August 19, 2021

ADVANCE NOTICE OF ADOPTION OF EMERGENCY REGULATIONS

This notice is sent in accordance with Government Code Section 11346.1(a)(2), which requires that State of California agencies give a five working day advance notice of intent to file emergency regulations with the Office of Administrative Law (OAL). The California Health Benefit Exchange ("Exchange") intends to file a request for adoption of the Emergency Rulemaking package with OAL that amends the regulations for applications and eligibility and enrollment in the Small Business Health Options Program (SHOP) Exchange. As required by subdivisions (a)(2) and (b)(2) of Government Code Section 11346.1, this notice appends the following: (1) the specific language of the proposed regulation to amend Sections 6520, 6522, 6524, 6526, 6528, 6530, 6532, 6534, 6538, 6542, and 6550 of Chapter 12, Title 10 of California Code of Regulations; and (2) the Finding of Emergency, including specific facts demonstrating the need for immediate action, the authority and reference citations, the informative digest and policy statement overview, attached reports, and required determinations.

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

Comments should be sent simultaneously to:

Courtney Leadham
Regulations Coordinator
California Health Benefit Exchange
1601 Exposition Blvd.
Sacramento, CA 95815

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

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

Upon filing, OAL will have ten (10) calendar days within which to review and make a decision on the proposed emergency rule. If approved, OAL will file the regulation with

the Secretary of State, and the emergency regulation will become effective on the day of filing. These regulations will remain in effect until September 2026 or until revised by the Board pursuant to Government Code Section 100504(a)(6). Please note that this advance notice and comment period is not intended to replace the public's ability to comment during the subsequent certification period of the permanent rulemaking process. The Exchange will hold a public hearing and 45-day comment period after it has published notice to make this regulation permanent.

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

https://hbex.coveredca.com/regulations/.

If you have any questions concerning this advance notice, please contact Courtney Leadham at (916) 281-2562.

FINDING OF EMERGENCY

The Director of the California Health Benefit Exchange ("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.

The Exchange seeks an emergency adoption to allow for the necessary and immediate incorporation of state requirements. The Exchange acts in accordance with Government Code § 100504, which authorizes the Exchange to adopt rules and regulations to be in effect for five years. Specifically, the Exchange is proposing to modify regulations related to the establishment of the Small Business Health Options Program (SHOP) as required under Government Code § 100502(m). These will update requirements related to eligibility and enrollment in the Exchange's SHOP and clean up language throughout for improved clarity and understanding.

DEEMED EMERGENCY

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

> The Exchange may "adopt rules and regulations, as necessary. Until January 1, 2025, any necessary rules and regulations, except those implementing Section 1043, may be adopted as emergency regulations in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2). The adoption of emergency regulations pursuant to this section shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare. Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 including subdivisions (e) and (h) of Section 11346.1, any emergency regulation adopted pursuant to this section shall be repealed by operation of law unless the adoption, amendment, or repeal of the regulation is promulgated by the board pursuant to Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code within five years of the initial adoption of the emergency regulation. A rule or regulation adopted pursuant to this section shall be discussed by the board during at least one properly noticed board meeting prior to the board meeting at which the board adopts the rule or regulation. Notwithstanding subdivision (h) of Section 11346.1, until January 1, 2030, the Office of Administrative Law may approve more than two adoptions of an emergency regulation adopted pursuant to this section. The amendments made to this paragraph by the act that added this subparagraph also shall apply to any regulation adopted pursuant to this section prior to January 1, 2022."

CHANGES MADE TO THE REGULATIONS

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

Changes Made to Article 6:

- Section 6520:
    - Revised subdivision (a) to align with 10 C.C.R. § 6410 of these regulations which defines "QHP Issuer" as "the licensed health care service plan or insurer who has been selected and certified by the Exchange to be offered to Qualified Individuals and Qualified Employers purchasing health insurance coverage through the Exchange." This term is added to avoid confusion with Qualified Health Plans (QHP), which QHP Issuers offer on the Exchange's SHOP.
    - Revised subdivision (a)(1) to remove the billing address from the required information that the employer must provide in the application to participate in the Exchange's SHOP. Because most small employers do not have a billing address that is separate from their mailing address, this will streamline the application without impacting the acquisition of necessary information from employers.
    - Revised subdivision (a)(4) to clarify that qualified employers may also offer dependent dental coverage to employees' spouses, domestic partners, or children.
    - Added dental coverage to subdivisions (a)(5) and (a)(7) to clarify that the employer's offering may include dental coverage.
    - Revised subdivision (a)(12) to clarify that the employer's offering may include dental coverage and to require the employer to select a reference plan in the application.
    - Revised subdivision (a)(12)(A) to clarify that the employer must indicate the rate of contribution to employees' health plan premiums. This clarification distinguishes this contribution from the dental contribution rate that is added in subdivision (a)(12)(E).
    - Revised language in subdivision (a)(12)(B) to clarify that the premium contribution rate applies to health plan premiums related to dependent health coverage.
    - Revised subdivision (a)(12)(C) to add three contiguous and four contiguous tiers to the employer's choice of health coverage offerings.
    - Added subdivision (a)(12)(E) to specify that if employers choose to offer dental coverage to their employees, the employer must also select a dental reference plan, indicate the contribution rate for the dental plan premium, and the contribution rate for dependent dental coverage. This subsection will be effective August 1, 2021.
    - Added language to subdivision (b)(6) to clarify that information provided by the employer for dental coverage will also be kept private as required by federal and state law.

- Revised subdivision (b)(10) to require employers to pay the first month's total premium payment to the Exchange's SHOP before the employer is approved for health or dental coverage. Prior to this change, the Exchange's enrollment and financial management system for SHOP could not account for credits due to employers for employee terminations. Employers were able to adjust their invoice payments up to 85% of the amount due, to account for this situation. The Exchange's new enrollment and financial management system for SHOP is updated to accept real time, accurate invoice payments. This regulation amendment aligns with the system's new capability and makes employer payments easier, more efficient, and more accurate.
- Revised subdivision (b)(11) to require employers to pay the total premium payment by the due date to maintain eligibility for coverage in the Exchange's SHOP. Prior to this change, the Exchange's enrollment and financial management system for SHOP could not account for credits due to employers for employee terminations. Employers were able to adjust their invoice payments up to 85% of the amount due, to account for this situation. The Exchange's new enrollment and financial management system for SHOP is updated to accept real time, accurate invoice payments. This regulation amendment aligns with the system's new capability and makes employer payments easier, more efficient, and more accurate.
- Added language to subdivision (b)(12) to clarify that employers must inform its eligible employees of the availability of dental coverage. This subdivision previously only required employers to inform employees of available health coverage.
- Revised subdivision (b)(13) to clarify that employers may change coverage plans with the same QHP issuer within the first 30 days of the effective coverage date.
- Revised subdivision (b)(14) to clarify that dental coverage is also subject to terms and conditions of the QHP issuer contract, policy, or state law. Previously, this subdivision's language only included health coverage.
- Revised subdivision (b)(15) to clarify that information is transmitted to the QHP issuers who manage the QHP.
- Revised subdivision (b)(16) to clarify language and distinguish QDPs from QHPs because 10 C.C.R. § 6410 of these regulations includes QDPs in the definition of QHPs. This change makes clear that employees may enroll in QDPs without enrolling in a health plan.
- Added language to subdivision (d) to clarify when employees are required to submit information to the Exchange's SHOP. This revision requires employees to submit information five days prior to the requested effective date.
- Revised subdivision (d)(2) to clarify that employees may submit their social security number or a taxpayer identification number in their applications. The language previously only included taxpayer identification number which created confusion for employees who may not know or have easy

access to their taxpayer identification numbers. This change will make it easier and faster for employees to complete the application.
    - Revised subdivision (d)(3)(A) to clarify that this subdivision refers to the employer's health plan.
    - Added language to subdivision (d)(3)(B) to add clarity to the sentence.
    - Revised subdivision (d)(6) to clarify the reference to health plans and dental plans. Previously, this subdivision referred to "QHP and dental plan," which created redundancy because, in these regulations, 10 C.C.R. § 6410 includes dental plans in the definition of QHP.
    - Revised subdivision (e)(1) to clarify that the arbitration may be required by a QHP Issuer as the entity managing the QHP.
    - Revised subdivision (g) to clarify that plan selection includes health plans and dental plans. Additionally, the revision clarifies that the SHOP will share necessary information with the QHP Issuer rather than the QHP. Language was added to clarify that eligibility determinations and enrollment apply to dental coverage as well as health coverage. A typo was fixed by adding a period at the end of the sentence.
- Section 6522:
    - Revised subdivision (a)(4)(A) to allow QHP issuers to agree to an earlier date for the SHOP to provide notice of change to the minimum participation rate that employers are required to meet to participate in the SHOP. This was previously a fixed date of 210 days prior to the effective date of the proposed change. Additionally, language was cleaned up for clarity and consistency with other sections of the regulations.
    - Revised subdivision (a)(4)(A)(1) to align terminology with other sections in of these regulations.
    - Revised subdivision (a)(4)(B) to clarify what type of coverage a qualified employee may waive when calculating the employer's participation rate. This revision considers any health coverage that meets the definition of minimum essential coverage under the Health and Safety Code § 1345.5 as excluded in the calculation towards minimum participation. This change prevents the employer and their employees from experiencing barriers to participation in SHOP when employees elect to maintain other minimum essential coverage.
    - Revised subdivision (a)(5)(A) to align terminology with other subdivisions of these regulations.
    - Revised subdivisions (h), (h)(2), (h)(2), and (h)(3) to align terminology with other subdivisions of these regulations.
- Section 6524:
    - Revised subdivision (a) to provide clarity that employers may offer dental coverage as well as health coverage to their employees.
    - Added language to subdivision (b)(1) to clarify that employers may also offer dental coverage to employees.
- Section 6526:
    - Revised subdivision (a) to clarify that employers may elect to offer dental coverage to their eligible employees.

    - Revised subdivision (b) to clarify that dental coverage is included through SHOP and referencing and maintaining consistency with Section 6522(h)(3) of these regulations related to employer group contribution requirements for dental coverage.
    - Revised subdivision (d) to include dental coverage in the employer's offerings to employees.
- Section 6528:
    - Revised subdivision (f) to clarify that QHPs are offered by QHP issuers to align with definitions set forth in these regulations in 10 C.C.R. § 6410.
    - Revised subdivisions (f)(1) and (f)(2) to align terminology with definitions set forth by 10 C.C.R. § 6410, specifically by replacing "plan" with "QHP". There was also a typo corrected in subdivision (f)(2).
    - Revised subdivisions (h) through (i) to clarify language to align with definitions set forth in 10 C.C.R. § 6410. The revisions replace "QHP" with "health plan" when the reference is meant to exclude dental plans, which are included in the definition of a QHP.
- Section 6530:
    - Removed "and QDPs" from subdivision (a) to avoid redundancy. This subdivision refers to QHPs, which include QDPs.
    - Revised subdivision (b)(1)(A)(1) to clarify that this subdivision is specific to health coverage and excludes dental coverage. This subdivision refers to loss of Minimum Essential Coverage, which refers to health coverage, not stand-alone dental coverage. Specifying the type of coverage to which this subdivision applies avoids ambiguity and confusion.
    - Revised subdivision (b)(1)(C) to clarify that the loss of coverage referred to in this subdivision is Medi-Cal coverage.
    - Revised subdivision (b)(5) to include a dental coverage issuer's violation of a material provision of its contract as a trigger for a special enrollment period to enroll or change dental coverage per subdivision (b).
    - Revised subdivisions (b)(10)(A) through (b)(16)(B) aligns terminology with other subdivisions in these regulations and definitions set forth by 10 C.C.R. § 6410. This includes replacing removing "insurance" from the phrase "health insurance coverage," removing "benefit" from "health benefit plan(s)," and inserting "QHP" for "health insurance coverage" or "coverage." This revision also clarifies when coverage is specific to health coverage and does not apply to dental coverage by specifying "health coverage."
    - Removed "coverage for the qualified employee or his or her eligible dependents" from subdivision (c)(2) for clarity and simplicity.
    - Revised subdivision (d) by adding dental coverage as a possible offering to employees' dependents from employers.
    - Revised subdivisions (e)(1) through (g)(3) to align terminology with other subdivisions within these regulations and the definitions put forth by 10 C.C.R. § 6410. This includes replacing "health insurance coverage" with "health coverage," specifying when "plans" are specific to health plans, replacing benefits with "health coverage," correcting "QHP" to "QHP

Issuer" when appropriate, replacing "dental insurance coverage" with "dental coverage," specifying when "coverage" are specific to dental coverage, and correcting "QDP" with "QDP Issuer" when appropriate.

- Section 6532:
  - Revised subdivision (a)(1) to require employers to pay their first premium payment in full by the due date to effectuate coverage. This is consistent with the revision in Section 6520(b)(10) and (11).
  - Revised subdivision (b) to clarify that effective coverage includes dental coverage.
  - Revised subdivision (b)(2) to require employers to pay the full monthly premium balance by the due date. This is consistent with the revision in 6520(b)(11).
  - Revised subdivision (c) to align terminology and maintain consistency with other subdivisions within these regulations and the definitions put forth by 10 C.C.R. § 6410. This revision replaces "health coverage and dental benefits" with "health coverage and dental coverage."
  - Added language to subdivision (e) to clarify that any payment to the Exchange that is returned for insufficient funds will be considered non-payment for the premium invoice and will trigger the 30-day Grace period for non-payment. Removed the word "unpaid" for clarity and to avoid redundancy.
- Section 6534:
  - Revised subdivision (a) for clarification. Because 10 C.C.R. § 6410 defines QHPs to include QDPs, the phrase "or QDP" was removed to avoid redundancy and confusion.
- Section 6538:
  - Revised subdivision (a)(1) to provide clarity that the SHOP must ensure that it is the QHP Issuer that terminates coverage of employees and dependents after the employer terminates coverage of the group health plan. "Issuer" was added after "QHP."
  - Revised subdivisions (c), (c)(3), (d), and (g)(3) to correct typos related to word capitalization.
  - Revised subdivision (c)(4) for consistency of terminology within the subdivision. Replaced "plan" with "QHP."
  - Revised subdivisions (e)(1)(A), (e)(1)(B), and (e)(2)(C) to update terminology to maintain consistency with other subdivisions and definition set forth in 10 C.C.R. § 6410. Added "Issuer" after "QHP" to make it clear that these subdivisions refer to a QHP Issuer rather than a QHP.
  - Revised subdivision (e)(6) to update terminology to maintain consistency with other subdivisions and definitions set forth in 10 C.C.R. § 6410. Replaced "issuer" with "QHP Issuer."
- Section 6542:
  - Revised subdivision (b)(2) to correct a typo.
- Section 6550:
  - Revised subdivision (a) to clarify that the appeal process also includes situations in which there is an immediate need for dental coverage.

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

The Exchange intends to make these proposed regulations within the five years Government Code Section 100504(a)(6) provides for.

AUTHORITY AND REFERENCE

Authority: Section 100504, Government Code.

Reference: Sections 100502, 100503, 100504, and 100506 Government Code; 45 CFR Sections 147.104, 155.260, 155.420, 155.705, 155.710, 155.715, 155.720, 155.725, 155.730, 155.735, 155.740, 155.1080, 156.140, and 156.285; 26 CFR Sections 1.36B-2, 1.5000A-2, and 54.9801-2.

DOCUMENTS RELIED ON

None.

INFORMATIVE DIGEST/POLICY STATEMENT OVERVIEW

Documents incorporated by reference:

None.

Summary of Existing Laws

Under the federal Patient Protection and Affordable Care Act (PPACA), each state is required, by January 1, 2014, to establish an American Health Benefit Exchange that makes available qualified health plans to qualified individuals and small employers. Existing state law, the California Patient Protection and Affordable Care Act, established the California Health Benefit Exchange within state government. (Gov. Code, § 100500 et seq.) The Exchange is required to establish the Small Business Health Options Program (SHOP), separate from the activities of the individual market, to assist qualified small employers in facilitating the enrollment of their employees in qualified health plans offered through the Exchange in the small employer market. (Gov. Code § 100502(m).

The proposed regulations will amend the regulations regarding the Exchange's policies and procedures in the SHOP to update employer and employee application requirements, eligibility and enrollment requirements and processes, and requirements for premium payments. The proposed regulations will expand available employer and employee options for metal tiers and associated health plans. Additionally, the proposed regulations will provide employers and employees clear standards when submitting applications to the Exchange. They also clarify the employer eligibility requirements

regarding the employee minimum participation rate. Finally, these proposed regulations will benefit employers and employees by making the administrative process related to premium payments clearer and more efficient.

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

JUSTIFICATION FOR DUPLICATION

These proposed regulations do not duplicate existing law.

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

None.

LOCAL MANDATE

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

FISCAL IMPACT ESTIMATES

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

COSTS OR SAVINGS TO STATE AGENCIES AND TO FEDERAL FUNDING

There will be no costs or savings in federal funding to the state. The proposal results in additional costs to the Exchange, which are minor and absorbable with existing budgetary resources. The proposal does not result in any costs or savings to any other state agency.