing completed by a trusted entity

Q6: What services will CMS provide to support identity proofing?

A6: CMS will provide a remote identity proofing (RIDP) service that is available to Marketplaces, state Medicaid agencies, and state CHIP agencies through the Data Services Hub (Hub) and supports CMS assurance levels 2 and 3. This service will accept core data elements from the requesting entity, provide identity proofing questions (also known as "out-of-wallet" questions) as applicable, validate the core data elements and responses to identity proofing questions, and provide a response as to whether proofing is complete, or whether additional

proofing is necessary. If additional proofing is necessary, the requesting entity will refer the individual who is being proofed to a call center that is associated with the RIDP service, which will provide the individual with an additional opportunity to complete proofing. The RIDP service will notify the requesting entity regarding the outcome of this interaction. Please see question 11 regarding the process for application filers who are unable to complete electronic proofing, which will be managed by the Marketplace, state Medicaid agency, or state CHIP agency that is accepting the application. CMS will also provide a multi-factor authentication (MFA) service that is available to Marketplaces, state Medicaid agencies, and state CHIP agencies through the hub.

Q7: Will federal tax information (FTI) obtained from the IRS via the data services hub, data regarding income from title II benefits obtained from SSA via the data services hub, or the number of quarters of coverage obtained from SSA via the data services hub[2] be disclosed to an application filer, an applicant, or an individual who is identified on the application as assisting the application filer (agent, broker, certified application counselor, in-person assister, or Navigator) through the application process?

A7: No. In order to reduce the amount of identity proofing needed during the application process, Federal tax information, data regarding income from title II benefits obtained from SSA via the hub, and the number of quarters of coverage obtained from SSA via the hub will be disclosed only to the requesting Marketplace, state Medicaid agency, or state CHIP agency, and used by those entities in the eligibility process. The single, streamlined application will not enable the disclosure of FTI, data regarding income from title II benefits obtained from SSA via the hub, and the number of quarters of coverage obtained from SSA via the hub (for example, through pre-population of the application), and a receiving entity may not disclose it on an eligibility notice or in response to a customer service inquiry. FTI, data regarding income from title II benefits obtained from SSA via the hub, and the number of quarters of coverage obtained from SSA via the hub may be used internally by the Marketplace, state Medicaid agency, and state CHIP agency for the purposes of conducting verifications and determining eligibility for enrollment in a QHP through the Marketplace and for insurance affordability programs as applicable, and must be safeguarded in accordance with applicable regulations and IRS publication 1075 (for FTI). This change has been made to ensure adherence with Federal law, avoid significant consumer experience challenges associated with additional identity proofing for application filers, as well as for other adults in certain circumstances, and to avoid the need to make changes to systems design to facilitate this level of identity proofing.

Changes to the Application

Accordingly, the model single, streamlined application and any state-developed alternative application will not display FTI or data regarding income from title II benefits obtained from SSA via the hub. During the "expedited" income component of the application, the model application for 2014 includes an option for an application filer to attest that his or her projected annual household income for 2014 will be the same as his or her FTI and data regarding income

[2] Certain states require that an applicant who is a lawful permanent resident have 40 quarters of coverage or more in order to be eligible for Medicaid in that state. These quarters of coverage can be earned by the applicant themselves, a spouse or former spouse of the applicant, if earned when married to the applicant, or a parent of the applicant, if earned while the applicant was under age 18.

from title II benefits obtained from SSA via the hub (without viewing the IRS and SSA data within the application) or to provide another figure. If an application filer attests that the data on file is an accurate representation of his or her projected annual household income for 2014, the FFM will utilize this attestation for the eligibility determination, and not allow the application filer to view the underlying FTI or data regarding income from title II benefits obtained from SSA via the hub in his or her electronic account, and may not include it on his or her eligibility notice. We note that prior versions of the model single, streamlined application were designed to display FTI and data regarding income from title II benefits obtained from SSA via the Hub. Unfortunately, this disclosure is not possible without additional proofing. The FFM will also not display the number of quarters of coverage obtained from SSA via the hub in the application, electronic account, or eligibility notice. The non-disclosure of quarters of coverage obtained from SSA via the hub does not represent a change from prior drafts of the model application.

Customer Service Inquiries

If an application filer contacts the Marketplace, state Medicaid agency, or state CHIP agency and requests the FTI, data regarding income from title II benefits obtained from SSA via the hub, or the number of quarters of coverage obtained from SSA via the hub used in processing his or her application, the Marketplace, state Medicaid agency, or state CHIP agency will provide the application filer with information on how to move forward to resolve any open verification issue, and may not provide the underlying data. If the applicant is still interested in obtaining the underlying FTI, data regarding income from title II benefits obtained from SSA via the hub, or the number of quarters of coverage obtained from SSA via the hub used in processing his or her application, the Marketplace, state Medicaid agency or state CHIP agency will be able to provide instructions to the applicant on how to locate the data in tax and Social Security benefit documents they already have or how to interact directly with IRS or SSA.

Unresolved Income Inconsistencies for Advance Payments of the Premium Tax Credit and Cost-Sharing Reductions

45 CFR 155.320(c)(3)(vi)(E) specifies that if the Marketplace is unable to verify projected annual household income at the conclusion of the inconsistency period, it will determine eligibility based on FTI and income from title II benefits obtained from SSA via the hub. In this situation, the Marketplace notice to the application filer will include the resulting eligibility determination, including the maximum amount of the advance payment of the premium tax credit (if applicable), and may not include the underlying data. The Marketplace may explain in the notice to the application filer that the resulting determination is based on data from the Internal Revenue Service and the Social Security Administration.

Eligibility Appeals

If an individual appeals his or her eligibility determination and needs access to FTI, the Marketplace, state Medicaid agency, or state CHIP agency will collect a handwritten signature (either an original or a copy) from the adult application filer to authorize the disclosure. If an application includes more than one tax household, or if the individual needs access to data regarding income from title II benefits obtained from SSA via the hub or the number of quarters of coverage obtained from SSA via the hub, the Marketplace, state Medicaid agency, or state CHIP agency will collect handwritten signatures from every adult listed on the application to authorize the disclosure. These signatures can be mailed or uploaded to the Marketplace, state

Medicaid agency, or state CHIP agency, and the Marketplace, state Medicaid agency, or state CHIP agency may also elect to receive them via facsimile. We are working with our federal partners to develop appropriate authorizing language to pair with the signature or signatures, and will share this with states in the future.

Annual Redetermination
We intend to address the treatment of FTI and data regarding income from title II benefits obtained from SSA via the Hub with respect to pre-populated redetermination notices in future guidance.

Failure to Reconcile
Regulations at 45 CFR 155.305(f)(4) provide that APTC will not be provided when the IRS notifies the Marketplace as part of the income verification process for eligibility determinations for 2015 and beyond that APTC was provided on behalf of the tax filer or his or her spouse for a year for which tax data would be utilized for verification of household income and family size, and the tax filer or his or her spouse did not comply with the requirement to file an income tax return for that year. We are working with IRS to ensure that this can be implemented within the constraints on disclosure, and expect that the responsibility of the Marketplace in such a situation will be to notify the application filer to contact the IRS to get information regarding the issue and how to resolve it. We also note that this situation will not occur until the open enrollment period that begins on October 15, 2015.

Data that May be Disclosed
We note that any information provided on an application by an application filer may be displayed as part of the application, eligibility notice, and electronic account. Further, the following data elements that are calculated by the Marketplace, state Medicaid agency, or state CHIP agency are based on multiple sources of data and may be disclosed as part of the eligibility and enrollment process: income and household size as a percentage of the federal poverty level; the maximum amount of advance payments of the premium tax credit (APTC); and the actual amount of APTC elected by a tax filer during the plan selection process and applied for a given time period.

Q8: Can current income data obtained from Equifax Workforce Solutions via the data services hub be disclosed to an application filer, an applicant, or an individual who is identified on the application as assisting the application filer (agent, broker, certified application counselor, in-person assister, or Navigator) through the application process?

A8: Current income data for an adult obtained from Equifax Workforce Solutions via the data services hub may be disclosed only to the adult himself or herself, to his or her authorized representative, or to any individual identified on the application as assisting the adult (agent, broker, certified application counselor, in-person assister, or Navigator), provided that the adult completes identity proofing sufficient to provide CMS assurance level 2, and any individual identified on the application as assisting the adult completes identity that provides a sufficient level of assurance. Current income data for a minor child obtained from Equifax Workforce Solutions via the data services hub may be disclosed to the legal guardian of the minor child,

provided that the legal guardian completes identity proofing sufficient to provide CMS assurance level 2.

If an application filer contacts the Marketplace, state Medicaid agency, or state CHIP agency and requests the data obtained from Equifax Workforce Solutions via the data services hub used in processing his or her application, the Marketplace, state Medicaid agency, or state CHIP agency will provide the application filer with instructions on how to submit information to resolve any open verification issue. The Marketplace, state Medicaid agency, and state CHIP agency will also be able to direct such an individual to Equifax to obtain the source information if necessary.

If an individual appeals his or her eligibility determination and needs access to the data obtained from Equifax Workforce Solutions via the hub, the Marketplace, state Medicaid agency, or state CHIP agency will collect a physical signature (either an original or a copy) from every adult whose data is needed. These signatures can be mailed or uploaded to the Marketplace, state Medicaid agency, or state CHIP agency, and the Marketplace, state Medicaid agency, or state CHIP agency may also elect to receive them via facsimile.

We intend to address the treatment of current income data obtained from Equifax Workforce Solutions via the Hub with respect to pre-populated redetermination notices in future guidance.

Q9: Is Social Security number (SSN) required for the remote identity proofing (RIDP) service?

A9: No. SSN will greatly improve the ability of the RIDP process to provide a sufficient level of assurance, but is not required.

Q10: How does identity proofing affect paper applications?

A10: The identity proofing process described in this set of questions and answers is designed to support the online and telephonic application processes, which will provide immediate feedback based on information contained in federal data sources. For a paper application, the adult application filer will sign his or her name under penalty of perjury, which is sufficient to enable the Marketplace, state Medicaid agency, or state CHIP agency to adjudicate the application. If an individual who submitted a paper application then wants to move into an electronic process (e.g. to conduct QHP selection online), he or she will need to complete the identity proofing process described in this set of questions and answers.

Q11: What if an individual who needs to complete identity proofing cannot complete the electronic proofing process?

A11: In order to ensure the security of the electronic process, an individual who cannot complete the electronic proofing process will need to submit satisfactory documentation to the Marketplace, state Medicaid agency, or state CHIP agency in order to proceed electronically. Upon receipt of satisfactory documentation, the Marketplace, state Medicaid agency, or state CHIP agency will upgrade the individual to CMS assurance level 2.

First, an individual can submit a copy of one of the following documents to the Marketplace, state Medicaid agency, or state CHIP agency, provided that such document has either a photograph of the individual or other identifying information of the individual such as name, age, sex, race, height, weight, eye color, or address. Submission can occur through mail or via an electronic upload process.

- Driver's license issued by state or territory
- School identification card
- Voter registration card
- U.S. military card or draft record
- Identification card issued by the federal, state, or local government, including a U.S. passport
- Military dependent's identification card
- Native American Tribal document
- U.S. Coast Guard Merchant Mariner card

If an individual cannot provide a copy of one of these documents, he or she can also submit two of the following documents that corroborate one another: a birth certificate, Social Security card, marriage certificate, divorce decree, employer identification card, high school or college diploma (including high school equivalency diplomas), and/or property deed or title. A Marketplace, state Medicaid agency, or state CHIP agency may accept additional documents, provided that these documents are described in the Marketplace/agency's security artifacts. The Marketplace, state Medicaid agency, and state CHIP agency should clearly explain to applicants that they should not submit original documents, and should be able to answer questions regarding acceptable documentation and the identity proofing process.

Further, if one of the above documents or combination of documents has been accepted by another state agency, the Marketplace, State Medicaid agency, or State CHIP agency may use this as the basis to upgrade an account to CMS assurance level 2.

Lastly, we also note that an individual who submits a paper application and does not seek electronic access to the eligibility process will not need to provide the documentation for identity proofing purposes.

Q12: Can in-person proofing be substituted for electronic proofing?

A12: A Marketplace, state Medicaid agency, or state CHIP agency may choose to allow in-person proofing when an individual is filing an application in person, although it may not require in-person proofing. In-person proofing for CMS assurance level 2 involves the presentation of a document or documents in accordance with the standards outlined in question 11.

Q13: If identity proofing is successful, does a Marketplace, state Medicaid agency, or state CHIP agency need to repeat it at any point in the future?

A13: We have not yet determined which events would trigger reproofing.

Q14: Can an individual still complete an online or telephonic application if he or she is unable to complete the electronic proofing process?

A14: Yes, such an individual can complete an electronic application that is structured to not provide any real-time feedback (e.g. no interactive SSN validation process, no income verification, no eligibility results). Eligibility results may be provided once proofing is completed through the alternate process.

Technical Questions

Q15: Does the remote identity proofing (RIDP) service have any prevention/detection controls to prevent extensive verification performed for the same information/individual?

A15: Yes. There are a number of fraud detection capabilities through the RIDP service which help determine the level of confidence (e.g., behavior of transaction, IP address blacklists, SSN fraud lists, etc.). CMS will select settings that limit the number of attempts that can be made, the duration in which a person must answer a question and the number of times data can be repeated or presented.

Q16: Does the remote identity proofing (RIDP) service provide a score that will help the requesting entity determine the level of confidence with the verification? If not, how is the level of confidence determined? And, will the confidence rating be returned back?

A16: The RIDP service will return whether an individual passed or failed the RIDP process, and will not provide a score. The pass/fail assessment is based upon a confidence matrix which is maintained by CMS.

Q17: Can states use the remote identity proofing (RIDP) service and/or the proofing results obtained through the service for SNAP, TANF and other programs?

A17: The RIDP service can only be initiated for the purposes of identity proofing related to eligibility for enrollment in a QHP through the Marketplace (including through the SHOP), Medicaid, and CHIP or eligibility for an exemption from the shared responsibility payment. However, other programs could use the identity proofing results that were obtained through the RIDP service.

Q18: What are the inputs and outputs for the remote identity proofing (RIDP) service?

A18: Please refer to the RIDP and MFA BSDs available through Centrasite. (DSH_RD_BSD_Remote_ID_Proofing(1).docx and DSH_RD_BSD_MFAUsrMgtAuth.doc, respectively)

Q19: When will the Web Services Description Language (WSDL) for the remote identity proofing (RIDP) service be available?

A19: The service specification for the RIDP service, including the WSDL, is available through Centrasite.

Q20: When will the remote identity proofing (RIDP) service be available for testing?

A20: The RIDP service was made available as part of the wave testing process in March. The MFA service will likely not be available for testing until June.

Q21: Can a Marketplace, state Medicaid agency, or state CHIP agency choose specific identity proofing questions within the remote identity proofing (RIDP) service?

A21: The identity proofing questions available through the RIDP service will be standardized.

Q22: Do any individuals need to be proofed at assurance level 4? Is a hard token mandatory for this level of assurance?

A22: Level 4 is primarily for those with system level or root access to systems and databases. A hard token is required to achieve this level of assurance. CMS suggests that states explore various vendor options as there are several cost-effective solutions in this area.

Q23: Have the identity proofing questions been subject to any federal focus group reviews to ensure the questions are appropriate and easy to understand?

A23: The vendor providing services to CMS conducts regular consumer studies regarding their question to ensure they are clear and easily understood. CMS is evaluating additional targeted consumer testing and will also be monitoring the implementation of identity proofing and maintaining the capability to make adjustments as needed.

Q24: Is the remote identity proofing (RIDP) service available in Spanish?

A24: Yes, the RIDP service will be available in Spanish.

Title 10. Investment

Chapter 12. California Health Benefit Exchange

Article 4. General Provisions

§ 6464. Identity Verification Requirement.

(a) Definitions. For purposes of this section, the following terms shall have the following meanings:

(1) RIDP: Remote Identity Proofing service;

(2) FDSH: Federal Data Service Hub;

(3) Certified Representative:

(A) Service Center Representative: an Exchange employee operating in a call center as set forth in 45 C.F.R. Section 155.205(a) (December 22, 2016), hereby incorporated by reference;

(B) Certified Enrollment Counselor as defined in section 6650;

(C) Certified Application Counselor as defined in 45 C.F.R. section 155.225 (March 8, 2016), hereby incorporated by reference;

(D) Certified Insurance Agent as defined in section 6800;

(E) Certified Plan-Based Enroller as defined in section 6410.

(b) Paper Applications

(1) The Exchange shall accept only paper applications for health insurance coverage that are accompanied by a signature in ink, under penalty of perjury in the declaration and signature section of the Exchange's paper application as defined in section 6470.

(2) The Exchange shall not accept or process any paper application lacking an attestation of identity signed by the applicant in ink under penalty of perjury.

(c) Non-paper applications

(1) Prior to initiating an application as set forth in section 6470, an applicant shall consent to having his or her identity verified in one of the following ways:

(A) If the applicant applies through CalHEERS without the assistance of a Certified Representative, the applicant shall consent by clicking the “Yes” button on the CalHEERS Screen in response to being asked, “Do you give your permission to Covered California to confirm your identity?”

(B) If the applicant applies through CalHEERS with the assistance of a Certified Representative, he or she shall provide this consent to the Certified Representative orally. The Certified Representative shall attest to having received this consent from the applicant in one of the following ways:

1. Clicking the “Yes” button next to the statement “I attest that I have visually verified this person's identity”;

2. Clicking the “Yes” button next to the statement “I have the consumer's consent to access their identity information through the Federal Data Services Hub Remote Identity Proofing service.”

(2) Prior to initiating an application as set forth in section 6470, an applicant shall submit his or her identity for verification using one of the following methods:

(A) Visual Verification

1. An applicant shall mail, present in person, or electronically transmit through CalHEERS to the Exchange or to a Certified Representative acceptable proof of identity as follows:

(i) A copy of a valid identification card issued by a federal, state, or local governmental entity that bears a recognizable photograph of the applicant or other identifying information of the individual such as name, age, sex, race, height, weight, eye color, or address, including school identification card, voter registration card, Military Dependent's identification card, Native American Tribal document, U.S. Coast Guard Merchant Mariner card, a Certificate of Naturalization (Form N-550 or N-570), Certificate of U.S. Citizenship (Form N-560 or N-561), Permanent Resident Card or Alien Registration Receipt Card (Form I-551), employment authorization document that includes a photograph (Form I-766), Foreign Passport or identification card issued by a foreign embassy or consulate that contains a photograph, or

(ii) Two of the following: a birth certificate, Social Security card, marriage certificate, divorce decree, employer identification card, high school or college diploma (including high school equivalency diplomas), property deed or title, an adoption decree for the adoptee, foreign school record that includes a photograph, notice from a public benefits agency, or a union or worker center identification card.

2. If submitted in person or by mail, a Certified Representative shall upload a copy of the identity documents to CalHEERS.

(B) Federal Data Service Hub Remote Identity Proofing service

1. If the applicant does not elect to have his or her identity verified pursuant to subdivision (c)(2)(A), he or she shall consent to allowing the Exchange or Certified Representative to use the FDSH RIDP service to access his or her identity information.

2. The applicant shall answer a number of questions generated by the FDSH RIDP service. Examples of these questions include, but are not limited to:

(i) Please select the number of bedrooms in your home from the following choices. If the number of bedrooms in your home is not one of the choices please select 'NONE OF THE ABOVE.'

(ii) Please select the county for the address you provided.

(iii) Please select the range that includes the year the home was built for the address that you provided.

3. Based on the accuracy of the applicant's answers to the questions referenced in (c)(2)(B)2. of this section the FDSH RIDP service will either verify the applicant's identity or provide information on how to complete an alternative identity verification process.

(3) If the Exchange is unable to verify the identity of an applicant in accordance with subdivision (c)(2) of this section, neither the Exchange nor a Certified Representative shall accept an application for health insurance from that same applicant until one of the following is satisfied:

(A) The applicant successfully completes the alternative identity verification process by calling the Help Desk number listed in CalHEERS and successfully answers additional personalized questions, and the FDSH RIDP service informs the Exchange or Certified Representative of such;

(B) The applicant completes the visual verification process as set forth in (c)(2)(A) of this section; or

(C) The applicant submits a paper application in accordance with subdivision (b) of this section.

(d) An applicant who successfully completes the identity verification requirements set forth in this section may, if otherwise permitted, apply for health insurance for himself or herself and for members of his or her household, without those household members also satisfying the requirements set forth in this section.

(e) Consumers who submitted an application prior to the effective date of this section are subject to the requirements of this section if they make a change to the Primary Contact screen.

(f) This section shall not apply to individuals applying through CCSB (as defined in section 6410).

Note: Authority cited: Section 100504(a)(6), Government Code. Reference: Sections 100503(a), 100503(h) and 100503(s), Government Code; 45 C.F.R Sections 155.205 and 155.225 .

§155.205 Consumer assistance and Exchange operations.

(a) *Call center.* The Exchange must provide for operation of a toll-free call center that addresses the needs of consumers requesting assistance and meets the requirements outlined in paragraphs (c)(1), (c)(2)(i), and (c)(3) of this section, unless it enters into a Federal platform agreement through which it relies on HHS to carry out call center functions, in which case the Exchange must provide adequate resources to direct requests for assistance and appropriately directs consumers to Federal platforms to apply for and enroll in, Exchange coverage.

(b) *Internet Web site.* The Exchange must maintain an up-to-date Internet Web site that is user-friendly and outlined in paragraph (c) of this section and:

(1) Provides standardized comparative information on each available QHP, which may include differential display of standardized options on consumer-facing plan comparison and shopping tools, and at a minimum includes:

(i) Premium and cost-sharing information;

(ii) The summary of benefits and coverage established under section 2715 of the PHS Act;

(iii) Identification of whether the QHP is a bronze, silver, gold, or platinum level plan as defined by section 1302(d) of the Affordable Care Act, or a catastrophic plan as defined by section 1302(e) of the Affordable Care Act;

(iv) The results of the enrollee satisfaction survey, as described in section 1311(c)(4) of the Affordable Care Act;

(v) Quality ratings assigned in accordance with section 1311(c)(3) of the Affordable Care Act;

(vi) Medical loss ratio information as reported to HHS in accordance with 45 CFR part 158;

(vii) Transparency of coverage measures reported to the Exchange during certification in accordance with §155.1040; and

(viii) The provider directory made available by the Exchange in accordance with §156.230.

(2) Publishes the following financial information:

(i) The average costs of licensing required by the Exchange;

(ii) Any regulatory fees required by the Exchange;

(iii) Any payments required by the Exchange in addition to fees under paragraphs (b)(2)(i) and (ii) of this section;

(iv) Administrative costs of such Exchange; and

(v) Methods to waste, fraud, and abuse.

(3) Provides applicants with information about Navigators as described in §155.210 and other consumer assistance services, including the toll-free telephone number of the Exchange call center required in paragraph (a) of this section.

(4) Allows for an eligibility determination to be

(5) Allows a qualified individual to select a QHP

(6) Makes available by electronic means a calculator to facilitate the comparison of available QHPs after the application of any advance payments of the premium tax credit and any cost-sharing reductions.

(7) A State-based Exchange on the Federal platform must at a minimum maintain an informational Internet Web site that includes the capability to direct consumers to Federal platform services to apply for, and enroll in, Exchange coverage.

(c) *Accessibility.* Information must be provided to applicants and enrollees in plain language and in a manner that is accessible and timely to—

(1) Individuals living with disabilities including accessible services at no cost to the individual in accordance with the A icans with Disabilities Act and section 504 of the Rehabilitation Act.

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

(i) For all entities subject to this standard, oral interpretation.

(A) For Exchanges and QH P issuers, this standard also includes telephonic interpreter serv at least 150 languages.

(B) For an agent or broker subject to §155.220(c)(3)(i), beginning November 1, 2015, or when such entity been registered with the Exchange for at least 1 year, whichever is later, this standard also includes telephonic interpreter services in at least 150 languages.

(ii) Written translations; and

(iii) For all entities subject to this standard, taglines in non-English languages indicating the availability of language services.

(A) For Exchanges and QH issuers, this standard also includes taglines on Web site content and any document that is critical for obtaining health insurance coverage or access to health care services through a QH P qualified individuals, applicants, qualified e ed e me e loy s, or nrollees. A doc dee emp me loyers, qua critical for obtaining health insurance coverage or access to health care services through a required to be QH provided by law or regulation to a qualified individual, applicant, qualified e e e, or enrollee. Such taglines must indicate the availability of language services in at least the top 15 languages spoken by the li e mi t d Enolish proficient population of the relevant State or States, as deter mi ned in guidance published by the Secretary. If an Exchange is operated by an entity that operates me e Exch anges, or if an Exchange relies on an entity to conduct its eligibility or enroll me e Exchanges, and that the Exchange may aggregate the li mi ted English proficient populations ac oss all th States the entity operates the Exchange or conducts its eligibility or enroll e the top 15 languages required for taglines. A QHP issuer ma y e aggregat e the li mi ted English proficient p health insurance issuers within the issuer's controlled group (defined for purposes of this section as a group of two or mo re persons as tr treated as a single emp loyer under sections 52(a), 52(b), 414(e Internal Revenue Code of 1986, as a me nded), whether or not those health insurance issuers off Exchange in each of those States, to deter e e e ed for taglines. Exchanges ma and n th top 15 lan issuers mi sfy tagline requir espect to nts with r ent if they pos sta cont ently on their ho mee pag s individuals to the full text of the taglines indicating how individuals anguage assistance services, and if they also include taglines on any critical stand-alone docu e e mb ed in the We exchange site. Ed e also subject to §92.8 of this subtitle, will be dee d in me co mp liance with paragraph (c)(2)(iii)(A) of this section if they are in co le.

(B) For an agent or broker subject to §155.220(c)(3)(i), beginning when such entity has been registered with the Exchange for at least 1 year, this standard also includes taglines on We site content and any document that is critical for obtaining health insurance coverage or access to health care services through a alified individuals, applicants, qualified e emp loyers or enrollees. A doc uloyers, qualified to be critical nt is d for obtaining health insurance coverage or access to health care services through a equired to be provided by law or regulation to a qualified individual, applicant, qualified e e e, or enrollee. Such taglines must indicate the availability of language services in at least the top 15 languages spoken by the li e mi t d Enolish proficient population of the relevant State or States, as deter e e published by the Secretary. An agent or broker subject to §155.220(c)(3)(i) that is licensed in and serving e e ma y aggregate the li mi ted English populations in the States in which deter mi e to th 15 languages required for taglines. An agent or broker subject to §155.220(c)(3)(i) e require ma y satisfy this to We b site content if it posts a We b link pro e mi nently on its ho taglines indicating how individuals ma y obtain access to language assistance services, and if it also includes taglines on any critical stand-alone docu e me e nt linked to or mb edd

(iv) For Exchanges, issuers, and an agent or broker subject to QH §155.220(c)(3)(i),

(A) For an Exchange, beginning no later than the first day of the individual e e 2017 benefit year, content that is intended for qualified individuals, applicants, qualified employers, qualified

e mp ee loy s, or enrolle s on a We b site that is language that is spoken by a li ted English proficient population that reaches 10 percent or of the relevant State, as determined in guidance published by the Secretary.

(B) For a QHP issuer, beginning no later than the first day of the individual market open enroll me period for the 2017 benefit year, if the content of a Web site ma tained by the QHP issuer is critical for obtaining health insurance coverage or access to health care services through a chapter, it QH mu es tra nslated into any non-English language that is spoken by a li e ion that reaches 10 percent or e po pu lation of the relevant State, as deter mi ned in guidance pu by the Secretary.

(C) For an agent or broker subject to §155.220(c)(3)(i), beginning on the first day of the individual ma rket open enrollment period for the 2017 benefit year, or when such entity has been registered with the Exchange for at least 1 year, whichever is later, content that is intended for qualified individuals, applicants, qualified employers, qualified emp loyees, or ollees on a e We b si that is any no ma- intained English language that is spoken by a li ed English proficient population that reaches 10 percent or more of the population of the relevant State, as deter mi ned in guidance published by the Secretary.

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

(d) *Consumer assistance.* (1) The Exchange mu have a consumer assistance function that meets the standards in paragraph (c) of this section, including the Navigator program described in §155.210. Any individual providing such consu me e mu assist to train regarding QH P options, insurance affordability pr eligibility, and benefits rules and regulations governing all insurance affordability progra e the State, as i mp le the State, prio to providing such assistance or the outreach and education activities specified in paragraph (e) of this section.

(2) The Exchange must provide referrals to any applicable office of health insurance consumer assistance or health insurance ombuds ma established under section 2793 of the Public Health Service Act, or any other appropriate State agency or agencies, for any enrollee with a grievance, co estion regarding their health plan, coverage, or a deter er such plan or coverage.und

(e) *Outreach and education.* The Exchange must conduct outreach and education activities that meet the standards in paragraph (c) of this section to educate consumers about the Exchange and insurance affordability progra courage ns participation. to

[77 FR 18444, Ma 2 r. 7, 2012, as a me nded at 78 FR 42859, July 17, 2013; 81 FR 10861, Feb. 27, FR 94175, Dec. 22, 2016]

Back to Top

§155.225 Certified application counselors.

(a) *General rule.* The Exchange must have a requirements of this section.

(b) *Exchange designation of organizations.* (1) The Exchange may designate an organization, including an organization designated as a Medicaid certified application counselor organization by a state Medicaid or CHIP agency, to certify its staff members or volunteers to act as certified application counselors who perform the duties and meet the standards and require ments for certified application counselors

(i) Enters into an agreement with the Exchange to comply with the standards and requirements of this section, including the standards specified in paragraphs (d)(3) through (d)(5) of this section; and

(ii) Has a Medicaid registration process and trains its certified application counselors in the method to

(iii) Provides data and information to the Exchange regarding the number and performance of its certified application counselors and regarding the consumer assistance provided by its certified application counselors, upon request, in the form and manner specified by the Exchange. Beginning for the third quarter of calendar year 2017, in a Federally-facilitated Exchange, organizations designated by the Exchange must report that include, at a minimum, data regarding individuals who have been certified by the organization, the total number of consumers received application and enrollment assistance from the organization; the number of consumers who received assistance in applying for and selecting a plan in a or applying for Medicaid or CHIP.

(2) An Exchange may comply with paragraph (a) of this section either by—

(i) Designating organizations to certify application counselors in accordance with the standards of this section;

(ii) Directly certifying individual staff members or volunteers of Exchange designated organizations to provide the duties specified in paragraph (c) of this section if the staff member or volunteer enters into an agreement with the Exchange to comply with the standards and requirements for certified application counselors in this section; or

(iii) A combination of paragraphs (b)(2)(i) and (b)(2)(ii) of this section.

(3) In a Federally-facilitated Exchange, no individual or entity shall be ineligible to operate as a certified application counselor or organization designated by the Exchange under paragraph (b) of this section solely because its principal place of business is outside of the Exchange service area.

(c) *Duties.* Certified application counselors are certified to—

(1) Provide information to individuals and employees about the full range of QHP options and insurance affordability programs for which they are eligible, which includes: providing fair, impartial, and accurate information that assists consumers with submitting the eligibility application; clarifying the distinctions among coverage options, including QHPs; and helping consumers make informed decisions during the enrollment process;

(2) Assist individuals and employees to apply for coverage in a QHP and for insurance affordability programs; and

(3) Help to facilitate enrollment of eligible individuals in a QHP.

(d) *Standards of certification.* An organization designated by the Exchange to provide certified application counselor services, or an Exchange that chooses to certify individual staff members or volunteers directly under paragraph (b)(2)(ii) of this section, must require each staff member or volunteer to perform any of the duties specified in paragraph (c) of this section only if the staff member

(1) Completes Exchange approved training regarding QHP options, insurance affordability programs, eligibility, and benefits rules and regulations governing all insurance affordability programs operated in the state, as implemented in the State, and achieves a passing score on all Exchange approved certification examinations, prior to functioning as a certified application counselor;

(2) Discloses to the organization, or to the Exchange if directly certified by an Exchange, and potential applicants any relationships the certified application counselor or sponsoring agency has with affordability programs, or other potential conflicts of interest;

(3) Co mp ies with the Exchange's privacy and security standards adopted consistent with §155.260, and applicable authentication and data security standards;

(4) Agrees to act in the best interest of the applicants assisted;

(5) Either directly or through an appropriate referral to a Navigator or non-Navigator assistance personnel authorized under §155.205(d) and (e) or §155.210, or to the Exchange call center authorized under §155.205(a), provides information in a ma nner that is accessible to individuals with disabilities, as defin ed by the Americans with Disabilities Act, as a me nd ed, 42 U.S.C. 12 101 et seq. or section 504 of the Rehabilitation Act, as amended, 29 U.S.C. 794;

(6) Enters into an agreement with the organization regarding co e with the standards specified in paragraphs (d), (f), and (g) of this section;

(7) Is recertified on at least an annual basis after successfully co required by the Exchange; and

(8) Meets any licensing, certification, or other standards prescribed by the State or Exchange, if applicable, so long as such standards do not prevent the application of the provisions of title I of the Affordable Care Act. Standards that would prevent the application of the provisions of title I of the Affordable Care Act include but are not li mi the following:

(i) Requirements that certified application counselors refer consu er entities not required to provide fair, accurate, and i ar mp l information.

(ii) Requirements that would prevent certified application counselors fro e persons to who they are required to provide assistance.

(iii) Requirements that would prevent certified application counselors fro e regarding pro viding advic substantive benefits or comparative benefits of different health plans.

(iv) I osing mp standards that would, as applied or as implemented in a State, prevent the application of Federal require me ts applicable to certified application counselors, to an organization designated by the Exchange under paragraph (b) of this section, or to the Exchange's i ed application counselor progra mp

(e) *Withdrawal of designation and certification.* (1) The Exchange must establish procedures to withdraw designation from a particular organization it has designated under paragraph (b) of this section, when it finds nonco with mp the ti ance e organiz ation's agreem conditions of th) of this me section.

(2) If an Exchange directly certifies organizations' individual certified application counselors, it mu establish procedures to withdraw certification from individual certified application counselors when it finds noncompliance with the requireme ts of this section.

(3) An organization designated by the Exchange under paragraph (b) of this section mu establish procedures to withdraw certification from individual certified application counselors when it finds nonco mp iance with the require f this sec tion. nts o

(f) *Availability of infor ma tion; authorization.* An organization designated by the Exchange under paragraph (b) of this section, or, if applicable, an Exchange that certifies staff members or volunteers of organizations directly mu establish procedures to ensure that applicants—

(1) Are infor me, prior to receiving assistance, of the functions and responsibilities of certified application counselors, including that certified application counselors are not acting as tax advisers or attorneys when providing assistance as certified application counselors and cannot provide tax or legal advice within their capacity as certified application counselors;

(2) Provide authorization in a for nd ma ner as det r mi ned by the Exchange, for certified application counselor obtaining access to an applicant's personally identifiable infor tion, and that the organization or certified

application counselor e ma intains a record of th authorization in a for The Exchange must establish a reasonable retention period for maintaining these records. In Federally-facilitated Exchanges, this period is no less than six years, unless a different and longer retention period has already been provided under other applicable Federal law; and

(3) May revoke at any ti e authorization provided the certified application counselor, pursuant to paragraph (f)(2) of this section.

(g) *Fees, consideration, solicitation, and marketing.* Organizations designated by the Exchange under paragraph (b) of this section and certified application counselors must not—

(1) Impose any charge on applicants or enrollees for application or other assistance related to the Exchange;

(2) Receive any consideration directly or indirectly from any health insurance issuer or issuer of stop-loss insurance in connection with the enrollment of any individuals in a QHP or a non-QHP. In a Federally-facilitated Exchange, no health care provider shall be ineligible to operate as a certified application counselor or organization designated by the Exchange under paragraph (b) of this section solely because it receives consideration from a health insurance issuer for health care services provided;

(3) Beginning November 15, 2014, if operating in a Federally-facilitated Exchange, provide compensation to individual certified application counselors on a per-application, per-individual-assisted, or per-enrollment basis;

(4) Provide to an applicant or potential enrollee gifts of any value as an inducement for enrollment. The value of gifts provided to applicants and potential enrollees for purposes other than as an inducement for enrollment must not exceed nominal value, either individually or in the aggregate, when provided to that individual during a single encounter. For purposes of this paragraph (g)(4), the term gifts includes gift items, gift cards, cash cards, cash, and promotional items ma e rk t or pro ervices of a third party, but does not include the reimbursement of legitimate expenses incurred by a consumer in effort to receive Exchange application me r assistance, such as travel or postage expenses;

(5) Solicit any consumer for application or enrollment assistance by going door-to-door or through other unsolicited means of direct contact, including calling a consumer to provide application or enrollment assistance without the consumer initiating the contact, unless the individual has a pre-existing relationship with the individual certified application counselor or designated organization and other applicable State and Federal laws are otherwise complied with. Outreach and education activities may be conducted by going door-to-door or through other unsolicited means of direct contact, including calling a consumer

(6) Initiate any telephone call to a consumer using an automatic telephone dialing system or an artificial or prerecorded voice, except in cases where the individual certified application counselor or designated organization has a relationship with the consumer and so long as other applicable State and Federal laws are complied with.

[78 FR 42861, July 17, 2013, as amended at 79 FR 30345, 8, 2016]

Back to Top

STATE OF CALIFORNIA — DEPARTMENT OF FINANCE

ECONOMIC AND FISCAL IMPACT STATEMENT (REGULATIONS AND ORDERS)

STD. 399 (REV. 12/2013)

ECONOMIC IMPACT STATEMENT

DEPARTMENT NAME	CONTACT PERSON	EMAIL ADDRESS	TELEPHONE NUMBER
California Health Benefit Exchange	Brian M. Kearns	Brian.Kearns@covered.ca.gov	(916) 228-8843

DESCRIPTIVE TITLE FROM NOTICE REGISTER OR FORM 400	NOTICE FILE NUMBER
Identity Verification Requirement	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: 0

Describe the types of businesses (Include nonprofits): _____

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

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

Explain: The regulations establish identity verification procedures

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: The regulations establish identity verification procedures and formalize the obligations and options of individual applicants to verify their identity

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: _____

STATE OF CALIFORNIA — DEPARTMENT OF FINANCE

ECONOMIC AND FISCAL IMPACT STATEMENT
(REGULATIONS AND ORDERS)

STD. 399 (REV. 12/2013)

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? $ 0

   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: None

2. If multiple industries are impacted, enter the share of total costs for each industry: N/A

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.* $ Unknown

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: CCR Title 10. Investment Chapter 12. California Health Benefit Exchange Article 4. General Provisions

   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: Protecting and safeguarding California consumers from the unauthorized and illegal access to,

or disclosure of sensitive information such as fed

[redacted]

Budget Act of [redacted] Chapter

[redacted]

Case or

of Proposition No

c. Implements a mandate of the people of this State expressed in their approv

[redacted]

f. Provides for savings or a transfer of funds between state and local government which will improve efficiency and outcomes with respect to each

[redacted]

g. Other. Explain

STATE OF CALIFORNIA — DEPARTMENT OF FINANCE

ECONOMIC AND FISCAL IMPACT STATEMENT

It is anticipated that State agencies will:

Fiscal Year

ent State Fiscal Year. (Approximate)

| | 2. Savings in the cu

Fiscal Summary

(Dollars in thousands)

BCP No.	Title	Program
N/A	Medi-Cal Managed Care Plan Regulations	N/A

Personal Services	Positions			Dollars (in thousands)		
	CY	BY	BY + 1	CY	BY	BY + 1
Total Salaries and Wages	136.0	136.0	136.0	$125.1	$131.4	$137.6
Total Staff Benefits				$71.3	$74.9	$78.5
Total Personal Services	136.0	136.0	136.0	$196.4	$206.2	$216.1
Operating Expenses and Equipment						
General Expense						
Printing						
Communications						
Postage						
Travel-In State						
Travel-Out of State						
Training						
Facilities Operations						
Utilities						
Consulting & Professional Services: Interdepartmental						
Consulting & Professional Services: External						
Data Center Services						
Information Technology						
Equipment [3]						
Other/Special Items of Expense:						
list your item						
Standard OE&E Allocation				$19.7	$19.7	$19.7
Total Operating Expenses and Equipment				$19.7	$19.7	$19.7
Total State Operations Expenditures				$216.1	$225.9	$235.8

Fund Source	Item Number					
	Org	Ref	Fund			
General Fund						
Special Funds	4800	001	3175	$216.1	$225.9	$235.8
Federal Funds						
Other Funds (Specify)						
Reimbursements						
Total Local Assistance Expenditures				$0	$0	$0

Fund Source	Item Number					
	Org	Ref	Fund			
General Fund						
Special Funds	4800	001	3175			
Federal Funds						
Other Funds (Specify)						
Reimbursements						
Grand Total, State Operations and Local Assistance				$216.1	$225.9	$235.8

California Health Benefit Exchange
Regulation Package
Personal Cost Calulations

SALARY DETAILS

Classification[1/]	Salary Range			Benefit Rate	OE&E
	Min	Mid	Max	(Standard)	(Standard)
Program Technician III	$ 3,403	$ 3,833	$ 4,263	57.0%	$ 7,241

POSITION DETAILS

Classification[1/]	Current Year 2018-19				Budget Year 2019-20				Budget Year +1 2020-21			
	Positions[2/]	Months	Time Allocation[3/]	Month - Equivalent[4/]	Positions[2/]	Months	Time Allocation[3/]	Month - Equivalent[4/]	Positions[2/]	Months	Time Allocation[3/]	Month - Equivalent[4/]
Program Technician III	136.0	12.0	2%	0.2	136.0	12.0	2%	0.2	136.0	12.0	2%	0.2
				-				-				-
				-				-				-
Total PYs & Adjusted Months	**136.0**			**0.2**	**136.0**			**0.2**	**136.0**			**0.2**

SALARIES & BENEFITS CALCULATIONS

Classification[1/]	Current Year 2018-19	Budget Year 2019-20	Budget Year+1 2021-21
Program Technician III	$ 125,109	$ 131,364	$ 137,620
Total Salaries & Wages[5/]	$ 125,109	$ 131,364	$ 137,620
Staff Benefits[6/]	$ 71,312	$ 74,878	$ 78,443
Total Salaries & Benefits	**$ 196,421**	**$ 206,242**	**$ 216,063**

OPERATING EXPENSE & EQUIPMENT

Classification[1/]	Current Year 2018-19	Budget Year 2019-20	Budget Year+1 2021-21
Program Technician III	$ 19,697	$ 19,697	$ 19,697
Total OE&E (Standard)[7/]	$ 19,697	$ 19,697	$ 19,697
Total Contracts[8/]	$ -	$ -	$ -
Total OE&E & Contracts	**$ 19,697**	**$ 19,697**	**$ 19,697**
TOTAL COST	**$ 216,118**	**$ 225,939**	**$ 235,760**

Notes:

1. Classifications provided by program.
2. Position count provided by program.
3. Time allocation provided by program, based on amount of time spent on CAC activities.
4. Month-Equivalent = Months x Time Allocation.
5. Salary calculations based on mid-step of the classifications salary range, including GSI and MSA
6. Benefit calculations based on standard benefit rate used for budgeting purposes.
7. Based on standard OE&E used for budgeting purposes and prorated based month-equivalent.
9. No contractual expenditures per program

COST BREAKDOWN BY FUNDING SOURCE

Fund	Current Year 2018-19	Budget Year 2019-20	Budget Year+1 2020-21
General Fund			
Special Funds	$ 216,118	$ 225,939	$ 235,760
Federal Funds		$ -	
	$ 216,118	**$ 225,939**	**$ 235,760**