Notice Published March 2, 2018

NOTICE OF PROPOSED RULEMAKING
CALIFORNIA CODE OF REGULATIONS, TITLE 10, CHAPTER 12, ARTICLES 2, 4, 5, and 7
ADOPT SECTIONS 6408 and 6410 (Art. 2); 6450, 6452, and 6454 (Art. 4); 6470, 6472, 6474, 6476, 7478, 6480, 6482, 6484, 6486, 6490, 6492, 6494, 6496, 6498, 6500, 6502, 6504, 6506, 6508, and 6510 (Art. 5); 6600, 6602, 6604, 6606, 6608, 6610, 6612, 6614, 6616, 6618, 6620, and 6622 (Art. 7)

The California Health Benefit Exchange/Covered California (the Exchange) Board proposes to adopt the regulations 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 from 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 at **5:00 p.m. on April 16, 2018 (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:

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

Comments may also be submitted by facsimile (FAX) at 916-403-4468 or by e-mail to regulations@covered.ca.gov.

AUTHORITY AND REFERENCE
Government Code Section 100504(a)(6) authorizes the Exchange Board to adopt rules and regulations, as necessary. The proposed regulations implement, interpret, and make specific sections 15438; and 100500 and following of the Government Code; sections 1346.2 and 1366.6 of the Health and Safety Code; and sections 10112.3 and 10112.4 of the Insurance Code. They also implement, interpret, and make specific the policies and

requirements of the federal Patient Protection and Affordable Care Act of 2010 (Pub. Law 111-148), as amended by the federal Health Care and Education Reconciliation Act (Pub. L. 111-152) and Title 45, Code of Federal Regulations (CFR) section 155.10 and following.

SUMMARY OF EXISTING LAWS

Under the federal Patient and Protection and Affordable Care Act (ACA), each state is required, by January 1, 2014, to establish an American Health Benefit Exchange that makes available qualified health plans to qualified individuals and small employers. State law, the California Patient Protection and Affordable Care Act (Gov. Code, § 100500 et seq.), established the California Health Benefit Exchange within state government, and it specifies the powers and duties of the executive board of the Exchange.

INFORMATIVE DIGEST/POLICY STATEMENT OVERVIEW AND EFFECT OF THE REGULATIONS

In the spring of 2010, President Obama signed federal healthcare reform legislation, the Affordable Care Act (ACA) (ACA refers to the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111 - 48), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub.L. 111- 152).

The ACA provides the authority and establishes requirements for states to create health insurance exchanges. These Exchanges make Qualified Health Plans (QHPs) available to individuals and/or qualified employers (small businesses; also known as the Small Business Health Options Program or SHOP). Under the ACA states may choose to operate their own exchanges, participate in a regional (multi-state) or subsidiary exchange or defer to a federally-facilitated exchange (an Exchange established and operated by the federal Secretary of Health and Human Services (HHS). States that choose to operate an exchange may choose to operate an exchange for that provides for the purchase of coverage in the individual market and the establishment of a SHOP, or for the establishment of a SHOP only.

That same year, 2010, California chose to operate its own exchange as the California Legislature enacted and the governor signed, legislation establishing the California Health Exchange (now also known as "Covered California,") and its governing Board. (Stats. 2010, ch. 659, section 2, (SB 900, [Alquist, Steinberg]); Stats 2010, ch. 655 (AB 1602, [Perez].)

Section 2 of AB 1602 expressed the Legislature's intent in creating the Exchange and its governing Board as follows: "It is the intent of the Legislature to enact the necessary statutory changes to California law in order to establish an American Health Benefit Exchange in California and its administrative authority in a manner that is consistent with the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended

by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), hereafter the federal act. In doing so, it is the intent of the Legislature to do all of the following: Reduce the number of uninsured Californians by creating an organized, transparent marketplace for Californians to purchase affordable, quality health care coverage, to claim available federal tax credits and cost-sharing subsidies, and to meet the personal responsibility requirements imposed under the federal act. (b) Strengthen the health care delivery system. (c) Guarantee the availability and renewability of health care coverage through the private health insurance market to qualified individuals and qualified small employers. (d) Require that health care service plans and health insurers issuing coverage in the individual and small employer markets compete on the basis of price, quality, and service, and not on risk selection. (e) Meet the requirements of the federal act and all applicable federal guidance and regulations."

Pursuant to the requirements and guidance of state and federal law, these regulations provide definitions, abbreviations and standards for notice (Articles 2, 4); standards for eligibility, eligibility determination and redetermination for Qualified Health Plans (QHP), Advance Payment of Premium Tax Credit (APTC); Cost Sharing Reduction (CSR); and termination of coverage (Article 5); and an appeals process, including notice, eligibility pending appeal, informal resolution, hearing requirements, and an expedited appeal procedure (Article 7).

OBJECTIVES

The broad objectives of this proposed regulatory action are to:

- Provide structure for the Exchange and give predictability and clear standards to the public and qualified health plan issuers.

- Specifically provide the public with clear standards and eligibility requirements to qualify for federal tax subsidies through the Exchange.

- Establish the criteria and process for eligibility determination, enrollment, and disenrollment of enrollees and potential enrollees in the Exchange.

- Establish a fair and efficient appeals process for prospective and current enrollees of the Exchange. More specifically, this action creates clear guidelines for the public to request and receive a fair hearing.

- Put California in compliance with the federal act.

- Allow the Exchange to administer the ACA systematically and predictably for the public on an ongoing basis through eligibility determination, enrollment, and disenrollment procedures.

- Reduce health care costs and provide increased and quality health care to the public in California.

BENEFITS

Anticipated benefits including nonmonetary benefits to the protection of public health and safety, worker safety, the environment, the prevention of discrimination, or the promotion of fairness or social equity, from this proposed regulatory action are:

- Making quality health care available to all Californians;

- Providing structure for the Exchange to give predictability and clear standards to the public and qualified health plan issuers now and into the future;

- Providing the public with clear standards and eligibility requirements to qualify for federal tax subsidies through the Exchange;

- Establishing the criteria and process for eligibility determination, enrollment, and disenrollment of enrollees and potential enrollees in the Exchange;

- Establishing an appeals process for prospective and current enrollees of the Exchange and thereby providing due process to applicants denied insurance or with other appealable rights. More specifically, this action includes clear guidelines for the public to request and receive a fair hearing;

- Aligning California's regulations with the federal act and complying with state law;

- Reducing health care costs for Californians;

- Providing increased health care access to the public in California; and

- Ultimately, helping to save lives and increase the health of the public in California.

EVALUATION OF CONSISTENCY AND COMPATIBILITY

The Exchange has evaluated whether the proposed regulations are inconsistent or incompatible with existing state regulations. This evaluation included a review of the laws that regulate the Exchange and specifically those statutes and regulations related to health insurance. Exchange staff also conducted an internet search of other state agency regulations.

Several California statutes and regulations govern health insurance. The Exchange has made its best effort to conform its regulations to State law, and does not know of any State statutes or regulations conflicting with these proposed regulations. Some compatible statutes, such as the Health and Safety Code Section 1399.849 and the Insurance Code Section 10965.3, provide additional requirements that affect the Exchange's proposal as noted throughout this document and the proposed regulatory text. Each is compatible with this proposal.

DOCUMENTS TO BE INCORPORATED BY REFERENCE
None.

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

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

FISCAL IMPACTS
COST TO ANY LOCAL AGENCY OR SCHOOL DISTRICT WHICH MUST BE REIMBURSED PURSUANT TO GOVERNMENT CODE SECTION 17500 ET SEQ.
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 STATE AGENCIES

The proposal results in additional costs to the California Health Benefit Exchange, which is currently funded by federal grant money and will become financially self-sustaining in 2015. The proposal does not result in any costs or savings to any other state agency.

OTHER NONDISCRETIONARY OR SAVINGS IMPOSED ON LOCAL AGENCIES

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

COSTS OR SAVINGS IN FEDERAL FUNDING TO THE STATE

The proposal results in additional costs to the California Health Benefit Exchange, which is currently funded by federal grant money and will become financially self-sustaining in 2015. There is no other impact on federal funding to the state as a result of these regulations.

SIGNIFICANT EFFECT ON HOUSING COSTS

None.

EFFECT ON SMALL BUSINESS

This proposal may impact small business with whom the Exchange contract to accomplish the goals and objectives of the regulations herein proposed.

SIGNIFICANT, STATEWIDE ADVERSE ECONOMIC IMPACT DIRECTLY AFFECTING BUSINESS, INCLUDING THE ABILITY OF CALIFORNIA BUSINESSES TO COMPETE WITH BUSINESSES IN OTHER STATES

Covered California makes an initial determination that this proposal will not have a significant, statewide adverse economic impact directly affecting business, including the ability of California businesses to compete with businesses in other states.

COST IMPACTS ON A REPRESENTATIVE PRIVATE PERSON OR BUSINESS

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

RESULTS OF THE STANDARDIZED REGULATORY IMPACT ASSESSMENT/ANALYSIS

1. **The Creation or Elimination of Jobs Within the State of California**

The implementation of these regulations will yield both positive and negative impacts on the employment in California, but will generate an overall net positive employment impact.

2. **The Creation of New Businesses or the Elimination of Existing Businesses within the State of California.**

Since the proposed regulations only pertain to enrollment in individual health insurance policies, they will not directly result in the creation or elimination of businesses. The

establishment and growth of a health insurance exchange in the nation's most populous state will likely attract insurance carriers who did not previously sell policies in California.

3. Competitive advantages or disadvantages for businesses currently doing business within the state

When comparing the competitive advantage of businesses outside of California to those in California, no direct impact is projected.

4. Increase or decrease of investment in the state

These regulations do not require or mandate any additional investment from individuals or businesses. Any additional investment in the state would be an indirect effect of induced changes in medical care and consumer spending.

5. Incentives for innovation in products, materials, or processes

Improved access to affordable individual health insurance coverage will create a unique opportunity for individuals and businesses. Since healthcare will now be more readily available, the reluctance to leave a job due to uncertainties related to healthcare coverage will diminish. As individuals enjoy more employment mobility, opportunities for innovation, self-employment, independent contracting, and consulting will increase.

Businesses will also be able to dedicate more dollars to research and development, innovation, and expansion. The reduction of healthcare costs and "job lock" will free up capital for individuals and businesses, allowing for more opportunities of expansion and innovation. [1]

6. Benefits of the regulations, including, but not limited to, benefits to the health, safety, and welfare of California residents, worker safety, and the state's environment and quality of life, among any other benefits identified by the agency

The proposed regulations will benefit California residents who apply for health benefits through the Exchange. It will make quality health care available to all Californians and provide the public with clear standards and eligibility requirements to qualify for federal tax subsidies. It will benefit the public by clarifying the criteria and process for eligibility determination, enrollment and disenrollment, and an appeals process.

SUMMARY OF DOF COMMENTS ON THE SRIA AND AGENCY RESPONSE

Covered California summarized the comments received on February 16, 2016 from DOF.

1. *DOF Comment:* The description of the baseline must include what likely happens in the absence of the regulations, including the impacts to local governments.

Covered California Response:

[1] The Economic Impact of the Affordable Care Act on California, May 2012, Bay Area Council, Micah Weinberg and Jon Haveman.

The agency has included additional information in the SRIA explaining that the purpose of the proposed regulations is to improve the affordability of health insurance by determining the eligibility of Californians for Advance Premium Tax Credits.

2. *DOF Comment:* The SRIA must include a discussion of how the proposed eligibility and enrollment regulations affect the uninsured rate in California. There are more than twice as many uninsured Californians under the age of 65 as there are enrolled through the exchange, and the SRIA must address the steps the exchange has taken to facilitate enrollment and how the proposed regulations affect the number of insured Californians.

Covered California Response:
Since 2013, the rate of the uninsured in California has dropped by more than half, from 17 percent to 6.8 percent in 2017 – a record low for California, according to data from the U.S. Centers for Disease Control. The decrease in the uninsured was due to both the Medicaid expansion and the establishment of the Exchange under the Affordable Care Act, which was facilitated through robust marketing and outreach to the uninsured. More than 3.6 million people have purchased health insurance through Covered California since the agency opened its doors five years ago. The regulations provide the ongoing framework for this success, ensuring that individuals who need help to afford health insurance continue to get the coverage they need available under the law. With the regulations in place, California can expect to see ongoing success maintaining the rate of the uninsured at record levels, and lower than the U.S. rate of 9 percent.

The agency has included additional information in the SRIA explaining that the Affordable Care Act provided state-based marketplaces with full discretion on how to market the Exchange to its own state-specific market conditions. The implementation of very robust outreach and marketing efforts resulted in not only more enrollees, but healthier enrollees, which in turn translated into lower statewide premiums than would have been charged otherwise. The 2017 report, *MARKETING MATTERS: Lessons From California to promote Stability and Lower Costs in National and State Individual Insurance Markets*, provides an overview of California's marketing and outreach experience, strategy and tactics as well as its impact on enrollment and premiums.

3. *DOF Comment:* Given the uncertainty about federal policy changes, the SRIA could include a discussion of what assumptions might change, or how impacts might be different.

Covered California Response:
The SRIA indicates that the elimination of the individual mandate penalty "would have the most negative short-term impact on enrollment with Covered California." In turn, this reduction in enrollment would substantially reduce the positive economic impacts identified in the SRIA, including moderating the anticipated job and income gains. Our

own published estimates of the potential magnitude of the reduction in enrollment vary from 14 percent to 30 percent nationwide, with a somewhat smaller impact in California. Ultimately, the economic impact would depend on the reaction of California's individual health insurance market in terms of premiums charged, advance premium tax credits paid by the federal government, and health plan participation and any market stabilization measures that may be enacted at the federal level in the coming weeks and months.

Covered California is engaged in ongoing research and analysis to assess the most likely outcome of the elimination of the penalty as well as other potential federal policy actions. For example, Covered California recently produced "The Roller Coaster for Consumers Continues: The Prospect for Individual Health Insurance Markets Nationally for 2019: Risk Factors, Uncertainty and Potential Benefits of Stabilizing Policies," that was informed by review by outside academic and policy experts. It includes a review of market factors and impacts on 2018 enrollment, potential premium impacts for 2019 and federal policies that could mitigate those factors. This and other analyses will be crucial considerations in the upcoming development and approval of the Exchange's fiscal year 2018-19 budget. Therefore, we believe it would be premature to include preliminary estimates of this impact in this SRIA at this time.

CONSIDERATION OF ALTERNATIVES

In accordance with Government Code section 11346.5, subdivision (a)(13), the Board must determine that no reasonable alternative it considered or that has otherwise been identified and brought to the attention of the agency would be more effective in carrying out the purpose for which the action is proposed or would be as effective in carrying out the purpose for which the action is proposed or 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.

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:

Bahara Hosseini
California Health Benefit Exchange (Covered California)
1601 Exposition Blvd.
Sacramento, CA 95815
Telephone: (916) 228-8486

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

Sarah Vu
California Health Benefit Exchange (Covered California)
1601 Exposition Blvd.
Sacramento, CA 95815
Telephone: (916) 228-8727

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 Bahara Hosseini at the above contact information.

AVAILABILITY OF INITIAL 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 will consist of this notice, the proposed text of the regulation and the Initial Statement of Reasons. There is currently no other information upon which the proposed rulemaking is based. Copies may be obtained by contacting Bahara Hosseini at the address or phone number listed above.

AVAILABILITY OF CHANGED OR MODIFIED TEXT

After holding a hearing, if requested, and considering all timely and relevant comments received, 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 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 Bahara Hosseini 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 Bahara Hosseini at the above address.

AVAILABILITY OF DOCUMENTS ON THE INTERNET

Copies of the Notice of Proposed Rulemaking, the Initial Statement of Reasons and the proposed text of the regulations in underline and strikeout can be accessed through our website at www.healthexchange.ca.gov/regulations.

INITIAL STATEMENT OF REASONS
FOR
ELIGIBILITY, ENROLLMENT, AND APPEALS PROCESS
FOR THE INDIVIDUAL EXCHANGE

CALIFORNIA CODE OF REGULATIONS TITLE 10 INVESTMENT

CHAPTER 12 CALIFORNIA HEALTH BENEFIT EXCHANGE

ARTICLE 2
SECTIONS 6408 AND 6410

ARTICLE 4
SECTIONS 6450, 6452 AND 6454

ARTICLE 5
SECTIONS 6470, 6472, 6474, 6476, 6478, 6480, 6482, 6484, 6486, 6490, 6492, 6494, 6496, 6498, 6500, 6502, 6504, 6506, 6508 AND 6510

AND

ARTICLE 7
SECTIONS 6600, 6602, 6604, 6606, 6608, 6610, 6612, 6614, 6616, 6618 AND 6620

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

INTRODUCTION

On September 30, 2013, the California Health Benefit Exchange (the Exchange) adopted emergency regulations in Title 10, California Code of Regulations (CCR), Chapter 12, Article 2, Sections 6408 and 6410; Article 4, Sections 6450, 6452 and 6454; Article 5, Sections 6470, 6472, 6474, 6476, 6478, 6480, 6482, 6484, 6486, 6490, 6492, 6494, 6496, 6498, 6500, 6502, 6504, 6506, 6508 and 6510; and Article 7, Sections 6600, 6602, 6604, 6606, 6608, 6610, 6612, 6614, 6616, 6618 and 6620. These emergency regulations are now in effect, and they established the Exchange's policies and procedures for: (1) eligibility determination and redetermination; (2) enrollment in qualified health plans; (3) termination of coverage through the Exchange; and (4) an appeals process in the individual Exchange. The emergency regulations provided the public with clear standards and eligibility requirements to qualify for federal

tax subsidies through the Exchange. The emergency regulations also set out the standards and requirements for the qualified health plan issuers regarding enrollment of qualified individuals in the qualified health plans and termination of coverage for qualified individuals through the Exchange. In addition, the emergency regulations established procedures for appeal of eligibility determinations and redeterminations so as to provide the public with an opportunity to request and receive a fair hearing.

The Exchange is now proposing to make those temporary emergency regulations permanent. This proposed regulatory action will make permanent Title 10 CCR, Chapter 12, Article 2, Sections 6408 and 6410; Article 4, Sections 6450, 6452 and 6454; Article 5, Sections 6470, 6472, 6474, 6476, 6478, 6480, 6482, 6484, 6486, 6490, 6492, 6494, 6496, 6498, 6500, 6502, 6504, 6506, 6508 and 6510; and Article 7, Sections 6600, 6602, 6604, 6606, 6608, 6610, 6612, 6614, 6616, 6618 and 6620.

PROBLEM STATEMENT

The Exchange is a relatively new state entity administering recent federal and state health care legislation. The California enabling legislation requires the Exchange to establish criteria and processes for eligibility determination, enrollment, and disenrollment of enrollees and potential enrollees in the Exchange. (Gov. Code, § 100503(a).) The Exchange is also required to establish an appeals process for prospective and current enrollees of the Exchange that complies with all requirements of the federal act. (Gov. Code, § 100506.) The eligibility determination, enrollment, disenrollment, and appeals procedures are not only required by federal and State law, but they are necessary to administer the Exchange; without such regulations, the Exchange could not function.

SUMMARY OF THE PROPOSED REGULATIONS

The purpose of these proposed regulations are to make permanent the Exchange's emergency policies and procedures for health insurance eligibility determination and redetermination, enrollment in qualified health plans, termination of coverage through the Exchange, and the appeals process in the individual Exchange. The proposed permanent regulations will provide the public with clear standards and eligibility requirements to qualify for federal tax subsidies through the Exchange. Additionally, the proposed regulations will provide the standards and requirements for the qualified health plan issuers regarding enrollment of qualified individuals in the qualified health plans and termination of coverage for qualified individual through the Exchange. The proposed regulations will further provide the public with clear guidelines and standards for adjudicating appeals of individual eligibility determinations.

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

benefit the public by providing them an opportunity to exercise their right to due process if they are denied coverage or federal tax subsidies, disagree with the Exchange's eligibility determinations, or do not receive adequate, timely notice of their eligibility determinations.

Purpose:
The purpose of this proposed regulatory action is to establish the Exchange's policies and procedures for eligibility determination and redetermination, enrollment in qualified health plans, termination of coverage through the Exchange, and appeals process in the individual market, consistent with state and federal law.

This regulatory action will enable the Exchange provide health insurance coverage to eligible applicants, to improve the health of Californians, to increase access to quality medical care, to fairly and promptly resolve eligibility appeals, and to better protect the public health, safety and welfare.

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

Pursuant to its authorities, the Exchange proposes to permanently adopt Articles 2, 4, 5, and 7 of Title 10, Investment, Chapter 12, and the regulations contained in these Articles. The detailed discussion of the specific purpose, rationale, problems addressed, and statement of reasons for each Article and the sections within these Articles is as follows:

Article 2. Abbreviations and Definitions

Article 2, in its entirety, specifies, clarifies, and defines the abbreviations and all the terms that are applicable to Chapter 12. This is necessary to provide the public with clarity as to the abbreviations and specific terms that are being used throughout these proposed regulations and commonly used in the health insurance statutes and regulations. This is also necessary to comport these abbreviations and definitions with those being used in the relevant federal and State rules to create consistency and to prevent confusion.

§ 6408. Abbreviations

Section 6408, in its entirety, implements, clarifies, and makes specific the abbreviations used throughout these proposed regulations and commonly used in health insurance statutes and regulations. This is necessary to provide clarity to the public and regulated community as to the meaning of common acronyms used in these regulations and in the relevant federal and State health care laws and regulations. Using abbreviations throughout the regulations is necessary to shorten and clarify the regulatory text. It

would be inefficient to keep spelling out these abbreviated terms in full throughout these proposed regulations. The "California Healthcare Eligibility, Enrollment, and Retention System" is a good example of such a term, which appears frequently throughout the regulations and, if not abbreviated as "CalHEERS," would significantly lengthen and complicate the regulatory text. Unless the abbreviations used in the regulations are defined in one location, readers might struggle to understand them or to conveniently find their meanings. Listing and defining the abbreviations used in these proposed regulations in one section, in turn, is necessary so that readers may quickly and easily determine what the abbreviations used in the regulations mean by referring back to a complete list of abbreviations. The abbreviations used are logical and track commonly used and understood abbreviations for the same terms (e.g., "HHS" for "U.S. Department of Health and Human Services"). There is no reasonable alternative to listing abbreviations and their meanings in a single section.

§ 6410. Definitions

Section 6410, in its entirety, implements, clarifies, and makes specific 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. The following is a more specific, detailed discussion of the necessity for the definitions included in this section:

Defining "Advance Payments of Premium Tax Credit" (APTC) is necessary to avoid confusion regarding a specialized, technical term, to specify the term's bases in federal law, and to ensure consistency with Section 1412 of the Affordable Care Act, Section 36B of the Internal Revenue Code, and its implementing regulations. Under the Affordable Care Act and its implementing regulations, as well as Government Code 100502(k), the Exchange is responsible for determining eligibility for APTC, which is a refundable and advanceable tax credit to reduce the cost of purchasing Qualified Health Plans through the Exchange for Qualified Individuals. It is necessary to define this term to enable interested individuals, including participating issuers and members of the public, to determine the means for devising eligibility for federal subsidies.

Defining "Affordable Care Act" is necessary to clarify that the term refers to the federal Patient Protection and Affordable Care Act of 2010 (Pub.L. 111–148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Pub.L. 111–152), and not to the California law of a similar name. It is also necessary to align the term as used in these regulations with the definition of the same term in 45 CFR Section 155.20.

Defining "Annual Open Enrollment Period" is necessary to specify and clarify the purpose of the annual open enrollment period and the sections of the Health and Safety Code and Insurance Code that define the dates of open enrollment, when individuals

are permitted to enroll in and change their selected health plan. It is also necessary to ensure consistency with the definition provided in 45 CFR Section 155.20.

Defining “Applicable Children's Health Insurance Program (CHIP) MAGI–based Income Standard” is necessary to avoid confusion regarding a specialized, technical term, and to conform to the federal definition set forth in 45 CFR Section 155.300. The Exchange’s eligibility and enrollment system must determine eligibility for the CHIP, based on a MAGI-based income standard that is defined in federal law for that program. Additionally, under Section 6484 of Article 5, the Exchange is required to accept a tax filer’s attestation regarding annual household income provided, among other things, that the applicant’s MAGI-based income is not within the CHIP MAGI-based income standard, which would make the applicant eligible for CHIP.

Defining “Applicable Medi-Cal Modified Adjusted Gross Income (MAGI)-Based Income Standard” is necessary to avoid confusion regarding a specialized, technical term, and to conform to the federal definition set forth in 45 CFR Section 155.300. The Exchange’s eligibility and enrollment system must determine eligibility for the Medi-Cal Program, based on a MAGI-based income standard that is defined in federal law for that program. Additionally, under Section 6484 of Article 5, the Exchange is required to accept a tax filer’s attestation regarding annual household income provided, among other things, that the applicant’s MAGI-based income is not within the Medi-Cal MAGI-based income standard, which would make the applicant eligible for Medi-Cal.

Defining “Applicant” is necessary to specify and clarify the term’s exclusions and limits, some of which would not be apparent based on the term’s standard meaning, and to conform to the federal definition set forth in 45 CFR Section 155.20. Applicant includes all individuals seeking coverage for him or herself, other than those seeking an exemption from the shared responsibility payment, as well as individuals transferred to the Exchange by an agency administering an insurance affordability program. It also includes employers, employees, or former employees seeking coverage through the SHOP for themselves, or for their dependents if dependent coverage is offered.

Defining “Application Filer” is necessary to specify and clarify the term’s exclusions and limits, some of which would not be apparent based on the term’s standard meaning, and to conform to the federal definition set forth in 45 CFR Section 155.20. Application Filer is broader than “Applicant,” and an Application Filer is not necessarily seeking coverage for him or herself. As a result, Application Filers do not need to submit the same amount of information as part of their applications as Applicants must.

Defining “Authorized Representative” is necessary to specify and clarify the term’s exclusions and limits, some of which would not be apparent based on the term’s standard meaning. Under 45 CFR Section 155.227, the Exchange must permit applicants and enrollees to designate an Authorized Representative to act on their

behalf in applying for an eligibility determination or redetermination, and to carry out ongoing communications with the Exchange. The definition of "Authorized Representative" makes specific the Exchange's obligation to allow Authorized Representatives to perform various functions on behalf of applicants and enrollees.

Defining "Benefit Year" is necessary to specify and clarify that the term denotes a calendar year rather than a year measured from another date, and to conform to the federal definition set forth in 45 CFR Section 155.20. This definition also is consistent with practice in the market outside the Exchange, where coverage is provided on a calendar year basis with selections and eligibility determinations occurring during the annual open enrollment period.

Defining "Board" is necessary to specify and clarify that the term refers to the executive board that governs the California Health Benefit Exchange, established by Government Code Section 100500, which might not otherwise be apparent.

Defining "California Health Benefit Exchange" or the "Exchange" is necessary to specify and clarify that these terms refer to the entity established pursuant to Government Code Section 100500 and are synonymous with "Covered California," which might not otherwise be apparent to members of the public.

Defining "California Healthcare Eligibility, Enrollment, and Retention System" is necessary to avoid confusion regarding a specialized, technical term and to specify the term's bases Government Code Sections 100502 and 100503, as well as in 42 USC Section 18031. The California Healthcare Eligibility, Enrollment, and Retention System, also known as "CalHEERS," is the online portal required by federal law to process applications and enrollments into insurance affordability programs, as well as to maintain consumer data. Defining this term is necessary to clarify the provisions of state and federal law that required CalHEERS to be created and the other provisions of the Exchange regulations that refer to CalHEERS.

Defining "Cancellation of Enrollment" is necessary to specify and clarify that the term refers to specific type of termination action that ends a qualified individual's enrollment on or before the coverage effective date, which might not otherwise be apparent to members of the public.

Defining "Captive Agent" is necessary to avoid confusion regarding a specialized, technical industry term, the meaning of which might be unclear to the public. This term is used in Article 9 of the Exchange's regulations, regarding the Plan-Based Enroller Program, and is meant to differentiate between employees of health insurance issuers who assist with enrollment and are also health insurance agents licensed by the Insurance Commissioner and those who are not health insurance agents. Because Captive Agents are licensed by the Insurance Commissioner and have passed the

Department of Insurance's fingerprint-based criminal background check, unlike their colleagues at their health insurance issuer who have not previously passed such a background check, they are not required to pass the Exchange's fingerprint-based criminal background check in addition. Defining this term is necessary to aid the public in distinguishing between which categories of enrollment assistance personnel employed by the issuers and seeking certification by the Exchange need to undergo a criminal background check.

Defining "Carrier" is necessary to specify and clarify that the term refers to either a private health insurer holding a valid outstanding certificate of authority from the Insurance Commissioner or a health care service plan, as defined under subdivision (f) of Section 1345 of the Health and Safety Code, licensed by the Department of Managed Health Care, which might not otherwise be apparent to members of the general public. The term "Carrier" is typically used in State law, while federal law generally uses the term "Issuer" for the same concept. It is necessary to include this definition to harmonize State and federal law and to minimize confusion about possible use of both terms.

Defining "Catastrophic Plan" is necessary to specify and clarify that the term refers to a health plan described in Section 1302(e) of the Affordable Care Act, Section 1367.008(c)(1) of the Health and Safety Code, and Section 10112.295(c)(1) of the Insurance Code, which might not otherwise be apparent, as well as to ensure consistency with the definition of the same term found in 45 CFR Section 155.20. Some qualified individuals are legally permitted to enroll in the Catastrophic Plan, also known as the Minimum Coverage Plan. The Exchange is required to make the Catastrophic Plan available to individuals who qualify and has defined it consistent with federal and State law.

Defining "Certified Enrollment Counselor" is necessary to avoid confusion regarding a specialized, technical term and to specify the term's basis in Section 6650 of Article 8 of the Exchange's regulations. The Certified Enrollment Counselor program is a new program not explicitly defined in federal law, although it has substantially the same meaning as the "non-Navigator assistance personnel" is used in 45 CFR Section 155.215. As described further in Article 8, the program is designed to provide community-based organizations with funding to engage in enrollment activities, particularly in hard-to-reach communities that have historically been underserved by the health care industry.

Defining "Certified Insurance Agent" is necessary to specify and clarify a technical term and its basis in Section 6800 of Article 10 of the Exchange's regulations, which might not otherwise be apparent. The Exchange certifies insurance agents to provide enrollment assistance to Qualified Individuals and Qualified Employers. The definition is consistent with existing State law in Insurance Code Section 1626.

Defining “Certified Plan-Based Enroller” is necessary to avoid confusion regarding a specialized, technical term and to specify the term’s basis in State and federal law. The Exchange permits QHP Issuers to register their staff to enroll Qualified Individuals directly into their QHPs under the Plan-Based Enroller Program. Defining Certified Plan-Based Enroller is necessary to make clear to the public which individuals are eligible to provide such enrollment assistance.

Defining “Certified Plan-Based Enroller Program” is necessary to avoid confusion regarding a specialized, technical term. The Exchange permits QHP Issuers to register their staff to enroll Qualified Individuals directly into their QHPs under the Plan-Based Enroller Program. Defining Certified Plan-Based Enroller Program is necessary to make clear to the public that this program is being operated by the Exchange as permitted by 45 CFR Section 155.415.

Defining “Certified Plan-Based Enrollment Entity” is necessary to avoid confusion regarding a specialized, technical term and to specify the term’s basis in state law. The Exchange permits QHP Issuers to register their staff to enroll Qualified Individuals directly into their QHPs under the Plan-Based Enroller Program. This is permitted under 45 CFR Section 155.415. Defining Certified Plan-Based Enrollment Entity is necessary to make clear to the public which entities are eligible to participate in this program.

Defining “Child” is necessary because, as used in the regulations, the term has a specific meaning under State law. To the extent possible, the Exchange has attempted to define all terms consistent with existing state law so as to minimize market disruption. Child as defined here includes any adopted child, stepchild, or recognized natural child, as well as an individual with whom an adult has assumed a parent-child relationship and a disabled adult child over age 26.

Defining “Cost-share or Cost-sharing” is necessary to avoid confusion regarding a specialized, technical term, and to conform to the federal definition set forth in 45 CFR Section 155.20. The two major elements of the cost of a plan for consumers are the premium and the cost sharing. It is necessary to define what is meant by cost sharing for purposes of the standard benefit design because the consumer’s cost share is an essential ingredient of the actuarial value of a plan. The greater the consumer’s cost share at the point of service, the lower the actuarial value of the plan. Defining any exclusions from cost sharing also is necessary to maintain consistency with the existing health insurance market. Premiums, balance-billing amounts for non-network providers, and spending for non-covered services are traditionally excluded from the cost sharing amount. Including those amounts in cost sharing would be contrary to existing market

practice and would skew the actuarial value of all products.

Generally speaking, premiums are higher for products that have a higher actuarial value, because the issuer will cover more of the cost of covered services at the point of service. Including premium within cost share would drive up the cost share for product that actually have a higher actuarial value and cause them to appear to have a lower actuarial value than they have.

Balance-billing amounts reflect the difference between an issuer's rate for a service and the amount a non-network provider charges for a service. Ordinarily, the enrollee must bear the cost of balance-billing amounts because the enrollee selected an out-of-network provider for the service. Including those amounts in the cost share would drive down the actuarial value of a product and make it appear to have poorer coverage than it does, even though the market rule is for issuers not to pay for balance-billing amounts. As a result, the Exchange excluded those amounts from cost sharing.

In a similar vein, cost sharing does not include non-covered services. Under the Affordable Care Act, all individual and small group plans must cover the ten Essential Health Benefits, which in California are the services covered by the Kaiser Small Group 30 HMO. Requiring cost sharing to include any services beyond the Essential Health Benefits would drive down actuarial value of plans that provide full-scope coverage in a manner that is inconsistent with current market practices.

Defining "Cost-Sharing Reduction" is necessary to avoid confusion regarding a specialized, technical term, and to conform to the federal definition set forth in 45 CFR Section 155.20. Under the Affordable Care Act, Qualified Individuals enrolled in a silver-level QHP and whose annual household income is at 250% of the Federal Poverty Level, as well as Indians enrolled in a QHP in the Exchange, are entitled to Cost-Sharing Reductions to reduce the enrollee's cost share at the point of service. In effect, an individual enrolled in a silver QHP that is enhanced with Cost-Sharing Reductions is paying the premium for a silver-level QHP but receiving the enhanced actuarial value and lowered cost-sharing of a gold or platinum QHP, or, for the very lowest-income enrollees, even better than platinum. The Federal Department of Health and Human Services (HHS) compensates the QHP issuers for the difference between the standard silver cost-sharing and the actual amounts paid by those enrolled in silver QHPs with Cost-Sharing Reductions. The Exchange has defined this term to be consistent with the federal definition to ensure that the standard benefit designs are appropriately calibrated for actuarial value and cost sharing for each service.

Defining "Day" is necessary to avoid confusion regarding whether the term refers to a calendar day or a business day. Many of the sections in these regulations include deadlines based on days, and this section clarifies that calendar day is meant unless business day is specified.

Defining “Dental Exclusive Provider Organization” is necessary to avoid confusion regarding a specialized, technical term. As part of the Exchange’s Dental Plan certification and recertification process, the Exchange asks bidders which type of Dental Plan provider payment arrangement each Dental Issuer proposes to offer with a view toward ensuring a mix of arrangements and maximizing affordability for the consumer.

Defining “Dental Health Maintenance Organization” is necessary to avoid confusion regarding a specialized, technical term. As part of the Exchange’s Dental Plan certification and recertification process, the Exchange asks bidders which type of Dental Plan provider payment arrangement each Dental Issuer proposes to offer with a view toward ensuring a mix of arrangements and maximizing affordability for the consumer.

Defining “Dental Preferred Provider Organization” is necessary to avoid confusion regarding a specialized, technical term. As part of the Exchange’s Dental Plan certification and recertification process, the Exchange asks bidders which type of Dental Plan provider payment arrangement each Dental Issuer proposes to offer with a view toward ensuring a mix of arrangements and maximizing affordability for the consumer.

Defining “Dependent” is necessary because this familiar term, as used in the regulations, carries a specific and technical meaning informed by State and federal law that would not otherwise be apparent.

In the Individual Exchange, Dependent has two different meanings for different purposes. For purposes of determining eligibility for APTC and CSR, Dependent is defined as a tax dependent. This choice was mandated by federal law, and the Exchange does not have discretion to do otherwise. An applicant’s eligibility for APTC and CSR depends on the applicant’s family size and MAGI household income. The relevant household for determining MAGI and percentage of federal poverty level is the tax household, so it is necessary to define Dependent by reference to the definition applicable to tax filing. The definition also clarifies that domestic partners are included within this definition only for purposes of eligibility determination for enrollment in a QHP without APTC or CSR because domestic partners are not recognized under the federal tax rules, and therefore, they will not be considered part of the same tax household for purposes of eligibility determination for APTC or CSR.

However, for purposes of enrollment in a QHP, Dependent is defined by reference to State law, which somewhat limits the definition of dependent such that it is defined in some cases more narrowly than in the federal tax rules. This definition includes only the spouse or registered domestic partner as well as child until age 26, or disabled child of any age, of the Qualified Individual or Enrollee. This definition is necessary to comport with existing State law regarding who can enroll under the same plan as the

main subscriber. There was concern that permitting all tax dependents to enroll under one family policy would enable the group to reach the annual out-of-pocket maximum, now prescribed under federal law, more quickly because there would be more enrollees under one policy. In turn, this would drive up premiums. As a result, the Exchange chose to define Dependent for these purposes to be consistent with existing State law and market practice.

In the SHOP Exchange, Dependent is defined with reference to existing state law as well, and also permits non-registered domestic partners who meet the Qualified Employer's standards for non-registered domestic partners to enroll under the main applicant's policy. This is consistent with market practice and State law.

Defining "Domestic Partner" is necessary because this familiar term, as used in the regulations, carries a specific and technical meaning informed by various provisions of State law and that differs depending on whether the context is the Individual Exchange or the SHOP. The term therefore would be unclear if it were not defined. Moreover, the precise definition used was arrived at after extensive consultation with stakeholders, and it is intended to ensure coverage of all appropriate individuals. In particular, for the SHOP, the term encompasses nonregistered domestic partners who meet the Qualified Employer's standards for non-registered domestic partners. This definition is consistent with market practices.

Defining "Eligible Employee" is necessary to specify and clarify a technical term informed by various provisions of State law that would not otherwise be clear to readers. Only Eligible Employees may enroll in a Qualified Employer's QHP through the SHOP, so this term is necessary to identify which employees are eligible. The term is defined consistent with existing State law regarding employee eligibility for employer health benefits.

Defining "Eligible Employer-sponsored Plan" is necessary to avoid confusion regarding a specialized, technical term, and to conform to the federal definition set forth in 45 CFR Section 155.20. Under federal law, an applicant for the Exchange is ineligible for federal subsidies, including APTC and CSR, if the applicant is eligible for an Eligible Employer-sponsored Plan. This is a plan that is affordable—meaning that the annual premiums for self-only coverage do not exceed 9.5% of the employee's annual gross household income—and provides minimum value—meaning that, on average, it pays at least 60% of the cost of the covered benefits. Because the Exchange must verify whether an applicant is eligible for such a plan as part of the application process, and because applicants are ineligible for subsidized coverage if they have access to an Eligible Employer-Sponsored Plan, it is necessary to define this term. It is also necessary to define this term consistent with federal law because the federal standards determine when an applicant is eligible for APTC and CSR.

Defining “Employee” is necessary because this familiar term, as used in the regulations, carries a specific and technical meaning informed by federal law, which would not otherwise be apparent, and to conform to the federal definition specified in 45 CFR Section 155.20. Because the federal law determines who is eligible for the SHOP, it is necessary to define this term so as to clarify which individuals are eligible for employer-sponsored coverage in the SHOP.

Defining “Employer” is necessary because this familiar term, as used in the regulations, carries a specific and technical meaning, which would not otherwise be apparent, and to conform to the federal definition specified in 45 CFR Section 155.20. Because the federal law determines who is eligible for the SHOP, it is necessary to define this term so as to clarify which individuals are eligible for employer-sponsored coverage in the SHOP and when an entity is considered an employer. The federal regulations require that an Employer have at least one common-law employee. This definition excludes sole proprietors, certain owners of S corporations, and certain relative of those groups because they do not meet the definition under federal law. The Exchange has no discretion to broaden the definition to include those groups.

Defining “Employer Contributions” is necessary to specify and clarify that the term includes any financial contributions towards an employer-sponsored health plan, or other eligible employer-sponsored benefit made by the employer, including those made by salary reduction agreement that is excluded from gross income. It is also necessary to conform to the federal definition specified in 45 CFR Section 155.20. The special enrollment regulations for the individual Exchange and the SHOP in Articles 5 and 6 of the Exchange’s regulations provide that termination of Employer Contributions for non-COBRA coverage constitutes a qualifying event for a special enrollment period, so it is necessary to define that term in order to clarify when an individual or employee would be eligible for such special enrollment periods.

Defining “Enrollee” is necessary to specify and clarify that the term refers to a qualified individual or qualified employee enrolled in a QHP, which might not otherwise be apparent, and to conform to the federal definition specified in 45 CFR Section 155.20. It is also necessary to clarify that the term also refers to the dependent of a qualified employee enrolled in a QHP through the SHOP, and any other person who is enrolled in a QHP through the SHOP. And, if at least one employee enrolls in a QHP through the SHOP, “enrollee” also means a business owner enrolled in a QHP through the SHOP, or the dependent of a business owner enrolled in a QHP through the SHOP. This term is used throughout the Exchange’s regulations so it is necessary to clarify who is included.

Defining “Essential Community Providers” is necessary to avoid confusion regarding a specialized, technical term and to specify its basis in federal law. In multiple areas in the Exchange’s QHP Solicitation, the Exchange requests information about the Bidders’

contracts with Essential Community Providers, including, but not limited to, 340B providers. The Exchange is attempting to encourage and promote access to care in traditionally medically-underserved communities, and a major element of that effort is asking questions about and encouraging contracts with the providers that serve those communities. Additionally, it is a federal requirement that QHP Issuers have contracts with a minimum standard of Essential Community Providers. The definition is consistent with federal law in order to ensure that participating QHP Issuers are compliant with the federal standard.

Defining "Essential Health Benefits" is necessary to avoid confusion regarding a specialized, technical term and to specify its basis in State and federal law. Under the Affordable Care Act, specifically 45 CFR Section 147.150, all individual and small group health insurance products must cover the ten Essential Health Benefits described in federal law. Under 45 CFR Section 156.100, the essential health benefits package is the package of benefits covered by an existing product that each state may select from among a group of specified products already in existence. The selected product is known as the "benchmark plan." In California, the Legislature selected a Kaiser Small Group 30 HMO to be the benchmark plan, whose benefits all individual and small group products now must cover. In multiple places in the regulations, including the QHP Solicitation, the Exchange uses the term and asks for information about the Bidders' coverage of Essential Health Benefits, so this definition and consistency with State and federal law is necessary.

Defining "Exchange Service Area" is necessary to specify and clarify that the term encompasses the entire geographic area of the State of California, which might not otherwise be apparent, and to conform to the federal definition specified in 45 CFR Section 155.20. The Exchange's regulations in Article 5 require that, in order to be eligible for the Exchange, an applicant must reside in the Exchange's Service Area, and provide special rules for when members of the same family reside in multiple Exchange Service Areas. This definition is necessary to clarify that the Exchange's Service Area is coextensive with the entire State, as federal law does permit service areas that are smaller than a state or that encompass several states.

Defining "Exclusive Provider Organization" is necessary to avoid confusion regarding a specialized, technical term and to specify its basis in the State regulations. The QHP Solicitation permits Bidders to propose multiple payment and care models, including Exclusive Provider Organizations, and the Standard Benefit Plan Designs include an Exclusive Provider Organization model as well. It is necessary to define this term so as to facilitate the bidding process and clarify the Standard Benefit Plan Designs for the public.

Defining “Executive Director” is necessary to specify and clarify that the term refers to the Executive Director of the Exchange, not to some other executive director.

Defining “Federal Poverty Level” is necessary to avoid confusion regarding a specialized, technical term, and to conform to the federal definition specified in 45 CFR Section 155.300. Many of the standards for eligibility for Insurance Affordability Programs depend on an applicant’s household income relative to the Federal Poverty Level, which is therefore included in many places in the sections that determine eligibility. The definition used is consistent with the federal definition to ensure that applicants to the Exchange have their eligibility determined in accordance with federal law and remain eligible for these Insurance Affordability Programs.

Defining “Full-time employee” is necessary to specify and clarify that the term refers to a permanent employee with a normal workweek of an average of at least 30 hours per week over the course of a month, which might not otherwise be apparent (especially as conceptions of “full time” work likely differ widely). The term “Full-time Employee” is used in the context of sending out potential penalty notices to large employers whose employees participate in the Exchange with subsidies as well as for purposes of determining employer eligibility for the SHOP. It is necessary to include this definition in order to clarify these standards.

Defining “Geographic Service Area” is necessary to specify and clarify that the term refers to a defined geographic area within the State of California that a proposed QHP proposes to serve and is approved by the applicable State Health Insurance Regulator to serve, which might not otherwise be apparent. The term is used extensively in the QHP Solicitation for purposes of determining where a Bidder is licensed to provide coverage and what regions it proposes to cover through the Exchange.

Defining “Group Contribution Rule” is necessary to avoid confusion regarding a specialized, technical term. The term is used in the context of determining an employer’s eligibility to participate in the SHOP and is necessary to provide clarity about such eligibility, including the minimum amount of premiums an employer must pay for.

Defining “Group Dental Plan” is necessary to specify and clarify that this is a plan certified by the Exchange and is offered in the small group marketplace and provides pediatric dental benefits. It also includes coverage for certain benefits for adult enrollees and is available to qualified employers.

Defining “Group Participation Rate” is necessary to avoid confusion regarding a specialized, technical term that means the minimum percentage of all eligible individuals or employees of an employer that must be enrolled.

Defining “Health Insurance Coverage” is necessary to specify and clarify that this seemingly familiar term has a specific meaning in the context of the regulations that is defined by federal regulation, which might not otherwise be apparent. This term is used in various places throughout the regulations and is made consistent with the federal definition through this definition.

Defining “Health Insurance Issuer” is necessary to specify and clarify that the term has the specific meaning specified in 42 USC Section 300gg-91 and 45 CFR Section 144.103, and that it is synonymous with “Carrier”, “Health Issuer,” and “Issuer,” which might not otherwise be apparent. It is also necessary to ensure consistency with the definition in 45 CFR Section 155.20. This term is used extensively in the QHP Solicitation document and must be defined because all Health Insurance Issuers are potential Bidders. The term “Health Insurance Issuer” is used interchangeably in federal law with “Health Issuer” and “Issuer,” while State law generally uses the term “Carrier” for the same concept. This definition helps harmonize the various terms and ensures consistency.

Defining “Health Maintenance Organization” is necessary to avoid confusion regarding a specialized, technical term. The QHP Solicitation permits Bidders to propose multiple payment and care models, including Health Maintenance Organizations, and the Standard Benefit Plan Designs include a Health Maintenance Organization model as well. It is necessary to define this term so as to facilitate the bidding process and clarify the Standard Benefit Plan Designs for the public. This term is not defined in State law, so the federal definition is used to explain the concept.

Defining “Health plan” is necessary to specify and clarify that the term refers to a plan as defined in Section 1301(b)(1) of the Affordable Care Act, which might not otherwise be apparent. This term is used extensively throughout the regulations and it is necessary to define it in order to provide clarity and ensure consistency with federal law.

Defining “High Deductible Health Plan” is necessary to specify and clarify that the term has the same meaning as defined in Section 223(c)(2) of IRC (26 USC § 223(c)(2)), which might not otherwise be apparent. This definition clarifies that design is consistent with federal law and the term is the same as it is used in federal law.

Defining “Incarcerated” is necessary because individuals who are incarcerated, other than incarcerated pending disposition of charges, are not eligible to purchase QHPs through the Exchange. This definition is consistent with the definition specified in the IRS regulations.

Defining “Indian” is necessary to specify and clarify that this potentially ambiguous term carries the meaning set forth in Section 4(d) of the Indian Self–Determination and Education Assistance Act (Pub.L. 93–638; 25 USC § 450b(d)), which otherwise might not be apparent, and to conform to the federal definition set forth in 45 CFR Section 155.300. Under the Affordable Care Act, Indians are eligible for various services and subsidies for which non-Indians are not eligible, including cost-sharing reductions outside of the silver level plans, a zero-cost-sharing plan, and monthly special enrollment periods. As a result, it is necessary to define “Indian” to clarify who is eligible under those provisions.

Defining “Indian Tribe” is necessary to specify and clarify that this term carries the specific meaning set forth in Section 4(e) of the Indian Self–Determination and Education Assistance Act (Pub.L. 93–638; 25 USC § 450b(e)), which otherwise might not be apparent. Because an Indian is defined as a member of an Indian Tribe, this definition is necessary and very important. Several groups commented to the federal government that its definition of Indian Tribe was too narrow and that it should extend past Federally-recognized tribes. However, the federal government kept its proposed definition of Indian Tribe consistent with the Indian Self-Determination and Education Assistance Act, and in order to comply with federal law, the Exchange follows that definition.

Defining “Individual and Small Business Health Options Program (SHOP) Exchanges” is necessary to avoid confusion regarding a specialized term, the meaning of which is informed by state and federal law. Together, these two Exchanges are the marketplaces through which individuals and small employers can purchase subsidized health insurance, and which the Exchange is legally obligated to operate. As a result, it is necessary to define these terms.

Defining “Individual Market” is necessary to specify and clarify that the term refers to a market as defined in Section 1304(a)(2) of the Affordable Care Act, which otherwise might not be apparent, and to conform to the federal definition specified in 45 CFR Section 155.20. It is necessary to contrast this term with the group market. Additionally, the term is used in the regulations in the context of eligibility for special enrollment periods and required notices about eligibility for other coverage in the event of termination. Because this term is not defined in state law, it is consistent with the federal law.

Defining “Initial Open Enrollment Period” is necessary to specify and clarify that the term refers to the initial period in which Qualified Individuals may enroll in QHPs, from October 1, 2013 to March 31, 2014, subject to 45 CFR Section 155.410(b), Section 1399.849(c)(1) of the Health and Safety Code, and Section 10965.3(c)(1) of the Insurance Code, and to conform to the federal definition specified in 45 CFR Section 155.20. The regulations clarify that this is the only period during which an individual

may purchase coverage through the Exchange for plan year 2014, unless the individual qualifies for a special enrollment period. Additionally, under the federal and State laws cited above, this is the only period during which an Exchange may offer coverage, or an issuer may sell a product, in the individual market.

Defining “Insurance Affordability Program” is necessary to avoid confusion regarding a specialized, technical term, and to conform to the federal definition specified in 45 CFR Section 155.300. Federal law requires that the Exchange determine eligibility for, and enroll eligible individuals in, any Insurance Affordability Program for which the individual is determined eligible. The various enrollment assistance program training and conflict standards also require that any personnel engaged in enrollment assistance must be prepared to advise applicants about the full range of Insurance Affordability Programs that are available to them. Defining this term is necessary to clarify the scope of the obligations on the Exchange and its enrollment assistance personnel.

Defining “Lawfully Present” is necessary to specify and clarify that the term takes its meaning from a particular federal regulation, which otherwise might not be apparent, and to conform to the federal definition specified in 45 CFR Section 155.2. In order to be eligible for the Exchange, an individual must be either a citizen or lawfully present in the United States. The meaning of this term is not immediately obvious, so it is defined with reference to federal law. This clarification is necessary to determine eligibility for enrollment in a QHP through the Exchange.

Defining “Level of Coverage” is necessary to specify and clarify that the term refers to one of four standardized actuarial values as defined in 42 USC Section 18022(d), Sections 1367.008 and 1367.009 of the Health and Safety Code, and Sections 10112.295 and 10112.297 of the Insurance Code, and the catastrophic level of coverage as defined in 42 USC Section 18022(e), Section 1367.008(c)(1) of the Health and Safety Code, and Section 10112.295(c)(1) of the Insurance Code. Defining “Metal Tier” is necessary to clarify that all products in the individual and small group markets must meet one of the four levels of coverage, meaning platinum (equivalent to a 90% actuarial value), gold (80% actuarial value), silver (70% actuarial value) and bronze (60% actuarial value). Additionally, issuers participating in the Exchange may offer the catastrophic level of coverage within the Exchange to individuals who qualify for that level of coverage. “Level of Coverage” is used extensively in the Standard Benefit Plan Designs, which provide designs at each level of coverage. It is necessary to specify what these terms mean in order to provide clarity for members of the public.

Defining “Medi-Cal Managed Care Plan” is necessary to avoid confusion regarding a specialized term informed by various provisions of State law. This term is used in the context of the new applicant rules for plan year 2015, which permit certain Medi-Cal

Managed Care Plans to enter the Exchange even if they were not participating in the Exchange in plan year 2014. Additionally, Section 6710 of Article 9 of the Exchange's regulations permits Plan-Based Enrollers to assist Medi-Cal-eligible applicants to select a Medi-Cal Managed Care Plan once Medi-Cal plan selection is available through CalHEERS. It is necessary to define this term in order to explain the extent of these requirements.

Defining "Minimum Essential Coverage" is necessary to avoid confusion regarding a specialized term informed by federal law. Under federal law, an applicant for the Exchange is ineligible for APTC or CSR if the applicant is eligible for other Minimum Essential Coverage. That term includes various non-Exchange sources of public and private health insurance, including Medi-Cal, employer-sponsored coverage, and Medicare. It is necessary to define this term consistent with federal law in order to clarify the eligibility standards for APTC and CSR throughout Article 5 of these proposed regulations.

Defining "Minimum Value" is necessary to avoid confusion regarding a specialized term informed by federal law, and to conform to the federal definition set forth in 45 CFR Section 155.300. Under federal law, an applicant for the Exchange is ineligible for APTC and CSR if the applicant is eligible for employer-sponsored coverage that provides minimum value. Providing minimum value means that the employer-sponsored plan pays for at least 60% of the cost of covered benefits. It is necessary to define this term consistent with federal law in order to ensure that Exchange applicants in California remain eligible for federal subsidies for purchasing health insurance.

Defining "Modified Adjusted Gross Income" is necessary to avoid confusion regarding a specialized term, and to conform to the federal definition specified in 45 CFR Section 155.300. Eligibility for Insurance Affordability Programs depends on the applicant's Modified Adjusted Gross Income, a term of art from tax law, relative to the Federal Poverty Level. It is necessary to clarify what this income standard is and that it is consistent with federal law in order to specify to the public how the income-based portion of eligibility is determined.

Defining "Modified Adjusted Gross Income (MAGI)-based income" is necessary to specify and clarify that the term refers to income as defined in 42 CFR Section 435.603(e), which otherwise might not be apparent, and to conform to the federal definition specified in 45 CFR Section 155.300. Eligibility for Insurance Affordability Programs depends on the applicant's MAGI (Modified Adjusted Gross Income)-based income, a term of art from tax law, relative to the Federal Poverty Level. It is necessary to clarify what this income standard is and that it is consistent with federal law in order to specify to the public how the income-based portion of eligibility is determined.

Defining “Non-citizen” is necessary to avoid confusion regarding a specialized term informed by federal law. Citizenship is an element of eligibility for the Exchange as well as Medi-Cal. Only some non-citizens are Exchange-eligible, as determined by federal law. This term is defined consistent with Section 101(a)(3) of the Immigration and Nationality Act to ensure consistency with federal law for purposes of Insurance Affordability Program eligibility.

Defining “Part-time Eligible Employee” is necessary to clarify that the term refers to a permanent employee who works at least 20 hours but not more than 29 hours and who otherwise meets the definition of an eligible employee except for the number of hours worked. The SHOP rule under Section 6520 of Article 6 of the Exchange’s regulations requires Qualified Employers to indicate when their employees enrolled through the SHOP are Part-time Eligible Employees, so this definition is necessary to clarify who those employees are.

Defining “Plan Year” is necessary because the term has a specific, technical meaning that may not be apparent to the general public, and to conform to the federal definition specified in 45 CFR Section 155.20. This term is used throughout the QHP Solicitation, QHP minimum standard, and Eligibility and Enrollment regulations. It is necessary to define Plan Year to minimize confusion about the dates of coverage and/or Exchange certification for QHPs.

Defining “Plain Language” is necessary because the term has a specific, technical meaning that may not be apparent to the general public, and to conform to the federal definition specified in 45 CFR Section 155.20. Various parts of Articles 5 and 7 require that communications with applicants and enrollees be in Plain Language, as does federal law. This term is defined in this way so as to minimize confusion and promote comprehension when communicating with applicants and enrollees.

Defining “Preferred Provider Organization” is necessary because this term has a specific meaning within the health care industry that members of the public may not understand. Preferred Provider Organization is one of the models of health care coverage that Bidders may propose under the QHP Solicitation. It is necessary to define this term in order to identify it specifically so that both potential Bidders and members of the public understand QHP offerings.

Defining “Premium Payment Due Date” is necessary because the term has a specific, technical meaning that may not be apparent to the general public. Various provisions in Article 5 of these proposed regulations require that Qualified Individuals pay their initial premium payment by the Premium Payment Due Date in order to have effectuated coverage. It is necessary to specify those dates in order to have an enforceable due

date.

Defining “QHP Issuer” is necessary to avoid confusion regarding a specialized term, the meaning of which otherwise might not be apparent. Various provisions of the QHP Solicitation and regulations impose requirements on Issuers in order for them to be certified to offer QHPs through the Exchange and become QHP Issuers. It is necessary to define this term in order to clarify the class of Issuers to which these requirements apply.

Defining “Qualified Dental Plan” is necessary to avoid confusion regarding a specialized term, the meaning of which otherwise may not be apparent. These plans provide limited scope dental benefits, including pediatric.

Defining “Qualified Employee” is necessary to avoid confusion regarding a specialized term the meaning of which might not be otherwise apparent, and to conform to the federal definition specified in 45 CFR Section 155.20. Federal law and Article 6 of the Exchange’s regulations permit only Qualified Employees to purchase QHPs through the SHOP. It is necessary to define this term in order to clarify who is eligible for this purchase.

Defining “Qualified Employer” is necessary to avoid confusion regarding a specialized term informed by federal law, and to conform to the federal definition specified in 45 CFR Section 155.20. Federal law under 42 USC Section 18032(f)(2) and 45 CFR Section 155.710 restricts which employers may make available QHPs to their qualified employees through the SHOP. This definition serves to clarify which employers may offer coverage through the SHOP and follows the federal requirements.

Defining “Qualified Health Plan” is necessary to avoid confusion regarding a specialized term whose meaning is specified in the Patient Protection and Affordable Care Act Section 1301 (42 USC Section 18021) as well as Government Code Section 100501(f). A central function of the Exchange is to set the minimum criteria for Qualified Health Plans, and to select and make available Qualified Health Plans to individuals and small businesses with subsidies to purchase them. The term is used extensively throughout the Exchange’s regulations, and it is necessary to define it consistent with federal and State law in order to specify which products are being made available through the Exchange and any requirements that are imposed on them.

Defining “Qualified Individual” is necessary to avoid confusion regarding a specialized term informed by federal law. Only Qualified Individuals are eligible to purchase Qualified Health Plans through the Exchange. Federal law under 42 USC Section 18032(f)(1) and 45 CFR Section 155.305(a) set out detailed requirements regarding who may purchase Qualified Health Plans through the Exchange. It is necessary to incorporate these definitions in order to provide clarity about which applicants are

eligible for Exchange coverage.

Defining “Qualifying Coverage in an Eligible Employer-Sponsored Plan” is necessary to avoid confusion regarding a specialized term informed by federal law. Under federal law, an individual who is eligible for Qualifying Coverage in an Eligible Employer-Sponsored Plan is ineligible for APTC or CSR. Such coverage is defined as coverage that is available to the individual through an employer or by virtue of a relationship to an individual who has such employer-based coverage, that is affordable (meaning the employee’s portion of annual premiums for self-only coverage does not exceed 9.5% of the employee’s annual household income) and that provides minimum value (meaning that the plan pays for at least 60% of the cost of covered benefits provided to the employee). It is necessary to define this term in order to clarify who is eligible for federal subsidies through the Exchange consistent with federal law.

Defining “Rating Region” is necessary to avoid confusion regarding a specialized term informed by State law. Under State law, the premium charged to a consumer may vary based only on age, family size, and rating region. California law divided the state into 19 rating regions for this purpose. In the QHP Solicitation, Bidders are required to designate the rating regions in which they are proposing to offer their products, or, if their products are not offered throughout the entire rating region, the portions of the rating regions in which they propose to offer their products. Defining this term is necessary to clarify that the existing State law determines the regions on which the Bidders must base their offerings.

Defining “Reasonably Compatible” is necessary to avoid confusion regarding a specialized term, the meaning of which might not otherwise be apparent. Various provisions in Article 5 pf these proposed regulations require the Exchange to conduct further verification of information to which an applicant or enrollee attests if the attested information is not “Reasonably Compatible” with other information available to the Exchange. It is necessary to define this term in order to clarify the circumstances under which the Exchange is required to perform additional verification, and not simply accept the applicant’s or enrollee’s attestation regarding a matter affecting eligibility. The term was defined in a way that requires additional data verification only if the incompatibility affects the applicant’s or enrollee’s eligibility, including the amount of ATPC or level of CSR.

Defining “Reconciliation” is necessary to avoid confusion regarding a specialized term, the meaning of which might not otherwise be apparent. It clarifies that this term regards the coordination of premium tax credit with advance payments of premium tax credit as described in in Section 36B(f) of IRC (26 USC § 36B(f)) and 26 CFR Section 1.36B-4(a)
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Defining “Reference Plan” is necessary to avoid confusion regarding a specialized term, the meaning of which might not otherwise be apparent. Under Section 6520 of Article 6 of the Exchange’s regulations, Qualified Employers purchasing coverage through the SHOP are required to provide the SHOP, as part of their application, with their Reference Plan to facilitate the SHOP’s determination about how much the Qualified Employer must contribute to employee premiums. It is necessary to define this term to clarify the data elements and plan selections a Qualified Employer must make as part of its application.

Defining “Restatement of Enrollment” is necessary to avoid confusion regarding a specialized term, the meaning of which might not otherwise be apparent. The term is used to denote a correction of an erroneous termination of coverage or cancellation of enrollment action, resulting in restoration of an enrollment with no break in coverage.

Defining “Self-only Coverage” is necessary to avoid confusion regarding a specialized term, and to conform to the federal definition specified in 26 CFR Section 1.5000A-1. Under federal law, an individual is eligible for APTC and CSR only if the individual is not eligible for Minimum Essential Coverage, including Employer-Sponsored Coverage that is affordable and provides minimum value. Employer-Sponsored Coverage is affordable if the employee’s required annual contribution for self-only coverage is no greater than 9.5% of the employee’s annual household income. It is necessary to define self-only coverage to provide consistency with federal law and to clarify when an individual is eligible for APTC and CSR.

Defining “SHOP” is necessary to avoid confusion regarding a specialized term, the meaning of which might not otherwise be apparent, and to conform to the federal definition specified in 45 CFR Section 155.20. Under federal law and State law at Government Code 100502(m), the Exchange is required to operate a SHOP Exchange to facilitate the purchase of Qualified Health Plans by small businesses and their employees. It is necessary to define the SHOP consistent with federal and State law to distinguish it from the Individual Exchange.

Defining “SHOP Application Filer” is necessary to avoid confusion regarding a specialized term, the meaning of which might not be otherwise apparent. An application filer may be an applicant, an authorized representative, an agent or broker of the employer, or an employer filing for its employees where not prohibited by law.

Defining “SHOP Plan Year” is necessary to clarify that the term refers to a 12-month period beginning with the Qualified Employer's effective date of coverage, rather than to a year beginning on a set date (e.g., January 1). This definition is consistent with existing practice in the small group market that predates the Affordable Care Act and therefore minimizes disruption.

Defining “Small Employer” is necessary to avoid confusion regarding a specialized term informed by State law. Only Small Employers are eligible to make available Qualified Health Plans to their employees through the SHOP Exchange. While federal law permitted the definition of “small employer” to include employers with up to 100 full-time equivalent employees, it permits states to include employers of no more than 50 full-time equivalent employees. State law currently does not permit employers with more than 50 full-time equivalent employees to participate in the small group market. As a result, the Exchange’s definition for purposes of SHOP eligibility follows the State definition.

Defining “Small Group Market” is necessary to avoid confusion regarding a specialized term informed by federal law, and to conform to the federal definition specified in 45 CFR Section 155.20. It is necessary to contrast this term with the individual market. It is used repeatedly in the Solicitation and related documents with respect to the Bidders’ current activities in that market. Because this term is not defined in State law, it is consistent with the federal law.

Defining “Special Enrollment Period” is necessary to avoid confusion regarding a specialized term informed by federal and State law. Under federal and State law, applicants are permitted to enroll in a health insurance policy, or to change health insurance policies, only during the initial or annual open enrollment periods, or a special enrollment period if the applicant qualifies for it. It is necessary to define this term consistent with federal law and State law, which applies to both inside and outside of the Exchange, in order to ensure that applicants are permitted to enroll in the Exchange only if they are legally permitted to do so.

Defining “State Health Insurance Regulator or Regulators” is necessary to clarify that the term refers to the Department of Managed Health Care and the California Department of Insurance, not to other state agencies (including the Exchange). If this term were not defined, members of the public might mistakenly believe that the Exchange is a State Health Insurance Regulator.

Defining “Tax Filer” is necessary to avoid confusion regarding a specialized, technical term informed by federal law, and to conform to the federal definitions specified in 45 CFR Section 155.300 and 26 CFR Section 1.36B-2(b). Because APTC is administered through the federal income tax return, these proposed regulations extensively refer to tax filers to clarify eligibility for APTC. It is necessary to define this term consistent with the federal definition in order to clarify various obligations related to the application process.

Defining “Termination of Coverage” or “Termination of Enrollment” is necessary to avoid confusion regarding a specialized term, the meaning of which might not otherwise be apparent. These terms are used to denote an action taken after a coverage effective date that ends an enrollee's coverage through the Exchange for a date after the original coverage effective date, resulting in a period during which the individual was enrolled in coverage through the Exchange.

Defining “TIN” is necessary to establish that the term refers to a list of various tax identification numbers issued by various agencies, which otherwise might not be apparent to members of the public. The application for the Individual Exchange requires that an applicant submit a Social Security Number, or, if one has not been issued to the applicant, an ITIN, if one has been issued to the applicant in lieu of a Social Security Number. Under federal law, it is necessary to be lawfully present in the United States in order to purchase a QHP through the Exchange. As a result, most applicants for the Exchange who are Qualified Individuals will have a Social Security Number. However, not all Qualified Individuals do have a Social Security Number, so the Exchange decided to permit applicants to use their ITIN, if they have one instead of a SSN, in their application. It is necessary to use the SSN or ITIN to verify income and other eligibility data elements through the federal and State data sources. One of the State data sources that the Exchange will use as a secondary data source (in cases where the federal data hub is unavailable or does not return any information) to verify the applicant’s or enrollee’s family size and household income is the Franchise Tax Board (FTB). FTB accepts an ITIN and will return available data to the Exchange for verification purposes. As a result, it is necessary to define TIN to specify what identification information may be provided to the Exchange for purposes of verification and eligibility determination for Insurance Affordability Programs.

Article 4. General Provisions

§ 6450. Meaning of Words

Section 6450, in its entirety, implements, clarifies, and makes specific that words have their usual meanings unless context or definition clearly indicates otherwise. This is necessary to explain and clarify the way language is used in the Exchange’s regulations. In particular, this is necessary to explain that the potentially confusing words “shall,” “may,” and “should” have particular meanings. Providing this clarification is necessary to ensure that members of the public can fully and correctly understand the Exchange’s regulations.

§ 6452. Accessibility and Readability Standards

Section 6452, in its entirety, implements, clarifies, and makes specific the Exchange's accessibility and readability standards designed to ensure that the public can easily access and understand applications, forms, notices, and other correspondence provided by the Exchange and QHP issuers. This is necessary to ensure that such forms, notices, and correspondence provide the public with the information required to successfully apply and enroll in QHPs through the Exchange.

Section 6452(a) clarifies and makes specific that applications, forms, notices and correspondence provided to enrollees and potential enrollees by the Exchange or QHP issuers must conform to the standards specified in Section 6452(b) and (c). It also clarifies that this section will not limit the application of existing State laws and regulations regarding accessibility and readability standards, if any, that apply to the QHP issuers. The Exchange added the clarifying language about the existing State laws and regulations to provide the QHP issuers with clarity that these proposed regulations do not limit their obligations to comply with the existing State law that applies to them. This is necessary to ensure that accessibility and readability standards are actually followed, and to comply with the federal requirements specified in 45 CFR Section 155.205(c).

Section 6452(b) clarifies and makes specific that applications, forms, notices and correspondence must be provided to applicants and enrollees in a format and in language that are accessible to individuals with limited education. This is necessary to ensure that the public can access and understand applications, forms, notices and correspondence sent by the Exchange and QHP issuers. These requirements will benefit the public by ensuring that those interested in obtaining insurance through the Exchange can successfully navigate the application process. The Exchange considered requiring that all applications, forms, notices and correspondence be understandable to one with a sixth-grade education. After extensive consultation with stakeholders, however, the Exchange rejected this alternative because it might not be possible to communicate all necessary information at a sixth-grade level. Instead, the Exchange adopted the goal of communicating necessary information at a sixth-grade level while requiring only that necessary information be communicated at a ninth-grade level.

Section 6452(c) clarifies and makes specific that the Exchange and QHP issuers must provide information to applicants and enrollees in an accessible manner, including by providing appropriate services to those with disabilities and to those who do not speak English. This section is necessary to ensure that the disabled and non-English speakers have equal and adequate access to Exchange programs and benefits, as well as to clarify what is required to make such access possible. This is also necessary to comply with, and is substantively identical to, the federal requirements specified in 45 CFR Section 155.205(c). The Exchange has no discretion to do otherwise.

Section 6452(d) clarifies and makes specific that the Exchange shall provide applicants and enrollees information in a way that is compliant with Section 1557 of the ACA (42 USC § 18116) which prohibits discrimination based on race, color, national origin, sex, age or disability. This is necessary to comply with the above federal regulation and the Exchange has no discretion to do otherwise.

§ 6454. General Standards for Exchange Notices

Section 6454, in its entirety, implements, clarifies, and makes specific the standards governing the Exchange's notices. It is necessary to ensure that notices sent by the Exchange are easily readable and understandable, and that they contain all pertinent information. This is necessary to comply with, and is substantively identical, to the federal notice requirements specified in 45 CFR Section 155.230.

Section 6454(a) clarifies and makes specific the specific kinds of information each notice from the Exchange must contain. This is necessary to ensure that each notice from the Exchange contains all pertinent information. This is also necessary to comply with, and is substantively identical to, the federal requirements specified in 45 CFR Section 155.230(a). The Exchange does not have discretion to do otherwise.

Section 6454(b) clarifies and makes specific that all Exchange notices must conform to the accessibility and readability standards specified in Section 6452 of these proposed regulations. This is necessary to clarify that those standards apply to all Exchange notices. This is also necessary to comply with, and is substantively identical to, the federal requirements specified in 45 CFR Section 155.230(b). The Exchange does not have discretion to do otherwise.

Section 6454(c) requires the Exchange to reevaluate the appropriateness and usability of all notices on at least an annual basis. This is necessary to ensure that the Exchange does not send out-of-date or misleading notices. This is also necessary to comply with, and is substantively identical to, the federal requirements specified in 45 CFR Section 155.230(c). The Exchange does not have discretion to do otherwise. The Exchange did, however, clarify and make specific that notices will be reevaluated at least once a year to provide clarity since the federal rules do not specify how frequent the Exchange must reevaluate notices. The Exchange considered reevaluating its notices less frequently than annually, but rejected that alternative because it would not adequately protect the public from out-of-date or misleading notices.

Section 6454(d) clarify and make specific that the Exchange (individual) must send required notices by regular mail unless an individual elects to receive notices electronically, and requires the Exchange's electronic notices to meet certain requirements specified in 42 CFR Section 435.918. These provisions are necessary to

ensure that members of the public receive notices reliably and in a manner convenient to them. These provisions are also necessary to comply with, and are substantively identical to, the federal requirements specified in 45 CFR Section 155.230(d). The Exchange does not have discretion to do otherwise.

Section 6454(e) clarify and make specific that the Exchange (SHOP), unless otherwise required by State or Federal law, shall send notices electronically or, if the employer requests, through standard mail, and requires the Exchange's electronic notices to meet certain requirements specified in 42 CFR Section 435.918. These provisions are necessary to ensure that members of the public receive notices reliably and in a manner convenient to them. These provisions are also necessary to comply with, and are substantively identical to, the federal requirements specified in 45 CFR Section 155.230(d).

Section 6454(f) clarify and make specific that when there are technical limitations, the Exchange (individual and SHOP) may send select required notices by regular mail, even when an individual elects to receive notices electronically. These provisions are also necessary to comply with, and are substantively identical to, the federal requirements specified in 45 CFR Section 155.230(d).

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

Article 5, in its entirety, implements, clarifies, and makes specific the eligibility requirements for enrollment in a qualified health plan (QHP) and for federal advance premium tax credit (APTC) and cost-sharing reduction (CSR), if applicable, through the Exchange, and the process for applying for coverage, eligibility determination and redetermination, enrollment, and termination of coverage through the Exchange. This article is necessary to provide the public with clear standards and guidelines to request and receive an eligibility determination for enrollment in a QHP and for APTC and CSR, if applicable, through the Exchange. This article is also necessary to provide the standards and requirements for the QHP issuers regarding enrollment of qualified individuals in the QHPs and termination of coverage for qualified individual through the Exchange.

§ 6470. Application

Section 6470, in its entirety, clarifies and makes specific the application and all the required information and declarations that the applicants must provide in the application for the Exchange to determine the applicants' eligibility for enrollment in a QHP and for APTC and CSR, if applicable. This is necessary to provide the public with clear standards and guidelines on how to complete and submit the application for coverage

through the Exchange, and to comply with the federal requirement specified in 45 CFR Section 155.405(a).

Section 6470(a) clarifies and makes specific the purpose of the single, streamlined application, which is to apply for and enroll in an insurance affordability program (IAP), including Medi-Cal, CHIP (Medi-Cal for children), APTC, and CSR. This is necessary to provide the public with clear guidance on what programs they can apply for using the single, streamlined application. This is also necessary to comply with, and is substantively identical to, the federal requirement specified in 45 CFR Section 155.405(a).

Section 6470(b) specifies and clarifies that an applicant or an application filer must submit all information, documentation, and declarations required on the single, streamlined application, as specified in subdivisions (c), (d), and (e) of Section 4670, and must sign and date the application in order to receive an eligibility determination for an IAP. This is necessary to provide the public with clear guidance on what they are required to provide on the application to receive an eligibility determination. It is necessary for the application to include all information, documentation and declarations so that eligibility can be accurately determined based on all information.

Section 6470(c) clarifies and makes specific all the required information an applicant or an application filer must provide on the single, streamlined application. This is necessary to provide the public with clear guidance on what information the Exchange must collect in order to properly determine an applicant's eligibility for IAPs. The required information is described below.

Section 6470(c)(1) requires the applicant's full name (first, middle, if applicable, and last). This is necessary to identify the applicant.

Section 6470(c)(2) requires the applicant's date of birth. This is necessary for the Exchange to determine the appropriate program and plan and premium rating, if applicable, for the applicant based on the applicant' age.

Section 6470(c)(3) requires the home and mailing address, if different from home address (or if the applicant does not have a home address), for the applicant and for all persons for whom application is being made, the applicant's county of residence and telephone number(s). This is necessary for the Exchange to determine the appropriate plan and premium rating based on the applicant's zip code (which determines the applicant's rating region).

Section 6470(c)(4) requires the applicant's SSN, if one has been issued to the applicant (or the applicant's TIN, if the applicant has been issued a TIN instead of a SSN), and if the applicant does not have a SSN, the reason for not having one. This is

necessary for the Exchange's electronic verification of the applicant's information through the federal and State data sources to determine the applicant's eligibility.

Section 6470(c)(5) and (6) require the applicant's gender and marital status. This is necessary to determine the applicant's eligibility for the appropriate program, such as Medi-Cal, CHIP, or APTC/CSR. For example, if the applicant is married, the applicant must file his or her federal income tax return as "married filing jointly" to be eligible for APTC/CSR.

Section 6470(c)(7) requires the applicant's status as a U.S. Citizen or U.S. National, or the applicant's immigration status, if the applicant is not a U.S. Citizen or U.S. National and attests to having satisfactory immigration status. This is necessary to determine the applicant's eligibility for the appropriate program, such as Medi-Cal, CHIP, or APTC/CSR. Only individuals who are U.S. Citizen, U.S. National, or lawfully present (i.e., they have satisfactory immigration status) may be eligible to enroll in a QHP or receive APTC/CSR through the Exchange. The individuals without satisfactory immigration status may be eligible for limited-scope Medi-Cal.

Section 6470(c)(8) requires the applicant's employment status. This is necessary because for the employed applicants who have been determined eligible for APTC/CSR, the Exchange is required to notify the applicants' employers of:

- The employee's identity;
- The employee's eligibility for APTC/CSR;
- The employer's liability for the tax penalty imposed under the federal employer's shared responsibility rule if the employer is a large employer (i.e., the employer has 50 or more full-time or full-time-equivalent employees); and
- The employer's right to appeal the determination of the shared responsibility penalty, if applicable, through the U.S. Department of Health and Human Services (HHS).

Section 6470(c)(9), (10), (11), and (13) require the sources, amount, and payment frequency of the applicant's gross income (and the net income from self-employment, if applicable); the applicant's expected annual household income from all sources; the number of members in the applicant's household; and the applicant's expected type and amount of any tax deductions. This is necessary to determine the applicant's family size and household income (the modified adjusted gross income or MAGI) to calculate the applicant's federal poverty level (FPL) for purposes of determining the applicant's eligibility for, and the amount of, APTC/CSR.

Section 6470(c)(12) requires information regarding whether the applicant is an American Indian or Alaska Native, and if so, requires the applicant to provide the following information:

- Name and state of the tribe;

- Whether the applicant has ever received a service from the Indian Health Service, a tribal health program, or an urban Indian health program or through a referral from one of these programs, and if not, whether he or she is eligible to receive such services; and
- The sources, amount, and frequency of payment for any income the applicant receives due to his or her status as American Indian or Alaska Native, if applicable.

This information is necessary to determine the applicant's eligibility for special zero-cost-sharing and limited-cost-sharing benefits that only applies to an American Indian or Alaska Native who is a member of a federally-recognized tribe. The information about the tribe-related income, if applicable, is necessary because this income will be included to determine the applicant's MAGI.

Section 6470(c)(14) and (15) require information on whether the applicant currently has minimum essential coverage (MEC) through either any government sponsored programs or an employer-sponsored plan, and if the applicant has MEC through his or her employer, the amount of monthly premium the applicant pays for self-only coverage and whether it meets the minimum value standards, as defined in Section 6410 of Article 2 of these regulations. This is necessary to determine eligibility for APTC/CSR because to be eligible for APTC/CSR, the applicant must not have MEC through a government sponsored program (such as Medi-Cal or Medicare) or an employer-sponsored plan that meets both the affordability standard (i.e., the total cost of annual premium the employee has to pay for "self-only" coverage is not more than 9.5 percent of the employee's annual household income) and the minimum value standard (i.e., the employer-sponsored insurance plan pays at least 60 percent of the total allowed costs of benefits the plan provides to the employee).

Section 6470(c)(16) and (17) require information on whether the applicant has any physical, mental, emotional, or developmental disability, or needs help with long-term care or home and community-based services. This is necessary to determine the applicant's eligibility for non-MAGI Medi-Cal based on disability or long-term care need.

Section 6470(c)(18) requires the applicant's pregnancy status, if applicable, and if pregnant, the number of babies expected and the expected delivery date. This is necessary to determine:

- The appropriate family/household size for Medi-Cal because the unborn babies are included in the family size for purposes of Medi-Cal but are excluded for purposes of APTC/CSR; and
- To determine the applicant's eligibility for non-MAGI Medi-Cal based on pregnancy.

Section 6470(c)(19) and (20) require the applicant's preferred written and spoken language and preferred method of communication, including telephone, mail, and email, and if email has been selected, the applicant's email address. This is necessary to provide the applicants with adequate and language-appropriate notices.

Section 6470(c)(21) and (22) requires information on whether the applicant is 18 to 20 years old and a full-time student, and whether the applicant is 18 to 26 years old and lived in foster care on his or her 18th birthday or whether the applicant was in foster care and enrolled in Medicaid in any state. This is necessary to determine the applicant's eligibility for Medi-Cal or CHIP.

Section 6470(c)(23) requires information on whether the applicant is temporarily living out of state. This is necessary to determine whether the applicant meets the residency requirements for Medi-Cal or enrollment in a QHP.

Section 6470(c)(24) and (25) require information on whether the applicant:

- Intends to file a federal income tax return for the year for which he or she is requesting coverage, and if so, the applicant's expected tax-filing status; and
- Is a primary tax filer or a tax dependent, and if a tax dependent, the information in subdivision(c)(1) through (13), except for the information in subdivision (c)(7) regarding citizenship, status as a national, or immigration status, of Section 6470 for the primary tax filer.

This is necessary to determine the applicable taxpayer, the applicant's family/household size, and the applicant's household income for purposes of determining eligibility for IAPs, including Medi-Cal, CHIP, or APTC/CSR.

Section 6470(c)(26) requires, for each person for whom the applicant is applying for coverage, the relationship of each person to the applicant and the information in subdivision(c)(1) through (25) of Section 6470. This is necessary to determine eligibility of each person for whom the applicant or the application filer is applying for coverage.

Section 6470(c)(27) requires information on the applicant's designated authorized representative and the authorized representative's name and address, and the applicant's signature authorizing the designated representative to act on the applicant's behalf for the application, eligibility and enrollment, and appeals process, if applicable. This is necessary to identify the applicant's authorized representative to assure that the authorized representative receives notices appropriately.

Section 6470(d) clarifies and makes specific all the required declarations the applicants or application filers must make under penalty of perjury on the single, streamlined application before signing and dating the application. This is necessary to ensure that the consumers understand their rights and responsibilities and the declarations or

attestations the Exchange needs to properly determine an applicant's eligibility for IAPs. The required declarations are described below.

Section 6470(d)(1) requires the applicants or application filers to attest that they understood all questions on the application, gave true and correct answers to the best of their personal knowledge, and where they did not know the answer personally, they made every effort to confirm the answer. This is necessary to insure that the consumers understood all the information they were asked to provide and provided true and accurate information to the Exchange to correctly determine their eligibility.

Section 6470(d)(2) requires the applicants or application filers to attest that they do not tell the truth on the application, there may be a civil or criminal penalty for perjury that may include up to four years in jail under the State law. This is necessary to insure that the consumers know the consequences of not telling the truth or providing wrong information to the Exchange that may affect their eligibility determination.

Section 6470(d)(3) requires the applicants or the application filers to attest that they know their rights to privacy and confidentiality of their information, and that they know the Exchange will use their information only for purposes of eligibility determination and enrollment. This is necessary to insure that the consumers know their information will be kept private and confidential and will be only used to determine their eligibility and the eligibility of the persons for whom they applied for coverage.

Section 6470(d)(4) requires the applicants or the application filers to attest that they agree to notify the Exchange of any changes in information provided in the application for any person applying for coverage, which may affect their eligibility and the eligibility of other members of their household. This is necessary to insure that the consumers will understand the importance of reporting all changes to the Exchange because the changes may affect their eligibility and their tax liabilities.

Section 6470(d)(5) requires the applicants or application filers to attest that if they received premium tax credits for health coverage through the Exchange during the previous benefit year, they understand that they must have filed or file a federal tax return for that benefit year.

Section 6470(e) clarifies and makes specific the applicant's or application filer's rights and responsibilities, including self-attestations that the applicant or application filer must make in the single, streamlined application. This is necessary because the Exchange is required to inform the applicants or application filers of their rights, such as right to privacy and appeal. This is also necessary to collect the applicants' or application filers' required self-attestations the Exchange needs to determine their eligibility. These rights and responsibilities are described below.

Section 6470(e)(1) requires the applicants or application filers to attest that the information they provide on the application is true and accurate to the best of their knowledge, and that they may be subject to a penalty if they do not tell the truth. This is necessary because the Exchange relies on the applicants' self-attestation for certain eligibility requirements, such as residency or incarceration status, when data sources are unavailable to otherwise verify the applicants' attestations. Therefore, it is important for the applicants or application filers to understand that they must tell the truth and provide true and accurate information in the application that the Exchange will use to determine their eligibility.

Section 6470(e)(2) informs the applicant or the application filer that the information he or she provides on the application will be only used for purposes of eligibility determination and enrollment for all the individuals listed on the application. This is necessary to insure the applicants or application filers that the Exchange will not use their information for any other purpose, such as enforcement.

Section 6470(e)(3) informs the applicants or the application filers of their right to privacy. It also informs them that the Exchange shares such information with other federal and State agencies in order to verify the information and to make eligibility determinations for the applicants and for any other persons for whom the applicants may have requested coverage on the application. This is necessary to insure that the applicants or the application filers are informed about the privacy and sharing of their information.

Section 6470(e)(4) applies only to eligibility for Medi-Cal and requires the applicants to apply for other income or benefits to which they, or any members of their household, are entitled, including pensions, government benefits, retirement income, veterans' benefits, annuities, disability benefits, Social Security benefits, and unemployment benefits but excluding public assistance benefits, such as CalWORKs or CalFresh. This is necessary for Medi-Cal eligibility determination because to be eligible for Medi-Cal, an applicant is required under the State law to apply for all other benefits he or she is entitled to.

Section 6470(e)(5) requires the applicants or application filers to report any changes to the information they provided on the application to the Exchange. This is necessary because the changes may affect the applicants' eligibility for Medi-Cal or APTC/CSR, and the Exchange must redetermine the applicants' eligibility based on the reported changes. Furthermore, the applicants must report changes to avoid additional tax liabilities for the excess APTC they might have received during the benefit year when they file their tax returns for that year.

Section 6470(e)(6) informs the applicants or the application filers that the Exchange cannot not discriminate against them or anyone on the application because of race,

color, national origin, religion, age, sex, sexual orientation, marital status, veteran's status, or disability. This is necessary to insure that the public is properly informed of their right against discrimination.

Section 6470(e)(7) requires the applicants or application filers to attest that, except for purposes of applying for Medi-Cal, the applicant and any other person(s) the applicant has included in the application is not confined, after the disposition of charges (judgment), in a jail, prison, or similar penal institution or correctional facility. This is necessary because an incarcerated person is not eligible to enroll in a QHP through the Exchange, and the Exchange relies on the applicant's self-attestation when data sources are unavailable to otherwise verify the incarceration status.

Section 6470(e)(8) applies only to the applicants or any other persons the applicants included in the application who are eligible for Medi-Cal, and informs them that if Medi-Cal pays for a medical expense, any money the applicants, or any other persons included in the application, receive from other health insurance, legal settlements, or judgments covering that medical expense will be used to repay Medi-Cal until the medical expense is paid in full. This is necessary to inform the public of this Medi-Cal-specific rule.

Section 6470(e)(9) informs the applicants or application filers of their rights to appeal any action or inaction taken by the Exchange and that they can get help on how to file an appeal. This is necessary to insure that the consumers know that they have the right to due process and know how to request and get a fair hearing.

Section 6470(e)(10) informs the applicants or application filers that any changes in their information or information of any members in their household may affect the eligibility of other members of the household. This is necessary because the applicants must understand that when they report a change, the Exchange will redetermine the eligibility of the applicant's tax household, including the eligibility of each member of the household, for all IAPs based on the reported change.

Section 6470(f) clarifies and makes specific the required information an applicant or an application filer must provide if he or she is selecting a health insurance plan or a qualified dental plan (QDP) in the application. This is necessary to provide the public with clear guidance on what information they must provide in their application to properly select the plan they wish to enroll in. The required information is described below.

Section 6470(f)(1) requires the applicants or application filers to provide the name of the applicant and each family member who is enrolling in a plan and the selected plan's information, including plan name, metal tier, metal number, coverage level and plan type, as applicable. This information is necessary to insure that the consumers will be

enrolled in their selected plans if the Exchange determines them eligible to enroll in the plans.

Section 6470(f)(2) requires the applicants, responsible parties, or authorized representatives, age 18 or older who select health plans in the application to agree to, sign, and date the binding arbitration agreements for the Exchange plans and for a Kaiser Medi-Cal plan, which are specified in subdivision (f)(2)(A) and (B) of this section. The Exchange, after extensive consultation with the stakeholders, chose binding arbitration over other dispute resolution methods to keep the single, streamlined application consistent and aligned with the Medi-Cal application. This is necessary because any disputes or claims against a health plan, any contracted health care providers, administrators, or other associated parties, about the membership in the health plan, the coverage for, or the delivery of, services or items, medical or hospital malpractice, or premises liability will be resolved by arbitration under the State law.

Section 6470(g) requires the applicants or tax filers applying for their household members to specify whether or not they authorize the Exchange to obtain updated tax return information to conduct an annual redetermination. The tax filers may authorize the Exchange to obtain the tax information for up to five years or decline to give the Exchange such authorization, and may discontinue, change, or renew their authorization at any time. This is necessary because the Exchange must have an active authorization on file for every applicant or enrollee to conduct an annual eligibility redetermination (or renewal) each year around the same time as annual open enrollment as required by the federal regulations in 45 CFR § 155.335(k). Additionally, the tax information is necessary to make an eligibility redetermination. The Exchange has no discretion to do otherwise.

Section 6470(h) clarifies and makes specific the required information a certified enrollment counselor, a plan-based enroller, or a certified insurance agent who has assisted the applicant or application filer in completing the application must provide. The required information is as follows:

- His or her name;
- His or her certification or license number, if applicable;
- The name of the entity he or she is affiliated with;
- An attestation that he or she assisted the applicant complete the application free of charge;
- An attestation that he or she provided true and correct answers to all questions on the application to the best of his or her knowledge and explained to the applicant in plain language, and the applicant understood, the risk of providing inaccurate or false information; and
- His or her signature with date.

This is necessary to insure that each assister will be attached or linked to the correct applicant's account for purposes of payment processing, if applicable, and enforcement of the rules and regulations that apply to each assister.

Section 6470(i) clarifies and makes specific the required information and declarations an applicant or application filer who is seeking enrollment in a QHP without requesting an eligibility determination for an IAP must provide for the applicant and any other person(s) included in the application. The required information is as follows:

- Full name;
- Date of birth;
- Home and mailing address, if different from home address or if there is no home address;
- SSN if he or she has one, and if he or she does not have a SSN, the reason for not having one;
- Gender and marital status;
- Status as a U.S. Citizen or National, or the immigration status, if he or she is not a U.S. Citizen or U.S. National and attests to having satisfactory immigration status;
- Status as an American Indian or Alaska Native, and the name and state of the tribe, if applicable;
- The preferred written and spoken language and preferred method of communication;
- The relationship of each person included in the application to the applicant;
- Designation of an authorized representative and the representative's information, if applicable;
- All the declarations and self-attestations specified in subdivision (d) of this section except for the declarations related to Medi-Cal specified in subdivision (d)(4) and (8) of this section;
- All the required declarations under penalty of perjury specified in subdivision (e) of this section;
- The required information about the selected health insurance plans or pediatric dental plans, as applicable, and the applicant's or responsible party's declaration that he or she agrees with the Exchange plans' binding arbitration agreement with signature and date; and
- The required information of an assister, if applicable, as specified in subdivision (h) of this section.

This is necessary to determine eligibility for enrollment in a QHP. The information relating to the applicant's household size and income and the applicant's tax information is not necessary since subdivision 6470(i) only applies to applicants or application filers who are seeking enrollment in a QHP without requesting an eligibility determination for an IAP, such as Medi-Cal, CHIP, or APTC/CSR.

Section 6470(j) clarifies and makes specific all the channels applicants or application filers may use to submit their applications, which include the Exchange's Internet Web Site, telephone, fax, mail, or in person. This is necessary to comply with the federal requirement specified in 45 CFR Section 155.405(c). However, the Exchange went beyond the minimum federally-mandated channels and added fax to insure that the public has adequate access to different channels to submit applications to the Exchange.

Section 6470(k) clarifies and makes specific that the Exchange will accept the applications from applicants or application filers and will make eligibility determinations for applicants seeking an eligibility determination at any point in time during the year. This is necessary to provide the public with clear guidelines regarding application submission and receiving an eligibility determination through the Exchange, and to comply with, and is substantively identical to, the federal requirement specified in 45 CFR Section 155.310(c). The Exchange has no discretion to do otherwise.

Section 6470(l) clarifies, implements, and makes specific the process of handling incomplete applications that do not include sufficient information for the Exchange to conduct an eligibility determination for enrollment in a QHP or for an IAP, if applicable. This is necessary to comply with the federal requirement specified in 45 CFR Section 155.310(k) and to provide the public with clear standard and guidelines regarding incomplete applications, including:

- What is considered an incomplete application;
- How they will be notified of an incomplete application and the content of the notice;
- How long they have to complete the application or to submit missing information to the Exchange, and how the Exchange will proceed with their eligibility determinations in the meantime; and
- What the consequences of failure to complete their application or to provide the required information to the Exchange will be.

As for the applicant's time limit to complete the application or to submit missing information to the Exchange, federal regulations in 45 CFR Section 155.310(k)(2) require the Exchange to provide the applicant with "a period of no less than 10 days and no more than 90 days from the date on which the notice" of the incomplete application "is sent to the applicant to provide the information needed to complete the application to the Exchange." The Exchange, after extensive consultation with the stakeholders, chose to provide the longest time limit allowable under the federal regulations (90 days) to the consumers to complete their applications with the exception of when the 90-day time limit would exceed the duration of an open enrollment period in which case, the consumer will still have at least 30 days from the date of the notice of an incomplete application to complete the application.

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

Section 6472, in its entirety, clarifies and makes specific the eligibility requirements to enroll in a QHP and QDP through the Exchange. This is necessary to provide the public with clear standards and guidelines on what requirements they have to meet to be determined eligible for coverage through the Exchange. This is also necessary to comply with, and is substantively identical to, the requirements of the federal rules specified in 45 CFR Section 155.305. The Exchange does not have discretion to determine eligibility for enrollment in QHPs otherwise.

Section 6472(a) clarifies and makes specific that regardless of the eligibility for federal subsidies (APTC/CSR), the applicants who are seeking enrollment in QHPs that are not catastrophic plans must meet the requirements of this section, except for the requirements specified in subdivision (f) of this section that only apply to enrollment in a catastrophic plan. It also specifies that applicants who are seeking enrollment in catastrophic QHPs must also meet the requirements specified in subdivision (f) of this section. It further specifies that applicants who are seeking enrollment in a QDP must also meet the requirements specified in subdivision (g) of this section. This is necessary to provide the consumers with clear standards as to what requirements they must meet to be eligible to enroll in catastrophic or non-catastrophic QHPs and in QDPs.

Section 6472(b) requires an applicant who has a SSN to provide his or her SSN to the Exchange. This is necessary to comply with, and is substantively identical to, the requirements of the federal rules under 45 CFR Section 155.310(a)(3). Additionally, the Exchange needs the applicant's SSN to verify his or her information and to determine the applicant's eligibility for enrollment in a QHP as required under the federal rules.

Section 6472(c), (d), and (e) clarify and make specific the eligibility requirements relating to citizenship or immigration status, incarceration status, and residency the applicants must meet to be eligible to enroll in QHPs. These provisions are necessary to provide the public with clear eligibility standards, and to comply with, and is substantively identical to, the requirements of the federal rules under 45 CFR Section 155.305(a). The Exchange does not have discretion to do otherwise.

Section 6472(f) clarifies and makes specific the eligibility requirements for enrollment in catastrophic QHPs. It specifies that to be eligible to enroll in a catastrophic plan, an applicant must either have less than 30 years of age or have a certificate of exemption for unaffordability of coverage or hardship from HHS. It also specifies that APTC will not be available to support enrollment in a catastrophic QHP through the Exchange. This is necessary to provide the consumers with clear standards as to what requirements they must meet to be eligible to enroll in catastrophic QHPs. This is also necessary to comply with, and is substantively identical to, the requirements of the

federal rules under 45 CFR Section 155.305(h). The Exchange does not have discretion to do otherwise.

Section 6472(g) clarifies and makes specific the eligibility requirements for enrollment in a QDP. It specifies that to be eligible to enroll in a QDP, at least one adult in the applicant's family who is enrolled in a non-catastrophic QHP through the Exchange is enrolled in the QDP. It also specifies that the family may continue enrollment in the QDP even if the adult later ceases enrollment in the non-catastrophic QHP through the Exchange. Finally, it clarifies that to enroll one child in a family in a QDP, all children in the family under 19 years of age shall also enroll in the same QDP. This is necessary to provide the consumers with clear standards as to what requirements they must meet to be eligible to enroll in a QDP.

§ 6474. Eligibility Requirements for APTC and CSR

Section 6474, in its entirety, clarifies and makes specific the eligibility requirements to receive APTC and CSR through the Exchange. This is necessary to provide the public with clear standards and guidelines on what requirements they have to meet to be determined eligible for subsidized coverage (APTC and CSR) through the Exchange. This is also necessary to comply with, and is substantively identical to, the requirements of the federal rules specified in 45 CFR Section 155.305(f) and (g). The Exchange does not have discretion to determine eligibility for APTC/CSR otherwise.

Section 6474(a) clarifies and makes specific that the applicants applying for APTC and CSR must meet the requirements of this section in addition to the eligibility requirements of Section 6472 relating to enrollment in a QHP through the Exchange, except for the requirements specified in Section 6472(f), which only apply to enrollment in a catastrophic QHP. This is necessary to comply with, and is substantively identical to, the requirements of the federal rules specified in 45 CFR Section 155.305(f)(1). This is also to provide clarity to the consumers that eligibility for enrollment in a non-catastrophic QHP through the Exchange is the prerequisite of eligibility for APTC and CSR, meaning that an applicant cannot meet the eligibility requirements for APTC and CSR if the applicant does not meet all the eligibility requirements for enrollment in a non-catastrophic QHP through the Exchange.

Section 6474(b) defines "household income" for purposes of this section. This is necessary to be consistent with the definition the federal rules use, as specified in 45 CFR Section 155.305(f)(1)(i) and (g)(4). This is also necessary to provide the consumers with clarity as to the meaning of "household income" because the Exchange determines an applicant's eligibility for APTC and CSR based on the applicant's household income, in compliance with the federal rule cited above.

Section 6474(c) sets forth the eligibility requirements for APTC. This is necessary to comply with, and is substantively identical to, the federal requirements specified in 45 CFR Section 155.305(f). The Exchange has no discretion to do otherwise. This is also necessary to provide the public with clear standards and guidelines as to the requirements they have to meet to be determined eligible for APTC.

Section 6474(c)(1) specifies that to be eligible for APTC, a tax filer must meet the following requirements:

(A) Tax filer's expected household income for the benefit year must be between 100% and 400%, inclusive, of the federal poverty level (FPL); and

(B) The tax filer and/or the tax filer's tax household member he or she is applying for must:

1. Meet all the eligibility requirements specified in Section 6472 for enrollment in a non-catastrophic QHP through the Exchange;
2. Not be eligible for minimum essential coverage (MEC), except for coverage in the individual market; and
3. Enroll in a QHP that is neither a catastrophic plan nor a QDP through the Exchange.

This is necessary to comply with, and is substantively identical to, the federal requirements specified in 45 CFR Section 155.305(f)(1) and (3). The Exchange has no discretion to do otherwise.

Section 6474(c)(2) specifies the special APTC eligibility requirements for non-citizen tax filers who are lawfully present in the U.S. and ineligible for Medi-Cal because of their immigration status, and are not otherwise eligible for APTC under subdivision (c)(1) of this section. These applicants have to meet all the requirement of subdivision (c)(1), outlined above, except for the income requirements. They meet the APTC eligibility requirements even if their household income is less than 100% of the FPL. This is necessary to comply with, and is substantively identical to, the federal requirements specified in 45 CFR Section 155.305(f)(2) and (3). The Exchange has no discretion to do otherwise. This is also necessary to provide the non-citizen, lawfully-present applicants with clear standards regarding the eligibility requirements for APTC.

Section 6474(c)(3) specifies that a tax filer will not be eligible for APTC if the Exchange verifies that the tax filer has previously received APTC for a prior tax year but the tax filer failed to properly file his or her federal income tax return and reconcile his or her APTC for that tax year. This is necessary to comply with, and is substantively identical to, the federal requirements specified in 45 CFR Section 155.305(f)(4). The Exchange has no discretion to do otherwise. This is also necessary to provide the tax filers with clear standards regarding their tax filing responsibilities and the eligibility requirements for APTC.

Section 6474(c)(4) specifies that the Exchange will calculate the applicants' APTC amounts according to the requirements of the Internal Revenue Code (IRC) and its implementing regulations in Title 26 of the Federal Code of Regulations (CFR). This is necessary to comply with, and is substantively identical to, the federal requirements specified in 45 CFR Section 155.305(f)(5).

Section 6474(c)(5) requires an application filer to provide the SSN of a non-applicant tax filer only if an applicant attests that the tax filer has a SSN and filed a tax return for the year for which the Exchange will use tax data to verify the applicant's household income and family size. This is necessary to comply with, and is substantively identical to, the federal requirements specified in 45 CFR Section 155.305(f)(6). The Exchange must use the tax filer's SSN to verify the applicant's household size and income for the purposes of determining the applicant's eligibility for APTC, consistent with the federal requirements. The Exchange has no discretion to do otherwise.

Section 6474(c)(6) requires the Exchange to send direct notification consistent with Section 6454 to a tax filer prior to denying eligibility for APTC. This is necessary to comply with the federal requirements specified in 45 CFR Section 155.305(f)(4). The Exchange has no discretion to do otherwise

Section 6474(d) sets forth the eligibility requirements for CSR. This is necessary to comply with, and is substantively identical to, the federal requirements specified in 45 CFR Section 155.305(g). This is also necessary to provide the public with clear standards and guidelines as to the requirements they have to meet to be determined eligible for CSR.

Section 6474(d)(1) specifies that to be eligible for CSR, an applicant must meet the following requirements:

(A) He or she must meet all the eligibility requirements specified in Section 6472 for enrollment in a QHP through the Exchange;
(B) He or she must meet all the eligibility requirements specified in subdivision (c) of this section for APTC; and
(C) His or her expected household income for the benefit year must be between 100% and 250%, inclusive, of the FPL.

This is necessary to comply with, and is substantively identical to, the federal requirements specified in 45 CFR Section 155.305(g)(1)(i). The Exchange has no discretion to do otherwise.

Section 6474(d)(2) clarifies and makes specific that only the applicants who are not an Indian and enroll in a silver-level QHP, as defined in the ACA, through the Exchange may be determined eligible for CSR. This is necessary to comply with, and is substantively identical to, the federal requirements specified in 45 CFR Section

155.305(g)(1)(ii). It is also necessary to provide clarity for the consumers regarding certain QHPs they must enroll in to be able to receive CSR.

Section 6474(d)(3) specifies the CSR categories the Exchange will use when determining the applicants' eligibility. These categories are as follows:

(A) Individuals with expected household incomes between 100% and 150%, inclusive, of the FPL (or less than 100% of the FPL for the non-citizen, lawfully-present individuals who are ineligible for Medi-Cal because of their immigration status);
(B) Individuals with expected household incomes of more than 150% but less than or equal to 200% of the FPL; and
(C) Individuals with expected household incomes of more than 200% but less than or equal to 250% of the FPL.

This is necessary to comply with, and is substantively identical to, the federal requirements specified in 45 CFR Section 155.305(g)(2). The Exchange has no discretion to do otherwise.

Section 6474(d)(4) clarifies and makes specific that if two or more individuals in the same tax household enroll in a single family policy, the Exchange will determine all the members enrolled in the same family policy eligible for the same category of CSR, which will be the last category of CSR listed below for which all the individuals covered by the family policy would be eligible:

(A) Not eligible for CSR;
(B) Special CSR eligibility standards and process for Indians regardless of income specified in Section 6494(a)(3) and (4);
(C) Subdivision (d)(3)(C) of this section for expected household incomes of more than 200% but less than or equal to 250% of the FPL;
(D) Subdivision (d)(3)(B) of this section for expected household incomes of more than 150% but less than or equal to 200% of the FPL;
(E) Subdivision (d)(3)(A) of this section for expected household incomes between 100% and 150%, inclusive, of the FPL (or less than 100% of the FPL for the non-citizen, lawfully-present individuals who are ineligible for Medi-Cal because of their immigration status); or
(F) Special CSR eligibility standards and process for Indians with household incomes under 300 percent of FPL specified in Section 6494(a)(1) and (2).

For example, if a household with income of 240% of the FPL consists of an American Indian individual to whom the special CSR rules specified in Section 6494(a)(1) and (2) apply and a non-American Indian individual who are both enrolled in the same family policy, they will both get the third category of CSR specified in subdivision (d)(3)(C) of this section because that is the category for which both these individuals would be eligible for. This is necessary to comply with, and is substantively identical to, the

federal requirements specified in 45 CFR Section 155.305(g)(3). This is also necessary to provide clarity for the consumers regarding the specific category of CSR that members of the same household who are enrolled in the same family policy may be eligible for through the Exchange. The Exchange has no discretion to do otherwise.

§ 6476. Eligibility Determination Process

Section 6476, in its entirety, implements, clarifies, and makes specific the process the Exchange will use to determine the applicants' eligibility for enrollment in a QHP and/or APTC/CSR. This is necessary to provide consumers with clear standards and guidelines as to the Exchange's eligibility process. This is also necessary to comply with the requirements of federal rules specified in 45 CFR Section 155.310. The Exchange does not have discretion to use any alternative eligibility determination process.

Section 6476(a) allows an applicant to request only an eligibility determination for enrollment in an unsubsidized QHP through the Exchange (i.e., without requesting APTC/CSR). This is necessary to give the applicants the option or choice to apply for unsubsidized QHPs through the Exchange without providing any information about their income or tax filing statuses. This is also necessary because it is mandated by, and is substantively identical to, the federal regulations under 45 CFR Section 155.310(b). The Exchange has no discretion to do otherwise.

Section 6476(b) prohibits an applicant to request an eligibility determination for less than all IAPs. For example, an applicant cannot request an eligibility determination for APTC/CSR but not for Medi-Cal. This is necessary to comply with, and is substantively identical to, the requirements of federal rules specified in 45 CFR Section 155.310(b). The Exchange does not have discretion to do otherwise.

Section 6476(c) clarifies and makes specific that the Exchange will determine an applicant eligible for an enrollment period if he or she meets the criteria for an enrollment period, as specified in Sections 6502 and 6504. This is necessary to comply with, and is substantively identical to, the requirements of federal rules specified in 45 CFR Section 155.305(b). The Exchange does not have discretion to do otherwise.

Section 6476(d) clarifies and makes specific special rules that only apply to the eligibility determination process for APTC. It specifies an enrollee's option to accept less than the full amount of APTC he or she is eligible for and the attestations the enrollee must make to be determined eligible for APTC. This is necessary to comply with, and is substantively identical to, the requirements of federal rules specified in 45 CFR Section 155.310(d)(2). The Exchange does not have discretion to do otherwise.

Section 6476(e) clarifies and makes specific that if the Exchange determines an applicant eligible for Medi-Cal or CHIP, the Exchange will notify the Department of Health Care Services (DHCS) and transmit to DHCS, within three business days from the date of the eligibility determination, all information that is necessary for DHCS to provide the applicant with coverage. The federal provision under 45 CFR Section 155.310(d)(3) requires the Exchange to notify and transmit this information to DHCS "promptly and without undue delay" but do not specify any timeline nor define "promptly and without undue delay." After extensive consultation with stakeholders, including DHCS, the Exchange established the timeline of "three business days from the date of the eligibility determination" to notify and send required information to DHCS. The Exchange considered a shorter timeline but rejected that alternative because it was not administratively feasible. Exchange also considered a longer timeline but rejected that alternative because the notification and transmittal of information to DHCS will be done electronically, which will make the three-business-day timeline administratively feasible and more closely aligned with the federal requirements. This is necessary to insure that DHCS will be notified and receive the required eligibility information "promptly and without undue delay," to provide clarity to the consumers, and to comply with the requirements of 45 CFR Section 155.310(d)(3).

Section 6476(f) clarifies and makes specific that the Exchange will determine an applicant's eligibility within 10 calendar days from the date the Exchange receives the applicant's paper application. It also clarifies that the 10-calendar-day timeline does not apply to the eligibility determinations for applications submitted online, which occur real time, if administratively feasible. The federal provision under 45 CFR Section 155.310(e)(1) requires the Exchange to determine an applicant's eligibility "promptly and without undue delay" but again do not specify any timeline nor define "promptly and without undue delay." However, the federal provision under 45 CFR Section 155.310(e)(2) requires the Exchange to assess the timeliness of eligibility determinations based on the period from the date of application or transfer from an agency administering an IAP (e.g., DHCS or County) to the date the Exchange notifies the applicant of its decision or the date the Exchange transfers the application to another agency administering an IAP, such as DHCS or County, when applicable. After extensive consultation with stakeholders, the Exchange established the timelines of "within 10 calendar days from the date the Exchange receives the applicant's completed application" for paper applications and "real time" for electronic applications. The Exchange considered a shorter timeline for paper application but rejected that alternative because it was not administratively feasible. The Exchange also considered a longer timeline (e.g., 15 calendar days) but rejected that alternative because the 10-calendar-day timeline is administratively feasible, insures that the applicants receive their eligibility determinations promptly, and is more closely aligned with the federal requirements. This is necessary to provide clarity to the consumers, and to comply with the requirements of 45 CFR Section 155.310(e).

Section 6476(g) clarifies and makes specific the effective dates of the Exchange's eligibility determinations for enrollment in a QHP, APTC, and CSR. This is necessary to comply with, and is substantively identical to, the requirements of federal rules specified in 45 CFR Section 155.310(f). The Exchange does not have discretion to do otherwise.

Section 6476(h) clarifies and makes specific that the Exchange will provide an applicant with written notice of an eligibility determination within five business days from the date of the eligibility determination. The federal provision under 45 CFR Section 155.310(g) requires the Exchange to provide an applicant with "timely" written notice of an eligibility determination but does not specify any timeline nor define "timely." After extensive consultation with stakeholders, the Exchange established the timeline of "within five business days from the date of the eligibility determination" to provide written notice of an eligibility determination to the applicants. The Exchange considered a shorter timeline but rejected that alternative because it was not administratively feasible. Exchange also considered a longer timeline (e.g., 10 calendar days) but rejected that alternative because the five-business-day timeline is administratively feasible, insures that the applicants receive the written notice of their eligibility determinations in a timely manner, and is more closely aligned with the federal requirements. This is necessary to provide clarity to the consumers and to comply with the requirements of 45 CFR Section 155.310(g).

Section 6476(i) and (j) clarify and make specific the Exchange's process for notifying the applicant's employer of the applicant's eligibility for APTC, if applicable, and the process for the applicants who do not select a QHP within their enrollment periods or are not eligible for an enrollment period. These provisions are necessary to comply with, and are substantively identical to, the federal rules specified in 45 CFR Section 155.310(h) and (j). The Exchange does not have discretion to do otherwise.

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

Section 6478, in its entirety, implements, clarifies, and makes specific the Exchange's process for verification of the applicant's information that the Exchange uses to determine the applicant's eligibility for enrollment in a QHP. This is necessary to provide consumers with clear standards and guidelines as to the Exchange's verification process, and to comply with the requirements of federal rules specified in 45 CFR Section 155.315.

Section 6478(a) through (c) clarify and make specific that the Exchange will verify the applicant's information according to the process outlined in this section and specify the verification process for the applicant's SSN and citizenship status, status as a national, or lawful presence. These provisions are necessary to comply with, and are

substantively identical to, the requirements of federal rules specified in 45 CFR Section 155.315(a) through (c). The Exchange does not have discretion to do otherwise.

Section 6478(d)(1) clarifies and makes specific the Exchange's process for verification of residency where there are no inconsistencies. The federal provisions in 45 CFR Section 155.315(d)(1) and (2) provide that except where there are inconsistencies, the Exchange may follow one of the two following ways to verify the applicant's residency:

1. Accept the applicant's attestation that he or she meets the standards of Section 6472(e) without further verification; or
2. Examine electronic data sources that are available to the Exchange and which have been approved by HHS for this purpose, based on evidence showing that such data sources are sufficiently current and accurate, and minimize administrative costs and burdens.

After extensive consultation with stakeholders, the Exchange selected the first option to accept the applicant's attestation without further verification. The Exchange considered the second option of examining available data sources to verify residency but rejected it because the Exchange's eligibility, enrollment, and reenrollment computer system (California Healthcare Eligibility, Enrollment, and Retention System or CalHEERS) does not currently have the capability of interfacing with the State data sources, such as DMV, to verify the applicant's California residency, and California residency information will not be available through the federal data sources. This is necessary to provide the public with clear standards and guidelines as to the Exchange's process for verification of the applicants' California residency where there are no inconsistencies.

Section 6478(d)(2) and (3) clarify and make specific the Exchange's process for verification of residency where the residency information provided by an applicant is not reasonably compatible (as defined in Section 6410 of Article 2 of these proposed regulations) with other information provided by the applicant, in the records of the Exchange, or obtained through available data sources, the Exchange must follow the verification process specified in 45 CFR Section 155.315(d)(3) and (4). These provisions are necessary to comply with, and are substantively identical to, the requirements of federal rules specified in 45 CFR Section 155.315(d)(3) and (4). The Exchange does not have discretion to do otherwise.

Section 6478(e) clarifies and makes specific the Exchange's process for verification of the applicant's incarceration status. This is necessary to comply with, and is substantively identical to, the requirements of federal rules specified in 45 CFR Section 155.315(e). The Exchange does not have discretion to do otherwise.

Section 6478(f) clarifies and makes specific the Exchange's verification process related to the applicants' eligibility for enrollment in catastrophic QHPs through the Exchange. This is necessary to provide the consumers with clear standards and guidelines as to

the Exchange's verification process for enrollment in catastrophic QHPs and to comply with the requirements of 45 CFR Section 155.315(j).

Section 6478(f)(1)(A) clarifies and makes specific the Exchange's process for verification of the applicants' attestation of age for enrollment in catastrophic QHPs. The federal provisions in 45 CFR Section 155.315(j)(1)(i) and (ii) provide that except where there are inconsistencies, the Exchange may follow one of the two following ways to verify the applicant's attestation of age:

1. Accept the applicant's attestation without further verification; or
2. Examine electronic data sources that are available to the Exchange and which have been approved by HHS for this purpose, based on evidence showing that such data sources are sufficiently current and accurate, and minimize administrative costs and burdens.

After extensive consultation with stakeholders, the Exchange selected the first option to accept the applicant's attestation without further verification, as specified in Section 6478(f)(1)(A)1. The Exchange considered but rejected the second option of examining available data sources to verify the applicant's age to reduce the administrative burden on the Exchange and to encourage the young consumers (under 30 years old) to apply for coverage through the Exchange.
This is necessary to provide the public with clear standards and guidelines as to the Exchange's process for verification of the applicants' age for enrollment in catastrophic QHPs.

Where the applicant's attestation of age is not reasonably compatible with other information provided by the applicant or in the records of the Exchange, the Exchange must follow the process specified in 45 CFR Section 155.315(j)(1)(iii). This provision, as specified in Section 6478(f)(1)(A)2, is necessary to comply with, and is substantively identical to, the requirements of federal rules specified in 45 CFR Section 155.315(j)(1)(iii). The Exchange does not have discretion to do otherwise.

Section 6478(f)(1)(B) and (f)(2) clarify and make specific the Exchange's process for verification of an applicant's attestation that he or she has a certificate of exemption and the process the Exchange must follow if unable to verify information required to determine the applicant's eligibility for enrollment in a catastrophic QHP. These provisions are necessary to comply with, and are substantively identical to, the federal rules specified in 45 CFR Section 155.315(j)(2) and (3). The Exchange does not have discretion to do otherwise.

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

Section 6480, in its entirety, implements, clarifies, and makes specific the process the Exchange uses to verify the applicant's eligibility for minimum essential coverage (MEC)

other than through an eligible employer-sponsored plan, Medi-Cal, or CHIP as part of the eligibility determination process for APTC and CSR. This is necessary to comply with, and is substantively identical to, the requirements of federal rules specified in 45 CFR Section 155.320(b)(1). The Exchange does not have discretion to do otherwise.

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

Section 6482, in its entirety, implements, clarifies, and makes specific the process the Exchange uses to verify the applicant's family size and household income as part of the eligibility determination process for APTC and CSR. This is necessary to provide the consumers with clear standards and guidelines for the Exchange's process for verification of their information regarding their family size and household income, which is necessary to determine their eligibility for APTC and CSR. This is also necessary to comply with the federal requirements in 45 CFR Section 155.320(c).

Section 6482(a) defines "family size" and "household income" for purposes of this section. This is necessary to provide the consumers with clarity as to the meaning of "family size" and "household income" because the Exchange determines an applicant's eligibility for APTC and CSR based on the applicant's family size and household income. This is also necessary to comport with, and is identical to, the federal definition of these terms specified in Section 45 CFR Section 155.320(c)(3)(vii) and (viii). The Exchange does not have discretion to define these terms otherwise.

Section 6482(b) through (e) clarify and make specific the Exchange's verification process for the applicant's family size and annual household income to determine the applicant's eligibility for APTC and CSR. These provisions are necessary to comply with, and are substantively identical to, the requirements of federal rules specified in 45 CFR Section 155.320(c)(1)(i), (3)(i) and (ii). The Exchange does not have discretion to do otherwise.

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

Section 6484, in its entirety, implements, clarifies, and makes specific the Exchange's verification process for increases in the applicant's household income as part of the eligibility determination process for APTC and CSR. This is necessary to provide the consumers with clear standards and guidelines process the Exchange uses for verification of their attestations that their household income has increased, which would affect their eligibility for APTC and CSR. This is also necessary to comply with the federal requirements in 45 CFR Section 155.320(c)(3)(iii).

Section 6484(a) requires the Exchange to accept the applicant's attestation of his or her (or the tax filer's) annual household income without further verification if:

1. The applicant attests that his or her (or the tax filer's) annual household income has increased, or is reasonably expected to increase, from the income the Exchange has computed based on the applicant's (or the tax filer's) tax return information obtained through the available electronic data sources for the benefit year; and
2. The Exchange has verified that the applicant is not eligible for Medi-Cal or CHIP.

This is necessary to comply with, and is substantively identical to, the requirements of federal rules specified in 45 CFR Section 155.320(c)(3)(iii)(A). The Exchange has no discretion to do otherwise.

Section 6484(b) specifies that if the electronic data sources to verify the attested income are not available, the applicant must provide additional documentation, as requested by the Exchange, to prove their attested income, in accordance with Section 6492.

This is necessary to simplify the income verification process and to provide the public with clear standards and guidelines as to the Exchange's process to verify increases in the applicant's or tax filer's household income as part of the eligibility determination process for APTC and CSR. It is also necessary to provide an alternative means of verifying income if the data sources described in subdivision (a) are not available.

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

Section 6486, in its entirety, implements, clarifies, and makes specific the Exchange's verification process for decreases in the applicant's household income, or when the tax return data is unavailable, as part of the eligibility determination process for APTC and CSR. This is necessary to provide the consumers with clear standards and guidelines as to the Exchange's process for verification of decreases in their annual household income, or if the applicant's tax return data is unavailable. The Exchange is required under the federal rules to verify the applicant's annual household income in order to determine the applicant's eligibility for APTC and CSR.

Section 6486(a) clarifies and makes specific the eligibility requirements for alternate verification process for decreases in annual household income and situations in which tax return data is unavailable. This is necessary to comply with, and is substantively identical to, the requirements of federal rules specified in 45 CFR Section 155.320(c)(3)(iv). The Exchange has no discretion to do otherwise.

Section 6486(b) clarifies and makes specific the Exchange's verification process for decreases in annual household income if (1) the applicant is eligible for an alternate verification process under subdivision (a) of this section, and (2) the applicant's attestation to projected annual household income is no more than twenty-five percent below the annual household income the Exchange has computed based on the applicant's or tax filer's tax return data obtained from HHS. This is necessary to provide a clear standard for the consumers on how their attested income is verified and to comply with the requirements of federal rules specified in 45 CFR Section 155.320(c)(3)(v).

Section 6486(c) clarifies and makes specific the Exchange's verification process for decreases in annual household income if (1) the applicant is eligible for an alternate verification process under subdivision (a) of this section, and (2) the applicant's attestation to projected annual household income is greater than twenty-five percent below the annual household income the Exchange has computed based on the applicant's or tax filer's tax return data obtained from HHS, or if the tax return data is unavailable. This is necessary to provide a clear standard for the consumers on how their attested income is verified and to comply with the requirements of federal rules specified in 45 CFR Section 155.320(c)(3)(vi)(A) and (D) through (G).

Federal rules under 45 CFR Section 155.320(c)(3)(vi), which outline the alternate verification process for decreases in annual household income estimates and for situations in which tax return data is unavailable, allow the Exchange to establish a "reasonable threshold" for verification of attested income that are below the annual household income computed based on the federal electronic data hub. A reasonable threshold must not be less than 10 percent, and can also include a threshold dollar amount.

After extensive consultation with the stakeholders, and consistent with the federal Marketplace, the Exchange established its reasonable threshold to be twenty five (25) percent. This means that an individual who attests to a projected household income that is below the household income the Exchange computed or verified through the federal electronic data hub by more than 25% will be placed into an inconsistency and will be given 95 days to provide documentation to prove the attested income or otherwise resolve the inconsistency.

The Exchange considered alternative options of adopting a lower threshold, such as 10, 15, or 20 percent but rejected those alternatives because they would have led to a much higher number of people who would all into an income inconsistency. That would have placed an unnecessary burden on the consumers to provide paper documentation to resolve the resulted inconsistencies. The Exchange also considered adopting a higher threshold, such as 30, 35, or 40 percent but rejected those alternatives as well

because those higher thresholds could have led to the consumers receiving too much premium assistance and therefore incurring too much tax liabilities.

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

Section 6490, in its entirety, implements, clarifies, and makes specific the Exchange's verification process for the applicant's enrollment in an eligible employer-sponsored plan and the applicant's eligibility for qualifying coverage in an eligible employer-sponsored plan as part of the eligibility determination process for APTC and CSR. This is necessary to provide the consumers with clear standards and guidelines as to the Exchange's process for verification of their enrollment in an eligible employer-sponsored plan and eligibility for qualifying coverage in an eligible employer-sponsored plan, which is required under the federal rules to determine the applicant's eligibility for APTC and CSR.

Although the Exchange is generally required to verify the applicant's enrollment in and eligibility for an eligible employer-sponsored coverage through available electronic data sources, the federal rules under 45 CFR Section 155.320(d)(3)(iii)-(iv) and (4) provided the Exchanges with the following options if the Exchange does not have any information for an applicant through available data sources to conduct such verification:

1. For eligibility determinations for APTC and CSR that are effective before January 1, 2016, the Exchanges:
    A. Must select a "statistically significant random sample" of the applicants for whom the Exchange does not have the information to conduct such verification and follow the procedures specified in 45 CFR Section 155.320(d)(3)(iii)(A) through (G); or
    B. May accept an applicant's attestation regarding enrollment in an eligible employer-sponsored plan and eligibility for qualifying coverage in an eligible employer-sponsored plan for the benefit year without further verification instead of the sampling procedure specified in paragraph (A) above.

For eligibility determinations for APTC and CSR that are effective before January 1, 2016, the Exchange will accept an applicant's attestation regarding enrollment in an eligible employer-sponsored plan and eligibility for qualifying coverage in an eligible employer-sponsored plan for the benefit year without further verification if the Exchange does not have any information for an applicant through available data sources to conduct such verification. The Exchange considered the option of selecting a statistically significant random sample of the applicants for whom the Exchange does not have the information to conduct this verification but rejected that option because it

would be administratively burdensome and very costly for the Exchange to conduct such sampling retroactively.

For eligibility determinations for APTC and CSR that are effective after January 1, 2016, the Exchange will consider the option of selecting a statistically significant random sample of the applicants for whom the Exchange does not have the information to conduct this verification.

This is necessary to provide clarity to the consumers regarding the process the Exchange will use to verify their attestation of enrollment in an eligible employer-sponsored plan and eligibility for qualifying coverage in an eligible employer-sponsored plan for the benefit year as part of the eligibility determination process for APTC and CSR.

Section 6490(a) and (b) clarify and make specific the general requirements under the federal rules that the Exchange must verify whether an applicant reasonably expects to be enrolled in an eligible employer-sponsored plan or is eligible for qualifying coverage in an eligible employer-sponsored plan for the benefit year and must obtain data from specified data sources for this verification. These provisions are necessary to comply with, and are substantively identical to, the federal rules specified in 45 CFR Section 155.320(d)(1) and (2). The Exchange does not have discretion to do otherwise.

Section 6490(c) clarifies and makes specific that except as specified in subdivisions (d) and (e), the Exchange will accept an applicant's attestation regarding enrollment in an eligible employer-sponsored plan and eligibility for qualifying coverage in an eligible employer-sponsored plan for the benefit year without further verification. This is necessary to comply with, and are substantively identical to, the federal rules specified in 45 CFR Section 155.320(d)(3)(ii). The Exchange does not have discretion to do otherwise.

Section 6490(d) clarifies that if the applicant’s attestation is not reasonably compatible with the information obtained by the Exchange, other information provided by the application filer, or other information in the records of the Exchange, the Exchange will follow the inconsistency procedures specified in Section 6492 of these proposed regulations. This is necessary to comply with, and are substantively identical to, the federal rules specified in 45 CFR Section 155.320(d)(3)(i). The Exchange does not have discretion to do otherwise.

Section 6490(e) clarifies and makes specific that if the Exchange does not have any information for an applicant through available data sources to conduct such verification the Exchange will conduct a statistically valid random sampling, in accordance with the process outlined in this subdivision. This is necessary to provide clarity to the consumers regarding the process the Exchange will use to verify their attestation of

enrollment in an eligible employer-sponsored plan and eligibility for qualifying coverage in an eligible employer-sponsored plan for the benefit year as part of the eligibility determination process for APTC and CSR. They are also necessary to comply with requirements of federal rules specified in 45 CFR Section 155.320(d)(4).

§ 6492. Inconsistencies

Section 6492, in its entirety, implements, clarifies, and makes specific the inconsistency process the Exchange must follow when the applicants' attestations are inconsistent with the data obtained by the Exchange from available data sources, or when the Exchange cannot verify the applicants' information required to determine their eligibility for enrollment in QHPs, or for APTC and CSR. This is necessary to provide clarity for consumers regarding the Exchange's inconsistency process. This is also necessary to comply with, and is substantively identical to, the requirements of federal rules specified in 45 CFR Section 155.315(f), (g), and (i). The Exchange has no discretion to follow a different inconsistency process.

§ 6494. Special Eligibility Standards and Verification Process for Indians

Section 6494, in its entirety, implements, clarifies, and makes specific the special eligibility and verification process that only applies to American Indians or Alaska Natives who are members of federally-recognized tribes, as defined by Section 4(d) and (e) of the Indian Self–Determination and Education Assistance Act (Pub.L. 93–638; 25 USC § 450b(d)-(e)). The federal rules under 45 CFR Section 155.350 refers to the Section of 1402(d) of the ACA for the special cost-sharing rules for Indians. The Exchange sets forth these ACA requirements in subdivision (a)(2) and (4) of this section of the proposed regulations for clarity and readability purposes. This is necessary to provide clarity for consumers regarding the special eligibility rules for CSR and verification process that only applies to federally-recognized Indians. This is also necessary to comply with, and is substantively identical to, the requirements of federal rules specified in 45 CFR Section 155.350 and 42 USC Section 18071(d)(1)-(2). The Exchange has no discretion to do otherwise.

§ 6496. Eligibility Redetermination during a Benefit Year

Section 6496, in its entirety, implements, clarifies, and makes specific the Exchange's process for eligibility redetermination during a benefit year if the Exchange receives and verifies new information reported by an enrollee or identifies updated information through a periodic data matching required under the federal rules. This is necessary to provide clarity for the consumers and to comply with the federal requirements specified in 45 CFR Section 155.330.

Section 6496(a) through (c) specify that the applicants who have applied for IAPs must report any changes of circumstances related to the eligibility standards to the Exchange within 30 days of such changes through any of the channels available for the submission of an application. These provisions are necessary to comply with, and are substantively identical to, the federal rules specified in 45 CFR Section 155.330(a) and (b)(1), (2), and (4). The Exchange does not have discretion to do otherwise.

Section 6496(d) specifies that enrollees who experience changes in income that do not impact the amount of APTC or the level of CSR for which they are eligible are not required to report such changes. The federal rules in 45 CFR Section 155.330(b)(3) allows the Exchange to establish a reasonable threshold for changes in income, such that an enrollee who experiences a change in income that is below that threshold is not required to report such change. After extensive consultation with the stakeholders, the Exchange determined the threshold as "any change in income that impact the amount of APTC or the level of CSR for which the applicant is eligible," meaning that the applicant does not need to report a change that does not have such an impact. The Exchange considered the alternative of determining a percent (e.g., 10% or 20%) threshold for changes in income that must be reported, such that an enrollee who experiences a change in income that is below that threshold is not required to report such change. The Exchange rejected that option because even a very small change in income can change an applicant's eligibility for, or the amount of APTC or the level of CSR. For example, an income change of only a couple of dollars can make an applicant's FPL fall into Medi-Cal levels or change his or her level of CSR. Therefore, defining this threshold as "any change that impact the amount of APTC or the level of CSR for which the applicant is eligible" leads to more accuracy. To help the consumers determine what changes in income will fall within this threshold, however, the Exchange educates the consumer by providing factsheets and frequently-asked questions and answers on its Website and by including an FPL chart in the notices the Exchange sends to the consumers. This is necessary to provide the consumers with clear standards as to when they are required to report changes in income.

Section 6496(e) and (f) require the Exchange to verify all the reported changes before using such information in an eligibility determination and to provide electronic notifications to the enrollees, if they have selected to receive electronic notifications, regarding their reporting requirements. These provisions are necessary to comply with, and are substantively identical to, the federal rules specified in 45 CFR Section 155.330(c). The Exchange does not have discretion to do otherwise.

Section 6496(g) requires the Exchange to examine available data sources on a semiannual basis to identify changes of circumstances regarding death and for APTC/CSR recipients, eligibility determinations for Medicare, Medi-Cal, or CHIP, and the tax filer's failure to file an income tax returns for the last benefit year during which he or she received APTC and failure to reconcile the APTC. The federal rules in 45 CFR

Section 155.330(d) requires the Exchange to "periodically" examine available data sources but leave it up to the Exchange to specify or define "periodically." After extensive consultation with the stakeholders, the Exchange made the decision to examine the available data sources "semiannually." The Exchange considered conducting this examination more frequently, such as quarterly, but rejected that option because it would be administratively burdensome both for the Exchange and for the consumers since they have to comply with the requirements of subdivisions (i) and (j) of this section, as described below. This is necessary to provide the consumers clarity as to how often the Exchange conducts the required periodic data matching and what information or changes of circumstances are subject to this data matching. This is also necessary to comply with the requirements of 45 CFR Section 155.330(d).

Section 6496(h) through (i) clarify and make specific the Exchange's process for verifying the reported or identified changes, notifying the enrollees (and the enrollee's employer if applicable), and redetermining their eligibility based on those changes. These provisions are necessary to provide the consumers with clear standards as to the Exchange's verification and notification processes and their responsibilities to respond to those notifications. These provisions are also necessary to comply with, and are substantively identical to, the federal rules specified in 45 CFR Section 155.330(e). The Exchange does not have discretion to do otherwise.

Section 6496(j), (k), and (l) require the Exchange to implement changes on specified dates. The federal rules specified in 45 CFR Section 155.330(f)(2) provides an option for the Exchange to determine a reasonable point in a month, no earlier than the 15th of the month, after which a change will not be effective until the first day of the second month following the month of the notice of eligibility determination or the month in which the Exchange is notified. After extensive consultation with the stakeholders, the Exchange determined the 15th of the month as a reasonable point in a month after which any change reported would be implemented on the first day of the second month following the month of the date of the redetermination notice or the date on which the Exchange is notified of the change.

These provisions are necessary to provide the consumer with clear standards and guidelines as to effective dates that apply to them when their eligibility is redetermined by the Exchange based on their changes of circumstances. These provisions are also necessary to comply with, and are substantively identical to, the federal rules specified in 45 CFR Section 155.330(f). The Exchange does not have discretion to do otherwise, except for the option explained above that the federal rules provided and the Exchange exercised.

Section 6496(m) and (n) require the Exchange to recalculate an enrollee's APTC amount in a specified manner and to redetermine the enrollee's eligibility for CSR based on the enrollee's expected annual household income for the benefit year when a

redetermination results in a change in the amount of APTC or the level of CSR. These provisions are necessary to comply with, and are substantively identical to, the federal rules specified in 45 CFR Section 155.330(g). The Exchange does not have discretion to do otherwise.

§ 6498. Annual Eligibility Redetermination

Section 6498, in its entirety, implements, clarifies, and makes specific the Exchange's annual eligibility redetermination process. This is necessary to provide the consumers with clear standards and guidelines as to the process the Exchange will follow to redetermine their eligibility for enrollment in QHPs and for IAPs annually. This is also necessary to comply with the federal requirements specified in 45 CFR Section 155.335.

Section 6498(a) requires the Exchange to redetermine the qualified individuals' eligibility on an annual basis. This is necessary to comply with, and is substantively identical to, the federal requirement specified in 45 CFR Section 155.335(a). The Exchange does not have discretion to do otherwise.

Section 6498(b) requires the Exchange to have an active authorization to obtain updated tax return information from a qualified individual who requested an eligibility determination for IAPs on file before conducting an annual redetermination for such individual. The qualified individuals may provide the Exchange with such authorization for up to five years or may decline to provide it, and may discontinue, change, or renew their authorization at any time. This is necessary to comply with, and is substantively identical to, the federal requirements specified in 45 CFR Section 155.335(k). The Exchange does not have discretion to do otherwise.

Section 6498(c) specifies the information the Exchange will obtain through the federal and State data sources, such as updated tax data and information regarding Social Security benefits and MAGI-based income, to use for the annual eligibility redetermination if the Exchange has an active authorization on file. This is necessary to comply with, and is substantively identical to, the federal requirements specified in 45 CFR Section 155.335(b). The Exchange does not have discretion to do otherwise.

Section 6498(d) clarifies and makes specific that if the Exchange does not have an active authorization on file from a qualified individual who requested an eligibility determination for IAPs, the Exchange will notify that individual at least 30 days prior to the date of the notice of annual redetermination and will redetermine the individual's eligibility only for enrollment in a QHP. The Exchange cannot redetermine the individual's eligibility for IAPs until it receives such authorization from the individual, or the qualified individual who never enrolled in a QHP during an enrollment period in the past 12 months continues to request an eligibility determination for IAPs. This is

necessary to comply with, and is substantively identical to, the federal requirements specified in 45 CFR Section 155.335(b). The Exchange does not have discretion to do otherwise.

Section 6498(e) clarifies and makes specific the process for sending and the content of the Exchange's annual redetermination notice. The federal rules in 45 CFR Section 155.335(c)(1)-(2) were amended on July 15, 2013 when the language about the content of this notice was "reserved" for future rulemaking. It was noted in the preamble that HHS reserved paragraphs (c)(1) and (c)(2) as it continues "to evaluate the appropriate information that will be included in the annual redetermination notice." (78 Fed.Reg. 42260 (July 15, 2013).) These provisions are still "reserved" to this date. However, several federal guidance bulletins have been released to describe the federal Marketplace's renewal approach, including renewal notices. After extensive stakeholders' engagement, the Exchange established the annual redetermination notice process specified in Section 6498(e), which was approved by HHS, to provide the consumers clarity as to what they should expect to receive in their annual redetermination notices. If any of these provisions will be inconsistent with the federal future rules, the Exchange will amend this section of the proposed regulations in the future to resolve the inconsistency. This is necessary to provide consumers with clear standards and guidelines regarding the Exchange's annual redetermination process.

Section 6498(f) specifies that the Exchange will send the consumers one combined, coordinated notice for both the annual redetermination and annual open enrollment period. The federal rules under 45 CFR Section 155.335(d)(1) require the Exchange to provide a qualified individual with an annual redetermination notice and an annual open enrollment notice through a single, coordinated notice only for annual redeterminations for 2015 and 2016 benefit years. For annual redeterminations for coverage effective on or after January 1, 2017, the federal rules under 45 CFR Section 155.335(d)(2) provide the Exchange with an option to send the two notices separately provided that the annual redetermination notice would be sent no earlier than the notice of annual open enrollment to allow a reasonable amount of time for the enrollee to review the notice and provide a timely response, and for the Exchange to implement any changes in coverage elected during the annual open enrollment period. After extensive consultation with the stakeholders, the Exchange made the decision to continue sending the annual redetermination notice and the annual open enrollment notice through a single, coordinated notice for 2017 benefit year and beyond to provide clarity and consistency for the consumers. The Exchange considered the option of separating these notices for 2017 benefit year and beyond but rejected that alternative for the following reasons:

1. It will create confusion for the public to receive a single notice for 2015 and 2016 and two separate notices for years 2017 and beyond.

2. The Exchange will conduct an annual redetermination around the same time as the annual open enrollment period; therefore, it makes more sense to just send one single notice for both.
3. The CalHEERS will have to be programmed to comply with the federal requirement of 45 CFR Section 155.335(d)(1) to provide a single, coordinated notice for 2015 and 2016 benefit years. Thus, changing the system's design to send the notices separately would create unnecessary administrative burden and extra cost on the Exchange.

This is necessary to provide the consumers with clarity and consistency as to the notices the Exchange will send them regarding the annual redetermination process and the annual open enrollment period, and to comply with the requirements of the federal rules specified in 45 CFR Section 155.335(d).

Section 6498(g) and (h) require the qualified individuals and the enrollees to report any changes related to the eligibility standards within 30 days of such change, using any of the channels available for the submission of an application, and require the Exchange to verify any such reported changes prior to using such information to determine eligibility. These provisions are necessary to comply with, and are substantively identical to, the federal rules specified in 45 CFR Section 155.335(e) and (f). The Exchange does not have discretion to do otherwise.

Section 6498(i) specifies that the current enrollees and qualified individuals who have selected a QHP but their coverage has not been effectuated must complete the Exchange's online renewal process within 30 days from the date of the annual redetermination notice. This section also establishes and specifies the process for the consumers to complete the Exchange's online renewal process. This is necessary to provide the consumers with clarity as to the Exchange's online renewal process and with instructions as to how consumers can complete such process. It includes the necessary information needed by the Exchange to process the renewal.

Section 6498(j) specifies that if the consumers fail to complete the Exchange's online renewal process, as specified in Section 6498(i), after 30 days, the Exchange must (1) redetermine their eligibility using the most recent information they provided to the Exchange and passively renew their coverage for the following benefit year, in accordance with the process specified in Section 6498(l); (2) notify them of the eligibility redetermination and renewal result; and (3) notify their employers, if applicable. This is necessary to comply with, and is substantively identical to, the federal rules specified in 45 CFR Section 155.335(h)(1). The Exchange does not have discretion to do otherwise.

Section 6498(k) specifies the effective date of an annual eligibility redetermination. This is necessary, and is substantively identical to, the federal rules specified in 45 CFR Section 155.335(i). The Exchange does not have discretion to do otherwise.

Section 6498(l) clarifies and makes specific the Exchange's passive or automatic reenrollment (renewal) process if an enrollee remains eligible for coverage in a QHP upon annual redetermination and he or she does not terminate coverage or actively enroll in a different QHP. These provisions are necessary to comply with, and are substantively similar to, the federal rules specified in 45 CFR Section 155.335(j). They are also necessary to provide the consumers with clarity as to the Exchange's passive renewal process.

Section 6498(m) specifies that the Exchange will conduct only one annual redetermination for a qualified individual who was previously determined eligible to enroll in a QHP but did not select a QHP during an enrollment period in the past 12 months. This is necessary, and is substantively identical to, the federal rules specified in 45 CFR Section 155.335(m). The Exchange does not have discretion to do otherwise.

§ 6500. Enrollment of Qualified Individuals into QHPs

Section 6500, in its entirety, implements, clarifies, and makes specific the process for qualified individuals to enroll into QHPs through the Exchange. This is necessary to provide the consumers with clear standards and guidelines as to the Exchange's enrollment process, and to comply with the requirements of the federal rules specified in 45 CFR Sections 155.400 and 156.265.

Section 6500(a) specifies that qualified individuals may enroll in QHPs (or change their QHPs) only during an open enrollment period or a special enrollment period. This is necessary, and is substantively identical to, the federal rules specified in 45 CFR Section 155.410(a)(2). The Exchange does not have discretion to do otherwise.

Section 6500(b) requires the Exchange to accept a QHP selection from an applicant who meets all the eligibility requirements to enroll in a QHP. This is necessary, and is substantively identical to, the federal rules specified in 45 CFR Section 155.400(a). The Exchange does not have discretion to do otherwise. This subdivision also specifies that once the Exchange accepts the qualified applicant's QHP selection, it will follow the notification and transmittal procedures specified in subdivisions (b)(1) through (4), as explained below.

Section 6500(b)(1) requires the Exchange to notify the applicant of her or his initial premium payment method options and of the requirement that the applicant's initial premium payment must be received in full by the QHP issuer on or before the premium

payment due date in order for the applicant's coverage to be effectuated. This is necessary to provide the consumers with clarity as to their responsibility to make timely payments of their initial premiums to the QHP issuers to have their coverage effectuated by the issuers.

Section 6500(b)(2) requires the Exchange to notify the QHP issuer that the individual is a qualified individual and of the applicant's selected QHP and premium payment method option. This is necessary to provide the required information to the QHP issuers to effectuate the qualified individual's coverage. This is also necessary to comply with the federal rules specified in 45 CFR Section 155.400(a)(1).

Section 6500(b)(3) requires the Exchange to send the QHP issuer information necessary to enable the issuer to enroll the applicant within three business days from the date the Exchange obtains the information. This is necessary, and is substantially identical to, the federal rules specified in 45 CFR Section 155.400(b)(1). The Exchange does not have discretion to do otherwise, except to determine what is considered "promptly and without undue delay." The federal rule under 45 CFR Section 155.400(b)(1) requires the Exchange to send eligibility and enrollment information to the QHP issuers "promptly and without undue delay" but do not specify any timeline nor define "promptly and without undue delay." After consultation with stakeholders, the Exchange established the timeline of "within three business days from the date the Exchange obtains the information" to send this information to the QHP issuers. Although the Exchange electronically submits the eligibility and enrollment information to the issuers on a daily basis, the Exchange determined that three business day is a reasonable time limit to set in its regulations in case the system is down and the daily transmittal would not be possible.

Section 6500(b)(4) requires the Exchange to send HHS eligibility and enrollment information promptly and without undue delay, in a manner and timeframe as specified by HHS. This is necessary, and is substantively identical to, the federal rules specified in 45 CFR Section 155.400(b)(3). The Exchange does not have discretion to do otherwise.

Section 6500(c) and (d) clarifies and makes specific that the Exchange will maintain records of all enrollments in QHPs through the Exchange and will reconcile enrollment information with QHP issuers and HHS no less than once a month. These provisions are necessary, and are substantively identical to, the federal rules specified in 45 CFR Section 155.400(c) and (d). The Exchange does not have discretion to do otherwise.

Section 6500(e) requires the QHP issuers to accept enrollment information specified in subdivision (b) of this section consistent with the federal and State privacy and security standards and in an electronic format that is consistent with 45 CFR Section 155.270. This is necessary, and is substantively identical to, the federal rules specified in 45 CFR

Section 156.265(c). This subdivision also specifies that once a QHP issuer accepts the enrollment information form the Exchange, the issuer must:

- Acknowledge receipt of enrollment information transmitted from the Exchange upon the receipt of such information;
- Enroll a qualified individual only during the initial and annual open enrollment periods and special enrollment periods;
- Notify a qualified individual of his or her premium payment due date;
- Abide by the effective dates of coverage established by the Exchange;
- Notify the Exchange of the issuer's timely receipt of a qualified individual's initial premium payment and his or her effective date of coverage;
- Notify a qualified individual of his or her effective date of coverage upon the timely receipt of the individual's initial premium payment; and
- Provide new enrollees an enrollment information package.

This is necessary to provide clarity for the consumers regarding the enrollment process, and to comply with the federal requirements specified in 45 CFR Sections 156.260 and 156.265.

Section 6500(f) requires a QHP issuer to proceed in accordance with the following process when an applicant requests assistance from a QHP issuer for enrollment through the Exchange:

- The issuer must direct the individual to file an application with the Exchange; or
- The issuer must insure the applicant received an eligibility determination for coverage through the Exchange Internet Website by assisting the applicant to apply for and receive an eligibility determination for coverage through the Exchange through CalHEERS, provided that the QHP issuer:
    - Complies with the federal and State privacy and security standards;
    - Complies with the consumer assistance standards specified in 45 CFR Section 155.205(d);
    - Informs the applicant of the availability of other QHP products offered through the Exchange and displays the Web link to, and describes how to access, the Exchange Web site; and
    - Complies with the requirements of Article 9 of this chapter relating to the plan-based enrollers.

This is necessary to provide the consumers with clear standards and guidelines as to the enrollment process that applies if they ask the QHP issuers directly for help with their enrollment in the QHPs through the Exchange. This is also necessary to comply with, and is substantially identical to, the federal requirements specified in 45 CFR Sections 155.205(d), 156.265(b)(2), and 156.1230.

Section 6500(g) requires a QHP issuer to comply with the premium payment process established by the Exchange. In accordance with this process, the QHP issuer must:

1. Accept, at a minimum, for all payments, paper checks, cashier's checks, money orders, EFT, and all general-purpose pre-paid debit cards as methods of payment and present all payment method options equally for a consumer to select their preferred payment method.
2. Effectuate coverage upon receipt of an initial premium payment from the applicant on or before the premium payment due date. In cases of retroactive enrollment dates, the initial premium will consist of the premium due for all months of retroactive coverage through the first month of coverage following the plan selection date. If the consumer makes partial premium payment for less than all months of retroactive coverage, the issuer must only effectuate prospective coverage in accordance with the regular coverage effective dates specified in Section 6504(g).
3. Acknowledge receipt of qualified individuals' premium payments by transmitting to the Exchange information regarding all received payments.
4. Initiate cancellation of enrollment if the issuer does not receive the initial premium payment by the due date.
5. Transmit to the Exchange the notice of cancellation of enrollment no earlier than the first day of the month when coverage is effectuated.
6. Send a written notice of the cancellation to the enrollee within five business days from the date of cancellation of enrollment due to nonpayment of premiums.

This is necessary to provide the QHP issuers and the consumers with clear standards and guidelines regarding the Exchange's premium payment process and to comply with the federal requirements specified in 45 CFR Sections 155.240 and 156.1240.

Section 6500(h) requires a QHP issuer to reconcile enrollment and premium payment files with the Exchange no less than once a month. This is necessary, and is substantively identical to, the federal rules specified in 45 CFR Section 156.265(f).

Section 6500(i) clarifies and makes specific the premium proration methodology for coverage lasting less than one month. This is necessary to provide the QHP issuers and the consumers with clear standards and guidelines regarding the Exchange's premium calculation process, and it aligns with the federal premium proration methodology specified in 45 CFR Section 155.240(e).

Section 6500(j) clarifies and makes specific the Exchange's APTC allocation process, which specifies how the APTC will be apportioned among multiple QHPs when members of the tax filer's tax household are enrolled in more than one QHP, and one or more APTC are to be made on behalf of the tax filer. The federal rule in 45 CFR Section 155.340(e) requires the Exchange to allocate the APTC among the QHP policies, and the remaining APTC among the stand-alone dental policies, "in a reasonable and consistent manner specified by the Exchange." The federal rules do

not specify nor define “in a reasonable and consistent manner” but they do specify, in 45 CFR Section 155.340(f), the APTC allocation method that a Federally-facilitated Exchange (FFE) will use. The FFE will allocate APTC among QHP and the stand-alone dental policies based on the number of enrollees covered under each policy, weighted by the age of the enrollees, using the default uniform age rating curve established by the Secretary of HHS under 45 CFR 147.102(e), with the portion allocated to any single policy not to exceed the portion of the plan's adjusted monthly premium properly allocated to the essential health benefits (EHB). If the portion of the APTC allocated to a policy exceeds the portion of the same plan's adjusted monthly premium properly allocated to EHB, the remainder will be allocated evenly among all other policies in which individuals in the tax filers' tax households are enrolled. After consulting with the stakeholders and considering their input, the Exchange decided to adopt the FFE’s allocation method. The Exchange considered other methods, such as dividing APTC equally between the plans based only on the numbers of enrollees in each plan, but rejected the alternatives because they did not result in allocating the APTC “in a reasonable and consistent manner,” as required by the federal rules. However, the Exchange excluded the APTC allocation to standalone dental plans because all the QHPs in California now have the pediatric dental benefits embedded in them. Additionally, the benefits provided to adults in the family dental plans in the Exchange are considered supplemental benefits, not essential health benefits, and therefore, no APTC is allocable to those plans. This is necessary to provide the public and the QHP issuers with clarity regarding the Exchange’s APTC allocation method and to comply with the federal requirements specified in 45 CFR Section 155.340(e).

§ 6502. Initial and Annual Open Enrollment Periods

Section 6502, in its entirety, implements, clarifies, and makes specific the initial and annual open enrollment periods and the coverage effective dates associated with these enrollment periods. This is necessary to provide clarity for the consumers and the QHP issuers as to when the consumers can enroll in QHPs through the Exchange and when the QHP issuers can enroll the consumers in their selected QHPs.

Section 6502(a) clarifies and makes specific that a qualified individual may enroll in a QHP, or an enrollee may change QHPs, only during the initial open enrollment period, the annual open enrollment period, or a special enrollment period, as described in Section 6504, for which the qualified individual has been determined eligible. This is necessary to comply with, and is substantively identical to, the federal requirements specified in 45 CFR Section 155.410(a).

Section 6502(b) clarifies and makes specific that the initial open enrollment period begins October 1, 2013 and extends through March 31, 2014. This is necessary to comply with, and is substantively identical to, the federal requirements specified in 45 CFR Section 155.410(b).

Section 6502(c) clarifies and makes specific the coverage effective dates for initial open enrollment period. This is necessary to provide the consumers and the QHP issuers with clarity as to when a consumer's coverage would be effective following his or her plan selection during the initial open enrollment period. This is also necessary to comply with, and is substantively identical to, the federal requirements specified in 45 CFR Section 155.410(c)(1).

Section 6502(d) and (f) specify the annual open enrollment periods and the coverage effective dates for benefit years beginning on January 1, 2015, January 1, 2016 through December 31, 2018, and January 1, 2019. For benefit years beginning on January 1, 2015, the annual open enrollment period begins on November 15, 2014 and extends through February 15, 2015. For benefit years beginning on or after January 1, 2016 through December 31, 2018, the annual open enrollment period begins on November 1 of the calendar year preceding the benefit year and extends through January 31 of the benefit year. For benefit years beginning on or after January 1, 2019, the annual open enrollment period begins on November 1 and extends through December 15 of the calendar year preceding the benefit year. These provisions are necessary to provide clarity for the consumers and the QHP issuers as to the dates of the annual open enrollment periods and as to when a consumer's coverage would be effective following his or her plan selection during the annual open enrollment period. These are also necessary to comply with, and are substantively identical to, the federal law in 45 CFR Section 155.410(e) and State law in Health and Safety Code Section 1399.849(c) and Insurance Code Section 10965.3(c).

Section 6502(e) clarifies and makes specific that beginning 2014, the Exchange will provide a written annual open enrollment notice to each enrollee no earlier than the first day of the month before the open enrollment period begins and no later than the first day of the open enrollment period. This is necessary to provide the Exchange's enrollees with clarity as to when the Exchange will notify them of the annual enrollment period. This is also necessary to comply with, and is substantively identical to, the federal requirement specified in 45 CFR Section 155.410(d).

Section 6502(g) clarifies and makes specific that a qualified individual's coverage will be effectuated in accordance with the coverage effective dates specified in subdivisions (c) and (f) of this section only if the individual makes his or her initial premium payment, reduced by the APTC amount he or she is determined eligible for by the Exchange, by the premium payment due date and the applicable QHP issuer receives such payment on or before the due date. This is consistent with the federal rules for the FFE, as specified in 45 CFR Section 156.265(d)(2), and is necessary to provide the consumers with clarity as to their responsibilities to make timely payments of their initial premiums for their coverage to be effectuated by the QHP issuers.

§ 6504. Special Enrollment Periods

Section 6504, in its entirety, implements, clarifies, and makes specific the special enrollment process, including the qualifying life events that trigger a special enrollment period, the length of a special enrollment period, and the coverage effective dates that apply to each special enrollment triggering event. This is necessary to provide the consumers with clear standards and guidelines as to how they can enroll in QHPs, or change their QHPs if they are the Exchange's enrollees, outside of an open enrollment period, and to comply with the federal requirements specified in 45 CFR Section 155.420.

Section 6504(a) clarifies and makes specific that a qualified individual may enroll in a QHP, or an enrollee may change from one QHP to another, during special enrollment periods only if one of the qualifying life events specified in this subdivision occurs. The triggering events in this section are substantively identical to the ones outlined in 45 CFR Section 155.420(d) except that subdivision (a)(15) has been added to this section to comport to and to be consistent with the State law in the Health and Safety Code Section 1399.849(d)(1) and the Insurance Code Section 10965.3(d)(1). This is necessary to provide the consumers with clear standards and guidelines as to the qualifying life events that will trigger a special enrollment period, and to comply with the State and federal requirements.

Section 6504(b) and (c) specify what events or circumstances are considered "loss of MEC" and what events or circumstances are not. These are necessary to comply with, and are substantively identical to, the federal requirements specified in 45 CFR Section 155.420(e). The federal rule in Section 155.420(e) does not list the circumstances considering loss of MEC; rather, it only cites to the IRS regulation specified in 26 CFR Section 54.9801-6(a)(3)(i) through (iii) that includes those circumstances. The Exchange specifies those circumstances in subdivision (b) of this section to provide the consumers with more clarity.

Section 6504(d) and (e) require a qualified individual or an enrollee to attest that he or she meets at least one of the triggering events specified in subdivision (a) of this section, and require the Exchange to accept the qualified individual's or the enrollee's attestation without further verification. Additionally, Section 6504(d) requires the Exchange to inform the consumers that pursuant to 45 CFR Section 155.285, HHS may impose civil money penalties of up to $25,000 on the consumers who fail to provide the correct information due to their negligence or disregard of the federal or State rules or regulations or up to $250,000 on those who knowingly and willfully provide false or fraudulent information or knowingly and willfully use or disclose information in violation of Section 1411(g) of the ACA (42 USC § 18081(g)). The federal regulations in 45 CFR Section 155.420 are silent as to the verification process that applies to the special enrollment triggering events. After extensive consultation with the stakeholders,

including the QHPs issuers, the Exchange chose to accept the consumers' attestations made under the penalty of perjury. However, consumers who have attested to have met at least one of the triggering events specified in subdivision (a) of this section will be subject to the federal civil monies penalties specified in this subdivision and will also be subject to statistically valid random sampling. These are necessary to provide the consumers with clarity as to their responsibility to truthfully attest to their qualifying life events and the Exchange's process to verify their attestations.

Section 6504(f) specifies the availability and length of special enrollment periods. This is necessary to provide the consumers with clarity about how much time they have to select and enroll in a QHP during a special enrollment period. This is also necessary to comply with, and is substantively identical to, the federal requirement specified in 45 CFR Section 155.420(c).

Section 6504(g) and (h) specify the regular and special coverage effective dates that apply to the triggering events specified in subdivision (a) of this section. These are necessary to provide the consumers with clear standards and guidelines as to the coverage effective dates associated with each qualifying life event. These are also necessary to comply with, and are substantively identical to, the federal requirements specified in 45 CFR Section 155.420(b).

Section 6504(i) clarifies and makes specific that a qualified individual's coverage will be effectuated in accordance with the coverage effective dates specified in subdivisions (g) and (h) of this section only if the individual makes his or her initial premium payment, reduced by the APTC amount he or she is determined eligible for by the Exchange, by the premium payment due date and the applicable QHP issuer receives such payment on or before the due date. It also specifies that in cases of retroactive enrollment dates, the initial premium will consist of the premium due for all months of retroactive coverage through the first month of coverage following the plan selection date. If the consumer makes partial premium payment for less than all months of retroactive coverage, the issuer must only effectuate prospective coverage in accordance with the regular coverage effective dates specified in subdivision (g) of this section. This is consistent with the federal rules for the FFE, as specified in 45 CFR Sections 155.400(e) and 156.265(d), and is necessary to provide the consumers with clarity as to their responsibilities to make timely payments of their initial premiums for their coverage to be effectuated by the QHP issuers.

Section 6504(j) clarifies and makes specific that APTC and CSR must adhere to the effective dates specified in subdivisions (j) through (l) of Section 6496. This is necessary to comply with, and is substantively identical to, the federal requirement specified in 45 CFR Section 155.420(b)(4). The Exchange does not have discretion to do otherwise.

§ 6506. Termination of Coverage in a QHP

Section 6506, in its entirety, implements, clarifies, and makes specific the termination process. This is necessary to provide the consumers with clear standards and guidelines regarding voluntary and involuntary termination of their coverage through the Exchange, and to comply with the federal requirements specified in 45 CFR Sections 155.430 and 156.270.

Section 6506(a) clarifies and makes specific that an enrollee may initiate termination of his or her coverage in accordance with the specified process. This is necessary to provide the consumers with clarity as to the process they must follow if they wish to terminate their coverage through the Exchange.

Section 6506(a)(1) clarifies and makes specific that an enrollee may terminate his or her coverage in a QHP, including as a result of the enrollee obtaining other MEC, by notifying the Exchange or the QHP issuer. This is necessary to provide the consumers with clarity as to the notification requirement they have to comply with if they wish to terminate their coverage for any reason, and to comply with the federal requirements specified in 45 CFR Section 155.430(b)(1)(i).

Section 6506(a)(2) clarifies and makes specific that an enrollee may choose to remain enrolled in a QHP at the time of plan selection if he or she becomes eligible for other MEC and the enrollee does not request termination. If the enrollee does not choose to remain enrolled in a QHP in such a situation, the enrollee may request or initiate termination of his or her coverage, and the Exchange must terminate the enrollee's enrollment in the QHP upon completion of the redetermination process specified in Section 6496. This is necessary to provide the consumers with clarity as to their options when they obtain other MECs. This is also necessary to comply with, and is substantively identical to, the federal requirements specified in 45 CFR Section 155.430(b)(1)(ii).

Section 6506(a)(3) establishes and clarifies the Exchange's process to permit consumers to report the death of an enrollee for purposes of initiating termination of the enrollee's Exchange enrollment. The federal rules in 45 CFR Section 155.430(b)(1)(iii) require the Exchange to establish such a process for the consumers but do not outline a specific process; however, HHS has issued a guidance outlining process established by the federally-facilitated Marketplace (FFM). After consultation with stakeholders, the Exchange established a process very similar to the FFM's process to allow the consumers to report an enrollee's death to the Exchange. This is necessary to provide the consumers with clarity as to the process they must follow to report an enrollee's death to the Exchange and to initiate termination of the deceased enrollee's coverage. This is also necessary to comply with the federal requirements specified in 45 CFR Section 155.430(b)(1)(iii).

Section 6506(a)(4) clarifies and makes specific that the Exchange must allow an enrollee to retroactively terminate his or her coverage in accordance with the specified process if the enrollee demonstrates that there was a technical error, an erroneous enrollment, or a fraudulent enrollment by a third party without the enrollee's knowledge or consent. This is necessary to provide the consumers with clarity as to the process they must follow if they wish to retroactively terminate their coverage through the Exchange. This is also necessary to comply with, and is substantively identical to, the federal requirements specified in 45 CFR Section 155.430(b)(1)(iv).

Section 6506(b) clarifies and makes specific the circumstances under which the Exchange may initiate termination of an enrollee's coverage in a QHP, and must permit a QHP issuer to terminate such coverage, provided that the issuer makes reasonable accommodations for all individuals with disabilities (as defined by the Americans with Disabilities Act) before terminating coverage for such individuals. This is necessary to provide the consumers clarity as to the circumstances under which their coverage will be involuntarily terminated. This is also necessary to comply with, and is substantively identical to, the federal requirements specified in 45 CFR Section 155.430(b)(2) and (c)(3).

Section 6506(c) clarifies and makes specific the termination process of the Exchange's enrollees due to their failure to pay their premiums, including the QHP issuers' responsibilities to notify the enrollees of their delinquency, to provide a three-month grace period to the enrollees receiving APTC who, when receiving APTC, failed to pay their premium, and to follow specified procedures during such grace period and after the exhaustion of the grace period. The federal rules in 45 CFR Section 156.270(d)(1) allow the QHP issuers to pend claims for services rendered to the enrollees during their second and third months of the grace period. However, the Exchange did not adopt this section of the federal rules because such pending of the claims is not permitted under the State law. This is necessary to provide clarity to the enrollees who are receiving APTC and fail to timely pay their premiums as to the grace periods that are entitled to get before their coverage is terminated. This is also necessary to comply with, and is substantially identical to, the federal requirements specified in 45 CFR Section 156.270(d) through (g).

Section 6506(d) clarifies and makes specific the effective dates for termination of coverage. This is necessary to provide clarity for the consumers as to the last day of their coverage in cases of voluntary or involuntary terminations of their coverage in QHPs. This is also necessary to comply with, and is substantively identical to, the federal requirements specified in 45 CFR Section 155.430(d).

Section 6506(e) clarifies and makes specific the QHP issuers' obligations if an enrollee's coverage in a QHP is terminated due to the enrollee's initiation, enrollee's

failure to pay premiums for coverage, or rescission of coverage. The federal rules in 45 CFR Section 156.270(b) require the QHP issuers to provide a notice of termination to the enrollees with the termination effective date and reason if the enrollees' coverage is terminated. However, the content of this notice in Section 156.270(b)(2) has been "reserved" for future rulemaking. After extensive stakeholders' engagement, the Exchange added the requirement that the QHP issuers also include in this notice the notice of appeals right, in accordance with the requirements specified in Section 6604 of Article 7 of the Exchange regulations. If any of these provisions will be inconsistent with the federal future rules, the Exchange will amend this section of the proposed regulations in the future to resolve the inconsistency. This is necessary to provide the consumers with clear standards and guidelines regarding the termination notice and their appeals right, and to provide the QHP issuers with clear standards and guidelines regarding their obligations. This is also necessary to comply with the federal requirements specified in 45 CFR Section 156.270(b), (h), and (i).

Section 6506(f) clarifies and makes specific the Exchange's obligations if an enrollee's coverage in a QHP is terminated for any reason other than termination due to the enrollee's initiation or request, enrollee's failure to pay premiums for coverage, or rescission of coverage. The federal rule in 45 CFR Section 155.430(c)(2) requires the Exchange to send termination information to the QHP issuers "promptly and without undue delay" but do not specify any timeline nor define "promptly and without undue delay." After consultation with stakeholders, the Exchange established the timeline of "within three business days from the date of termination" to send this information to the QHP issuers. Although the Exchange electronically submits the eligibility and enrollment information to the issuers on a daily basis, the Exchange determined that three business day is a reasonable time limit to set in its regulations in case the system is down and the daily transmittal would not be possible. This is necessary to provide the consumers and QHP issuers with clarity as to the Exchange's obligations and to comply with the federal requirements specified in 45 CFR Section 155.430(c).

§ 6508. Authorized Representative

Section 6508, in its entirety, implements, clarifies, and makes specific the right of an applicant or enrollee to have an authorized representative act on his or her behalf in dealing with the Exchange regarding an eligibility determination and redetermination and other ongoing communication. It outlines a process for designation of the authorized representative, the permitted scope of the representative's duties, and the responsibilities and legal obligations of the authorized representative, including compliance with applicable State and federal laws regarding conflicts of interest and confidentiality of information. This is necessary to provide the consumers with clarity as to the Exchange's process for designating an authorized representative, and to comply with the federal requirements specified in 45 CFR Section 155.227.

Section 6508(a) clarifies and makes specific the Exchange's duty to allow an applicant or enrollee in the individual or small group market to designate an individual or organization to act on his or her behalf in applying for an eligibility determination or redetermination and in carrying out other ongoing communications with the Exchange. This is necessary to comply with, and is substantively identical to, the federal requirements specified in 45 CFR Section 155.227(a)(1). The Exchange has no discretion to do otherwise.

Section 6508(b) requires that the designation outlined in subdivision(a) be in a written document, or through other legally binding format subject to applicable authentication and data security standards as required by 45 CFR 155.270. If submitted, such legal documentation will serve in the place of the applicant's or enrollee's signature. This is necessary to comply with, and is substantively identical to, the federal requirements specified in 45 CFR Section 155.227(a)(2). The Exchange has no discretion to do otherwise.

Section 6508(c) requires the authorized representative to agree, or be legally bound to, maintain the confidentiality of any information regarding the applicant or enrollee provided by the Exchange. This is necessary to comply with, and is substantively identical to, the federal requirements specified in 45 CFR Section 155.227(a)(3). The Exchange has no discretion to do otherwise.

Section 6508(d) requires the authorized representative to be responsible for fulfilling all responsibilities encompassed within the scope of the authorized representation to the same extent as the applicant or enrollee he or she represents. This is necessary to comply with, and is substantively identical to, the federal requirements specified in 45 CFR Section 155.227(a)(4). The Exchange has no discretion to do otherwise.

Section 6508(e) clarifies and makes specific that an applicant or enrollee may designate an authorized representative at the time of application or at other times through any of the methods used to submit an application, as described in Section 6470(j). This is necessary to comply with, and is substantively identical to, the federal requirements specified in 45 CFR Section 155.227(b). The Exchange has no discretion to do otherwise.

Section 6508(f) clarifies and makes specific that an applicant or enrollee may authorize his or her representative to perform the following responsibilities on his or her behalf:

1. Sign an application;
2. Submit an update or respond to a redetermination in accordance with Sections 6496 and 6498;
3. Receive copies of the applicant's or enrollee's notices or other Exchange communication; and
4. Act on behalf of the applicant or enrollee in all other matters with the Exchange.

This is necessary to comply with, and is substantively identical to, the federal requirements specified in 45 CFR Section 155.227(c)(1). The Exchange has no discretion to do otherwise.

Section 6508(g) clarifies and makes specific that an applicant or enrollee may authorize a representative to perform fewer than all of the activities described in subdivision (f) of this section. The federal rules in 45 CFR Section 155.227(c)(2) provide the Exchange with an option to permit an applicant or enrollee to authorize a representative to perform fewer than all of the specified activities, provided that the Exchange tracks the specific permissions for each authorized representative. The Exchange made the policy decision to provide the applicants or enrollees with such option to give them flexibility and will track the specific permissions for each authorized representative, as required under the federal rules. This is necessary, and is substantively identical to, the federal requirements specified in 45 CFR Section 155.227(c)(2).

Section 6508(h) requires the Exchange to provide information both to the applicant or enrollee, and to the authorized representative, regarding the powers and duties of authorized representative. This is necessary, and is substantively identical to, the federal requirements specified in 45 CFR Section 155.227(a)(5). The Exchange has no discretion to do otherwise.

Section 6508(i) requires the Exchange to consider the designation of an authorized representative valid until such time as follows:

1. The applicant or enrollee, using one of the methods for application submission provided in Section 6470(j), notifies the Exchange that the representative is no longer authorized to act on behalf of the applicant or enrollee, in which case, the Exchange will notify the authorized representative of such change; or
2. The authorized representative informs the Exchange that he or she is no longer acting in such capacity. An authorized representative must notify the Exchange and the applicant or enrollee on whose behalf he or she is acting when the authorized representative no longer has legal authority to act on behalf of the applicant or enrollee.

This is necessary, and is substantively identical to, the federal requirements specified in 45 CFR Section 155.227(d). The Exchange has no discretion to do otherwise.

Section 6508(j) requires an authorized representative to comply with all applicable State and federal laws regarding conflicts of interest and confidentiality of information. This is necessary, and is substantively identical to, the federal requirements specified in 45 CFR Section 155.227(e). The Exchange has no discretion to do otherwise.

§ 6510. Right to Appeal

Section 6510, in its entirety, implements, clarifies, and makes specific that the Exchange must include the notice of the right to appeal and instructions regarding how to file an appeal in any eligibility determination and redetermination notice the Exchange sends to the applicant. This is necessary to ensure that an applicant or enrollee wishing to appeal an eligibility determination or redetermination notice issued by the Exchange is informed concurrently of his or her appeal rights. This is also necessary, and is substantively identical to, the federal requirements specified in 45 CFR Sections 155.355 and 155.515. The Exchange has no discretion to do otherwise.

Article 7. Appeals Process for the Individual Exchange

Article 7, in its entirety, implements, clarifies, and makes specific the appeals process for the individual Exchange. This is necessary to provide the consumers with clear standards and guidelines as to their right to due process, and to comply with the federal requirements specified in 45 CFR Sections 155.500 through 155.555.

§ 6600. Definitions

Section 6600, in its entirety, implements, clarifies, and makes specific the definitions of various terms used in Article 7. Defining the terms set forth in this section is necessary to ensure the clarity and consistency of the regulations, to ensure consistency with State and federal law, and to avoid reader confusion. The following is a more specific discussion of the included definitions' necessity:

Defining "Appeal Record" is necessary to clarify what is and is not included in the record on appeal, to clarify a technical term that may not be familiar to the general public, and to conform to the definition of the term specified in 45 CFR Section 155.500. Deviating from the definition of this term used in parallel federal regulations would cause significant confusion.

Defining "Appeal Request" is necessary to specify and clarify what an applicant or enrollee must do to have an Exchange eligibility determination or redetermination reviewed by the Exchange appeals entity, to clarify a technical term that may not be familiar to the general public, and to conform to the definition of the term specified in 45 CFR Section 155.500. Deviating from the definition of this term used in parallel federal regulations would cause significant confusion.

Defining "Appeals Entity" is necessary to specify and clarify that the term refers to a body designated by the Exchange to hear appeals of any Exchange eligibility determination or redetermination, and that the entity so designated by the Exchange shall be The California Department of Social Services (CDSS). This is a technical term

that might not be familiar to the general public, and, if it were not defined, it is unlikely that the general public would know that the CDSS is the Exchange appeals entity. The Exchange also defined the term as it did to conform to the definition of the term specified in 45 CFR Section 155.500. Deviating from the definition of this term used in parallel federal regulations would cause significant confusion. The Exchange included in the definition of the term the fact that the Exchange has designated the CDSS to be its appeals entity. Providing this information in the definition of "Appeals Entity" is necessary to inform the public of relevant information it might not otherwise know. Finally, the decision to designate CDSS as the Exchange appeals entity was necessary because CDSS already serves as the appeals entity for Medi-Cal appeals, and using the same entity for Exchange appeals ensures efficiency, consistency, and compliance with the federal requirement of having a "coordinated Exchange and Medicaid appeals process" under 45 CFR Section 155.510. The Exchange runs on the CalHEERS system, which is a joint venture with the Department of Health Care Services (DHCS), the agency that administers Medi-Cal. CalHEERS accepts and routes applications to the Exchange or to DHCS, as appropriate. Certain appeals may involve issues regarding whether CalHEERS routed an application appropriately; therefore, in order to insure the efficient, correct and coordinated resolution of appeals (as required under 45 CFR Section 155.510), it is necessary for the same appeals entity to handle both Medi-Cal and Exchange appeals.

Defining "Appellant" is necessary because this is a technical legal term that might not be familiar to the general public and to conform to the definition of the term specified in 45 CFR Section 155.500. Deviating from the definition of this term used in parallel federal regulations would cause significant confusion.

Defining "De Novo Review" is necessary because this is a technical legal term that might not be familiar to the general public and to conform to the definition of the term specified in 45 CFR Section 155.500. Deviating from the definition of this term used in parallel federal regulations would cause significant confusion.

Defining "Eligibility Determination" is necessary to specify and clarify a specialized term that might not be familiar to the general public, to specify what kinds of determinations the term refers to, and to specify the regulations that inform the meaning of the term. Specifically, it is necessary to comport with Sections 6472, 6474 and 6476 of these proposed regulations.

Defining "Evidentiary Hearing" is necessary because this is a technical legal term that might not be familiar to the general public and to conform to the definition of the term specified in 45 CFR Section 155.500. Deviating from the definition of this term used in parallel federal regulations would cause significant confusion.

Defining “Statement of Position” is necessary because this is a technical legal term that might not be familiar to the general public. The definition used is necessary to conform to the requirements of section 10952.5 of the Welfare and Institutions Code,

Defining “Vacate” is necessary because this is a technical legal term that might not be familiar to the general public.

§ 6602. General Eligibility Appeals Requirements

Section 6602, in its entirety, implements, clarifies, and makes specific the general rules that govern appeals of the Exchange’s eligibility determinations and redeterminations. This is necessary to set forth and clarify the types of Exchange’s eligibility determinations and redeterminations that can be appealed, as well as the general role of the appeals entity, the general role of an administrative law judge, the availability of appeal to HHS and the courts, and various procedural rules that govern appeals. This section benefits the public by ensuring an orderly and clear appeals process. This is also necessary to comply with the federal requirements specified in 45 CFR Section 155.505.

Section 6602(a) specifies the kinds of determinations that an applicant or enrollee has the right to appeal, including initial determinations and redeterminations. This is necessary to make clear to applicants and enrollees that they have the right to appeal certain kinds of decisions. This is also necessary to comply with, and is substantively identical to, the federal requirements specified in 45 CFR Section 155.505(b). The Exchange does not have discretion to do otherwise.

Section 6602(b) specifies that the Exchange appeals entity will conduct all eligibility appeals except for appeals of an eligibility determination for an exemption made in accordance with 45 CFR Section 155.605. This is necessary to clarify which appeals shall be conducted by the Exchange appeals entity. The federal regulations specified in 45 CFR Section 155.505(c) provided the Exchange with the option of either establishing its own appeals process or relying on the HHS to conduct the appeals for the Exchange. The Exchange chose to handle the majority of appeals because it wanted to be as responsive as possible to the needs of the California public. It chose not to handle the exemption appeals under section 155.605, and instead to refer such appeals to HHS, because the volume of such appeals might have strained Exchange resources and led to inconvenient delays.

Section 6602(c) specifies that an administrative law judge designated by the CDSS will determine the validity of all appeal requests and whether good cause exists, including, but not limited to, good cause for an untimely appeal request and continuance. This is necessary to clarify the powers of the administrative law judge in this context, which otherwise might not be apparent. The Exchange considered allowing the Exchange

staff to determine the validity of the appeals request but rejected that alternative because of stakeholders' opposition.

Section 6602(d) clarifies and makes specific that an applicant or enrollee may appeal to HHS upon exhaustion of the Exchange appeals process. This is necessary to make clear to the public that the Exchange appeals process is not the final available administrative appeal, which might not otherwise be apparent. This is also necessary to comply with, and is substantively identical to, the federal requirements specified in 45 CFR Section 155.505(c)(2)(i). The Exchange does not have discretion to do otherwise.

Section 6602(e) clarifies and makes specific that appellants may represent themselves or be represented by a wide range of representatives, including lawyers, friends, relatives and others. This is necessary to make clear that members of the public who wish to appeal an Exchange determination do not need to proceed alone and may be assisted by representatives of their choice. This is also necessary to comply with, and is substantively identical to, the federal requirements specified in 45 CFR Section 155.505(e). The Exchange does not have discretion to do otherwise.

Section 6602(f) requires the Exchange appeals process established under this Article to comply with the accessibility and readability requirements specified in Section 6452 of these proposed regulations. This is necessary to ensure that the public can understand and navigate the Exchange appeals process. This is also necessary to comply with, and is substantively identical to, the federal requirements specified in 45 CFR Section 155.505(f). The Exchange does not have discretion to do otherwise.

Section 6602(g) clarifies and makes specific that an appellant may seek judicial review to the extent it is available by law. This is necessary to make clear to appellants that they may have recourse to courts if they are dissatisfied with the results of their administrative appeal. This is also necessary to comply with, and is substantively identical to, the federal requirements specified in 45 CFR Section 155.505(g). The Exchange does not have discretion to do otherwise.

Section 6602(h) requires the Exchange to refer appeals of adverse MAGI Medi-Cal or CHIP determinations to DHCS via secure electronic interface within three business days from the date the appeal request is received. Under the Exchange's "no-wrong-door" policy, the Exchange must initially process applications for MAGI Medi-Cal and CHIP. But DHCS is the department that oversees these programs, so it is the DHCS that should conduct the appeals regarding these programs. The federal provision under 45 CFR Section 155.510(b)(2) requires the Exchange appeals entity to transmit this information to the Medicaid or CHIP agency (i.e., DHCS) "promptly and without undue delay" but do not specify any timeline nor define "promptly and without undue delay." After extensive consultation with stakeholders, including DHCS, the Exchange established the timeline of "three business days from the date the appeal request is

received" to send the required information to DHCS. The Exchange considered a shorter time limit but rejected that alternative because it was not administratively feasible. Exchange also considered a longer timeline but rejected that alternative because the notification and transmittal of information to DHCS will be done electronically, which will make the three-business-day timeline administratively feasible and more closely aligned with the federal requirements. This is necessary to insure that DHCS will be notified and receive the required information "promptly and without undue delay," to provide clarity for the consumers, and to comply with the requirements of 45 CFR Section 155.510(b)(2).

Section 6602(i) requires the appeals entity to comply with federal and State privacy and security standards, and to comply with all data sharing requests made by HHS. This is necessary to provide clarity regarding the appeal entity's privacy and security obligations and to ensure that the appeals entity cooperates appropriately with HHS. This is also necessary to comply with, and is substantively identical to, the federal requirements specified in 45 CFR Section 155.510(c). The Exchange does not have discretion to do otherwise.

Section 6602(j) requires the Exchange to provide the appellant with the opportunity to review his or her entire eligibility file, including all papers, requests, documents, and relevant information in the Exchange's possession at any time from the date on which an appeal request is filed to the date on which the appeal decision is issued. This is necessary to ensure that appellants have adequate access to their eligibility files to effectively appeal adverse determinations. It was drafted in close consultation with stakeholders and represents a reasonable compromise among competing interests.

§ 6604. Notice of Appeal Procedures

Section 6604, in its entirety, implements, clarifies, and makes specific the notice of appeal procedures. It outlines in detail, when an applicant will receive notice of his or her right to appeal and what that notice will contain. This is necessary to provide consumers with clarity regarding their right to due process, which at its heart requires notice and an opportunity to be heard. It provides applicants, enrollees subject to redetermination and the public with a clear picture of an essential part of the appeal process and an essential element of due process – notice. This is also necessary to comply with the federal requirements specified in 45 CFR Section 155.515.

Section 6604(a) specifies that applicants will receive notice of their appeal procedures when they submit their applications and when the Exchange sends them notice of an eligibility determination or redetermination. This is necessary to provide the consumers as to when they will receive notice of appeal procedures. This is also necessary to comply with, and is substantively identical to, the federal requirements specified in 45 CFR Section 155.515(a). The Exchange does not have discretion to do otherwise.

Section 6604(b) requires that the notice of appeal procedures comply with the technical requirements of Section 6454 (General Standards for Exchange Notices) and contain:

- An explanation of the applicant's or enrollee's (collectively, appellant) appeal rights;
- A description of the procedures by which an appellant may request an appeal, including an expedited appeal;
- Information about the right of the appellant to be represented by counsel, or a representative of his or her choice;
- Information regarding obtaining a Legal Aid referral, or free legal help;
- An explanation that all hearings will be conducted by telephone, video conference, or in person, in accordance with the CDSS' Manual of Policies and Procedures Section 22-045;
- An explanation of the circumstances under which the appellant's eligibility may be maintained or reinstated pending an appeal decision; and
- An explanation that an appeal decision for one household member may result in a change in eligibility for other household members and that the Exchange will handle such a change as a redetermination of eligibility for all household members.

This is necessary to provide the consumers with clarity as to what they should expect to see in the Exchange's notices regarding their rights to fair hearings, including right to counsel or other representation, necessary procedures, potential effect on family members and, importantly, maintenance or reinstatement of eligibility pending appeal. This is also necessary to comply with, and is substantially identical to, the federal requirements specified in 45 CFR Section 155.515(b).

§ 6606. Appeal Requests

Section 6606, in its entirety, implements, clarifies, and makes specific the rules that govern appeal requests. This is necessary to provide the consumers with clarity and to comply with the mandates of 45 CFR Section 155.520.

Section 6606(a) requires the Exchange and the appeals entity:

1. To accept appeals requests submitted through the Exchange's Web site, as well as by telephone, facsimile, mail, and by personal delivery;
2. To assist the applicant or enrollee in making an appeal request; and
3. Not to interfere with an applicant's or enrollee's right to submit an appeal.

This is necessary to specify and clarify the particular methods by which applicants and enrollees may appeal, and to ensure that applicants and enrollees have the help they need to submit appeals and are not hampered in their attempts to exercise their appeal rights, as well as to ensure that the methods of submitting appeals track the methods of

submitting applications set forth in Section 6470(j) of these proposed regulations. The Exchange chose to provide a broad range of methods to submit appeals in order to ensure that applicants and enrollees can conveniently and easily submit appeals. This is also necessary to comply with, and is substantively identical to, the federal requirements specified in 45 CFR Section 155.520(a)(1) through (3).

Section 6606(b) clarifies and makes specific the circumstances under which the appeal entity must consider an appeal request valid. Specifically, it provides that the appeals entity must consider an appeal request valid (i.e., must adjudicate it pursuant to Section 6602(c)), if it is submitted in accordance with the requirements of subdivisions (c) and (d) of this section. This is necessary to ensure that trivial defects do not prevent applicants and enrollees from having the merits of their appeals duly considered. This is also necessary to comply with, and is substantively identical to, the federal requirements specified in 45 CFR Section 155.520(a)(4).

Section 6606(c) clarifies and makes specific the time period in which applicants and enrollees may request an appeal, as well as the standard under which the appeals entity may extend that period and the maximum length of any such extension. This is necessary both to clarify these key rules and standards and to comply with the federal requirements specified in 45 CFR Section 155.520(b). The Exchange chose to align the timeframe and the good cause standard with that set forth in Welfare and Institution Code Section 10951 both because it believes that standard is appropriate and in order to avoid confusion since CDSS uses the same timeframe and standard for Medi-Cal appeals. The Exchange chose to use the timing rules set forth in Government Code Sections 6700 and 6707 for the same reasons.

Section 6606(d) clarifies and makes specific that an appellant who is dissatisfied with the Exchange appeals entity's decision can appeal to HHS within 30 days of the date of the appeals entity's notice of appeal decision or notice of denial of a request to vacate a dismissal. This is necessary to comply with, and is substantively identical to, the requirements of federal rules specified in 45 CFR Section 155.520(c). The Exchange does not have discretion to do otherwise.

Section 6606(e) clarifies and makes specific the Exchange appeals entity's obligations upon receiving a valid appeal request, including the requirement to inform the appellant of the receipt of his or her valid appeal request and of the opportunity for informal resolution; information regarding the appellant's eligibility pending appeal pursuant to Section 6608; and an explanation that any APTC paid on behalf of the tax filer pending appeal is subject to reconciliation under Section 36B(f) of the Internal Revenue Code (IRC). It also specifies and clarifies that the appeals entity must, within three business days, transmit to the Exchange or DHCS, as applicable, notice of the appeal request and, if applicable, instructions to provide eligibility pending appeal pursuant to Section

6608. The federal regulations in 45 CFR Section 155.520(d)(1)(i), (ii) and (iv) require the appeals entity to:

- Send "timely" acknowledgment to the appellant of the receipt of his or her valid appeal request;
- Send "timely" notice via secure electronic interface of the appeal request and, if applicable, instructions to provide eligibility pending appeal pursuant to §155.525, to the Exchange and to the agencies administering Medicaid or CHIP, where applicable; and
- "Promptly" confirm receipt of the records transferred to the Exchange or the Exchange appeals entity, as applicable.

However, the federal regulations do not define "timely" or "promptly" and leave it to the Exchanges to specify what is considered "timely" or "promptly." After extensive consultation with stakeholders, the Exchange established the following timeframes for the appeals entity:

- "Within five business days from the date on which the valid appeal request is received" to send written acknowledgment to the appellant of the receipt of his or her valid appeal request;
- "Within three business days from the date on which the valid appeal request is received" to transmit via secure electronic interface notice of the appeal request and, if applicable, instructions to provide eligibility pending appeal, to the Exchange and the DHCS, as applicable; and
- "Within two business days of the receipt of the records" to confirm receipt of the appeal request and the appellant's eligibility record transferred by the Exchange pursuant to subdivision (g) of this section.

The Exchange considered shorter timeframes than the ones listed above but rejected the alternatives because shorter timeframes were not administratively feasible. Exchange also considered longer timeframes but rejected those alternatives as well because the timeframes established by the Exchange, as listed above, are administratively feasible, insure that the appellants, DHCS, and the Exchange receive the required information in a timely manner, and are more closely aligned with the federal requirements. This is necessary to provide clarity to the consumers, to facilitate, streamline, specify and clarify the procedures and obligations relating to the receipt of and response to valid appeals requests, as well as to comply with the requirements of 45 CFR Section 155.520(d)(1).

Section 6606(f) clarifies and makes specific the Exchange appeals entity's obligations upon receiving an appeal request that the appeals entity determines not valid, including the requirement to inform the appellant, within five business days from the date on which the appeal request is received, that his or her appeal request has not been accepted; information about the nature of the defect in the appeal request; and an explanation that the appellant may cure the defect and resubmit the appeal request within 30 calendar days from the date on which the invalid appeal request is received. It

also requires the appeals entity to treat as valid an amended appeal request that meets the requirements of this section and of Section 6602(a). The Exchange did clarify and make specific the federal requirement that written notice be sent "[p]romptly and without undue delay" by requiring such notice to be sent "within five business days from the date on which the appeal request is received" based on the same reasoning and alternatives discussed above for subdivision (e) of this section. The Exchange also clarified and made specific the timeframe to resubmit a cured appeal request to be "within 30 calendar days from the date on which the invalid appeal request is received." This timeframe provides the appellant sufficient time to cure the defect and still meets the reasonableness standard specified in 45 CFR Section 155.520(b)(2) and (d)(2)(i)(C). This is necessary to comply with, and is substantially identical to, the requirements of federal rules specified in 45 CFR Section 155.520(d)(2).

Section 6606(g) requires the Exchange to transmit to the appeals entity via secure electronic interface the appellant's appeal request and the eligibility record upon receipt of an appeal request from an appellant, or upon receipt of the notice of an appeal request from the appeals entity under subdivision (e)(2) of this section. This section is necessary to comply with, and is substantively identical to, the requirements of federal rules specified in 45 CFR Section 155.520(d)(3). The Exchange does not have discretion to do otherwise.

Section 6606(h) clarifies and makes specific that upon receipt of the notice of an appeals request made to HHS, the Exchange appeals entity must transmit to the HHS appeals entity via secure electronic interface the appellant's appeal record, including the appellant's eligibility record as received from the Exchange within three business days from the date on which the appeal request is received. The federal regulations in 45 CFR Section 155.520(d)(4) did not specify a timeframe for the Exchange appeals entity to transmit such information to HHS. The Exchange clarified and made specific this timeframe to be "within three business days from the date on which the appeal request is received." This timeframe provides consistency for the appeals entity since the same three-business-day timeframe has been specified by the Exchange as reasonable for other electronic transmittals required under the federal regulations, and ensures that the required information will be transmitted to the HHS on a timely basis. This is necessary to comply with, and is substantially identical to, the requirements of federal rules specified in 45 CFR Section 155.520(d)(4).

§ 6608. Eligibility Pending Appeal

Section 6608, in its entirety, implements, clarifies, and makes specific the rules that govern the appellant's eligibility for enrollment in a QHP and for APTC/CSR pending an appeal of an eligibility redetermination. It specifies that if the tax filer or appellant accepts eligibility pending an appeal and agrees to timely make his or her premium payments, reduced by the APTC amount he or she is determined eligible for by the

Exchange, the Exchange must continue the appellant's eligibility for enrollment in a QHP, APTC and CSR, as applicable, in accordance with the level of eligibility immediately before the redetermination being appealed. This is necessary to provide the consumers with clarity regarding their eligibility pending appeal, and to comply with the requirements of federal rules as specified in 45 CFR Section 155.525.

§ 6610. Dismissals

Section 6610, in its entirety, implements, clarifies, and makes specific the Exchange's standards and procedures regarding the dismissal of appeals. This is necessary to establish clear rules and procedures, to provide the consumers with clarity, to ensure a fair and rational dismissal process, and to comply with the federal requirements specified in 45 CFR Section 155.530.

Section 6610(a) requires the Exchange's appeals entity to dismiss an appeal under the following circumstances:

1. The appellant unconditionally or conditionally withdraws the appeal request in writing prior to the hearing date;
2. The appellant fails to appear at a scheduled hearing without good cause;
3. The appellant fails to submit a valid appeal request without good cause; and
4. The appellant dies while the appeal is pending, unless the appeal affects the remaining member(s) of the deceased appellant's household, or the appeal can be carried forward by a representative of the deceased appellant's estate, or by an heir of the deceased appellant if the decedent's estate is not in probate, in accordance with Section 22-004.4 of the CDSS' Manual of Policies and Procedures.

The detailed discussion of the dismissal under each of these circumstances is as follows:

Section 6610(a)(1) sets forth the Exchange's process for unconditional and conditional withdrawals. It requires the appeals entity to immediately dismiss the appeal if the appellant withdraws his or her appeal unconditionally and in writing. This is necessary to comply with, and is substantively identical to, the requirements of federal rules specified in 45 CFR Section 155.530(a)(1). However, the Exchange chose to adopt the CDSS' standards regarding unconditional verbal withdrawals specified in 22-054.211(a) of the CDSS Manual of Policies and Procedures. Under subdivision (a)(1)(B) of this section, if the appellant has verbally withdrawn his or her appeal request prior to the hearing, and such withdrawal is unconditional, the appeals entity must send the appellant a written confirmation of the withdrawal within five business days from the date on which the appellant's verbal withdrawal is received. CDSS's regulation does not specify a timeline to send the confirmation letter to the appellant but the Exchange adopted the same timeframe that applies to all written correspondence or notices that must be sent to the applicants, enrollees, or appellants for clarity and consistency

purposes. This written confirmation will serve as the appellant's written withdrawal and the appeal will be dismissed unless the appellant notifies the appeals entity, in writing or verbally, within 15 days of the date of the written confirmation, that the appellant has not withdrawn his or her appeal request.

This subdivision also sets forth the following standards if the withdrawal is conditional:

1. The withdrawal must be accompanied by an agreement signed by the appellant and by the Exchange as part of the informal resolution process specified in Section 6612 of these proposed regulations;
2. Upon receipt of the signed conditional withdrawal, the appeal entity must vacate the hearing date, if any;
3. Both appellant and the Exchange must complete their actions under the agreement specified in paragraph (1) above within 30 calendar days of the date on the agreement; and
4. Upon the satisfactory completion of the actions of the appellant and the Exchange under the agreement, the appeals entity must dismiss the appeals request unless the hearing request is reinstated within the time limits set forth in Section 6606(c) of these proposed regulations.

The Exchange adopted the above conditional withdrawal standards as the result of extensive negotiations with stakeholders and consultation with CDSS. These standards are necessary to ensure that, in the event of a conditional withdrawal, an unnecessary hearing is not held. They are also necessary to align the Exchange process and regulations with the appeals entity's existing regulations governing conditional withdrawals (CDSS Manual of Policies and Procedures Section 20-054(b)(3)). It is necessary to require a conditional withdrawal to be accompanied by an agreement signed by both the appellant and the Exchange as part of the informal resolution process because an oral agreement would be more easily subject to misinterpretation and would be insufficiently reliable to serve the purpose. It is necessary to specify that the hearing date will be vacated upon receipt of the signed conditional withdrawal in order to avoid the expense of preparing for or holding an unnecessary hearing. It is necessary to require that the actions of both parties under the agreement be completed within 30 calendar days to ensure that conditional withdrawals are finalized in a timely manner and that circumstances do not materially change before the agreed-upon resolution is effectuated. Finally, requiring the appeals entity to dismiss the appeals request upon satisfactory completion of the agreed-upon actions of the Exchange and the appellant is necessary to bring administrative finality to a situation that has been resolved. The Exchange considered establishing independent procedures to govern the conditional withdrawal process but chose to adopt the appeals entity's existing procedures instead because those procedures are sound and achieve all of the Exchange's objectives and because using the appeals entity's existing procedures is likely to reduce confusion and implementation problems and ensures coordination of Exchange and Medi-Cal appeal processes.

This section also clarifies that both unconditional and conditional withdrawals must be accepted by telephone if the appellant's statement and telephonic signature made under penalty of perjury is recorded in full, and the appellant is provided with a written confirmation documenting the telephonic interaction. This is necessary to provide the consumers with clarity as to the process of telephonic withdrawals and to comply with the federal rule in 45 CFR § 155.530(a)(1)(i).

Section 6610(a)(2) requires the appeal to be dismissed if the appellant does not appear at a scheduled hearing without good cause. This is necessary to comply with, and is substantively identical to, the federal requirement specified in 45 CFR Section 155.530(a)(2). The Exchange does not have discretion to do otherwise.

Section 6610(a)(3) requires the appeal to be dismissed if the appellant does not submit a valid appeal request as specified in Section 6606(b) without good cause. This is necessary to comply with, and is substantively identical to, the federal requirement specified in 45 CFR Section 155.530(a)(3). The Exchange does not have discretion to do otherwise, except that the Exchange chose to implement the State good cause standard, as explained in the necessity statement for Section 6606(c) above.

Section 6610(a)(4) requires the appeal to be dismissed if the appellant dies while the appeal is pending unless the appeal affects the remaining members of the deceased appellant's household, or the appeal can be carried forward by the deceased appellant's representative, or by his or her heir if the decedent's estate is not in probate, in accordance with the California Department of Social Services' Manual of Policies and Procedures Section 22-004.4. The Exchange chose to allow the remaining members of the deceased appellant's household to continue the appeal if the appeal affects their rights. This is necessary to provide the appellant's family with the opportunity to carry the appeal over rather than dismissing the appeal and forcing the family to start all over again, especially since the facts of the case are the same. The Exchange also chose to adopt the CDSS' regulation that allows the appeal to be carried over by the deceased appellant's representative or heir. This is necessary to provide consistency by coordinating the Exchange appeal process with the Medi-Cal appeal process. This is also necessary to comply with the federal requirement specified in 45 CFR Section 155.530(a)(4).

Section 6610(b) clarifies and makes specific that if an appeal is dismissed under subdivision (a) of this section, the appeals entity must provide written notice to the appellant within five business days from the date of the dismissal. This notice must include the reason for the dismissal, an explanation of the dismissal's effect on the appellant's eligibility, and an explanation of how the appellant may show good cause as to why the dismissal should be vacated. This section is necessary to comply with, and is substantively identical to, the requirements of federal rules specified in 45 CFR

Section 155.530(b), except that the Exchange specified and made clear the federal requirement of sending a "timely" notice by replacing "timely" with "within five business days from the date of the dismissal" for clarity and consistency purposes. This is necessary to provide clarity for the appellants and the appeals entity and to ensure that the appellant will receive the notice of dismissal in a "timely" manner.

Section 6610(c) clarifies and makes specific that if an appeal is dismissed under subdivision (a) of this section, the appeals entity must, within three business days from the date of the dismissal, provide notice of the dismissal to the Exchange, and to the DHCS, as applicable, including instructions to, no earlier than five business days from the date of the dismissal:

1. Implement the eligibility determination; and
2. Discontinue eligibility pending appeal provided under Section 6608.

This is necessary to comply with, and is substantially identical to, the requirements of federal rules specified in 45 CFR Section 155.530(c). The Exchange does not have discretion to do otherwise. The Exchange did, however, clarify that the "timely notice" required under Section 155.530(c) shall mean notice "within three business days from the date of the dismissal." This timeframe provides consistency for the appeals entity since the same three-business-day timeframe has been specified by the Exchange as reasonable for other electronic transmittals required under the federal regulations, and ensures that the Exchange or DHCS will receive the notice of dismissal on a timely basis. However, the Exchange specified and made clear that the Exchange or DHCS must not implement their eligibility determinations (or discontinue the appellant's eligibility pending appeal, if applicable) earlier than five business days from the date of the dismissal. This is necessary to ensure that the implementation of the eligibility determination and discontinuance of the appellant's coverage (and APTC, if applicable) will not occur before the appellant is notified of the dismissal since the appellant is notified within five business days from the date of the dismissal, as required by subdivision (b) of this section.

Section 6610(d) requires the appeals entity to vacate a dismissal and proceed with the appeal if the appellant makes a written request within 30 calendar days of the date of the notice of the dismissal showing good cause why the dismissal should be vacated. If the appellant's request to vacate a dismissal is denied, the appeals entity must provide the appellant with written notice of the denial of the request within five business days from the date of such denial. This is necessary to comply with, and is substantively identical to, the requirements of federal rules specified in 45 CFR Section 155.530(d). The Exchange does not have discretion to do otherwise. The Exchange did, however, clarify that the "timely written notice" required under Section 155.530(d)(2) shall mean written notice "within five business days from the date of the denial." This timeframe provides consistency for the appellants and appeals entity since the same five-business-day timeframe has been specified and implemented by the Exchange as

reasonable for all written notices or correspondence that must be sent to the applicants, enrollees, or appellants, and ensures that they will receive written notices on a timely basis.

§ 6612. Informal Resolution

Section 6612, in its entirety, implements, specifies, and establishes the obligation of the Exchange to provide an informal resolution process to all appellants prior to a formal hearing. It establishes notice requirements, scope of review and the right of the appellant to a fair hearing if he or she is dissatisfied with the outcome of the informal resolution process. This is necessary to establish clear rules and procedures, to provide the consumers with clarity, to ensure a fair and rational informal resolution process, and to comply with the federal requirements specified in 45 CFR Section 45 CFR Section 155.535(a).

Section 6612(a) and (b) establish the right of the appellant to request an informal resolution prior to a hearing and the duty of the Exchange to contact the appellant to resolve the appeal informally and the right to request information and documentation. These are necessary to provide the appellant with an opportunity to informally resolve his or her appeal with the Exchange before his or her scheduled hearing, and to be consistent with the federally-facilitated Exchange (FFE) that provide an opportunity for informal resolution, as specified in 45 CFR Section 155.535(a).

Section 6612(c) defines the "scope of review" of the informal resolution process with reference to Section 6614(e) of these regulations providing that the appeals entity shall consider the information used to determine the appellant's eligibility, as well as any additional relevant evidence presented during the appeals process, including the informal resolution process. This is necessary to comply with, and is substantively identical to, the federal requirements specified in 45 CFR Section 155.535(a)(1). The Exchange does not have discretion to do otherwise.

Section 6612(d) clarifies and makes specific that the appellant's right to appeal must be preserved notwithstanding the outcome of the informal resolution process, unless the appellant withdraws (conditionally or unconditionally) his or her appeal request prior to the hearing date in accordance with the procedures set forth in Section 6610(a)(1) of these proposed regulations. This is necessary to comply with, and is substantively identical to, the federal requirements specified in 45 CFR Section 155.535(a)(2). The Exchange does not have discretion to do otherwise.

Section 6612(e) clarifies and makes specific that if an appeal advances to hearing, the Exchange must issue a Statement of Position and transmit via secure electronic interface the Statement of Position and all papers, requests, and documents that the Exchange obtained during the informal resolution process to the appeals entity, the

appellant, and to the appellant's representative, if applicable, at least two business days prior to the hearing. The Exchange chose to adopt this subdivision based on the CDSS' existing process for Medi-Cal appeals to provide consistency for the appellants and to coordinate the Exchange appeals process with the Medi-Cal appeals process, as required by the federal rules in 45 CFR Section 155.510. Additionally, this subdivision provides that the appellant must not be asked to provide duplicative information or documentation that he or she previously provided during the application or informal resolution process. This is necessary to comply with, and is substantively identical to, the federal requirements specified in 45 CFR Section 155.535(a)(3). The Exchange does not have discretion to do otherwise.

Section 6612(f) clarifies and makes specific the procedures and process, including notice requirements, for the Exchange when an appellant is satisfied with the outcome of the informal resolution process and conditionally withdraws his or her appeal request and the appeal does not advance to hearing. The Exchange adopted the same timeframes of three business days for providing electronic notice of the informal resolution outcome to the appeals entity, and five business days for providing a written notice of the informal resolution outcome (including the effective date of such outcome) to the appellant for the same reasons stated above. This is necessary for clarity and consistency purposes. Subdivision (f)(3) of this section provides that if an appeal is dismissed pursuant to Section 6610, the informal resolution decision will be final and binding. This is necessary to comply with, and is substantively identical to, the federal requirements specified in 45 CFR Section 155.535(a)(4).

§ 6614. Hearing Requirements

Section 6614, in its entirety, implements, clarifies, and makes specific the requirements applicable to appellate hearings. It is necessary to specify and clarify the procedural rules that govern such hearings, to ensure due process for the appellants, and to comply with the mandatory requirements of 45 CFR Section 155.535(b) through (f).

Section 6614(a) clarifies and makes specific that an appellant shall have the opportunity for a hearing in accordance with the requirements of this section. This is necessary to specify and clarify that appellants have the right to a hearing, and to comply with the requirements of federal rules specified in 45 CFR Section 155.535(a), which requires the hearings to be conducted in accordance with that section. The Exchange does not have discretion to do otherwise.

Section 6614(b) clarifies and makes specific that when a hearing is scheduled, the appeals entity must send written notice to the appellant, and the appellant's authorized representative, if any, of the date, time, location, and format of the hearing no later than 15 days prior to the hearing date. This is necessary to comply with, and is substantively identical to, the requirements of federal rules specified in 45 CFR Section 155.535(b). The Exchange has no discretion to do otherwise.

Section 6614(c) clarifies and makes specific the requirements for the appeals entity to conduct a hearing. This section is necessary to comply with, and for the most part is substantively identical to, the requirements of federal rules specified in 45 CFR Section 155.535(c). However, in addition to the provisions required under that federal regulation, this section clarifies and makes specific the provisions of Section 155.535(c)(1) by requiring a hearing to be held within 90 days of the date on which a valid appeal is received and by expressly permitting hearings to be conducted by telephone, video conference, or in person, in accordance with Section 22-045.1 of the CDSS' Manual of Policies and Procedures. The Exchange chose to further clarify and make specific the requirements of Section 155.135(c) in order to afford appellants even faster resolution and to ensure them greater flexibility in presenting their appeals, and to coordinate its appeals process with the existing Medi-Cal appeals process.

Section 6614(d) sets forth the required opportunities the appeals entity must provide to the appellants. This is necessary to comply with, and is substantively identical to, the requirements of federal rules specified in 45 CFR Section 155.535(d). The Exchange does not have discretion to do otherwise.

Section 6614(e) and (f) clarify and make specific the information and evidence to be considered during the appeal and the standard of review. These provisions are necessary to comply with, and are substantively identical to, the requirements of the federal rules specified in 45 CFR Section 155.535(e) and (f). The Exchange does not have discretion to do otherwise.

Section 6614(g) clarifies and makes specific that postponements and continuances will be conducted in accordance with Section 22-053 of the CDSS' Manual of Policies and Procedures, which provides a reasonable standard under which to determine whether a postponement or continuance is appropriate. Section 22-053 specifies comprehensive standards under which postponements and continuances may be granted. The Exchange adopted that standard both to ensure maximal due process to appellants and to avoid the confusion and administrative burden that would be caused if it required its appeals entity to follow a different and unfamiliar standard. It also ensures an appeals process that is coordinated with the existing Medi-Cal appeals process, as required by the federal rules specified in 45 CFR Section 155.510.

§ 6616. Expedited Appeals

Section 6616, in its entirety, implements, clarifies, and makes specific the expedited appeals process. This is necessary to specify and clarify the procedural rules that govern expedited appeals, to ensure due process for the appellants who have immediate needs for health services and a standard appeal could jeopardize their life or

health or ability to attain, maintain, or regain maximum function. This is also necessary to comply with the mandatory requirements of 45 CFR Section 155.540.

Section 6616(a) requires the appeals entity to establish an expedited appeals process pursuant to which an appellant may request an expedited appeal where there is an immediate need for health services because the delay inherent in a standard appeal process could jeopardize the appellant's life or health or ability to attain, maintain, or regain maximum function. This is necessary to comply with, and is substantively identical to, the requirements of federal rules specified in 45 CFR Section 155.540(a). The Exchange does not have discretion to do otherwise.

Section 6616(b) establishes a process the appeals entity must follow if it denies a request for an expedited appeal, including notice requirements. It requires the appeals entity to conduct the appeal under the standard appeals process and to inform the appellant of the denial of a request for an expedited appeal through electronic or verbal notification, if possible, within three business days from the date of denial. If notification is verbal, the appeals entity must follow up with the appellant by written notice within five business days of the denial, unless a shorter timeframe is established by HHS. This is necessary to comply with, and is substantively identical to, the requirements of 45 CFR Section 155.540(b). The Exchange does not have discretion to do otherwise. The Exchange did, however, clarify and make specific the federal requirement of informing the appellant "promptly and without undue delay" by requiring such notice to be sent electronically or verbally "within three business days from the date of denial," and requiring a verbal notice to be followed by a written notice "within five business days of the denial." The Exchange established these timeframes based on the same timeframes the Exchange established for providing electronic and written notices throughout these proposed regulations for clarity and consistency purposes.

Section 6616(c) establishes a process, including notice requirements for the appellant, the Exchange and DHCS if the appeals entity grants the appellant's request for an expedited appeal. It requires the appeals entity to:

1. Provide the appellant with written notice within three business days from the date on which the appellant's request for an expedited appeal is granted:
    A. That his or her request for an expedited appeal is granted; and
    B. Of the date, time, and type of the hearing;
2. Ensure a hearing date is set within 10 calendar days from the date on which the appellant's request for an expedited appeal is granted; and
3. Provide notice via secure electronic interface to the Exchange and to the DHCS, as applicable, within three business days from the date on which the appellant's request for an expedited appeal is granted, specifying that the appellant's request for an expedited appeal is granted and a hearing will be set on an expedited basis.

After extensive consultation with CDSS and the stakeholders, the Exchange adopted the three-business-day timeframe for the appeals entity to send a written notice to the appellant. The 10-calendar-day timeframe for scheduling a hearing is adopted based on the existing CDSS' expedited appeals process used for Medi-Cal cases for clarity and consistency purposes, and to ensure a coordinated appeals process. This is necessary to ensure that an appellant granted an expedited appeal is given adequate notice to take advantage of such grant, and to provide timely notice to the Exchange and DHCS, if applicable, to prepare, and make available to the appellant, their statements of position and to prepare for the expedited hearing.

§ 6618. Appeals Decisions

Section 6618, in its entirety, implements, clarifies, and makes specific the requirements relating to the appeals decisions that the appeals entity issues. This is necessary to specify and clarify the procedural rules that govern the appeals decisions for the appellants. This is also necessary to comply with the mandatory requirements of 45 CFR Section 155.545.

Section 6618(a) clarifies and makes specific the requirements that the appeals entity's decisions must meet. This is necessary to comply with, and is substantively identical to, the requirements of federal rules specified in 45 CFR Section 155.545(a). The Exchange does not have discretion to do otherwise. However, in addition to the federal requirements, this subdivision requires that appeals decisions provide information about judicial review available to the appellant pursuant to the State law (Section 1094.5 of the California Code of Civil Procedure). The Exchange included this additional requirement, above and beyond the requirements of Section 155.545(a), to ensure that appellants are aware of their judicial rights both under the federal and State law.

Section 6618(b) clarifies and makes specific the appeals entity's notice requirements for the appellants, the Exchange, and DHCS. This is necessary to comply with, and for the most part is substantively identical to, the requirements of federal rules specified in 45 CFR Section 155.545 (b). The Exchange does not have discretion to deviate from the requirements of 45 CFR Section 155.545(b). The Exchange did, however, clarify and make specific that the federal rule (specified in 45 CFR Section 155.545(b)(2)) requiring the appeals entity to issue expedited appeals decisions "as expeditiously as reasonably possible" shall mean issuing such decisions "no later than five business days after the hearing, unless the appellant agrees to delay to submit additional documents for the appeals record." The Exchange adopted this timeframe based on the State law in Government Code, Section 100506.4(a)(1). This is necessary for clarity and consistency purposes and to comply with the State and federal rules.

Section 6618(c) requires the Exchange to promptly, but no later than 30 days from the date of the appeal decision, implement the appeal decision either prospectively or

retroactively, at the option of the appellant, and to redetermine the eligibility of the appellant's household members who are affected by the appeal decision, if applicable. After extensive consultation with the stakeholders, the Exchange adopted the 30-day timeframe based on the existing State law governing the implementation of Medi-Cal appeals decisions. This is necessary to comply with federal rules specified in 45 CFR Section 155.545(c) and to insure that the Exchange's appeals process is coordinated with the Medi-Cal appeals process, as required under the federal rules.

§ 6620. Appeal Record

Section 6620, in its entirety, implements, clarifies, and makes specific the rules regarding the appeal records. It requires the appeal entity to make the appeal record accessible to the appellant for at least five years after the date of the notice of appeal decision, as provided in Section 6618(b)(1), and to make the appeal record available to the public, subject to all applicable federal and State laws regarding privacy, confidentiality, disclosure and personally identifiable information. This is necessary to comply with, and is substantively identical to, the federal requirements specified in 45 CFR Section 155.550. The Exchange did, however, clarify and make specific that the appeals entity must make the appeal record accessible to the appellant "for at least five years after the date of the written notice of the appeal decision" to provide the appellants with clarity as to the length of time they have to access their appeal records.

§ 6622. Employer Appeals Process

Section 6622, in its entirety, applies to the employers appeals process through which an employer may, in response to a notice under §155.310(h), appeal a determination that the employer does not provide minimum essential coverage through an employer-sponsored plan or that the employer does provide that coverage but it is not affordable coverage with respect to an employee. The federal rules in 45 CFR § 155.555(b) provides an option for the Exchange to rely on HHS for providing an employer appeals process rather than establishing its own employer appeal process. After consultation with stakeholders, the Exchange chose to take this option Section 6622(a) provides that this section applies to this type of appeal. This is necessary to provide consumers and employers with clarity about how to begin the employer appeals process and to comply with the federal requirements specified in 45 CFR Section 155.555.

Section 6622(b) clarifies and makes specific that employers who seek an appeal must request such an appeal directly to HHS in accordance with the process specified in 45 CFR Section 155.555 and the process established by HHS. This is necessary to provide employers with clarity about the employer appeals process.

Section 6622(c) specifies the process of implementation of the federal employer appeal decision. The federal rules in 45 CFR § 155.555(l) provides an option for the Exchange to implement a federal appeal decision that affects the enrollee's/employee's eligibility promptly by either (1) redetermining the employee's eligibility and the eligibility of the employee's household members, if applicable, or (2) notifying the enrollee/employee of the requirement to report changes in eligibility. After consultation with stakeholders, the Exchange chose the second option, and therefore, specifies in this subdivision that the Exchange must, within 30 days from the date on which the Exchange receives the decision, notify the enrollee of the requirement to report changes in eligibility, as described in Section 6496(b) of Article 5 of this chapter. The Exchange chose this option because it is a more consumer protective approach, notifying the enrollee of the requirement to report the change and allowing them to voluntarily report their employer-sponsored coverage to the Exchange rather than the Exchange taking their financial assistance away without notifying them and giving them an opportunity to report a change. Further, this option is less administratively burdensome on the Exchange. This is necessary to provide consumers with clarity about the employer appeals process and the effects of the appeal decisions on their eligibility and enrollment. This is also necessary to comply with the federal requirements specified in 45 CFR Section 155.555(l).

STANDARDIZED REGULATORY IMPACT ASSESSMENT (SRIA)

A. SUMMARY

1. Statement of the Need of the Proposed Regulations

In March 2010, President Obama signed federal health reform legislation called the Patient Protection and Affordable Care Act, or "Affordable Care Act" (ACA). That same year, California chose to operate its own exchange as the California Legislature enacted and the governor signed legislation establishing the California Health Benefit Exchange (now also known as "Covered California") and its governing Board.[1] The enacting legislation required that the Exchange:

- Provide the public with clear standards and eligibility requirements to qualify for federal tax subsidies through the Exchange.
- Establish the criteria and process for eligibility determination, enrollment, and disenrollment of enrollees and potential enrollees in the Exchange.
- Establish a fair and efficient appeals process for prospective and current enrollees of the Exchange. More specifically, this action creates clear guidelines for the public to request and receive a fair hearing.

[1] Stats. 2010, ch. 659, section 2, (SB 900, [Alquist, Steinberg]); Stats 2010, ch. 655 (AB 1602, [Perez]).

The Eligibility and Enrollment in the Individual Market regulations establish the Exchange's policies and procedures for: (1) eligibility determination and redetermination; (2) enrollment in qualified health plans; (3) termination of coverage through the Exchange; and (4) an appeals process in the individual Exchange. They provide clear standards and eligibility requirements to qualify for federal tax subsidies through the Exchange and set out the standards and requirements for the qualified health plan issuers regarding enrollment of qualified individuals and termination of coverage for individuals who qualified through the Exchange.

2. Major Regulation Determination

The Overall economic impact these regulations will exceed $50 million each year beginning in 2014. The impacts are the result of changes in the shares of consumer spending devoted to health insurance, healthcare services, and all other categories as well as changes in health insurance company margins and state government spending.

3. Economic Baseline

The proposed regulations were not needed prior to federal health reform legislation passed in 2010. The Exchange opened in October 2013 and its first policies became effective January 1, 2014. Prior to that date, health insurance consumers had no access to a statewide health insurance marketplace nor were federal subsidies available. For a variety of reasons, including its prohibitive cost, approximately 5 million California residents lacked health insurance. Prior to the opening of the Exchange, health insurance was acquired by individuals from insurance companies directly or through agents, as a benefit of employment, or through a public program such as Medi-Cal.

The provision of federal Advance Premium Tax Credits (APTC) greatly improved the affordability of individual health insurance. The proposed regulations establish the criteria that determine which individuals are eligible for APTC and have been in place since October of 2013. It is important to note that APTC is only available through health insurance exchanges, which is the primary driver leading to the reduction in the number of uninsured Californians attributable to the Exchange.

Since 2013, the rate of the uninsured in California has dropped by more than half, from 17 percent to 6.8 percent in 2017 – a record low for California, according to data from the U.S. Centers for Disease Control. The decrease in the uninsured was due to both the Medicaid expansion and the establishment of the Exchange under the Affordable Care Act, which was facilitated through robust marketing and outreach to the uninsured. More than 3.6 million people have purchased health insurance through Covered California since the its launch. The regulations provide the ongoing framework for this by ensuring that individuals who need help to afford health insurance continue to get the coverage they need.

4. Public Outreach and Input

In the process of developing these regulations, the Exchange met with the Department of Health Care Services and stakeholder groups. The regulations were discussed and approved in publicly held, duly noticed meetings of the California Health Exchange Board where interested members of the public were given the opportunity to offer suggestions and comments. In conjunction with these meetings, the regulations were posted on the Exchange's web site. The proposed regulations reflect comments received from a variety of affected parties.

B. BENEFITS

The ACA has made it possible for millions of Americans to receive health care who could not previously afford it. The proposed regulations facilitate the purchase of qualified health plans through California's marketplace by individuals, most of whom are eligible for federal subsidies to offset a portion of their premiums. Expanded health coverage will improve access to quality health care for nonelderly California adults, thereby helping to save lives and increase the overall health of the public in California.

Expanding healthcare coverage through Covered California will decrease the cost for health care in California by increasing preventative care and providing health care access to more Californians. This will reduce health care costs overall and allow funds that would otherwise be spent on emergency room visits and sick patient care to be spent in other ways that benefit the health and welfare of California residents, worker safety, the environment, or on other state priorities.

Enrolling for health insurance coverage through Covered California is principally determined by a complex decision making process by individuals and firms who are influenced by four principle factors.

- First, given that employer sponsored insurance (ESI) accounts for over half of all forms of health insurance coverage, the choice of employers to offer health insurance and of employees to take up those offers is a substantial determinant of demand for individual policies, including those offered on the Exchange (see Table 1 below). Economic conditions and labor market conditions in particular can also impact the aggregate availability of ESI offers.
- Since affordability is a dominant factor for individuals that may consider purchasing coverage directly on the individual market, the provision of financial assistance by the ACA, which is only available with policies sold on the Exchange, will strongly influence take up of Exchange policies. This financial assistance is provided on a sliding scale based on each applicant's household income based on Modified Adjusted Gross Income (MAGI). Thus, similar to offers of ESI, changes in the economy, such as increases in the minimum wage, that affect family incomes will drive changes in the number of individuals eligible for assistance.

- Eligibility for no-cost Medi-Cal coverage makes that a more attractive alternative for families with income below 138 percent of the federal poverty level.
- Lastly, through 2018, most individuals who did not purchase qualified health insurance coverage through enrollment in Medicaid, Medicare, Children's Health Insurance Plan (CHIP), employer-based, or individually-purchased insurance plans faced the prospect of gradually rising federal penalties that reached $695 per person (up to a maximum of $2,085 per family) or 2.5 percent of taxable income in 2016.

A more extensive description of how these, and other factors, interact to determine the level of take up of various forms of health insurance in California as a result of the implementation of the ACA can be found in California Simulation of Insurance Markets (CalSIM) Version 1.8, Methodology & Assumptions.[2]

1. Individuals

The financial benefit of these regulations for individuals who enroll for coverage through the Exchange is related to their prior health insurance status and their eligibility for federal subsidies. Enrollees who were previously uninsured will now have better and more timely access to healthcare. Enrollees who were previously insured and now receive a federal subsidy will spend less on health insurance, which allows them to spend more on non-health insurance goods and services. The spending shift is equal to the subsidies received. Spending by enrollees who were previously insured but did not receive a federal subsidy will be unchanged.

The implementation of the ACA has significantly reduced the number of Californians who lack health insurance, both by increasing coverage by Medi-Cal and by enrollment through the Exchange. Table 1 below provides a detailed breakdown of the types of coverage used by Californians under the age of 65, which indicates that the use of ESI remains the dominant source of insurance coverage.

Table 1
Types of Coverage for Californians under Age 65
2016 (Millions of Persons)

Employer Sponsored Insurance (ESI)	15.96
Medi-Cal	11.38
Other Public[1]	0.70
Individual Market	
On Exchange with Subsidies	1.16
On Exchange without Subsidies	0.15
Off Exchange	0.96
Uninsured	2.81

Source: 2016 California Health Interview Survey

[1] Inclusive of TRI-CARE, Healthy Kids, Indian Health Services, and other military/veterans programs.

[2] Available at http://healthpolicy.ucla.edu/publications/Documents/PDF/calsim_methods.pdf

In the absence of state based marketplace regulations, the take-up of insurance by those who were uninsured prior to 2014 would be significantly lower. By 2016, the Exchange achieved a take-up rate among individuals eligible for APTCs that was nearly 25 percent higher than the average for states with access only to the Federally Facilitated Marketplace.[3]

But this increased take-up rate may be more attributable to the Exchange's robust and successful outreach and marketing campaign than the proposed regulations. The reason for this is likely that the proposed regulations, which determine the extent to which uninsured Californians were eligible to purchase insurance, for the most part must adhere to federal requirements. With a few exceptions, such as those noted in section E. ALTERNATIVES below, California's eligibility standards mirror federal eligibility criteria.

Although the proposed regulations establish the eligibility and enrollment standards to enroll in health insurance coverage through the Exchange, the ACA also provided state-based marketplaces with full discretion on how to market the Exchange to its own state-specific market conditions. Most significant for the Exchange was the implementation of very robust outreach and marketing efforts that resulted in not only more enrollees, but healthier enrollees, which in turn translated into lower statewide premiums than would have been charged otherwise. The 2017 report, *MARKETING MATTERS: Lessons From California to promote Stability and Lower Costs in National and State Individual Insurance Markets*, provides an overview of California's marketing and outreach experience, strategy and tactics as well as its impact on enrollment and premiums.

2. Businesses

Health Insurance Carriers

Carriers that participate in the Exchange will have access to previously uninsured participants and associated premium revenue streams.

Healthcare Providers

Providers of healthcare goods and services will see increased revenue from the expansion of the number of individuals with health coverage.

C. COSTS

1. Individuals

[3] MARKETING MATTERS: Lessons From California to Promote Stability and Lower Costs in National and State Individual Insurance Markets, September 2017

Individuals who purchase insurance on the Exchange who were previously uninsured will reduce their spending on goods and services not related to health insurance and healthcare. The reduction will be equal to the amount of the unsubsidized portion of their premiums and their additional out-of-pocket healthcare spending based on the actuarial value of the policies purchased.

2. Businesses

The proposed regulations impose no direct costs on businesses. Indirectly, businesses outside of the health insurance and healthcare industries will see a reduction in spending on the part of newly insured individuals equal to their new premiums (net of subsidies) and additional out-of-pocket healthcare spending.

D. ECONOMIC IMPACTS

1. Economic Analysis Methodology

The REMI model of the California economy was used to assess economic impacts of the proposed regulations. The annual changes to consumer and healthcare spending beginning in 2014 were entered into the model. Multiple sectors are directly impacted: pharmaceuticals, health care, physician services, dental services, paramedical services, hospitals, nursing homes, health insurance, and state government. The spending impacts were apportioned to these sectors based on premiums paid, out-of-pocket healthcare spending, and federal subsidies paid.

2. Inputs and Assumptions

Enrollment in Exchange policies will have positive and negative impacts on spending on consumer goods and services and on spending in the healthcare and finance sectors. The overall economic impact of these regulations will be determined by the number and type of persons who enroll and pay for insurance coverage through the Exchange. Enrollees consist of those that are eligible for and received federal subsidies and those that do not. Within each of these groups are those that previously had health insurance and those that didn't. The direct economic impact of this enrollment is reflected in the value of the policies sold to these groups and depends on (1) the premiums paid for the policies, (2) the extent to which the people covered by these policies were previously insured and (3) what share of the premiums paid were offset by federal Advance Premium Tax Credits (APTC).

i. *Enrollment and Payments*

The impact of these regulations is fundamentally determined by the level and nature of enrollment in health plans sold through the Exchange. After the completion of its second open enrollment, 1.3 million Californians had purchased health insurance

through the Exchange. The vast majority of the enrollees reported income levels that made them eligible for financial assistance—earning from 138 percent to 400 percent of the federal poverty level. Silver tier plans were the most popular, accounting for nearly two-thirds of plans selected. Half of all enrollees range from 45 to 64 years of age. The geographic distribution of Exchange enrollees closely mirrors that of the California population as a whole. Appendices 1 through 4 on pages 12 through 17 contain more information on Exchange enrollees. Appendix 6 provides a breakdown of the Covered California enrollment in 2017 by region, plan type and carrier.

Table 2 details the Health Plan Premiums paid during 2016 during which enrollees paid $6.5 billion for health insurance premiums, $5.8 billion of which was paid by those who received federal subsidizes. Of the latter amount, $4.2 billion was offset by APTC, with the remaining $1.6 billion was paid directly by subsidized enrollees. In addition, $724 million was paid as Cost Sharing Reductions (CSR) to reduce out-of-pocket expenses paid by subsidized enrollees for expenses such as copayments and deductibles.

Table 2
2016 Covered California Healthplan Premiums
$Millions

	All	Previously Insured	Previously Uninsured
Subsidized	$5,772	$4,423	$1,349
Un-Subsidized	$735	$563	$172
Total	**$6,508**	**$4,986**	**$1,521**
APTC Recieved	$4,201	$3,219	$982
Net Subsidized Premiums	$1,572	$1,204	$367
CSR	$724	$555	$169

Table 3
APTC Payments by Federal Poverty Level
2016 ($Millions)

138% FPL or less	$	89
138% FPL to 250% FPL	$	3,320
250% FPL to 400% FPL	$	783
400% FPL or greater	$	6
FPL Unavailable	$	1
Unsubsidized Application	$	1
Total	**$**	**4,202**

The Medical Loss Ratio provision of the ACA requires insurance companies to spend at least 80 percent of premium payments on medical care. Expenses such as administrative costs (including the PMPM) and profits, including executive salaries, overhead, and marketing must be paid out the remaining 20 percent. In 2016, health

plans paid approximately $219 million to the Exchange in the form of a Per Member Per Month fee (PMPM).

ii. Modeling Impacts in REMI

Consumer spending not related to healthcare

Spending on goods and services not related to health insurance and healthcare in 2016 increased by $2,687 million. Enrollees who were previously uninsured reduced their spending by the amount spent on the unsubsidized portion of their premiums and the additional out-of-pocket healthcare spending[4] in 2016—$914 million. Enrollees who previously had health insurance could increase spending not related to health insurance and healthcare by the amount of subsidies received and cost sharing reductions paid—$3,773 million.

Healthcare and State Government Spending

Spending on health insurance increased by $1.5 billion, which was equal to the amount of premiums paid by enrollees who were not previously insured. In accordance with the ACA, 80 percent of those premiums, or $1,217 million, was spent on healthcare goods and services. The remaining premium revenues could be used to pay for administration, marketing, and profits, which includes fees paid to marketplaces. After paying PMPMs to the Exchange, Net Insurance spending increased $85 million. An additional $548 million was spent on healthcare goods and services in the form of additional out-of-pocket healthcare spending by those who were not previously insured. Thus overall spending on healthcare goods and services in 2016 increased $1,764 million.

Table 4 shows the estimated annual spending impacts to the affected sectors using the REMI model. The total increase in spending on healthcare goods and services represents the total increase in healthcare spending resulting from the expansion of health insurance enrollment facilitated by the Exchange. This increase was distributed across the healthcare subsectors based on the relative size of these sectors according to REMI model baseline data for 2016.

[4] Based on the actuarial value of the policies purchased

Table 4
2016 Spending Impacts from Enrollment in the Exchange

Component	REMI Category	Amount $Millions
Net increase in consumer spending not related to health insurance and healthcare by individuals who were previously uninsured.[1]	Consumer Spending (excluding healthcare goods and services)	$2,687
Increased spending on healthcare goods and services	Consumer Spending (healthcare)	
	Physician services	$420
	Dental services	$92
	Paramedical services	$295
	Hospitals	$809
	Nursing homes	$148
	Total	$1,764
Per Member Per Month fees paid to the Exchange	State Government Spending	$219
Increased health plan spending on administration, marketing, and profits (less PMPM fees)	Net health insurance	$85

[1] Additional consumer spending by the previously insured who now receive subsidies net of reduction in non-health insurance spending by those previously uninsured.

These impacts were projected from 2016 through 2020 based on the assumptions that (1) total enrollment through the Exchange remains stable at approximately 1.3 million from 2016 to 2020[5], (2) that premiums increase 6.7 percent per year on average over the same period and (3) that the ratios of spending between these sectors remains constant.

3. Impact Assessment Results

i. Competitiveness

When comparing the competitive advantage of businesses outside of California to those in California, no direct impact is projected. All of the significant effects of enrollment in individual policies sold through the Exchange will apply to all states, even those that do not operate their own exchanges. The Eligibility and Enrollment regulations will align the policies and procedures of the Health Benefit Exchange with Federal standards and are designed in such a way to preserve competitiveness and market stability.

ii. Job Impacts in California

The implementation of these regulations will have both positive and negative impacts on employment in California, but will generate an overall net positive employment impact. As modeled, total employment increased 77,000 in 2016 and an increase of about 103,900 is expected in 2020. The cumulative total over the five years is an increase of about 466,000 jobs.

[5] Appendix 6 describes the Exchange's forecast methodology used to derive these enrollment projections.

iii. California Business Impacts

Since the proposed regulations only pertain to enrollment in individual health insurance policies, they will not directly result in the creation or elimination of businesses. Indirectly however, the enrollment for health insurance through the Exchange, part of which will be subsidized by the federal government, will result in additional consumer spending overall. It will also alter the mix of spending between healthcare providers, health insurance carriers and providers of other categories of consumer goods and services. In addition, the establishment and growth of a health insurance exchange in the nation's most populous state will likely attract insurance carriers who did not previously sell policies in California.

iv. Investment and Incentives

These regulations do not require or mandate any additional investment from individuals or businesses. Any additional investment in the state would be an indirect effect of induced changes in medical care and consumer spending. As modeled, private investment in California increased $1,304 billion in 2016 and is expected to increase $2,124 billion in 2020. The cumulative total over the five years is an increase of $9,380 billion.

v. Personal Income

The direct and indirect impacts of the changes in the affected economic sectors also led to changes in personal income: an increase of $4,735 billion in 2016 and an expected increase of $8,751 billion in 2020. The cumulative total over the five years is an increase of $34,642 billion.

vi. Gross State Product

Increased access to affordable health insurance in California had a positive impact on Gross State Product of $6,321 billion in 2016 and an expected increase of $8,921 billion in 2020. The cumulative total over the five years is an increase of $39,093 billion.

vii. Incentives for Innovation in Products, Materials, or Processes

Improved access to affordable individual health insurance coverage will create new opportunities for individuals and businesses. Since individual health insurance will now be more readily available, the reluctance to leave a job due to uncertainties related to healthcare coverage will diminish. The dependence on employer supplied insurance (ESI) has long been thought to be a source of labor market inefficiencies[6].

Dependence on affordable health insurance creates a substantial inhibition for workers with jobs they are not satisfied with or where their skills are not a good fit to seek other employment opportunities. Research suggests that the dependence on ESI may

[6] Dean Baker, AARP Public Policy Institute, Job Lock and Employer-Provided Health Insurance: Evidence from the Literature, March 2015

reduce turnover among make workers by as much as 15–25 percent for men in the absence of affordable insurance alternatives. Without an affordable source of individual health insurance, such as that offered on the Exchange, workers are discouraged from seeking new jobs at which they will be more productive and paid more or from starting a business.

In addition to improved access to affordable insurance, the ACA implemented various measures to control the cost of healthcare itself. It simplified various administrative processes that will reduce paperwork and create uniform electronic standards and operating rules used by private insurers, Medicare, and Medicaid that may save the federal government as much as $20 billion over 10 years. At the same time the federal government made complimentary investments in health information technology. "Electronic health records will supply providers with more accurate and real-time data on their patients, as well as provide checks on drug interactions and decision support to improve the quality of care." The ACA created, the Patient-Centered Outcomes Research Institute (PCORI) that "will empower physicians and patients with new information regarding the effectiveness of various medical technologies and interventions. The integration of the PCORI's research findings with decision supports, guidelines, and other aspects of electronic health records should greatly enhance the information that physicians and patients can use in choosing the right tests and treatments for a particular situation." It also created incentives for physicians and hospitals to coordinate care for patients with chronic illnesses, such as congestive heart failure, diabetes, and hypertension.

4. Summary and Interpretation of Economic Impacts

As modeled, these regulations will likely improve the California economy. Significant increases in Gross State Product, investment and personal income will lead to positive impacts throughout the economy. Table 5 provides a summary of the impacts on employment, investment and incentives, personal income, and Gross State Product detailed above.

Table 5
Difference compared to Conforming California Forecast based on REMI Simulation Analysis

Category	2016	2017	2018	2019	2020	Cumulative
Total Employment *1,000s of Jobs*	77.0	88.5	95.3	101.2	103.9	466.0
Gross Private Domestic Fixed Investment *Billions of Fixed (2009) Dollars*	$1.304	$1.800	$2.024	$2.127	$2.124	$9.380
Personal Income *Billions of Current Dollars*	$4.735	$6.090	$7.047	$8.019	$8.751	$34.642
Gross Domestic Product *Billions of Fixed (2009) Dollars*	$6.321	$7.317	$7.965	$8.569	$8.921	$39.093

5. Federal Policy Uncertainties

Beginning with the change in the federal administration, there have been ongoing discussions and legislative proposals about repealing, replacing or making substantial changes to the Patient Protection and Affordable Care Act. These actions create a great deal of uncertainty about future enrollment in Covered California policies and thus and the level of premium payments and federal tax credits that will flow into the California economy.

Of the proposed policy changes, the elimination of the individual mandate would have the most negative short-term impact on enrollment with Covered California. The Federal Tax Reform act that passed both houses of Congress and has been (as of this writing) sent to the President's desk for signature repeals the individual mandate beginning in 2019. This could lead open enrollment and special enrollment plan selections to drop significantly, leading to a decline in enrollment potentially in excess of 400,000. Additionally, the losses would be weighted to individuals with better health status, which would lead to a deterioration in the risk mix and an increase in premiums up to 25%. While this would have substantial negative impacts on the hundreds of thousands of Californians who would either choose to or would be forced to go without coverage, the resultant rise in premiums caused by a deterioration of the risk mix would to some extent be offset by increased APTC payments which are adjusted in concert with benchmark Silver Plan premiums.

Beyond the Tax Bill, the most prominent other proposals to modify and stabilize ACA health exchange markets are included in The Bipartisan Health Care Stabilization Act of 2017. If enacted, this legislation would (1) fund the ACA's cost sharing reduction (CSR) subsidy payments to insurers; (2) streamline approval and relax affordability guidelines for 1332 Waivers; (3) add catastrophic "copper plans; (4) compel HHS to issue regulations on selling insurance across state lines; and (5) fund consumer outreach initiatives and state reinsurance programs. The principle provisions[7] included as of mid-December 2017 are as follows:

Allow States to Offer Value-Based Insurance Plans:

- *Creates more flexibility for states in the 1332 "guardrail" on affordability to allow for more variation in cost sharing and other health plan design elements, with protections for vulnerable and low-income populations and people with serious health conditions.*
- *Would not diminish existing patient protections under the Affordable Care Act (ACA), including the prohibition on charging more for pre-existing conditions, guaranteed issue, adult child coverage up to age 26, and the prohibition on annual and lifetime limits.*

[7] https://www.help.senate.gov/imo/media/doc/THE%20BIPARTISAN%20HEALTH%20CARE%20STABILIZATION%20ACT%20OF%202017-%20SECTION%20BY%20SECTION.pdf

More Funding Options:

- *Clarifies that states can opt to redirect a portion of their premium tax credits, cost sharing reductions, small business tax credits, and Basic Health Program funds to use for programs like reinsurance or invisible high-risk pools.*
- *Clarifies the "budget neutrality" test is over the entire term of a waiver and the required 10-year budget plan instead of expecting budget neutrality in the first year or every year under a waiver.*
- *Fixes the "double cap" by allowing the Secretary of Health and Human Services (HHS) to take into consideration the effect of the 1332 waiver on other federal programs when calculating deficit neutrality.*
- *Allows funds from the ACA Basic Health Program to be used towards a 1332 waiver and allow 1332 pass-through funding to be used for a Basic Health Program, making it easier for states with a Basic Health Plan to get a waiver.*

Streamlined 1332 Waiver Application Process:

- *Allows Governors to use their existing executive authority to apply for a waiver without needing additional state legislation.*
- *Reduces the HHS review period from 180 days to 90 days.*
- *Establishes a fast-track 45-day approval process, while maintaining the same approval standard as for other waivers, for waivers submitted in response to an urgent situation in a state, such as the risk of "bare counties" or excessive premium increases, or waivers that are the same or similar to a waiver that has already been approved for another state. Waivers granted for urgent situations will be granted three-year provisional approval, with the option to extend, subject to approval.*
- *Requires HHS to create a menu of waiver options that can help states receive approval faster.*
- *More Certainty for States After a Waiver is Approved:*
- *Waivers would be for 6 years, unless a shorter waiver is requested by a state. This is an increase from a current maximum period of 5 years.*
- *Creates unlimited 6-year renewals of a waiver, subject to approval of the renewal.*
- *Prohibits the Secretary of HHS from suspending or terminating a waiver unless the Secretary determines that the state materially failed to comply with the terms and conditions of the waiver.*

Cost Sharing Payments.

- *Appropriates cost sharing reduction subsidies (CSRs) for 2017, 2018, and 2019.*
- *To prevent "double dipping" by insurance companies, requires states to certify that qualified health plan issuers that receive cost sharing reduction subsidy payments after rates are filed for 2018 will ensure that consumers and the Federal Government receive a financial benefit.*

Allow All Individuals to Purchase a Lower-Premium "Copper" Plan in the Individual Market.

- *Under current law, only individuals who are under the age of 30 or who meet a hardship exemption are allowed to purchase a lower premium "copper plan," which is also known as a catastrophic health plan.*
- *Section 4 allows anyone to purchase a copper plan, regardless of age or hardship status.*
- *These plans would be sold in the same risk pool as other metal-level plans.*
- *Copper plans would still be subject to same rules on out-of-pocket cost caps and benefits as catastrophic plans under current law.*

Consumer Outreach, Education, and Assistance.

- *Requires HHS to report on consumer outreach, education, and assistance activities.*
- *Allows HHS to contract with states to conduct outreach and enrollment activities funded by existing user fees designated for these activities.*
- *For plan years 2018 and 2019, requires HHS to fund outreach and enrollment activities using $106 million from existing user fees at the level designated for these activities in the 2018 benefit rule.*

Offering Health Plans in More than One State.

- *Requires HHS to promulgate regulations for the implementation of Health Care Choice Compacts established under section 1333 of the ACA, which would allow plans to be sold across state lines in the individual or small group market.*

E. ALTERNATIVES

State law created the California Health Benefit Exchange and the Health Benefit Exchange Board thereby codifying the establishment of a state-based exchange in California consistent with the federal Affordable Care Act. It also expressly requires the Exchange to adopt all of the requirements of the federal ACA and the requirements

contained in federal guidance and regulations. With these mandates to adhere to federal law and regulations, the Exchange had no ability implement alternative approaches in general, and had only limited opportunities to consider alternative approaches to specific provisions within the regulations.

Given these constraints, there are very few instances in these regulations where the Exchange exercised its discretion to adopt requirements in the absence of strict federal guidance. Nearly all of these cases involve administrative requirements that have no effective impact on the value of policies offered or the number of policies sold.

1. Alternative 1: Do not expand definition of Other Qualifying Life Event to include "Victims of domestic abuse and spousal abandonment"

The imposition of guaranteed issue on insurance carriers in 2014, created the possibility for consumers to sign up and pay premiums only when they needed medical treatment. To ensure healthcare cost stability and predictability, consumers must experience a "qualifying life event" (QLE) to be eligible to enroll in coverage outside of Covered California's open-enrollment period. When enrolling outside of open enrollment, consumers must certify that they have experienced one of several events in order to obtain coverage.

While Covered California's QLEs largely conform to federal guidelines, the Exchange was given the option to expand the definition of Other Qualifying Life Event to include "*Victims of domestic abuse and spousal abandonment.*" The Exchange adopted this option which will entitle more individuals to enroll through the Exchange than if it had not.

i. Costs and Benefits

Alternative 1 results in less enrollment through the Exchange which would reduce the benefits of expanded insurance coverage but would also enhance the stability of the insurance risk pool during special enrollment periods and reduce the number of applications processed by the Exchange and the carriers. According to U.S. Department of Justice Special Report Nonfatal Domestic Violence, 2003–2012, April 2014, "*serious violence by immediate family members fluctuated between 0.3 and 0.6 per 1,000 from 2003 to 2012.*" During the 2016 Special Enrollment period, there were 22,700 enrollments allowed under Other Qualifying Life Event.[8] Thus in 2016, between 700 and 1,300 enrollments may have occurred for this reason.

ii. Economic Impacts

As modeled, Alternative 1 would lead to a 0.13% reduction in enrollment and would thus lead to a very small reduction in the estimated economic impact. Compared to the baseline estimate, from 2016 through 2020, estimated employment gains would be

[8] Includes "Null" reason code.

reduced by 274,000 jobs, private investment gains by $5.4 billion, income gains by $19 billion, and state GDP gains by $23 billion.

iii. Reason for Rejection

Alternative 1 was rejected because it would have led to less enrollment on the Exchange, whose mission is to increase the number of insured Californians. Lower enrollment would also lead to reduced economic benefits for California. The potential marginal additional stability for the risk pool and cost savings from processing fewer applications is far outweighed by the benefits of additional enrollment.

2. Alternative 2: Adopt Minimum Grace Period for Incomplete Applications

In order to assess an applicant's eligibility to enroll on the Exchange and eligibility for financial assistance, applicants are asked to supply various pieces of personal information. Since many enrollment actions are executed via the Exchange's web site (www.coveredca.com) or by a phone call to a service center, it would be unrealistic to expect each and every applicant to be able to immediately supply all information requested in real time. Therefore a grace period was granted for enrollees to supply missing information after their applications were submitted. If the missing information is not supplied during the grace period, their coverage would be terminated.

The Exchange was given the option to set the grace period for applicants who submit incomplete applications to provide the missing information. The regulations allow applicants 90 calendar days from the date they were notified that their application was incomplete to provide the missing information or until the end of the relevant enrollment period but no less than 30 days from the date of the incomplete application notice. Federal regulations allow the Exchange to set the grace period from as little as 10 calendar days to as much as 90 days from the date of the incomplete application notice.

i. Costs and Benefits

During 2014[9], an estimated 42,500 incomplete applications were received, of which 30,700 were completed within 10 days and another 18,900 were completed within 90 days. On average each application received in 2014 represented 1.3 enrollees. Thus, limiting the grace period to 10 days would have reduced enrollment by 24,600. Since potential enrollees who submit incomplete applications can ultimately be enrolled if the missing information is supplied, their applications must be retained and tracked during the grace period. Restricting the duration of the grace period could potentially reduce the quantity of incomplete application files the Exchange must store.

ii. Economic Impacts

As modeled, Alternative 2 would lead to a 2.6% reduction in enrollment and would thus lead to a very small reduction in the estimated economic impact. Compared to the

[9] The latest date that information is available.

baseline estimate, from 2016 through 2020, estimated employment gains would be reduced by 273,000 jobs, private investment gains by $5.4 billion, income gains by $18.7 billion, and state GDP gains by $23 billion.

iii. Reason for Rejection

Alternative 2 was rejected because it would have led to less enrollment on the Exchange, whose mission is to increase the number of insured Californians. Lower enrollment would also lead to reduced economic benefits for California. The potential administrative cost savings from maintaining fewer incomplete applications is far outweighed by the benefits of additional enrollment.

F. FISCAL IMPACTS

1. Local Government

The proposed regulations do not affect local government.

2. Covered California

California chose to operate its own exchange (”marketplace”) thereby creating Covered California and its governing Board. The Exchange will be funded through a combination of federal grant funds and policy assessments on an ongoing basis. No state California General Fund money can be used to support the Exchange. No liability incurred by the Exchange or any of its officers or employees may be satisfied using moneys from the General Fund.

3. Other State Agencies

Covered California interacts with a number of state publicly funded health programs which include the Department of Social Services, the Office of Systems Integration/Department of Health Care Services, the California Department of Insurance, and the Department of Managed Health Care. Typically these interactions are funded through reimbursement agreements or interagency agreements. Covered California utilizes the Health Care Trust Fund with resources largely assessed on premiums to pay interagency agreement costs. In total, the amount budgeted for FY 2017-18 is $42.5 million paid from the Health Care Trust Fund from assessments levied on insurance premiums.

i. Department of Social Services

Government Code Section 100506.3 requires the Board to enter into a contract with the State Department of Social Services to serve as the Exchange appeals entity to hear appeals as specified. For FY 2017-18 Covered California has budgeted approximately $11.4 million for work associated with appeals provided by Department of Social Services. To the extent there are more or less appeals in the future, the interagency agreement will be amended to adjust costs as appropriate.

In addition to appeals, the Exchange has also budgeted approximately $3 million for a separate contract with California Department of Social Services for the purpose of reimbursing the Department of Social Services for a designated portion of the total application maintenance costs for the Statewide Automated Welfare Systems (SAWS)/California Health Care Eligibility, Enrollment & Retention System (CALHEERS) interface.

ii. Department of Managed Health Care/California Department of Insurance

Regulation and oversight of health insurance in California is performed by two departments: the Department of Managed Health Care (which primarily regulates health maintenance organizations) and the California Department of Insurance (which regulates traditional health insurance.) Most of the Health Plans offered through Covered California are regulated by the Department of Managed Health Care. Both Departments license and review rates for health plans under their jurisdiction. Health plans are required to apply for and maintain a license to operate as a health plan in California. The Departments review all aspects of the plan's operations to ensure compliance with California law. This includes, but is not limited to, Evidences of Coverage, contracts with doctors and hospitals, provider networks, and complaint and grievance systems. Additionally, the Departments review proposed premium rate increases to make sure health plans are providing detailed information to the public to justify proposed increases. While the Departments do not have the authority to deny rate increases, their efforts improve accountability in health plan rate setting. The Departments incurs costs for licensing and rate review for Covered California plans. Those costs are funded by fees assessed on plans by the Departments.

iii. Office of Systems Integration

Government Code Section 100503 requires the board to determine the criteria and process for eligibility, enrollment, and disenrollment of enrollees and potential enrollees in the Exchange and coordinate that process with state and local government entities administering other health care coverage as specified. Through interagency agreements between the Office of Systems Integration and, Covered California and the Department of Health Care Services, the State of California operates the California Health Care Eligibility, Enrollment, and Retention System (CalHEERS). This system serves as the consolidated system support for eligibility, enrollment, and retention for Covered California, Medi-Cal, and Healthy Families. As authorized by the Center for Medicaid Services (CMS), funding for the CalHEERS system is cost allocated with Covered California proposing to pay 12.1 percent and Department of Health Care Services paying 87.9 percent for FFY 2017-18. The Department of Health Care Services uses a combination of Federal Funds and State General Fund to pay their share. For FY 2017-18 Covered California has budgeted $31.4 million to reimburse the California Office of Systems Integration for CalHEERS and other system related costs. As total project costs change and membership changes in the future, adjustments will be made to the cost allocation as necessary.

iv. Department of Health Care Services

Covered California has a number of interagency agreements and relationships with the Department of Health Care Services. These include an interagency agreement for a timekeeping system ($115,000); access to the Medi-Cal Eligibility Data System (MEDS) ($3,000); and support in detecting, investigating and prosecuting fraud and abuse ($50,000).

In addition, Government Code Section 100504(a)(7) authorizes the Board to collaborate with the state Department of Health Services to the extent possible to allow an individual the option to remain enrolled with his or her carrier and provider network in the event the individual experiences a loss of eligibility of premium tax credits and becomes eligible for the Medi-Cal program or, loses eligibility for the Medi-Cal program or the Healthy Families Program and becomes eligible for premium tax credits through the exchange. Covered California and Medi-Cal have and continue to work collaboratively on transitioning consumers from one program to the other.

Furthermore when consumers determine eligibility for Medi-Cal, some will likely be determined eligible for Covered California and conversely when consumers determine eligibility for Covered California some will likely be determined eligible for Medi-Cal.

Covered California supports enrollees who are members of families or households in which other members are eligible for and receive health insurance from the state's Medi-Cal program. From 10 to 20 percent of Covered California enrollees are members of these mixed cases and present an additional workload on county eligibility workers. Medi-Cal recipients are subject to an annual recertification or renewal process that is spread evenly throughout each calendar year. Covered California's annual open enrollment period, in contrast, is limited to a few specific Open Enrollment months each year during which all of these mixed household cases are reevaluated for eligibility for Medi-Cal. This results in a very large unseasonal volume of mixed case Medi-Cal redeterminations and increased workload for local eligibility workers.

v. Employment Development Department

The Employment Development Department (EDD) provides inserting and mailing services for Covered California. Covered California provides and insert for inclusion into existing Unemployment Insurance program jobs and mailed to approximately 4.7 million recipients. The FY 2017-18 budget for these services is $87,000.

G. APPENDICES

See Appendix 1 through Appendix 6 on pages 14-45 of the attached SRIA (Attachment 1).

ADVISORY GROUP OR OTHER AGENCY COMMENT, CONSULTATION AND/OR APPROVAL

The Exchange met with the Department of Health Care Services and stakeholder groups in advance of proposing this permanent regulatory action.

TECHNICAL, THEORETICAL, AND/OR EMPIRICAL STUDY, REPORTS OR DOCUMENTS RELIED UPON

U.S. Department of Justice Special Report Nonfatal Domestic Violence, 2003–2012, April 2014, "*serious violence by immediate family members fluctuated between 0.3 and 0.6 per 1,000" from 2003 to 2012.*"
Covered California September 2017 Report, "*MARKETING MATTERS: Lessons From California to promote Stability and Lower Costs in National and State Individual Insurance Markets.*"
Covered California January 18, 2018 Report, "*The Roller Coaster Continues — The Prospect for Individual Health Insurance Markets Nationally for 2019: Risk Factors, Uncertainty and Potential Benefits of Stabilizing Policies.*"

SIGNIFICANT, STATEWIDE ADVERSE ECONOMIC IMPACT DIRECTLY AFFECTING BUSINESS

As evidenced by the SRIA included 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.

BENEFITS

Anticipated benefits including nonmonetary benefits to the protection of public health and safety, worker safety, the environment, the prevention of discrimination, or the promotion of fairness or social equity, from this proposed regulatory action are:

- Making quality health care available to all Californians;
- Providing structure for the Exchange to give predictability and clear standards to the public and qualified health plan issuers now and into the future;
- Providing the public with clear standards and eligibility requirements to qualify for federal tax subsidies through the Exchange;
- Establishing the criteria and process for eligibility determination, enrollment, and disenrollment of enrollees and potential enrollees in the Exchange;
- Establishing an appeals process for prospective and current enrollees of the Exchange and thereby providing due process to applicants denied insurance or with other appealable rights. More specifically, this action includes clear guidelines for the public to request and receive a fair hearing;
- Aligning California's regulations with the federal act and complying with state law;

- Reducing health care costs for Californians;
- Providing increased health care access to the public in California; and
- Ultimately, helping to save lives and increase the health of the public in California.

REASONABLE ALTERNATIVES CONSIDERED

In accordance with Government Code Section 11346.5(a)(13), the Exchange has described the reasonable alternatives for certain Articles and Sections below. Other than these alternatives, the Exchange has determined that no other 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 regulatory 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 provisions of law.

Alternative 1: Doing nothing and relying on the federal eligibility and enrollment and appeals rules and regulations.

Analysis: The Exchange considered relying on the federal eligibility and enrollment and appeals rules and regulations instead of adopting regulations. The Exchange rejected this option because the Exchange enabling State legislation in Government Code Section 100503(a) requires the Exchange to establish the criteria and process for eligibility determination, enrollment, and disenrollment of enrollees and potential enrollees in the Exchange. The Exchange is also required under Government Code Section 100506 to establish an appeals process for prospective and current enrollees of the Exchange that complies with all requirements of the federal act.

Alternative 2: Defining or specifying different timelines for "promptly and without undue delay" or "timely" than the ones discussed below.

- The federal provision under 45 CFR Section 155.310(d)(3) requires the Exchange to notify and transmit eligibility determination information to the Department of Health Care Services (DHCS) "promptly and without undue delay" but do not specify any timeline nor define "promptly and without undue delay."

  Analysis: After extensive consultation with stakeholders, including DHCS, the Exchange established the timeline of "three business days from the date of the eligibility determination" to notify and send required information to DHCS. The Exchange considered a shorter timeline but rejected that alternative because it was not administratively feasible. Exchange also considered a longer timeline but rejected that alternative because the notification and transmittal of information to DHCS will be done electronically, which will make the three-business-day timeline administratively feasible and more closely aligned with the federal requirements.

- The federal provision under 45 CFR Section 155.310(e)(1) requires the Exchange to determine an applicant's eligibility "promptly and without undue delay" but again do not specify any timeline nor define "promptly and without undue delay." However, the federal provision under 45 CFR Section 155.310(e)(2) requires the Exchange to assess the timeliness of eligibility determinations based on the period from the date of application or transfer from an agency administering an IAP (e.g., DHCS or County) to the date the Exchange notifies the applicant of its decision or the date the Exchange transfers the application to another agency administering an IAP, such as DHCS or County, when applicable.

  Analysis: After extensive consultation with stakeholders, the Exchange established the timelines of "within 10 calendar days from the date the Exchange receives the applicant's completed application" for paper applications and "real time" for electronic applications. The Exchange considered a shorter timeline for paper application but rejected that alternative because it was not administratively feasible. The Exchange also considered a longer timeline (e.g., 15 calendar days) but rejected that alternative because the 10-calendar-day timeline is administratively feasible, insures that the applicants receive their eligibility determinations promptly, and is more closely aligned with the federal requirements.

- The federal provision under 45 CFR Section 155.310(g) requires the Exchange to provide an applicant with "timely" written notice of an eligibility determination but does not specify any timeline nor define "timely."

  Analysis: After extensive consultation with stakeholders, the Exchange established the timeline of "within five business days from the date of the eligibility determination" to provide written notice of an eligibility determination to the applicants. The Exchange considered a shorter timeline but rejected that alternative because it was not administratively feasible. Exchange also considered a longer timeline (e.g., 10 calendar days) but rejected that alternative because the five-business-day timeline is administratively feasible, insures that the applicants receive the written notice of their eligibility determinations in a timely manner, and is more closely aligned with the federal requirements.

- There are other provisions throughout these proposed regulations that the Exchange chose to specify and define the timeliness standards required under federal rules as "timely" or "promptly and without undue delay" for clarity purposes. The Exchange applied the same logic and reasoning explained above to specify and define these timeliness standards and to consider and reject the alternatives.

Alternative 3: Defining a ''reasonable threshold'' as a percent (e.g., 10% or 20%) or a threshold dollar amount.

Analysis: The federal regulations specified in 45 CFR Section 155.320(c)(3)(vi) require the Exchange to follow specified verification process in situations where a tax filer qualifies for an alternate verification process for decreases in household income and the applicant's attestation to projected annual household income is more than a “reasonable threshold” below the annual household income computed by the Exchange using the federal data sources, or where data from such sources is unavailable. However, the federal rules do not specify nor define the phrase “reasonable threshold.” Rather, the federal rules provide the Exchanges with flexibility or discretion to determine what constitutes a reasonable threshold, provided that the threshold is not less than 10 percent and is approved by HHS. After extensive research and consultation with the stakeholders, the Exchange chose to define ‘‘reasonable threshold’’ as 25%. The Exchange considered the alternative thresholds of 10%, 15%, or 20% but rejected all of those alternatives because those lower thresholds would not have a significant effect on (i.e., reduction in) the number of applicants who would fall in an income inconsistency and would have been required to provide proof of income due to such an inconsistency. The Exchange intended to choose a threshold that would provide the optimal balance between reducing the consumers’ burden of producing documents and reducing the consumers’ potential tax liabilities due to receiving excess APTC. The Exchange strongly believes that the optimal balance is best achieved by implementing the 25% reasonable threshold. Furthermore, this threshold has been approved as reasonable by HHS and is consistent with the threshold that HHS has implemented for the Federally-Facilitated Marketplace or FFM (HHS has also established 25% as a reasonable threshold for the FFM).

Alternative 4: Adopting minimum allowed deadline for applicants to complete incomplete applications.

Analysis: The federal regulations in 45 CFR Section 155.310(k)(2) require the Exchange to provide the applicant with “a period of no less than 10 days and no more than 90 days from the date on which the notice” of the incomplete application “is sent to the applicant to provide the information needed to complete the application to the Exchange.” The Exchange, after extensive consultation with the stakeholders, chose to provide the longest time limit allowable under the federal regulations (90 days) to the consumers to complete their applications with the exception of when the 90-day time limit would exceed the duration of an open enrollment period in which case, the consumer will still have at least 30 days from the date of the notice of an incomplete application to complete the application. The Exchange considered the alternative of using the minimum timeline allowed by the federal rules (10 days) but rejected that alternative for the following reasons. During 2014, an estimated 42,500 incomplete applications were received, of which 30,700 were completed within 10 days and another 18,900 were completed within 90 days. On average each application received in 2014 represented 1.3 enrollees. Thus, limiting the applicant’s timeline to 10 days would have reduced enrollment by 24,600. Since potential enrollees who submit incomplete

applications can ultimately be enrolled if the missing information is supplied, their applications must be retained and tracked during this timeframe. Restricting the duration of this timeframe could potentially reduce the quantity of incomplete application files the Exchange must store. That alternative was rejected because it would have led to less enrollment through the Exchange, whose mission is to increase the number of insured Californians. Lower enrollment would also lead to reduced economic benefits for California. The potential administrative cost savings from maintaining fewer incomplete applications is far outweighed by the benefits of additional enrollment.

Alternative 5: Not expanding the definition of Other Qualifying Life Event to include "Victims of domestic abuse and spousal abandonment."

Analysis: The Exchange was given the option to expand the definition of Other Qualifying Life Event for enrolling during special enrollment periods, under the federal rules in 45 CFR Section 155.420(d)(9), to include "Victims of domestic abuse and spousal abandonment." After extensive consultation with the stakeholders, the Exchange adopted this option which will entitle more individuals to enroll through the Exchange than if it had not. The Exchange considered the alternative of not expanding the definition of Other Qualifying Life Event to include "Victims of domestic abuse and spousal abandonment." That alternative would result in less enrollment through the Exchange which would reduce the benefits of expanded insurance coverage but would also enhance the stability of the insurance risk pool during special enrollment periods and reduce the number of applications processed by the Exchange and the carriers. The Exchange rejected that alternative because it would have led to less enrollment on the Exchange, whose mission is to increase the number of insured Californians. Lower enrollment would also lead to reduced economic benefits for California. The potential marginal additional stability for the risk pool and cost savings from processing fewer applications is far outweighed by the benefits of additional enrollment.

California Code of Regulations

Title 10. Investment

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

Article 2. Abbreviations and Definitions

§ 6408. Abbreviations.

The following abbreviations shall apply to this chapter:

ACO	Accountable Care Organization
APTC	Advance Payments of Premium Tax Credit
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CalHEERS	California Healthcare Eligibility, Enrollment, and Retention System
CCR	California Code of Regulations
CEC	Certified Enrollment Counselor
CFR	Code of Federal Regulations
CHIP	Children's Health Insurance Program
CSR	Cost-Sharing Reduction
DHCS	Department of Health Care Services
DHS	U.S. Department of Homeland Security
EPO	Exclusive Provider Organization
FPL	Federal Poverty Level
FQHC	Federally-Qualified Health Center
HDHP	High Deductible Health Plan
HEDIS	Health Effectiveness Data and Information Set
HHS	U.S. Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104–191)
HMO	Health Maintenance Organization
HSA	Health Savings Account
IAP	Insurance Affordability Program
IPA	Independent Practice Association
IRC	Internal Revenue Code of 1986
IRS	Internal Revenue Services

LEP	Limited English Proficient
MAGI	Modified Adjusted Gross Income
MEC	Minimum Essential Coverage
MMCP	Medi-Cal Managed Care Plan
PBE	Certified Plan-Based Enroller
PBEE	Certified Plan-Based Enrollment Entity
POS	Point of Service
QDP	Qualified Dental Plan
QHP	Qualified Health Plan
SHOP	Small Business Health Options Program
SSA	Social Security Administration
SSN	Social Security Number
TIN	Taxpayer Identification Number
USC	United States Code

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

§ 6410. Definitions.

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

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

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

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

"Applicable Children's Health Insurance Program (CHIP) MAGI–based Income Standard" means the applicable income standard as defined at 42 CFR Section 457.310(b)(1), as applied under the State plan adopted in accordance with title XXI of the Social Security Act, or waiver of such plan and as certified by the State CHIP Agency in accordance with 42 CFR Section 457.348(d), for

determining eligibility for child health assistance and enrollment in a separate child health program.

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

"Applicant" means:

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

(1) Enrollment in a QHP through the Exchange; or

(2) Medi-Cal and CHIP.

(b) An employer, employee, or former employee seeking eligibility for enrollment in a QHP through the SHOP for himself or herself, and, if the qualified employer offers dependent coverage through the SHOP, seeking eligibility to enroll his or her dependents in a QHP through the SHOP.

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

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

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

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

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

"California Healthcare Eligibility, Enrollment, and Retention System" (CalHEERS) means the California Healthcare Eligibility, Enrollment, and Retention System, created pursuant to Government Code Sections 100502 and 100503, as well as 42 USC Section 18031, to enable

enrollees and prospective enrollees of QHPs to obtain standardized comparative information on the QHPs as well as apply for eligibility, enrollment, and reenrollment in the Exchange.

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

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

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

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

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

"Certified Insurance Agent" means an agent as defined in Section 6800 of Article 10 of this chapter.

"Certified Plan-Based Enroller" (PBE) means an individual who provides Enrollment Assistance to Consumers, as defined in Section 6700 of Article 9 of this chapter, in the Individual Exchange through a Certified Plan-Based Enroller Program. Such an individual may be:

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

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

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

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

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

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

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

"Day" means a calendar day unless a business day is specified.

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

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

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

"Dependent" means:

(a) In the Individual Exchange:

(1) For purposes of eligibility determination for APTC and CSR, a dependent as defined in Section 152 of IRC (26 USC § 152) and the regulations thereunder. For purposes of eligibility determinations for enrollment in a QHP without requesting APTC or CSR, "dependent" also includes domestic partners.

(2) For purposes of enrollment in a QHP, including enrollment during a special enrollment period specified in Section 6504 of Article 5 of this chapter, a dependent as defined in Section 1399.845(b) of the Health and Safety Code and in Section 10753(e) of the Insurance Code, referring to the spouse or registered domestic partner, or child until attainment of age 26 (as defined in subdivisions (n) and (o) of Section 599.500 of Title 2 of the CCR) unless the child is disabled (as defined in subdivision (p) of Section 599.500 of Title 2 of the CCR and as specified in Section 1373(d) of the Health and Safety Code), of a qualified individual or enrollee.

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

"Domestic Partner" means:

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

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

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

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

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

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

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

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

"Essential Community Providers" means providers that serve predominantly low-income, medically underserved individuals, as defined in 45 CFR Section 156.235.

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

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

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

"Executive Director" means the Executive Director of the Exchange.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"Initial Open Enrollment Period" means the initial period in which Qualified Individuals may enroll in QHPs, from October 1, 2013 to March 31, 2014, subject to 45 CFR Section 155.410(b), Section 1399.849(c)(1) of the Health and Safety Code, and Section 10965.3(c)(1) of the Insurance Code.

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

(a) The Medi-Cal program under title XIX of the federal Social Security Act (42 USC § 1396 et seq.).
(b) The State children's health insurance program (CHIP) under title XXI of the federal Social Security Act (42 USC § 1397aa et seq.).
(c) A program that makes available to qualified individuals coverage in a QHP through the Exchange with APTC established under Section 36B of the Internal Revenue Code (26 USC § 36B).
(d) A program that makes available coverage in a QHP through the Exchange with CSR established under section 1402 of the Affordable Care Act.

"Lawfully Present" means a non-citizen individual as defined in 45 CFR Section 152.2.

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

"Medi-Cal Managed Care Plan" (MMCP) means a person or an entity contracting with DHCS to provide health care services to enrolled Medi-Cal beneficiaries, as specified in Section 14093.07(b) of the Welfare and Institutions Code.

"Minimum Essential Coverage" (MEC) means coverage as defined in Section 5000A(f) of IRC (26 USC § 5000A(f)) and in 26 CFR Section 1.36B-2(c).

"Minimum Value" when used to describe coverage in an eligible employer-sponsored plan, means that the plan meets the requirements with respect to coverage of the total allowed costs of benefits set forth in Section 36B(c)(2)(C)(ii) of IRC (26 USC § 36B(c)(2)(C)(ii)) and in 26 CFR Section 1.36B-2(c)(3)(vi).

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

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

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

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

"Plan Year" means:

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

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

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

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

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

"Premium Payment Due Date" means a date no earlier than the fourth remaining business day of the month prior to the month in which coverage becomes effective.

"QHP Issuer" means a licensed health care service plan or insurer who has been selected and certified by the Exchange to be offered to Qualified Individuals and Qualified Employers purchasing health insurance coverage through the Exchange.

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

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

"Qualified Employer" has the same meaning as the term is defined in 42 USC Section 8032(f)(2) and 45 CFR Section 155.710.

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

"Qualified Individual" means an individual who meets the requirements of 42 USC Section 18032(f)(1) and 45 CFR Section 155.305(a).

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

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

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

"Reconciliation" means coordination of premium tax credit with advance payments of premium tax credit (APTC), as described in Section 36B(f) of IRC (26 USC § 36B(f)) and 26 CFR Section 1.36B-4(a).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

NOTE: Authority: Sections 100502, 100503, 100504, and 100505, Government Code. Reference: Sections 100501, 100502, 100503, and 100505, Government Code; Section 10753, Insurance Code; 45 CFR Sections 144.103, 155.20, 155.300, 155.415, 155.430, 155.700, 155.705, 155.710, 155.725, and 156.1230; 26 CFR Section 1.5000A-1(d).

Article 4. General Provisions.

§ 6450. Meaning of Words.

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

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

§ 6452. Accessibility and Readability Standards.

(a) All applications, including the single, streamlined application described in Section 6470 of Article 5 of this chapter, forms, notices, and correspondence provided to the applicants and

enrollees by the Exchange and QHP issuers shall conform to the standards outlined in subdivisions (b), (c), and (d) of this section. This section shall not be interpreted as limiting the application of existing State laws and regulations regarding accessibility and readability standards, if any, that apply to the QHP issuers.

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

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

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

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

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

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

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

(A) Oral interpretation or written translation; and

(B) Taglines in non-English languages indicating the availability of language services.

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

(d) Information shall be provided to applicants and enrollees in a manner that is compliant with Section 1557 of the ACA (42 USC § 18116) and its implementing regulations under Part 92 of Title 45 of Code of Federal Regulations (45 CFR Part 92), which prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs and activities.

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

§ 6454. General Standards for Exchange Notices.

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

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

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

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

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

(5) An explanation of appeal rights.

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

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

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

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

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

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; 45 CFR Section 155.230.

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

§ 6470. Application.

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

(1) Medi-Cal,
(2) CHIP,
(3) APTC, and
(4) CSR.

(b) To apply for any of the programs listed in subdivision (a) of this section, an applicant or an application filer shall submit all information, documentation, and declarations required on the single, streamlined application, as specified in subdivisions (c), (d), and (e) of this section, and shall sign and date the application.

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

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

(2) The applicant's date of birth.

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

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

(5) The applicant's gender.

(6) The applicant's marital status.

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

(8) The applicant's employment status.

(9) Sources, amount, and payment frequency of the applicant's gross income including tax-exempt income, such as foreign earned income, income from interest that the applicant receives or accrues during the taxable year, and income from Social Security benefits, but

excluding income from child support payments, veteran's payments, and Supplemental Security Income/State Supplementary Payment (SSI/SSP). If self-employed, the type of work, and the amount of net income.

(10) The applicant's expected annual household income from all sources.

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

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

(A) Name and state of the tribe;

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

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

(13) The applicant's expected type and amount of any tax deductions, including but not limited to student loan interest deduction, tuition and fees, educator expenses, IRA contribution, moving expenses, penalty on early withdrawal of savings, health savings account deduction, alimony paid, and domestic production activities deduction.

(14) Whether the applicant currently has MEC through an employer-sponsored plan, as defined in Section 5000A(f)(2) of IRC (26 USC § 5000A(f)(2)), and if so, the amount of monthly premium the applicant pays for self-only coverage through his or her employer and whether it meets the minimum value standards, as defined in Section 6410 of Article 2 of this chapter.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(e) An applicant or an application filer shall indicate that he or she understands his or her rights and responsibilities by providing, on the single, streamlined application, a declaration that:

(1) The information the applicant provides on the application is true and accurate to the best of his or her knowledge, and that the applicant may be subject to a penalty if he or she does not tell the truth.

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

(3) The applicant understands that information he or she provides on the application shall be kept private in accordance with the applicable federal and State privacy and security laws and that the Exchange shares such information with other federal and State agencies in order to verify the information and to make an eligibility determination for the applicant and for any other person(s) for whom he or she has requested coverage on the application, if applicable.

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

(5) The applicant understands that he or she is required to report any changes to the information provided on the application to the Exchange.

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

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

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

other health insurance, legal settlements, or judgments covering that medical expense shall be used to repay Medi-Cal until the medical expense is paid in full.

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

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

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

(1) He or she shall provide:

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

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

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

(A) For an Exchange Plan: "I understand that every participating health plan has its own rules for resolving disputes or claims, including, but not limited to, any claim asserted by me, my enrolled dependents, heirs, or authorized representatives against a health plan, any contracted health care providers, administrators, or other associated parties, about the membership in the health plan, the coverage for, or the delivery of, services or items, medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), or premises liability. I understand that, if I select a health plan that requires binding arbitration to resolve disputes, I accept, and agree to, the use of binding arbitration to resolve disputes or claims (except for Small Claims Court cases and claims that cannot be subject to binding arbitration under governing law) and give up my right to a jury trial and cannot have the dispute decided in court, except as applicable law provides for judicial review of arbitration proceedings. I understand that the full arbitration provision for each participating health plan, if they have one, is in the health plan's coverage document, which is available online at CoveredCA.com for my review, or, I can call Covered California at 1-800-300-1506 (TTY: 1-888-889-4500) for more information."

(B) For a Kaiser Medi-Cal health plan: "I have read the plan description. I understand that Kaiser requires the use of binding neutral arbitration to resolve certain disputes.

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

(g) The Exchange may request on the application that the applicant authorizes the Exchange to obtain updated tax return information, as described in Section 6498(c), for up to five years to conduct an annual redetermination, provided that the Exchange inform the applicant that he or she shall have the option to:

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

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

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

(1) Provide his or her name;

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

(3) Provide the name of the entity with which he or she is affiliated;

(4) Certify that he or she assisted the applicant complete the application free of charge;

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

(6) Date and sign the application.

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

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

(2) Subdivision (d) of this section;

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

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

(5) Subdivision (h) of this section.

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

(1) The Exchange's Internet Web site;
(2) Telephone;
(3) Facsimile;
(4) Mail; or
(5) In person.

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

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

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

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

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

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

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

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

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

(b) An applicant who has a SSN shall provide his or her SSN to the Exchange.

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

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

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

(1) For an individual who is age 21 and over, is not living in an institution as defined in 42 CFR Section 435.403(b), is capable of indicating intent, and is not receiving Supplemental Security Income/State Supplemental Program payments as defined in Title 22, Division 3, Section 50095 of CCR, the service area of the Exchange of the individual is the service areas of the Exchange in which he or she is living and:

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

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

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

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

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

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

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

(A) Except as specified in subdivision (e)(4)(B) of this section, if all of the members of a tax household are not within the same Exchange service area, in accordance with the applicable standards in subdivisions (e)(1), (2), and (3) of this section, any member of the tax household may enroll in a QHP through any of the Exchanges for which one of the tax filers meets the residency standard.

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

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

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

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

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

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

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

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

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

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

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

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

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; 45 CFR Section 155.305.

§ 6474. Eligibility Requirements for APTC and CSR.

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

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

(c) Eligibility for APTC.

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

(A) Tax filer is expected to have a household income of greater than or equal to 100 percent but not more than 400 percent of the FPL for the benefit year for which coverage is requested; and

(B) One or more applicants for whom the tax filer expects to claim a personal exemption deduction on his or her tax return for the benefit year, including the tax filer and his or her spouse:

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

2. Is not eligible for MEC, with the exception of coverage in the individual market, in accordance with section 36B(c)(2)(B) and (C) of IRC (26 USC § 36B(c)(2)(B), (C)) and 26 CFR Section 1.36B-2(a)(2) and (c); and

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

(2) A non-citizen tax filer who is lawfully present and ineligible for Medi-Cal by reason of immigration status, and is not otherwise eligible for APTC under subdivision (c)(1) of this section, shall be eligible for APTC if:

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

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

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

(3) Tax filer shall not be eligible for APTC if:

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

(B) Tax filer (or his or her spouse) did not comply with the requirement to file an income tax return for that year, as required by Sections 6011 and 6012 of IRC (26 USC §§ 6011, 6012) and implementing regulations; and

(C) The APTC was not reconciled for that period.

(4) The APTC amount shall be calculated in accordance with section 36B of IRC (26 USC § 36B) and 26 CFR Section 1.36B-3.

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

(6) Notwithstanding the requirement in subdivision (c)(3) of this section, the Exchange shall not deny eligibility for APTC under subdivision (c)(3) of this section unless the Exchange first sends direct notification to the tax filer, consistent with the standards set forth in Section 6454, that his or her eligibility will be discontinued as a result of the tax filer's failure to comply with the requirement specified under subdivision (c)(3) of this section.

(d) Eligibility for CSR.

(1) An applicant shall be eligible for CSR if he or she:

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

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

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

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

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

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

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

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

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

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

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

(A) Not eligible for CSR;
(B) Section 6494(a)(3) and (4) – Special CSR eligibility standards and process for Indians regardless of income;
(C) Subdivision (d)(3)(C) of this section;
(D) Subdivision (d)(3)(B) of this section;
(E) Subdivision (d)(3)(A) of this section; or
(F) Section 6494(a)(1) and (2) – Special CSR eligibility standards and process for Indians with household incomes under 300 percent of FPL.

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; 45 CFR Section 155.305.

§ 6476. Eligibility Determination Process

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

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

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

(d) The following special rules relate to APTC.

(1) An enrollee may accept less than the full amount of APTC for which he or she is determined eligible.

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

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

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

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

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

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

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

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

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

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

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

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

(1) Identify the employee;

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

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

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

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

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

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

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

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

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

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

(b) Verification of SSN.

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

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

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

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

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

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

(d) Verification of residency.

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

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

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

(e) Verification of incarceration status.

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

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

(B) Except as provided in subdivision (e)(2) of this section, if a HHS-approved data source is unavailable, accepting the applicant's attestation without further verification.

(2) If an applicant's attestation is not reasonably compatible with information from HHS approved data sources described in subdivision (e)(1)(A) of this section or other information provided by the applicant or in the records of the Exchange, the Exchange shall follow the inconsistencies procedures specified in Section 6492.

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

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

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

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

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

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

(2) If the Exchange is unable to verify the information required to determine eligibility for enrollment through the Exchange in a QHP that is a catastrophic plan as described in

subdivision (f)(1) of this section, the Exchange shall follow the procedures specified in Section 6492, except for Section 6492(a)(4).

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

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

(a) The Exchange shall verify whether an applicant is eligible for MEC other than through an eligible employer-sponsored plan, Medi-Cal, or CHIP, using information obtained from the HHS.

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

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

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

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

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

(1) Request tax return data regarding MAGI and family size from the Secretary of the Treasury and data regarding Social security benefits described in 26 CFR Section 1.36B-1(e)(2)(iii) from the Commissioner of Social Security by transmitting identifying information specified by HHS to HHS; and

(2) Proceed in accordance with the procedures specified in Section 6492(a)(1) if the identifying information for one or more individuals does not match a tax record on file with the IRS.

(c) For all individuals whose income is counted in calculating a tax filer's household income, in accordance with Section 36B(d)(2) of IRC (26 USC § 36B(d)(2)) and 26 CFR Section 1.36B-1(e), or an applicant's household income, calculated in accordance with 42 CFR Section

435.603(d), the Exchange shall request data regarding MAGI-based income in accordance with 42 CFR Section 435.948(a).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) The Exchange shall accept the applicant's attestation regarding the tax filer's annual household income without further verification if:

(1) An applicant attests, in accordance with Section 6482(e)(2), that a tax filer's annual household income has increased, or is reasonably expected to increase, from the income described in Section 6482(e)(1) for the benefit year for which the applicant(s) in the tax filer's family are requesting coverage; and

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

(b) If the data sources described in subdivision (a)(1) of this section are unavailable, the applicant shall provide additional documentation requested by the Exchange to support the attestation, in accordance with Section 6492.

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

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

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

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

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

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

(4) One of the following conditions is met:

(A) The IRS does not have tax return data that may be disclosed under Section 6103(l)(21) of IRC (26 USC § 6102(l)(21)) for the tax filer that is at least as recent as the calendar year two years prior to the calendar year for which APTC and CSR would be effective;

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

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

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

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

(b) If a tax filer qualifies for an alternate verification process based on the requirements specified in subdivision (a) of this section and the applicant's attestation to projected annual household

income, as described in Section 6482(e)(2), is no more than 25 percent below the annual household income computed in accordance with Section 6482(e)(1), the applicant's attestation shall be accepted without further verification.

(c) If a tax filer qualifies for an alternate verification process based on the requirements specified in subdivision (a) of this section and the applicant's attestation to projected annual household income, as described in Section 6482(e)(2), is greater than 25 percent below the annual household income computed in accordance with Section 6482(e)(1), or if the tax data described in Section 6482(b)(1) is unavailable, the Exchange shall verify the applicant's attestation of the tax filer's projected annual household income in accordance with the following procedures:

(1) The Exchange shall use:

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

(B) Other HHS-approved electronic data sources.

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

(3) If electronic data are unavailable or the applicant's attestation to projected annual household income, as described in Section 6482(e)(2), is more than 25 percent below the annual household income computed using data sources described in subdivision (c)(1) of this section, the Exchange shall follow procedures specified in Section 6492(a)(1) through (4).

(4) The Exchange shall accept the applicant's attestation without further verification if:

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

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

(C) The applicant's attestation to projected annual household income specified in subdivision (c)(4)(A) of this section is reasonably compatible with other information provided by the applicant, if applicable. If the Exchange finds that the applicant's attestation is not reasonably compatible with other information provided by the applicant, the Exchange shall request additional documentation from the applicant in accordance with the procedures specified in Section 6492.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) The Exchange shall obtain:

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

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

(3) Any available data from SHOP.

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

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

(e) For any benefit year for which the Exchange is unable to obtain sufficient verification data as described in subdivisions (b)(1) through (3) of this section, the Exchange shall conduct random sampling in accordance with the following process

(1) The Exchange shall select a statistically significant random sample of applicants for whom the Exchange does not have any of the information specified in subdivision (b)(1) through (3) of this section and:

(A) Provide notice to the applicant indicating that the Exchange will be contacting any employer identified on the application for the applicant and the members of his or her household, as defined in 26 CFR Section 1.36B-1(d), to verify whether the applicant is enrolled, or is eligible for qualifying coverage, in an eligible employer-sponsored plan for the benefit year for which coverage is requested;

(B) Proceed with all other elements of the eligibility determination using the applicant's attestation, and provide eligibility for enrollment in a QHP to the extent that an applicant is otherwise qualified;

(C) Ensure that APTC and CSR are provided on behalf of an applicant who is otherwise qualified for such payments and reductions, as described in Section 6474, if the tax filer attests to the Exchange that he or she understands that any APTC paid on his or her behalf are subject to reconciliation;

(D) Make reasonable attempts to contact any employer identified on the application for the applicant and the members of his or her household, as defined in 26 CFR 1.36B-1(d), to verify whether the applicant is enrolled, or is eligible for qualifying coverage, in an eligible employer-sponsored plan for the benefit year for which coverage is requested;

(E) If the Exchange receives any information from an employer relevant to the applicant's enrollment, or eligibility for qualifying coverage, in an eligible employer-sponsored plan:

1. Determine the applicant's eligibility based on such information and in accordance with the effective dates specified in subdivisions (j) through (l) of Section 6496; and

2. If such information changes his or her eligibility determination, notify the applicant and his or her employer(s) of such determination in accordance with the notice requirements specified in Section 6476(h) and (i); and

(F) If, after a period of 90 days from the date on which the notice described in subdivision (e)(1)(A) of this section is sent to the applicant, the Exchange is unable to obtain the necessary information from an employer, determine the applicant's eligibility based on his or her attestation(s) regarding coverage provided by that employer.

(2) To carry out the random sampling process described in subdivision (e)(1) of this section, the Exchange shall only disclose an individual's information to an employer to the extent necessary for the employer to identify the employee.

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

§ 6492. Inconsistencies.

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

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

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

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

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

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

(4) During the period described in subdivision (a)(2)(B) of this section, shall:

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

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

(C) Clear the inconsistencies for which the Exchange receives satisfactory documentary evidence from the applicant or the enrollee. For income inconsistencies, the Exchange shall

clear the inconsistency if the income shown on the documents provided by the applicant or enrollee is within 10% of the applicant's or enrollee's attestation.

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

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

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

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

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

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

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

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

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

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

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

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

(1) An Indian applicant shall be eligible for CSR if he or she:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; 45 CFR Section 155.350.

§ 6496. Eligibility Redetermination during a Benefit Year.

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

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

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

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

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

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

(g) The Exchange shall examine available data sources on a semiannual basis to identify the following changes of circumstances:

(1) Death; and

(2) For an enrollee on whose behalf APTC or CSR are being provided:

(A) Eligibility determination for or enrollment in Medicare, Medi-Cal, or CHIP; and

(B) Failure of the tax filer for the enrollee's household or the tax filer's spouse to comply with the requirement to file an income tax return for the last benefit year during which he or she received APTC, as required by Sections 6011 and 6012 of IRC (26 USC §§ 6011, 6012) and implementing regulations, and to reconcile the APTC received for that period.

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

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

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

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

(i) If the Exchange identifies updated information through semiannual data matching regarding death, eligibility for or enrollment in Medicare, Medi-Cal, or CHIP, or failure to meet the requirements of Section 6474(c)(3), in accordance with subdivision (g) of this section, the Exchange shall:

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

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

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

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

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

(k) Except as specified in subdivision (l) of this section, the Exchange shall implement changes for which the date of the notice of eligibility redetermination described in subdivision (h)(2) of this section or the date on which the Exchange is notified is after the 15th of the month, on the first day of the second month following the month of the notice described in subdivision (h)(2) of this section or the month in which the Exchange is notified.

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

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

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

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

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

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; 45 CFR Section 155.330.

§ 6498. Annual Eligibility Redetermination.

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

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

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

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

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

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

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

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

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

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

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

(A) His or her APTC and CSR will end on the last day of the current benefit year; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(E) An explanation that if he or she does not complete the Exchange's renewal process to obtain an updated eligibility determination by December 15 of the current benefit year for coverage effective January first of the following benefit year, the Exchange will redetermine the enrollee's eligibility and renew the enrollee's coverage for the following benefit year, in accordance with the process specified in subdivision (l) of

this section, using the most recent information the enrollee provided to the Exchange; and

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

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

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

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

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

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

(f) For eligibility redeterminations under this section, the Exchange shall provide the annual redetermination notice, as specified in subdivision (e) of this section, and the notice of annual open enrollment period, as specified in Section 6502(e), through a single, coordinated notice.

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

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

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

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

(A) Log in to his or her existing account on the Exchange Website;

(B) Check his or her application information for accuracy, and make any changes to the application information, as required under subdivision (g) of this section;

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

(D) Declare under penalty of perjury that he or she:

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

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

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

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

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

6. Understands that, unless he or she has already provided authorization for the Exchange to use electronic data sources to obtain his or her updated tax return information to conduct the annual redetermination for all IAPs, except for MediCal or CHIP, he or she is giving the Exchange authorization to obtain updated tax return information to provide him or her with an updated eligibility determination for the following benefit year; and

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

(E) Provide his or her electronic signature and PIN;

(F) Submit any reported changes and the signed declarations to obtain an updated eligibility determination for the following benefit year; and

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

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

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

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

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

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

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

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

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

(l) If an enrollee remains eligible for enrollment in a QHP through the Exchange upon annual redetermination, and he or she does not terminate coverage, including termination of coverage in connection with voluntarily selecting a different QHP in accordance with Section 6506, the Exchange shall proceed in accordance with the following process:

(1) The enrollee shall be enrolled in the same QHP as the enrollee's current QHP, unless the enrollee's current QHP is not available.

(2) If the enrollee is not eligible for the same level of CSR as the enrollee's current level of CSR, he or she shall be enrolled in a silver-tier QHP offered by the same QHP issuer at the CSR level for which the enrollee is eligible. If the enrollee is not eligible for any level of CSR, he or she shall be enrolled in a standard silver-tier QHP offered by the same QHP issuer without CSR.

(3) If the enrollee's current QHP is not available and the current QHP is a HDHP as defined in Section 6410, the enrollee shall be enrolled in the lowest cost HDHP offered by the same QHP issuer at the same metal tier, as determined by the Exchange on a case-by-case basis.

(4) If the enrollee's current QHP is not available and the current QHP is not a HDHP, the enrollee shall be enrolled in the lowest cost QHP that is not a HDHP offered by the same QHP issuer at the same metal tier, as determined by the Exchange on a case-by-case basis.

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

(6) If the issuer of the QHP in which the enrollee is currently enrolled is no longer available, the enrollee shall be enrolled in the lowest cost QHP offered by a different QHP issuer that is available to the enrollee through the Exchange at the same metal tier and in accordance with the same hierarchy specified in subdivision (l)(3) through (5) of this section, as determined by the Exchange on a case-by-case basis.

(7) If the enrollee who is currently enrolled in a QHP as a dependent attains the age of 26 before the beginning of the following benefit year, the enrollee shall be enrolled in his or her own individual QHP through the Exchange in accordance with the process specified in subdivision (l)(1) through (6) of this section.

(8) Notwithstanding the process specified in subdivision (l)(1) through (7) of this section, a federally-recognized American Indian or Alaska Native enrollee who is currently enrolled in a zero cost sharing QHP shall be enrolled in the lowest cost zero cost sharing QHP that offers the same benefits and provider networks offered by the same QHP issuer. If the issuer of the QHP in which the enrollee is currently enrolled is no longer available, the enrollee shall be enrolled in the lowest cost zero cost sharing QHP offered by a

different QHP issuer that is available to the enrollee through the Exchange, as determined by the Exchange on a case-by-case basis.

(m) The Exchange shall not redetermine a qualified individual's eligibility in accordance with this section if the qualified individual's eligibility was redetermined under this section during the prior year, and the qualified individual was not enrolled in a QHP through the Exchange at the time of such redetermination, and has not enrolled in a QHP through the Exchange since such redetermination.

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

§ 6500. Enrollment of Qualified Individuals into QHPs.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) Notify a qualified individual of his or her premium payment due date;

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

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

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

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

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

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

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

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

(B) Complies with the consumer assistance standards specified in 45 CFR Section 155.205(d);

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

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

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

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

(2) Effectuate coverage upon receipt of an initial premium payment from the applicant on or before the premium payment due date. In cases of retroactive enrollment dates, the initial premium shall consist of the premium due for all months of retroactive coverage through the first month of coverage following the plan selection date. If only partial premium for less than all months of retroactive coverage is paid, only prospective coverage shall be effectuated, in accordance with the regular coverage effective dates specified in Section 6504(g).

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

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

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

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

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

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

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

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

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

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

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

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

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

§ 6502. Initial and Annual Open Enrollment Periods.

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

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

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

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

(2) Between December 24, 2013 and December 31, 2013, shall be February 1, 2014;

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

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

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

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

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

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

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

(f) Coverage effective dates are as follows:

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

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

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

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

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

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

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

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

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

(1) The individual makes his or her initial premium payment, reduced by the APTC amount he or she is determined eligible for by the Exchange, by the premium payment due date, as defined in Section 6410 of Article 2 of this chapter; and

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

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

§ 6504. Special Enrollment Periods.

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

(1) A qualified individual or his or her dependent either:

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

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

2. If loss of MEC occurs due to a QHP decertification, the date of the notice of decertification as described in 45 CFR Section 155.1080(e)(2);

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

(C) Loses Medi-Cal coverage for pregnancy-related services, as described under Section 1902(a)(10)(A)(i)(IV) and (a)(10)(A)(ii)(IX) of the Social Security Act (42 USC 1396a(a)(10)(A)(i)(IV), (a)(10)(A)(ii)(IX)) and Section 14005.18 of the Welfare and Institutions Code. The date of the loss of coverage shall be the last day the consumer would have pregnancy-related coverage; or

(D) Loses Medi-Cal coverage for medically needy, as described under Section 1902(a)(10)(C) of the Social Security Act and Section 14005.21 of the Welfare and Institutions Code, only once per calendar year. The date of the loss of coverage shall be the last day the consumer would have medically needy coverage.

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

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

(4) A qualified individual, or his or her dependent, becomes newly eligible for enrollment in a QHP through the Exchange because he or she newly meets the requirements specified in Section 6472(c) or (d).

(5) A qualified individual's, or his or her dependent's, enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, misconduct, or inaction of an officer, employee, or agent of the Exchange or HHS, its instrumentalities, a QHP issuer, or a non-Exchange entity providing enrollment assistance or conducting enrollment activities. For purposes of this provision, misconduct, as determined by the Exchange, includes the failure to comply with applicable standards under this title, or other applicable Federal or State laws.

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

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

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

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

(10) A qualified individual who:

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

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

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

(A) If an individual receives a certificate of exemption for hardship based on the eligibility standards described in 45 CFR Section 155.605(g)(1) for a month or months during the coverage year, and based on the circumstances of the hardship attested to, he or she is no longer eligible for a hardship exemption within a coverage year but outside of an open enrollment period described in Section 6502, the individual and his or her dependents shall be eligible for a special enrollment period if otherwise eligible for enrollment in a QHP.

(B) If an individual with a certificate of exemption reports a change regarding the eligibility standards for an exemption, as required under 45 CFR Section 155.620(b), and the change resulting from a redetermination is implemented, the certificate provided for the month in which the redetermination occurs, and for prior months, remains effective. If the individual is no longer eligible for an exemption, the individual and his or her dependents shall be eligible for a special enrollment period if otherwise eligible for enrollment in a QHP.

(C) If an enrollee provides satisfactory documentary evidence to verify his or her eligibility for an IAP or enrollment in a QHP through the Exchange within 30 days following his or her termination of Exchange enrollment due to a failure to verify such status within the 95-day period specified in Section 6492(a)(2)(B), the enrollee shall be eligible for a special enrollment period if otherwise eligible for enrollment in a QHP.

(12) A qualified individual or enrollee is a victim of domestic abuse or spousal abandonment, as specified in 26 CFR Section 1.36B-2 (b)(2)(ii) through (v), including a dependent or unmarried victim within a household, is enrolled in MEC, and seeks to enroll in coverage

separate from the perpetrator of the abuse or abandonment. A dependent of a victim of domestic abuse or spousal abandonment who is on the same application as the victim may enroll in coverage at the same time as the victim.

(13) A qualified individual, or his or her dependent:

(A) Applies for coverage on the Exchange during the annual open enrollment period or due to a qualifying life event, is assessed by the Exchange as potentially eligible for Medi-Cal or CHIP, and is determined ineligible for Medi-Cal or CHIP by the State Medi-Cal or CHIP agency either after open enrollment period has ended or more than 60 days after the qualifying life event; or

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

(14) The qualified individual or enrollee, or his or her dependent, adequately demonstrates to the Exchange, as determined by the Exchange on a case-by-case basis, that a material error related to plan benefits, service area, or premium influenced the qualified individual's or enrollee's decision to purchase a QHP through the Exchange.

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

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

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

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

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

(B) Loss of eligibility for coverage through Medicare, Medi-Cal, or other government-sponsored health care programs, other than programs specified as not MEC under 26 CFR Section 1.5000A-2(b)(1)(ii);

(C) In the case of coverage offered through an HMO or similar program in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual);

(D) In the case of coverage offered through an HMO or similar program in the group market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual), and no other benefit package is available to the individual; and

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

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

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

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

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

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

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

(1) Failure to pay premiums on a timely basis, including COBRA premiums prior to exhaustion of COBRA coverage; or

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

(d) A qualified individual or an enrollee shall attest under penalty of perjury that he or she meets at least one of the triggering events specified in subdivision (a) of this section. The Exchange shall inform the qualified individual or the enrollee that pursuant to 45 CFR Section 155.285, HHS may impose civil money penalties of:

(1) Up to $25,000 on the qualified individual or the enrollee who fails to provide the correct information requested by the Exchange, subject to the exception specified in subdivision (e)(4) of this section, due to his or her negligence or disregard of the federal or State rules or regulations related to the Exchange with negligence and disregard defined as they are in section 6662 of IRC (26 USC § 6662), as follows:

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

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

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

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

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

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

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

(2) The qualified individual or the enrollee shall provide the requested document(s) within 30 days from the date of the Exchange's written request, as specified in subdivision (e)(1) of this section, to the Exchange for verification. The Exchange may extend this period if

the Exchange determines on a case-by-case basis that the qualified individual or the enrollee has demonstrated that he or she has made a good-faith effort but was unable to obtain the requested documentation during the 30-day time period.

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

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

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

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

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

(A) The qualified individual or the enrollee does not have the requested documentation with which to prove a triggering event through the process described in subdivision (e)(1) through (3) of this section because such documentation does not exist or is not reasonably available;

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

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

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

(f) Except as provided in subdivision (f)(1) and (2) of this section, a qualified individual or an enrollee shall have 60 days from the date of a triggering event to select a QHP.

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

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

(g) Except as specified in subdivision (h) of this section, regular coverage effective dates for a special enrollment period for a QHP selection received by the Exchange from a qualified individual:

(1) Between the first and fifteenth day of any month, shall be the first day of the following month; and

(2) Between the sixteenth and last day of any month, shall be the first day of the second following month.

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

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

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

(B) On the first day of the month following the date of birth, adoption, placement for adoption, or placement in foster care, at the option of the qualified individual or the enrollee.

(2) In the case of marriage or entry into domestic partnership, the coverage and APTC and CSR, if applicable, shall be effective on the first day of the month following plan selection.

(3) In the case where a qualified individual, or his or her dependent, loses coverage, as described in subdivisions (a)(1) and (a)(8) of this section, the coverage and APTC and CSR, if applicable, shall be effective:

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

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

(4) In the case of a qualified individual or enrollee eligible for a special enrollment period described in subdivisions (a)(5), (a)(6), (a)(11), (a)(13), or (a)(14) of this section, the coverage shall be effective on an appropriate date, including a retroactive date, determined by the Exchange on a case-by-case basis based on the circumstances of the special enrollment period.

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

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

(B) In accordance with the regular coverage effective dates specified in subdivision (g) of this section, at the option of the qualified individual or the enrollee.

(6) If an enrollee or his or her dependent dies, as described in subdivision (a)(2)(B) of this section, the coverage shall be effective on the first day of the month following the plan selection.

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

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

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

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

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; 45 CFR Section 155.420.

§ 6506. Termination of Coverage in a QHP.

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

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

(2) An enrollee may choose to remain enrolled in a QHP at the time of plan selection if he or she becomes eligible for other MEC and the enrollee does not request termination in accordance with subdivision (a)(1) of this section. If the enrollee does not choose to remain enrolled in a QHP in such a situation, the Exchange shall initiate termination of his or her enrollment in the QHP upon completion of the redetermination process specified in Section 6496.

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

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

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

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

1. Full name of the deceased;
2. Date of birth of the deceased;
3. The Exchange application ID or case number (if known) of the deceased;
4. Social Security Number (if known) of the deceased; and
5. Contact information for the person submitting the documentation, including full name, address, and phone number.

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

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

(B) His or her enrollment in a QHP through the Exchange was unintentional, inadvertent, or erroneous and was the result of the error or misconduct of an officer, employee, or agent of the Exchange or HHS, its instrumentalities, a QHP issuer, or a non-Exchange entity providing enrollment assistance or conducting enrollment activities. Such enrollee must request cancellation within 60 days of discovering the unintentional, inadvertent, or erroneous enrollment. For purposes of this provision, misconduct includes the failure to comply with applicable standards under this title, or other applicable Federal or State requirements as determined by the Exchange; or

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

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

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

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

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

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

(3) The enrollee's coverage is rescinded by the QHP issuer because the enrollee has made a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan, in accordance with 45 CFR Section 147.128, after the QHP issuer demonstrates

to the Exchange that the rescission is appropriate, due to the enrollee's fraudulent claim or intentional misrepresentation of a material fact;

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

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

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

(7) Any other reason for termination of coverage described in 45 CFR Section 147.106.

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

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

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

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

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

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

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

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

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

(A) Terminate the enrollee's coverage on the effective date described in subdivision (d)(4) of this section, provided that the QHP issuer meets the notice requirements specified in subdivision (e)(1) and (2) of this section; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(A) The enrollee receives the APTC and CSR for which he or she is determined eligible;

(B) The enrollee is refunded any excess premiums paid or out-of-pocket payments made by or for the enrollee for covered benefits and services, including prescription drugs, incurred after the retroactive termination date;

(C) The enrollee's premium and cost sharing are adjusted to reflect the enrollee's obligations under the new QHP, if applicable; and

(D) Consistent with 45 CFR Section 156.425(b), in the case of a change in the level of CSR (or a QHP without CSR) under the same QHP issuer during a benefit year, any cost sharing paid by the enrollee under the previous level of CSR (or a QHP without

CSR) for that benefit year is taken into account in the new level of CSR for purposes of calculating cost sharing based on aggregate spending by the individual, such as for deductibles or for the annual limitations on cost sharing.

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

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

(A) The termination effective date;

(B) The reason for termination; and

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

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

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

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

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

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

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

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

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; 45 CFR Sections 155.430 and 156.270.

§ 6508. Authorized Representative.

(a) The Exchange shall permit an applicant or enrollee in the individual or small group market, subject to applicable privacy and security requirements, to designate an individual or organization to act on his or her behalf in applying for an eligibility determination or redetermination and in carrying out other ongoing communications with the Exchange.

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

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

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

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

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

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

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

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

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

(g) The Exchange shall:

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

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

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

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

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

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

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

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

§ 6510. Right to Appeal.

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

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

Article 7. Appeals Process for the Individual Exchange.

§ 6600. Definitions.

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

"Appeal Record" means the appeal decision, all papers and requests filed in the proceeding, and, if a hearing was held, the transcript or recording of hearing testimony or an official report

containing the substance of what happened at the hearing and any exhibits introduced at the hearing.

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

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

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

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

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

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

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

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

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

§ 6602. General Eligibility Appeals Requirements.

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

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

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

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

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

(2) An eligibility determination for an exemption made in accordance with 45 CFR Section 155.605 to the HHS;

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

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

(b) The Exchange appeals entity shall conduct all eligibility appeals, except for appeals of an eligibility determination for an exemption made in accordance with 45 CFR Section 155.605.

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

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

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

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

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

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

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

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

(i) The appeals entity shall:

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

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

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

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100503 and 100506, Government Code; 45 CFR Sections 155.505 and 155.510.

§ 6604. Notice of Appeal Procedures.

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

(1) Applicant submits an application; and

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

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

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

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

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

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

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

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

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

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

§ 6606. Appeal Requests.

(a) The Exchange and the appeals entity shall:

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

(A) The Exchange's Internet Web site;

(B) Telephone;

(C) Facsimile;

(D) Mail; or

(E) In person.

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

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

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

(c) The Exchange and the appeals entity shall allow an applicant or enrollee to request an appeal within 90 days of the date of the notice of eligibility determination, unless the appeals entity determines, in accordance with Section 6602(c), that there is good cause, as defined in Section 10951 of the Welfare and Institution Code, for filing the appeals request beyond the 90-day period. No filing timeline shall be extended for good cause for more than 180 days after the date of the notice of eligibility determination. For purposes of this subdivision, if the last day of the filing period falls on a Saturday, Sunday, or holiday, as defined in Government Code Section 6700, the filing period shall be extended to the next business day, in accordance with Government Code Section 6707.

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

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

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

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

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

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

(2) Except as provided in Section 6618(b)(2), within three business days from the date on which the valid appeal request is received, transmit via secure electronic interface notice of the appeal request and, if applicable, instructions to provide eligibility pending appeal pursuant to Section 6608, to the Exchange and to the DHCS, as applicable; and

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

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

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

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

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

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

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

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

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

(2) The appellant's eligibility record.

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

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100503 and 100506, Government Code; 45 CFR Section 155.520.

§ 6608. Eligibility Pending Appeal.

(a) Upon receipt of a valid appeal request or notice under Section 6606(e)(2) that concerns an appeal of a redetermination under Sections 6496(h) or 6498(j) of Article 5 of this chapter or an appeal of an erroneous termination of enrollment, the Exchange shall continue to consider

the appellant eligible while the appeal is pending in accordance with standards set forth in subdivision (b) of this section.

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

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100503 and 100506, Government Code; 45 CFR Section 155.525.

§ 6610. Dismissals.

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

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

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

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

1. The appeals entity shall send the appellant a written confirmation of the withdrawal within five business days from the date on which the appellant's verbal withdrawal request is received by the appeals entity. The written confirmation shall serve as the appellant's written withdrawal and the appeal shall be dismissed unless the appellant notifies the appeals entity, in writing or verbally, within 15 days of the date of the written confirmation, that the appellant has not withdrawn his or her appeal request

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

(C) If the withdrawal is conditional:

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

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

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

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

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

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

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

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

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

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

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

(1) The reason for the dismissal;

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

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

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

(1) Implement the eligibility determination; and

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

(d) The appeals entity shall:

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

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

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

§ 6612. Informal Resolution.

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

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

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

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

(e) If the appeal advances to hearing:

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

(2) The Exchange shall:

(A) Issue a Statement of Position; and

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

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

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

(A) Notify the appellant of:

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

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

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

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

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

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

§ 6614. Hearing Requirements.

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

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

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

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

(c) The hearing shall be conducted:

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

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

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

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

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

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

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

(2) Bring witnesses to testify;

(3) Establish all relevant facts and circumstances;

(4) Present an argument without undue interference;

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

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

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

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

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

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

§ 6616. Expedited Appeals.

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

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

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

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

(A) The reason for the denial;

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

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

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

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

(A) That his or her request for an expedited appeal is granted; and

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

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

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

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

§ 6618. Appeal Decisions.

(a) Appeal decisions shall:

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

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

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

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

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

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

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

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

(b) The appeals entity shall:

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

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

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

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

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

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

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

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

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100503 and 100506, Government Code; 45 CFR Section 155.545.

§ 6620. Appeal Record.

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

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

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

§ 6622. Employer Appeals Process.

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

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

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

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

Attachment 1

Covered California

Standardized Regulatory Impact Assessment

Proposed Regulations for the Eligibility and Enrollment in the Individual Market

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Submitted to the California Department of Finance on January 12, 2018 and revised February 20, 2018, in accordance with Senate Bill 617, chapter 496, statutes of 2011.

A. SUMMARY

1. Statement of the Need of the Proposed Regulations

In March 2010, President Obama signed federal health reform legislation called the Patient Protection and Affordable Care Act, or "Affordable Care Act" (ACA). That same year, California chose to operate its own exchange as the California Legislature enacted and the governor signed legislation establishing the California Health Benefit Exchange (now also known as "Covered California") and its governing Board.[1] The enacting legislation required that the Exchange,

- Provide the public with clear standards and eligibility requirements to qualify for federal tax subsidies through the Exchange.

- Establish the criteria and process for eligibility determination, enrollment, and disenrollment of enrollees and potential enrollees in the Exchange.

- Establish a fair and efficient appeals process for prospective and current enrollees of the Exchange. More specifically, this action creates clear guidelines for the public to request and receive a fair hearing.

The Eligibility and Enrollment in the Individual Market regulations establish the Exchange's policies and procedures for: (1) eligibility determination and redetermination; (2) enrollment in qualified health plans; (3) termination of coverage through the Exchange; and (4) an appeals process in the individual Exchange. They provide clear standards and eligibility requirements to qualify for federal tax subsidies through the Exchange and set out the standards and requirements for the qualified health plan issuers regarding enrollment of qualified individuals and termination of coverage for individuals who qualified through the Exchange.

2. Major Regulation Determination

The overall economic impact of these regulations will exceed $50 million each year beginning in 2016. The impacts are the result of changes in the shares of consumer spending devoted to health insurance, healthcare services, and all other categories as well as changes in health insurance company margins and state government spending.

3. Economic Baseline

The proposed regulations were not needed prior to federal health reform legislation passed in 2010. The Exchange opened in October 2013 and its first policies became effective January 1, 2014. Prior to that date, health insurance consumers had no access to a statewide health insurance marketplace nor were federal subsidies available. For a variety of reasons, including its prohibitive cost, approximately 5 million California residents lacked health insurance. Prior to the opening of the Exchange, health insurance was acquired by individuals from insurance companies directly or through agents, as a benefit of employment, or through a public program such as Medi-Cal.

The provision of federal Advance Premium Tax Credits (APTC) greatly improved the affordability of individual health insurance. The proposed regulations establish the criteria that determine which individuals are eligible for APTC and have been in place since October of 2013. It is important to note that APTC is only available through health insurance exchanges, which is the primary driver leading to the reduction in the number of uninsured Californians attributable to the Exchange.

[1] Stats. 2010, ch. 659, section 2, (SB 900, [Alquist, Steinberg]); Stats 2010, ch. 655 (AB 1602, [Perez].

Since 2013, the rate of the uninsured in California has dropped by more than half, from 17 percent to 6.8 percent in 2017 – a record low for California, according to data from the U.S. Centers for Disease Control. The decrease in the uninsured was due to both the Medicaid expansion and the establishment of the Exchange under the Affordable Care Act, which was facilitated through robust marketing and outreach to the uninsured. More than 3.6 million people have purchased health insurance through Covered California since the its launch. The regulations provide the ongoing framework for this by ensuring that individuals who need help to afford health insurance continue to get the coverage they need.

4. Public Outreach and Input

In the process of developing these regulations, the Exchange met with the Department of Health Care Services and stakeholder groups. The regulations were discussed and approved in publicly held, duly noticed meetings of the California Health Exchange Board where interested members of the public were given the opportunity to offer suggestions and comments. In conjunction with these meetings, the regulations were posted on the Exchange's web site. The proposed regulations reflect comments received from a variety of affected parties.

B. BENEFITS

The ACA has made it possible for millions of Americans to receive health care who could not previously afford it. The proposed regulations facilitate the purchase of qualified health plans through California's marketplace by individuals, most of whom are eligible for federal subsidies to offset a portion of their premiums. Expanded health coverage will improve access to quality health care for nonelderly California adults, thereby helping to save lives and increase the overall health of the public in California.

Expanding healthcare coverage through Covered California will decrease the cost for health care in California by increasing preventative care and providing health care access to more Californians. This will reduce health care costs overall and allow funds that would otherwise be spent on emergency room visits and sick patient care to be spent in other ways that benefit the health and welfare of California residents, worker safety, the environment, or on other state priorities.

Enrolling for health insurance coverage through Covered California is principally determined by a complex decision making process by individuals and firms who are influenced by four principle factors.

- First, given that employer sponsored insurance (ESI) accounts for over half of all forms of health insurance coverage, the choice of employers to offer health insurance and of employees to take up those offers is a substantial determinant of demand for individual policies, including those offered on the Exchange (see Table 1 below). Economic conditions and labor market conditions in particular can also impact the aggregate availability of ESI offers.
- Since affordability is a dominant factor for individuals that may consider purchasing coverage directly on the individual market, the provision of financial assistance by the ACA, which is only available with policies sold on the Exchange, will strongly influence take up of Exchange policies. This financial assistance is provided on a sliding scale based on each applicant's household income based on Modified Adjusted Gross Income (MAGI). Thus, similar to offers of ESI, changes in the economy, such as increases in the minimum wage, that affect family incomes will drive changes in the number of individuals eligible for assistance.
- Eligibility for no-cost Medi-Cal coverage makes that a more attractive alternative for families with income below 138 percent of the federal poverty level.
- Lastly, through 2018, most individuals who did not purchase qualified health insurance coverage through enrollment in Medicaid, Medicare, Children's Health Insurance Plan (CHIP), employer-based, or individually-purchased insurance plans faced the prospect of

gradually rising federal penalties that reached $695 per person (up to a maximum of $2,085 per family) or 2.5 percent of taxable income in 2016.

A more extensive description of how these, and other factors, interact to determine the level of take up of various forms of health insurance in California as a result of the implementation of the ACA can be found in *California Simulation of Insurance Markets (CalSIM) Version 1.8, Methodology & Assumptions*.[2]

1. Individuals

The financial benefit of these regulations for individuals who enroll for coverage through the Exchange is related to their prior health insurance status and their eligibility for federal subsidies. Enrollees who were previously uninsured now have better and timelier access to healthcare. Enrollees who were previously insured and now receive a federal subsidy will spend less on health insurance, which allows them to spend more on non-health insurance goods and services. The spending shift is equal to the subsidies received. Spending by enrollees who were previously insured but did not receive a federal subsidy will be unchanged.

The implementation of the ACA has significantly reduced the number of Californians who lack health insurance, both by increasing coverage by Medi-Cal and by enrollment through the Exchange. Table 1 below provides a detailed breakdown of the types of coverage used by Californians under the age of 65, which indicates that the use of ESI remains the dominant source of insurance coverage.

Table 1
Types of Coverage for Californians under Age 65
2016 (Millions of Persons)

Employer Sponsored Insurance (ESI)	15.96
Medi-Cal	11.38
Other Public[1]	0.70
Individual Market	
On Exchange with Subsidies	1.16
On Exchange without Subsidies	0.15
Off Exchange	0.96
Uninsured	2.81

Source: 2016 California Health Interview Survey

[1] Inclusive of TRI-CARE, Healthy Kids, Indian Health Services, and other military/veterans programs.

In the absence of state based marketplace regulations, the take-up of insurance by those who were uninsured prior to 2014 would be significantly lower. By 2016, the Exchange achieved a take-up rate among individuals eligible for APTCs that was nearly 25 percent higher than the average for states with access only to the Federally Facilitated Marketplace. [3]

But this increased take-up rate may be more attributable to the Exchange's robust and successful outreach and marketing campaign than the proposed regulations. The reason for this is likely that the proposed regulations, which determine the extent to which uninsured Californians were eligible to purchase insurance, for the most part must adhere to federal requirements. With a few exceptions, such as those noted in section E. ALTERNATIVES below, California's eligibility standards mirror federal eligibility criteria.

[2] Available at http://healthpolicy.ucla.edu/publications/Documents/PDF/calsim_methods.pdf

[3] MARKETING MATTERS: Lessons From California to Promote Stability and Lower Costs in National and State Individual Insurance Markets, September 2017

Although the proposed regulations establish the eligibility and enrollment standards to enroll in health insurance coverage through the Exchange, the ACA also provided state-based marketplaces with full discretion on how to market the Exchange to its own state-specific market conditions. Most significant for the Exchange was the implementation of very robust outreach and marketing efforts that resulted in not only more enrollees, but healthier enrollees, which in turn translated into lower statewide premiums than would have been charged otherwise. The 2017 report, *MARKETING MATTERS: Lessons From California to promote Stability and Lower Costs in National and State Individual Insurance Markets*, provides an overview of California's marketing and outreach experience, strategy and tactics as well as its impact on enrollment and premiums.

2. Businesses

Health Insurance Carriers

Health insurance carriers that participate in the Exchange will have access to previously uninsured participants and associated premium revenue streams.

Healthcare Providers

Providers of healthcare goods and services will see increased revenue from the expansion of the number of individuals with health coverage.

C. COSTS

1. Individuals

Individuals who purchase insurance on the Exchange who were previously uninsured will reduce their spending on goods and services not related to health insurance and healthcare. The reduction will be equal to the amount of the unsubsidized portion of their premiums and their additional out-of-pocket healthcare spending based on the actuarial value of the policies purchased.

2. Businesses

The proposed regulations impose no direct costs on businesses. Indirectly, businesses outside of the health insurance and healthcare industries will see a reduction in spending on the part of newly insured individuals equal to their new premiums (net of subsidies) and additional out-of-pocket healthcare spending.

D. ECONOMIC IMPACTS

1. Economic Analysis Methodology

The REMI model of the California economy was used to assess economic impacts of the proposed regulations. The annual changes to consumer and healthcare spending beginning in 2016 were entered into the model. Multiple sectors are directly impacted: pharmaceuticals, health care, physician services, dental services, paramedical services, hospitals, nursing homes, health insurance, and state government. The spending impacts were apportioned to these sectors based on premiums paid, out-of-pocket healthcare spending, and federal subsidies paid.

2. Inputs and Assumptions

Enrollment in Exchange policies will have positive and negative impacts on spending on consumer goods and services and on spending in the healthcare and finance sectors. The overall economic impact of these regulations will be determined by the number and type of persons who enroll and pay for insurance coverage through the Exchange. Enrollees consist of those that are eligible for

and received federal subsidies and those that do not. Within each of these groups are those that previously had health insurance and those that didn't. The direct economic impact of this enrollment is reflected in the value of the policies sold to these groups and depends on (1) the premiums paid for the policies, (2) the extent to which the people covered by these policies were previously insured and (3) what share of the premiums paid were offset by APTC.

i. Enrollment and Payments

The impact of these regulations is fundamentally determined by the level and nature of enrollment in health plans sold through the Exchange. After the completion of its second open enrollment, 1.3 million Californians had purchased health insurance through the Exchange. The vast majority of the enrollees reported income levels that made them eligible for financial assistance—earning from 138 percent to 400 percent of the federal poverty level. Silver tier plans were the most popular, accounting for nearly two-thirds of plans selected. Half of all enrollees range from 45 to 64 years of age. The geographic distribution of Exchange enrollees closely mirrors that of the California population as a whole. Appendices 1 through 4 on pages 12 through 17 contain more information on Exchange enrollees. Appendix 6 provides a breakdown of the Covered California enrollment in 2017 by region, plan type and carrier.

Table 2 details the Health Plan Premiums paid during 2016 during which enrollees paid $6.5 billion for health insurance premiums, $5.8 billion of which was paid by those who received federal subsidizes. Of the latter amount, $4.2 billion was offset by APTC, with the remaining $1.6 billion was paid directly by subsidized enrollees. In addition, $724 million was paid as Cost Sharing Reductions (CSR) to reduce out-of-pocket expenses paid by subsidized enrollees for expenses such as copayments and deductibles.

Table 2
2016 Covered California Healthplan Premiums
$Millions

	All	Previously Insured	Previously Uninsured
Subsidized	$5,772	$4,423	$1,349
Un-Subsidized	$735	$563	$172
Total	**$6,508**	**$4,986**	**$1,521**
APTC Recieved	$4,201	$3,219	$982
Net Subsidized Premiums	$1,572	$1,204	$367
CSR	$724	$555	$169

Table 3
APTC Payments by Federal Poverty Level
2016 ($Millions)

138% FPL or less	$	89
138% FPL to 250% FPL	$	3,320
250% FPL to 400% FPL	$	783
400% FPL or greater	$	6
FPL Unavailable	$	1
Unsubsidized Application	$	1
Total	**$**	**4,202**

The Medical Loss Ratio provision of the ACA requires insurance companies to spend at least 80 percent of premium payments on medical care. Expenses such as administrative costs (including the PMPM) and profits, including executive salaries, overhead, and marketing must be paid out the remaining 20 percent. In 2016, health plans paid approximately $219 million to the Exchange in the form of a Per Member Per Month fee (PMPM).

ii. Modeling Impacts in REMI

Consumer spending not related to healthcare

Spending on goods and services not related to health insurance and healthcare in 2016 increased by $2,687 million. Enrollees who were previously uninsured reduced their spending by the amount spent on the unsubsidized portion of their premiums and the additional out-of-pocket healthcare spending[4] in 2016—$914 million. Enrollees who previously had health insurance could increase spending not related to health insurance and healthcare by the amount of subsidies received and cost sharing reductions paid—$3,773 million.

Healthcare and State Government Spending

Spending on health insurance increased by $1.5 billion, which was equal to the amount of premiums paid by enrollees who were not previously insured. In accordance with the ACA, 80 percent of those premiums, or $1,217 million, was spent on healthcare goods and services. The remaining premium revenues could be used to pay for administration, marketing, and profits, which includes fees paid to marketplaces. After paying PMPMs to the Exchange, Net Insurance spending increased $85 million. An additional $548 million was spent on healthcare goods and services in the form of additional out-of-pocket healthcare spending by those who were not previously insured. Thus overall spending on healthcare goods and services in 2016 increased $1,764 million.

Table 4 shows the estimated annual spending impacts to the affected sectors using the REMI model. The total increase in spending on healthcare goods and services represents the total increase in healthcare spending resulting from the expansion of health insurance enrollment facilitated by the Exchange. This increase was distributed across the healthcare subsectors based on the relative size of these sectors according to REMI model baseline data for 2016.

Table 4
2016 Spending Impacts from Enrollment in the Exchange

Component	REMI Category	Amount $Millions
Net increase in consumer spending not related to health insurance and healthcare by individuals who were previously uninsured.[1]	Consumer Spending (excluding healthcare goods and services)	$2,687
Increased spending on healthcare goods and services	Consumer Spending (healthcare)	
	Physician services	$420
	Dental services	$92
	Paramedical services	$295
	Hospitals	$809
	Nursing homes	$148
	Total	$1,764
Per Member Per Month fees paid to the Exchange	State Government Spending	$219
Increased health plan spending on administration, marketing, and profits (less PMPM fees)	Net health insurance	$85

[1] Additional consumer spending by the previously insured who now receive subsidies net of reduction in non-health insurance spending by those previously uninsured.

These impacts were projected from 2016 through 2020 based on the assumptions that (1) total enrollment through the Exchange remains stable at approximately 1.3 million from 2016 to 2020[5], (2) that premiums increase 6.7 percent per year on average over the same period and (3) that the ratios of spending between these sectors remains constant.

3. Impact Assessment Results

[4] Based on the actuarial value of the policies purchased

[5] Appendix 6 describes the Exchange's forecast methodology used to derive these enrollment projections.

i. Competitiveness

When comparing the competitive advantage of businesses outside of California to those in California, no direct impact is projected. All of the significant effects of enrollment in individual policies sold through the Exchange will apply to all states, even those that do not operate their own exchanges. The Eligibility and Enrollment regulations will align the policies and procedures of the Health Benefit Exchange with Federal standards and are designed in such a way to preserve competitiveness and market stability.

ii. Job Impacts in California

The implementation of these regulations will have both positive and negative impacts on employment in California, but will generate an overall net positive employment impact. As modeled, total employment increased 77,000 in 2016 and an increase of about 103,900 is expected in 2020. The cumulative total over the five years is an increase of about 466,000 jobs.

iii. California Business Impacts

Since the proposed regulations only pertain to enrollment in individual health insurance policies, they will not directly result in the creation or elimination of businesses. Indirectly however, the enrollment for health insurance through the Exchange, part of which will be subsidized by the federal government, will result in additional consumer spending overall. It will also alter the mix of spending between healthcare providers, health insurance carriers and providers of other categories of consumer goods and services. In addition, the establishment and growth of a health insurance exchange in the nation's most populous state will likely attract insurance carriers who did not previously sell policies in California.

iv. Investment and Incentives

These regulations do not require or mandate any additional investment from individuals or businesses. Any additional investment in the state would be an indirect effect of induced changes in medical care and consumer spending. As modeled, private investment in California increased $1,304 billion in 2016 and is expected to increase $2,124 billion in 2020. The cumulative total over the five years is an increase of $9,380 billion.

v. Personal Income

The direct and indirect impacts of the changes in the affected economic sectors also led to changes in personal income: an increase of $4,735 billion in 2016 and an expected increase of $8,751 billion in 2020. The cumulative total over the five years is an increase of $34,642 billion.

vi. Gross State Product

Increased access to affordable health insurance in California had a positive impact on Gross State Product of $6,321 billion in 2016 and an expected increase of $8,921 billion in 2020. The cumulative total over the five years is an increase of $39,093 billion.

vii. Incentives for Innovation in Products, Materials, or Processes

Improved access to affordable individual health insurance coverage will create new opportunities for individuals and businesses. Since individual health insurance will now be more readily available, the reluctance to leave a job due to uncertainties related to healthcare coverage will diminish. The dependence on employer supplied insurance (ESI) has long been thought to be a source of labor market inefficiencies[6].

Dependence on affordable health insurance creates a substantial inhibition for workers with jobs they are not satisfied with or where their skills are not a good fit to seek other employment opportunities. Research suggests that the dependence on ESI may reduce turnover among make

[6] Dean Baker, AARP Public Policy Institute, Job Lock and Employer-Provided Health Insurance: Evidence from the Literature, March 2015

workers by as much as 15–25 percent for men in the absence of affordable insurance alternatives. Without an affordable source of individual health insurance, such as that offered on the Exchange, workers are discouraged from seeking new jobs at which they will be more productive and paid more or from starting a business.

In addition to improved access to affordable insurance, the ACA implemented various measures to control the cost of healthcare itself. It simplified various administrative processes that will reduce paperwork and create uniform electronic standards and operating rules used by private insurers, Medicare, and Medicaid that may save the federal government as much as $20 billion over 10 years. At the same time the federal government made complimentary investments in health information technology. “Electronic health records will supply providers with more accurate and real-time data on their patients, as well as provide checks on drug interactions and decision support to improve the quality of care.” The ACA created, the Patient-Centered Outcomes Research Institute (PCORI) that “will empower physicians and patients with new information regarding the effectiveness of various medical technologies and interventions. The integration of the PCORI's research findings with decision supports, guidelines, and other aspects of electronic health records should greatly enhance the information that physicians and patients can use in choosing the right tests and treatments for a particular situation.” It also created incentives for physicians and hospitals to coordinate care for patients with chronic illnesses, such as congestive heart failure, diabetes, and hypertension.

4. Summary and Interpretation of Economic Impacts

As modeled, these regulations will likely improve the California economy. Significant increases in Gross State Product, investment and personal income will lead to positive impacts throughout the economy. Table 5 provides a summary of the impacts on employment, investment and incentives, personal income, and Gross State Product detailed above.

Table 5
Difference compared to Conforming California Forecast based on REMI Simulation Analysis

Category	2016	2017	2018	2019	2020	Cumulative
Total Employment *1,000s of Jobs*	77.0	88.5	95.3	101.2	103.9	466.0
Gross Private Domestic Fixed Investment *Billions of Fixed (2009) Dollars*	$1.304	$1.800	$2.024	$2.127	$2.124	$9.380
Personal Income *Billions of Current Dollars*	$4.735	$6.090	$7.047	$8.019	$8.751	$34.642
Gross Domestic Product *Billions of Fixed (2009) Dollars*	$6.321	$7.317	$7.965	$8.569	$8.921	$39.093

5. Federal Policy Uncertainties

Beginning with the change in the federal administration, there have been ongoing discussions and legislative proposals about repealing, replacing or making substantial changes to the Patient Protection and Affordable Care Act. These actions create a great deal of uncertainty about future enrollment in Covered California policies and thus and the level of premium payments and federal tax credits that will flow into the California economy.

Of the proposed policy changes, the elimination of the individual mandate would have the most negative short-term impact on enrollment with Covered California. The Federal Tax Reform act that passed both houses of Congress and has been (as of this writing) sent to the President’s desk for signature repeals the individual mandate beginning in 2019. This could lead open enrollment and special enrollment plan selections to drop significantly, leading to a decline in enrollment potentially in excess of 400,000. Additionally, the losses would be weighted to individuals with better health status, which would lead to a deterioration in the risk mix and an increase in premiums up to 25%. While this would have substantial negative impacts on the hundreds of thousands of Californians

who would either choose to or would be forced to go without coverage, the resultant rise in premiums caused by a deterioration of the risk mix would to some extent be offset by increased APTC payments which are adjusted in concert with benchmark Silver Plan premiums.

Beyond the Tax Bill, the most prominent other proposals to modify and stabilize ACA health exchange markets are included in The Bipartisan Health Care Stabilization Act of 2017. If enacted, this legislation would (1) fund the ACA's cost sharing reduction (CSR) subsidy payments to insurers; (2) streamline approval and relax affordability guidelines for 1332 Waivers; (3) add catastrophic "copper plans; (4) compel HHS to issue regulations on selling insurance across state lines; and (5) fund consumer outreach initiatives and state reinsurance programs. The principle provisions[7] included as of mid-December 2017 are as follows:

Allow States to Offer Value-Based Insurance Plans:

- *Creates more flexibility for states in the 1332 "guardrail" on affordability to allow for more variation in cost sharing and other health plan design elements, with protections for vulnerable and low-income populations and people with serious health conditions.*
- *Would not diminish existing patient protections under the Affordable Care Act (ACA), including the prohibition on charging more for pre-existing conditions, guaranteed issue, adult child coverage up to age 26, and the prohibition on annual and lifetime limits.*

More Funding Options:

- *Clarifies that states can opt to redirect a portion of their premium tax credits, cost sharing reductions, small business tax credits, and Basic Health Program funds to use for programs like reinsurance or invisible high-risk pools.*
- *Clarifies the "budget neutrality" test is over the entire term of a waiver and the required 10-year budget plan instead of expecting budget neutrality in the first year or every year under a waiver.*
- *Fixes the "double cap" by allowing the Secretary of Health and Human Services (HHS) to take into consideration the effect of the 1332 waiver on other federal programs when calculating deficit neutrality.*
- *Allows funds from the ACA Basic Health Program to be used towards a 1332 waiver and allow 1332 pass-through funding to be used for a Basic Health Program, making it easier for states with a Basic Health Plan to get a waiver.*

Streamlined 1332 Waiver Application Process:

- *Allows Governors to use their existing executive authority to apply for a waiver without needing additional state legislation.*
- *Reduces the HHS review period from 180 days to 90 days.*
- *Establishes a fast-track 45-day approval process, while maintaining the same approval standard as for other waivers, for waivers submitted in response to an urgent situation in a state, such as the risk of "bare counties" or excessive premium increases, or waivers that are the same or similar to a waiver that has already been approved for another state. Waivers granted for urgent situations will be granted three-year provisional approval, with the option to extend, subject to approval.*

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[7] https://www.help.senate.gov/imo/media/doc/THE%20BIPARTISAN%20HEALTH%20CARE%20STABILIZATION%20ACT%20OF%202017-%20SECTION%20BY%20SECTION.pdf

- *Requires HHS to create a menu of waiver options that can help states receive approval faster.*
- *More Certainty for States After a Waiver is Approved:*
- *Waivers would be for 6 years, unless a shorter waiver is requested by a state. This is an increase from a current maximum period of 5 years.*
- *Creates unlimited 6-year renewals of a waiver, subject to approval of the renewal.*
- *Prohibits the Secretary of HHS from suspending or terminating a waiver unless the Secretary determines that the state materially failed to comply with the terms and conditions of the waiver.*

Cost Sharing Payments.

- *Appropriates cost sharing reduction subsidies (CSRs) for 2017, 2018, and 2019.*
- *To prevent "double dipping" by insurance companies, requires states to certify that qualified health plan issuers that receive cost sharing reduction subsidy payments after rates are filed for 2018 will ensure that consumers and the Federal Government receive a financial benefit.*

Allow All Individuals to Purchase a Lower-Premium "Copper" Plan in the Individual Market.

- *Under current law, only individuals who are under the age of 30 or who meet a hardship exemption are allowed to purchase a lower premium "copper plan," which is also known as a catastrophic health plan.*
- *Section 4 allows anyone to purchase a copper plan, regardless of age or hardship status.*
- *These plans would be sold in the same risk pool as other metal-level plans.*
- *Copper plans would still be subject to same rules on out-of-pocket cost caps and benefits as catastrophic plans under current law.*

Consumer Outreach, Education, and Assistance.

- *Requires HHS to report on consumer outreach, education, and assistance activities.*
- *Allows HHS to contract with states to conduct outreach and enrollment activities funded by existing user fees designated for these activities.*
- *For plan years 2018 and 2019, requires HHS to fund outreach and enrollment activities using $106 million from existing user fees at the level designated for these activities in the 2018 benefit rule.*

Offering Health Plans in More than One State.

- *Requires HHS to promulgate regulations for the implementation of Health Care Choice Compacts established under section 1333 of the ACA, which would allow plans to be sold across state lines in the individual or small group market.*

E. ALTERNATIVES

State law created the California Health Benefit Exchange and the Health Benefit Exchange Board thereby codifying the establishment of a state-based exchange in California consistent with the federal Affordable Care Act. It also expressly requires the Exchange to adopt all of the requirements of the federal ACA and the requirements contained in federal guidance and regulations. With these mandates to adhere to federal law and regulations, the Exchange had no ability to implement alternative approaches in general, and had only limited opportunities to consider alternative approaches to specific provisions within the regulations.

Given these constraints, there are very few instances in these regulations where the Exchange could exercise its discretion to adopt requirements in the absence of strict federal guidance. Nearly all of these cases involve administrative requirements that have no effective impact on the value of policies offered and minimal impact the number of policies sold.

1. Alternative 1: Do not expand definition of Other Qualifying Life Event to include "Victims of domestic abuse and spousal abandonment"

The imposition of guaranteed issue on insurance carriers in 2014, created the possibility for consumers to sign up and pay premiums only when they needed medical treatment. To ensure healthcare cost stability and predictability, consumers must experience a "qualifying life event" (QLE) to be eligible to enroll in coverage outside of Covered California's open-enrollment period. When enrolling outside of open enrollment, consumers must certify that they have experienced one of several events in order to obtain coverage.

While Covered California's QLEs largely conform to federal guidelines, the Exchange was given the option to expand the definition of Other Qualifying Life Event to include "*Victims of domestic abuse and spousal abandonment.*" The Exchange adopted this option which will entitle more individuals to enroll through the Exchange than if it had not.

i. Costs and Benefits

Alternative 1 results in less enrollment through the Exchange which would reduce the benefits of expanded insurance coverage but would also enhance the stability of the insurance risk pool during special enrollment periods and reduce the number of applications processed by the Exchange and the carriers. According to U.S. Department of Justice Special Report Nonfatal Domestic Violence, 2003–2012, April 2014, "*serious violence by immediate family members fluctuated between 0.3 and 0.6 per 1,000 from 2003 to 2012.*" During the 2016 Special Enrollment period, there were 22,700 enrollments allowed under Other Qualifying Life Event.[8] Thus in 2016, between 700 and 1,300 enrollments may have occurred for this reason.

ii. Economic Impacts

As modeled, Alternative 1 would lead to a 0.13% reduction in enrollment and would thus lead to a very small reduction in the estimated economic impact. Compared to the baseline estimate, from 2016 through 2020, estimated employment gains would be reduced by 274,000 jobs, private investment gains by $5.4 billion, income gains by $19 billion, and state GDP gains by $23 billion.

iii. Reason for Rejection

Alternative 1 was rejected because it would have led to less enrollment on the Exchange, whose mission is to increase the number of insured Californians. Lower enrollment would also lead to reduced economic benefits for California. The potential marginal additional stability for the risk pool and cost savings from processing fewer applications is far outweighed by the benefits of additional enrollment.

2. Alternative 2: Adopt Minimum Grace Period for Incomplete Applications

In order to assess an applicant's eligibility to enroll on the Exchange and eligibility for financial assistance, applicants are asked to supply various pieces of personal information. Since many enrollment actions are executed via the Exchange's web site (www.coveredca.com) or by a phone call to a service center, it would be unrealistic to expect each and every applicant to be able to immediately supply all information requested in real time. Therefore a grace period was granted for enrollees to supply missing information after their applications were submitted. If the missing information is not supplied during the grace period, their coverage would be terminated.

[8] Includes "Null" reason code.

The Exchange was given the option to set the grace period for applicants who submit incomplete applications to provide the missing information. The regulations allow applicants 90 calendar days from the date they were notified that their application was incomplete to provide the missing information or until the end of the relevant enrollment period but no less than 30 days from the date of the incomplete application notice. Federal regulations allow the Exchange to set the grace period from as little as 10 calendar days to as much as 90 days from the date of the incomplete application notice.

i. Costs and Benefits

During 2014[9], an estimated 42,500 incomplete applications were received, of which 30,700 were completed within 10 days and another 18,900 were completed within 90 days. On average each application received in 2014 represented 1.3 enrollees. Thus, limiting the grace period to 10 days would have reduced enrollment by 24,600. Since potential enrollees who submit incomplete applications can ultimately be enrolled if the missing information is supplied, their applications must be retained and tracked during the grace period. Restricting the duration of the grace period could potentially reduce the quantity of incomplete application files the Exchange must store.

ii. Economic Impacts

As modeled, Alternative 2 would lead to a 2.6% reduction in enrollment and would thus lead to a very small reduction in the estimated economic impact. Compared to the baseline estimate, from 2016 through 2020, estimated employment gains would be reduced by 273,000 jobs, private investment gains by $5.4 billion, income gains by $18.7 billion, and state GDP gains by $23 billion.

iii. Reason for Rejection

Alternative 2 was rejected because it would have led to less enrollment on the Exchange, whose mission is to increase the number of insured Californians. Lower enrollment would also lead to reduced economic benefits for California. The potential administrative cost savings from maintaining fewer incomplete applications is far outweighed by the benefits of additional enrollment.

F. FISCAL IMPACTS

1. Local Government

The proposed regulations do not affect local government.

2. Covered California

California chose to operate its own exchange (”marketplace”) thereby creating Covered California and its governing Board. The Exchange is funded exclusively by policy assessments on health plans sold through the Exchange, which totaled $219 million in 2016. Starting in 2017, the plan assessment was changed to a Percent of Premium basis, initially set at 4 percent. No state California General Fund money can be used to support the Exchange. No liability incurred by the Exchange or any of its officers or employees may be satisfied using moneys from the General Fund.

3. Other State Agencies

Covered California interacts with a number of state publicly funded health programs which include the Department of Social Services, the Office of Systems Integration/Department of Health Care Services, the California Department of Insurance, and the Department of Managed Health Care. Typically these interactions are funded through reimbursement agreements or interagency agreements. Covered California utilizes the Health Care Trust Fund with resources largely assessed

[9] The latest date that information is available.

on premiums to pay interagency agreement costs. In total, the amount budgeted for FY 2017-18 is $42.5 million paid from the Health Care Trust Fund from assessments levied on insurance premiums.

i. Department of Social Services

Government Code Section 100506.3 requires the Board to enter into a contract with the State Department of Social Services to serve as the Exchange appeals entity to hear appeals as specified. For FY 2017-18 Covered California has budgeted approximately $11.4 million for work associated with appeals provided by Department of Social Services. To the extent there are more or less appeals in the future, the interagency agreement will be amended to adjust costs as appropriate.

In addition to appeals, the Exchange has also budgeted approximately $3 million for a separate contract with California Department of Social Services for the purpose of reimbursing the Department of Social Services for a designated portion of the total application maintenance costs for the Statewide Automated Welfare Systems (SAWS)/California Health Care Eligibility, Enrollment & Retention System (CALHEERS) interface.

ii. Department of Managed Health Care/California Department of Insurance

Regulation and oversight of health insurance in California is performed by two departments: the Department of Managed Health Care (which primarily regulates health maintenance organizations) and the California Department of Insurance (which regulates traditional health insurance.) Most of the Health Plans offered through Covered California are regulated by the Department of Managed Health Care. Both Departments license and review rates for health plans under their jurisdiction. Health plans are required to apply for and maintain a license to operate as a health plan in California. The Departments review all aspects of the plan's operations to ensure compliance with California law. This includes, but is not limited to, Evidences of Coverage, contracts with doctors and hospitals, provider networks, and complaint and grievance systems. Additionally, the Departments review proposed premium rate increases to make sure health plans are providing detailed information to the public to justify proposed increases. While the Departments do not have the authority to deny rate increases, their efforts improve accountability in health plan rate setting. The Departments incurs costs for licensing and rate review for Covered California plans. Those costs are funded by fees assessed on plans by the Departments.

iii. Office of Systems Integration

Government Code Section 100503 requires the board to determine the criteria and process for eligibility, enrollment, and disenrollment of enrollees and potential enrollees in the Exchange and coordinate that process with state and local government entities administering other health care coverage as specified. Through interagency agreements between the Office of Systems Integration and, Covered California and the Department of Health Care Services, the State of California operates the California Health Care Eligibility, Enrollment, and Retention System (CalHEERS). This system serves as the consolidated system support for eligibility, enrollment, and retention for Covered California, Medi-Cal, and Healthy Families. As authorized by the Center for Medicaid Services (CMS), funding for the CalHEERS system is cost allocated with Covered California proposing to pay 12.1 percent and Department of Health Care Services paying 87.9 percent for FFY 2017-18. The Department of Health Care Services uses a combination of Federal Funds and State General Fund to pay their share. For FY 2017-18 Covered California has budgeted $31.4 million to reimburse the California Office of Systems Integration for CalHEERS and other system related costs. As total project costs change and membership changes in the future, adjustments will be made to the cost allocation as necessary.

iv. Department of Health Care Services

Covered California has a number of interagency agreements and relationships with the Department of Health Care Services. These include an interagency agreement for a timekeeping system ($115,000); access to the Medi-Cal Eligibility Data System (MEDS) ($3,000); and support in detecting, investigating and prosecuting fraud and abuse ($50,000).

In addition, Government Code Section 100504(a)(7) authorizes the Board to collaborate with the state Department of Health Services to the extent possible to allow an individual the option to remain enrolled with his or her carrier and provider network in the event the individual experiences a loss of eligibility of premium tax credits and becomes eligible for the Medi-Cal program or, loses eligibility for the Medi-Cal program or the Healthy Families Program and becomes eligible for premium tax credits through the exchange. Covered California and Medi-Cal have and continue to work collaboratively on transitioning consumers from one program to the other.

Furthermore when consumers determine eligibility for Medi-Cal, some will likely be determined eligible for Covered California and conversely when consumers determine eligibility for Covered California some will likely be determined eligible for Medi-Cal.

Covered California supports enrollees who are members of families or households in which other members are eligible for and receive health insurance from the state's Medi-Cal program. From 10 to 20 percent of Covered California enrollees are members of these mixed cases and present an additional workload on county eligibility workers. Medi-Cal recipients are subject to an annual recertification or renewal process that is spread evenly throughout each calendar year. Covered California's annual open enrollment period, in contrast, is limited to a few specific Open Enrollment months each year during which all of these mixed household cases are reevaluated for eligibility for Medi-Cal. This results in a very large unseasonal volume of mixed case Medi-Cal redeterminations and increased workload for local eligibility workers.

v. Employment Development Department

The Employment Development Department (EDD) provides inserting and mailing services for Covered California. Covered California provides and insert for inclusion into existing Unemployment Insurance program jobs and mailed to approximately 4.7 million recipients. The FY 2017-18 budget for these services is $87,000.

G. APPENDICES

1. Covered California Enrollees by Metal Tier by County
2. Covered California Enrollees by Gender by County
3. Covered California Enrollees by Age by County
4. Covered California Enrollees by Federal Poverty Level by County
5. 2017 Covered California Enrollment by Region, Plan and Carrier
6. Covered California Enrollment and Revenue Forecast

APPENDIX 1: Covered California Enrollees by Metal Tier by County

County	Minimum Coverage	Bronze	Silver	Silver - Enhanced 73	Silver - Enhanced 87	Silver - Enhanced 94	Gold	Platinum	Grand Total
Alameda	440	17,650	9,270	6,170	14,680	7,120	3,060	3,040	**61,430**
Alpine	0	20	10	10	10	0	10	0	**60**
Amador	10	340	170	160	390	150	50	30	**1,300**
Butte	20	2,300	840	700	1,740	800	250	170	**6,820**
Calaveras	10	580	310	180	380	180	90	50	**1,780**
Colusa	0	410	100	80	250	160	20	10	**1,030**
Contra Costa	220	10,210	6,380	3,520	8,720	4,060	2,360	2,270	**37,740**
Del Norte	0	220	80	60	150	60	40	10	**620**
El Dorado	20	2,440	1,320	810	1,810	710	370	320	**7,800**
Fresno	90	5,630	2,030	1,960	6,310	3,670	640	630	**20,960**
Glenn	0	350	100	80	240	100	30	10	**910**
Humboldt	30	1,840	840	670	1,420	650	190	140	**5,780**
Imperial	10	3,310	280	300	1,020	640	80	30	**5,670**
Inyo	0	210	120	60	150	80	40	20	**680**
Kern	110	4,310	1,550	1,500	5,230	3,060	680	650	**17,090**
Kings	10	530	170	230	610	340	90	40	**2,020**
Lake	10	680	310	260	620	230	110	50	**2,270**
Lassen	0	120	70	60	110	30	10	10	**410**
Los Angeles	2,490	65,460	42,900	34,470	103,770	66,940	20,740	17,780	**354,550**
Madera	10	980	470	410	1,230	580	130	110	**3,920**
Marin	60	3,960	2,470	980	2,020	930	790	750	**11,960**
Mariposa	0	160	130	70	200	80	40	20	**700**
Mendocino	20	1,390	610	530	1,080	410	170	110	**4,320**
Merced	20	1,580	920	1,000	3,100	1,430	370	150	**8,570**
Modoc	0	80	30	30	70	50	10	0	**270**
Mono	0	350	120	100	210	80	30	20	**910**
Monterey	50	5,120	1,900	1,210	3,110	1,550	430	220	**13,590**
Napa	30	1,730	820	530	1,170	400	280	240	**5,200**
Nevada	20	2,220	930	620	1,440	580	250	140	**6,200**
Orange	710	26,010	17,540	12,260	34,820	21,090	8,090	6,440	**126,960**
Placer	70	4,180	2,230	1,280	2,970	1,520	730	510	**13,490**
Plumas	0	250	150	110	190	70	30	10	**810**
Riverside	330	14,410	7,470	6,240	18,720	11,010	3,660	3,410	**65,250**
Sacramento	250	12,750	4,810	3,940	11,120	6,210	1,480	1,610	**42,170**
San Benito	0	410	310	220	460	230	90	50	**1,770**
San Bernardino	260	11,550	5,390	4,930	15,080	9,290	2,460	2,490	**51,450**
San Diego	860	32,140	15,600	10,810	30,670	17,210	6,970	6,390	**120,650**
San Francisco	400	11,440	5,170	3,480	8,070	3,300	1,750	1,820	**35,430**
San Joaquin	110	5,350	2,640	2,350	7,390	3,720	970	820	**23,350**
San Luis Obispo	60	3,550	1,950	1,260	2,660	1,240	540	320	**11,580**
San Mateo	170	7,660	4,320	2,460	5,210	2,180	1,490	1,290	**24,780**
Santa Barbara	100	4,800	2,330	1,580	3,710	1,720	730	430	**15,400**
Santa Clara	550	19,830	8,900	5,370	12,810	6,930	2,690	2,270	**59,350**
Santa Cruz	40	3,660	2,540	1,500	3,350	1,390	840	450	**13,770**
Shasta	20	2,590	880	610	1,530	860	250	100	**6,840**
Sierra	0	30	10	10	30	10	10	0	**100**
Siskiyou	10	660	190	150	320	150	40	30	**1,550**
Solano	70	3,400	1,450	1,140	2,690	1,360	410	640	**11,160**
Sonoma	140	7,470	3,680	2,200	4,680	1,900	1,060	860	**21,990**
Stanislaus	60	3,800	2,190	2,050	5,500	2,690	740	770	**17,800**
Sutter	20	1,300	250	270	850	630	100	50	**3,470**
Tehama	0	670	230	170	470	240	70	30	**1,880**
Trinity	0	160	60	60	150	70	10	20	**530**
Tulare	30	1,710	1,060	1,300	3,750	1,790	390	160	**10,190**
Tuolumne	10	670	290	270	540	290	100	50	**2,220**
Ventura	150	9,140	4,950	3,260	7,920	4,350	1,580	1,140	**32,490**
Yolo	30	1,640	660	480	1,330	650	300	240	**5,330**
Yuba	10	480	170	170	520	230	50	50	**1,680**
TOTAL	**8,140**	**325,890**	**172,670**	**126,690**	**348,750**	**197,400**	**68,990**	**59,470**	**1,308,000**

Source: Covered California Active Member Profile

APPENDIX 2: Covered California Enrollees by Gender by County

County	Female	Male	Grand Total
Alameda	32,070	29,300	**61,370**
Alpine	30	30	**60**
Amador	710	590	**1,300**
Butte	3,690	3,130	**6,820**
Calaveras	960	820	**1,780**
Colusa	530	480	**1,010**
Contra Costa	19,880	17,820	**37,700**
Del Norte	330	280	**610**
El Dorado	4,090	3,700	**7,790**
Fresno	10,660	10,260	**20,920**
Glenn	460	440	**900**
Humboldt	3,070	2,710	**5,780**
Imperial	2,760	2,890	**5,650**
Inyo	360	320	**680**
Kern	9,040	8,020	**17,060**
Kings	1,060	960	**2,020**
Lake	1,230	1,030	**2,260**
Lassen	220	200	**420**
Los Angeles	181,340	172,870	**354,210**
Madera	2,080	1,830	**3,910**
Marin	6,460	5,470	**11,930**
Mariposa	370	330	**700**
Mendocino	2,270	2,040	**4,310**
Merced	4,380	4,180	**8,560**
Modoc	150	120	**270**
Mono	440	460	**900**
Monterey	7,080	6,500	**13,580**
Napa	2,830	2,370	**5,200**
Nevada	3,340	2,840	**6,180**
Orange	66,650	60,220	**126,870**
Placer	7,200	6,280	**13,480**
Plumas	430	380	**810**
Riverside	34,180	30,970	**65,150**
Sacramento	21,730	20,410	**42,140**
San Benito	940	830	**1,770**
San Bernardino	27,250	24,110	**51,360**
San Diego	62,640	57,920	**120,560**
San Francisco	17,180	18,210	**35,390**
San Joaquin	12,120	11,200	**23,320**
San Luis Obispo	6,210	5,350	**11,560**
San Mateo	12,890	11,860	**24,750**
Santa Barbara	8,190	7,190	**15,380**
Santa Clara	30,710	28,580	**59,290**
Santa Cruz	7,190	6,580	**13,770**
Shasta	3,710	3,110	**6,820**
Sierra	40	60	**100**
Siskiyou	830	700	**1,530**
Solano	6,070	5,070	**11,140**
Sonoma	12,060	9,900	**21,960**
Stanislaus	9,380	8,420	**17,800**
Sutter	1,790	1,690	**3,480**
Tehama	1,010	880	**1,890**
Trinity	280	260	**540**
Tulare	5,300	4,880	**10,180**
Tuolumne	1,230	970	**2,200**
Ventura	17,290	15,180	**32,470**
Yolo	2,700	2,600	**5,300**
Yuba	900	770	**1,670**
TOTAL	**679,990**	**626,570**	**1,306,560**

Source: Covered California Active Member Profile

APPENDIX 3: Covered California Enrollees by Age by County

County	Age 0 to 18	Age 19 to 29	Age 30 to 44	Age 45 to 64	Age 65+	Grand Total
Alameda	4,100	11,190	16,410	28,820	910	**61,430**
Alpine	0	0	20	40	0	**60**
Amador	60	140	240	830	20	**1,290**
Butte	330	980	1,460	3,940	110	**6,820**
Calaveras	100	180	300	1,170	30	**1,780**
Colusa	40	140	220	600	20	**1,020**
Contra Costa	2,980	6,400	8,730	19,030	610	**37,750**
Del Norte	40	70	110	390	10	**620**
El Dorado	560	1,080	1,480	4,580	110	**7,810**
Fresno	670	3,850	4,740	11,350	330	**20,940**
Glenn	40	110	170	580	10	**910**
Humboldt	320	770	1,650	2,970	70	**5,780**
Imperial	120	940	980	3,450	150	**5,640**
Inyo	40	80	160	390	10	**680**
Kern	670	2,940	3,740	9,480	250	**17,080**
Kings	50	290	410	1,230	40	**2,020**
Lake	80	230	380	1,550	40	**2,280**
Lassen	20	50	70	280	0	**420**
Los Angeles	15,380	66,520	88,340	179,850	4,450	**354,540**
Madera	170	620	750	2,330	60	**3,930**
Marin	1,330	1,440	2,260	6,700	210	**11,940**
Mariposa	30	80	150	410	20	**690**
Mendocino	220	410	980	2,610	90	**4,310**
Merced	290	1,490	1,990	4,650	160	**8,580**
Modoc	20	20	40	190	10	**280**
Mono	50	140	250	460	10	**910**
Monterey	780	2,180	3,010	7,410	210	**13,590**
Napa	360	860	1,180	2,720	80	**5,200**
Nevada	420	680	1,390	3,600	100	**6,190**
Orange	7,940	23,230	28,220	65,890	1,680	**126,960**
Placer	1,120	2,130	3,180	6,880	170	**13,480**
Plumas	20	70	120	580	10	**800**
Riverside	3,210	10,570	14,240	36,270	960	**65,250**
Sacramento	1,940	8,130	11,060	20,440	600	**42,170**
San Benito	110	280	360	990	30	**1,770**
San Bernardino	2,030	8,910	11,240	28,490	760	**51,430**
San Diego	7,380	21,200	29,440	60,730	1,890	**120,640**
San Francisco	1,560	6,470	11,050	15,950	410	**35,440**
San Joaquin	1,090	4,200	5,530	12,100	420	**23,340**
San Luis Obispo	750	1,740	2,480	6,430	170	**11,570**
San Mateo	1,860	4,300	5,670	12,490	450	**24,770**
Santa Barbara	1,000	2,640	3,240	8,270	240	**15,390**
Santa Clara	4,010	10,520	13,380	30,390	1,040	**59,340**
Santa Cruz	920	2,160	3,080	7,380	250	**13,790**
Shasta	410	780	1,460	4,080	100	**6,830**
Sierra	0	10	10	70	0	**90**
Siskiyou	60	150	250	1,040	30	**1,530**
Solano	580	2,060	2,590	5,750	170	**11,150**
Sonoma	1,650	3,310	5,010	11,680	330	**21,980**
Stanislaus	870	3,080	4,170	9,470	230	**17,820**
Sutter	120	590	870	1,850	60	**3,490**
Tehama	100	200	360	1,200	50	**1,910**
Trinity	20	40	100	360	10	**530**
Tulare	300	1,600	2,010	6,090	190	**10,190**
Tuolumne	120	240	440	1,360	40	**2,200**
Ventura	2,340	5,580	6,790	17,330	460	**32,500**
Yolo	320	1,080	1,280	2,560	80	**5,320**
Yuba	70	230	320	1,030	30	**1,680**
TOTAL	**71,170**	**229,380**	**309,560**	**678,760**	**18,980**	**1,307,850**

Source: Covered California Active Member Profile

APPENDIX 4: Covered California Enrollees by Federal Poverty Level (FPL) by County

County	138% FPL or less	138% FPL to 150% FPL	150% FPL to 200% FPL	200% FPL to 250% FPL	250% FPL to 400% FPL	400% FPL or greater	Unsubsidized Application	Grand Total
Alameda	1,660	6,960	18,820	11,150	16,890	2,670	3,270	**61,420**
Alpine	0	10	20	10	20	0	10	**70**
Amador	30	150	450	250	350	30	50	**1,310**
Butte	150	790	2,300	1,350	1,870	150	210	**6,820**
Calaveras	20	200	490	320	600	60	90	**1,780**
Colusa	40	160	440	160	190	10	20	**1,020**
Contra Costa	1,060	4,020	11,170	6,560	11,370	1,480	2,100	**37,760**
Del Norte	20	60	190	120	190	10	20	**610**
El Dorado	150	740	2,320	1,420	2,550	240	390	**7,810**
Fresno	760	3,610	8,380	3,560	3,810	360	470	**20,950**
Glenn	20	90	360	190	210	20	30	**920**
Humboldt	100	680	1,870	1,160	1,640	170	180	**5,800**
Imperial	200	940	2,410	1,120	920	20	30	**5,640**
Inyo	10	90	200	120	210	30	30	**690**
Kern	780	2,910	6,950	2,800	2,960	260	420	**17,080**
Kings	80	330	820	400	330	30	30	**2,020**
Lake	40	230	800	420	630	70	70	**2,260**
Lassen	10	30	140	90	130	10	10	**420**
Los Angeles	11,620	67,230	126,390	56,680	63,510	11,540	17,570	**354,540**
Madera	120	580	1,550	680	880	40	80	**3,930**
Marin	350	960	2,700	1,880	4,170	660	1,230	**11,950**
Mariposa	20	80	240	130	180	20	20	**690**
Mendocino	110	430	1,380	870	1,240	160	150	**4,340**
Merced	300	1,290	3,610	1,500	1,640	110	130	**8,580**
Modoc	20	40	90	70	50	0		**270**
Mono	30	80	260	190	300	20	30	**910**
Monterey	400	1,550	4,350	2,590	3,950	300	460	**13,600**
Napa	120	420	1,590	980	1,640	180	280	**5,210**
Nevada	110	580	1,810	1,130	2,070	200	300	**6,200**
Orange	3,680	20,810	41,900	20,850	30,210	3,770	5,720	**126,940**
Placer	320	1,490	3,870	2,360	4,470	380	610	**13,500**
Plumas	10	70	240	180	270	30	10	**810**
Riverside	2,320	10,720	23,890	11,050	13,210	1,530	2,540	**65,260**
Sacramento	1,310	6,260	15,100	7,840	9,540	910	1,220	**42,180**
San Benito	50	210	550	330	550	40	40	**1,770**
San Bernardino	1,670	9,300	19,530	8,950	9,360	1,130	1,500	**51,440**
San Diego	3,700	17,490	40,230	20,520	28,960	3,780	5,960	**120,640**
San Francisco	930	3,360	10,640	6,780	9,020	1,980	2,720	**35,430**
San Joaquin	720	3,560	9,030	3,980	5,020	510	530	**23,350**
San Luis Obispo	210	1,260	3,360	2,160	3,830	370	370	**11,560**
San Mateo	750	2,170	6,830	4,490	7,780	1,090	1,660	**24,770**
Santa Barbara	440	1,760	4,700	2,850	4,480	490	680	**15,400**
Santa Clara	1,640	7,100	17,500	10,540	16,450	2,470	3,640	**59,340**
Santa Cruz	360	1,300	4,050	2,480	4,420	560	610	**13,780**
Shasta	140	890	2,110	1,230	2,140	140	180	**6,830**
Sierra	0	10	30	20	40	0	0	**100**
Siskiyou	20	160	480	310	470	30	70	**1,540**
Solano	330	1,340	3,580	2,140	3,120	300	330	**11,140**
Sonoma	550	1,950	6,360	4,040	7,320	750	1,020	**21,990**
Stanislaus	490	2,540	6,580	3,420	4,090	310	380	**17,810**
Sutter	140	630	1,320	620	640	60	70	**3,480**
Tehama	60	240	660	340	540	30	40	**1,910**
Trinity	10	70	180	120	130	10	10	**530**
Tulare	340	1,630	4,290	1,880	1,760	120	180	**10,200**
Tuolumne	50	270	660	440	670	70	50	**2,210**
Ventura	910	4,300	10,190	5,860	9,240	760	1,230	**32,490**
Yolo	190	640	1,840	970	1,240	170	280	**5,330**
Yuba	60	210	680	310	340	30	40	**1,670**
TOTAL	**39,730**	**196,980**	**442,480**	**224,960**	**303,810**	**40,670**	**59,370**	**1,308,000**

Source: Covered California Active Member Profile

APPENDIX 5: 2017 Covered California Enrollment by Region, Plan and Carrier

Region		Carrier	Network Type	Metal Level	Plan Type	Premium/Mo.	Enrollment
1	Alpine, Del Norte, Siskiyou, Modoc, Lassen, Shasta, Trinity, Humboldt, Tehama, Plumas, Nevada, Sierra, Mendocino, Lake, Butte, Glenn, Sutter, Yuba, Colusa, Amador, Calaveras, and Tuolumne.	Anthem	EPO	Catastrophic		$ 242.92	230
		Anthem	EPO	Bronze		$ 287.20	11,106
		Anthem	EPO	Silver		$ 407.86	23,936
		Anthem	EPO	Gold		$ 515.51	886
		Anthem	EPO	Platinum		$ 613.25	367
		Anthem	EPO	HDHP		$ 281.33	6,618
		Blue Shield	HMO	Silver		$ 540.02	3
		Blue Shield	HMO	Gold		$ 654.97	-
		Blue Shield	HMO	Platinum		$ 809.41	-
		Blue Shield	PPO	Catastrophic		$ 352.48	6
		Blue Shield	PPO	Bronze		$ 382.90	1,601
		Blue Shield	PPO	Silver		$ 450.37	9,167
		Blue Shield	PPO	Gold		$ 559.11	433
		Blue Shield	PPO	Platinum		$ 715.50	132
		Blue Shield	PPO	HDHP		$ 370.84	1,186
		HealthNet CA	HCSP	Catastrophic		$ 308.46	-
		HealthNet CA	HCSP	Bronze		$ 391.40	4
		HealthNet CA	HCSP	Silver		$ 519.39	4
		HealthNet CA	HCSP	Gold		$ 647.36	-
		HealthNet CA	HCSP	Platinum		$ 764.84	1
		Kaiser	HMO	Catastrophic		$ 254.48	3
		Kaiser	HMO	Bronze		$ 291.25	135
		Kaiser	HMO	Silver		$ 401.60	325
		Kaiser	HMO	Gold	Coinsurance	$ 444.76	8
		Kaiser	HMO	Gold	Copay	$ 465.46	12
		Kaiser	HMO	Platinum		$ 513.73	23
		Kaiser	HMO	HDHP		$ 293.65	31

Region		Carrier	Network Type	Metal Level	Plan Type	Premium/Mo.	Enrollment
2	Napa, Sonoma, Solano, and Marin.	Anthem	EPO	Catastrophic		$ 314.56	36
		Anthem	EPO	Bronze		$ 371.90	1,717
		Anthem	EPO	Silver		$ 528.13	1,438
		Anthem	EPO	Gold		$ 667.54	125
		Anthem	EPO	Platinum		$ 794.09	125
		Anthem	EPO	HDHP		$ 364.28	716
		Blue Shield	HMO	Silver		$ 536.46	-
		Blue Shield	HMO	Gold		$ 650.65	-
		Blue Shield	HMO	Platinum		$ 804.08	-
		Blue Shield	PPO	Catastrophic		$ 369.51	8
		Blue Shield	PPO	Bronze		$ 401.40	919
		Blue Shield	PPO	Silver		$ 472.13	6,379
		Blue Shield	PPO	Gold		$ 586.14	670
		Blue Shield	PPO	Platinum		$ 750.08	155
		Blue Shield	PPO	HDHP		$ 388.77	533
		HealthNet Life	EPO	Catastrophic		$ 299.07	9
		HealthNet Life	EPO	Bronze		$ 379.47	135
		HealthNet Life	EPO	Silver		$ 503.56	168
		HealthNet Life	EPO	Gold		$ 627.62	15
		HealthNet Life	EPO	Platinum		$ 741.53	10
		Kaiser	HMO	Catastrophic		$ 267.88	223
		Kaiser	HMO	Bronze		$ 306.58	8,239
		Kaiser	HMO	Silver		$ 422.74	16,935
		Kaiser	HMO	Gold	Coinsurance	$ 468.16	510
		Kaiser	HMO	Gold	Copay	$ 489.96	1,308
		Kaiser	HMO	Platinum		$ 540.77	1,489
		Kaiser	HMO	HDHP		$ 309.10	2,881
		Western	HMO	Catastrophic		$ 246.73	91
		Western	HMO	Bronze		$ 302.85	2,448
		Western	HMO	Silver		$ 395.04	4,498
		Western	HMO	Gold		$ 473.87	230
		Western	HMO	Platinum		$ 513.73	214
		Western	HMO	HDHP		$ 310.04	483

Region		Carrier	Network Type	Metal Level	Plan Type	Premium/Mo.	Enrollment
3	Sacramento, Placer, El Dorado, and Yolo.	Anthem	HMO	Silver		$ 705.61	4
		Anthem	HMO	Gold		$ 863.53	1
		Anthem	HMO	Platinum		$ 1,039.92	3
		Anthem	EPO	Catastrophic		$ 280.47	109
		Anthem	EPO	Bronze		$ 331.60	5,115
		Anthem	EPO	Silver		$ 470.89	5,953
		Anthem	EPO	Gold		$ 595.19	153
		Anthem	EPO	Platinum		$ 708.02	115
		Anthem	EPO	HDHP		$ 324.80	2,415
		Blue Shield	HMO	Silver		$ 512.04	33
		Blue Shield	HMO	Gold		$ 621.04	5
		Blue Shield	HMO	Platinum		$ 767.48	1
		Blue Shield	PPO	Catastrophic		$ 374.85	11
		Blue Shield	PPO	Bronze		$ 407.19	1,240
		Blue Shield	PPO	Silver		$ 478.95	8,350
		Blue Shield	PPO	Gold		$ 594.59	611
		Blue Shield	PPO	Platinum		$ 760.90	249
		Blue Shield	PPO	HDHP		$ 394.37	696
		HealthNet CA	HCSP	Catastrophic		$ 297.72	5
		HealthNet CA	HCSP	Bronze		$ 377.78	111
		HealthNet CA	HCSP	Silver		$ 501.31	68
		HealthNet CA	HCSP	Gold		$ 624.82	6
		HealthNet CA	HCSP	Platinum		$ 738.22	3
		Kaiser	HMO	Catastrophic		$ 254.48	397
		Kaiser	HMO	Bronze		$ 291.25	11,093
		Kaiser	HMO	Silver		$ 401.60	28,809
		Kaiser	HMO	Gold	Coinsurance	$ 444.76	729
		Kaiser	HMO	Gold	Copay	$ 465.46	1,575
		Kaiser	HMO	Platinum		$ 513.73	1,768
		Kaiser	HMO	HDHP		$ 293.65	3,593
		Western	HMO	Catastrophic		$ 271.29	28
		Western	HMO	Bronze		$ 332.60	799
		Western	HMO	Silver		$ 426.16	3,403
		Western	HMO	Gold		$ 511.80	276
		Western	HMO	Platinum		$ 567.22	222
		Western	HMO	HDHP		$ 344.00	190

Region		Carrier	Network Type	Metal Level	Plan Type	Premium/Mo.	Enrollment
4	San Francisco.	Anthem	EPO	Catastrophic		$ 323.42	55
		Anthem	EPO	Bronze		$ 382.38	922
		Anthem	EPO	Silver		$ 543.01	803
		Anthem	EPO	Gold		$ 686.34	85
		Anthem	EPO	Platinum		$ 816.46	126
		Anthem	EPO	HDHP		$ 374.54	479
		Blue Shield	HMO	Silver		$ 496.69	52
		Blue Shield	HMO	Gold		$ 602.42	21
		Blue Shield	HMO	Platinum		$ 744.47	3
		Blue Shield	PPO	Catastrophic		$ 378.59	46
		Blue Shield	PPO	Bronze		$ 411.26	1,013
		Blue Shield	PPO	Silver		$ 483.73	6,298
		Blue Shield	PPO	Gold		$ 600.53	860
		Blue Shield	PPO	Platinum		$ 768.51	380
		Blue Shield	PPO	HDHP		$ 398.31	474
		Chinese C.	HMO	Catastrophic		$ 310.27	12
		Chinese C.	HMO	Bronze		$ 313.64	3,358
		Chinese C.	HMO	Silver		$ 406.85	6,100
		Chinese C.	HMO	Gold		$ 501.58	59
		Chinese C.	HMO	Platinum		$ 553.40	58
		HealthNet Life	EPO	Catastrophic		$ 322.61	27
		HealthNet Life	EPO	Bronze		$ 409.35	79
		HealthNet Life	EPO	Silver		$ 543.20	93
		HealthNet Life	EPO	Gold		$ 677.03	4
		HealthNet Life	EPO	Platinum		$ 799.91	13
		Kaiser	HMO	Catastrophic		$ 281.27	411
		Kaiser	HMO	Bronze		$ 321.91	5,163
		Kaiser	HMO	Silver		$ 443.88	6,811
		Kaiser	HMO	Gold	Coinsurance	$ 491.57	234
		Kaiser	HMO	Gold	Copay	$ 514.46	546
		Kaiser	HMO	Platinum		$ 567.81	646
		Kaiser	HMO	HDHP		$ 324.56	1,736
		Oscar	EPO	Catastrophic		$ 350.95	1
		Oscar	EPO	Bronze		$ 371.60	42
		Oscar	EPO	Silver		$ 482.98	32
		Oscar	EPO	Gold		$ 559.52	16
		Oscar	EPO	Platinum		$ 635.63	7

Region		Carrier	Network Type	Metal Level	Plan Type	Premium/Mo.	Enrollment
5	Contra Costa.	Anthem	EPO	Catastrophic		$ 314.08	21
		Anthem	EPO	Bronze		$ 371.34	397
		Anthem	EPO	Silver		$ 527.33	365
		Anthem	EPO	Gold		$ 666.53	34
		Anthem	EPO	Platinum		$ 792.88	37
		Anthem	EPO	HDHP		$ 363.73	199
		Blue Shield	HMO	Silver		$ 523.24	18
		Blue Shield	HMO	Gold		$ 634.63	2
		Blue Shield	HMO	Platinum		$ 784.27	1
		Blue Shield	PPO	Catastrophic		$ 352.49	12
		Blue Shield	PPO	Bronze		$ 382.91	1,172
		Blue Shield	PPO	Silver		$ 450.38	9,499
		Blue Shield	PPO	Gold		$ 559.13	1,004
		Blue Shield	PPO	Platinum		$ 715.52	267
		Blue Shield	PPO	HDHP		$ 370.85	510
		HealthNet Life	EPO	Catastrophic		$ 290.68	25
		HealthNet Life	EPO	Bronze		$ 368.83	175
		HealthNet Life	EPO	Silver		$ 489.43	233
		HealthNet Life	EPO	Gold		$ 610.02	35
		HealthNet Life	EPO	Platinum		$ 720.74	16
		Kaiser	HMO	Catastrophic		$ 254.48	247
		Kaiser	HMO	Bronze		$ 291.25	6,394
		Kaiser	HMO	Silver		$ 401.60	15,667
		Kaiser	HMO	Gold	Coinsurance	$ 444.76	633
		Kaiser	HMO	Gold	Copay	$ 465.46	1,274
		Kaiser	HMO	Platinum		$ 513.73	1,427
		Kaiser	HMO	HDHP		$ 293.65	2,056

Region		Carrier	Network Type	Metal Level	Plan Type	Premium/Mo.	Enrollment
6	Alameda.	Anthem	EPO	Catastrophic		$ 314.84	46
		Anthem	EPO	Bronze		$ 372.23	1,199
		Anthem	EPO	Silver		$ 528.59	1,392
		Anthem	EPO	Gold		$ 668.13	115
		Anthem	EPO	Platinum		$ 794.79	102
		Anthem	EPO	HDHP		$ 364.60	386
		Blue Shield	HMO	Silver		$ 418.62	27
		Blue Shield	HMO	Gold		$ 507.73	3
		Blue Shield	HMO	Platinum		$ 627.45	-
		Blue Shield	PPO	Catastrophic		$ 324.58	27
		Blue Shield	PPO	Bronze		$ 352.59	2,483
		Blue Shield	PPO	Silver		$ 414.72	15,101
		Blue Shield	PPO	Gold		$ 514.86	1,125
		Blue Shield	PPO	Platinum		$ 658.87	401
		Blue Shield	PPO	HDHP		$ 341.49	916
		Kaiser	HMO	Catastrophic		$ 261.19	561
		Kaiser	HMO	Bronze		$ 298.91	11,534
		Kaiser	HMO	Silver		$ 412.17	20,503
		Kaiser	HMO	Gold	Coinsurance	$ 456.46	608
		Kaiser	HMO	Gold	Copay	$ 477.71	1,501
		Kaiser	HMO	Platinum		$ 527.25	1,867
		Kaiser	HMO	HDHP		$ 301.38	3,819

Region		Carrier	Network Type	Metal Level	Plan Type	Premium/Mo.	Enrollment
7	Santa Clara.	Anthem	HMO	Silver		$ 446.76	644
		Anthem	HMO	Gold		$ 546.75	29
		Anthem	HMO	Platinum		$ 658.36	10
		Anthem	EPO	Catastrophic		$ 243.85	194
		Anthem	EPO	Bronze		$ 288.30	6,539
		Anthem	EPO	Silver		$ 409.41	10,266
		Anthem	EPO	Gold		$ 517.47	307
		Anthem	EPO	Platinum		$ 615.59	118
		Anthem	EPO	HDHP		$ 282.40	2,313
		Blue Shield	HMO	Silver		$ 448.13	307
		Blue Shield	HMO	Gold		$ 543.52	17
		Blue Shield	HMO	Platinum		$ 671.68	1
		Blue Shield	PPO	Catastrophic		$ 407.73	12
		Blue Shield	PPO	Bronze		$ 442.92	861
		Blue Shield	PPO	Silver		$ 520.96	3,897
		Blue Shield	PPO	Gold		$ 646.75	529
		Blue Shield	PPO	Platinum		$ 827.65	154
		Blue Shield	PPO	HDHP		$ 428.97	342
		HealthNet CA	HCSP	Catastrophic		$ 285.20	11
		HealthNet CA	HCSP	Bronze		$ 361.88	257
		HealthNet CA	HCSP	Silver		$ 480.21	625
		HealthNet CA	HCSP	Gold		$ 598.52	54
		HealthNet CA	HCSP	Platinum		$ 707.15	37
		Kaiser	HMO	Catastrophic		$ 261.19	297
		Kaiser	HMO	Bronze		$ 298.91	7,351
		Kaiser	HMO	Silver		$ 412.17	13,731
		Kaiser	HMO	Gold	Coinsurance	$ 456.46	421
		Kaiser	HMO	Gold	Copay	$ 477.71	1,083
		Kaiser	HMO	Platinum		$ 527.25	1,219
		Kaiser	HMO	HDHP		$ 301.38	2,258
		Valley	HMO	Catastrophic		$ 223.48	223
		Valley	HMO	Bronze		$ 277.85	1,707
		Valley	HMO	Silver		$ 367.58	3,737
		Valley	HMO	Gold		$ 427.53	141
		Valley	HMO	Platinum		$ 480.64	74

Region		Carrier	Network Type	Metal Level	Plan Type	Premium/Mo.	Enrollment
8	San Mateo.	Anthem	EPO	Catastrophic		$ 305.98	42
		Anthem	EPO	Bronze		$ 361.75	932
		Anthem	EPO	Silver		$ 513.72	1,149
		Anthem	EPO	Gold		$ 649.31	87
		Anthem	EPO	Platinum		$ 772.42	48
		Anthem	EPO	HDHP		$ 354.34	393
		Blue Shield	HMO	Silver		$ 564.39	24
		Blue Shield	HMO	Gold		$ 684.53	-
		Blue Shield	HMO	Platinum		$ 845.94	1
		Blue Shield	PPO	Catastrophic		$ 425.56	9
		Blue Shield	PPO	Bronze		$ 462.29	501
		Blue Shield	PPO	Silver		$ 543.75	2,566
		Blue Shield	PPO	Gold		$ 675.04	375
		Blue Shield	PPO	Platinum		$ 863.85	94
		Blue Shield	PPO	HDHP		$ 447.73	248
		Chinese C.	HMO	Catastrophic		$ 339.75	1
		Chinese C.	HMO	Bronze		$ 343.44	724
		Chinese C.	HMO	Silver		$ 445.50	1,287
		Chinese C.	HMO	Gold		$ 549.23	8
		Chinese C.	HMO	Platinum		$ 605.97	5
		HealthNet Life	EPO	Catastrophic		$ 347.02	11
		HealthNet Life	EPO	Bronze		$ 440.32	194
		HealthNet Life	EPO	Silver		$ 584.29	326
		HealthNet Life	EPO	Gold		$ 728.25	56
		HealthNet Life	EPO	Platinum		$ 860.42	30
		Kaiser	HMO	Catastrophic		$ 281.27	197
		Kaiser	HMO	Bronze		$ 321.91	4,079
		Kaiser	HMO	Silver		$ 443.88	8,806
		Kaiser	HMO	Gold	Coinsurance	$ 491.57	305
		Kaiser	HMO	Gold	Copay	$ 514.46	628
		Kaiser	HMO	Platinum		$ 567.81	705
		Kaiser	HMO	HDHP		$ 324.56	1,186

Region		Carrier	Network Type	Metal Level	Plan Type	Premium/Mo.	Enrollment
9	Santa Cruz, Monterey, and San Benito.	Anthem	EPO	Catastrophic		$ 335.51	60
		Anthem	EPO	Bronze		$ 396.68	4,273
		Anthem	EPO	Silver		$ 563.30	4,893
		Anthem	EPO	Gold		$ 712.00	159
		Anthem	EPO	Platinum		$ 846.98	77
		Anthem	EPO	HDHP		$ 388.55	1,815
		Blue Shield	HMO	Silver		$ 417.37	2,380
		Blue Shield	HMO	Gold		$ 506.21	51
		Blue Shield	HMO	Platinum		$ 625.58	3
		Blue Shield	PPO	Catastrophic		$ 421.19	9
		Blue Shield	PPO	Bronze		$ 457.54	1,440
		Blue Shield	PPO	Silver		$ 538.17	7,465
		Blue Shield	PPO	Gold		$ 668.11	394
		Blue Shield	PPO	Platinum		$ 854.99	94
		Blue Shield	PPO	HDHP		$ 443.14	553
		HealthNet Life	EPO	Catastrophic		$ 302.76	15
		HealthNet Life	EPO	Bronze		$ 384.16	304
		HealthNet Life	EPO	Silver		$ 509.78	225
		HealthNet Life	EPO	Gold		$ 635.38	12
		HealthNet Life	EPO	Platinum		$ 750.69	10
		Kaiser	HMO	Catastrophic		$ 261.19	43
		Kaiser	HMO	Bronze		$ 298.91	1,959
		Kaiser	HMO	Silver		$ 412.17	1,859
		Kaiser	HMO	Gold	Coinsurance	$ 456.46	108
		Kaiser	HMO	Gold	Copay	$ 477.71	87
		Kaiser	HMO	Platinum		$ 527.25	55
		Kaiser	HMO	HDHP		$ 301.38	704

Region		Carrier	Network Type	Metal Level	Plan Type	Premium/Mo.	Enrollment
10	San Joaquin, Stanislaus, Merced, Mariposa, and Tulare.	Anthem	EPO	Catastrophic		$ 208.58	203
		Anthem	EPO	Bronze		$ 246.58	7,549
		Anthem	EPO	Silver		$ 350.18	32,272
		Anthem	EPO	Gold		$ 442.58	1,238
		Anthem	EPO	Platinum		$ 526.48	797
		Anthem	EPO	HDHP		$ 241.55	2,949
		Blue Shield	HMO	Silver		$ 468.57	23
		Blue Shield	HMO	Gold		$ 568.31	-
		Blue Shield	HMO	Platinum		$ 702.32	1
		Blue Shield	PPO	Catastrophic		$ 354.07	-
		Blue Shield	PPO	Bronze		$ 384.63	263
		Blue Shield	PPO	Silver		$ 452.41	2,898
		Blue Shield	PPO	Gold		$ 561.65	212
		Blue Shield	PPO	Platinum		$ 718.75	80
		Blue Shield	PPO	HDHP		$ 372.52	123
		HealthNet Life	EPO	Catastrophic		$ 296.24	7
		HealthNet Life	EPO	Bronze		$ 375.90	100
		HealthNet Life	EPO	Silver		$ 498.82	162
		HealthNet Life	EPO	Gold		$ 621.72	12
		HealthNet Life	EPO	Platinum		$ 734.55	2
		Kaiser	HMO	Catastrophic		$ 227.70	149
		Kaiser	HMO	Bronze		$ 260.59	3,831
		Kaiser	HMO	Silver		$ 359.33	11,146
		Kaiser	HMO	Gold	Coinsurance	$ 397.94	325
		Kaiser	HMO	Gold	Copay	$ 416.47	725
		Kaiser	HMO	Platinum		$ 459.65	1,009
		Kaiser	HMO	HDHP		$ 262.74	1,070

Region		Carrier	Network Type	Metal Level	Plan Type	Premium/Mo.	Enrollment
11	Madera, Fresno, and Kings.	Anthem	HMO	Silver		$ 411.64	113
		Anthem	HMO	Gold		$ 503.80	13
		Anthem	HMO	Platinum		$ 606.68	13
		Anthem	PPO	Catastrophic		$ 212.52	104
		Anthem	PPO	Bronze		$ 251.22	2,493
		Anthem	PPO	Silver		$ 356.78	4,501
		Anthem	PPO	Gold		$ 450.92	220
		Anthem	PPO	Platinum		$ 536.40	132
		Anthem	PPO	HDHP		$ 246.10	1,561
		Blue Shield	PPO	Catastrophic		$ 253.88	8
		Blue Shield	PPO	Bronze		$ 275.79	789
		Blue Shield	PPO	Silver		$ 324.39	11,924
		Blue Shield	PPO	Gold		$ 402.72	426
		Blue Shield	PPO	Platinum		$ 515.36	107
		Blue Shield	PPO	HDHP		$ 267.11	185
		HealthNet CA	HCSP	Catastrophic		$ 265.34	1
		HealthNet CA	HCSP	Bronze		$ 336.68	17
		HealthNet CA	HCSP	Silver		$ 446.76	11
		HealthNet CA	HCSP	Gold		$ 556.84	4
		HealthNet CA	HCSP	Platinum		$ 657.90	3
		Kaiser	HMO	Catastrophic		$ 216.98	92
		Kaiser	HMO	Bronze		$ 248.33	2,012
		Kaiser	HMO	Silver		$ 342.42	5,528
		Kaiser	HMO	Gold	Coinsurance	$ 379.21	118
		Kaiser	HMO	Gold	Copay	$ 396.87	345
		Kaiser	HMO	Platinum		$ 438.02	420
		Kaiser	HMO	HDHP		$ 250.37	712

Region		Carrier	Network Type	Metal Level	Plan Type	Premium/Mo.	Enrollment
12	San Luis Obispo, Santa Barbara, and Ventura.	Anthem	PPO	Catastrophic		$ 260.16	266
		Anthem	PPO	Bronze		$ 307.54	7,769
		Anthem	PPO	Silver		$ 436.77	10,789
		Anthem	PPO	Gold		$ 552.01	693
		Anthem	PPO	Platinum		$ 656.65	509
		Anthem	PPO	HDHP		$ 301.28	4,520
		Blue Shield	HMO	Silver		$ 327.84	1,618
		Blue Shield	HMO	Gold		$ 397.63	64
		Blue Shield	HMO	Platinum		$ 491.39	7
		Blue Shield	PPO	Catastrophic		$ 304.96	25
		Blue Shield	PPO	Bronze		$ 331.28	2,276
		Blue Shield	PPO	Silver		$ 389.65	25,890
		Blue Shield	PPO	Gold		$ 483.74	1,430
		Blue Shield	PPO	Platinum		$ 619.04	336
		Blue Shield	PPO	HDHP		$ 320.85	764
		Kaiser	HMO	Catastrophic		$ 244.04	87
		Kaiser	HMO	Bronze		$ 279.29	2,804
		Kaiser	HMO	Silver		$ 385.11	4,405
		Kaiser	HMO	Gold	Coinsurance	$ 426.50	152
		Kaiser	HMO	Gold	Copay	$ 446.35	328
		Kaiser	HMO	Platinum		$ 492.64	374
		Kaiser	HMO	HDHP		$ 281.59	983

Region		Carrier	Network Type	Metal Level	Plan Type	Premium/Mo.	Enrollment
13	Mono, Inyo, and Imperial.	Anthem	PPO	Catastrophic		$ 274.76	6
		Anthem	PPO	Bronze		$ 324.79	1,040
		Anthem	PPO	Silver		$ 461.27	1,312
		Anthem	PPO	Gold		$ 582.97	65
		Anthem	PPO	Platinum		$ 693.49	16
		Anthem	PPO	HDHP		$ 318.18	289
		Blue Shield	PPO	Catastrophic		$ 383.88	-
		Blue Shield	PPO	Bronze		$ 417.01	206
		Blue Shield	PPO	Silver		$ 490.49	796
		Blue Shield	PPO	Gold		$ 608.93	46
		Blue Shield	PPO	Platinum		$ 779.25	14
		Blue Shield	PPO	HDHP		$ 403.88	79
		Kaiser	HMO	Catastrophic		$ 231.72	-
		Kaiser	HMO	Bronze		$ 265.19	7
		Kaiser	HMO	Silver		$ 365.67	17
		Kaiser	HMO	Gold	Coinsurance	$ 404.96	-
		Kaiser	HMO	Gold	Copay	$ 423.81	-
		Kaiser	HMO	Platinum		$ 467.76	1
		Kaiser	HMO	HDHP		$ 267.37	2
		Molina	HMO	Catastrophic		$ 235.98	9
		Molina	HMO	Bronze		$ 242.79	955
		Molina	HMO	Silver		$ 310.08	4,622
		Molina	HMO	Gold		$ 347.58	1,733
		Molina	HMO	Platinum		$ 401.65	1,398

Region		Carrier	Network Type	Metal Level	Plan Type	Premium/Mo.	Enrollment
14	Kern.	Anthem	PPO	Catastrophic		$ 207.24	53
		Anthem	PPO	Bronze		$ 244.98	1,653
		Anthem	PPO	Silver		$ 347.91	2,303
		Anthem	PPO	Gold		$ 439.71	88
		Anthem	PPO	Platinum		$ 523.07	83
		Anthem	PPO	HDHP		$ 239.98	1,090
		Blue Shield	HMO	Silver		$ 376.51	13
		Blue Shield	HMO	Gold		$ 456.66	1
		Blue Shield	HMO	Platinum		$ 564.34	-
		Blue Shield	PPO	Catastrophic		$ 265.68	4
		Blue Shield	PPO	Bronze		$ 288.62	317
		Blue Shield	PPO	Silver		$ 339.47	6,267
		Blue Shield	PPO	Gold		$ 421.44	370
		Blue Shield	PPO	Platinum		$ 539.32	101
		Blue Shield	PPO	HDHP		$ 279.53	108
		HealthNet CA	HMO	Silver		$ 298.25	2,366
		HealthNet CA	HMO	Gold		$ 375.83	58
		HealthNet CA	HMO	Platinum		$ 416.69	31
		HealthNet CA	HCSP	Catastrophic		$ 230.61	5
		HealthNet CA	HCSP	Bronze		$ 292.62	45
		Kaiser	HMO	Catastrophic		$ 221.74	29
		Kaiser	HMO	Bronze		$ 253.77	700
		Kaiser	HMO	Silver		$ 349.92	1,993
		Kaiser	HMO	Gold	Coinsurance	$ 387.52	82
		Kaiser	HMO	Gold	Copay	$ 405.56	156
		Kaiser	HMO	Platinum		$ 447.62	231
		Kaiser	HMO	HDHP		$ 255.86	227

Region		Carrier	Network Type	Metal Level	Plan Type	Premium/Mo.	Enrollment
15	Los Angeles County ZIP Codes starting with 906 to 912, inclusive, 915, 917, 918, and 935.	Anthem	HMO	Silver		$ 286.55	3,378
		Anthem	HMO	Gold		$ 350.66	201
		Anthem	HMO	Platinum		$ 422.24	93
		Anthem	EPO	Catastrophic		$ 215.87	292
		Anthem	EPO	Bronze		$ 255.22	2,400
		Anthem	EPO	Silver		$ 362.43	2,650
		Anthem	EPO	Gold		$ 458.09	292
		Anthem	EPO	Platinum		$ 544.94	225
		Anthem	EPO	HDHP		$ 249.99	1,873
		Blue Shield	HMO	Silver		$ 283.97	1,234
		Blue Shield	HMO	Gold		$ 344.42	124
		Blue Shield	HMO	Platinum		$ 425.63	30
		Blue Shield	PPO	Catastrophic		$ 232.47	148
		Blue Shield	PPO	Bronze		$ 252.53	4,705
		Blue Shield	PPO	Silver		$ 297.03	50,058
		Blue Shield	PPO	Gold		$ 368.75	3,565
		Blue Shield	PPO	Platinum		$ 471.89	1,376
		Blue Shield	PPO	HDHP		$ 244.58	1,739
		HealthNet CA	HMO	Silver		$ 269.16	31,172
		HealthNet CA	HMO	Gold		$ 339.17	1,122
		HealthNet CA	HMO	Platinum		$ 376.04	956
		HealthNet CA	HCSP	Catastrophic		$ 211.09	120
		HealthNet CA	HCSP	Bronze		$ 267.84	115
		Kaiser	HMO	Catastrophic		$ 202.97	904
		Kaiser	HMO	Bronze		$ 232.29	7,144
		Kaiser	HMO	Silver		$ 320.30	11,247
		Kaiser	HMO	Gold	Coinsurance	$ 354.72	361
		Kaiser	HMO	Gold	Copay	$ 371.23	961
		Kaiser	HMO	Platinum		$ 409.73	1,790
		Kaiser	HMO	HDHP		$ 234.20	2,351
		L.A. Care	HMO	Catastrophic		$ 219.08	10
		L.A. Care	HMO	Bronze		$ 230.73	1,697
		L.A. Care	HMO	Silver		$ 258.27	8,735
		L.A. Care	HMO	Gold		$ 304.18	396
		L.A. Care	HMO	Platinum		$ 353.60	298
		Molina	HMO	Catastrophic		$ 190.85	227
		Molina	HMO	Bronze		$ 196.35	9,554
		Molina	HMO	Silver		$ 250.76	15,141
		Molina	HMO	Gold		$ 281.09	510
		Molina	HMO	Platinum		$ 324.81	145

Region		Carrier	Network Type	Metal Level	Plan Type	Premium/Mo.	Enrollment
16	Los Angeles County ZIP Codes in other than those identified in clause (xv).	Anthem	HMO	Silver		$ 302.04	12,471
		Anthem	HMO	Gold		$ 369.64	597
		Anthem	HMO	Platinum		$ 445.09	225
		Anthem	EPO	Catastrophic		$ 250.52	346
		Anthem	EPO	Bronze		$ 296.20	5,334
		Anthem	EPO	Silver		$ 420.63	6,905
		Anthem	EPO	Gold		$ 531.66	743
		Anthem	EPO	Platinum		$ 632.46	714
		Anthem	EPO	HDHP		$ 290.13	2,162
		Blue Shield	HMO	Silver		$ 358.23	387
		Blue Shield	HMO	Gold		$ 434.48	34
		Blue Shield	HMO	Platinum		$ 536.94	12
		Blue Shield	PPO	Catastrophic		$ 298.36	101
		Blue Shield	PPO	Bronze		$ 324.11	3,200
		Blue Shield	PPO	Silver		$ 381.22	31,541
		Blue Shield	PPO	Gold		$ 473.27	4,433
		Blue Shield	PPO	Platinum		$ 605.64	1,992
		Blue Shield	PPO	HDHP		$ 313.90	1,240
		HealthNet CA	HMO	Silver		$ 289.12	29,918
		HealthNet CA	HMO	Gold		$ 364.33	1,318
		HealthNet CA	HMO	Platinum		$ 403.94	947
		HealthNet CA	HCSP	Catastrophic		$ 244.42	77
		HealthNet CA	HCSP	Bronze		$ 310.15	58
		Kaiser	HMO	Catastrophic		$ 212.51	1,804
		Kaiser	HMO	Bronze		$ 243.22	13,058
		Kaiser	HMO	Silver		$ 335.37	19,502
		Kaiser	HMO	Gold	Coinsurance	$ 371.41	774
		Kaiser	HMO	Gold	Copay	$ 388.70	1,685
		Kaiser	HMO	Platinum		$ 429.01	2,558
		Kaiser	HMO	HDHP		$ 245.22	4,540
		L.A. Care	HMO	Catastrophic		$ 229.45	36
		L.A. Care	HMO	Bronze		$ 241.65	2,594
		L.A. Care	HMO	Silver		$ 270.49	9,123
		L.A. Care	HMO	Gold		$ 318.57	544
		L.A. Care	HMO	Platinum		$ 370.34	329
		Molina	HMO	Catastrophic		$ 194.95	729
		Molina	HMO	Bronze		$ 200.57	18,668
		Molina	HMO	Silver		$ 256.16	31,698
		Molina	HMO	Gold		$ 287.13	1,673
		Molina	HMO	Platinum		$ 331.80	444
		Oscar	EPO	Catastrophic		$ 241.57	40
		Oscar	EPO	Bronze		$ 255.78	1,286
		Oscar	EPO	Silver		$ 332.44	1,996
		Oscar	EPO	Gold		$ 385.13	322
		Oscar	EPO	Platinum		$ 437.52	161

Region		Carrier	Network Type	Metal Level	Plan Type	Premium/Mo.	Enrollment
17	San Bernardino and Riverside.	Anthem	HMO	Silver		$ 322.44	1,465
		Anthem	HMO	Gold		$ 394.60	66
		Anthem	HMO	Platinum		$ 475.17	57
		Anthem	EPO	Catastrophic		$ 235.09	138
		Anthem	EPO	Bronze		$ 277.94	1,654
		Anthem	EPO	Silver		$ 394.70	2,207
		Anthem	EPO	Gold		$ 498.89	188
		Anthem	EPO	Platinum		$ 593.46	239
		Anthem	EPO	HDHP		$ 272.25	730
		Blue Shield	HMO	Silver		$ 301.66	1,355
		Blue Shield	HMO	Gold		$ 365.88	115
		Blue Shield	HMO	Platinum		$ 452.15	16
		Blue Shield	PPO	Catastrophic		$ 255.29	45
		Blue Shield	PPO	Bronze		$ 277.33	2,679
		Blue Shield	PPO	Silver		$ 326.20	23,386
		Blue Shield	PPO	Gold		$ 404.96	1,911
		Blue Shield	PPO	Platinum		$ 518.23	770
		Blue Shield	PPO	HDHP		$ 268.60	1,068
		HealthNet CA	HMO	Silver		$ 267.70	26,741
		HealthNet CA	HMO	Gold		$ 337.33	1,511
		HealthNet CA	HMO	Platinum		$ 374.01	1,265
		HealthNet CA	HCSP	Catastrophic		$ 239.00	49
		HealthNet CA	HCSP	Bronze		$ 303.26	25
		Kaiser	HMO	Catastrophic		$ 214.57	509
		Kaiser	HMO	Bronze		$ 245.57	7,078
		Kaiser	HMO	Silver		$ 338.61	12,224
		Kaiser	HMO	Gold	Coinsurance	$ 375.00	386
		Kaiser	HMO	Gold	Copay	$ 392.46	1,163
		Kaiser	HMO	Platinum		$ 433.16	1,858
		Kaiser	HMO	HDHP		$ 247.59	2,331
		Molina	HMO	Catastrophic		$ 194.95	378
		Molina	HMO	Bronze		$ 200.57	13,873
		Molina	HMO	Silver		$ 256.16	20,266
		Molina	HMO	Gold		$ 287.13	1,174
		Molina	HMO	Platinum		$ 331.80	317

Region		Carrier	Network Type	Metal Level	Plan Type	Premium/Mo.	Enrollment
18	Orange.	Anthem	HMO	Silver		$ 345.38	1,660
		Anthem	HMO	Gold		$ 422.71	80
		Anthem	HMO	Platinum		$ 508.98	61
		Anthem	EPO	Catastrophic		$ 221.97	508
		Anthem	EPO	Bronze		$ 262.44	8,432
		Anthem	EPO	Silver		$ 372.68	5,823
		Anthem	EPO	Gold		$ 471.06	357
		Anthem	EPO	Platinum		$ 560.35	369
		Anthem	EPO	HDHP		$ 257.06	3,625
		Blue Shield	HMO	Silver		$ 345.88	824
		Blue Shield	HMO	Gold		$ 419.50	128
		Blue Shield	HMO	Platinum		$ 518.42	38
		Blue Shield	PPO	Catastrophic		$ 282.84	72
		Blue Shield	PPO	Bronze		$ 307.25	3,748
		Blue Shield	PPO	Silver		$ 361.39	34,223
		Blue Shield	PPO	Gold		$ 448.65	3,592
		Blue Shield	PPO	Platinum		$ 574.14	1,420
		Blue Shield	PPO	HDHP		$ 297.58	1,386
		HealthNet CA	HMO	Silver		$ 299.37	27,152
		HealthNet CA	HMO	Gold		$ 377.24	822
		HealthNet CA	HMO	Platinum		$ 418.26	549
		HealthNet CA	HCSP	Catastrophic		$ 228.03	87
		HealthNet CA	HCSP	Bronze		$ 289.34	339
		Kaiser	HMO	Catastrophic		$ 231.72	475
		Kaiser	HMO	Bronze		$ 265.19	6,270
		Kaiser	HMO	Silver		$ 365.67	8,856
		Kaiser	HMO	Gold	Coinsurance	$ 404.96	395
		Kaiser	HMO	Gold	Copay	$ 423.81	846
		Kaiser	HMO	Platinum		$ 467.76	1,387
		Kaiser	HMO	HDHP		$ 267.37	1,906
		Molina	HMO	Catastrophic		$ 221.63	100
		Molina	HMO	Bronze		$ 228.01	7,552
		Molina	HMO	Silver		$ 291.21	7,679
		Molina	HMO	Gold		$ 326.42	432
		Molina	HMO	Platinum		$ 377.20	78
		Oscar	EPO	Catastrophic		$ 239.14	6
		Oscar	EPO	Bronze		$ 253.21	642
		Oscar	EPO	Silver		$ 329.11	1,041
		Oscar	EPO	Gold		$ 381.26	79
		Oscar	EPO	Platinum		$ 433.12	60

Region		Carrier	Network Type	Metal Level	Plan Type	Premium/Mo.	Enrollment
19	San Diego.	Anthem	HMO	Silver		$ 444.04	146
		Anthem	HMO	Gold		$ 543.43	26
		Anthem	HMO	Platinum		$ 654.40	29
		Anthem	EPO	Catastrophic		$ 277.47	43
		Anthem	EPO	Bronze		$ 328.05	1,769
		Anthem	EPO	Silver		$ 465.86	1,729
		Anthem	EPO	Gold		$ 588.81	102
		Anthem	EPO	Platinum		$ 700.45	150
		Anthem	EPO	HDHP		$ 321.33	632
		Blue Shield	HMO	Silver		$ 433.34	35
		Blue Shield	HMO	Gold		$ 525.59	10
		Blue Shield	HMO	Platinum		$ 649.53	2
		Blue Shield	PPO	Catastrophic		$ 317.77	25
		Blue Shield	PPO	Bronze		$ 345.19	1,999
		Blue Shield	PPO	Silver		$ 406.02	14,689
		Blue Shield	PPO	Gold		$ 504.05	1,837
		Blue Shield	PPO	Platinum		$ 645.04	701
		Blue Shield	PPO	HDHP		$ 334.32	1,085
		HealthNet CA	HMO	Silver		$ 306.91	18,328
		HealthNet CA	HMO	Gold		$ 386.75	827
		HealthNet CA	HMO	Platinum		$ 428.80	528
		HealthNet CA	HCSP	Catastrophic		$ 230.33	142
		HealthNet CA	HCSP	Bronze		$ 292.27	602
		Kaiser	HMO	Catastrophic		$ 224.30	349
		Kaiser	HMO	Bronze		$ 256.70	8,484
		Kaiser	HMO	Silver		$ 353.97	12,997
		Kaiser	HMO	Gold	Coinsurance	$ 392.00	340
		Kaiser	HMO	Gold	Copay	$ 410.25	1,106
		Kaiser	HMO	Platinum		$ 452.80	1,424
		Kaiser	HMO	HDHP		$ 258.82	2,921
		Molina	HMO	Catastrophic		$ 225.72	22
		Molina	HMO	Bronze		$ 232.24	9,779
		Molina	HMO	Silver		$ 296.60	13,390
		Molina	HMO	Gold		$ 332.47	502
		Molina	HMO	Platinum		$ 384.19	140
		Sharp	HMO	Catastrophic		$ 201.37	830
		Sharp	HMO	Bronze		$ 250.14	9,891
		Sharp	HMO	Silver		$ 375.29	2,645
		Sharp	HMO	Silver		$ 355.55	7,419
		Sharp	HMO	Gold		$ 431.88	537
		Sharp	HMO	Gold		$ 419.19	798
		Sharp	HMO	Platinum		$ 488.47	517
		Sharp	HMO	Platinum		$ 468.01	805
		Sharp	HMO	HDHP		$ 252.25	2,226

Appendix 6: Covered California Enrollment and Revenue Forecast

The following describes the forecasting methodology used to develop the enrollment and revenue outlook to support the Exchange's fiscal year 2017-18 budget (source: *Covered California Fiscal Year 2017-18 Budget,* August 17, 2017).

VI. Covered California Enrollment and Revenue Forecast

The enrollment and revenue forecast used for the FY 2017–18 budget was informed by modeling done by PricewaterhouseCoopers in partnership with the University of California. The forecast relies on the experience gained from 37 months of active enrollment through the fourth open-enrollment period that ended on Jan. 31, 2017. The enrollment activity achieved during this open enrollment was consistent with the FY 2016–17 forecast, which projected that Covered California had entered a phase of stable enrollment. Open enrollment for the 2017 benefit year resulted in enrollment in line with the Base Estimate of approximately 1.4 million enrollees. The Base Estimate used in the FY 2017–18 forecast continues to project a stable enrollment outlook going forward, but Covered California has modeled alternate enrollment to reflect the uncertainty of the political environment.

The Base Estimate takes into consideration two factors that affect the overall enrollment trend. Covered California has adopted a policy of pre-verification of qualifying life events that allows individuals to enroll during special enrollment. Based on survey evidence, this policy could notably dampen the pace of enrollment outside of open enrollment. Conversely, based on a market analysis completed by PricewaterhouseCoopers (PwC) in 2016, the scheduled increase in California's minimum wage anticipates additional enrollment by boosting income for those near the subsidy-eligibility range that could shift people from Medi-Cal to Covered California.

Effective January 2017, Covered California's assessment fee switched from a flat per-member, per-month fee to a percentage assessment on total premiums paid. Currently at 4 percent, this fee is being assessed on Covered California's 1.4 million enrollees. In addition, there are approximately 800,000 people in the individual market who benefit from the rates negotiated by Covered California, even though they are not directly enrolled through the exchange. The Affordable Care Act requires the rates for these on- and off-exchange plans be the same. Since the specific health plan products offered by Covered California represent approximately 62 percent of the total enrollment in individual coverage, the Affordable Care Act assessment essentially requires the health plans to spread the assessment fee across the entire individual market. To the extent that carriers have members who do not purchase through Covered California, but who pay the same rate, the actual assessment is spread across the entire individual market for those health plans offered by Covered California. With this budget, Covered California will maintain the 4 percent on-exchange assessment, which converts to an estimate that the actual average effective assessment rate is approximately 2.5 percent across the entire individual market.

Forecasting Potential Enrollment

The 2016 enrollment forecast, used for the FY 2016–17 budget, was based on the experience and lessons learned in 2015 as well as insights from the market analysis completed by PwC and the University of California. Adding to these insights, the 2017 forecast reflected the experience of an additional year of enrollment history. Based on the 2016 benefit year and the 2017 open-enrollment experience, Covered California's Base Estimate is that it will see stable enrollment going forward with the exception of the impact of more stringent pre-verification of qualifying life events beginning with 2018 special enrollment. This "stable enrollment" is based on Covered California's maintaining its significant marketing, outreach and customer service investments — all of which contribute to both our retention of existing insured and the ability to enroll about 700,000 new enrollees needed to maintain the same overall enrollment figure.

Table 2 summarizes the Base Estimate's revenue projections derived from the individual market and Covered California for Small Business forecasts. Due to the assumed impact of pre-verification beginning with 2018 special enrollment, projected enrollment during FY 2017–18 is approximately 60,000 lives, or 4 percent, below the 2016 forecast for this period.

TABLE 2
Covered California Revenue and Outlook Enrollment Summary
(Base Estimate)

Market	PMPM Revenue ($millions), Cash Basis				
	2016-17	**2017-18**	**2018-19**	**2019-20**	**2020-21**
Individual Market - Medical	$234.6	$302.5	$311.6	$313.4	$311.2
Individual Market - Dental	$1.1	$1.1	$1.1	$1.1	$1.2
CCSB	$6.4	$10.8	$13.0	$16.6	$19.5
Total Revenue	$242.1	$314.4	$325.8	$331.0	$331.9
Effectuated Enrollment (year-end)	1.37	1.32	1.31	1.31	1.33

Key Assumptions of the Individual Market Base Estimate

This projection begins after the fourth open enrollment period and takes into account the following factors, each of which is then described in more detail:

- The number of new consumers who chose health plans during open enrollment.
- The pace that new enrollees acquired coverage through Covered California during 2016 special enrollment and the likely impact of pre-verification.
- The rate at which enrolled individuals leave Covered California through termination or by failing to renew coverage.
- The likelihood that an individual who selects a plan will pay his or her premium.

- The impact of rising minimum wage on the subsidy-eligible population.
- Potential medical cost trends reflected in premiums.

Health Plan Selections During Open Enrollment
During the 2017 open enrollment, approximately 412,000 new consumers signed up for coverage. The forecast projects that a comparable level of new consumers will select plans during future open-enrollment periods.

Monthly Enrollment Rate During Special Enrollment
During the entire 2016 special-enrollment period (April through December), plan selections averaged 33,700 per month. This pace is expected to slow noticeably beginning in 2018. Covered California plans to implement pre-enrollment verification of consumers' eligibility for special enrollment in 2018. Based on a random sampling of special-enrollment enrollees to verify their qualifying life event that they had self-certified prior to enrollment, 28 percent of the sampled enrollees either (a) responded and were determined ineligible, (b) did not respond and were then unenrolled, or (c) had already unenrolled. A special enrollment verification on the federal exchange indicated a non-verification rate of 20 percent. While non-verification of eligibility does not mean consumers are not in fact eligible, for this forecast, the special enrollment assumption was reduced 25 percent from historic trends. Combining this adjustment with the increase in the minimum wage resulted in a net reduction in the assumed average special-enrollment pace to 24,800 as the base monthly enrollment assumption for 2018 and beyond.

Effectuation Rate
Based on the experience of 2016 and the fourth open enrollment, 80 percent of new enrollees during open enrollment will pay at least their first month's premium. Likewise, during special enrollment, 69 percent of enrollees on average will make their first payment. These rates are comparable to those used in previous forecasts.

Disenrollment Rate
Based on the experience of 2016, the forecast projects that, on average, 3 percent of enrollees will leave Covered California each month and 17.2 percent of those enrolled at the end of the year will not renew coverage.

Subsidized and Unsubsidized Enrollments
In line with the previous forecast, this outlook projects that 90 percent of enrollees qualify for financial assistance on average.

Impact of Rising Minimum Wage
The base forecast projects that the scheduled escalation of California's minimum wage will result in additional enrollment of individuals as they become eligible for subsidies and transition from Medi-Cal. The assumed enrollment impacts were derived from estimates produced by PwC as part of its 2016 market analysis. Given the stability of enrollment through the latest open enrollment, the projected impact going forward is

approximately one-fourth of the potentially newly eligible. The previous forecast assumed one-third of the newly eligible would enroll.

Revenue and Change in Health Insurance Premiums
The revenue forecast reflects the shift to a percent of premium assessment in 2017, with a rate of 4 percent of gross health insurance premiums through 2018, which equates to 2.6 percent across the entire individual market for plans controlled by Covered California. The base forecast currently projects its assessment rate to gradually decrease to 3.25 percent by 2021, which equates to 2.1 percent across the entire individual market for the plans contracted by Covered California.

The projected premium growth for the Base Estimate assumes an underlying 7 percent-per-year medical trend driven by annual cost increases in hospital services, professional medical services and pharmaceuticals. In 2018, the renewal of the health insurance provider fee will boost that growth rate to 9 percent for that year only. The assumed cost, and thus premium, growth trend in the forecast is 7 percent per year thereafter.

According to the base enrollment outlook, annual individual plan assessments are projected to decrease as a percentage of premiums, as total premiums increase, in upcoming years. On a cash basis, Covered California received $235.7 million in individual market revenues in FY 2016–17, and projects to have $302.5 million in 2017–18, $311.6 million in 2018–19, $313.4 million in 2019–20 and $311.2 million in 2020–21.

Forecast Uncertainties

The greatest uncertainties facing Covered California's enrollment and revenue outlook stem from the potential for major federal legislative or regulatory actions to change key provisions of the Affordable Care Act. The new administration has been working with Congress to pass legislation that could substantially alter the nature of the tax credit subsidies, abolish the individual mandate, change the regulatory basis for premium setting, and/or change a variety of other provisions of the Affordable Care Act. It is possible that some changes could be made by executive order without legislation. At this point, none of the changes being considered has been enacted, but legislation — the American Health Care Act (AHCA) — was passed by the U.S. House of Representatives and will now be considered by the Senate.

To prepare for a range of outcomes that could result from these efforts, Covered California engaged PwC to supplement their work on the 2016 Market Analysis, which evaluated some of the potential policy changes now being considered. The supplemental analysis focused on several key changes that were included in the AHCA.

Of the policy changes analyzed, the elimination of the individual mandate would have the most negative short-term impact on enrollment with Covered California. Based on the PwC analysis, if the enforcement of the individual mandate ended, open enrollment and special enrollment plan selections would drop significantly, leading to a decline in enrollment potentially in excess of 400,000 by the end of 2018. Additionally, the losses

would be weighted to individuals with better health status, which would lead to a deterioration in the risk mix and an increase in premiums.

This enrollment decline would be dramatic, representing nearly one-third of Covered California's enrollees. While this would have huge negative impacts on the hundreds of thousands of Californians who would either choose to or would be forced to go without coverage, from Covered California's financial perspective, this loss could be manageable. Covered California plans to maintain reserves adequate to cover between nine and 12 months of operating costs. The FY 2017–18 multi-year spending plan projects ending the year with 11 months of reserves.

Supplemental Adult Dental Forecast

In 2016, Covered California added dental coverage for adults as a supplemental benefit. Pediatric dental coverage is defined by law as an "essential health benefit" and has always been part of our offerings. As a supplemental benefit, purchase by consumers is voluntary and there are no federal subsidies to reduce the cost of those premiums. The forecast of dental coverage in the individual market extends to 2021. For the first three months of 2016, about 12 percent of those who enrolled or renewed signed up for dental coverage. The dental forecast projects the same 12 percent rate of enrollment through 2021. In 2017, the revenue assessment shifts to a percentage of premium similar to that of the individual market program for health plans. Premium growth for dental insurance assumes the same rate of growth as the medical program (see the "Revenue and Change in Health Insurance Premiums" section). The revenue projected in the dental forecast reflects premium growth and an assessment rate, 4 percent of gross premiums, equal to the individual medical forecast. The base dental forecast projects that $1.1 million in dental assessment revenues will be generated annually from FY 2017–18 through FY 2020–21.

Covered California for Small Business Forecast

The enrollment outlook of Covered California for Small Business (CCSB) builds on the operational improvements (e.g., group onboarding at, or better than, industry standard; timely commission payments; quickly resolving account maintenance issues), and better support from our agents and brokers. The CCSB program anticipates that enrollment will continue to grow in 2018. The sales and operations teams are continuing to improve and maintain better relationships with brokers. The focus continues to be on expanding activities such as implementation of agency-level agreements and strategic technology implementations. They continue to focus on group retention by improving communication outreach.

Key Assumptions of the Covered California for Small Business Market Forecast

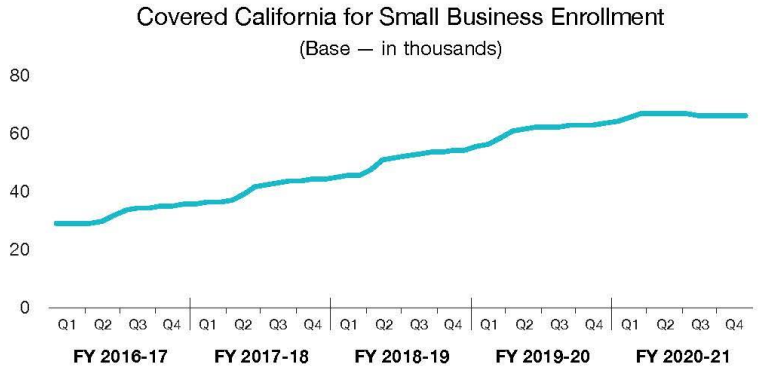
Because of these anticipated improvements and the trends seen over the past year, overall CCSB enrollment is expected to rise modestly through FY 2020–21. Similar to the individual market enrollment projections, a Base Estimate enrollment forecast has been developed. (See Figure 1.) The updated forecast is built on the experience of the

past three years and takes into account the overall size and expected growth of the small business exchange market in California. CCSB currently represents about 8 percent of the exchange market. The base forecast assumes that expected program improvements will grow CCSB market share to 9 percent in 2019. Thereafter, CCSB enrollment growth will keep pace with the anticipated growth of the small business exchange market.

Beginning in 2017, the Covered California assessment rate was based on a percentage of gross health plan premium at 5.2 percent. For plan year 2018, this rate will be continued at 5.2 percent.

FIGURE 1

Covered California for Small Business
Base Estimate Enrollment and Revenue Scenarios



Covered California for Small Business Sensitivity Analysis

The base enrollment forecast assumes a moderately improved market share for CCSB. The low alternative assumes that CCSB does not keep pace with the overall small-business exchange market and its share drops from its current 8 percent to

approximately 6 percent. The high alternative assumes that the share increases to 20 percent by 2020 and then keeps pace with overall market growth. (See Table 3.)

TABLE 3

Covered California for Small Business

	Fiscal Year End Enrollment					Revenue ($millions)				
Fiscal Year	**2016-17**	**2017-18**	**2018-19**	**2019-20**	**2020-21**	**2016-17**	**2017-18**	**2018-19**	**2019-20**	**2020-21**
High	36,682	54,210	88,261	129,400	170,480	$7.3	$11.1	$18.5	$31.1	$44.8
Base	35,251	44,314	54,288	63,459	67,176	$7.3	$10.8	$13.1	$16.7	$19.6
Low	34,861	40,022	44,564	49,303	53,670	$7.3	$9.3	$11.2	$13.2	$15.3