June 13, 2014

ADVANCE NOTICE OF RE-ADOPTION OF EMERGENCY REGULATIONS

This notice is sent in accordance with Government Code Section 11346.1(a)(2), which requires that State of California agencies give advance notice at least five working days of their intent to file emergency regulations with the Office of Administrative Law (OAL). The California Health Benefit Exchange ("Exchange") intends to file a re-adoption of an Emergency Rulemaking package with the Office of Administrative Law (OAL) that establishes the Certified Plan-Based Enrollment Program in the Individual Exchange. As required by subdivisions (a)(2) and (b)(2) of Government Code Section 11346.1, this notice appends the following: (1) the specific language of the proposed regulation and (2) the Finding of Emergency, including specific facts demonstrating the need for immediate action, the authority and reference citations, the informative digest and policy statement overview, attached reports, and required determinations.

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

Comments should be sent simultaneously to:

California Health Benefit Exchange
Attn: Gabriela Ventura Gonzales
1601 Exposition Blvd.
Sacramento, CA 95815

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

Upon filing, OAL will have ten (10) calendar days within which to review and make a decision on the proposed emergency rule. If approved, OAL will file the regulations with the Secretary of State, and the emergency regulations will become effective for one hundred eighty days (180) days. Please note that this advance notice and comment period is not intended to replace the public's ability to comment once the emergency regulations are approved. There will be a 45-day comment period within the 180-day certification period following the effective date of the emergency regulations.

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You may also view the proposed regulatory language and Finding of Emergency on the Exchange's website at the following address: https://www.coveredca.com/hbex/regulations/.

If you have any questions concerning this Advance Notice, please contact Gabriela Ventura Gonzales at 916-228-8477.

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FINDING OF EMERGENCY

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

This emergency rulemaking was previously adopted by OAL on September 30, 2013 and readopted on April 1, 2014. The Exchange now seeks a second readoption. The Exchange is also in the process of making this rulemaking permanent and has proceeded with diligence to comply with the requirements in Government Code § 11346.1(e), and has made substantial progress in that regard. During the first readoption, the Exchange reviewed and refined the proposed emergency regulations to streamline processes and to remove duplication for improved clarity. We seek to readopt the same rules again. The Exchange is also in the process of developing economic cost estimates for this rulemaking package in preparation for the permanent filing. The Exchange cannot seek a permanent rulemaking at this time as we continue to gather information from the program's first months of operation through the end of the Exchange's first open enrollment and evaluate the functions of the PBE program in preparation for the Exchange's second open enrollment period in Fall 2014, which will for the first time involve eligibility redeterminations (renewals). The Exchange continues to welcome stakeholder feedback on this rulemaking and we intend to provide a full 45-day comment period for formal comments during the subsequent process for permanent adoption.

DEEMED EMERGENCY

The Exchange may "Adopt rules and regulations, as necessary. Until January 1, 2016, any necessary rules and regulations may be adopted as emergency regulations in accordance with the Administrative Procedures Act. The adoption of these regulations shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare." (Gov. Code, § 100504(a)(6)).

AUTHORITY AND REFERENCE

Authority: Sections 1043, 100503, 100504, Government Code.
Reference: 45 Code of Federal Regulations, Sections 155.20, 155.205(d), 155.415, 156.260, 156.265, 156.1230. Section 11015, Penal Code.

INFORMATIVE DIGEST/POLICY STATEMENT OVERVIEW

Summary of Existing Laws

Under the federal Patient and Protection and Affordable Care Act (ACA), each state is required, by January 1, 2014, to establish an American Health Benefit Exchange that makes available qualified health plans (QHPs) to qualified individuals and small

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employers. Existing state law, the California Patient Protection and Affordable Care Act, established the California Health Benefit Exchange within state government, and specifies the powers and duties of the executive board of the Exchange.

Federal regulations implementing the ACA at 45 CFR 155.415 and 156.1230 allow at state-option the creation of a QHP Issuer-based consumer assistance function for the direct enrollment of consumers in a manner deemed to be through the Exchange. These regulations create a Certified Plan-Based Enrollment Program to establish the policies and procedures for QHP Issuers to conduct eligibility determinations and redeterminations, enrollment in QHPs, and appropriate handling of applications deemed eligible for other insurance affordability programs, including Medi-Cal. The proposed regulations will also provide QHP Issuers applying for the Certified Plan-Based Enroller Program with the standards and requirements for issuers and their employees or contractors to qualify for participation in the PBE Program. These requirements include program eligibility requirements, training and certification standards, fingerprinting and criminal record checks, specific roles and responsibilities, conflict of interest standards, compensation standards, suspension and revocation rules, and allowable appeals.

After an evaluation of current regulations, the Exchange has determined that these proposed regulations are not inconsistent or incompatible with any existing regulations. The Exchange has determined these are the only regulations that concern the participation of QHP Issuers to conduct specified consumer assistance functions of the Exchange in a manner deemed to be through the Exchange.

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

None.

LOCAL MANDATE

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

FISCAL IMPACT ESTIMATES (Attached Form 399)

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

COSTS OR SAVINGS TO STATE AGENCIES (Attached Form 399)

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

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California Code of Regulations
Readopt Article 9. Plan-Based Enrollers (§§ 6700 et seq.)
Title 10. Investment
Chapter 12. California Health Benefit Exchange

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§ 6700 – Definitions

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

(a) Cold-Calling: A Plan-Based Enrollment Entity or Plan Based-Enroller's unsolicited outgoing phone calls that were not prompted by a permissible lead, to an individual that has not expressed an interest in the PBE's QHPs in the Individual Exchange. Permissible leads include lists that are consumer opt-in and outreach to a PBEE's current or former members.

(b) Consumer: For the purposes of this article, Consumer shall mean the following targeted populations:
   (1) Issuer's non-group members that meet the requirements of a Qualified Individual in Section 6410 of Article 2 of this chapter;
   (2) Issuer's members receiving coverage required by the Consolidated Omnibus Budget and Reconciliation Act of 1985 ("COBRA") and the California Continuation Benefits Replacement Act, or Health and Safety Code Section 1366.20 et seq. ("Cal-COBRA") that meet the requirements of a Qualified Individual;
   (3) Issuer's current members meeting the requirements of a Qualified Individual, or those current members terminating their individual or group coverage including 25 year old dependents;
   (4) Qualified Individuals interested in obtaining health care coverage through the Exchange; and
   (5) Individuals eligible for other Insurance Affordability Programs, as defined in Section 6410 of Article 2 of this chapter (e.g. Medi-Cal).

(c) Enrollment Assistance: A Certified Plan-Based Enroller may provide the following direct enrollment assistance to Consumers in the Individual Exchange, provided that the Certified Plan-Based Enroller meets the requirements set forth in this article:
   (1) Applying for an eligibility determination or redetermination for coverage through the Exchange;
   (2) Applying for Insurance Affordability Programs;
   (3) Facilitating the enrollment in a QHP offered by the Issuer; and
   (4) If the consumer is determined eligible for Medi-Cal following the process in Section 6710(a)(12).

Note: Authority cited: Sections 100503 and 100504, Government Code. Reference: 45 Code of Federal Regulations, Sections 155.20, 155.415, 156.265, and 156.1230.

§ 6702 – Certified Plan-Based Enrollment Program Eligibility Requirements

(a) The following entities and individuals are eligible to apply to participate in the Plan-Based Enrollment Program through the Exchange (Covered California):
   (1) Qualified Health Plan Issuers, as defined in Section 6410 of Article 2 of this chapter, under contract with the Exchange to provide at least one QHP through the Exchange that seek to provide enrollment assistance to Consumers.
   (2) Issuer Application Assisters, as defined in 45 C.F.R. § 155.20, or Captive Agents, as defined in Section 6410 of Article 2 of this chapter, that are employed or contracted by a Certified Plan-Based Enrollment Entity.

(b) Certified Plan-Based Enrollment Entity Eligibility Requirements

(1) QHP Issuers in subdivision (a)(1) shall complete the application for the Certified Plan-Based Enrollment Program pursuant to Section 6704.
(2) Complete training through the Exchange as required under Section 6706 to become eligible to register to provide enrollment assistance to consumers and help them apply for health coverage in a manner considered to be through the Exchange.
(3) Demonstrate access to Consumers, as defined in Section 6700, for the Certified Plan-Based Enrollment Program.

(c) Certified-Plan Based Enroller Eligibility Requirements
(1) Be employed or contracted by a registered Certified Plan-Based Enrollment Entity as a Captive Agent or Issuer Application Assister pursuant to subdivision (a)(2).
(2) Complete required training on the following:
(A) QHP options and Insurance Affordability Programs, eligibility, and benefits rules and regulations;
(B) Requirements of the Plan-Based Enroller Training and Certification Standards in Section 6706.
(3) Comply with the Exchange's privacy and security requirements in 45 C.F.R. § 155.260;
(4) Comply with applicable State law related to the sale, solicitation, and negotiation of insurance products, including applicable State law related to agent, broker, and producer licensure; and conflicts of interest;
(5) Pass the certification exam identified in Section 6706;
(6) Sign a code of conduct relating to confidentiality and adherence with any applicable state laws and regulations, including this article and Section 6500(f) of Article 5 of this chapter;
(7) Complete and pass the Exchange's fingerprinting and criminal background check process in Section 6708;
(8) Complete refresher trainer, testing and certification renewal each year, and at other times if required by the Exchange.

Note: Authority cited: Sections 100503 and 100504, Government Code. Reference: Section 100503, Government Code; and 45 Code of Federal Regulations, Sections 155.415, 155.260, 156.265, and 156.1230.

§ 6704 – Program Application

(a) An entity or individual who is eligible for the Certified Plan-Based Enrollment program may apply to become a Certified Plan-Based Enrollment Entity or a Certified Plan-Based Enroller according to the following process.
(1) The entity or individual shall submit all information, documentation, and declarations required in subdivision (b) of this Section.
(2) The application shall demonstrate that the entity or individual is capable of carrying out at least those duties described in the Certified Plan-Based Enrollment Entity eligibility requirements in this Article and has existing relationships, or could readily establish relationships, with Consumers, as defined in Section 6700.
(3) The Exchange shall review the program application and, if applicable, request any additional or missing information necessary to determine eligibility.
(4) Entities or individuals who have submitted a completed application and demonstrated ability to meet the above requirements shall be notified of available opportunities by the Exchange for the entity or individual's authorized contact, or his or her designee, to complete the training requirements.
(5) Entities or individuals who complete and pass the training requirements shall be

registered as Certified Plan-Based Enrollment Entities or Certified Plan-Based Enrollers, respectively, by the Exchange and assigned a Certified Plan-Based Enrollment Entity or Enroller number. If the authorized contact, or his or her designee, fails to complete the training standards within 90 calendar days, the applicant shall be deregistered.

(6) All individuals who are not yet certified by the Exchange as Certified Plan-Based Enrollers and included in the initial application of the Certified Plan-Based Enrollment Entity shall become certified in accordance with the following process:

(A) Pass the Certified Plan-Based Enroller Fingerprinting and Criminal Record Check process in Section 6708;

(B) Complete the required training in Section 6706; and

(C) Pass the required certification exam administered by the Exchange pursuant to Section 6706.

(7) Entities and individuals who have been denied certification by the Exchange may appeal the denial of their certification through the process established by Section 6718 or 6708.

(b) A Certified Plan-Based Enrollment Entity application shall contain the following information.

(1) Full name;

(2) Legal name;

(3) Primary e-mail address;

(4) Primary phone number;

(5) Secondary phone number;

(6) Fax number;

(7) An indication of whether the entity prefers to communicate via e-mail, phone, fax, or mail;

(8) Web site address;

(9) Federal Employment Identification Number;

(10) State Tax Identification Number;

(11) Identification of applicant's status as a non-profit, for-profit, or governmental organization and a copy of supporting documentation;

(12) Identification of the type of organization and, if applicable, a copy of the license or other certification;

(13) Identification of the counties served;

(14) An indication of whether applicant received an Outreach & Education Grant from the Exchange and/or the Department of Health Care Services and, if applicable, the Grant Contract Number and Grant Award Amount;

(15) A certification that the applicant and all of its employees comply with the above requirements;

(16) For the primary site and each sub-site, the following information:

(A) Site Location Address;

(B) Mailing Address;

(C) County;

(D) Contact name;

(E) Primary e-mail address;

(F) Primary phone number;

(G) Secondary phone number;

(H) An indication of whether the entity or individual wants to receive referrals for individuals seeking assistance at this site;

(I) Hours of operation;

(J) Estimated number of Individuals served annually;

(K) Spoken languages;
(L) Written languages;

(17) Name, e-mail address, primary and secondary phone number, and an indication of the preferred method of communication for the Authorized Contact, Primary Contact, and Financial Contact;

(18) A certification by the Authorized Contact that the information presented is true and correct to the best of the signer's knowledge;

(19) For each Certified Plan-Based Enroller to be affiliated with the applicant entity, the following must be included in the entity's application:

(A) Name, e-mail address;

(B) An indication of whether the individual is licensed in good standing as an agent with the California Department of Insurance, and if so the individual's license number;

(C) An indication of whether or not he or she is certified by the Exchange as a Certified Insurance Agent, Certified Enrollment Counselor, Certified Application Counselor, or serves in any other enrollment function of the Exchange including Service Center Representative, and County Eligibility Worker, and, if applicable, the certification number;

(c) An individual who is not included in an initial Certified Plan-Based Enrollment Entity application may become a Certified Plan-Based Enroller according to the following process:

(1) The Certified Enrollment Entity shall notify the Exchange of the individual to be affiliated according to the process described in subdivision (f) of this Section.

(2) The individual shall:

(A) Submit all information, documentation, and declarations required in subdivision (d) of this Section;

(B) Pass the Certified Plan-Based Enroller Fingerprinting and Criminal Record Check in Section 6708;

(C) Complete the required training in Section 6706; and

(D) Pass the required certification exam administered by the Exchange in Section 6706.

(3) Individuals who complete the training requirements and pass the required certification exam shall be certified as Certified Plan-Based Enrollers by the Exchange.

(d) An individual's application to become a Certified Plan-Based Enroller shall contain the following information:

(1) Name, e-mail address;

(2) Identification of the Certified Plan-Based Enrollment Entity that the individual will affiliate with;

(3) Affiliated Certified Plan-Based Enrollment Entity's primary site location address;

(4) Site(s) served by the individual;

(5) Mailing Address of the primary site for the Certified Plan-Based Enrollment Entity;

(6) An indication of the languages that the Certified Plan-Based Enroller can speak;

(7) An indication of the languages that the Certified Plan-Based Enroller can write;

(8) Disclosure of all criminal convictions and administrative actions taken against the individual;

(9) A certification by the individual that:

(A) The individual complies with the Certified Plan-Based Enroller requirements;

(B) The individual is a natural person of not less than 18 years of age; and

(C) The statements made in the application are true, correct and complete to the best of his or her knowledge and belief.

(10) For the individual applying to become a Certified Plan-Based Enroller, signature, and

date signed; and

(11) For the Authorized Contact from the Certified Plan-Based Enrollment Entity that the individual will be affiliated with, name, signature, and date signed.

(e) A Certified Plan-Based Enrollment Entity shall notify the Exchange of every individual to be added or removed as an affiliated Certified Plan-Based Enroller. Such notification shall include:

(1) Name of the Certified Plan-Based Enrollment Entity~~ and the Certified Plan-Based Enrollment Entity Number~~;

(2) Name and signature of the Authorized Contact from the Certified Plan-Based Enrollment Entity;

(3) Name, e-mail, and primary phone number of the individual to be added or removed;

(4) Effective date for the addition or removal of the individual; and

(5) An indication of whether the individual is certified by the Exchange as a Certified Insurance Agent, Certified Enrollment Counselor, Certified Application Counselor, or serves in any other enrollment function of the Exchange, including Service Center Representative, and County Eligibility Worker, and if so, the following information:

(A) Certification number; and

(B) When adding an individual, site(s) to be served by the individual.

(f) The Certified Plan-Based Enrollment Entity shall submit an executed agreement conforming to the Roles and Responsibilities of the Certified Plan-Based Enroller Program.

Note: Authority cited: Sections 100503 and100504, Government Code. Reference: Section 100503, Government Code; and 45 Code of Federal Regulations, Sections 155.415 and 156.1230.

§ 6706 – Training and Certification Standards

(a) All entities who apply to become a Certified Plan-Based Enrollment Entity shall have their authorized contact complete training for the management of Certified Plan-Based Enrollers prior to any affiliated Certified Plan-Based Enrollers carrying out any consumer assistance functions under this article.

(b) To ensure that all Certified Plan-Based Enrollers are knowledgeable about the Individual Exchange, all individuals or entities who carry out enrollment assistance functions shall complete training in the following subjects prior to carrying out any enrollment assistance functions pursuant to this article:

(1) QHPs (including the metal levels described at 45 C.F.R. § 156.140(b)) and how they operate, including benefits covered, payment processes, rights and processes for appeals and grievances;

(2) The range of Insurance Affordability Programs, including Medi-Cal, and other public programs;

(3) The tax implications of enrollment decisions;

(4) Eligibility requirements for APTC, as defined in Section 6410 of Article 2 of this chapter, and cost-sharing reductions, and the impacts of APTC on the cost of premiums;

(5) Contact information for appropriate federal, state, and local agencies for consumers seeking additional information about specific coverage options not offered through the Exchange;
(6) Basic concepts about health insurance and the Exchange; the benefits of having health insurance and enrolling through the Exchange; and the individual responsibility to have health insurance;
(7) Eligibility and enrollment rules and procedures, including how to appeal an eligibility determination;
(8) Providing culturally and linguistically appropriate services;
(9) Ensuring physical and other accessibility for people with a full range of disabilities;
(10) Understanding the Individual Exchange marketplace and differences among health plans;
(11) Privacy and security standards applicable under 45 CFR § 155.260 for handling and safeguarding consumers' personally identifiable information;
(12) Working effectively with, and not discriminating against, individuals of various racial and ethnic backgrounds, persons with limited English proficiency, people with a full range of disabilities, people of any gender identity, people of any sexual orientation, and vulnerable, rural, and underserved populations;
(13) Customer service standards;
(14) Outreach and education methods and strategies; and
(15) Applicable administrative rules, processes and systems related to Exchanges and QHPs.

(c) Training pursuant to this Section shall be provided by the Exchange through computer-based training, or through another channel at the discretion of the Exchange.

(d) Certified Plan-Based Enrollers shall pass the exam administered by the Exchange on an annual basis to maintain certification.

Note: Authority cited: Section 100504, Government Code. Reference: Section 100503, Government Code; and 45 Code of Federal Regulations, Sections 155.205(d), 155.415, 155.260, and 156.1230.

§ 6708 – Certified Plan-Based Enroller Fingerprinting and Criminal Record Checks

(a) Roles Requiring Fingerprinting.
(1) Individuals seeking certification as a Plan-Based Enroller that are not Captive Agents, as defined in Section 6410 of Article 2 of this chapter, shall submit fingerprint images and associated criminal history information pursuant to Gov. Code 1043 and Section 6456(a)-(e) of Article 4 of this chapter.
(2) Captive Agents seeking certification as Plan-Based Enrollers are required to be licensed in good standing with the California Department of Insurance and shall not be subject to subdivision (a)(1).

(b) Interim Fitness Determination.
(1) Before any final determination or certification decision is made based on the criminal record, the Exchange shall comply with the requirements of Section 6456(d)-(e) of Article 4 of this chapter.

(2) If the Exchange finds that an individual seeking certification as a Plan-Based Enroller has a potentially disqualifying criminal record under Section 6456(d)-(e) of Article 4 of this chapter, the Exchange shall promptly provide the individual with a copy of his or her criminal record pursuant to Penal Code Section 11105(t), notify the individual of the specific disqualifying offense(s) for the interim determination, and provide the individual information on how to request a written appeal, including examples of the types of additional evidence the individual may provide, to dispute the accuracy and relevancy of the criminal record.

(c) Appeal and Final Determination.

(1) Inaccurate or Incomplete Federal and Out of State Disqualifying Offenses.

(A) If the individual believes that the potentially disqualifying offense in the Federal Bureau of Investigation national criminal response identified in the notice sent pursuant to subdivision (b)(2) of this Section is inaccurate or incomplete, within 60 calendar days from the date of the notice, the individual may seek to correct or complete the response by providing information to the Exchange, including official court and law enforcement records, identifying and correcting the incomplete or inaccurate criminal history information. Upon receipt of such information, the Exchange shall reevaluate the interim fitness determination. The Exchange, within 60 calendar days, shall respond to the individual with a final determination.

(2) Inaccurate or Incomplete California Disqualifying Offenses.

(A) If the individual believes that the potentially disqualifying offense in the California Department of Justice state criminal response identified in the notice sent pursuant to subdivision (b)(2) is inaccurate or incomplete, within 60 calendar days from the date of the notice, the individual shall notify the Exchange and follow the procedures set forth in Penal Code Sections 11120-11127 to correct or complete the criminal response with the DOJ. The fitness determination shall not be final until the DOJ has acted to correct the state criminal response. Upon receipt of the corrected response, the Exchange shall reevaluate the interim fitness determination. The Exchange, within 60 calendar days, shall respond to the individual with a final determination.

(3) If the individual determines that his or her criminal record is accurate, within 60 days from the date of the notice in subdivision (b)(2) of this Section, the individual may dispute the interim determination by producing additional written evidence of rehabilitation and mitigating circumstances related to any potentially disqualifying offense. The Exchange, within 60 calendar days, shall respond to the individual with a final determination.

(A) For purposes of reevaluating the interim determination pursuant to subdivision (c)(3) of this Section, the Exchange shall take into account any of the following:

(i) Any additional evidence of rehabilitation and mitigating circumstances provided by the individual in subdivision (c)(3) of this Section;

(ii) Information received as a result of the criminal record check;

(iii) Information received through the individual's application process for a position requiring fingerprinting in subdivision (a) of this Section.

(iv) Information received as a result of the individual's employment history or qualifications for a position requiring fingerprinting in subdivision (a) of this Section.

(4) Absent good cause for late filing as determined by the Exchange on a case by case basis, the interim fitness determination shall become final.

(d) Costs.

(1) Background check costs for individual Plan-Based Enrollers shall be paid by the Plan-Based Enrollment Entity.

Note: Authority cited: Sections 1043, 100503, and 100504, Government Code. Reference: Section 11105, Penal Code; Section 100503, Government Code; and 45 Code of Federal Regulations, Sections 155.415, 155.260, and156.1230.

§ 6710 – Roles and Responsibilities

(a) A Certified Plan-Based Enrollment Entity and its Certified Plan-Based Enrollers shall perform the following functions:

(1) Maintain expertise in eligibility, enrollment, and Plan-Based Enrollment Program specifications.

(2) Provide enrollment assistance to consumers in a manner considered to be through the Exchange pursuant to 45 C.F.R. § 156.265(b)(2) and Section 6500(f) of Article 5 of this chapter.

(3) Provide information and services in a fair and accurate manner. Such information and services shall include assistance with other Insurance Affordability Programs (e.g., Medi-Cal).

(4) Provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under Section 2793 of the Public Health Service (PHS) Act, 42 U.S.C. § 300gg-93, or any other appropriate State agency or agencies, for any enrollee with a grievance, complaint, or question regarding their health plan, coverage, or a determination under such plan or coverage.

(5) Comply with the privacy and security standards in 45 CFR § 155.260.

(6) Comply with any applicable federal or state laws and regulations.

(7) Inform all applicants of the availability of other QHP products or stand-alone dental plans offered through the Exchange through an HHS-approved universal disclaimer and display the Web link to access the Exchange Web Site on the PBEE's Web Site, and describe how to access the Exchange Web Site or the Service Center of the Exchange.

(8) Facilitate the enrollment in a QHP offered in the Individual Exchange by the entity represented by the Certified Plan-Based Enroller.

(A) The QHP Issuer must be able to provide applicants standardized information for its available QHPs in the Individual Exchange, including at a minimum the following data elements:

(i) Premium and cost-sharing information;

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

(iii) Identification of whether the QHP is a bronze, silver, gold or platinum level plan as defined by Section 1302(e) of the Affordable Care Act (ACA), 42 U.S.C. 18022, or a catastrophic plan as defined by section 1032(e) of the Affordable Care Act;

~~(iv) The results of the enrollee satisfaction survey, as described in Section 1311(c)(4) of the ACA, 42 U.S.C. 18031;~~

~~(v)~~(iv) Quality ratings assigned in accordance with Section 1311(c)(3) of the ACA, 42 U.S.C. 18031, when available;

~~(vi)~~(v) Medical loss ratio information as reported to HHS in accordance with 45 C.F.R. § 158, when available;

~~(vii)~~(vi) Transparency of coverage measures reported to the Exchange during certification with 45 C.F.R. § 155.1040;

~~(viii)~~(vii) The provider directory made available to the Exchange in accordance with 45 C.F.R. § 156.230;

~~(ix)~~(viii) Potential total cost, including premium and out-of-pocket expenses; and

~~(x)~~(ix) Participation of the preferred provider of the consumer in the QHP Issuer's available QHPs.

(9) Clearly distinguish between QHPs for which the consumer is eligible and other non-QHPs that the issuer may offer, and indicate that advance payments of the premium tax credit and cost sharing reductions apply only to QHPs offered through the Exchange.

(10) Inform all applicants of the availability of stand-alone dental plans offered through the Exchange and provide the individual information on how to access the Exchange Web Site or the Service Center of the Exchange.

(A) If the applicant's household includes children the PBE shall transfer the applicant to the Service Center of the Exchange following enrollment in a QHP offered by the PBEE.

(11) Allow applicants to select and attest to an APTC amount, if applicable, in accordance with 45 C.F.R. § 155.310(d)(2) and Section 6476(c) of Article 5 of this chapter.

(12) If the consumer is determined to be eligible for Medi-Cal, the PBE shall either transfer the consumer to the county of residence for enrollment in Medi-Cal or transmit all eligibility information to DHCS consistent with 45 C.F.R. § 155.310 and Section 6476(d) of Article 5 of this chapter. A PBE shall not facilitate Medi-Cal plan selection until the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS) has been programmed to allow a beneficiary to select a Medi-Cal managed care plan, as defined in Section 6410 of Article 2 of this chapter, pursuant to subdivision (p) of Section 14016.5 of the Welfare and Institutions Code.

(13) Advise all consumers found ineligible for Insurance Affordability Programs of their appeal rights, including the time limits and methods for filing appeals, in accordance with Sections 6604 and 6606 of Article 7 of this chapter.

(14) Advise all consumers found ineligible for Insurance Affordability Programs that there may be other health insurance products outside of the Individual Exchange that may be suitable to their needs. The PBE shall offer to transfer the consumer to a Captive Agent or Solicitor, as defined in Health and Safety Code Section 1345(m), affiliated with the PBEE capable of offering the consumer the full range of health plans offered by the Issuer in the Individual Market and Individual Exchange.

(b) To ensure that information provided as part of any enrollment assistance is culturally and linguistically appropriate to the needs of the population being served, including individuals with limited English proficiency, all Certified Plan-Based Enrollment Entities and Certified Plan-Based Enrollers shall:

(1) Develop and maintain general knowledge about the racial, ethnic, and cultural groups in their service area, including each group's diverse cultural health beliefs and practices, preferred languages, health literacy, and other needs;

(2) Collect and maintain updated information to help understand the composition of the communities in the service area, including the primary languages spoken;

(3) Provide consumers with information and assistance in the consumer's preferred language, at no cost to the consumer, including the provision of oral interpretation of

non-English languages and the translation of written documents in non-English languages when necessary to ensure meaningful access. Use of a consumer's family or friends as oral interpreters can satisfy the requirement to provide linguistically appropriate services only when requested by the consumer as the preferred alternative to an offer of other interpretive services;

(4) Provide oral and written notice to consumers with limited English proficiency informing them of their right to receive language assistance services and how to obtain them;

(5) Receive ongoing education and training in culturally and linguistically appropriate service delivery; and

(6) Implement strategies to recruit, support, and promote a staff that is representative of the demographic characteristics, including primary languages spoken, of the communities in their service area.

(c) To ensure that enrollment assistance is accessible to people with disabilities, all Certified Plan-Based Enrollment Entities and Certified Plan-Based Enrollers shall:

(1) Ensure that any consumer education materials, Web sites, or other tools utilized for consumer assistance purposes are accessible to people with disabilities, including those with sensory impairments, such as visual or hearing impairments, and those with mental illness, addiction, and physical, intellectual, and developmental disabilities;

(2) Provide auxiliary aids and services for individuals with disabilities, at no cost, where necessary for effective communication. Use of a consumer's family or friends as interpreters can satisfy the requirement to provide auxiliary aids and services only when requested by the consumer as the preferred alternative to an offer of other auxiliary aids and services;

(3) Provide assistance to consumers in a location and in a manner that is physically and otherwise accessible to individuals with disabilities;

(4) Ensure that legally authorized representatives are permitted to assist an individual with a disability to make informed decisions; and

(5) Acquire sufficient knowledge to refer people with disabilities to local, state, and federal long-term services and supports programs when appropriate.

(d) All Certified Plan-Based Enrollment Entities and Certified Plan-Based Enrollers shall provide the same level of service to all individuals regardless of age, disability, culture, race, ethnicity, income, sexual orientation, or gender identity and seek advice or experts when needed.

(e) If capacity necessitates, for those culturally and linguistically appropriate services in this Section which are not otherwise required of the Certified Plan-Based Enrollment Entity in federal or state law, a Certified Plan-Based Enroller may transfer consumers seeking those services under this Section to other Exchange resources including the Exchange Service Center and describe how to access Exchange-provided services.

(f) All Certified Plan-Based Enrollers shall complete the Certified Plan-Based Enrollment Entity and Certified Plan-Based Enroller Section of a consumer's application to the Exchange, including the following:

(1) Name, certification number of the Certified Plan-Based Enroller, signature~~, and~~ date, and PIN, if applicable;

(2) Name of the Certified Plan-Based Enrollment Entity~~ and the Certified Plan-Based Enrollment Entity Number~~; and

(3) Signature and date of signature by the Certified Plan-Based Enroller.

(g) If any of the information listed in subdivision (f) of this Section is not included on the consumer's original application, it may not be added at a later time.

(h) Certified Plan-Based Enrollers that do not meet the definition of a Captive Agent, as defined in Section 6410 of Article 2 of this chapter, shall report to the Exchange any criminal

convictions and administrative actions taken by any other agency within 30 days of the date of the conviction or action.

(i) Certified Plan-Based Enrollers that are Captive Agents shall be licensed in good standing through the California Department of Insurance.

(j) Prohibited Activities for Certified Plan-Based Enrollment Entities and Certified Plan-Based Enrollers.

(1) All Certified Plan-Based Enrollment Entities and their Contractors and Employees that are Certified Plan-Based Enrollers may not:

(A) Conduct door-to-door marketing;

(B) Employ marketing practices or offer information and assistance only to certain members in a manner that will have the effect of enrolling a disproportionate number of the Issuer's non-QHP members with significant health needs in QHPs offered in the Individual Exchange;

(C) Cold-call non-member target populations;

(D) Mail the paper application for the consumer;

(E) Advise the consumer to provide inaccurate information on the application regarding income, residency, immigration status and other eligibility criteria;

(F) Select a QHP for the potential applicant while providing application assistance;

(G) Solicit or accept any consideration from an applicant in exchange for application assistance;

(H) Pay any part or any other type of consideration to or on behalf of the consumer;

(I) Sponsor a person eligible for the program by paying family contribution amounts or co-payments;

(J) Offer applicants any inducements such as gifts or monetary payments to apply for coverage in a QHP or Medi-Cal Managed Care Plan represented by the PBE;

(K) Intentionally create multiple applications from the same household, as defined in 45 C.F.R § 435.603(f);

(L) Invite, influence, or arrange for an individual whose existing coverage through an eligible-employer sponsored plan is affordable and provides minimum value, as described in 26 U.S.C. § 36B(c)(2)(C) and in 26 C.F.R. §§ 1.36B-2(c)(3)(v) and (vi), to separate from employer-based group health coverage;

(M) Request, view or obtain claims data information while providing application assistance;

(N) Request, view or obtain health status information including any pre-existing conditions for purposes other than connecting the consumer to the appropriate IAP;

(O) Violate conflict of interest standards in Section 6712;

(P) Be a Certified Insurance Agent through the Exchange pursuant to Section 6800 of Article 10 of this chapter; or

(Q) Retain any information related to income, citizenship, immigration status, or disability.

Note: Authority cited: Section 100504, Government Code. Reference: Section 100503, Government Code; and 45 Code of Federal Regulations, Sections 155.205(d), 155.260, 155.415, 156.265, and 156.1230.

§ 6712 – Conflict of Interest Standards

(a) All Certified Plan-Based Enrollment Entities and Certified Plan-Based Enrollers shall:

(1) Only receive consideration pursuant to the exclusive agreement between the Certified Plan-Based Enrollment Entity and the Certified Plan-Based Enroller in connection with the enrollment of any individuals in the Entity's QHPs pursuant to this article.

(2) Create a written plan to manage conflicts of interest while carrying out enrollment assistance functions which shall be provided to the Exchange as requested.

(3) Only make representations that are accurate and not misleading.

(A) The Certified Plan-Based Enroller may only make representations regarding the QHPs offered by the Certified Plan-Based Enrollment Entity represented by the PBE.

(4) Disclose conflicts of interest to Consumers.

(A) At a minimum, a Certified Plan-Based Enrollment Entity and its Certified Plan-Based Enrollers shall disclose to the consumer when contact is initiated that:

(i) The Certified Plan-Based Enroller is employed or contracted by a QHP Issuer and is able to provide plan details and enrollment assistance only for QHPs offered by the Certified Plan-Based Enrollment Entity represented by the PBE.

(B) After a consumer is determined eligible for coverage through the Exchange, the PBE shall:

(i) Disclose to the consumer that the Individual Exchange offers other QHPs sold by other QHP Issuers,— and stand-alone dental plans as defined in Section 6410 of Article 2 of this chapter, that may meet the consumer's needs;

(ii) Provide information to consumers about the availability of the full range of QHP options and Insurance Affordability Programs for which they are eligible. It must be apparent to consumers that if determined eligible they would be free to choose among all QHPs offered in the Individual Exchange through the Service Center of the Exchange;

(iii) ~~Clearly distinguish between QHPs for which the consumer is eligible and other non-QHPs that the PBEE may offer outside of the Individual Exchange, and indicate that APTC and CSRs apply only to QHPs offered through the Exchange~~Provide information required in Section 6710(a)(9); and

(iv) Inform the consumer that there may be an insurance agent of record in connection with any existing health insurance policy the consumer may currently have, and if the consumer acknowledges having an agent of record, offer to attach the agent to the consumer's enrollment in a QHP, unless:

1. The consumer is determined eligible for coverage through the Exchange, and the insurance agent of record is not authorized to sell QHPs in the Individual Exchange; or

2. The consumer would prefer not to seek further assistance from the consumer's insurance agent of record.

(5) On the consumer's request following the Certified Plan-Based Enroller's disclosures in either subdivision (4)(A) or (4)(B):

(A) Transfer the consumer for further enrollment assistance to the Service Center of the Exchange.

(6) Document that the Certified Plan-Based Enroller has provided the required disclosures and the consumer has acknowledged that the consumer:

(A) Understands the disclosures;

(B) Does not want to be referred to the Service Center of the Exchange; and

(C) Wants to receive information and enrollment assistance solely from the Certified Plan-Based Enroller.

(b) A record of the documentation required under subdivision (a)(6) of this Section shall be:

(1) Retained by the Certified Plan-Based Enrollment Entity for at least 3 years;

(2) Subject to the Exchange's review of program conduct at the discretion of the Exchange; and

(3) Provided to the Exchange at its request~~on a quarterly basis~~.

(c) Where enrollment services pursuant to this article are provided to consumers over the phone, the Certified Plan-Based Enrollment Entity shall keep copies of such conversations and shall make those records available for review by the Exchange on a quarterly basis.

(d) With regards to any QHP or other products offered in the Individual Exchange by QHP issuers other than the Certified Plan-Based Enrollment Entity with which the Certified-Plan Based Enroller has an exclusive appointment, a PBE:

(1) May not provide enrollment services related to QHPs or other products not offered by the entity represented by the PBE; and

(2) Shall at any time transfer any requests for information or enrollment services related to QHPs or stand-alone dental plans in the Individual Exchange not offered by the PBEE represented by the PBE to the Service Center of the Exchange and provide information on how to access the Exchange Web Site.

(e) With regards to any other products offered by the Certified Plan-Based Enrollment Entity outside the Individual Exchange with which the Certified Plan-Based Enroller has an exclusive appointment, a PBE shall cease to provide enrollment services in a manner deemed to be through the Exchange in order to provide any information or services related to other products offered by the entity.

Note: Authority cited: Sections 100503 and 100504, Government Code. Reference: Section 100503, Government Code; and 45 Code of Federal Regulations, Sections 155.415 and 156.1230.

§ 6714 – Compensation

(a) Certified Plan-Based Enrollment Entities will not receive compensation from the Exchange in exchange for application and enrollment assistance.

(b) Certified Plan-Based Enrollment Entities may compensate affiliated individual Certified Plan-Based Enrollers for enrollment in their compensation agreement with their Certified Plan-Based Enrollers.

Note: Authority cited: Sections 100503 and 100504, Government Code. Reference: Section 100503, Government Code; and 45 Code of Federal Regulations, Sections 155.415 and 156.1230.

§ 6716 – Suspension and Revocation

(a) Each of the following shall be justification for the Exchange to suspend or revoke the certification of any Certified Plan-Based Enrollment Entity or Certified Plan-Based Enroller:
   (1) Failure to comply with all applicable federal and state laws;
   (2) If the Certified Plan-Based Enroller is not a Captive Agent, a potentially disqualifying criminal record under Section 6708 of Article 4 of this chapter; and
   (3) If the Certified Plan-Based Enroller is a Captive Agent, failure to maintain a license in good standing with the California Department of Insurance.

(b) Appeals.
   (1) Individuals or entities may appeal a determination made pursuant to subdivision (a)(1) of this Section through the process described in Section 6718 of this Article.
   (2) Individuals or entities may appeal a determination made pursuant to subdivision (a)(2) of this Section through the process described in Section 6708, subdivision (c).
   (3) Until a final determination or decision is made regarding an individual or entity's appeal, the appellant shall be disqualified from performing any functions under this Article.

Note: Authority cited: Sections 100503 and 100504, Government Code. Reference: 100503, Government Code; and 45 Code of Federal Regulations, Sections 155.415 and 156.1230.

§ 6718 – Appeal Process

(a) Other than a determination made pursuant to Section 6708, Certified Plan-Based Enroller Fingerprinting and Criminal Record Checks, a decision that an individual or entity is not eligible or qualified to participate or continue to participate in a program under this Article may be appealed to the Exchange in accordance with the requirements of this Section.

(b) The Exchange shall allow an applicant to request an appeal within 60 calendar days of the date of the notice of eligibility determination.

(c) The first phase of the Appeal Process shall include an informal review by the Exchange. The Exchange shall consider the information used to determine the appellant's eligibility as well as any additional relevant evidence presented during the course of the appeal. The Exchange shall make an informal resolution decision within 45 calendar days from the receipt of the appeal. The Exchange shall notify the appellant in writing of the decision.

(d) If the appellant is satisfied with the outcome of the informal resolution decision, the appeal may be withdrawn. If the appellant is dissatisfied with the outcome of the informal resolution, the appellant may escalate the appeal to the second phase of the Appeal Process by notifying the Exchange in writing and providing additional evidence within 45 calendar days

of the date of the decision in subdivision (c). During the second phase, an independent unit within the Exchange that had no involvement in the original eligibility or qualification determination or informal resolution decision shall review the eligibility or qualification of the appellant *de novo*. The Exchange shall consider all relevant evidence presented during the course of the appeal and notify the appellant in writing of the final decision within 60 calendar days from the receipt of the appeal.

Note: Authority cited: Sections 100503 and 100504, Government Code. Reference: Section 100503, Government Code; and 45 Code of Federal Regulations, Sections 155.415 and 156.1230.

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: _____ and the 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 that may result from this regulation and who will benefit: _____

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

Explain: _____

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

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: _____

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.) Cal/EPA boards, offices, and departments are subject to the following additional requirements per Health and Safety Code section 57005.

1. Will the estimated costs of this regulation to California business enterprises exceed $10 million ? ☐ Yes ☐ No (If No, skip the rest of this section.)

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

Alternative 1: _____

Alternative 2: _____

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

Regulation:	$ _____	Cost-effectiveness ratio: $ _____
Alternative 1:	$ _____	Cost-effectiveness ratio: $ _____
Alternative 2:	$ _____	Cost-effectiveness ratio: $ _____

FISCAL IMPACT STATEMENT

A. FISCAL EFFECT ON LOCAL GOVERNMENT (Indicate appropriate boxes1 through 6 and attach calculations and assumptions of fiscal impact for the current year and two subsequent Fiscal Years.)

☐ 1. Additional expenditures of approximately $ _____ in the current State Fiscal Year which are reimbursable by the State pursuant to Section 6 of Article XIII B of the California Constitution and Sections 17500 et seq. of the Government Code. Funding for this reimbursement:

☐ a. is provided in _____, Budget Act of _____ or Chapter _____, Statutes of _____

☐ b. will be requested in the _____ (FISCAL YEAR) Governor's Budget for appropriation in Budget Act of _____

☐ 2. Additional expenditures of approximately $ _____ in the current State Fiscal Year which are not reimbursable by the State pursuant to Section 6 of Article XIII B of the California Constitution and Sections 17500 et seq. of the Government Code because this regulation:

☐ a. implements the Federal mandate contained in _____

☐ b. implements the court mandate set forth by the _____

court in the case of _____ vs. _____

☐ c. implements a mandate of the people of this State expressed in their approval of Proposition No. _____ at the _____ (DATE) election;

☐ d. is issued only in response to a specific request from the _____

_____, which is/are the only local entity(s) affected;

☐ e. will be fully financed from the _____ (FEES, REVENUE, ETC.) 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 such unit;

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

☐ 3. Savings of approximately $ _____ annually.

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

ECONOMIC AND FISCAL IMPACT STATEMENT cont. (STD. 399, Rev. 12/2008)

☑ 5. No fiscal impact exists because this regulation does not affect any local entity or program.

☐ 6. Other.

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 of approximately $ _____ in the current State Fiscal Year. It is anticipated that State agencies will:

☐ a. be able to absorb these additional costs within their existing budgets and resources.

☐ b. request an increase in the currently authorized budget level for the _____ fiscal year.

☐ 2. Savings of approximately $ _____ in the current State Fiscal Year.

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

☑ 4. Other. Estimated costs of $81,000 in FY 2014-15, and $162,000 in FY 2015-16. These costs will be funded by the California Heath Trust Fund -3175. See Attachment A. There is no impact on the General Fund.

C. FISCAL EFFECT ON FEDERAL FUNDING OF STATE PROGRAMS (Indicate appropriate boxes1 through 4 and attach calculations and assumptions of fiscal impact for the current year and two subsequent Fiscal Years.)

☐ 1. Additional expenditures of approximately $ _____ in the current State Fiscal Year.

☐ 2. Savings of of approximately $ _____ in the current State Fiscal Year.

☐ 3. No fiscal impact exists because this regulation does not affect any federally funded State agency or program.

☑ 4. Other. Estimated costs of $439,000 in FY 2013-14, and $81,000 in FY 2014-15. These costs will be funded by Federal Grant. See Attachment B. There is no impact on the General Fund.

FISCAL OFFICER SIGNATURE		DATE 9-11-2013
AGENCY SECRETARY [1] APPROVAL/CONCURRENCE		DATE
DEPARTMENT OF FINANCE [2] APPROVAL/CONCURRENCE	PROGRAM BUDGET MANAGER	DATE

1. *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 department not under an Agency Secretary must have the form signed by the highest ranking official in the organization.*

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

Plan Management Unit - Total Projected State Costs

Expenditure Category	FY 2013/14	FY 2014/15 *	FY 2015/16	Total
Salaries 1/	-	142,523	285,046	427,568
Benefits 2/	-	48,458	96,916	145,373
OE&E	-	14,468	28,936	43,404
Total	-	205,449	410,897	616,346

1/ - The Plan Mgmt unit consists of 1 SSM I and 4 AGPAs, and costed out at mid-range. Unit is projected to start taking over the responsibilities in Jan 2014. Used a position costing master to calculate the Salaries, and then reduced the total by 5% to account for Salary Savings. (=$300,048*0.95; FY 2015/16)

2/ - Benefits was calculated at approximately 34% of Salaries.

** The amount reflected for FY 2014/15 shows 6 months of projected costs (Jan 2015 - June 2015), which represents the state funding for that fiscal year. The begining of FY 2014/15 (July 2014 - Dec 2014) is supported by federal funds.*

Projected State Costs Associated for Plan-Based Enrollers

Expenditure Category	FY 2013/14	FY 2014/15	FY 2015/16	Total
Plan Mgmt Unit Costs	-	205,449	410,897	616,346
PBE Workload @ 15%	-	30,817	61,635	92,452
Plan Mgmt Unit Contractual a/	-	50,000	100,000	150,000
Total		$ 80,817	$ 161,635	$ 242,452

Assumption: 15% of the Plan Mgmt unit's time will be dedicated to supporting Plan-Based Enrollers.

a/ The Plan Mgmt Unit Contractual is for future contracts that may include training PBE's and for Monitoring & Oversight of PBEs.

Plan Managment Unit - Total Projected Federal Costs

Expenditure Category	FY 2013/14 *	FY 2014/15 **	FY 2015/16	Total
Salaries [1/]	142,523	142,523	-	285,046
Benefits [2/]	48,458	48,458	-	96,916
OE&E	23,990	14,468	-	38,458
Total	**214,971**	**205,449**	-	**420,419**

1/ - The Plan Mgmt unit consists of 1 SSM I and 4 AGPAs, and costed out at mid-range. Unit is projected to start taking over the responsibilities in Jan 2014.
Used a position costing master to calculate the Salaries, and then reduced the total by 5% to account for Salary Savings. (=$150,024*0.95)

2/ - Benefits was calculated at 34% of Salaries.

** The amount reflected for FY 2013/14 shows 6 months of projected costs (Jan 2014 - June 2014), as that is when the Plan Mgmt unit is projected to take over the duties.*

*** The amount reflected for FY 2014/15 shows 6 months of projected costs (July 2014 - Dec 2014), which represents the duration of federal funding.*
The remainder of FY 2014/15 (Jan 2015 - June 2015) will be supported by Fund 3175 - California Health Trust Fund, and not federal funds.

Projected Federal Costs Associated for Plan-Based Enrollers

Expenditure Category	FY 2013/14	FY 2014/15	FY 2015/16	Total
Plan Mgmt Unit Costs	214,971	205,449	-	**420,419**
PBE Workload @ 15%	**32,246**	**30,817**	-	**63,063**
Consultants (Tori Group) [a/]	116,400	-	-	116,400
Training (Maximus) [b/]	190,575	-	-	190,575
Monitoring & Oversight [c/]	100,000	50,000	-	150,000
Plan Mgmt Unit Contractual				
Sub-Total Contractual	**406,975**	**50,000**	-	**456,975**
Total	**$ 439,221**	**$ 80,817**	**$ -**	**$ 520,038**

Assumption: 15% of the Plan Mgmt unit's time will be dedicated to supporting Plan-Based Enrollers.

a/ Through the Tori Group contract Covered CA is using one Sr Associate at a rate of $160/hr and one Analyst at $50/hr. Both work an average of 200 hr/month and will be working through December 2013 (3 months). The Sr Associate will only be working for 90% while the Analyst will be Full Time.

b/ The Maximus, Inc. contract will provide "Train-the-Trainer" training and create an evaluation standard in FY 2013/14 and then Covered CA will take over those duties.

c/ The Monitoring & Oversight contract will be responsible for the monitoring and oversight of PBEs certification until the Plan Mgmt unit inherits the responsibility.
The $100,000 amount was determined using the "Field Monitoring of IPA Program" costs within an admin contract, and prorated based on PBE volume to In-Person Assisters (IPA) volume.

CALIFORNIA HEALTH BENEFIT EXCHANGE
BOARD RESOLUTION NO. 2014-22

In the matter of the readoption of the Certified Plan-Based Enrollment Program Regulations.

The Board hereby resolves that, in accordance with Sections 100500(i), 100503(s), and 100504(a)(6) of the Government Code, the Executive Director or his authorized designee be authorized to finalize and submit to the Office of Administrative Law an emergency regulations package for the readoption of the Certified Plan-Based Enrollment Program Regulations.

* * * * * * * * * * * * *

CERTIFICATION

I, Peter V. Lee, Executive Director of the California Health Benefit Exchange, do hereby certify that the foregoing action was duly passed and adopted by the California Health Benefit Exchange Board at an official meeting thereof on March 20, 2014.

Peter V. Lee
Executive Director
California Health Benefit Exchange

COVERED CALIFORNIA

March 21, 2014

STATEMENT OF CONFIRMATION OF MAILING OF FIVE-DAY EMERGENCY NOTICE
(Title 1, CCR section 50(a)(5)(A))

The California Health Benefit Exchange sent notice of the proposed emergency action to every person who has filed a request for notice of regulatory action at least five working days before submitting the emergency regulation to the Office of Administrative law in accordance with the requirements of Government Code section 11346.1, subdivision (a)(2).

BOARD MEMBERS Diana S. Dooley, Chair Kimberly Belshé Paul Fearer Susan Kennedy Robert Ross, MD **EXEC DIRECTOR** Peter V. Lee

CALIFORNIA HEALTH BENEFIT EXCHANGE
BOARD RESOLUTION NO. 2014-39

In the matter of the readoption of the Certified Plan-Based Enrollment Program Regulations.

The Board hereby resolves that, in accordance with Sections 100500(i), 100503(s), and 100504(a)(6) of the Government Code, the Executive Director or his authorized designee be authorized to finalize and submit to the Office of Administrative Law an emergency regulations package for the readoption of the Certified Plan-Based Enrollment Program Regulations.

* * * * * * * * * * * * *

CERTIFICATION

I, Peter V. Lee, Executive Director of the California Health Benefit Exchange, do hereby certify that the foregoing action was duly passed and adopted by the California Health Benefit Exchange Board at an official meeting thereof on May 22, 2014.

Peter V. Lee
Executive Director
California Health Benefit Exchange