Notice Published March 29, 2024

NOTICE OF PROPOSED RULEMAKING

CALIFORNIA CODE OF REGULATIONS, TITLE 10,
CHAPTER 12, ARTICLE 6
ADOPT SECTIONS 6520, 6522, 6524, 6526, 6528, 6530, 6532, 6534, 6536, 6538, 6542, 6544, 6548, and 6550

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, pursuant to Government Code section 11346.8(a), from any interested person, or such person's duly authorized representative, no later than 15 days before the close of the written comment period.

WRITTEN COMMENT PERIOD

Any interested person, or such person's duly authorized representative, may submit written statements, arguments or contentions (hereafter referred to as comments) relevant to the proposed regulatory action to the Exchange. The written comment period closes at **5:00 p.m. on May 14, 2024.** The Exchange will consider only comments received at the Exchange's office by that time. Submit written comments to:

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

Comments may also be submitted by e-mail to regulations@covered.ca.gov.

AUTHORITY AND REFERENCE

Government Code Section 100504(a)(6) authorizes the California Health Benefit Exchange/Covered California (the Exchange) Board to adopt rules and regulations, as necessary. The proposed regulations implement, interpret, and make specific sections 100503, 100504 and 100506. 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. Law 111-152) and Title 45, Code of Federal Regulations (CFR) section 155.700 and following.

INFORMATIVE DIGEST/POLICY STATEMENT OVERVIEW

Summary of Existing Laws and Regulations

Under the federal Patient and Protection and Affordable Care Act (PPACA), each state is required, by January 1, 2014, to establish an American Health Benefit Exchange that makes available qualified health plans to qualified individuals and small employers. Existing state law, the California Patient Protection and Affordable Care Act (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, also referred to as Covered California. Within the Exchange, California established its own Small Business Health Options Program (SHOP) or "CCSB."

The proposed regulations implement, interpret, and make specific the requirements in state and federal law. Government Code section 100504(a) authorizes the Exchange to adopt rules and regulations, as necessary to execute the requirements under the PPACA. The Exchange implemented regulations in the California Code of Regulations, title 10, section 6400 and following. These regulations include the policies and procedures related to eligibility and enrollment of individuals and small business employees. Additionally, Title 45, Section 155.700 et seq. of the Code of Federal Regulations requires states establishing a SHOP to provide policies and procedures for eligibility determination and redetermination, enrollment in qualified health plans, and termination of coverage processes for the SHOP.

On November 7, 2019, the Exchange adopted emergency regulations to amend California Code of Regulations, title 10, section 6532, subdivision (e). On September 7, 2021, the Exchange adopted emergency regulations to revise California Code of Regulations, title 10, sections 6520, 6522, 6524, 6526, 6528, 6530, 6532, 6534, 6538, 6542, and 6550. These emergency regulations are in effect.

The Exchange is now proposing to make permanent those emergency regulations at California Code of Regulations, title 10, sections 6520, 6522, 6524, 6526, 6528, 6530, 6532, 6534, 6538, 6542, and 6550 with amendments. The Exchange also proposes to amend the regulations in California Code of Regulations, title 10, sections 6536, 6544, and 6548 to implement and clarify the eligibility and enrollment process related to small business employees and their dependents.

Objectives and Anticipated Benefits of the Proposed Regulations

The broad objectives of this proposed regulatory action are to:

- Provide clarity to small employers of what is required to apply to provide health and dental coverage through CCSB to their employees and their dependents;

- Ensure that qualified employees who are offered coverage through CCSB are provided an appropriate open enrollment period;
- Provide clarity to participating small employers of the premium payment requirements;
- Ensure consistency with state law; and
- Complete Certificate of Compliance requirements for sections 6520, 6522, 6524, 6526, 6528, 6530, 6532, 6534, 6538, 6542, and 6550.

Anticipated benefits of the proposed action include 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. This includes:

- Providing structure for the Exchange to give predictable and clear standards to the public and qualified health plan issuers now and into the future.
- Establishing clear guidelines for the public regarding eligibility, enrollment, and termination of SHOP coverage.
- Establishing an appeal process for prospective and current enrollees of the SHOP and thereby providing due process to employers and employees 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 with Existing State Regulations

After an evaluation of current regulations, the Exchange has determined that these proposed regulations are not inconsistent or incompatible with any 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 and notably include provisions affecting the Exchange in the Government Code, the Health and Safety Code, and the Insurance Code. 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.

DOCUMENTS TO BE INCORPORATED BY REFERENCE:

CCSB New Business Late Submission Acknowledgement Form (Rev. 1/24)

DISCLOSURES REGARDING THE PROPOSED ACTION

The Executive Director of the California Health Benefit Exchange has made the following initial determinations:

Matters Prescribed by Statute Applicable to the Agency or to Any Specific Regulation or Class of Regulations
None.

Mandate on Local Agencies or 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.

Costs or Savings to State Agencies
The proposal results in additional costs to the California Health Benefit Exchange, which is currently financially self-sustaining. The proposal does not result in any costs or savings to any other state agency.

Cost to Any Local Agency or School District Which Must Be Reimbursed in Accordance with Government Code Sections 17500 through 17630
None. This proposal does not impose costs on any local agency or school district for which reimbursement would be required pursuant to Part 7 (commencing with Section 17500) of Division 4 of the Government Code.

Costs or Savings in Federal Funding to the State
The proposal results in additional costs to the California Health Benefit Exchange, which is currently financially self-sustaining and is not funded by federal grant money. There is no other impact on federal funding to the state as a result of these regulations.

Other Nondiscretionary Costs or Savings Imposed on Local Agencies
None.

Significant Effect on Housing Costs
None.

Effect on Small Business
The proposal results in an effect on participating small businesses with 1-100 employees statewide by clarifying the policies and procedures for applying for coverage, enrolling employees and their dependents in qualified health plans, and termination of coverage in the small business marketplace for health insurance through the Exchange. The proposed regulations do not create or expand small businesses within the State of California. There are no jobs created or eliminated from this proposal. The proposed regulations do not create or expand the operations of any small businesses.

Significant, Statewide Adverse Economic Impact Directly Affecting Business, Including the Ability of California Businesses to Compete With Businesses in Other States
None.

Known Cost Impacts on a Representative Private Person or Business
The Exchange is not aware of any cost impacts that a representative private person or business would necessarily incur in reasonable compliance with the proposed action.

Business Reporting Requirement
None.

RESULTS OF THE ECONOMIC IMPACT ASSESSMENT/ANALYSIS

Results of the Economic Impact Assessment/Analysis

The Exchange concludes regarding the proposed regulations:
(1) They are **unlikely** to create or eliminate jobs in the State;
(2) They are **unlikely** to create or eliminate businesses in the State;
(3) They are **unlikely** to impact the expansion of businesses currently doing business in California;
(4) They are **likely** to provide benefits to the health and welfare of California residents; and
(5) They are **unlikely** to provide benefits to worker safety and the state's environment.

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 employees and their dependents who apply for health benefits through the Exchange. It will benefit the public by clarifying the criteria and process for eligibility determinations, enrollment and disenrollment, and an appeal process through the SHOP. It will make quality health care available to all Californians and provide the public with clear standards and eligibility requirements to apply for and enroll in qualified health plans through the Exchange. It will increase access to affordable health coverage which will help save lives and increase the health of the public in California. This proposed regulatory action will not affect worker safety and the state's environment.

CONSIDERATION OF ALTERNATIVES

In accordance with Government Code section 11346.5, subdivision (a)(13), the Exchange must determine that no reasonable alternative it 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 the action is proposed, would be as effective and less burdensome to affected private persons than the proposed action, or would be more cost-effective to affected private persons and equally effective in implementing the statutory policy or other provision of law.

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

CONTACT PERSONS

Inquiries concerning the proposed administrative action may be directed to:

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

The backup contact person for inquiries is:

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

Please direct questions regarding the proposed text of the regulations, the Initial Statement of Reasons, the modified text of the regulations, if any, or other information upon which the rulemaking is based to Faviola Adams at the 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 this notice is published in the Notice Register, the rulemaking file consists of this notice, the proposed text of the regulation and the Initial Statement of Reasons. Copies may be obtained by contacting Faviola Adams at the address or phone number listed above.

AVAILABILITY OF CHANGED OR MODIFIED TEXT

After the hearing, if one is held, and after 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 Faviola Adams at the address indicated above. The Exchange will accept written comments on the modified regulations for 15 days after the date on which they are made available.

AVAILABILITY OF THE FINAL STATEMENT OF REASONS

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

AVAILABILITY OF DOCUMENTS ON THE INTERNET

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

INITIAL STATEMENT OF REASONS
APPLICATION, ELIGIBILITY, AND ENROLLMENT
IN THE SHOP EXCHANGE

CALIFORNIA CODE OF REGULATIONS, TITLE 10, CHAPTER 12, ARTICLE 6 SECTIONS 6520, 6522, 6524, 6526, 6528, 6530, 6532, 6534, 6536, 6538, 6542, 6544, 6548, and 6550

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

INTRODUCTION

On September 17, 2018 the Exchange adopted permanent regulations in Title 10, California Code of Regulations (CCR), Chapter 12, Article 6. Subsequently, the Exchange made amendments to Title 10, California Code of Regulations, Chapter 12, Article 6, Section 6532 on November 7, 2019 through its emergency rulemaking authority. On September 7, 2021, the Exchange filed emergency regulations to amend Sections 6520, 6522, 6524, 6526, 6528, 6530, 6532, 6534, 6538, 6542, and 6550 of Chapter 12, Title 10 of the California Code of Regulations. These emergency regulations are now in effect and they clarify the criteria and process for eligibility determinations for qualified small employers and qualified employees and their dependents, enrollment and disenrollment in Qualified Health Plans (QHPs), and appeals through the SHOP. The Exchange is now proposing to make these temporary emergency regulations permanent with amendments.

The Exchange also proposes to make changes to existing regulations in Title 10, California Code of Regulations, Chapter 12, Article 6, Sections 6536, 6544, and 6548. These changes correct typos in regulations affecting the operations of CCSB and the eligibility and enrollment of qualified employers' qualified employees and their dependents. The changes will clarify requirements related to CCSB applications, eligibility, and enrollment.

Amendments to Emergency Regulations

This rulemaking action proposes to adopt the emergency regulations as final regulations. The Exchange is adopting the emergency regulations with some modifications, which are listed below and described in the applicable subdivisions below.

The proposed regulations adopt the emergency regulations and do the following:

Revise the regulation text, section 6520 as follows:

- Amend subdivision (a)(12)(C) by making a non-substantive grammatical change;
- Amend subdivision (a)(13) to specify the date by which the CCSB New Business Late Submission Acknowledgement Form must be submitted to retroactively effectuate coverage and to revise the date of the incorporated CCSB New Business Late Submission Acknowledgement Form;
- Add a new subdivision (b)(17) to require qualified employers to attest to providing an initial enrollment period to qualified employees and their dependents;
- Renumber subdivision (b)(17) to (b)(18) and subdivision (b)(18) to (b)(19);
- Amend subdivision (d) to clarify the employee application due date; and
- Change “he or she,” “his or her,” and “him or her” to “they,” “their,” and “them” respectively as applicable throughout the section.

Revise the regulation text, section 6522 as follows:

- Amend subdivision (e) to replace “his or her” with “their.”

Revise the regulation text, section 6524 as follows:

- Amend subdivision (c)(2)(B) to replace “his or her” with “their.”

Revise the regulation text, section 6528 as follows:

- Amend subdivision (b) to specify that the initial employee open enrollment period must begin no later than 20 days before the employee application due date;
- Amend subdivision (e) to remove the requirement that the annual employee open enrollment period notice be provided after the employer’s annual election period;
- Amend subdivision (f) to replace a reference to “issuer” with “QHP Issuer”;
- Amend subdivision (i) to replace a reference to “issuer” with “QHP Issuer”; and
- Change “his or her” to “their” as applicable throughout the section.

Revise the regulation text, section 6530 as follows:

- Amend subdivisions (b)(1), (b)(2), (b)(3), (b)(4), (b)(5), (b)(6), (b)(15), (b)(16), and (b)(17) to replace the descriptions of the triggering events with cross-references to the triggering events described in the individual Exchange regulations;
- Amend subdivision (b)(14) to align with mandatory federal regulations; and
- Change “his or her,” “him or her,” and “he or she” to “their,” “them,” and “they” respectively as applicable throughout the section.

Revise the regulation text, section 6532 as follows:

- Amend subdivision (c) to specify how payments for less or more than the full amount due are allocated.

Revise the regulation text, section 6534 as follows:

- Amend subdivision (a) to replace a reference to the Exchange with a reference to the SHOP;
- Amend subdivision (b)(3) to make a non-substantive grammatical edit;
- Amend subdivision (b)(3)(B) to replace a reference to the Exchange with a reference to the SHOP.

Revise the regulation text, section 6536 as follows:

- Amend subdivision (c) to correct a typographical error in a cross-referenced section.

Revise the regulation text, section 6538 as follows:

- Amend subdivision (c) to insert a reference to the code in which the section of the law is found; and
- Amend subdivisions (e)(7), (g)(1), and (g)(4) to replace “his or her” with “their.”

Revise the regulation text, section 6542 as follows:

- Amend subdivision (j)(1) to replace “him or her” with “them”; and
- Amend subdivision (n) to replace “his or her” with “their.”

Revise the regulation text, section 6544 as follows:

- Amend subdivision (c) to replace “his or her” with “their”;
- Amend subdivision (d)(1) to replace “he or she” with “they”; and
- Amend subdivision (e) to replace “his or her” with “their.”

Revise the regulation text, section 6548 as follows:

- Amend subdivision (d)(1) to replace “his or her” with “their.”

Revise the regulation text, section 6550 as follows:

- Amend subdivision (c)(2)(A) to replace “his or her” with “their.”

PROBLEM STATEMENT

The Exchange is a relatively new state entity administering recent federal and state health care legislation. Federal law requires states to establish a small business health options program (SHOP) designed to assist qualified small employers in enrolling their employees in qualified health plans in the small group market. (42 U.S.C. § 18031(b)(1)(B).) The California enabling legislation requires the Exchange to establish a SHOP (also known as Covered California for Small Business (CCSB)) and administer all tasks necessary to offer qualified health plans to qualified employers’ employees and

their dependents, including collecting premiums. (Gov. Code, §§ 100502(m), 100503(w).) It further requires the Exchange to establish the criteria and process for eligibility determination, enrollment, and disenrollment of enrollees and potential enrollees in the Exchange's SHOP. (Gov. Code, § 100503(a).) 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 and the SHOP could not function.

Government Code Section 100503(a) requires the Exchange to establish the criteria and process for eligibility and enrollment in the SHOP. Government Code Section 100503(w) requires the SHOP to collect premiums and administer all other necessary tasks relating to enrollment and plan payment. These sections do not provide any further guidance on what the policies and procedures required to operate the SHOP must be. Federal regulations establish some policies and procedures through which small business employers can purchase coverage for their employees and their dependents, but largely leave most policy and procedures to the discretion of the Exchange. (45 CFR § 155.700 et seq.)

ANTICIPATED BENEFITS

It is anticipated that the proposed regulation will provide the following benefits:

- Providing structure for the Exchange to give predictable and clear standards to the public and qualified health plan issuers now and into the future.
- Establishing clear guidelines for the public regarding eligibility, enrollment, and termination of SHOP coverage.
- Establishing an appeal process for prospective and current enrollees of the SHOP and thereby providing due process to employers and employees 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.

PURPOSE AND NECESSITY

The purpose of these proposed regulations is 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 SHOP, and the appeals process in the SHOP, consistent with state and federal law.

This regulatory action will enable the Exchange provide health insurance coverage to eligible employees of qualified small businesses and their dependents, to improve the

health of Californians, to increase access to quality medical care, to resolve eligibility appeals fairly and promptly, and to better protect the public health, safety and welfare.

DETAILED DISCUSSION OF THE SPECIFIC PURPOSE, RATIONALE, AND PROBLEMS ADDRESSED FOR EACH PROPOSED AMENDMENT

Pursuant to its authorities, the Exchange proposes to permanently adopt Article 6 of Title 10, Investment, Chapter 12, and the regulations contained in this Article. The detailed discussion of the specific purpose, rationale, problems addressed, and statement of reasons for Article 6 and the sections within this Article is as follows:

Article 6. Application, Eligibility, and Enrollment in the Shop Exchange

Article 6, in its entirety implements, clarifies, and makes specific the eligibility requirements for small employers and employees and their dependents to enroll in a qualified health plan (QHP) through the SHOP, and the process for applying for coverage, eligibility determination and redetermination, enrollment, and termination of coverage through the SHOP. This article also implements, clarifies, and makes specific the appeals process for the SHOP. This article is necessary to provide small business employers, employees and their dependents, and the public with clear standards and guidelines to request and receive an eligibility determination for enrollment in a QHP through the SHOP and to their right to due process. This article is also necessary to provide the standards and requirements for the QHP issuers regarding enrollment of qualified employees and their dependents in the QHPs and termination of coverage for qualified individual through the SHOP. This is also necessary to comply with the federal requirements specified in 45 CFR Sections 155.700 through 155.741.

Section 6520. Employer and Employee Application Requirements

Section 6520, in its entirety clarifies and makes specific all the required information and declarations that the applicant must provide in the application in order for the SHOP to determine the applicants' eligibility for enrollment in a QHP. This is necessary to provide the employer groups and the public with clear standards and guidelines on how to complete and submit an application for coverage through the SHOP, and to comply with the federal requirement specified in 45 CFR Section 155.731.

The amended regulation changes "he or she," "his or her," and "him or her" to "they," "their," and "them" respectively as applicable throughout the section for gender neutrality and consistency purposes.

Section 6520(a): This subdivision, in its entirety clarifies and makes specific the application criteria required to enroll in the SHOP. The existing regulation specifies that small employers may purchase coverage from a QHP. This amendment adds "Issuer" to clarify that small employers may purchase coverage from a QHP Issuer for its eligible employees and their dependents through the SHOP. This is necessary to clarify the entity from which the health coverage is purchased and to align with the term "QHP Issuer" as defined in Title 10, California Code of Regulations, Chapter 12, Article 6, Section 6410.

Section 6520(a)(1): This subdivision specifies and clarifies that an employer must submit all information necessary to identify the employer, including business, billing, and mailing addresses. This amendment removes the billing address and makes corresponding grammatical edits. This is necessary because businesses do not have a billing address that is separate and distinct from their mailing address. This is also necessary to reduce the information that is collected from applicants and to comply with federal requirements specified in 45 CFR Section 155.731(b)(1).

Section 6520(a)(4): This subdivision currently requires the employer to indicate whether they are extending an offer of health coverage to dependents or non-registered domestic partners of the employee. The regulation is revised to include dental coverage such that the employer must indicate whether they are extending an offer of dependent health or dental coverage to dependents or non-registered domestic partners of the employee. This is necessary to determine which type(s) of coverage is available to dependents or non-registered domestic partners of the employee.

Section 6520(a)(5): This subdivision requires the employer to specify the desired coverage effective date which is necessary to establish the employer's desired effective date for QHP coverage. This amendment adds dental coverage to require the employer to specify the desired coverage effective date for health or dental coverage. This is necessary to establish the employer's desired effective date for health or dental coverage so the SHOP can properly instruct either the health or dental issuer to commence coverage.

Section 6520(a)(7): This regulation currently requires the employer to advise if they are currently offering coverage to their employees, and, if so, through which issuer. The amendment includes dental coverage in the types of coverage currently offered by the employer that must be reported to the SHOP. This information is necessary for SHOP to better understand the current health and dental insurance markets for small businesses and identify shifts in those markets to better serve employers and their employees and dependents.

Section 6520(a)(12): This subdivision, in its entirety, requires the employer to include the employer's health plan premium contribution amount for employees, metal tier and reference plan selection. The amended regulation includes dental coverage and the dental reference plan. The addition of dental coverage is necessary to inform the SHOP of the employer's dental plan premium contribution and dental reference plan so the SHOP can correctly calculate employer contribution dollar amounts for each employee and their dependents enrolled in dental coverage as specified in Section 6522(h)(3).

This regulation is also revised to move the reference plan from subdivision (a)(12)(C) to this subdivision (a)(12). Moving the reference plan information from subdivision (a)(12)(C) to this subdivision (a)(12) is necessary because the SHOP must collect the premium contribution rate for employees and spouses, non-registered domestic partners or dependent children, if applicable, toward the reference plan to correctly calculate the employer contribution dollar amounts for each enrolled employee and their dependents.

Section 6520(a)(12)(A): This regulation currently requires the employer to include the health premium contribution amount for employees. The amended regulation replaces "Qualified Health Plan (QHP)" with "health plan." "Qualified Health Plan" is defined in Section 6410 of Title 10 of the California Code of Regulations and includes both health and dental plans that have been qualified by the Exchange. Replacing the defined term with "health plan" is necessary to clarify that this subdivision (a)(12)(A) requires employers to provide only the health plan premium contribution rate as the dental plan premium contribution rate is required under subdivision (a)(12)(E) below.

Section 6520(a)(12)(B): This regulation currently requires the employer to include the health plan premium contribution amounts for spouse, non-registered domestic partner or dependent children, if applicable. The amended regulation inserts the word "plan" to the health premium contribution rate. This is necessary to clarify that the employer must provide the premium contribution rate of the health plan rather than some other health premium.

The amended regulation also replaces "coverage" with "health coverage." This is necessary to specify that the employer must provide the premium contribution rate for health coverage rather than an unspecified coverage and to resolve any ambiguities stemming from the existing text. This is also necessary to clarify that this subdivision (a)(12)(B) requires employers to provide the health plan premium contribution rate as the dental plan premium contribution rate is required under subdivision (a)(12)(E) below.

Section 6520(a)(12)(C): This regulation currently requires the employer to choose health insurance metal tier or tiers consisting of one tier or two contiguous tiers. This is necessary for the employer to provide their metal tier selection because the employer's premium contribution is based on their QHP metal tier. The amended regulation gives employers the option of electing one, two contiguous, three contiguous, or four contiguous tiers of health coverage. This is necessary to inform the SHOP of the metal tiers available to employees and their dependents. This is also necessary to allow employers to make a broader range of tiers of health coverage available to their employees and their dependents in furtherance of the PPACA's goal of expanding access to affordable comprehensive coverage to small employers and their employees and dependents.

The amended regulation also removes the reference plan. This is necessary because the reference plan is collected in the amended subdivision (a)(12) and it would be duplicative to collect it under this subdivision (a)(12)(C).

Section 6520(a)(12)(E): This subdivision requires employers to include the employer's dental plan premium contribution amount for employees and their dependents, and reference dental plan selection for employers who elect to offer dental coverage. This is necessary to inform the SHOP of the employer's dental plan premium contributions, and reference dental plan so the SHOP can correctly calculate employer contribution dollar amounts for each enrolled employee and their dependents.

Section 6520(a)(13): The regulation currently allows employers to submit a signed CCSB New Business Late Submission Acknowledgement Form to request a retroactive coverage effective date, but does not specify the date by which the form must be

submitted to effectuate coverage back to the 1st of the month. The amended regulation clarifies that the CCSB New Business Late Submission Acknowledgement Form must be submitted by the 7th day of the month to retroactively effectuate enrollment to the 1st of the month. This is necessary so new qualified employers and their agents know the deadline for submitting the CCSB New Business Late Submission Acknowledgement Form to obtain a retroactive coverage effective date. It is necessary for the form to be submitted by the 7th day of the month so employees who receive coverage retroactively can use their coverage during that month if necessary. If the form was due later in the month, the employees would have to pay for coverage during a time when they could not access care.

The amended regulation also updates the CCSB New Business Late Submission Acknowledgement Form to incorporate by reference the updated version of the form. This is necessary to incorporate the form that has been revised to include the amended due date for retroactive coverage.

Section 6520(b)(6): This regulation currently advises the employer that the information they provide will be used to determine eligibility and facilitate enrollment for health coverage and will otherwise be kept confidential as required by federal and state law. The amended regulation includes dental coverage. This is necessary to ensure that the employer understands that the information they provide will be used to determine eligibility and facilitate enrollment for dental coverage and will otherwise be kept confidential as required by federal and state law. This is necessary to ensure that the employer provides all information requested for both health and dental coverage, notwithstanding its confidential nature.

Section 6520(b)(10): This regulation currently ensures that the employer understands that the SHOP will not consider the qualified employer approved for health coverage until the SHOP has received the first premium payment. The amended regulation includes dental coverage. This is necessary to advise the employer it must remit payment for the entire invoiced amount in order to effectuate dental coverage. Without this subdivision, the employer may think that the dental coverage has commenced even though it has not paid the invoice.

The existing regulation allows health coverage to be effectuated so long as the employer pays at least 85 percent of the initial premium payment. This required QHP Issuers to provide health insurance coverage to employees and dependents for whom the premiums had not been paid. The amended regulation removes the 85 percent premium payment threshold and requires payment in full to effectuate coverage. This is necessary to advise the employer it must remit payment for the entire invoiced amount in order to effectuate health or dental coverage. Without this revision, the employer may think that coverage has commenced even though it has not paid the full amount due on the invoice.

Section 6520(b)(11): This regulation currently ensures that the employer is made aware of the requirement to continue to make the monthly premium payments each month by the invoice due date and advises that the total monthly premium payment cannot be less than 85 percent of the total amount due, including any past due premium amounts. This required QHP Issuers to continue to provide health insurance coverage to

employees and dependents for whom the full monthly premiums had not been paid. The amended regulation replaces the 85 percent premium payment threshold with a no less than $100 premium payment threshold to maintain eligibility. This revision is necessary because, pursuant to 45 CFR 155.735 and Section 6538, failure to timely pay the monthly premium could result in the termination of SHOP coverage.

Section 6520(b)(12): This subdivision currently requires that the employer advise all qualified employees of the availability of health coverage and that if they decline health coverage, they must wait until the next open enrollment period to sign up for coverage, unless the employee experiences an event that would entitle them to a special enrollment period pursuant to Section 6530. The amended regulation includes dental coverage. This is necessary to ensure that qualified employers understand that they must inform all qualified employees that if they do not enroll in dental coverage during the initial offering period, they will not have another opportunity to purchase dental coverage through the SHOP until the next open enrollment period or the occurrence of an event that would entitle them to a special enrollment period. Without this subdivision, the employer and employees may not realize that if they do not enroll during the open enrollment, they may not be able to obtain dental coverage until the next open enrollment period, a year later.

Section 6520(b)(13): The amended regulations add “QHP” to clarify that the issuer must be a qualified to offer health or dental plans through the SHOP and to capitalize the term Issuer. This is necessary for clarity purposes and to align with a defined term. This is also necessary to resolve any ambiguities stemming from the existing text and for consistent usage throughout the Title.

Section 6520(b)(14): The existing regulation ensures that the employer understands that health insurance coverage through the SHOP is subject to the applicable terms and conditions of the QHP contract or policy, as well as applicable state law, which will dictate procedures, exclusions, and limitations relating to coverage and will govern in the event of a conflict with SHOP or QHP issuer benefits comparison, summary or other description of coverage. The amended regulations include dental coverage. This is necessary to ensure that the employer understands that dental insurance coverage through the SHOP is subject to the applicable terms and conditions of the QHP contract or policy, as well as applicable state law, which will dictate procedures, exclusions, and limitations relating to dental coverage and will govern in the event of a conflict with SHOP or QHP issuer benefits comparison, summary or other description of coverage. This is necessary to ensure the employer understands that dental coverage through SHOP is subject to the applicable terms and conditions of the QHP policy as well as applicable state law.

Section 6520(b)(15): The existing regulation advises the employer that once employer and employee information is transmitted to the selected “QHPs”, the coverage effective date cannot be changed nor can the coverage be terminated until after the first month of coverage. The amended regulations add the term “Issuer.” This is necessary to specify the entity to whom the SHOP transmits the employer and employee information. This is also necessary to resolve any ambiguities stemming from the existing text and to ensure consistent usage throughout the Title.

Section 6520(b)(16): The existing regulation advises the employer that it must inform its qualified employees of the availability of child and family dental plans and that qualified employees may choose to enroll in a dental plan only, even if the qualified employee does not choose to enroll in a QHP. The amended regulation requires the employer to inform its qualified employees of the availability of child and family qualified dental plans. This is necessary because the SHOP can only offer child and family dental plans that have been qualified by the Exchange.

The amended regulation also replaces "QHP" with "health plan." "Qualified Health Plan" is defined in Section 6410 of Title 10 of the California Code of Regulations and includes both health and dental plans that have been qualified by the Exchange. Using the term "QHP" creates an ambiguity because it is defined to include both health and dental plans. Replacing the defined term with "health plan" is necessary to clarify that the qualified employees may choose to enroll in a qualified dental plan only, even if the qualified employee does not choose to enroll in a health plan. This is also necessary to resolve the ambiguity stemming from the existing text.

Section 6520(b)(17) advises the qualified employer that it must give its qualified employees and their dependents an initial enrollment period that must begin at least 20 days before the employee's application is due. This is necessary to ensure that employer is aware that they must provide an initial enrollment period and that the qualified employees and their dependents receive adequate time to make decisions about their health or dental coverage.

Sections 6520(b)(17) and (18): These subdivisions have been renumbered to (b)(18) and (b)(19) account for the addition of the new language in subdivision (b)(17). This is necessary for clarity purposes and to avoid confusion related to the organization of these subdivisions.

Section 6520(d): This subdivision, in its entirety, clarifies and makes specific the information that a qualified employee must provide in order to participate in the SHOP. The current regulation does not specify the date by which the information must be provided to the SHOP. The amended regulation requires qualified employees to submit the required information no later than 5 days before the requested effective date. This is necessary so new qualified employees know application deadlines and to allows the SHOP time to determine eligibility and communicate any enrollment information to the QHP Issuer. This is also necessary to allow employees to provide their information earlier than 5 days before the requested effective date.

Section 6520(d)(2): The current regulation requires the employee's first and last name, Taxpayer Identification Number, date of birth, home and mailing address, phone number, email address and if the employee is newly hired. The amended regulation clarifies that the qualified employee must provide their Social Security Number (SSN) or the Taxpayer Identification Number. The employee's SSN is a unique identifier that is necessary to ensure the integrity of that employee's record in both SHOP and QHP Issuer administrative systems. It is necessary to collect the SSN or the Taxpayer Identification Number because only individuals who cannot get a SSN, because they are a certain nonresident or resident alien, a spouse or dependent of a certain nonresident or resident alien, or are in the process of adopting a U.S. citizen or resident

child but cannot get an SSN for that child in time to file their tax return, are issued a Taxpayer Identification Number by the Internal Revenue Service.

Section 6520(d)(3)(A): Current regulations require qualified employees to inform the SHOP whether the employee currently has COBRA coverage under the employer's plan. The amended regulations insert the word "health" to clarify that the qualified employee should inform the SHOP if they have COBRA coverage through the employer's health plan. This is necessary to ensure that the public understands the correct information to provide to the SHOP.

Section 6520(d)(3)(B): The word "of" is added when requiring the qualified employee to inform the SHOP whether the employee has experienced a qualifying event that renders the employee eligible for continuation of coverage. This word was unintentionally omitted, and the addition is necessary to make the regulation grammatically correct.

Section 6520(d)(6): The amended regulation replaces "QHP and dental plan" with "the health plans and dental plans" when requiring the qualified employee to select health and dental plans for themselves and their dependents. "Qualified Health Plan" is defined in Section 6410 of Title 10 of the California Code of Regulations and includes both health and dental plans that have been qualified by the Exchange. Using the term "QHP" creates a redundancy because it is defined to include both health and dental plans and the current text asks the qualified employee to provide the dental plans in addition to the QHP. The revision is necessary to resolve any ambiguities stemming from the existing text and to ensure consistent usage throughout the Title.

Section 6520(e)(1): Current regulations require a qualified employee to agree to mandatory arbitration if the QHP selected by the employee requires arbitration. The amended regulation inserts "Issuer" to clarify that the entity offering the QHP, namely the QHP Issuer, requires arbitration. The revision is necessary to resolve any ambiguities stemming from the existing text and to ensure consistent usage throughout the Title.

Section 6520(g): The current regulation prohibits the SHOP from sharing any information collected on the employee application with respect to the qualified employees or their dependents with the qualified employer, other than the name, address, birth date, and plan selection. The amended regulations replace "plan" with "health or dental plan" to clarify that the SHOP may share health or dental plan selection information with the qualified employer. This is necessary to specify what information may be shared with the qualified employer and resolves any potential ambiguity by clearly informing the public that their health plan or dental plan selection may be shared with the qualified employer.

The current regulation allows the SHOP to share only application information that is strictly necessary for the purposes of eligibility and enrollment with the QHP or employer. The amended regulation inserts "Issuer" to clarify that the SHOP may share the information with the entity offering the QHP, namely the QHP Issuer. The revision is necessary to resolve any ambiguities stemming from the existing text and to ensure consistent usage throughout the Title.

The current regulation also prohibits the SHOP from using information obtained from the application for purposes other than eligibility determinations and enrollment in health coverage through the SHOP. The amended regulation replaces "health coverage" with "health or dental coverage." This allows the SHOP to use the information collected in the application to enroll qualified employees and their dependents in dental coverage through the SHOP. This is necessary to allow qualified employees and their dependents to enroll in dental coverage as permitted under Section 6522(h).

Section 6522. Eligibility Requirements for Enrollment in the SHOP

Section 6522, in its entirety, clarifies and makes specific employer eligibility requirements for the SHOP. This is necessary to provide an employer with a clear understanding of mandatory SHOP participation requirements, including minimum participation and contribution requirements.

Section 6522(a)(4)(A): The current regulatory text requires a minimum of 70 percent of eligible employees of the qualified employer to enroll in health insurance coverage through the SHOP or a lesser minimum percent as determined via a SHOP survey of prevailing market practices. The amended regulation removes the word "insurance" to ensure consistent usage throughout the Title.

Current regulatory text requires the SHOP to provide issuers notice of any change to the minimum participation rules. The amended regulation replaces "issuers" with "QHP Issuers." This is necessary to resolve any ambiguities stemming from the existing text about who the SHOP must provide notice of a change in the minimum participation rules, to align with a defined term, and to ensure consistent usage throughout the Title.

Current regulatory text requires notice to be provided at least 210 days before the effective date of the change. The amended regulation allows QHPs to agree to an earlier effective date for the proposed change. The minimum participation requirement itself is necessary to ensure that the financial risk of insuring sick enrollees is balanced by the enrollment of healthy enrollees and is a common business requirement in the small group health insurance market outside of the SHOP. Without minimum participation requirements, there is a higher risk that only sick enrollees will enroll in QHPs thus increasing the cost to provide insurance coverage in the marketplace. However, market practices can shift to accurately reflect risk based upon prevailing market conditions at the time and a lower participation requirement may be necessary. Allowing the QHP Issuers to agree to an earlier effective date for the proposed change to the minimum participation percentage is necessary to allow QHP Issuers and the SHOP to respond quickly to changes in the prevailing market conditions.

Section 6522(a)(4)(A)1.: The amended regulation removes the word "insurance" from the phrase "health insurance coverage." This is necessary to ensure consistent usage throughout the Title.

Section 6522(a)(4)(B): The current regulation specifies that qualified employees who waive coverage because they have other minimum essential coverage are not counted toward the minimum participation requirement. The amended regulation replaces "coverage" with "employer offered health coverage" to clarify that the waiver applies to

the health coverage offered by the qualified employer through the SHOP. This resolves any ambiguity in the text as to what coverage the qualified employee is waiving.

The current regulation specifies that the employee is not counted in calculating compliance with Section 6522(a)(4)(A) if the qualified employee is enrolled in coverage through another employer, an employee's union, Medicaid pursuant to 42 U.S.C § 1396 et seq., or Medicare pursuant to 42 U.S.C. § 1395 et seq., or any other federal or state health care program other than coverage through a QHP sold in the Individual Exchange. The amended regulations replace the exclusion of a QHP sold in the Individual Exchange with any health coverage meeting the definition of minimum essential coverage pursuant to Health and Safety Code section 1345.5. This is necessary to ensure that qualified employees enrolled in any form of minimum essential coverage may be excluded when determining whether the qualified employer meets the group minimum participation requirements. This is necessary to ensure that qualified employees who already have minimum essential coverage do not prevent qualified employees and their dependents who need health coverage from accessing health coverage through the SHOP due to the qualified employer's failure to meet the minimum participation requirement.

Section 6522(a)(5)(A): Current regulations clarify and makes specific the minimum employer contribution requirement to be applied toward premium costs for all qualified employees. The amended regulations replace "QHP" with "health plan" and insert "health" to clarify that the minimum contribution rate is based on the lowest cost premium for employee-only health coverage at the level of coverage selected by the qualified employer. "Qualified Health Plan" is defined in Section 6410 of Title 10 of the California Code of Regulations and includes both health and dental plans that have been qualified by the Exchange. The revisions are necessary to resolve any ambiguities stemming from the existing text about whether the minimum contribution rate is based on health or dental plan premiums and to ensure consistent usage throughout the Title.

The amended regulations also revise the cross reference to Section 6520(a)(12)(C) by removing (C). This is necessary to align with proposed changes to Section 6520(a)(12) and 6520(a)(12)(C) and to ensure that cross referenced citation is correct.

Section 6522(e): The amended regulation changes "his or her" to "their" for gender neutrality and consistency purposes.

Section 6522(h): The amended regulations replace "dental plan" with "QDP." This is necessary to clarify that the eligibility standards specified in this subdivision apply only to dental plans that have been qualified to be offered through the SHOP. This is necessary to resolve any ambiguities stemming from the existing text.

Section 6522(h)(1): The amended regulations replace "QHP" with "health plan." "Qualified Health Plan" is defined in Section 6410 of Title 10 of the California Code of Regulations and includes both health and dental plans that have been qualified by the Exchange. The revision is necessary to clarify that qualified employees are not required to enroll in a health plan in order to enroll in a dental plan and to resolve any ambiguities stemming from the existing text.

Section 6522(h)(2): The amended regulation replaces “dental plan” with “QDP.” This is necessary to clarify that the eligibility standards specified in this subdivision apply only to dental plans that have been qualified to be offered through the SHOP. This is necessary to resolve any ambiguities stemming from the existing text.

Section 6522(h)(3): The amended regulations replace “an employer-sponsored Group Dental Pan” with “dental plan coverage in a QDP.” This is necessary to ensure consistent usage throughout the Title.

Section 6524. Verification Process for Enrollment in the SHOP

Section 6524 in its entirety, makes specific the requirements of 45 CFR 155.715 and clarifies the SHOP processes to determine employer eligibility. This section also clarifies and makes specific the process the SHOP will follow to address employer and employee application inconsistencies, the timeframe to resolve such inconsistencies, and the SHOP’s eligibility notification requirements. This section is necessary to advise the employer and employee of the SHOP’s procedures for verifying eligibility, addressing employer and employee application inconsistencies, timeframes to resolve inconsistencies, and notification procedures.

Section 6524(a): The current regulation requires the SHOP to verify that an employer, employee, or dependent meets the eligibility requirements specified in Section 6522 prior to allowing an employer to offer health insurance coverage to its employees or to allow an employee to select a QHP through the SHOP. The amended regulation replaces “health insurance coverage” with “health coverage or dental coverage.” This is necessary to clarify that the SHOP will verify that an employer, employee, or dependent meets the eligibility requirements specified in Section 6522 prior to allowing an employer to offer health or dental coverage to its employees. Verification is necessary to ensure the SHOP provides health or dental coverage only to eligible people. Without the addition of dental coverage to the verification requirements, some ineligible employees could be enrolled in dental coverage through the SHOP as a result of submitting inaccurate information. This is also necessary to ensure consistent usage throughout the Title.

Section 6524(b)(1): The current regulation instructs the SHOP to verify that the employee has been identified by the qualified employer as an employee being offered health insurance coverage by the qualified employer. The amended regulation replaces “health insurance coverage” with “health coverage or dental coverage.” This is necessary to clarify that the SHOP will verify that the employee has been identified by the qualified employer as an employee before being offered health or dental coverage by the qualified employer. Verification is necessary to ensure the SHOP provides health or dental coverage only to eligible people. Without the addition of dental coverage to the verification requirements, some ineligible employees could be enrolled in dental coverage through the SHOP as a result of submitting inaccurate information. This is also necessary to ensure consistent usage throughout the Title.

Section 6524(c)(2)(B): The amended regulation changes “his or her” to “their” for gender neutrality and consistency purposes.

Section 6526. Qualified Employer Election of Coverage Periods

Section 6526, in its entirety, clarifies and specifies when a qualified employer may elect to offer health insurance coverage through the SHOP, and defines the term of the employer and employees' health insurance coverage once enrolled. Additionally, it establishes notification requirements and timelines for the employer's annual election period. This section is necessary to ensure the employer understands the rules and underlying plan year cycles controlling their annual election of coverage period.

Section 6526(a): Current regulations clarify and specify that a qualified employer who is not already participating in the SHOP may elect to offer health insurance coverage through the SHOP to its qualified employees at any time during the calendar year by submitting the information specified in Section 6520. The amended regulations replace "health insurance coverage" with "health coverage or dental coverage." This is necessary to advise a qualified employer who wishes to participate in the SHOP and offer health and dental coverage but is not already doing so, that he or she may apply to do so at any time during the year, and that unlike the individual marketplace, there is no specific open enrollment period in the SHOP. This is also necessary to ensure consistent usage throughout the Title.

Section 6526(b): The current regulation clarifies and specifies the timeframe in which a qualified employer that does not meet the minimum participation or contribution requirements in Section 6522(a)(4) and 6522(a)(5), but meets all remaining eligibility criteria, may elect to offer health insurance coverage through the SHOP. The amended regulations add a cross reference to 6522(h)(3) and replace "health insurance coverage" with "health coverage or dental coverage." This is necessary to clarify that qualified employers who do not meet the meet the dental plan minimum participation or group contribution requirements may sign up for dental coverage during the annual special enrollment period of from November 15 to December 15 of each year.

Section 6526(d): The current regulation clarifies and specifies that the employer may only change its offer of health insurance coverage, including making changes to the employer's reference plan, to employees during the employer's annual election period. The amended regulation replaces "health insurance coverage" with "health coverage or dental coverage." This is necessary to advise an employer when they may change their offer of dental coverage to employees and the timeframe in which they may make those changes. This is also necessary to ensure consistent usage throughout the Title.

Section 6528. Initial and Annual Enrollment Periods for Qualified Employees

Section 6528, in its entirety, specifies the period of time when an employee may enroll in or change to a different QHP, known as the initial or annual employee open enrollment period.

Section 6528(a): The amended regulation changes "his or her" to "their" for gender neutrality and consistency purposes.

Section 6528(b): Current regulations specify that the initial employee open enrollment period begins the day the employer submits the application, and the SHOP has

determined that the employer is a qualified employer. This does not allow an employer to offer an initial employee open enrollment that begins any day other than the application and approval date. This also does not account for employers requesting a retroactive coverage effective date who must provide the qualified employees with an initial employee open enrollment period before submitting their application.

The amended regulation clarifies that the initial employee open enrollment period must begin no later than 20 days before the employee application due date specified in Section 6520(d). This is necessary to allow qualified employers flexibility on when their initial employee open enrollment period begins while still requiring the employee information to be timely submitted to the SHOP. This is also necessary to ensure that qualified employees whose employers request retroactive coverage dates are given meaningful time before the application is submitted to review their options and select a QHP.

Section 6528(c): The amended regulation changes “his or her” to “their” for gender neutrality and consistency purposes.

Section 6528(e): The current regulation requires the SHOP to give qualified employers an annual employee open enrollment period notice for each qualified employee 60 days before the end of the qualified employer’s plan year and after that employer’s annual election period. The amended regulation removes the requirement that the notice be provided after the employer’s annual election period because the employer’s annual election period begins 60 days prior to the end of the qualified employer’s plan year and ends 30 days prior to the end of the qualified employer’s plan year. If the SHOP waited until after the annual employer election period to provide the annual employee open enrollment period notice, employees would not have sufficient time to plan for the annual employee open enrollment period. This is necessary to provide employees with sufficient time to plan for the annual employee open enrollment period and to remove conflicting language from the regulation.

Section 6528(f): The amended regulation replaces “issuer” with “QHP Issuer” to clarify that qualified employees may only move to a different QHP offered by the same QHP Issuer during the first 30 days after the coverage has been effectuated rather than some other undefined issuer. This is necessary to align with the term “QHP Issuer” as defined in Title 10, California Code of Regulations, Chapter 12, Article 6, Section 6410 and to ensure consistent usage throughout the Title.

Section 6528(f)(1): The amended regulation replaces “plan” with “QHP” to clarify that the effectives dates apply to requests to change QHPs rather than plans that have not been certified as qualified health plans. This is necessary because the Exchange, including the SHOP, can only enroll qualified employees and their dependents into QHPs pursuant to Section 1311(d)(2)(B)(i) of the PPACA as codified at 42 U.S.C. Section 18031(d)(2)(B)(i) and Government Code section 100502(m). This is also necessary to align with the term “QHP” as defined in Title 10, California Code of Regulations, Chapter 12, Article 6, Section 6410 and to ensure consistent usage throughout the Title.

Section 6528(f)(2): The amended regulation replaces “plan” with “QHP” to clarify that the effectives dates apply to requests to change QHPs rather than plans that have not been certified as qualified health plans. This is necessary because the Exchange, including the SHOP, can only enroll qualified employees and their dependents into QHPs pursuant to Section 1311(d)(2)(B)(i) of the PPACA as codified at 42 U.S.C. Section 18031(d)(2)(B)(i) and Government Code section 100502(m). This is also necessary to align with the term “QHP” as defined in Title 10, California Code of Regulations, Chapter 12, Article 6, Section 6410 and to ensure consistent usage throughout the Title.

The amended regulation also replaces “issuer” with “Issuer” to align with the term “QHP Issuer” as defined in Title 10, California Code of Regulations, Chapter 12, Article 6, Section 6410 and to ensure consistent usage throughout the Title.

Section 6528(g): The amended regulation changes “his or her” to “their” for gender neutrality and consistency purposes.

Section 6528(g)(1): The amended regulation changes “his or her” to “their” for gender neutrality and consistency purposes.

Section 6528(h): The current regulation provides that qualified employees who’s current QHP is not available will be enrolled in a QHP offered by the same QHP issuer at the same metal tier that is most similar to the qualified employee’s current QHP, as determined by the SHOP on a case-by-case basis, if the employee does not pick a different plan during the open enrollment period. The amended regulation replaces three instances of “QHP” with “health plan.” “QHP” is defined in Title 10, California Code of Regulations, Chapter 12, Article 6, Section 6410 and includes both qualified health plans and qualified dental plans. Qualified dental plans are not offered in metal tiers, so this provision does not apply to qualified dental plans. This revision is necessary to clarify that employees may be assigned to a new health plan but will not be moved to a new dental plan if the employee’s dental plan is no longer available and the employee does not pick a new health plan.

The amended regulation also replaces “issuer” with “Issuer” to align with the term “QHP Issuer” as defined in Title 10, California Code of Regulations, Chapter 12, Article 6, Section 6410 and to ensure consistent usage throughout the Title.

Section 6528(i): The current regulation provides that qualified employees who’s current QHP is not available and either the QHP Issuer is not available or another QHP is not available from the current QHP Issuer in the same metal tier will be enrolled in the lowest cost QHP offered by a different QHP Issuer in the same metal tier as the qualified employee’s current QHP if the qualified employee does not pick a different plan during the open enrollment period. The amended regulation replaces four instances of “QHP” with “health plan.” “QHP” is defined in Title 10, California Code of Regulations, Chapter 12, Article 6, Section 6410 and includes both qualified health plans and qualified dental plans. Qualified dental plans are not offered in metal tiers, so this provision does not apply to dental plans. This revision is necessary to clarify that employees who do not pick a new health plan may be assigned to a new health plan but

will not be moved to a new dental plan if the employee's dental plan issuer is no longer participating in the SHOP.

The amended regulation also replaces three instances of "issuer" with "Issuer" to align with the term "QHP Issuer" as defined in Title 10, California Code of Regulations, Chapter 12, Article 6, Section 6410 and to ensure consistent usage throughout the Title.

Section 6530. Special Enrollment Periods for Qualified Employees and Dependents

Section 6530, in its entirety, specifies the events that would allow an employee to enroll in or change coverage to a different QHP outside of the initial and annual open enrollment periods.

Section 6530(a): The current regulation requires the SHOP to allow qualified employees and their dependents to enroll in QHPs and QDPs and enrollees to change QHPs. The amended regulation removes "and QDPs" because "Qualified Health Plan" is defined in Section 6410 of Title 10 of the California Code of Regulations and includes both health and dental plans that have been qualified by the Exchange. The revision is necessary to eliminate redundant language and to resolve any ambiguities stemming from the existing text.

Section 6530(b): The amended regulation changes "his or her" to "their" for gender neutrality and consistency purposes.

Section 6530(b)(1): The current regulation specifies that a qualified individual or dependent who loses Minimum Essential Coverage is eligible for a special enrollment period. Federal regulations set forth at 45 CFR Section 155.726(c)(2)(i) require the SHOP to allow qualified employees and their dependents to enroll or change QHPs if the qualified employees or their dependents experience certain triggering events specified in the Exchange regulations that apply to the individual market. The amended regulation replaces the text of this subdivision (b)(1), including all subparagraphs, with a cross-reference to subdivision (a)(1) of Section 6504 of Article 5 of this chapter, excludes subdivision (a)(1)(B) of Section 6504 of Article 5 of this chapter, and makes corresponding grammatical edits. Replacing the text with a cross-reference is necessary to automatically incorporate any changes made to the triggering events available through the individual Exchange in the SHOP regulations. This ensures that qualified employees and their dependents and qualified individuals and their dependents are afforded the same opportunities to enroll in coverage based on the same triggering events through the SHOP and the individual Exchange. This is also necessary to comply with mandatory federal requirements set forth at 45 CFR Sections 155.726(c)(2)(i) and 155.420(d)(1).

The amended regulation also changes "his or her" to "their" for gender neutrality and consistency purposes.

Section 6530(b)(2): The current regulation specifies that a qualified individual who gains a dependent or becomes a dependent through marriage or entry into domestic partnership, birth, adoption, placement for adoption, placement in foster care,

assumption of a parent-child relationship, or through a child support order or other court order is eligible for a special enrollment period. Federal regulations set forth at 45 CFR Section 155.726(c)(2)(i) require the SHOP to allow qualified employees and their dependents to enroll or change QHPs if the qualified employees or their dependents experience certain triggering events specified in the Exchange regulations that apply to the individual market. The amended regulation replaces the text of this subdivision (b)(2) with a cross-reference to subdivision (a)(2) of Section 6504 of Article 5 of this chapter. Replacing the text with a cross-reference is necessary to automatically incorporate any changes made to the triggering events available through the individual Exchange in the SHOP regulations. This ensures that qualified employees and their dependents and qualified individuals and their dependents are afforded the same opportunities to enroll in coverage or change plans based on the same triggering events through the SHOP and the individual Exchange. This is also necessary to comply with mandatory federal requirements set forth at 45 CFR Sections 155.726(c)(2)(i) and 155.420(d)(2)(i).

Section 6530(b)(3): The current regulation specifies that an enrollee who loses a dependent, including due to death, is no longer considered a dependent through divorce or legal separation, or dies is eligible for a special enrollment period. Federal regulations set forth at 45 CFR Section 155.726(c)(2)(i) require the SHOP to allow qualified employees and their dependents to enroll or change QHPs if the qualified employees or their dependents experience certain triggering events specified in the Exchange regulations that apply to the individual market. The amended regulation replaces the text of this subdivision (b)(3) with a cross-reference to subdivision (a)(3) of Section 6504 of Article 5 of this chapter. Replacing the text with a cross-reference is necessary to automatically incorporate any changes made to the triggering events available through the individual Exchange in the SHOP regulations. This ensures that qualified employees and their dependents and qualified individuals and their dependents are afforded the same opportunities to enroll in coverage or change plans based on the same triggering events through the SHOP and the individual Exchange. This is also necessary to comply with mandatory federal requirements set forth at 45 CFR Sections 155.726(c)(2)(i) and 155.420(d)(2)(ii).

Section 6530(b)(4): The current regulation specifies that if a qualified employee's, or their dependent's, enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, misconduct or inaction of an officer, employee, or agent of the Exchange or HHS or its instrumentalities or a non-Exchange entity providing enrollment assistance or conducting enrollment activities, as evaluated and determined by the Exchange, then the qualified employee or the dependent is eligible for a special enrollment period. Federal regulations set forth at 45 CFR Section 155.726(c)(2)(i) require the SHOP to allow qualified employees and their dependents to enroll or change QHPs if the qualified employees or their dependents experience certain triggering events specified in the Exchange regulations that apply to the individual market. The amended regulation replaces the text of this subdivision (b)(4) with a cross-reference to subdivision (a)(5) of Section 6504 of Article 5 of this chapter. Replacing the text with a cross-reference is necessary to automatically incorporate any changes made to the triggering events available through the individual Exchange in the SHOP regulations. This ensures that qualified employees and their dependents and qualified individuals and their dependents are afforded the same

opportunities to enroll in coverage or change plans based on the same triggering events through the SHOP and the individual Exchange. This is also necessary to comply with mandatory federal requirements set forth at 45 CFR Sections 155.726(c)(2)(i) and 155.420(d)(4).

Section 6530(b)(5): The current regulation specifies that if an enrollee adequately demonstrates to the Exchange, with respect to health plans offered through the Exchange, or to the applicable regulator, with respect to health plans offered outside the Exchange, that the QHP in which he or she is enrolled, substantially violated a material provision of its contract in relation to the qualified employee or his or her dependents, then he or she is eligible for a special enrollment period. Federal regulations set forth at 45 CFR Section 155.726(c)(2)(i) require the SHOP to allow qualified employees and their dependents to enroll or change QHPs if the qualified employees or their dependents experience certain triggering events specified in the Exchange regulations that apply to the individual market. The amended regulation replaces the text of this subdivision (b)(5) with a cross-reference to subdivision (a)(6) of Section 6504 of Article 5 of this chapter. Replacing the text with a cross-reference is necessary to automatically incorporate any changes made to the triggering events available through the individual Exchange in the SHOP regulations. This ensures that qualified employees and their dependents and qualified individuals and their dependents are afforded the same opportunities to enroll in coverage or change plans based on the same triggering events through the SHOP and the individual Exchange. This is also necessary to comply with mandatory federal requirements set forth at 45 CFR Sections 155.726(c)(2)(i) and 155.420(d)(5).

Section 6530(b)(6): The current regulation specifies that if an enrollee, a qualified employee, or their dependent gains access to new QHPs as a result of a permanent move, then they are eligible for a special enrollment period. Federal regulations set forth at 45 CFR Section 155.726(c)(2)(i) require the SHOP to allow qualified employees and their dependents to enroll or change QHPs if the qualified employees or their dependents experience certain triggering events specified in the Exchange regulations that apply to the individual market. The amended regulation replaces the text of this subdivision (b)(6) with a cross-reference to subdivision (a)(9) of Section 6504 of Article 5 of this chapter. Replacing the text with a cross-reference is necessary to automatically incorporate any changes made to the triggering events available through the individual Exchange in the SHOP regulations. This ensures that qualified employees and their dependents and qualified individuals and their dependents are afforded the same opportunities to enroll in coverage or change plans based on the same triggering events through the SHOP and the individual Exchange. This is also necessary to comply with mandatory federal requirements set forth at 45 CFR Sections 155.726(c)(2)(i) and 155.420(d)(7).

Sections 6530(b)(7), (b)(8), (b)(9), and (b)(10): The amended regulations change “his or her” to “their” for gender neutrality and consistency purposes.

Section 6530(b)(10)(A): The amended regulation replaces the word “insurance” with “coverage” to ensure consistent usage throughout the Title. The amended regulation also changes “him or her” to “them” for gender neutrality and consistency purposes.

Section 6530(b)(11): The amended regulations replace two instances of “benefit” with “plans” and one instance of “benefit” with “plan” to ensure consistent usage throughout the Title and to clarify that the Exchange offers health plans, not health benefit. The amended regulations also replaces “he or she” with “they” and makes corresponding edits required to make the sentence grammatically correct for gender neutrality and consistency purposes.

Section 6530(b)(12): The amended regulation changes “his or her” to “their” for gender neutrality and consistency purposes. The amended regulation also replaces two instances of “benefit” with “plan” to ensure consistent usage throughout the Title and to clarify that the Exchange offers health plans, not health benefit.

Section 6530(b)(13): The amended regulation changes “his or her” to “their” for gender neutrality and consistency purposes. The amended regulation also inserts “health” before the word “Coverage” to clarify that the coverage that must be lost to qualify an employee or their dependent for a special enrollment period must be health coverage under a Medi-Cal or state child health plan. This is necessary for clarity purposes.

Section 6530(b)(14): The current regulation specifies that if a qualified employee or dependent becomes eligible for assistance, with respect to health insurance coverage under a SHOP, under a Medi-Cal plan (including any waiver or demonstration project conducted under or in relation to such a plan), then he or she is eligible for a special enrollment period in the SHOP. The amended regulation changes “his or her” to “their” for gender neutrality and consistency purposes. The amended regulation also replaces the word “insurance” with “coverage” to ensure consistent usage throughout the Title. The amended regulation further revises the current text by inserting “such” and “or a state child health plan.” This clarifies that becoming eligible for assistance under a Medi-Cal plan or a state child health plan makes a qualified employee or their dependent eligible for a special enrollment period in the SHOP. This is necessary to comply with mandatory federal requirements set forth at 45 CFR Section 155.726(c)(2)(iii).

Section 6530(b)(15): The current regulation specifies that if a qualified employee, or his or her dependent, is a victim of domestic abuse or spousal abandonment, as specified in 26 CFR Section 1.36B-2 (b)(2)(ii) through (v), is enrolled in MEC, and seeks to enroll in coverage separate from the perpetrator of the abuse or abandonment, then he or she is eligible for a special enrollment period. Federal regulations set forth at 45 CFR Section 155.726(c)(2)(i) require the SHOP to allow qualified employees and their dependents to enroll or change QHPs if the qualified employees or their dependents experience certain triggering events specified in the Exchange regulations that apply to the individual market. The amended regulation replaces the text of this subdivision (b)(15) with a cross-reference to subdivision (a)(12) of Section 6504 of Article 5 of this chapter. Replacing the text with a cross-reference is necessary to automatically incorporate any changes made to the triggering events available through the individual Exchange in the SHOP regulations. This ensures that qualified employees and their dependents and qualified individuals and their dependents are afforded the same opportunities to enroll in coverage or change plans based on the same triggering events through the SHOP and the individual Exchange. This is also necessary to comply with

mandatory federal requirements set forth at 45 CFR Sections 155.726(c)(2)(i) and 155.420(d)(10).

Section 6530(b)(16): The current regulation specifies that a qualified employee, or his or her dependent, applies for coverage on the Exchange during the annual open enrollment period, or due to a qualifying event, and is assessed by the Exchange as eligible for Medi-Cal or the Children's Health Insurance Program (CHIP), and put into one of those programs, only to be later determined to be ineligible, is given the opportunity to enroll in other health coverage through a special enrollment period. Federal regulations set forth at 45 CFR Section 155.726(c)(2)(i) require the SHOP to allow qualified employees and their dependents to enroll or change QHPs if the qualified employees or their dependents experience certain triggering events specified in the Exchange regulations that apply to the individual market. The amended regulation replaces the text of this subdivision (b)(16) with a cross-reference to subdivision (a)(13) of Section 6504 of Article 5 of this chapter. Replacing the text with a cross-reference is necessary to automatically incorporate any changes made to the triggering events available through the individual Exchange in the SHOP regulations. This ensures that qualified employees and their dependents and qualified individuals and their dependents are afforded the same opportunities to enroll in coverage or change plans based on the same triggering events through the SHOP and the individual Exchange. This is also necessary to comply with mandatory federal requirements set forth at 45 CFR Sections 155.726(c)(2)(i) and 155.420(d)(11).

Section 6530(b)(17): The current regulation specifies that a qualified employee, or his or her dependent, who demonstrates to the Exchange that a material error related to plan benefits, service area, or premium, influenced the qualified employee's or dependent's decision to purchase a QHP through the Exchange should be eligible for a special enrollment period. Federal regulations set forth at 45 CFR Section 155.726(c)(2)(i) require the SHOP to allow qualified employees and their dependents to enroll or change QHPs if the qualified employees or their dependents experience certain triggering events specified in the Exchange regulations that apply to the individual market. The amended regulation replaces the text of this subdivision (b)(17) with a cross-reference to subdivision (a)(14) of Section 6504 of Article 5 of this chapter. Replacing the text with a cross-reference is necessary to automatically incorporate any changes made to the triggering events available through the individual Exchange in the SHOP regulations. This ensures that qualified employees and their dependents and qualified individuals and their dependents are afforded the same opportunities to enroll in coverage or change plans based on the same triggering events through the SHOP and the individual Exchange. This is also necessary to comply with mandatory federal requirements set forth at 45 CFR Sections 155.726(c)(2)(i) and 155.420(d)(12).

The amended regulation also changes “his or her” to “their” for gender neutrality and consistency purposes.

Section 6530(b)(18): The amended regulation changes “his or her” to “their” for gender neutrality and consistency purposes.

Section 6530(c): The amended regulation changes “his or her” to “their” for gender neutrality and consistency purposes.

Section 6530(c)(2): The current regulation clarifies and makes specific that an employee or his or her dependent has 30 days from the date of the event described in paragraphs (b)(12) or (g)(1) of this section to select coverage for a qualified employee or his or her eligible dependents in through the SHOP. The amended regulation replaces the phrase "coverage for the qualified employee or his or her eligible dependents in" with "a QDP." This is necessary to make the regulation grammatically correct and to clarify that the qualified employee or their dependent may select a QDP through the SHOP.

Section 6530(d): The amended regulation replaces "health insurance coverage" with "health coverage or dental coverage." This is necessary to clarify that dependents are not eligible for a special enrollment period if the qualified employer does not offer health or dental coverage and to ensure consistent usage throughout the Title.

Section 6530(e)(1): The current regulation specifies what events or circumstances are considered "loss of MEC" and what events or circumstances are not. The amended regulation replaces "health insurance coverage" with "health coverage." This is necessary for clarity purposes and to ensure consistent usage throughout the Title.

Section 6530(e)(1)(A): The amended regulation removes "insurance" from the phrase "health insurance coverage" so only "health coverage" is referenced. This is necessary for clarity purposes and to ensure consistent usage throughout the Title.

Section 6530(e)(1)(A)3.: The amended regulations insert "health" before "plan." This is necessary for clarity purposes and to ensure consistent usage throughout the Title.

Sections 6530(e)(1)(C), (e)(1)(D), and (e)(1)(E): The amended regulations insert "health" before "coverage" and replace "benefits" with "health coverage." This is necessary for clarity purposes and to ensure consistent usage throughout the Title.

Section 6530(e)(2): The amended regulation removes "insurance" from the phrase "health insurance coverage" so only "health coverage" is referenced. This is necessary for clarity purposes and to ensure consistent usage throughout the Title.

Section 6530(e)(3): The amended regulation removes "insurance" from the phrase "health insurance coverage" so only "health coverage" is referenced. This is necessary for clarity purposes and to ensure consistent usage throughout the Title.

Section 6530(f): The amended regulation inserts "Issuer" after "QHP." This is necessary to clarify the entity that can request verification of a triggering event. This is also necessary to ensure consistent usage throughout the Title and to align with a defined term.

Section 6530(g): The amended regulation changes "his or her" to "their" for gender neutrality and consistency purposes.

Section 6530(g)(1): The amended regulation removes "insurance" from the phrase "dental insurance coverage" so only "dental coverage" is referenced. This is necessary for clarity purposes and to ensure consistent usage throughout the Title. The amended

regulation also changes “his or her” to “their” for gender neutrality and consistency purposes.

Section 6530(g)(2): The amended regulation removes “insurance” from the phrase “dental insurance coverage” so only “dental coverage” is referenced. This is necessary for clarity purposes and to ensure consistent usage throughout the Title.

Section 6530(g)(3): The amended regulation changes “his or her” to “their” for gender neutrality and consistency purposes. The amended regulation also inserts “Issuer” after “QDP” to clarify the entity that offers the dental coverage and to ensure consistent usage throughout the Title.

Section 6532. Employer Payment of Premiums.

Section 6532, in its entirety, specifies when invoices will be sent to employers and when payments are due. This is necessary to comply with 45 CFR 155.705 which requires the SHOP to create a standardized processes for premium calculation, premium payment, and premium collection and requires the SHOP to bill employers on a monthly basis. This section is also necessary to inform employers when and how they will be invoiced and how to make payment for their employees’ coverage.

Section 6532(a)(1): The current regulation specifies that a qualified employer's first premium payment shall be no less than 85 percent of the total amount due. However, QHP Issuers are unable to effectuate coverage if the initial premium payment is not paid in full. The amended regulation removes the premium payment threshold and clarifies that the first premium payment must be paid in full. This is necessary to ensure that employers pay the premiums due for the first month’s coverage and to provide employers with clear standards regarding the minimum amount of payment required from the employer.

Section 6532(b): The amended regulation replaces “health insurance coverage” with “health coverage or dental coverage.” This is necessary to inform employers when the SHOP will send ongoing invoices for health and dental coverage. Without this addition, the SHOP could not invoice the employers for dental coverage and QDP Issuers could not provide dental coverage to the employer’s employees. This is also necessary to ensure consistent usage throughout the Title.

Section 6532(b)(2): The current regulation specifies that the qualified employer must make a monthly premium payment of no less than 85 percent of the total balance due, including any amounts past due, by the due date on the invoice. The amended regulation revises the premium payment threshold to $100 less than the total balance due. The purpose of the revision is to specify and clarify that the qualified employer must make a monthly premium payment of no less than $100 less than the total balance due, including any amounts past due, by the due date on the invoice. This is necessary to inform employers regarding the amount of premium payment that the Exchange must timely receive for coverage to continue so that they know what to expect and can adjust their operations, if necessary, to accommodate this requirement.

Section 6532(c): The current regulation specifies that payments for less than the full amount of payment will be allocated by the total percentage paid across all amounts due for health and dental benefits, if any. The amended regulations clarify that payments made to the SHOP in amounts less than the total amounts due for health and dental coverage will be allocated by the oldest to newest amounts due. This is necessary to reduce confusion as to whether the employer is subject to termination for nonpayment of premium as described in Section 6538(c)(2). This is a very common occurrence in the small group market today and therefore it is necessary to clarify what will happen in these circumstances.

The amended regulation also clarifies how payments made to the SHOP in amounts greater than the total amount due are applied. This is necessary because sometimes employers make more than one payment in a month towards the monthly invoice and other times payments will exceed the cost of coverage for the month, so it is necessary to clarify what will happen in these circumstances.

Additionally, the amended regulation specifies how payments are applied after adjustments to the employer group are made due to new additions or terminations of employees or dependents. This is a common occurrence in the small group market and therefore it is necessary to clarify what will happen in these circumstances.

The amended regulation replaces “health and dental benefits” with “health coverage and dental coverage.” This is necessary to ensure consistent usage throughout the Title.

Section 6532(e): The current regulation specifies that the SHOP shall apply a $25 insufficient funds fee if a premium payment paid via check is returned for any reason. The amended regulation removes the reference to “via check” to clarify that premium payments returned for any reason are subject to the $25 insufficient funds fee. This is necessary to ensure that the insufficient funds fee applies to all forms of premium payment that are returned. The amended regulation also clarifies that employers who make a second premium payment that is returned unpaid for any reason within six months of the prior returned payment must submit premium payment and the insufficient funds fee in the form of a cashier’s check or money order for a 12-month period beginning with the first of the month following the last paid-through date. Additionally, the amended regulation specifies that the employer group may be subject to termination for non-payment of premium if the premium payment is not paid by cashier’s check or money order. These changes are necessary to inform employers of the consequences of having insufficient funds in their payment account to cover the amount of their premium payment on a one time and repeated basis so that they know what to expect and can adjust their operations, if necessary, to avoid this fee, the requirement to submit future premium payments in limited forms of payment, and termination for non-payment of premium.

Section 6534. Coverage Effective Dates for Special Enrollment Periods.

Section 6534, in its entirety, specifies when coverage will commence for QHP and QDP selections that an employee or their eligible dependent makes during a special enrollment period. This regulation is necessary to inform the employee or dependent

when they can begin to use their coverage as well as informing QHP and QDP issuers when to make that coverage effective. Additionally, this regulation is necessary to comply with 45 CFR 155.720(b)(7), which requires the SHOP Exchange to identify coverage effective dates for enrollments in the SHOP Exchange.

Section 6534(a): Current regulations specify that the coverage effective dates for special enrollment periods for a QHP or QDP selection received by the Exchange from a qualified employee will be no later than the first day of the following month for applications received between the first and the fifteenth day of any month. The amended regulations remove "or QDP." "Qualified Health Plan" is defined in Section 6410 of Title 10 of the California Code of Regulations and includes both health and dental plans that have been qualified by the Exchange. The revision is necessary to eliminate redundant language and to resolve any ambiguities stemming from the existing text.

The amended regulations also replace a reference to the "Exchange" with a reference to the "SHOP." The Exchange refers to the California Health Benefit Exchange, which includes the SHOP program, whereas SHOP refers specifically to CCSB. This is necessary to clarify that the coverage effective dates for special enrollment periods for a QHP apply to plan selections received by the SHOP. The revision is also necessary to resolve any ambiguities stemming from the existing text and to ensure consistent usage throughout the Title.

Section 6534(b)(3)(B): Current regulations provide that the effective date of coverage for an employee or his or her dependent who experiences a triggering event that gives rise to a special enrollment period as described in Section 6530(b)(4) or 6530(b)(5) will be the date of the triggering event, as described above, or the date that is least financially burdensome on the enrollee, as determined by the Exchange. The amended regulations replace a reference to the "Exchange" with a reference to the "SHOP." The Exchange refers to the California Health Benefit Exchange, which includes the SHOP program, whereas SHOP refers specifically to CCSB. This is necessary to clarify that the SHOP has the discretion to determine the appropriate effective date. The revision is also necessary to resolve any ambiguities stemming from the existing text and to ensure consistent usage throughout the Title.

Section 6536. Coverage Effective Dates for Qualified Employees

Section 6536, in its entirety, specifies when coverage will commence for QHP selections that an employee makes during the initial and annual open enrollment periods depending on when the employer pays the premium. This regulation is necessary to inform the employer when payment must be received by the SHOP Exchange for a certain coverage effective date. This is also necessary to inform the employee when they can begin to use their coverage as well as informing QHP issuers when to make that coverage effective.

Section 6536(c): The current regulation specifies the effective date of coverage for QHPs selected by a newly qualified employee. The existing regulation cross-references Section 6528(h), which refers to what happens when an employee's current health plan

is not available upon renewal. The amended regulations replace the cross-reference to Section 6528(h) with a cross-reference to Section 6528(j) because Section 6528(j) describes circumstances in which an employee becomes a qualified employee outside of the initial annual enrollment period, the annual open enrollment period, or a special enrollment period. The purpose of the change to this subdivision is to correct an inadvertent typographical error. This is necessary to reduce to confusion as to which qualified event this subdivision applies.

Section 6538. Disenrollment and Termination.

Section 6538 in its entirety, clarifies and makes specific valid termination and disenrollment reasons to terminate QHP coverage through the SHOP. This section also clarifies and makes specific the effective dates of QHP termination coverage based on the termination reason as well as written QHP termination notification requirements. This is necessary to provide clear guidance on disenrollment and termination of QHP coverage through the SHOP. This is also necessary to provide clear guidance on coverage termination effective dates based on disenrollment and termination reason.

Section 6538(a)(1): This subdivision clarifies and makes specific the SHOP's responsibility to ensure that each QHP terminates an employer's employees' and their dependents' coverage through the SHOP at the request of the qualified employer. The amended regulations insert "Issuer" following "QHP" to clarify that the entity responsible for terminating coverage is the QHP Issuer. This is necessary to align with the term "QHP Issuer" as defined in Title 10, California Code of Regulations, Chapter 12, Article 6, Section 6410 and to ensure consistent usage throughout the Title.

Section 6538(c): Current regulations outline the circumstances under which the SHOP may initiate termination of coverage and must allow a QHP Issuer to terminate coverage provided that the QHP Issuer makes reasonable accommodations for individuals with disabilities and complies with any and all requirements for cancellations, recissions, and nonrenewals pursuant to state law. The amended regulations include Insurance Code section 10384.17 and make corresponding grammatical edits. This reference was inadvertently omitted and the purpose of the addition is to clarify which provisions of the Insurance Code apply to rescissions. This is necessary to ensure that the SHOP and QHP Issuers comply with all requirements before rescinding coverage.

The amended regulations also replace "issuer" with "Issuer" to align with the term "QHP Issuer" as defined in Title 10, California Code of Regulations, Chapter 12, Article 6, Section 6410 and to ensure consistent usage throughout the Title.

Section 6538(c)(3): The amended regulations replace "issuer" with "Issuer" when referring to the "QHP Issuer." This is necessary to align with the term "QHP Issuer" as defined in Title 10, California Code of Regulations, Chapter 12, Article 6, Section 6410 and to ensure consistent usage throughout the Title.

Section 6538(c)(4): The current regulations allow the SHOP or a QHP Issuer to terminate coverage if the QHP terminates or is decertified unless the qualified employees and their dependents are eligible to be enrolled in a similar plan during the annual renewal period. The amended regulation replaces "plan" with "QHP" to clarify

that the employees and their dependents who lose coverage because the QHP terminates or is decertified will be enrolled into a similar QHP through the SHOP during the annual renewal period, not some other plan that has not been qualified by the Exchange. This is necessary because the Exchange, including the SHOP, can only enroll qualified employees and their dependents into QHPs pursuant to Section 1311(d)(2)(B)(i) of the PPACA as codified at 42 U.S.C. Section 18031(d)(2)(B)(i) and Government Code section 100502(m).

Section 6538(d): The amended regulation replaces two instances of "issuer" with "Issuer" when referring to the "QHP Issuer." This is necessary to align with the term "QHP Issuer" as defined in Title 10, California Code of Regulations, Chapter 12, Article 6, Section 6410 and to ensure consistent usage throughout the Title.

Section 6538(e)(1)(A): The amended regulation replaces "issuer" with "Issuer" when referring to the "QHP Issuer." This is necessary to align with the term "QHP Issuer" as defined in Title 10, California Code of Regulations, Chapter 12, Article 6, Section 6410 and to ensure consistent usage throughout the Title.

Section 6538(e)(1)(B): The amended regulation replaces "issuer" with "Issuer" when referring to the "QHP Issuer." This is necessary to align with the term "QHP Issuer" as defined in Title 10, California Code of Regulations, Chapter 12, Article 6, Section 6410 and to ensure consistent usage throughout the Title.

Section 6538(e)(2)(C): The amended regulation inserts "Issuer" after "QHP" to clarify the entity that can agree with the SHOP on an earlier effective date on a case-by-case basis. The is necessary to specify that the entity is the QHP Issuer, to align with a term as defined in Title 10, California Code of Regulations, Chapter 12, Article 6, Section 6410, and to ensure consistent usage throughout the Title.

Section 6538(e)(6): The amended regulation replaces "issuer" with "Issuer" when referring to the "QHP Issuer." This is necessary to align with the term "QHP Issuer" as defined in Title 10, California Code of Regulations, Chapter 12, Article 6, Section 6410 and to ensure consistent usage throughout the Title.

Section 6538(e)(7): The amended regulation changes "his or her" to "their" for gender neutrality and consistency purposes.

Section 6538(g)(1): The amended regulation changes "his or her" to "their" for gender neutrality and consistency purposes.

Section 6538(g)(3): The amended regulation replaces "issuer" with "Issuer" when referring to the "QHP Issuer." This is necessary to align with the term "QHP Issuer" as defined in Title 10, California Code of Regulations, Chapter 12, Article 6, Section 6410 and to ensure consistent usage throughout the Title.

Section 6538(g)(4): The amended regulation changes "his or her" to "their" for gender neutrality and consistency purposes.

Section 6542. General Eligibility Appeals Requirements for SHOP.

Section 6542, in its entirety, implements, clarifies, and makes specific the general rules that govern appeals of the SHOP's eligibility determinations and redeterminations.

Section 6542(b)(2): The amended regulation corrects a typographical error in the spelling of the word "provide." This is necessary to ensure that the regulation is free from typographical errors and all words are spelled correctly.

Section 6542(j)(1): The amended regulation changes "him or her" to "them" for gender neutrality and consistency purposes.

Section 6542(n): The amended regulation changes "his or her" to "their" for gender neutrality and consistency purposes.

Section 6544. Informal Resolution

Section 6544, in its entirety, implements, clarifies, and makes specific the general rules that govern informal resolution of appeals of the SHOP's eligibility determinations and redeterminations.

Section 6544(c): The amended regulation changes "his or her" to "their" for gender neutrality and consistency purposes.

Section 6544(d)(1): The amended regulation changes "he or she" to "they" for gender neutrality and consistency purposes.

Section 6544(e): The amended regulation changes "his or her" to "their" for gender neutrality and consistency purposes.

Section 6548. Hearing Requirements

Section 6548, in its entirety, implements, clarifies, and makes specific the rules that govern hearings of appeals of the SHOP's eligibility determinations and redeterminations.

Section 6548(d)(1): The amended regulation changes "his or her" to "their" for gender neutrality and consistency purposes.

Section 6550. Expedited Appeal Process

Section 6550, in its entirety, implements, clarifies, and makes specific the rules that govern expedited appeals of the SHOP's eligibility determinations and redeterminations.

Section 6550(a): The current regulation specifies that appellants have the right to request an expedited appeal process from the appeal entity if 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. The amended regulation replaces "health services" with "health coverage or dental coverage" because the SHOP and the appeals entity can provide health or dental coverage through an

appeal, expedited or otherwise, but cannot provide health services. This is necessary to provide the employers and employees with clear standards and guidelines as to their right to due process and to clarify what appellants must show to obtain an expedited appeal.

Section 6550(c)(2)(A): The amended regulation changes “his or her” to “their” for gender neutrality and consistency purposes.

RELIED ON DOCUMENTS

None.

ECONOMIC IMPACT ANALYSIS/ASSESSMENT (EIA)

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.

This proposed regulatory action will not affect worker safety and the state’s environment.

Potential Costs to Businesses Resulting from the Proposed Amendment

The proposed regulations seek to clarify and make specific some of the Exchange’s policies and procedures for eligibility determination and redetermination, enrollment in qualified health plans, termination of coverage through CCSB, and appeals. The

proposed regulatory package (1) clarifies several policies relating to employer payment of premiums, minimum participation standards, initial employee enrollment periods, and special enrollment periods, (2) specifies the CCSB New Business Late Submission Acknowledgement Form and employee application due dates, (3) revises certain terms and phrases, and (4) updates the regulations to be gender neutral. The proposed regulations have been circulated to and reviewed by affected parties including businesses and qualified health plans. No comments regarding the economic impact of the proposal were received.

Although the proposed action will directly affect businesses statewide, including small businesses, the Exchange concludes that the economic impact, including the ability of California businesses to compete with businesses in other states, will not be significant. These provisions will have no substantial impact on the operation of these entities and thus the proposed regulation is not expected to have a significant adverse economic impact on businesses.

Creation of Jobs

These proposed regulations are not expected to create or eliminate any jobs within the State of California.

Creation of Businesses

These proposed regulations are not expected to create or eliminate any new business within the State of California for the reasons stated above.

Expansion of Businesses

These proposed regulations are not expected to expand any business within the State of California because the proposed regulations will provide small employers and their employees with clear standards and eligibility requirements to qualify for health coverage through the SHOP.

REASONABLE ALTRNATIVES TO THE REGULATION AND THE AGENCY'S REASONS FOR REJECTING THOSE ALTERNATIVES

In accordance with Government Code Section 11346.5(a)(13), the Exchange has described the reasonable alternatives for certain Articles and Sections below. The Exchange must determine that no reasonable alternative it 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 the action is proposed, would be as effective and less burdensome to affected private persons than the proposed action, or would be more cost-effective to affected private persons and equally effective in implementing the statutory policy or other provision of law.

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.

Alternative 1: Doing nothing and rely 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 applicable to small group coverage available through the SHOP instead of adopting regulations. The Exchange rejected this option because the California enabling legislation requires the Exchange to establish a SHOP and administer all tasks necessary to offer qualified health plans to qualified employers' employees and their dependents, including collecting premiums. (Gov. Code, §§ 100502(m), 100503(w).) Federal regulations establish some policies and procedures through which small business employers can purchase coverage for their employees and their dependents, but largely leave most policy and procedures to the discretion of the Exchange. The SHOP would not be able to function if it did not adopt regulations.

Alternative 2: Continuing to require 85% remittance of the amount invoiced for premium due to CCSB to effectuate or continue coverage.

Analysis: The Exchange considered requiring payment in full for the initial premium payment and the ongoing monthly premium payments or having different thresholds for the initial premium payment and the ongoing monthly premium payments. State law does not require QHP Issuers to effectuate coverage if the employer does not pay the full premium payment based on the quoted premium charges. It is common industry practice to require payment in full before effectuating coverage. Therefore, the Exchange rejected the option of continuing to require 85% remittance of the amount invoiced for premium due to CCSB to effectuate coverage and opted to require payment in full of the initial premium payment.

For the ongoing monthly premium payment, it is common that the invoiced amount may not reflect the actual amount owed for the month due to the timing of changes in the covered employees. Often, invoices are generated for the following month before the employer informs CCSB of a termination that should be effective on the last day of the current month. These changes have an impact on premium due for the following month (as opposed to amount invoiced). When the Exchange adopted the 85% premium payment threshold, it was common that the employer attempted to mitigate by making an adjustment to the invoiced amount to derive the actual amount due. However, CCSB system changes allow for updates in real time, and the amount due is automatically adjusted when the employer reports the change. Employers no longer must make their own adjustments to the invoiced premium amount, so it is no longer necessary to consider employers to have paid in full if they underpay their invoiced amount by more than 15%.

It is common industry practice to allow employers some leeway in their monthly invoiced premium payment to ensure their employees do not lose coverage if the employer underpays by a small amount. Therefore, the Exchange rejected the 85% premium payment threshold and is proposing to adopt a $100 premium payment threshold for ongoing monthly premium payments. This adjusts the premium payment threshold to account for system changes while allowing employers limited leeway in their invoiced monthly premium payment to ensure their employees do not lose coverage if the employer underpays by a small amount. To date, there is a very low percentage of

employer groups who do not remit premium as invoiced. This practice is, by far, the exception rather than the rule.

Alternative 3: Establish a due date for the CCSB New Business Late Submission Acknowledgement Form either earlier or later than the 7th day of the month to retroactively effectuate enrollment.

Analysis: The Exchange considered earlier and later due dates for the CCSB New Business Late Submission Acknowledgement Form. If the Exchange required the CCSB New Business Late Submission Acknowledgement Form to be submitted earlier than the 7th day of the month, employers would not have a meaningful opportunity to request retroactive coverage. If the Exchange allowed employers to have a retroactive coverage effective date if they submitted the CCSB New Business Late Submission Acknowledgement Form after the 7th day of the month, employees would not have meaningful access to coverage due to processing timeframes. It takes CCSB and the QHP Issuers approximately two weeks to process new enrollments and send health insurance cards to the enrollees. If that process occurred later in the month, enrollees would have to pay for coverage that they were not able to access for most of the month because the QHP Issuer's system did not reflect the coverage and the enrollees did not have their health insurance cards. Therefore, the Exchange rejected the alternative of establishing a due date for the CCSB New Business Late Submission Acknowledgement Form either earlier or later than the 7th day of the month to balance employer opportunity to request retroactive enrollment with employee's meaningful access to care.

Alternative 4: Continuing to restate certain triggering events described in the individual Exchange regulations in the SHOP regulations.

Analysis: Federal regulations under 45 CFR section 155.726(c)(2) require the SHOP to allow qualified employees and their dependents and enrollees to enroll or change plans if they experience certain triggering events contained in the individual Exchange regulations. The triggering events contained in the individual Exchange regulations change frequently. It is common that they are amended in the annual Notice of Benefit and Payment Parameters federal regulation. If the Exchange were to continue restating certain triggering events rather than cross-referencing the individual Exchange regulations, the Exchange would have to amend the SHOP regulations and the individual regulations if any changes are made at the federal level. Cross-referencing allows the Exchange to automatically incorporate any changes made to the triggering events available through the individual Exchange in the SHOP regulations. This ensures that qualified employees and their dependents and qualified individuals and their dependents are afforded the same opportunities to enroll in coverage or change plans based on the same triggering events through the SHOP and the individual Exchange as quickly as possible.

SUPPORT FOR DETERMINATION OF NO SIGNIFICANT ADVERSE ECONOMIC IMPACT ON BUSINESS

<u>Background, Assumptions, and Calculations</u>

In 2022, nearly 1.3 million small employers with fewer than 100 employees employed nearly 6.7 million employees. Over 2.3 million employees and their dependents were enrolled in health insurance provided by small employers in California.[1] While only 76,400 of those enrollees are covered through CCSB, the program provides greater choice for employers. At about 4% of overall enrollment in the small group market, CCSB is an important option for some small businesses, but the great majority of small business employers who offer coverage in California provide benefits by contracting directly with health plan issuers. Even though enrollment is still lower than expected, the program has continued to grow each year.

Number of Small Businesses Eligible for the Tax Credit

To be eligible for a federal tax credit, a small business must cover at least 50 percent of the cost of single (not family) health care coverage for each of their eligible employees. They must also have fewer than 25 full-time equivalent employees (FTEs). Those employees must have average wages of less than $56,000 per year in 2023 (indexed annually for inflation). The small business must offer SHOP coverage to all full-time employees.

The maximum tax credit is 50 percent of premium expenses and 35 percent of premium expenses for small tax-exempt employers. The amount of credit a small employer may receive works on a sliding scale. Small employers with fewer than ten employees who are paid an average wage of $27,000 or less qualify for the maximum tax credit. The credit is available for eligible employers for two consecutive taxable years.

The information below is from the KFF Employer Health Benefits Survey and the California Employer Health Benefits: Cost Burden on Workers Varies report by the California Health Care Foundation. The survey was designed and analyzed by KFF and NORC and administered by Davis Research, an independent research organization based in Calabasas. Davis conducted interviews from February to July 2022. The findings are based on a random sample of 742 interviews with employee benefit managers in firms in or having employees in California.

- 64% of all California employers offered health benefits to at least some of their employees.
- 55% of California employers with three to nine workers, 72% of California employers with ten to twenty-four workers, and 76% of California employers with twenty-five to forty-nine workers offered health benefits.
- Although California small employers with three to nine workers accounted for 59% of all employers, only 5% of workers with health coverage were employed by those small businesses.

Although 45% of California employers with three to nine workers and 28% of California employers with ten to twenty-four workers to were not offering health benefits to their

[1] The Department of Managed Healthcare, Marketplace Dashboard, Enrollment over time, https://wpso.dmhc.ca.gov/dashboard/MarketPlace.aspx (December 2022); California Department of Insurance, Health Insurance Covered Lives Report (AB 1083 Report), https://www.insurance.ca.gov/01-consumers/110-health/coveredlivesrpt.cfm (December 2022).

employees and could potentially be eligible for the Small Business Health Care Tax Credit, it is becoming increasingly challenging for California employers to meet the average annual wage requirements. Beginning January 2024, the minimum wage in California is $16 per hour and some cities and counties have higher minimum wages than the state's rate.[2] The current federal minimum wage is $7.25 per hour. Given that employees paid the minimum wage in California earn more than twice the amount as employees paid the federal minimum wage, fewer small employers in California can meet the average annual wage requirement to qualify for the federal tax credit.

[2] California Department of Industrial Relations, News Release Number 2023-66, "California's Minimum Wage to Increase to $16 per hour in January 2024" (Sept. 26, 2023).

Title 10. Investment

Chapter 12. California Health Benefit Exchange

§ 6520. Employer and Employee Application Requirements.

(a) A small employer who is eligible to purchase coverage from a Qualified Health Plan (QHP) Issuer for its eligible employees through the Small Business Health Options Program (SHOP) pursuant to Section 6522, may apply to participate in the SHOP by submitting the following information to the SHOP:

(1) General employer information: business legal name and whether the employer is doing business under a fictitious name, Federal Employer Identification Number, State Employer Identification Number, organization type (private, nonprofit, government, church/church affiliated), Standard Industry Classification (SIC) code, principal business address, and mailing address~~, and billing address~~;

(2) The number of eligible employees being offered enrollment in SHOP and the total number of full-time equivalent (FTE) employees employed by the qualified employer, as calculated in accordance with Health and Safety Code Section 1357.500(k)(3) and Insurance Code Section 10753(q)(3);

(3) Whether you have employed 20 or more employees for 20 or more weeks in the current or preceding calendar year;

(4) Whether the qualified employer is offering dependent ~~health insurance coverage~~health coverage or dental coverage for spouses, registered or non-registered domestic partners and/or dependent children;

(5) The qualified employer's desired ~~health insurance coverage~~health coverage or dental coverage effective date;

(6) Whether the qualified employer is subject to COBRA or Cal-COBRA continuation coverage regulations;

(7) Whether the qualified employer is currently offering ~~health coverage~~health coverage or dental coverage, and if so, through which issuer;

(8) Whether the qualified employer intends to claim the Small Business Health Care Tax Credit with the IRS;

(9) The name, primary phone number, and email address for the primary contact and business owner/authorized company officer for the qualified employer and the preferred method of communication;

(10) Whether the qualified employer used an insurance agent and if so, the agent's name, general agency name (if applicable), CA insurance license number, the agency Federal Employer Identification Number if applicable, and whether the agent is an insurance agent certified by Covered California. If the qualified employer uses an insurance agent, the qualified employer must have that agent certify that ~~he or she~~they understand~~s he or she~~they may be subject to a civil penalty for providing false information under Health and Safety Code Section 1389.8 and Insurance Code Section 10119.3.

(11) Information about the qualified employer's qualified employees, in the employee application in subdivision (d);

(12) The employer's offer of ~~health insurance coverage~~health coverage or dental coverage and the reference plan or dental reference plan, which includes:

(A) The employer's contribution rate to each of its qualified employee's ~~Qualified Health Plan (QHP)~~health plan premiums pursuant to Section 6522(a)(5)(A);

(B) The employer's health plan premium contribution rate for spouse or non-registered domestic partner, or dependent children ~~coverage~~health coverage, if applicable; and

(C) The employer's ~~plan~~ selection for ~~a tier of health insurance coverage or for two contiguous tiers of health insurance coverage~~one, two contiguous, three contiguous, or four contiguous tiers of health coverage, pursuant to 45 CFR Section 156.140(b) (bronze, silver, gold, or platinum) (February 25, 2013), hereby incorporated by reference~~, and the reference plan~~;

(D) Whether the qualified employer wishes to include infertility benefits to qualified employees;

(E) Effective August 1, 2021, if the qualified employer is offering dental coverage to qualified employees, the employer must select a dental reference plan. The qualified employer must indicate its contribution rate for qualified employees' QDP premiums pursuant to Section 6522(h)(3). The qualified employer must indicate its QDP premium contribution rate for spouse's or non-registered domestic partner's, or dependent children's coverage, if applicable;

(13) New qualified employer application submissions are due five days prior to the requested effective date. Completed submissions received after this date will carry an effective date no earlier than the first of the following month unless the qualified employer submits a signed CCSB New Business Late Submission Acknowledgement Form (Rev. ~~3/18~~1/24), hereby incorporated by reference. The CCSB New Business Late Submission Acknowledgement Form must be submitted by the 7th day of the month to

retroactively effectuate enrollment to the 1st of the month. Exceptions for exceptional circumstances will be considered on a case-by-case basis.

(b) To participate in the SHOP, an employer must attest to the following:

(1) That the business has 100 or fewer full-time or FTE employees and has a principal business address in California;

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

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

(4) That the employer is signing the application under penalty of perjury, which means all information contained in the qualified employer application is true and correct to the best of the qualified employer's knowledge;

(5) That the employer knows that ~~he or she~~they may be subject to penalties under federal law if ~~he or she~~they intentionally provide~~s~~ false or untrue information pursuant to 45 CFR Section 155.285 (September 6, 2016), hereby incorporated by reference;

(6) That the employer knows that the information will only be used to determine eligibility and facilitate enrollment in ~~for health coverage~~health coverage or dental coverage and will otherwise be kept private as required by federal and state law;

(7) That any waiting period established by the qualified employer complies with 42 U.S.C. Section 300gg-7, 45 CFR Section 155.725 (April 18, 2017), hereby incorporated by reference, and applicable state law, and all qualified employees have complied with the qualified employer's waiting period;

(8) That the employer has the consent from every qualified employee listed on the application to include their personally identifiable information such as dates of birth, addresses, social security numbers or tax identification numbers, phone numbers, and email addresses;

(9) That the employer understands that discrimination is prohibited on the basis of race, color, national origin, religion, sex, age, sexual orientation, marital status, gender identity, veteran status, disability, or any other type of discrimination prohibited in the Health and Safety Code and Insurance Code;

(10) That the qualified employer understands that the SHOP will not consider the qualified employer approved for ~~health insurance coverage~~health coverage or dental coverage until the SHOP has received the qualified employer's first month's total premium payment~~, which shall be no less than 85 percent of the total amount due~~;

(11) That the qualified employer agrees to continue to make the total required monthly premium payment by the due date, and which at no time shall be less than ~~85 percent of~~ 100 dollars less than the total amount due each month, including any premium amounts past due, to maintain eligibility for coverage in the SHOP;

(12) That the qualified employer agrees to inform its eligible employees of the availability of ~~health insurance coverage~~health coverage and dental coverage and that those declining coverage must wait until the next open enrollment period, pursuant to Section 6528, to sign up for coverage, unless that employee experiences an event that would entitle ~~him or her~~them to a special enrollment period pursuant to Section 6530;

(13) That the qualified employer understands that once coverage in a QHP is approved by the SHOP, changes to the coverage cannot be implemented until the

qualified employer's annual election of coverage period pursuant to Section 6526, except to the extent the qualified employer exercises the right to change coverage with the same QHP issuer within the first 30 days of the effective date of coverage pursuant to Section 6528(f), Health and Safety Code 1357.504(d), and Insurance Code Section 10753.06.5(d);

(14) That the qualified employer understands that ~~health insurance coverage~~health coverage and dental coverage through the SHOP is subject to the applicable terms and conditions of the QHP issuer contract or policy and applicable state law, which will determine the procedures, exclusions and limitations relating to the coverage and will govern in the event of any conflict with SHOP or QHP issuer benefits comparison, summary or other description of the coverage;

(15) That the qualified employer understands that once employer and employee information is transmitted to the selected ~~QHPs~~ QHP Issuers, the qualified employer's coverage effective date cannot be changed nor can the qualified employer terminate coverage until after the first month of coverage;

(16) That the qualified employer agrees to inform its qualified employees of the availability of child and family dental plans and that qualified employees may choose to enroll only in a ~~dental plan~~QDP even if the qualified employee does not choose to enroll in a ~~QHP~~health plan;

(17) That the qualified employer has provided or will provide to its qualified employees an initial open enrollment period beginning at least 20 days prior to the employee application due date described in subdivision (d).

~~(17)~~(18) That the qualified employer understands that the attestations in this section are subject to audit by the SHOP at any time; and

~~(18)~~(19) That the qualified employer agrees to maintain compliance with the attestations in this section in order to continue eligibility for coverage through the SHOP.

(c) A qualified employer must provide the SHOP with its most recent Quarterly Contribution Return and Report of Wages (Form DE-9C), as filed with the California Employment Development Division, on which the qualified employer must identify on the face of the form whether each employee listed on the DE-9C is a full-time employee, part-time eligible employee, ineligible employee and whether the employee is still employed by the qualified employer. If there is not sufficient space on the face of the Form DE-9C for the qualified employer to add the required information, the qualified employer may attach additional sheets of paper to the Form DE-9C as necessary. A qualified employer must provide the SHOP with additional or other documents in the following circumstances:

(1) For a qualified employer who is a sole proprietor in business less than three (3) months, a California business license or Fictitious Business Name Filing and a DE-9C or payroll records for 30 days;

(2) For a qualified employer who is a sole proprietor who is in business three (3) months or more, a DE-9C. If the owner is not listed as earning wages on the DE-9C and wishes to enroll for coverage, a current IRS Form 1040 Schedule C Profit or Loss From Business (Sole Proprietorship) or, if a Form 1040 Schedule C is not available, a California business license or Fictitious Business Name filing may be substituted;

(3) For a qualified employer who is a corporation in business less than three (3) months, Articles of Incorporation, filed and stamped by the Secretary of State, and a Statement of Information or corporate meeting minutes listing all officers' names and a DE-9C or payroll records for 30 days;

(4) For a qualified employer who is a corporation in business three (3) months or more, a DE-9C, and, if officers who are not listed on DE-9C enroll for coverage, a Statement of Information;

(5) For a qualified employer who is a partnership in business less than three (3) months, a Partnership Agreement, a Federal Tax Identification appointment letter, and a DE-9C or payroll records for 30 days;

(6) For a qualified employer who is a partnership in business three (3) months or more, a DE-9C and a current IRS Form 1065 Schedule K-1, if the partners are not listed on DE-9C and want to enroll for coverage. If an IRS Form 1065 Schedule K-1 is not yet available, the Partnership Agreement and the Federal Tax Identification appointment letter can be substituted;

(7) For a qualified employer who is a limited partnership in business less than three (3) months, a Partnership Agreement, a Federal Tax Identification appointment letter, and a DE-9C or payroll records for 30 days;

(8) For a qualified employer who is a limited partnership in business three (3) months or more, a DE-9C. If general partners are not listed on DE-9C and wish to enroll in coverage, then a current IRS Form 1065 Schedule K-1. If an IRS Form 1065 Schedule K-1 is not available, the Partnership Agreement and a Federal Tax

Identification appointment letter can be substituted. Limited partners are not eligible for coverage unless they appear on a DE-9C;

(9) For a qualified employer who is a limited liability partnership in business less than three (3) months, a Partnership Agreement or a Federal Tax Identification appointment letter, and a DE-9C or payroll records for 30 days;

(10) For a qualified employer who is a limited liability partnership in business three (3) months or more, a DE-9C. If partners are not listed on the DE-9C and wish to enroll in coverage, then a current IRS Form 1065 Schedule K-1. If the IRS Form 1065 Schedule K-1 is not yet available, the Partnership Agreement and the Federal Tax Identification appointment letter can be substituted;

(11) For a qualified employer who is a limited liability company in business less than three (3) months, Articles of Organization with the Operating Agreement or the Statement of Information and a DE-9C or payroll records for 30 days;

(12) For a qualified employer who is a limited liability company in business three (3) months or more, a DE-9C. If managing members are not listed as earning wages on the DE-9C and wish to enroll for coverage, a current IRS Form 1065 Schedule K-1 for a partnership or IRS Form 1040 Schedule C for a sole proprietorship. If an IRS Form 1065 Schedule K-1 is not yet available, a Statement of Information or Articles of Organization with the Operating Agreement may be substituted; and

(13) For a qualified employer who was previously insured outside of the SHOP, the SHOP may waive or alter any additional documentation submission requirements in Section 6520(c)(1) - (12), if as determined by the SHOP on a case-by-case basis, the proof of coverage is sufficient to satisfy these requirements.

(d) To participate in the SHOP, a qualified employee must submit the following information to the SHOP no later than five days prior to the requested effective date:

(1) The employer's business name and business phone number;

(2) The qualified employee's first and last name, SSN or Taxpayer Identification Number, date of birth, home address, mailing address (if different from home address), telephone number, email address, and if the employee is newly hired;

(3) Whether the employee is applying for Cal-COBRA or COBRA continuation coverage pursuant to the following conditions:

(A) The COBRA coverage is currently in effect under the qualified employer's health plan; or

(B) The employee has had a qualifying event that renders the employee eligible for continuation of coverage and is applying for that coverage; and,

(C) If applicable, the effective date of coverage, the qualifying event that triggered that coverage, and the date of the qualifying event;

(4) If the qualified employer is offering coverage for dependents and the employee elects to offer ~~his or her~~their dependents coverage, the marital or domestic partnership status of the qualified employee;

(5) If the qualified employer is offering coverage for spouses, registered domestic partners, or non-registered domestic partners, and/or dependent children, and the employee elects to offer ~~his or her~~their dependents coverage, then information about the qualified employee's spouse, registered domestic partner, or non-registered partner, and/or dependent children, which includes:

(A) The first and last name of each spouse, registered domestic partner, or non-registered domestic partner, and/or each dependent child, their relationship to the qualified employee, SSN or taxpayer identification number, date of birth, age, gender, home address, and mailing address (if different from home address); and

(B) Whether the qualified employee would like to enroll a dependent who is a disabled child pursuant to Section 599.500 of Title 2 of the California Code of Regulations;

(6) The names ~~of the QHP and dental plan~~of the health plans and dental plans, if applicable, selected by the qualified employee and dependents.

(e) To participate in the SHOP, a qualified employee must do all of the following:

(1) Agree to mandatory arbitration if the QHP Issuer selected by the employee requires arbitration, which would require the employee and ~~his or her~~their dependents to arbitrate all claims relating to ~~his or her~~their QHP;

(2) Disclose whether the employee used an insurance agent and, if so, the agent's name, general agency name (if applicable), and whether the agent is an insurance agent certified by Covered California. If the employee uses an insurance agent, the employee must have that agent certify that ~~he or she~~they understand~~s~~ ~~he or she~~they may be subject to a civil penalty for providing false information under Health and Safety Code Section 1389.8 and Insurance Code Section 10119.3.

(3) Sign the application under penalty of perjury, that all information contained in the employee application is true and correct to the best of the employee's knowledge.

(4) Acknowledge that the employee understands that ~~he or she~~they may be subject to penalties under federal law if ~~he or she~~they intentionally provide~~s~~ false or

untrue information pursuant to 45 CFR Section 155.285 (September 6, 2016), hereby incorporated by reference.

(f) If a qualified employee declines coverage, the employee must sign the declination of coverage, which is part of the application, and state other sources of coverage, if any.

(g) The SHOP must keep all information received pursuant to this section private in accordance with applicable federal and state privacy and security laws pursuant to 45 CFR Section 155.260 (September 6, 2016), hereby incorporated by reference, and the Information Practices Act of 1977 (Cal. Civ. Code, commencing with Section 1798). The SHOP may not provide to the qualified employer any information collected on the employee application with respect to the qualified employees or dependents of qualified employees, other than the name, address, birth date, and ~~plan~~ health plan or dental plan selection of the spouse or dependent. The SHOP may only share information from an employee application with the QHP Issuer or employer that is strictly necessary for the purposes of eligibility and enrollment. Information obtained by the SHOP pursuant to this section may not be used for purposes other than eligibility determinations and enrollment in ~~health coverage~~health or dental coverage through the SHOP.

Note: Authority cited: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; and 45 CFR Sections 155.260, 155.705, 155.715, 155.725, 155.730, 156.140 and 156.285.

§ 6522. Eligibility Requirements for Enrollment in the SHOP.

(a) An employer is a qualified employer and eligible to participate in the SHOP if such employer:

(1) Is a small employer as defined in Section 6410;

(2) Elects to offer, at a minimum, all eligible full-time employees coverage in a QHP through the SHOP;

(3) Either --

(A) Has its principal business address in California and offers coverage to all its full-time employees through the SHOP in California or

(B) offers coverage to each eligible employee through the SHOP serving that employee's primary worksite;

(4) Meets the following minimum participation rules:

(A) A minimum of 70 percent of eligible employees of the qualified employer must enroll in health ~~insurance~~ coverage through the SHOP, or a lesser minimum percent that may be determined by prevailing market practice through a SHOP survey of market practices. SHOP must provide QHP Issuers ~~issuers~~ notice of such a change, if any, at least 210 days prior to the effective date of the proposed change, unless the QHP issuers agree to an earlier effective date for the proposed change. The percentage will be published on the Covered California for Small Business (CCSB) website.

1. If the qualified employer pays 100 percent of the qualified employees' QHP premiums, then all eligible employees not waiving coverage per Section 6522(a)(4)(B) of the qualified employer must enroll in ~~health insurance coverage~~health coverage through the SHOP.

(B) A qualified employee who waives ~~coverage~~employer offered health coverage because that qualified employee is enrolled in coverage through another employer, an employee's union, Medicaid pursuant to 42 U.S.C. Section 1396 et seq., Medicare pursuant to 42 U.S.C. Section 1395 et seq., or any other federal or state health coverage program ~~other than coverage through a QHP sold in the Individual Exchange~~, or any health coverage meeting the definition of minimum essential coverage pursuant to Health and Safety Code Section 1345.5 is not counted in calculating compliance with the group participation rules above.

(5) Meets the following group contribution rule:

(A) A qualified employer must contribute to each of its qualified employees' ~~QHP~~ health plan premiums, a minimum of 50 percent of the lowest cost premium for employee-only health coverage in the level of coverage selected by the qualified employer pursuant to Section 6520(a)(12)(C), or a lesser minimum percent that may be determined by prevailing market practice through a SHOP survey of market practices. The contribution rate will be published on the CCSB website.

(6) A qualified employer who wishes to offer infertility benefits to his/ her qualified employees must do so in accordance with Health and Safety Code Section 1374.55 and Insurance Code Section 10119.6.

(b) An employer that otherwise meets the criteria of this section except for subdivisions (a)(4)(A) and (a)(5)(A) of this section shall be a qualified employer, but may only elect to offer coverage to its employees during the period specified in Section 6526(b).

(c) A qualified employer who ceases to be a small employer solely by reason of an increase in the number of employees of such employer shall continue to be eligible for the SHOP until the qualified employer otherwise fails to meet the eligibility criteria of this section or elects to no longer purchase coverage for qualified employees through the SHOP.

(d) All qualified employees whose eligibility has been verified by the SHOP are eligible to enroll in a QHP through the SHOP.

(e) A qualified employee is eligible to enroll ~~his or her~~their dependent spouse, registered domestic partner, non-registered domestic partners, and dependent children, whose dependent eligibility has been verified by the SHOP, if the offer from the qualified employer includes an offer of dependent coverage.

(f) If an employer meets the criteria in subdivision (a) of this section and makes the election described in subdivision (a)(3)(B) of this section, a SHOP shall allow the employer to offer coverage to those employees whose primary worksite is in the SHOP's service area.

(g) A qualified employer shall immediately notify the SHOP of any change to the principal business location; if the new principal business address is in a different geographic rating area in California the SHOP shall only apply a new geographic rating factor upon renewal.

(h) The eligibility standards specified in this subdivision shall only apply to the eligibility determination for enrollment in a ~~dental plan~~QDP through the SHOP:

(1) Qualified employees may choose to enroll only in a dental plan even if the qualified employee does not choose to enroll in a ~~QHP~~health plan.

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

(3) A qualified employer may choose to offer ~~an employer-sponsored Group Dental Plan~~dental plan coverage in a QDP only if the employer meets the 50 percent contribution requirement and 70 percent participation requirement of eligible employees for enrollment in that Group Dental Plan.

Note: Authority cited: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; and 45 CFR Sections 147.104, 155.705, 155.710, 155.715 and 155.720.

§ 6524. Verification Process for Enrollment in the SHOP.

(a) The SHOP shall verify or obtain information as provided in this section to determine whether an employer, employee or dependent meets the eligibility requirements specified in Section 6522 prior to allowing an employer to offer ~~health insurance coverage~~health coverage or dental coverage to its employees or a qualified employee to select a QHP through the SHOP.

(b) For purposes of verifying employee eligibility, the SHOP must:

(1) Verify that the employee has been identified by the qualified employer as an employee being offered ~~health insurance coverage~~health coverage or dental coverage by the qualified employer;

(2) Accept the information attested to by the employee under Section 6520 unless the information is inconsistent with the qualified employer-provided information; and

(3) Collect only the minimum information necessary for verification of eligibility and enrollment in accordance with the eligibility requirements in Section 6522.

(c) Inconsistencies

(1) When the information submitted to the SHOP by an employer, or an agent or authorized representative on behalf of the employer, is inconsistent with the eligibility requirements in Section 6522, the SHOP must:

(A) Make a reasonable effort to identify and address the causes of such inconsistency, including through typographical or other clerical errors;

(B) Provide written notice to the employer of the inconsistency; and

(C) Provide the employer with a period of 30 days from the date on which the notice described in subdivision (c)(1)(B) of this section is sent to the employer to either present satisfactory documentary evidence to support the employer's application or resolve the inconsistency.

(D) If, after the 30-day period described in subdivision (c)(1)(C) of this section, the SHOP has not received satisfactory documentary evidence to support the employer's application or resolve the inconsistency, the SHOP must provide written notice to the employer of its denial of eligibility in accordance with subdivision (d) of this section and of the employer's right to appeal such determination pursuant to Section 6542(c).

(2) When the information submitted to the SHOP by an employee is inconsistent with the information provided by the employee's employer, the SHOP must:

(A) Make a reasonable effort to identify and address the causes of such inconsistency, including through typographical or other clerical errors;

(B) Provide written notice to the employee of the inability to substantiate ~~his or her~~their employee status and;

(C) Provide the employee with a period of 30 days from the date on which the notice described in subdivision (c)(2)(B) of this section is sent to the employee to either present satisfactory documentary evidence to support the employee's application or resolve the inconsistency.

(D) If, after the 30-day period described in subdivision (c)(2)(C) of this section, the SHOP has not received satisfactory documentary evidence to support the employee's application or resolve the inconsistency, the SHOP must provide written

notice to the employee of its denial of eligibility in accordance with subdivision (e) of this section.

(d) Notification of Employer Eligibility The SHOP must provide written notice to an employer applying to participate in the SHOP whether the employer is eligible in accordance with Section 6522 and the employer's right to appeal such determination pursuant to Section 6542(c).

(e) Notification of Employee Eligibility

The SHOP must provide written notice to an employee seeking to enroll in a QHP offered through the SHOP of the determination by the SHOP whether the employee is eligible in accordance with Section 6522(d) and the employee's right to appeal such eligibility determination pursuant to Section 6542(c).

Note: Authority cited: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; and 45 CFR Sections 155.715 and 155.720.

§ 6526. Qualified Employer Election of Coverage Periods.

(a) Subject to subdivision (b) of this section, a qualified employer who is not already participating in the SHOP may elect to offer ~~health insurance coverage~~health coverage or dental coverage through the SHOP for its eligible employees at any time during the calendar year by submitting the information required in Section 6520.

(b) If a qualified employer fails to meet the minimum participation or the group contribution requirements in Section 6522(a)(4) and (5) or Section 6522(h)(3), but satisfies the remaining eligibility criteria in Section 6522, the qualified employer may only elect to offer ~~health insurance coverage~~health coverage or dental coverage through SHOP for its eligible employees in an annual enrollment period from November 15 through December 15 of each year.

(c) A qualified employer's plan year is a 12-month period beginning on the coverage effective date for its qualified employees as described in Section 6536. All qualified employees of a qualified employer will have the same plan year as their qualified employer.

(d) A qualified employer may only change its offer of ~~health insurance coverage~~health coverage or dental coverage, including making changes to the reference plan, to its qualified employees, as described in Section 6520(a)(12), during the qualified employer's annual election period. The qualified employer's annual election period is at least 20 days, beginning on the day the SHOP sends written notice of the annual employer election period, which the SHOP must send at least 60 days prior to the completion of the employer's plan year.

(e) If a qualified employer's reference plan is no longer available at renewal, a qualified employer must select a new reference plan during the employer's annual election period.

(f) If the qualified employer's reference plan is no longer available at renewal and the qualified employer does not select a new reference plan prior to renewal quote creation, a default alternative reference plan will be auto-selected for the group.

(1) An auto-selected reference plan will be the lowest cost plan in qualified employer's selected metal tier.

(2) The contribution rate applied to the new reference plan will remain as the previous employer contribution rate selected.

Note: Authority cited: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; and 45 CFR Sections 147.104, 155.705, 155.720, 155.725 and 156.285.

§ 6528. Initial and Annual Enrollment Periods for Qualified Employees.

(a) A qualified employee may enroll in a QHP or change ~~his or her~~their QHP only during the initial employee open enrollment period and annual employee open enrollment period described in this section or during a special enrollment period as described in Section 6530.

(b) Subject to subdivision (e) of this section, a qualified employee's initial employee open enrollment period begins no later than 20 days before the employee application due date specified in Section 6520(d). ~~the day his or her employer submits all of the information required in Section 6520 and the SHOP has determined that the employer is a qualified employer.~~

(c) Subject to subdivision (e) of this section, the annual employee open enrollment period begins the day after ~~his or her~~their qualified employer's annual election period has ended.

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

(e) Beginning January 1, 2014, the SHOP shall provide to qualified employers, a written annual employee open enrollment period notification for each qualified employee 60 days prior to the end of the qualified employer's plan year ~~and after that employer's annual election period~~.

(f) Qualified employers may allow qualified employees to make a change to their selected QHP after the effective date of coverage during the first thirty (30) days of the new plan year, provided that the newly selected QHP is offered by the same QHP ~~issuer~~Issuer.

(1) Requests to the SHOP to make changes to ~~plan~~QHP selection received on the first through the fifteenth day of the month after the effective date shall become retroactively effective to the first day of the month, unless the employer requests an effective date of the first of the following month.

(2) Requests to the SHOP to make changes to ~~plan~~QHP selection received on the sixteenth day of the month up to the thirtieth day of the month after the effective date shall become effective on the first day of the following month, unless an earlier effective date is requested due to exceptional circumstances and is permitted by the SHOP and QHP ~~issuer~~Issuer, as determined on a case-by-case basis.

(g) If a qualified employee does not enroll in a different QHP during ~~his or her~~their annual employee open enrollment period, the qualified employee will remain in the QHP selected in the previous year unless:

(1) The qualified employee terminates ~~his or her~~their coverage from the QHP in accordance with Section 6538(b), or

(2) The QHP is no longer available to the qualified employee.

(h) Notwithstanding subdivision (g)(2), if the qualified employee's current ~~QHP~~ health plan is not available, the qualified employee shall be enrolled in a ~~QHP~~ health plan offered by the same QHP ~~issuer~~Issuer at the same metal tier that is the most similar to the qualified employee's current ~~QHP~~health plan, as determined by the SHOP on a case-by-case basis.

(i) If the QHP ~~issuer~~ Issuer of the ~~QHP~~ health plan in which the qualified employee is currently enrolled is no longer available, or if another ~~QHP~~ health plan is not available from the current QHP ~~issuer~~ Issuer in the same metal tier, the qualified

employee may be enrolled in the lowest cost ~~QHP~~ health plan offered by a different QHP ~~issuer~~ Issuer in the same metal tier as the qualified employee's current ~~QHP~~health plan, as determined by the SHOP on a case-by-case basis.

(j) An employee who becomes a qualified employee outside of the initial employee open enrollment period, the annual employee open enrollment period, or a special enrollment period shall have a 30-day period to enroll in a QHP beginning on the first day the employee becomes a qualified employee.

(k) For an employer with changes to report to the initial employer application information in Section 6520(a)(3) the employer shall notify the SHOP of the updated employee counts.

Note: Authority cited: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; and 45 CFR Sections 147.104, 155.720, 155.725 and 156.285.

§ 6530. Special Enrollment Periods for Qualified Employees and Dependents.

(a) The SHOP must provide special enrollment periods consistent with this section, during which certain qualified employees or a dependent of a qualified employee may enroll in QHPs ~~and QDPs~~ and enrollees may change QHPs.

(b) A qualified employee, or ~~his or her~~their dependent, may enroll in a QHP or change QHPs during special enrollment periods outside of the initial and annual open enrollment periods in the following situations:

(1) A qualified employee, or ~~his or her~~their dependent~~, either:~~ experiences an event described in subdivision (a)(1) of Section 6504 of Article 5 of this chapter, other than subdivision (a)(1)(B) of Section 6504 of Article 5 of this chapter.

~~(A) Loses Minimum Essential Coverage (MEC), as specified in subdivision (e) of this section. The date of the loss of MEC shall be:~~

~~1. The date of the last day the qualified employee, or his or her dependent, would have coverage under his or her previous plan or coverage; or~~

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

~~(B) Loses pregnancy-related coverage described under Section 1902(a)(10)(A)(i)(IV) and (a)(10)(A)(ii)(IX) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(i)(IV), (a)(10)(A)(ii)(IX)) and Section 14005.18 of the Welfare and Institutions Code. The date of the loss of coverage is the last day the consumer would have pregnancy-related coverage; or~~

~~(C) Loses Medi-Cal coverage for the medically needy, as described under section 1902(a)(10)(C) of the Social Security Act and Section 14005.21 of the Welfare and Institutions Code, only once per calendar year. The date of the loss of coverage is the last day the consumer would have medically needy coverage.~~

(2) ~~A qualified employee gains a dependent or becomes a dependent through marriage or entry into domestic partnership, birth, adoption, placement for adoption, placement in foster care, assumption of a parent-child relationship, or through a child support order or other court order~~Experiences an event described in subdivision (a)(2) of Section 6504 of Article 5 of this chapter.

(3) ~~The enrollee loses a dependent or is no longer considered a dependent through divorce or legal separation as defined by State law in the State in which the divorce or legal separation occurs, or if the enrollee, or his or her dependent, dies~~ Experiences an event described in subdivision (a)(3) of Section 6504 of Article 5 of this chapter.

(4) ~~The qualified employee's, or his or her dependent's, enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, misconduct, or inaction of an officer, employee, or agent of the Exchange or HHS, its instrumentalities, or a non-Exchange entity providing enrollment assistance or conducting enrollment activities, as evaluated and determined by the Exchange. In such cases, the Exchange shall take necessary actions to correct or eliminate the effects of such error, misrepresentation, inaction, or misconduct. For purposes of this provision, misconduct, as determined by the Exchange, includes the failure to comply with applicable standards under this title, or other applicable federal or~~

~~state laws~~Experiences an event described in subdivision (a)(5) of Section 6504 of Article 5 of this chapter.

(5) ~~An enrollee adequately demonstrates to the Exchange, with respect to QHPs offered through the Exchange, or to the applicable regulator, with respect to health plans offered outside the Exchange, that the health plan in which he or she is enrolled, substantially violated a material provision of its contract in relation to the enrollee or his or her dependents~~Experiences an event described in subdivision (a)(6) of Section 6504 of Article 5 of this chapter.

(6) ~~An enrollee, qualified employee, or his or her dependent, gains access to new QHPs as a result of a permanent move~~Experiences an event described in subdivision (a)(9) of Section 6504 of Article 5 of this chapter.

(7) The qualified employee, or ~~his or her~~their dependent, was released from incarceration.

(8) The qualified employee, or ~~his or her~~their dependent, is a member of the reserve forces of the United States military returning from active duty or a member of the California National Guard returning from active duty service under Title 32 of the United States Code.

(9) A qualified employee who is an Indian, as defined by Section 4 of the Indian Health Care Improvement Act (25 U.S.C. Section 1603(c)), and ~~his or her~~their dependent who is enrolled or is enrolling in a QHP through an Exchange on the same application as the qualified employee, may enroll in a QHP or change from one QHP to another one time per month.

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

(A) If a child who has been determined ineligible for Medi-Cal and CHIP, and for whom a party other than the party who expects to claim ~~him or her~~them as a tax dependent is required by court order to provide health ~~insurance~~ coverage for the child, the child shall be eligible for a special enrollment period if otherwise eligible for enrollment in a QHP.

(11) A qualified employee or dependent demonstrates to the Exchange, with respect to health ~~benefit~~ plans offered through the Exchange, or to the applicable regulator, with respect to health ~~benefit~~ plans offered outside the Exchange, that ~~he or she~~they did not enroll in a health ~~benefit~~ plan during the immediately preceding enrollment period available to the employee or dependent because ~~he or she~~they ~~was~~were misinformed that ~~he or she~~they ~~was~~were covered under MEC.

(12) A qualified employee, or ~~his or her~~their dependent, is receiving services from a contracting provider under a health ~~benefit~~ plan, as defined in Section 1399.845(f) of the Health and Safety Code or Section 10965(f) of the Insurance Code, for one of the conditions described in Section 1373.96(c) of the Health and Safety Code or section 10133.56(a) of the Insurance Code, and that provider is no longer participating in the health ~~benefit~~ plan.

(13) A qualified employee, or ~~his or her~~their dependent, loses eligibility for health coverage under a Medi-Cal plan under title XIX of the Social Security Act or a state child health plan under title XXI of the Social Security Act.

(14) A qualified employee, or ~~his or her~~their dependent, becomes eligible for assistance, with respect to health ~~insurance~~ coverage under a SHOP, under ~~a~~ such Medi-Cal plan or a state child health plan (including any waiver or demonstration project conducted under or in relation to such a plan).

(15) ~~A qualified employee, or dependent, is a victim of domestic abuse or spousal abandonment, as specified in 26 CFR Section 1.36B-2 (b)(2)(ii) through (v) (July 26, 2017), hereby incorporated by reference, 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~~ Experiences an event described in subdivision (a)(12) of Section 6504 of Article 5 of this chapter.

(16) A qualified employee or dependent-

~~(A) Applies for coverage on the Exchange during the annual open enrollment period or due to a qualifying event, is assessed by the Exchange as potentially eligible for Medi-Cal or the Children's Health Insurance Program (CHIP), and is determined ineligible for Medi-Cal or CHIP by the State Medi-Cal or CHIP agency either after open enrollment has ended or more than 60 days after the qualifying event; or~~

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

~~enrollment has ended~~ experiences an event described in subdivision (a)(13) of Section 6504 of Article 5 of this chapter.

(17) The qualified employee, or ~~his or her~~their dependent~~, adequately demonstrates to the Exchange that a material error related to plan benefits, service area, or premium influenced the qualified employee's or dependent's decision to purchase a QHP through the Exchange~~ experiences an event described in subdivision (a)(14) of Section 6504 of Article 5 of this chapter.

(18) The qualified employee or ~~his or her~~their dependent experiences any other triggering events identified in California Insurance Code section 10753.05(b)(3) and California Health and Safety Code section 1357.503(b).

(c) A qualified employee, or ~~his or her~~their dependent, who experiences one of the situations described in subdivision (b) of this section has:

(1) 30 days from the date of the event described in paragraphs (b)(1)-(11) and (b)(15)-(18) of that subdivision in this section to select a QHP through the SHOP.

(2) 30 days from the date of the event described in paragraphs (b)(12) or (g)(1) of this section to select ~~coverage for the qualified employee or his or her eligible dependents in~~ a QDP through the SHOP.

(3) 60 days from the date of the event described in paragraphs (b)(13) and (b)(14) of that subdivision in this section to select a QHP through the SHOP.

(d) A dependent of a qualified employee is not eligible for a special enrollment period if the qualified employer does not extend the offer of ~~health insurance coverage~~health coverage or dental coverage to dependents.

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

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

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

1. Legal separation;

2. Divorce;

3. Cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the health plan);

4. Death of an employee;

5. Termination of employment; and

6. Reduction in the number of hours of employment;

(B) Loss of eligibility for coverage through Medicare, Medicaid, or other government-sponsored health care programs, other than programs specified as not MEC under 26 CFR Section 1.5000A-2(b)(2) (November 26, 2014), hereby incorporated by reference;

(C) In the case of health coverage offered through an HMO or similar program in the individual market that does not provide health coverage ~~benefits~~ to individuals who no longer reside, live, or work in a service area, loss of health 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 health coverage offered through an HMO or similar program in the group market that does not provide ~~benefits~~ health coverage to individuals who no longer reside, live, or work in a service area, loss of health 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;

(E) A situation in which a health plan no longer offers any ~~benefits~~ health coverage to the class of similarly situated individuals that includes the individual; and

(F) Loss of that coverage due to the circumstances described in Section 1163 of Title 29 of the United States Code. “Loss of minimum essential coverage” also includes loss of that coverage for a reason that is not due to the fault of the individual.

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

(3) Exhaustion of COBRA or Cal-COBRA continuation health ~~insurance~~ coverage, meaning that such coverage ceases for any reason other than a reason specified in subdivision (e)(4) of this section. An individual is considered to have exhausted COBRA continuation coverage if such coverage ceases:

(A) Due to the failure of the employer or other responsible entity, but not of the employee or dependent receiving COBRA benefits, to remit premiums on a timely basis;

(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.

(4) Loss of MEC, as specified in subdivision (b)(1) of this section, does not include termination or loss due to:

(A) The employee's or dependent's failure to pay premiums on a timely basis, including COBRA premiums prior to expiration of COBRA coverage; or

(B) Subject to Section 10384.17 of the Insurance Code and Section 1365 of the Health and Safety Code, termination of coverage due to a carrier demonstrating fraud or an intentional misrepresentation of material fact under the terms of the policy by the policyholder, contractholder, or employer.

(f) If requested by a QHP Issuer or SHOP, an employee or a dependent of an employee who experiences a triggering event that gives rise to a special enrollment period pursuant to this section must provide verification of the triggering event to SHOP for review.

(g) A qualified employee or ~~his or her~~their dependent may enroll in a QDP during a special enrollment period outside of the initial and annual open enrollment periods in the following situations:

(1) Loss of eligibility for dental ~~insurance~~ coverage. Loss of eligibility for dental ~~insurance~~ coverage shall be consistent with any of following situations specified in subdivisions (b)(11) or (e)(1)-(3) of this section. The date of the loss of dental coverage shall be the date of the last day the qualified employee, or ~~his or her~~their dependent, would have dental coverage under ~~his or her~~their previous plan or coverage.

(2) Loss of eligibility for dental ~~insurance~~ coverage does not include termination or loss of dental coverage due to any of the situations specified in subdivisions (e)(4)(A)-(B).

(3) A qualified employee, or ~~his or her~~their dependent, loses eligibility for pediatric dental coverage subsequent to turning nineteen (19) years of age and wishes to continue dental coverage under a standalone dental plan offered by a QDP Issuer in the SHOP;

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

(i) Limitation. Qualified employees will not be able to enroll unless the employer group meets any applicable minimum participation rules under Section 6522(a)(4).

Note: Authority cited: Section 100504, Government Code. Reference: Sections 100502 and 10503, Government Code; 26 CFR Sections 1.36B-2, 1.5000A-2 and 54.9801-2; 45 CFR Sections 147.104, 155.420, 155.725, 155.1080 and 156.285; Sections 1357.503 and 1399.849, Health and Safety Code; and Sections 10753.05, 10753.063.5 and 10965, Insurance Code.

§ 6532. Employer Payment of Premiums.

(a) Upon completion of the initial employee open enrollment period by all of the qualified employees of a qualified employer, the SHOP will send an invoice to the qualified employer for the total premium amount due for all of that qualified employer's qualified employees.

(1) A qualified employer's first premium payment shall be ~~no less than 85 percent of the total amount due~~paid in full and must be delivered to the SHOP or postmarked by the due date indicated on the invoice, for effectuation to occur on the date requested on the employer's application.

(2) If a qualified employer's first payment does not meet the requirements in subdivision (a)(1), the SHOP will cancel the application of that qualified employer and the applications of that employer's qualified employees.

(b) Once coverage is effective, the SHOP will send invoices to qualified employers on the 15th of each month, or the following business day if the 15th falls on a weekend or holiday, for ~~health insurance coverage~~health coverage and dental coverage for the following month.

(1) A qualified employer's monthly premium payment must be delivered to the SHOP or postmarked by the last day of the invoicing month.

(2) After the first invoice, the qualified employer must make a monthly premium payment of no less than ~~85 percent of~~ 100 dollars less than the total balance due, including any amounts past due, by the due date on the invoice.

(c) ~~If a qualified employer makes a payment for less than the full amount due, the payment~~ Payment amounts less than the total amount due will be allocated by ~~the total~~

~~percentage paid~~the oldest to newest ~~across all~~ amounts due for ~~health and dental benefits~~health coverage and dental coverage.~~, if any~~. Excess payments will be applied as credit to the employer's future invoice. Payments will be allocated evenly to all members across the applicable coverage month.

(d) In any month after a qualified employer has paid its initial month's premium, if a qualified employer does not pay its premium pursuant to subdivision (b) of this section, the SHOP will, on the day following the due date of the invoice, mail a notice of delinquency to the qualified employer that shows the past due balance, informs the qualified employer of the applicable grace period pursuant to Section 10273.4(a)(1) of the California Insurance Code and Section 1365(a)(1) of the California Health and Safety Code, states the effective date of termination if payment is not received during the grace period, provides instructions for making the premium payment necessary in order to maintain coverage in force, and provides notice of the qualified employer's right to request review of the cancelation by the applicable regulator.

(e) If a qualified employer makes a premium payment ~~via check~~that is returned ~~unpaid~~ for any reason, the SHOP shall apply a $25.00 insufficient funds fee. If a qualified employer makes a second premium payment that is returned unpaid for any reason within six months of the prior returned payment, the qualified employer shall submit premium payment and the insufficient funds fee for returned payment in the form of a cashier's check or money order. This requirement to make monthly premium payments in the form of a cashier's check or money order shall continue for a period of 12 months beginning with the first of the month following the last paid-through date. If premium payment is not submitted in one of these two forms, the qualified employer

group may be subject to termination for non-payment of premium as described in Section 6538(c)(2).

(f) If a qualified employer has been terminated pursuant to Section 6538(a), then the group may request to be reinstated in the same coverage in which it was last enrolled within 30 days after the effective date of termination. Past due premiums, if any, must be paid before a group may be reinstated without a lapse in coverage.

(g) A qualified employer terminated due to non-payment of premium in Section 6538(c) may request to be reinstated in the same coverage in which it was last enrolled within 30 days after the effective date of termination. Past due premiums, if any, must be paid before a group may be reinstated without a lapse in coverage.

(h) A qualified employer may not reinstate coverage 31 or more days following the effective date of termination and may only reinstate once during the 12-month period beginning at the time of their original effective date or from their most recent renewal date, whichever is more recent. Exceptions will be considered on a case-by-case basis.

(i) Terminated groups seeking to reapply for coverage 31 or more days following the effective date of termination shall be considered a new group with an effective date consistent with the provisions of this Section and Section 6520 (a)(13).

(j) Collections for delinquent accounts payable will be performed as per State Accounting Manual (SAM) section 8776.6 (non-employee accounts receivable).

Note: Authority cited: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; and 45 CFR Sections 155.705, 155.720 and 156.285.

§ 6534. Coverage Effective Dates for Special Enrollment Periods.

(a) Except as specified in subdivision (b) of this section, coverage effective dates for special enrollment periods for a QHP ~~or QDP~~ selection received by the ~~Exchange~~SHOP from a qualified employee:

(1) Shall be no later than the first day of the following month for applications received between the first and fifteenth day of any month, or

(2) Shall be no later than the first day of the second following month for applications received between the sixteenth and last day of any month.

(b) Special coverage effective dates shall apply to the following situations:

(1) In the case of birth, adoption, placement for adoption, placement in foster care, and assumption of a parent-child relationship, coverage is effective for that enrollee on the date of birth, adoption, placement for adoption, placement in foster care, or assumption of a parent-child relationship, or on the first day of the following month if requested by the enrollee;

(2) In the case of marriage, domestic partnership or where a qualified employee loses Minimum Essential Coverage, as described in Section 6530(b)(1), coverage is effective for that qualified employee or dependent on the first day of the month following the date the request for special enrollment is received; and

(3) In the case of a qualified employee or dependent eligible for a special enrollment period as described in Section 6530(b)(4) and 6530(b)(5), the coverage is effective on either:

(A) The date of the event that triggered the special enrollment period under Section 6530(b)(4) or 6530(b)(5), or

(B) In accordance with subdivision (a) of this section, whichever is the least financially burdensome on the enrollee, as determined by the ~~Exchange~~SHOP.

Note: Authority cited: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; and 45 CFR Sections 155.725 and 156.285.

§ 6536. Coverage Effective Dates for Qualified Employees.

(a) If the premium payment from a qualified employer is made pursuant to Section 6520(b)(10) for all of its qualified employees and their dependents who selected coverage and is delivered to the SHOP or post-marked by the last calendar day of the month, the effective dates of coverage for qualified employees and dependents who selected QHPs during the initial employee open enrollment shall be the first day of the following month.

(b) The effective date of coverage for a qualified employee who selected a QHP during the employee's annual open enrollment period shall be the first day of the following plan year if the qualified employer has elected to offer coverage during its annual election of coverage period pursuant to Section 6526(d).

(c) The effective date of coverage for a qualified employee described in Section 6528~~(h)~~(j) shall be the first day of the month following the month in which the employee became a qualified employee.

Note: Authority cited: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; and 45 CFR Sections 155.720, 155.725 and 156.285.

§ 6538. Disenrollment and Termination.

(a) A qualified employer may terminate coverage during the plan year for all its qualified employees and their dependents covered by the employer group health plan at the end of each month, in accordance with subdivision (e) of this section. If a qualified employer terminates coverage through the SHOP, the SHOP must:

(1) Ensure that each QHP Issuer terminates the coverage of the qualified employer's qualified employees and their dependents enrolled in the QHP through the SHOP; and

(2) Send a notice to each of the qualified employer's qualified employees enrolled in a QHP through the SHOP within 15 days of receiving notice from the employer in subdivision (a) of this section. Such notification must provide information about other potential sources of coverage, including access to individual market coverage through the Exchange.

(b) A qualified employer must request that the SHOP terminate the coverage of a qualified employee or dependent upon receiving written request by the qualified employee.

(c) The SHOP may initiate termination of a qualified employee's coverage in a QHP or a dependent's coverage in a QHP, and shall permit a QHP ~~issuer~~ Issuer to terminate such coverage provided that the QHP ~~issuer~~ Issuer makes reasonable accommodations for all individuals with disabilities (as defined by the Americans with Disabilities Act) and complies with any and all requirements for cancellations, rescissions, and nonrenewals pursuant to Health and Safety Code section 1365 and Insurance Code sections 10273.4, ~~and~~ 10273.7, and 10384.17 ~~and~~ and relevant state

regulations before terminating coverage for such individuals, under the following circumstances:

(1) The qualified employee or dependent is no longer eligible for coverage in a QHP;

(2) The qualified employer fails to pay premiums for coverage, as specified in Section 6532, and the applicable grace period, as provided in 10 CCR § 2274.53 and 28 CCR § 1300.65, has been exhausted;

(3) The qualified employee's or the qualified employee's dependent coverage is rescinded by the QHP ~~issuer~~ Issuer in compliance with Health and Safety Code Section 1389.21 or California Insurance Code Sections 10384.17 and 10273.7;

(4) The QHP terminates or is decertified as described in 45 CFR Section 155.1080 (May 29, 2012), hereby incorporated by reference, except for those eligible for enrollment in a similar ~~plan~~ QHP as determined by the SHOP, on a case-by-case basis, pursuant to Section 6528(g);

(5) The qualified employee changes from one QHP to another QHP during an annual employee open enrollment period or special enrollment period in accordance with Sections 6528 and 6530;

(6) Upon the death of the qualified employee or a dependent of a qualified employee;

(7) The qualified employee chooses not to remain enrolled in the QHP at open enrollment. This election would only be effective for the new plan year and coverage in the current QHP would remain uninterrupted through the end of the current plan year;

(8) The qualified employee is no longer an employee or a dependent;

(9) The qualified employee is newly eligible for Medi-Cal or CHIP, but only if the qualified employee or dependent requests coverage to be terminated; and

(10) The qualified employer is ineligible to participate in the SHOP because it has lost its eligibility pursuant to Section 6522.

(d) If a QHP ~~issuer~~ Issuer terminates coverage pursuant to subdivision (c)(2) and (3) of this section, the QHP ~~issuer~~ Issuer must comply with Sections 10273.4, 10273.7, and 10384.17 of the California Insurance Code and Section 1365 of the California Health and Safety Code, and implementing state regulations.

(e) Effective Dates of Termination

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

(A) The end of the month in which the qualified employer provided notice of termination, if the qualified employer provides notice to the SHOP on or before the fifteenth of the month, or on a case-by-case basis an earlier date upon agreement between the QHP ~~issuer~~ Issuer and the SHOP; or

(B) If the qualified employer does not provide notice to the SHOP on or before the fifteenth of the month, the last day of the month following the month in which the qualified employer gave notice of termination or, on a case-by-case basis, an earlier date upon agreement between the QHP ~~issuer~~Issuer and the SHOP.

(2) In the case of a termination in accordance with subdivision (b) of this section, the effective date of termination shall be:

(A) No sooner than the last day of the month in which the SHOP receives the request,

(B) On a date in a subsequent month specified by the employee as long as that date is the last day of the month, or

(C) On a case-by-case basis, an earlier date upon agreement between the QHP Issuer and SHOP.

(D) In no case will the effective date of termination be a date other than the last day of the month.

(3) In the case of a termination in accordance with subdivision (c)(1) of this section, the last day of coverage shall be the last day of the month in which the qualified employee's eligibility or the eligibility of a qualified employee's dependent ceased.

(4) In the case of a termination in accordance with subdivision (c)(2) of this section, the last day of coverage shall be consistent with the grace periods in Section 10273.4 of the California Insurance Code and Section 1365 of the California Health and Safety Code, and implementing state regulations.

(5) In the case of a termination in accordance with subdivision (c)(3) of this section, the last day of coverage shall be the day prior to the day the fraud or intentional misrepresentation of material fact occurred.

(6) In the case of a termination in accordance with subdivision (c)(4) of this section, the last day of coverage shall be the day before the QHP was decertified or terminated, or the day on which the ~~issuer~~ QHP Issuer has met the requirements in Health and Safety Code 1365(a)(5) and (6) or Insurance Code 10273.4(d) or (e), whichever is later.

(7) In the case of a termination in accordance with subdivision (c)(5) of this section, the last day of coverage in an enrollee's prior QHP shall be the day before the effective date of coverage in ~~his or her~~their new QHP.

(8) In the case of a termination in accordance with subdivision (c)(6) of this section, the last day of coverage shall be the date of death.

(9) In the case of a termination in accordance with subdivision (c)(7) of this section, the last day of coverage shall be the last day of the qualified employer's plan year.

(10) In the case of a termination in accordance with subdivision (c)(8) of this section, the last day of coverage shall be the last day of the month in which the employee or dependent ceased being an employee or dependent.

(11) In the case of a termination in accordance with subdivision (c)(9), the effective date of termination of coverage shall be the day before such other coverage begins.

(f) If a qualified employee's coverage or the coverage of a qualified employee's dependent is terminated pursuant to subdivision (b) of this section, the SHOP shall provide the qualified employee or qualified employee's dependent with a notice of termination of coverage that includes the termination effective date and reason for termination.

(g) Notice of Termination

(1) Except as provided in subdivision (g)(3) of this section, if any enrollee's coverage or enrollment through the SHOP is terminated due to non-payment of premiums or due to a loss of the enrollee's eligibility to participate in the SHOP,

including where an enrollee loses ~~his or her~~their eligibility because a qualified employer has lost its eligibility, the SHOP must notify the enrollee of the termination. Such notice must include the termination effective date and reason for termination, and must be sent within three (3) business days if an electronic notice is sent, and within five (5) business days if a mailed hard copy notice is sent.

(2) Except as provided in subdivision (g)(3) of this section, if an employer group's coverage or enrollment through the SHOP is terminated due to non-payment of premiums or, where applicable, due to a loss of the qualified employer's eligibility to offer coverage through the SHOP, the SHOP must notify the employer of the termination. Such notice must include the termination effective date and reason for termination, and must be sent within three (3) business days if an electronic notice is sent, and within five (5) business days if a mailed hard copy notice is sent.

(3) Where state law requires a QHP ~~issuer~~ Issuer to send the notices described in subdivisions (g)(1) and (g)(2) of this section, a SHOP is not required to send such notices.

(4) When a primary subscriber and ~~his or her~~their dependents live at the same address, a separate termination notice need not be sent to each dependent at that address, provided that the notice sent to each primary subscriber at that address contains all required information about the termination for the primary subscriber and ~~his or her~~their dependents at that address.

Note: Authority cited: Section 100504, Government Code. Reference: Sections 100502 and 10503, Government Code; and 45 CFR Sections 155.720, 155.725, 155.735, 155.1080 and 156.285.

§ 6540. Definitions for the Small Business Health Options Program (SHOP) Appeals Process.

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

Appeal record: 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.

Appeals Representative: an authorized representative, an agent or broker of the employer, legal counsel, a relative, a friend, an employer filing for its employee or another spokesperson designated by the appellant.

Appeal request: A clear expression, either orally or in writing, by an applicant, enrollee, employer, or employee to have any SHOP eligibility determination reviewed by an appeals entity.

Appeals entity: A body designated to conduct appeals hearings of any SHOP eligibility determinations. The California Department of Social Services shall be the designated appeals entity for the SHOP.

Appellant: The applicant or enrollee, the employer, or employee who is requesting an appeal.

De novo review: A review of an appeal without deference to prior decisions in the case.

Eligibility determination: A determination that an applicant, enrollee, employer, or employee is eligible or not eligible for enrollment in a QHP pursuant to this Article.

Evidentiary hearing: A hearing conducted where evidence may be presented.

Good Cause: Cause as defined in Section 10951(b)(2) of the Welfare and Institutions Code.

Statement of Position: A writing submitted by the Appellant or SHOP that describes the Appellant's or SHOP's position regarding an appeal, as specified in Section 10952.5 of the Welfare and Institution Code.

Vacate: To set aside a previous action.

Note: Authority cited: Section 100504, Government Code. Reference: Section 100506, Government Code; and 45 CFR § 155.740.

§ 6542. General Eligibility Appeals Requirements for SHOP.

(a) An employer shall have the right to appeal:

(1) An eligibility determination made by the SHOP in accordance with this Article;

(2) A failure by the SHOP to provide a timely eligibility determination in accordance with this Article; or

(3) A failure of the SHOP to provide written notice to an employer of the SHOP's eligibility determination as provided in Section 6524(c) within 15 calendar days of receiving a completed application from an employer.

(b) An employee shall have the right to appeal:

(1) An eligibility determination made by the SHOP in accordance with this Article;

(2) A failure by the SHOP to ~~proivide~~provide a timely eligibility determination in accordance with this Article; or

(3) A failure of the SHOP to provide written notice to an employee of the SHOP's eligibility determination as provided in Section 6524(c) within 15 calendar days of receiving a completed application from an employee.

(c) Notices of the right to appeal an eligibility determination pursuant to Section 6524(c) and (d) shall include:

(1) The reason for the eligibility determination, including a citation to the applicable regulations; and

(2) The procedure by which the employer or employee may request an appeal of the eligibility determination.

(d) The SHOP and appeals entity shall:

(1) Allow an employer or employee to request an appeal within 90 days of the date of the notice of the eligibility determination, unless the appeals entity determines that good cause exists for allowing a late appeal request.

(2) Accept appeal requests submitted in person or through an appeals representative, via telephone, facsimile, mail, electronic mail or, as soon as it becomes available, the SHOP's Internet Web Site;

(3) Comply with the accessibility requirements specified in 45 CFR 155.205(c);

(4) Assist the employer or employee with the submission and processing of the appeal request, if requested, and not limit or interfere with the employer's or employee's right to request an appeal; and

(5) Consider an appeal request valid if it is submitted in accordance with the requirements of this section.

(e) Upon receipt of an appeal request pursuant to this section, the SHOP shall transmit the appeal request to the appeals entity via secure electronic interface within three (3) business days.

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

(2) All records concerning the eligibility of the employer or employee who is appealing.

(f) The appeals entity shall confirm receipt of the records transmitted pursuant to subdivision (e) of this section within three (3) business days.

(g) The appeals entity shall conduct all appeals on behalf of the SHOP pursuant to this Article.

(h) For purposes of this Article, an administrative law judge designated by the appeals entity shall determine, on a case-by-case basis, the validity of all appeals requests and all determinations of good cause.

(i) Upon receipt of a valid appeal request, the appeals entity shall send written acknowledgment to the appellant, or the employer and employee if the employee is the appellant, within five (5) business days from the date on which the valid appeal request is received. The written acknowledgment shall include:

(1) An explanation of the appeals process;

(2) Instructions for submitting additional evidence for consideration; and

(3) Information regarding the appellant's opportunity for informal resolution prior to the hearing pursuant to Section 6544.

(j) Upon receipt of an invalid appeal request because it fails to meet the requirements of this section, the appeals entity shall:

(1) Within five (5) business days from the date on which the invalid appeal request is received, send written notice to the appellant informing ~~him or her~~them:

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

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

(C) An explanation that the appellant may cure the defect, if curable, and resubmit the appeal request if it meets the timeliness requirements of subdivision (d)(1) of this section, or if the timeliness requirement in subdivision (d)(1) has lapsed, then within 10 calendar days from the date of the notice specified in subdivision (j)(1) of this section.

(2) Treat as valid an amended appeal request that meets the requirements of this section.

(k) The appellant has the right to be represented by an appeals representative.

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

(m) The appeals entity shall ensure that all data exchanges that are part of 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 that is consistent with 45 CFR Section 155.270.

(n) Both the SHOP and the appeals entity shall provide the appellant with the opportunity to review ~~his or her~~their entire eligibility file, including all papers, requests, documents, and relevant information in the SHOP'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.

Note: Authority cited: Section 100504, Government Code. Reference: Section 100506, Government Code; and 45 CFR § 155.740.

§ 6544. 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 a valid appeal request, the SHOP shall:

(1) Contact the appellant to attempt to informally resolve the appeal; and

(2) Provide the appellant the opportunity to submit relevant evidence to assist in the informal resolution of the appeal.

(c) An appellant's right to a hearing shall be preserved in any case notwithstanding the outcome of the informal resolution process, unless the appellant withdraws ~~his or her~~their appeal request prior to the hearing date, in accordance with the procedure set forth in Section 6546(a).

(d) If the appeal advances to hearing:

(1) The appellant shall not be asked to provide information or documentation that ~~he or she~~they previously provided during the application or informal resolution process.

(2) The SHOP shall issue a statement of position and transmit via secure electronic interface, the statement of position and all papers, requests, and documents the SHOP obtained during the informal resolution process, to the appeals entity no less than two (2) business days before the date of the hearing.

(3) The SHOP shall make the statement of position available to the appellant no less than two (2) business days before the date of the hearing.

(e) If the appellant is satisfied with the outcome of the informal resolution process and withdraws ~~his or her~~their appeal request in accordance with Section 6546(a) and the appeal does not advance to hearing:

(1) The SHOP shall, within five (5) business days from the date of the outcome of the informal resolution, send the appellant notice, which shall:

(A) State the outcome of the informal resolution, including a plain language description of the effect of such outcome on the appellant's appeal and eligibility;

(B) State the effective date of such outcome, if applicable; and

(2) Within three (3) business days from the date of the outcome of the informal resolution, send notice of the informal resolution outcome to the appeals entity via secure electronic interface.

Note: Authority cited: Section 100504, Government Code. Reference: Section 100506, Government Code; and 45 CFR § 155.740.

§ 6546. Dismissals of Appeals.

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

(1) Withdraws the request in writing prior to the hearing date; or

(2) Fails to submit an appeal request meeting the standards specified in Section 6542(d);

(3) Fails to appear at a scheduled hearing without good cause.

(b) If an appeal is dismissed, the appeals entity shall, within 15 business days from the date of the dismissal, provide written notice to the appellant including the reason for the dismissal. This notice shall include:

(1) The reason for the dismissal; and

(2) 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, the appeals entity shall, within 15 business days from the date of the dismissal, provide notice of the dismissal to the SHOP.

(d) The appeals entity may 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.

Note: Authority cited: Section 100504, Government Code. Reference: Section 100506, Government Code; and 45 CFR § 155.740.

§ 6548. Hearing Requirements.

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

(b) The appeals entity shall send written notice to the appellant of the date, time, and location or format of the hearing no later than 15 business days prior to the hearing date.

(c) The hearing shall be conducted:

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

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

(3) By an administrative law judge not directly involved in the eligibility determination implicated in the appeal; and

(4) 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~~their appeal record, including all documents and records to be used by the appeals entity at the hearing, at least two (2) 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 appeals representative.

(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 course of the appeals 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 process.

(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 cited: Section 100504, Government Code. Reference: Section 100506, Government Code; and 45 CFR § 155.740.

§ 6550. Expedited Appeal Process.

(a) An appellant shall have the right to request an expedited appeals process from the appeals entity where there is an immediate need for ~~health services~~health coverage or dental coverage 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) Handle the appeal request under the standard appeals process and issue the appeal decision in accordance with Section 6552; and

(2) Inform the appellant, within three (3) business days from the date of the denial of a request for an expedited appeal, through electronic, or oral notification if possible, of the denial and, if notification is oral, follow up with the appellant by written notice within five (5) business days of the denial. Written notice of the denial shall include:

(A) The reason for the denial;

(B) An explanation that the appeal request will be administered pursuant to 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) Ensure a hearing date is set on an expedited basis;

(2) Provide the appellant with written notice within 10 calendar days from the date on which the appellant's request for an expedited appeal is granted, informing the appellant:

(A) That ~~his or her~~their request for an expedited appeal is granted; and

(B) About the date, time, and type of the hearing that will be convened.

(3) Within three (3) 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 SHOP, specifying that the appellant's request for an expedited appeal is granted and a hearing will be set on an expedited basis.

Note: Authority cited: Section 100504, Government Code. Reference: Section 100506, Government Code; and 45 CFR § 155.740.

§ 6552. Appeal Decisions.

(a) The appeals decisions shall:

(1) Be based solely on the evidence referenced in Section 6548(e) and the eligibility requirements for SHOP under this Article.

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

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

(4) Summarize the facts relevant to the appeal;

(5) State the effective date of the decision; and

(6) 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 issue and provide a written appeal decision to the employer, or to the employer and employee if an employee is appealing, and to the SHOP, within 90 calendar days of the date on which a valid appeal request is received, unless the appeal request was determined by the appeals entity to meet the criteria for an expedited appeal.

(c) If the appeal request was determined by the appeals entity to meet the criteria for an expedited appeal, the appeals entity shall issue and provide a written appeal decision to the employer, or to the employer and employee if an employee is appealing, and to the SHOP, as expeditiously as reasonably possible, but not later than five business days from the date of the conclusion of the hearing.

(d) Upon issuance of an appeal decision, the SHOP shall implement the appeal decision, which shall be effective as follows:

(1) If an employer is found eligible under the decision, then at the employer's option, the effective date of coverage or enrollment through the SHOP under the decision can either be made retroactive to the effective date of coverage or enrollment through the SHOP that the employer would have had if the employer had been correctly determined eligible, or prospective to the first day of the month following the date of notice of the appeal decision;

(2) For employee appeal decisions only, if an employee is found eligible under the decision, then at the employee's option, the effective date of coverage or enrollment through the SHOP under the decision can either be made effective retroactive to the effective date of coverage or enrollment through the SHOP that the employee would have had if the employee had been correctly deemed eligible, or prospective to the first day of the month following the date of notice of the appeal decision; or

(3) If the employer or employee is found ineligible under the decision, then the appeal decision is effective as of the date of the notice of the appeal decision.

Note: Authority cited: Section 100504, Government Code. Reference: Section 100506, Government Code; and 45 CFR § 155.740.

COVERED CALIFORNIA
SMALL BUSINESS

Important information about your Covered California for Small Business Application

NEW BUSINESS LATE SUBMISSION ACKNOWLEDGEMENT

Your request to enroll with Covered California for Small Business has been received past the new business submission deadline date of 5 calendar days prior to requested effective date. It is important to note the following delays may occur:

- Approval of group policy
- Verification of eligibility with the carriers
- ID cards will be received 7-10 business days after the initial payment is processed.

Please work with the carrier directly to verify eligibility and benefits.

To ensure expedient coverage please note the following:

- All required documentation must be completed and received by the late submission deadline, **no later than the 7th day** of the requested effective month. Failure to do so will cause your group coverage to be effective the 1st of month following the original requested effective date.
- Enrollment **is not** effectuated until payment is received and posted to your account.

☐ I understand that by completing this form and meeting the submission requirements, our desired effective date will be granted, and **we will not be able to change or delay our effective date after group approval.**

_____
Company Name

_____
Requested Effective Date

_____
Signature of Business Owner/Authorized Company Officer Title

_____
Print Name Date

_____
Agent Signature Date

Print Form Reset Form

DocuSign Envelope ID: CCC4A7D5-BC21-4FB4-9253-2D304241E1ED

STATE OF CALIFORNIA — DEPARTMENT OF FINANCE

ECONOMIC AND FISCAL IMPACT STATEMENT (REGULATIONS AND ORDERS)

STD. 399 (Rev. 10/2019)

Instructions and Code Citations: SAM Section 6601-6616

ECONOMIC IMPACT STATEMENT

DEPARTMENT NAME	CONTACT PERSON	EMAIL ADDRESS	TELEPHONE NUMBER
California Health Benefit Exchange	Kambiz Elahi	kambiz.elahi@covered.ca.gov	(916) 228-8717

DESCRIPTIVE TITLE FROM NOTICE REGISTER OR FORM 400	NOTICE FILE NUMBER
Adopted Existing CCSB Eligibility and Enrollment Emergency Regulations to Permanent Regulations	Z

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

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

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

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

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

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

3. Enter the total number of businesses impacted: Less than 10,000

Describe the types of businesses (Include nonprofits): Small Businesses

Enter the number or percentage of total businesses impacted that are small businesses: 100%

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

Explain: This regulatory action will increase access to quality medical care

5. Indicate the geographic extent of impacts: ☒ Statewide

☐ Local or regional (List areas):

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

Describe the types of jobs or occupations impacted:

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

If YES, explain briefly:

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ECONOMIC IMPACT STATEMENT (CONTINUED)

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

1. What are the total statewide dollar costs that businesses and individuals may incur to comply with this regulation over its lifetime? $ 0

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

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

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

   d. Describe other economic costs that may occur: _____

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

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

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

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

   Number of units: _____

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

   Explain the need for State regulation given the existence or absence of Federal regulations: _____

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

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

1. Briefly summarize the benefits of the regulation, which may include among others, the health and welfare of California residents, worker safety and the State's environment: is regulatory action will enable the Exchange to provide health insurance coverage to eligible employees of qualified small businesses and their dependents, to improve the health of Californians, to increase access to quality medical care, to resolve eligibility appeals fairly and promptly.

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

   Explain: The changes will clarify requirements related to CCSB applications, eligibility, and enrollment.

3. What are the total statewide benefits from this regulation over its lifetime? $ 0

4. Briefly describe any expansion of businesses currently doing business within the State of California that would result from this regulation: _____

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

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

STATE OF CALIFORNIA — DEPARTMENT OF FINANCE

ECONOMIC AND FISCAL IMPACT STATEMENT (REGULATIONS AND ORDERS)

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ECONOMIC IMPACT STATEMENT (CONTINUED)

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

Regulation: Benefit: $ _____ Cost: $ _____

Alternative 1: Benefit: $ _____ Cost: $ _____

Alternative 2: Benefit: $ _____ Cost: $ _____

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

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

Explain: _____

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

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

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

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

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

Alternative 1: _____

Alternative 2: _____

(Attach additional pages for other alternatives)

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

Regulation: Total Cost $ _____ Cost-effectiveness ratio: $ _____

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

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

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

☐ YES ☒ NO

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

5. Briefly describe the following:

The increase or decrease of investment in the State: _____

The incentive for innovation in products, materials or processes: _____

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

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Instructions and Code Citations:
SAM Section 6601-6616

STATE OF CALIFORNIA — DEPARTMENT OF FINANCE

ECONOMIC AND FISCAL IMPACT STATEMENT (REGULATIONS AND ORDERS)

STD. 399 (Rev. 10/2019)

FISCAL IMPACT STATEMENT

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

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

$ _____

☐ a. Funding provided in _____

Budget Act of _____ or Chapter _____, Statutes of _____

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

Fiscal Year: _____

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

$ _____

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

☐ a. Implements the Federal mandate contained in _____

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

Case of: _____ vs. _____

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

Date of Election: _____

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

Local entity(s) affected: _____

_____

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

Authorized by Section: _____ of the _____ Code;

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

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

☐ 3. Annual Savings. (approximate)

$ _____

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

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

☐ 6. Other. Explain _____

_____

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Instructions and Code Citations:
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STATE OF CALIFORNIA — DEPARTMENT OF FINANCE

ECONOMIC AND FISCAL IMPACT STATEMENT (REGULATIONS AND ORDERS)

STD. 399 (Rev. 10/2019)

FISCAL IMPACT STATEMENT (CONTINUED)

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

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

$ _____

It is anticipated that State agencies will:

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

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

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

$ _____

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

☐ 4. Other. Explain _____

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

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

$ _____

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

$ _____

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

☐ 4. Other. Explain _____

FISCAL OFFICER SIGNATURE	DATE
DocuSigned by: Jim Watkins C13CA7A7E36A400...	3/6/2024

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

AGENCY SECRETARY	DATE
DocuSigned by: Karen Johnson 3DAAAB404CEF48D...	3/6/2024

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

DEPARTMENT OF FINANCE PROGRAM BUDGET MANAGER	DATE