State of California
Office of Administrative Law

In re:
California Health Benefit Exchange

Regulatory Action:

Title 10, California Code of Regulations

Adopt sections: **6520, 6522, 6524, 6526, 6528, 6530, 6532, 6534, 6536, 6538**
Amend sections:
Repeal sections:

NOTICE OF APPROVAL OF CERTIFICATE OF COMPLIANCE

Government Code Sections 11349.1 and 11349.6(d)

OAL Matter Number: 2018-0803-03

OAL Matter Type: Certificate of Compliance (C)

The California Health Benefit Exchange (Exchange) submitted this certificate of compliance action to make permanent emergency regulations providing policies and procedures for the application for coverage, employer and employee eligibility determination and redetermination, enrollment in qualified health plans, and termination of coverage through the Exchange's Small Business Health Options Program (SHOP).

OAL approves this regulatory action pursuant to section 11349.6(d) of the Government Code.

Date: September 17, 2018

Richard L. Smith
Senior Attorney

For: Debra M. Cornez
Director

Original: Peter Lee, Executive Director
Copy: Faviola Ramirez-Adams

CERT

STATE OF CALIFORNIA—OFFICE OF ADMINISTRATIVE LAW

NOTICE PUBLICATION/REGULATIONS SUBMISSION

(See Instructions on reverse)

For use by Secretary of State only

STD. 400 (REV. 01-2013)

OAL FILE NUMBERS	NOTICE FILE NUMBER	REGULATORY ACTION NUMBER	EMERGENCY NUMBER
	Z-2018 0320-07	2018-0803-03C	

ENDORSED - FILED
in the office of the Secretary of State
of the State of California
SEP 17 2018
1:55PM

For use by Office of Administrative Law (OAL) only

RECEIVED DATE	PUBLICATION DATE	2018 AUG -3 P 4:40
MAR 20 '18	MAR 30 '18	OFFICE OF ADMINISTRATIVE LAW
Office of Administrative Law		
NOTICE		REGULATIONS

AGENCY WITH RULEMAKING AUTHORITY: California Health Benefit Exchange

AGENCY FILE NUMBER (If any):

A. PUBLICATION OF NOTICE (Complete for publication in Notice Register)

1. SUBJECT OF NOTICE: SHOP Eligibility and Enrollment Process
TITLE(S): 10
FIRST SECTION AFFECTED: 6520
2. REQUESTED PUBLICATION DATE: March 30, 2018

3. NOTICE TYPE: [X] Notice re Proposed Regulatory Action [ ] Other
4. AGENCY CONTACT PERSON: Faviola Ramirez-Adams
TELEPHONE NUMBER: 916-228-8668
FAX NUMBER (Optional):

OAL USE ONLY — ACTION ON PROPOSED NOTICE: [ ] Approved as Submitted [ ] Approved as Modified [ ] Disapproved/ Withdrawn
NOTICE REGISTER NUMBER: 2018 13-Z
PUBLICATION DATE: 3-30-2018

B. SUBMISSION OF REGULATIONS (Complete when submitting regulations)

1a. SUBJECT OF REGULATION(S): Application, Eligibility, and Enrollment in the SHOP Exchange

1b. ALL PREVIOUS RELATED OAL REGULATORY ACTION NUMBER(S): See attached

2. SPECIFY CALIFORNIA CODE OF REGULATIONS TITLE(S) AND SECTION(S) (Including title 26, if toxics related)

SECTION(S) AFFECTED (List all section number(s) individually. Attach additional sheet if needed.)

ADOPT: 6520, 6522, 6524, 6526, 6528, 6530, 6532, 6534, 6536, 6538
AMEND:
REPEAL:
TITLE(S): 10

3. TYPE OF FILING

- [ ] Regular Rulemaking (Gov. Code §11346)
- [ ] Resubmittal of disapproved or withdrawn nonemergency filing (Gov. Code §§11349.3, 11349.4)
- [ ] Emergency (Gov. Code, §11346.1(b))
- [x] Certificate of Compliance: The agency officer named below certifies that this agency complied with the provisions of Gov. Code §§11346.2-11347.3 either before the emergency regulation was adopted or within the time period required by statute.
- [ ] Resubmittal of disapproved or withdrawn emergency filing (Gov. Code, §11346.1)
- [ ] Emergency Readopt (Gov. Code, §11346.1(h))
- [ ] File & Print
- [ ] Other (Specify)
- [ ] Changes Without Regulatory Effect (Cal. Code Regs., title 1, §100)
- [ ] Print Only

4. ALL BEGINNING AND ENDING DATES OF AVAILABILITY OF MODIFIED REGULATIONS AND/OR MATERIAL ADDED TO THE RULEMAKING FILE (Cal. Code Regs. title 1, §44 and Gov. Code §11347.1)
5/25/2018 - 6/9/2018 per agency request

5. EFFECTIVE DATE OF CHANGES (Gov. Code, §§ 11343.4, 11346.1(d); Cal. Code Regs. title 1, §100)
- [ ] Effective January 1, April 1, July 1, or October 1 (Gov. Code §11343.4(a))
- [x] Effective on filing with Secretary of State
- [ ] §100 Changes Without Regulatory Effect
- [ ] Effective other (Specify)

6. CHECK IF THESE REGULATIONS REQUIRE NOTICE TO, OR REVIEW, CONSULTATION, APPROVAL OR CONCURRENCE BY, ANOTHER AGENCY OR ENTITY
- [x] Department of Finance (Form STD. 399) (SAM §6660)
- [ ] Fair Political Practices Commission
- [ ] State Fire Marshal
- [ ] Other (Specify)

7. CONTACT PERSON: Faviola Ramirez-Adams
TELEPHONE NUMBER: 916-228-8668
FAX NUMBER (Optional):
E-MAIL ADDRESS (Optional): faviola.ramirez-adams@covered.ca

8. **I certify that the attached copy of the regulation(s) is a true and correct copy of the regulation(s) identified on this form, that the information specified on this form is true and correct, and that I am the head of the agency taking this action, or a designee of the head of the agency, and am authorized to make this certification.**

SIGNATURE OF AGENCY HEAD OR DESIGNEE:
DATE: 7/31/18
TYPED NAME AND TITLE OF SIGNATORY: Kathleen Keeshen, General Counsel

For use by Office of Administrative Law (OAL) only

ENDORSED APPROVED
SEP 17 2018
Office of Administrative Law

ALL PREVIOUS RELATED OAL REGULATORY ACTION NUMBER(S):

2013-0920-05E
2014-0321-01EE
2014-0620-06EE
2014-0922-02EE
2016-0926-04EE
2016-1116-03EE
2017-0407-02EE
2018-0410-03EE

§ 6520. Employer and Employee Application Requirements.

(a) A small~~qualified~~ employer who is eligible to purchase coverage from a Qualified Health Plan (QHP) for its eligible~~qualified~~ 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, 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 for spouses, registered or non-registered domestic partners and/or dependent children;

(5) The qualified employer's desired health insurance 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, 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 understands he or she 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, which includes:

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

(B) The employer's health premium contribution rate for spouse or non-registered domestic partner, or dependent children 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, 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) If applicable, the employer's contribution rate to each of its qualified employee's employer-sponsored Group Dental Plan premiums pursuant to Section 6522(h).~~

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

(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), hereby incorporated by reference. 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~~qualified~~ 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 may be subject to penalties under federal law if he or she intentionally provides 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 for health 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 (~~December 22, 2016~~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 until the SHOP has received the qualified employer's first month 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 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~~qualified~~ employees of the availability of health insurance 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 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 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 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, 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 even if the qualified employee does not choose to enroll in a QHP;

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

(18) 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:

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

(2) The qualified employee's first and last name, 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 plan; or

(B) The employee has had a qualifying event that renders the employee eligible for continuation 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 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 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 name of the QHP and dental plan, 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 selected by the employee requires arbitration, which would require the employee and his or her dependents to arbitrate all claims relating to his or her 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 understands he or she 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 may be subject to penalties under federal law if he or she intentionally provides 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 selection of the spouse or dependent. The SHOP may only share information from an employee application with the QHP 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 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 issuers notice of such a change, if any, at least 210 days prior to the effective date of 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 through the SHOP.

(B) A qualified employee who waives 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, 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 premiums, a minimum of 50 percent of the lowest cost premium for employee-only coverage in the level of coverage selected by the qualified employer pursuant to Section 6520(a)(12~~10~~)(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 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 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.

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

(3) A qualified employer may choose to offer an employer-sponsored Group Dental Plan 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 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 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 (cb)(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 (cb)(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 employee status and;

(C) Provide the employee with a period of 30 days from the date on which the notice described in subdivision (c~~b~~)(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~~b~~)(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 through the SHOP for its eligible~~qualified~~ 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), but satisfies the remaining eligibility criteria in Section 6522, the qualified employer may only elect to offer health insurance coverage through SHOP for its eligible~~qualified~~ 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, including making changes to the reference plan, to its qualified employees, as described in Section 6520(a)(12~~10~~), 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 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 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 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 issuer.

(1) Requests to the SHOP to make changes to plan 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 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, as determined on a case-by-case basis.

(g) If a qualified employee does not enroll in a different QHP during his or her 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 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 is not available, the qualified employee shall be enrolled in a QHP offered by the same QHP issuer at the same metal tier that is the most similar to the qualified employee's current QHP, as determined by the SHOP on a case-by-case basis.

(i) If the issuer of the QHP in which the qualified employee is currently enrolled is no longer available, or if another QHP is not available from the current QHP issuer in the same metal tier, the qualified employee may 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, 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) Waiting periods in the SHOP are calculated beginning on the date the employee becomes a qualified employee who is otherwise eligible for coverage, regardless of when a qualified employer notifies the SHOP about a newly qualified employee.~~

~~(l)~~(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 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 dependent, either:

(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.

(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.

(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.

(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.

(6) An enrollee, qualified employee, or his or her dependent, gains access to new QHPs as a result of a permanent move ~~and either~~

~~(A) Had MEC as described in 26 CFR Section 1.5000A-1(b) (December 26, 2013), hereby incorporated by reference, for one or more days during the 60 days preceding the permanent move; or~~

~~(B) Was living outside of the United States or in a United States territory at the time of the permanent move;~~

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

(8) The qualified employee, or his or her 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 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 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 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 ~~his or her~~ 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 did not enroll in a health benefit plan during the immediately preceding enrollment period available to the employee or dependent because he or she was misinformed that he or she was covered under MEC.

(12) A qualified employee, or his or her 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 dependent, loses eligibility for 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 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).

(15) 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) (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.

(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.

(17) The qualified employee, or his or her 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.

(18) The qualified employee or his or her 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 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)-(1112) and (b)(15)-(1817) 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)(1211) 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 to dependents.

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

(1) Loss of eligibility for health insurance 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 plan);

4. Death of an employee;

5. Termination of employment; and

6. Reduction in the number of hours of employment;~~ and~~

~~7. Any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing;~~

(B) Loss of eligibility for coverage through Medicare, 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 coverage offered through an HMO or similar program in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of health insurance coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual);

(D) In the case of coverage offered through an HMO or similar program in the group market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual), and no other benefit package is available to the individual;~~ and~~

(E) A situation in which a health plan no longer offers any benefits 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 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 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 dependent, would have coverage under his or her previous plan or coverage.

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

(3) A qualified employee, or his or her 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 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 100503, 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 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 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 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 will be allocated by the total percentage paid across all amounts due for health and dental benefits, if any.

(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.

(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 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.

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 postmarked 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) 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 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 to terminate such coverage provided that the QHP 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 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 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 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;~~ and~~

(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 terminates coverage pursuant to subdivision (c)(2) and (3) of this section, the QHP 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 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 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 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

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 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 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 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 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 dependents at that address.

Note: Authority cited: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; and 45 CFR Sections 155.720, 155.725, 155.735, 155.1080 and 156.285.

COVERED CALIFORNIA | FOR 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 business 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 approval

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 sent in by the **late submission deadline,** of no later than 5 business days after the requested effective date. Failure to do so will cause your group to be effective 1st of month following original requested date.
- Enrollment information **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, 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

ELECTRONIC CODE OF FEDERAL REGULATIONS

e-CFR data is current as of July 31, 2018

Title 26: Internal Revenue
PART 1—INCOME TAXES

§1.36B-2 Eligibility for premium tax credit.

(a) *In general.* An applicable taxpayer (within the meaning of paragraph (b) of this section) is allowed a premium assistance amount only for any month that one or more members of the applicable taxpayer's family (the applicable taxpayer or the applicable taxpayer's spouse or dependent)—

(1) Is enrolled in one or more qualified health plans through an Exchange; and

(2) Is not eligible for minimum essential coverage (within the meaning of paragraph (c) of this section) other than coverage described in section 5000A(f)(1)(C) (relating to coverage in the individual market).

(b) *Applicable taxpayer*—(1) *In general.* Except as otherwise provided in this paragraph (b), an applicable taxpayer is a taxpayer whose household income is at least 100 percent but not more than 400 percent of the Federal poverty line for the taxpayer's family size for the taxable year.

(2) *Married taxpayers must file joint return*—(i) *In general.* Except as provided in paragraph (b)(2)(ii) of this section, a taxpayer who is married (within the meaning of section 7703) at the close of the taxable year is an applicable taxpayer only if the taxpayer and the taxpayer's spouse file a joint return for the taxable year.

(ii) *Victims of domestic abuse and abandonment.* Except as provided in paragraph (b)(2)(v) of this section, a married taxpayer satisfies the joint filing requirement of paragraph (b)(2)(i) of this section if the taxpayer files a tax return using a filing status of married filing separately and the taxpayer—

(A) Is living apart from the taxpayer's spouse at the time the taxpayer files the tax return;

(B) Is unable to file a joint return because the taxpayer is a victim of domestic abuse, as described in paragraph (b)(2)(iii) of this section, or spousal abandonment, as described in paragraph (b)(2)(iv) of this section; and

(C) Certifies on the return, in accordance with the relevant instructions, that the taxpayer meets the criteria of this paragraph (b)(2)(ii).

(iii) *Domestic abuse.* For purposes of paragraph (b)(2)(ii) of this section, domestic abuse includes physical, psychological, sexual, or emotional abuse, including efforts to control, isolate, humiliate, and intimidate, or to undermine the victim's ability to reason independently. All the facts and circumstances are considered in determining whether an individual is abused, including the effects of alcohol or drug abuse by the victim's spouse. Depending on the facts and circumstances, abuse of the victim's child or another family member living in the household may constitute abuse of the victim.

(iv) *Abandonment.* For purposes of paragraph (b)(2)(ii) of this section, a taxpayer is a victim of spousal abandonment for a taxable year if, taking into account all facts and circumstances, the taxpayer is unable to locate his or her spouse after reasonable diligence.

(v) *Three-year rule.* Paragraph (b)(2)(ii) of this section does not apply if the taxpayer met the requirements of paragraph (b)(2)(ii) of this section for each of the three preceding taxable years.

(3) *Dependents.* An individual is not an applicable taxpayer if another taxpayer may claim a deduction under section 151 for the individual for a taxable year beginning in the calendar year in which the individual's taxable year begins.

(4) *Individuals not lawfully present or incarcerated.* An individual who is not lawfully present in the United States or is incarcerated (other than incarceration pending disposition of charges) is not eligible to enroll in a qualified health plan through an Exchange. However, the individual may be an applicable taxpayer if a family member is eligible to enroll in a qualified health plan. See sections 1312(f)(1)(B) and 1312(f)(3) of the Affordable Care Act (42 U.S.C. 18032(f)(1)(B) and (f)(3)) and §1.36B-3(b)(2).

(5) *Individuals lawfully present.* If a taxpayer's household income is less than 100 percent of the Federal poverty line for the taxpayer's family size and the taxpayer or a member of the taxpayer's family is an alien lawfully present in the United States, the taxpayer is treated as an applicable taxpayer if—

(i) The lawfully present taxpayer or family member is not eligible for the Medicaid program; and

(ii) The taxpayer would be an applicable taxpayer if the taxpayer's household income for the taxable year was between 100 and 400 percent of the Federal poverty line for the taxpayer's family size.

(6) *Special rule for taxpayers with household income below 100 percent of the Federal poverty line for the taxable year*—(i) *In general.* A taxpayer (other than a taxpayer described in paragraph (b)(5) of this section) whose household income for a taxable year is less than 100 percent of the Federal poverty line for the taxpayer's family size is treated as an applicable taxpayer for the taxable year if—

(A) The taxpayer or a family member enrolls in a qualified health plan through an Exchange for one or more months during the taxable year;

(B) An Exchange estimates at the time of enrollment that the taxpayer's household income will be at least 100 percent but not more than 400 percent of the Federal poverty line for the taxable year;

(C) Advance credit payments are authorized and paid for one or more months during the taxable year; and

(D) The taxpayer would be an applicable taxpayer if the taxpayer's household income for the taxable year was at least 100 but not more than 400 percent of the Federal poverty line for the taxpayer's family size.

(ii) *Exceptions.* This paragraph (b)(6) does not apply for an individual who, with intentional or reckless disregard for the facts, provides incorrect information to an Exchange for the year of coverage. A reckless disregard of the facts occurs if the taxpayer makes little or no effort to determine whether the information provided to the Exchange is accurate under circumstances that demonstrate a substantial deviation from the standard of conduct a reasonable person would observe. A disregard of the facts is intentional if the taxpayer knows the information provided to the Exchange is inaccurate.

(iii) Advance credit payments are authorized and paid for one or more months during the taxable year; and

(iv) The taxpayer would be an applicable taxpayer if the taxpayer's household income for the taxable year was between 100 and 400 percent of the Federal poverty line for the taxpayer's family size.

(7) *Computation of premium assistance amounts for taxpayers with household income below 100 percent of the Federal poverty line.* If a taxpayer is treated as an applicable taxpayer under paragraph (b)(5) or (b)(6) of this section, the taxpayer's actual household income for the taxable year is used to compute the premium assistance amounts under §1.36B-3(d).

(c) *Minimum essential coverage*—(1) *In general.* Minimum essential coverage is defined in section 5000A(f) and regulations issued under that section. As described in section 5000A(f), government-sponsored programs, eligible employer-sponsored plans, grandfathered health plans, and certain other health benefits coverage are minimum essential coverage.

(2) *Government-sponsored minimum essential coverage*—(i) *In general.* An individual is eligible for government-sponsored minimum essential coverage if the individual meets the criteria for coverage under a government-sponsored program described in section 5000A(f)(1)(A) as of the first day of the first full month the individual may receive benefits under the program, subject to the limitation in paragraph (c)(2)(ii) of this section. The Commissioner may define eligibility for specific government-sponsored programs further in additional published guidance, see §601.601(d)(2) of this chapter.

(ii) *Obligation to complete administrative requirements to obtain coverage.* An individual who meets the criteria for eligibility for government-sponsored minimum essential coverage must complete the requirements necessary to receive benefits. An individual who fails by the last day of the third full calendar month following the event that establishes eligibility under paragraph (c)(2)(i) of this section to complete the requirements to obtain government-sponsored minimum essential coverage (other than a veteran's health care program) is treated as eligible for government-sponsored minimum essential coverage as of the first day of the fourth calendar month following the event that establishes eligibility.

(iii) *Special rule for coverage for veterans and other individuals under chapter 17 or 18 of title 38, U.S.C.* An individual is eligible for minimum essential coverage under a health care program under chapter 17 or 18 of title 38, U.S.C. only if the individual is enrolled in a health care program under chapter 17 or 18 of title 38, U.S.C. identified as minimum essential coverage in regulations issued under section 5000A.

(iv) *Retroactive effect of eligibility determination.* If an individual receiving advance credit payments is determined to be eligible for government-sponsored minimum essential coverage that is effective retroactively (such as Medicaid), the individual

is treated as eligible for minimum essential coverage under that program no earlier than the first day of the first calendar month beginning after the approval.

(v) *Determination of Medicaid or Children's Health Insurance Program (CHIP) ineligibility.* An individual is treated as not eligible for Medicaid, CHIP, or a similar program for a period of coverage under a qualified health plan if, when the individual enrolls in the qualified health plan, an Exchange determines or considers (within the meaning of 45 CFR 155.302(b)) the individual to be not eligible for Medicaid or CHIP. This paragraph (c)(2)(v) does not apply for an individual who, with intentional or reckless disregard for the facts, provides incorrect information to an Exchange for the year of coverage. A reckless disregard of the facts occurs if the taxpayer makes little or no effort to determine whether the information provided to the Exchange is accurate under circumstances that demonstrate a substantial deviation from the standard of conduct a reasonable person would observe. A disregard of the facts is intentional if the taxpayer knows that information provided to the Exchange is inaccurate.

(vi) *Examples.* The following examples illustrate the provisions of this paragraph (c)(2):

Example 1. Delay in coverage effectiveness. On April 10, 2015, Taxpayer D applies for coverage under a government-sponsored health care program. D's application is approved on July 12, 2015, but her coverage is not effective until September 1, 2015. Under paragraph (c)(2)(i) of this section, D is eligible for government-sponsored minimum essential coverage on September 1, 2015.

Example 2. Time of eligibility. Taxpayer E turns 65 on June 3, 2015, and becomes eligible for Medicare. Under section 5000A(f)(1)(A)(i), Medicare is minimum essential coverage. However, E must enroll in Medicare to receive benefits. E enrolls in Medicare in September, which is the last month of E's initial enrollment period. Thus, E may receive Medicare benefits on December 1, 2015. Because E completed the requirements necessary to receive Medicare benefits by the last day of the third full calendar month after the event that establishes E's eligibility (E turning 65), under paragraph (c)(2)(i) and (c)(2)(ii) of this section E is eligible for government-sponsored minimum essential coverage on December 1, 2015, the first day of the first full month that E may receive benefits under the program.

Example 3. Time of eligibility, individual fails to complete necessary requirements. The facts are the same as in *Example 2,* except that E fails to enroll in the Medicare coverage during E's initial enrollment period. E is treated as eligible for government-sponsored minimum essential coverage under paragraph (c)(2)(ii) of this section as of October 1, 2015, the first day of the fourth month following the event that establishes E's eligibility (E turning 65).

Example 4. Retroactive effect of eligibility. In November 2014, Taxpayer F enrolls in a qualified health plan for 2015 and receives advance credit payments. F loses her part-time employment and on April 10, 2015 applies for coverage under the Medicaid program. F's application is approved on May 15, 2015, and her Medicaid coverage is effective as of April 1, 2015. Under paragraph (c)(2)(iv) of this section, F is eligible for government-sponsored minimum essential coverage on June 1, 2015, the first day of the first calendar month after approval.

Example 5. Determination of Medicaid ineligibility. In November 2014, Taxpayer G applies through the Exchange to enroll in health coverage for 2015. The Exchange determines that G is not eligible for Medicaid and estimates that G's household income will be 140 percent of the Federal poverty line for G's family size for purposes of determining advance credit payments. G enrolls in a qualified health plan and begins receiving advance credit payments. G experiences a reduction in household income during the year and his household income for 2015 is 130 percent of the Federal poverty line (within the Medicaid income threshold). However, under paragraph (c)(2)(v) of this section, G is treated as not eligible for Medicaid for 2015.

Example 6. Mid-year Medicaid eligibility redetermination. The facts are the same as in *Example 5,* except that G returns to the Exchange in July 2015 and the Exchange determines that G is eligible for Medicaid. Medicaid approves G for coverage and the Exchange discontinues G's advance credit payments effective August 1. Under paragraphs (c)(2)(iv) and (c)(2)(v) of this section, G is treated as not eligible for Medicaid for the months when G is covered by a qualified health plan. G is eligible for government-sponsored minimum essential coverage for the months after G is approved for Medicaid and can receive benefits, August through December 2015.

(3) *Employer-sponsored minimum essential coverage*—(i) *In general.* For purposes of section 36B, an employee who may enroll in an eligible employer-sponsored plan (as defined in section 5000A(f)(2) and the regulations under that section) that is minimum essential coverage, and an individual who may enroll in the plan because of a relationship to the employee (a related individual), are eligible for minimum essential coverage under the plan for any month only if the plan is affordable and provides minimum value. Except for the Nonappropriated Fund Health Benefits Program of the Department of Defense, established under section 349 of the National Defense Authorization Act for Fiscal Year 1995 (Public Law 103-337; 10 U.S.C. 1587 note), government-sponsored minimum essential coverage is not an eligible employer-sponsored plan. The Nonappropriated Fund Health Benefits Program of the Department of Defense is considered eligible employer-sponsored coverage, but not government-sponsored coverage, for purposes of determining if an individual is eligible for minimum essential coverage under this section.

(ii) *Plan year.* For purposes of this paragraph (c)(3), a plan year is an eligible employer-sponsored plan's regular 12-month coverage period (or the remainder of a 12-month coverage period for a new employee or an individual who enrolls during a special enrollment period).

(iii) *Eligibility for months during a plan year*—(A) *Failure to enroll in plan.* An employee or related individual may be eligible for minimum essential coverage under an eligible employer-sponsored plan for a month during a plan year if the employee or related individual could have enrolled in the plan for that month during an open or special enrollment period for the plan year. If an enrollment period relates to coverage for not only the upcoming plan year (or the current plan year in the case of an

enrollment period other than an open enrollment period), but also coverage in one or more succeeding plan years, this paragraph (c)(3)(iii)(A) applies only to eligibility for the coverage in the upcoming plan year (or the current plan year in the case of an enrollment period other than an open enrollment period).

(B) *Waiting periods.* An employee or related individual is not eligible for minimum essential coverage under an eligible employer-sponsored plan during a required waiting period before the coverage becomes effective.

(C) *Example.* The following example illustrates the provisions of this paragraph (c)(3)(iii):

Example. (i) Taxpayer B is an employee of Employer X. X offers its employees a health insurance plan that has a plan year (within the meaning of paragraph (c)(3)(ii) of this section) from October 1 through September 30. Employees may enroll during an open season from August 1 to September 15. B does not enroll in X's plan for the plan year October 1, 2014, to September 30, 2015. In November 2014, B enrolls in a qualified health plan through an Exchange for calendar year 2015.

(ii) B could have enrolled in X's plan during the August 1 to September 15 enrollment period. Therefore, unless X's plan is not affordable for B or does not provide minimum value, B is eligible for minimum essential coverage under X's plan for the months that B is enrolled in the qualified health plan during X's plan year (January through September 2015).

(iv) *Post-employment coverage.* A former employee (including a retiree), or an individual related (within the meaning of paragraph (c)(3)(i) of this section) to a former employee, who may enroll in eligible employer-sponsored coverage or in continuation coverage required under Federal law or a State law that provides comparable continuation coverage is eligible for minimum essential coverage under this coverage only for months that the former employee or related individual is enrolled in the coverage.

(v) *Affordable coverage*—(A) *In general*—(*1*) *Affordability for employee.* Except as provided in paragraph (c)(3)(v)(A)(*3*) of this section, an eligible employer-sponsored plan is affordable for an employee if the portion of the annual premium the employee must pay, whether by salary reduction or otherwise (required contribution), for self-only coverage does not exceed the required contribution percentage (as defined in paragraph (c)(3)(v)(C) of this section) of the applicable taxpayer's household income for the taxable year.

(*2*) *Affordability for related individual.* Except as provided in paragraph (c)(3)(v)(A)(*3*) of this section, an eligible employer-sponsored plan is affordable for a related individual if the portion of the annual premium the employee must pay for self-only coverage does not exceed the required contribution percentage, as described in paragraph (c)(3)(v)(A)(*1*) of this section.

(*3*) *Employee safe harbor.* An employer-sponsored plan is not affordable for an employee or a related individual for a plan year if, when the employee or a related individual enrolls in a qualified health plan for a period coinciding with the plan year (in whole or in part), an Exchange determines that the eligible employer-sponsored plan is not affordable for that plan year. This paragraph (c)(3)(v)(A)(*3*) does not apply to a determination made as part of the redetermination process described in 45 CFR 155.335 unless the individual receiving an Exchange redetermination notification affirmatively responds and provides current information on affordability. This paragraph (c)(3)(v)(A)(*3*) does not apply for an individual who, with intentional or reckless disregard for the facts, provides incorrect information to an Exchange concerning the portion of the annual premium for coverage for the employee or related individual under the plan. A reckless disregard of the facts occurs if the taxpayer makes little or no effort to determine whether the information provided to the Exchange is accurate under circumstances that demonstrate a substantial deviation from the standard of conduct a reasonable person would observe. A disregard of the facts is intentional if the taxpayer knows that the information provided to the Exchange is inaccurate.

(*4*) *Wellness program incentives.* Nondiscriminatory wellness program incentives offered by an eligible employer-sponsored plan that affect premiums are treated as earned in determining an employee's required contribution for purposes of affordability of an eligible employer-sponsored plan to the extent the incentives relate exclusively to tobacco use. Wellness program incentives that do not relate to tobacco use or that include a component unrelated to tobacco use are treated as not earned for this purpose. For purposes of this section, the term *wellness program incentive* has the same meaning as the term *reward* in §54.9802-1(f)(1)(i) of this chapter.

(*5*) *Employer contributions to health reimbursement arrangements.* Amounts newly made available for the current plan year under a health reimbursement arrangement that an employee may use to pay premiums, or may use to pay cost-sharing or benefits not covered by the primary plan in addition to premiums, reduce the employee's required contribution if the health reimbursement arrangement would be integrated, as that term is used in Notice 2013-54 (2013-40 IRB 287) (see §601.601(d) of this chapter), with an eligible employer-sponsored plan for an employee enrolled in the plan. The eligible employer-sponsored plan and the health reimbursement arrangement must be offered by the same employer. Employer contributions to a health reimbursement arrangement reduce an employee's required contribution only to the extent the amount of the annual contribution is required under the terms of the plan or otherwise determinable within a reasonable time before the employee must decide whether to enroll in the eligible employer-sponsored plan.

(*6*) *Employer contributions to cafeteria plans.* Amounts made available for the current plan year under a cafeteria plan, within the meaning of section 125, reduce an employee's or a related individual's required contribution if—

(*i*) The employee may not opt to receive the amount as a taxable benefit;

(*ii*) The employee may use the amount to pay for minimum essential coverage; and

(*iii*) The employee may use the amount exclusively to pay for medical care, within the meaning of section 213.

(*7*) *Opt-out arrangements.* [Reserved]

(B) *Affordability for part-year period.* Affordability under paragraph (c)(3)(v)(A) of this section is determined separately for each employment period that is less than a full calendar year or for the portions of an employer's plan year that fall in different taxable years of an applicable taxpayer (a part-year period). An eligible employer-sponsored plan is affordable for a part-year period if the employee's annualized required contribution for self-only coverage under the plan for the part-year period does not exceed the required contribution percentage of the applicable taxpayer's household income for the taxable year. The employee's annualized required contribution is the employee's required contribution for the part-year period times a fraction, the numerator of which is 12 and the denominator of which is the number of months in the part-year period during the applicable taxpayer's taxable year. Only full calendar months are included in the computation under this paragraph (c)(3)(v)(B).

(C) *Required contribution percentage.* The required contribution percentage is 9.5 percent. For plan years beginning in a calendar year after 2014, the percentage will be adjusted by the ratio of premium growth to income growth for the preceding calendar year and may be further adjusted to reflect changes to the data used to compute the ratio of premium growth to income growth for the 2014 calendar year or the data sources used to compute the ratio of premium growth to income growth. Premium growth and income growth will be determined under published guidance, see §601.601(d)(2) of this chapter. In addition, the percentage may be adjusted for plan years beginning in a calendar year after 2018 to reflect rates of premium growth relative to growth in the consumer price index.

(D) *Examples.* The following examples illustrate the provisions of this paragraph (c)(3)(v). Unless stated otherwise, in each example the taxpayer is single and has no dependents, the employer's plan is an eligible employer-sponsored plan and provides minimum value, the employee is not eligible for other minimum essential coverage, and the taxpayer, related individual, and employer-sponsored plan have a calendar taxable year:

Example 1. Basic determination of affordability. In 2014 Taxpayer C has household income of $47,000. C is an employee of Employer X, which offers its employees a health insurance plan that requires C to contribute $3,450 for self-only coverage for 2014 (7.3 percent of C's household income). Because C's required contribution for self-only coverage does not exceed 9.5 percent of household income, under paragraph (c)(3)(v)(A)(*1*) of this section, X's plan is affordable for C, and C is eligible for minimum essential coverage for all months in 2014.

Example 2. Basic determination of affordability for a related individual. The facts are the same as in *Example 1,* except that C is married to J and X's plan requires C to contribute $5,300 for coverage for C and J for 2014 (11.3 percent of C's household income). Because C's required contribution for self-only coverage ($3,450) does not exceed 9.5 percent of household income, under paragraph (c)(3)(v)(A)(*2*) of this section, X's plan is affordable for C and J, and C and J are eligible for minimum essential coverage for all months in 2014.

Example 3. Determination of unaffordability at enrollment. (i) Taxpayer D is an employee of Employer X. In November 2013 the Exchange for D's rating area projects that D's 2014 household income will be $37,000. It also verifies that D's required contribution for self-only coverage under X's health insurance plan will be $3,700 (10 percent of household income). Consequently, the Exchange determines that X's plan is unaffordable. D enrolls in a qualified health plan and not in X's plan. In December 2014, X pays D a $2,500 bonus. Thus, D's actual 2014 household income is $39,500 and D's required contribution for coverage under X's plan is 9.4 percent of D's household income.

(ii) Based on D's actual 2014 household income, D's required contribution does not exceed 9.5 percent of household income and X's health plan is affordable for D. However, when D enrolled in a qualified health plan for 2014, the Exchange determined that X's plan was not affordable for D for 2014. Consequently, under paragraph (c)(3)(v)(A)(*3*) of this section, X's plan is not affordable for D and D is not eligible for minimum essential coverage under X's plan for 2014.

Example 4. Determination of unaffordability for plan year. The facts are the same as in *Example 3,* except that X's employee health insurance plan year is September 1 to August 31. The Exchange for D's rating area determines in August 2014 that X's plan is unaffordable for D based on D's projected household income for 2014. D enrolls in a qualified health plan as of September 1, 2014. Under paragraph (c)(3)(v)(A)(*3*) of this section, X's plan is not affordable for D and D is not eligible for minimum essential coverage under X's plan for the coverage months September to December 2014 and January through August 2015.

Example 5. No affordability information affirmatively provided for annual redetermination. (i) The facts are the same as in *Example 3,* except the Exchange redetermines D's eligibility for advance credit payments for 2015. D does not affirmatively provide the Exchange with current information regarding affordability and the Exchange determines that D's coverage is not affordable for 2015 and approves advance credit payments based on information from the previous enrollment period. In 2015, D's required contribution for coverage under X's plan is 9.4 percent of D's household income.

(ii) Because D does not respond to the Exchange notification and the Exchange makes an affordability determination based on information from an earlier year, the employee safe harbor in paragraph (c)(3)(v)(A)(*3*) of this section does not apply. D's required contribution for 2015 does not exceed 9.5 percent of D's household income. Thus, X's plan is affordable for D for 2015 and D is eligible for minimum essential coverage for all months in 2015.

Example 6. Determination of unaffordability for part of plan year (part-year period). (i) Taxpayer E is an employee of Employer X beginning in May 2015. X's employee health insurance plan year is September 1 to August 31. E's required contribution for self-only coverage for May through August is $150 per month ($1,800 for the full plan year). The Exchange for E's rating area projects E's household income for purposes of eligibility for advance credit payments as $18,000. E's actual household income for the 2015 taxable year is $20,000.

(ii) Under paragraph (c)(3)(v)(B) of this section, whether coverage under X's plan is affordable for E is determined for the remainder of X's plan year (May through August). E's required contribution for a full plan year ($1,800) exceeds 9.5 percent of E's household income (1,800/18,000 = 10 percent). Therefore, the Exchange determines that X's coverage is unaffordable for May through August. Although E's actual household income for 2015 is $20,000 (and E's required contribution of $1,800 does not exceed 9.5 percent of E's household income), under paragraph (c)(3)(v)(A)(*3*) of this section, X's plan is unaffordable for E for the part of the plan year May through August 2015. Consequently, E is not eligible for minimum essential coverage under X's plan for the period May through August 2015.

Example 7. Affordability determined for part of a taxable year (part-year period). (i) Taxpayer F is an employee of Employer X. X's employee health insurance plan year is September 1 to August 31. F's required contribution for self-only coverage for the period September 2014 through August 2015 is $150 per month or $1,800 for the plan year. F does not enroll in X's plan during X's open season but enrolls in a qualified health plan for September through December 2014. F does not request advance credit payments and does not ask the Exchange for his rating area to determine whether X's coverage is affordable for F. F's household income in 2014 is $18,000.

(ii) Because F is a calendar year taxpayer and Employer X's plan is not a calendar year plan, F must determine the affordability of X's coverage for the part-year period in 2014 (September-December) under paragraph (c)(3)(v)(B) of this section. F determines the affordability of X's plan for the September through December 2014 period by comparing the annual premiums ($1,800) to F's 2014 household income. F's required contribution of $1,800 is 10 percent of F's 2014 household income. Because F's required contribution exceeds 9.5 percent of F's 2014 household income, X's plan is not affordable for F for the part-year period September through December 2014 and F is not eligible for minimum essential coverage under X's plan for that period.

(iii) F enrolls in Exchange coverage for 2015 and does not ask the Exchange to approve advance credit payments or determine whether X's coverage is affordable. F's 2015 household income is $20,000.

(iv) F must determine if X's plan is affordable for the part-year period January 2015 through August 2015. F's annual required contribution ($1,800) is 9 percent of F's 2015 household income. Because F's required contribution does not exceed 9.5 percent of F's 2015 household income, X's plan is affordable for F for the part-year period January through August 2015 and F is eligible for minimum essential coverage for that period.

Example 8. Coverage unaffordable at year end. Taxpayer G is employed by Employer X. In November 2014, the Exchange for G's rating area determines that G is eligible for affordable employer-sponsored coverage for 2015. G nonetheless enrolls in a qualified health plan for 2015 but does not receive advance credit payments. G's 2015 household income is less than expected and G's required contribution for employer-sponsored coverage for 2015 exceeds 9.5 percent of G's actual 2015 household income. Under paragraph (c)(3)(v)(A)(*1*) of this section, G is not eligible for minimum essential coverage under X's plan for 2015.

Example 9. Wellness program incentives. (i) Employer X offers an eligible employer-sponsored plan with a nondiscriminatory wellness program that reduces premiums by $300 for employees who do not use tobacco products or who complete a smoking cessation course. Premiums are reduced by $200 if an employee completes cholesterol screening within the first six months of the plan year. Employee B does not use tobacco and the cost of his premiums is $3,700. Employee C uses tobacco and the cost of her premiums is $4,000.

(ii) Under paragraph (c)(3)(v)(A)(*4*) of this section, only the incentives related to tobacco use are counted toward the premium amount used to determine the affordability of X's plan. C is treated as having earned the $300 incentive for attending a smoking cessation course regardless of whether C actually attends the course. Thus, the required contribution for determining affordability for both Employee B and Employee C is $3,700. The $200 incentive for completing cholesterol screening is treated as not earned and does not reduce their required contribution.

(vi) *Minimum value.* See §1.36B-6 for rules for determining whether an eligible employer-sponsored plan provides minimum value.

(vii) *Enrollment in eligible employer-sponsored plan*—(A) *In general.* Except as provided in paragraph (c)(3)(vii)(B) of this section, the requirements of affordability and minimum value do not apply for months that an individual is enrolled in an eligible employer-sponsored plan.

(B) *Automatic enrollment.* An employee or related individual is treated as not enrolled in an eligible employer-sponsored plan for a month in a plan year or other period for which the employee or related individual is automatically enrolled if the employee or related individual terminates the coverage before the later of the first day of the second full calendar month of that plan year or other period or the last day of any permissible opt-out period provided by the employer-sponsored plan or in regulations to be issued by the Department of Labor, for that plan year or other period.

(C) *Examples.* The following examples illustrate the provisions of this paragraph (c)(3)(vii):

Example 1. Taxpayer H is employed by Employer X in 2014. H's required contribution for self-only employer coverage exceeds 9.5 percent of H's 2014 household income. H enrolls in X's calendar year plan for 2014. Under paragraph (c)(3)(vii)(A) of this section, H is eligible for minimum essential coverage for 2014 because H is enrolled in an eligible employer-sponsored plan for 2014.

Example 2. The facts are the same as in *Example 1,* except that H terminates plan coverage on June 30, 2014. Under paragraph (c)(3)(vii)(A) of this section, H is eligible for minimum essential coverage under X's plan for January through June 2014 but is not eligible for

minimum essential coverage under X's plan for July through December 2014.

Example 3. The facts are the same as in *Example 1,* except that Employer X automatically enrolls H in the plan for calendar year 2015. H terminates the coverage on January 20, 2015. Under paragraph (c)(3)(vii)(B) of this section, H is not eligible for minimum essential coverage under X's plan for January 2015.

(4) *Special eligibility rules*—(i) *Related individual not claimed as a personal exemption deduction.* An individual who may enroll in minimum essential coverage because of a relationship to another person eligible for the coverage, but for whom the other eligible person does not claim a personal exemption deduction under section 151, is treated as eligible for minimum essential coverage under the coverage only for months that the related individual is enrolled in the coverage.

(ii) *Exchange unable to discontinue advance credit payments*—(A) *In general.* If an individual who is enrolled in a qualified health plan for which advance credit payments are made informs the Exchange that the individual is or will soon be eligible for other minimum essential coverage and that advance credit payments should be discontinued, but the Exchange does not discontinue advance credit payments for the first calendar month beginning after the month the individual informs the Exchange, the individual is treated as eligible for the other minimum essential coverage no earlier than the first day of the second calendar month beginning after the first month the individual may enroll in the other minimum essential coverage.

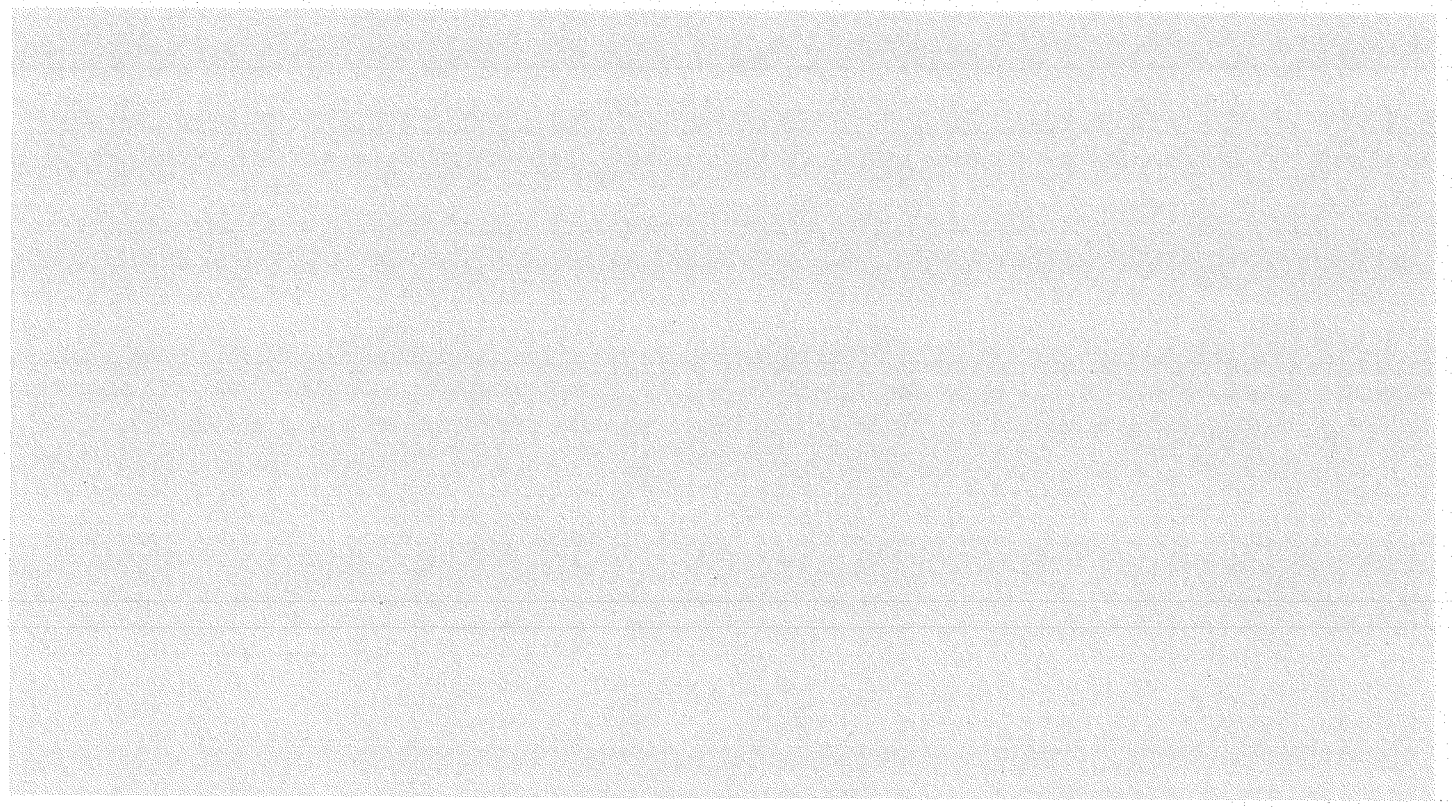
(B) *Medicaid or CHIP.* If a determination is made that an individual who is enrolled in a qualified health plan for which advance credit payments are made is eligible for Medicaid or CHIP but the advance credit payments are not discontinued for the first calendar month beginning after the eligibility determination, the individual is treated as eligible for the Medicaid or CHIP no earlier than the first day of the second calendar month beginning after the eligibility determination.

(d) *Applicability date.* Paragraphs (b)(2) and (c)(3)(v)(C) of this section apply to taxable years beginning after December 31, 2013.

(e) *Effective/applicability date.* (1) Except as provided in paragraph (e)(2) of this section, this section applies to taxable years ending after December 31, 2013.

(2) Paragraph (b)(6)(ii), the last three sentences of paragraph (c)(2)(v), paragraph (c)(3)(i), paragraph (c)(3)(iii)(A), the last three sentences of paragraph (c)(3)(v)(A)(*3*), and paragraph (c)(4) of this section apply to taxable years beginning after December 31, 2016. Paragraphs (b)(6), (c)(3)(i), (c)(3)(iii)(A), and (c)(4) of §1.36B-2 as contained in 26 CFR part I edition revised as of April 1, 2016, apply to taxable years ending after December 31, 2013, and beginning before January 1, 2017.

[T.D. 9590, 77 FR 30385, May 23, 2012, as amended by T.D. 9611, 78 FR 7265, Feb. 1, 2013; T.D. 9683, 79 FR 43626, July 28, 2014; 80 FR 78974, Dec. 18, 2015; T.D. 9804, 81 FR 91764, Dec. 19, 2016; T.D. 9822, 82 FR 34606, July 26, 2017]



ELECTRONIC CODE OF FEDERAL REGULATIONS

e-CFR data is current as of July 31, 2018

Title 26 → Chapter I → Subchapter A → Part 1 → §1.5000a-2

Title 26: Internal Revenue
PART 1—INCOME TAXES (CONTINUED)

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§1.5000A-2 Minimum essential coverage.

(a) *In general. Minimum essential coverage* means coverage under a government-sponsored program (described in paragraph (b) of this section), an eligible employer-sponsored plan (described in paragraph (c) of this section), a plan in the individual market (described in paragraph (d) of this section), a grandfathered health plan (described in paragraph (e) of this section), or other health benefits coverage (described in paragraph (f) of this section). Minimum essential coverage does not include coverage described in paragraph (g) of this section. All terms defined in this section apply for purposes of this section and §1.5000A-1 and §§1.5000A-3 through 1.5000A-5.

(b) *Government-sponsored program*—(1) *In general.* Except as provided in paragraph (2), *government-sponsored program* means any of the following:

(i) *Medicare.* The Medicare program under part A of Title XVIII of the Social Security Act (42 U.S.C. 1395c and following sections);

(ii) *Medicaid.* The Medicaid program under Title XIX of the Social Security Act (42 U.S.C. 1396 and following sections);

(iii) *Children's Health Insurance Program.* The Children's Health Insurance Program (CHIP) under Title XXI of the Social Security Act (42 U.S.C. 1397aa and following sections);

(iv) *TRICARE.* Medical coverage under chapter 55 of Title 10, U.S.C., including coverage under the TRICARE program;

(v) *Veterans programs.* The following health care programs under chapter 17 or 18 of Title 38, U.S.C.:

(A) The medical benefits package authorized for eligible veterans under 38 U.S.C. 1710 and 38 U.S.C. 1705;

(B) The Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) authorized under 38 U.S.C. 1781; and

(C) The comprehensive health care program authorized under 38 U.S.C. 1803 and 38 U.S.C. 1821 for certain children of Vietnam Veterans and Veterans of covered service in Korea who are suffering from spina bifida.

(vi) *Peace Corp program.* A health plan under section 2504(e) of Title 22, U.S.C. (relating to Peace Corps volunteers); and

(vii) *Nonappropriated Fund Health Benefits Program.* The Nonappropriated Fund Health Benefits Program of the Department of Defense, established under section 349 of the National Defense Authorization Act for Fiscal Year 1995 (Pub. L. 103-337; 10 U.S.C. 1587 note).

(2) *Certain health care coverage not minimum essential coverage under a government-sponsored program. Government-sponsored program* does not mean any of the following:

(i) Optional coverage of family planning services under section 1902(a)(10)(A)(ii)(XXI) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(ii)(XXI));

(ii) Optional coverage of tuberculosis-related services under section 1902(a)(10)(A)(ii)(XII) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(ii)(XII));

(iii) Coverage of pregnancy-related services 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));

(iv) Coverage limited to treatment of emergency medical conditions in accordance with 8 U.S.C. 1611(b)(1)(A), as authorized by section 1903(v) of the Social Security Act (42 U.S.C. 1396b(v));

(v) Coverage for medically needy individuals under section 1902(a)(10)(C) of the Social Security Act (42 U.S.C. 1396a(a)(10)(C)) and 42 CFR 435.300 and following sections;

(vi) Coverage authorized under section 1115(a) of the Social Security Act (42 U.S.C. 1315(a));

(vii) Coverage under section 1079(a), 1086(c)(1), or 1086(d)(1) of title 10, U.S.C., that is solely limited to space available care in a facility of the uniformed services for individuals excluded from TRICARE coverage for care from private sector providers; and

(viii) Coverage under sections 1074a and 1074b of title 10, U.S.C., for an injury, illness, or disease incurred or aggravated in the line of duty for individuals who are not on active duty.

(c) *Eligible employer-sponsored plan*—(1) *In general. Eligible employer-sponsored plan* means, with respect to any employee:

(i) Group health insurance coverage offered by, or on behalf of, an employer to the employee that is—

(A) A governmental plan (within the meaning of section 2791(d)(8) of the Public Health Service Act (42 U.S.C. 300gg-91(d)(8)));

(B) Any other plan or coverage offered in the small or large group market within a State; or

(C) A grandfathered health plan (within the meaning of paragraph (e) of this section) offered in a group market; or

(ii) A self-insured group health plan under which coverage is offered by, or on behalf of, an employer to the employee.

(2) *Government-sponsored program generally not an eligible employer-sponsored plan.* Except for the program identified in paragraph (b)(1)(vii) of this section, a government-sponsored program described in paragraph (b) of this section is not an eligible employer-sponsored plan.

(d) *Plan in the individual market*—(1) *In general. Plan in the individual market* means health insurance coverage offered to individuals in the individual market within a state, other than short-term limited duration insurance within the meaning of section 2791(b)(5) of the Public Health Service Act (42 U.S.C. 300gg-91(b)(5)).

(2) *Qualified health plan offered by an Exchange.* A qualified health plan offered by an Exchange is a plan in the individual market. If a territory of the United States elects to establish an Exchange under section 1323(a)(1) and (b) of the Affordable Care Act (42 U.S.C. 18043(a)(1), (b)), a qualified health plan offered by that Exchange is a plan in the individual market.

(e) *Grandfathered health plan. Grandfathered health plan* means any group health plan or group health insurance coverage to which section 1251 of the Affordable Care Act (42 U.S.C. 18011) applies.

(f) *Other coverage that qualifies as minimum essential coverage.* Minimum essential coverage includes any plan or arrangement recognized by the Secretary of Health and Human Services, in coordination with the Secretary of the Treasury, as minimum essential coverage.

(g) *Excepted benefits not minimum essential coverage.* Minimum essential coverage does not include any coverage that consists solely of excepted benefits described in section 2791(c)(1), (c)(2), (c)(3), or (c)(4) of the Public Health Service Act (42 U.S.C. 300gg-91(c)).

[T.D. 9632, 78 FR 53655, Aug. 30, 2013, as amended at 78 FR 78255, Dec. 26, 2013; T.D. 9705, 79 FR 70469, Nov. 26, 2014]

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Title 45: Public Welfare
PART 155—EXCHANGE ESTABLISHMENT STANDARDS AND OTHER RELATED STANDARDS UNDER THE AFFORDABLE CARE ACT
Subpart K—Exchange Functions: Certification of Qualified Health Plans

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§155.1080 Decertification of QHPs.

(a) *Definition.* The following definition applies to this section:

Decertification means the termination by the Exchange of the certification status and offering of a QHP.

(b) *Decertification process.* Except with respect to multi-State plans and CO-OP QHPs, the Exchange must establish a process for the decertification of QHPs, which, at a minimum, meets the requirements in this section.

(c) *Decertification by the Exchange.* The Exchange may at any time decertify a health plan if the Exchange determines that the QHP issuer is no longer in compliance with the general certification criteria as outlined in §155.1000(c).

(d) *Appeal of decertification.* The Exchange must establish a process for the appeal of a decertification of a QHP.

(e) *Notice of decertification.* Upon decertification of a QHP, the Exchange must provide notice of decertification to all affected parties, including:

(1) The QHP issuer;

(2) Exchange enrollees in the QHP who must receive information about a special enrollment period, as described in §155.420;

(3) HHS; and

(4) The State department of insurance.

[77 FR 18467, Mar. 27, 2012, as amended at 77 FR 31515, May 29, 2012]

Title 45: Public Welfare
PART 155—EXCHANGE ESTABLISHMENT STANDARDS AND OTHER RELATED STANDARDS UNDER THE AFFORDABLE CARE ACT
Subpart C—General Functions of an Exchange

§155.260 Privacy and security of personally identifiable information.

(a) *Creation, collection, use and disclosure.* (1) Where the Exchange creates or collects personally identifiable information for the purposes of determining eligibility for enrollment in a qualified health plan; determining eligibility for other insurance affordability programs, as defined in §155.300; or determining eligibility for exemptions from the individual shared responsibility provisions in section 5000A of the Code, the Exchange may only use or disclose such personally identifiable information to the extent such information is necessary:

(i) For the Exchange to carry out the functions described in §155.200;

(ii) For the Exchange to carry out other functions not described in paragraph (a)(1)(i) of this section, which the Secretary determines to be in compliance with section 1411(g)(2)(A) of the Affordable Care Act and for which an individual provides consent for his or her information to be used or disclosed; or

(iii) For the Exchange to carry out other functions not described in paragraphs (a)(1)(i) and (ii) of this section, for which an individual provides consent for his or her information to be used or disclosed, and which the Secretary determines are in compliance with section 1411(g)(2)(A) of the Affordable Care Act under the following substantive and procedural requirements:

(A) *Substantive requirements.* The Secretary may approve other uses and disclosures of personally identifiable information created or collected as described in paragraph (a)(1) of this section that are not described in paragraphs (a)(1)(i) or (ii) of this section, provided that HHS determines that the information will be used only for the purposes of and to the extent necessary in ensuring the efficient operation of the Exchange consistent with section 1411(g)(2)(A) of the Affordable Care Act, and that the uses and disclosures are also permissible under relevant law and policy.

(B) *Procedural requirements for approval of a use or disclosure of personally identifiable information.* To seek approval for a use or disclosure of personally identifiable information created or collected as described in paragraph (a)(1) of this section that is not described in paragraphs (a)(1)(i) or (ii) of this section, the Exchange must submit the following information to HHS:

(*1*) Identity of the Exchange and appropriate contact persons;

(*2*) Detailed description of the proposed use or disclosure, which must include, but not necessarily be limited to, a listing or description of the specific information to be used or disclosed and an identification of the persons or entities that may access or receive the information;

(*3*) Description of how the use or disclosure will ensure the efficient operation of the Exchange consistent with section 1411(g)(2)(A) of the Affordable Care Act; and

(*4*) Description of how the information to be used or disclosed will be protected in compliance with privacy and security standards that meet the requirements of this section or other relevant law, as applicable.

(2) The Exchange may not create, collect, use, or disclose personally identifiable information unless the creation, collection, use, or disclosure is consistent with this section.

(3) The Exchange must establish and implement privacy and security standards that are consistent with the following principles:

(i) *Individual access.* Individuals should be provided with a simple and timely means to access and obtain their personally identifiable information in a readable form and format;

(ii) *Correction.* Individuals should be provided with a timely means to dispute the accuracy or integrity of their personally identifiable information and to have erroneous information corrected or to have a dispute documented if their requests are denied;

(iii) *Openness and transparency.* There should be openness and transparency about policies, procedures, and technologies that directly affect individuals and/or their personally identifiable information;

(iv) *Individual choice.* Individuals should be provided a reasonable opportunity and capability to make informed decisions about the collection, use, and disclosure of their personally identifiable information;

(v) *Collection, use, and disclosure limitations.* Personally identifiable information should be created, collected, used, and/or disclosed only to the extent necessary to accomplish a specified purpose(s) and never to discriminate inappropriately;

(vi) *Data quality and integrity.* Persons and entities should take reasonable steps to ensure that personally identifiable information is complete, accurate, and up-to-date to the extent necessary for the person's or entity's intended purposes and has not been altered or destroyed in an unauthorized manner;

(vii) *Safeguards.* Personally identifiable information should be protected with reasonable operational, administrative, technical, and physical safeguards to ensure its confidentiality, integrity, and availability and to prevent unauthorized or inappropriate access, use, or disclosure; and,

(viii) *Accountability.* These principles should be implemented, and adherence assured, through appropriate monitoring and other means and methods should be in place to report and mitigate non-adherence and breaches.

(4) For the purposes of implementing the principle described in paragraph (a)(3)(vii) of this section, the Exchange must establish and implement operational, technical, administrative and physical safeguards that are consistent with any applicable laws (including this section) to ensure—

(i) The confidentiality, integrity, and availability of personally identifiable information created, collected, used, and/or disclosed by the Exchange;

(ii) Personally identifiable information is only used by or disclosed to those authorized to receive or view it;

(iii) Return information, as such term is defined by section 6103(b)(2) of the Code, is kept confidential under section 6103 of the Code;

(iv) Personally identifiable information is protected against any reasonably anticipated threats or hazards to the confidentiality, integrity, and availability of such information;

(v) Personally identifiable information is protected against any reasonably anticipated uses or disclosures of such information that are not permitted or required by law; and

(vi) Personally identifiable information is securely destroyed or disposed of in an appropriate and reasonable manner and in accordance with retention schedules;

(5) The Exchange must monitor, periodically assess, and update the security controls and related system risks to ensure the continued effectiveness of those controls.

(6) The Exchange must develop and utilize secure electronic interfaces when sharing personally identifiable information electronically.

(b) *Application to non-Exchange entities*—(1) *Non-Exchange entities.* A non-Exchange entity is any individual or entity that:

(i) Gains access to personally identifiable information submitted to an Exchange; or

(ii) Collects, uses, or discloses personally identifiable information gathered directly from applicants, qualified individuals, or enrollees while that individual or entity is performing functions agreed to with the Exchange.

(2) Prior to any person or entity becoming a non-Exchange entity, Exchanges must execute with the person or entity a contract or agreement that includes:

(i) A description of the functions to be performed by the non-Exchange entity;

(ii) A provision(s) binding the non-Exchange entity to comply with the privacy and security standards and obligations adopted in accordance with paragraph (b)(3) of this section, and specifically listing or incorporating those privacy and security standards and obligations;

(iii) A provision requiring the non-Exchange entity to monitor, periodically assess, and update its security controls and related system risks to ensure the continued effectiveness of those controls in accordance with paragraph (a)(5) of this section;

(iv) A provision requiring the non-Exchange entity to inform the Exchange of any change in its administrative, technical, or operational environments defined as material within the contract; and

(v) A provision that requires the non-Exchange entity to bind any downstream entities to the same privacy and security standards and obligations to which the non-Exchange entity has agreed in its contract or agreement with the Exchange.

(3) When collection, use or disclosure is not otherwise required by law, the privacy and security standards to which an Exchange binds non-Exchange entities must:

(i) Be consistent with the principles and requirements listed in paragraphs (a)(1) through (6) of this section, including being at least as protective as the standards the Exchange has established and implemented for itself in compliance with paragraph (a)(3) of this section;

(ii) Comply with the requirements of paragraphs (c), (d), (f), and (g) of this section; and

(iii) Take into specific consideration:

(A) The environment in which the non-Exchange entity is operating;

(B) Whether the standards are relevant and applicable to the non-Exchange entity's duties and activities in connection with the Exchange; and

(C) Any existing legal requirements to which the non-Exchange entity is bound in relation to its administrative, technical, and operational controls and practices, including but not limited to, its existing data handling and information technology processes and protocols.

(c) *Workforce compliance.* The Exchange must ensure its workforce complies with the policies and procedures developed and implemented by the Exchange to comply with this section.

(d) *Written policies and procedures.* Policies and procedures regarding the creation collection, use, and disclosure of personally identifiable information must, at minimum:

(1) Be in writing, and available to the Secretary of HHS upon request; and

(2) Identify applicable law governing collection, use, and disclosure of personally identifiable information.

(e) *Data sharing.* Data matching and sharing arrangements that facilitate the sharing of personally identifiable information between the Exchange and agencies administering Medicaid, CHIP or the BHP for the exchange of eligibility information must:

(1) Meet any applicable requirements described in this section;

(2) Meet any applicable requirements described in section 1413(c)(1) and (c)(2) of the Affordable Care Act;

(3) Be equal to or more stringent than the requirements for Medicaid programs under section 1942 of the Act; and

(4) For those matching agreements that meet the definition of "matching program" under 5 U.S.C. 552a(a)(8), comply with 5 U.S.C. 552a(o).

(f) *Compliance with the Code.* Return information, as defined in section 6103(b)(2) of the Code, must be kept confidential and disclosed, used, and maintained only in accordance with section 6103 of the Code.

(g) *Improper use and disclosure of information.* Any person who knowingly and willfully uses or discloses information in violation of section 1411(g) of the Affordable Care Act will be subject to a CMP of not more than $25,000 as adjusted annually under 45 CFR part 102 per person or entity, per use or disclosure, consistent with the bases and process for imposing civil penalties specified at §155.285, in addition to other penalties that may be prescribed by law.

[77 FR 18444, Mar. 27, 2012, as amended at 77 FR 31515, May 29, 2012; 79 FR 13837, Mar. 11, 2014; 79 FR 30346, May 27, 2014; 81 FR 12341, Mar. 8, 2016; 81 FR 61581, Sept. 6, 2016]

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Title 45: Public Welfare
PART 155—EXCHANGE ESTABLISHMENT STANDARDS AND OTHER RELATED STANDARDS UNDER THE AFFORDABLE CARE ACT
Subpart C—General Functions of an Exchange

§155.285 Bases and process for imposing civil penalties for provision of false or fraudulent information to an Exchange or improper use or disclosure of information.

(a) *Grounds for imposing civil money penalties.* (1) HHS may impose civil money penalties on any person, as defined in paragraph (a)(2) of this section, if, based on credible evidence, HHS reasonably determines that a person has engaged in one or more of the following actions:

(i) Failure to provide correct information under section 1411(b) of the Affordable Care Act where such failure is attributable to negligence or disregard of any rules or regulations of the Secretary with negligence and disregard defined as they are in section 6662 of the Internal Revenue Code of 1986:

(A) "Negligence" includes any failure to make a reasonable attempt to provide accurate, complete, and comprehensive information; and

(B) "Disregard" includes any careless, reckless, or intentional disregard for any rules or regulations of the Secretary.

(ii) Knowing and willful provision of false or fraudulent information required under section 1411(b) of the Affordable Care Act, where knowing and willful means the intentional provision of information that the person knows to be false or fraudulent; or

(iii) Knowing and willful use or disclosure of information in violation of section 1411(g) of the Affordable Care Act, where knowing and willful means the intentional use or disclosure of information in violation of section 1411(g). Such violations would include, but not be limited to, the following:

(A) Any use or disclosure performed which violates relevant privacy and security standards established by the Exchange pursuant to §155.260;

(B) Any other use or disclosure which has not been determined by the Secretary to be in compliance with section 1411(g)(2)(A) of the Affordable Care Act pursuant to §155.260(a); and

(C) Any other use or disclosure which is not necessary to carry out a function described in a contract with a non-Exchange entity executed pursuant to §155.260(b)(2).

(2) For purposes of this section, the term "person" is defined to include, but is not limited to, all individuals; corporations; Exchanges; Medicaid and CHIP agencies; other entities gaining access to personally identifiable information submitted to an Exchange to carry out additional functions which the Secretary has determined ensure the efficient operation of the Exchange pursuant to §155.260(a)(1); and non-Exchange entities as defined in §155.260(b) which includes agents, brokers, Web-brokers, QHP issuers, Navigators, non-Navigator assistance personnel, certified application counselors, in-person assistors, and other third party contractors.

(b) *Factors in determining the amount of civil money penalties imposed.* In determining the amount of civil money penalties, HHS may take into account factors which include, but are not limited to, the following:

(1) The nature and circumstances of the conduct including, but not limited to:

(i) The number of violations;

(ii) The severity of the violations;

(iii) The person's history with the Exchange including any prior violations that would indicate whether the violation is an isolated occurrence or represents a pattern of behavior;

(iv) The length of time of the violation;

(v) The number of individuals affected or potentially affected;

(vi) The extent to which the person received compensation or other consideration associated with the violation;

(vii) Any documentation provided in any complaint or other information, as well as any additional information provided by the individual to refute performing the violation; and

(viii) Whether other remedies or penalties have been imposed for the same conduct or occurrence.

(2) The nature of the harm resulting from, or reasonably expected to result from, the violation, including but not limited to:

(i) Whether the violation resulted in actual or potential financial harm;

(ii) Whether there was actual or potential harm to an individual's reputation;

(iii) Whether the violation hindered or could have hindered an individual's ability to obtain health insurance coverage;

(iv) [Reserved]

(v) The actual or potential impact of the provision of false or fraudulent information or of the improper use or disclosure of the information; and

(vi) Whether any person received a more favorable eligibility determination for enrollment in a QHP or insurance affordability program, such as greater advance payment of the premium tax credits or cost-sharing reductions than he or she would be eligible for if the correct information had been provided.

(3) No penalty will be imposed under paragraph (a)(1)(i) of this section if HHS determines that there was a reasonable cause for the failure to provide correct information required under section 1411(b) of the Affordable Care Act and that the person acted in good faith.

(c) *Maximum penalty.* The amount of a civil money penalty will be determined by HHS in accordance with paragraph (b) of this section.

(1) The following provisions provide maximum penalties for a single "plan year," where "plan year" has the same meaning as at §155.20:

(i) Any person who fails to provide correct information as specified in paragraph (a)(1)(i) of this section may be subject to a maximum civil money penalty of $25,000 as adjusted annually under 45 CFR part 102 for each application, as defined at paragraph (c)(1)(iii) of this section, pursuant to which a person fails to provide correct information.

(ii) Any person who knowingly and willfully provides false information as specified in paragraph (a)(1)(ii) of this section may be subject to a maximum civil money penalty of $250,000 as adjusted annually under 45 CFR part 102 for each application, as defined at paragraph (c)(1)(iii) of this section, on which a person knowingly and willfully provides false information.

(iii) For the purposes of this subsection, "application" is defined as a submission of information, whether through an online portal, over the telephone through a call center, or through a paper submission process, in which the information is provided in relation to an eligibility determination; an eligibility redetermination based on a change in an individual's circumstances; or an annual eligibility redetermination for any of the following:

(A) Enrollment in a qualified health plan;

(B) Premium tax credits or cost sharing reductions; or

(C) An exemption from the individual shared responsibility payment.

(2) Any person who knowingly or willfully uses or discloses information as specified in paragraph (a)(1)(iii) of this section may be subject to the following civil money penalty:

(i) A civil money penalty for each use or disclosure described in paragraph (a)(1)(iii) of this section of not more than $25,000 as adjusted annually under 45 CFR part 102 per use or disclosure.

(ii) For purposes of paragraph (c) of this section, a use or disclosure includes one separate use or disclosure of a single individual's personally identifiable information where the person against whom a civil money penalty may be imposed has made the use or disclosure.

(3) These penalties may be imposed in addition to any other penalties that may be prescribed by law.

(d) *Notice of intent to issue civil money penalty.* If HHS intends to impose a civil money penalty in accordance with this part, HHS will send a written notice of such intent to the person against whom it intends to impose a civil money penalty.

(1) This written notice will be either hand delivered, sent by certified mail, return receipt requested, or sent by overnight delivery service with signature upon delivery required. The written notice must include the following elements:

(i) A description of the findings of fact regarding the violations with respect to which the civil money penalty is proposed;

(ii) The basis and reasons why the findings of fact subject the person to a penalty;

(iii) Any circumstances described in paragraph (b) of this section that were considered in determining the amount of the proposed penalty;

(iv) The amount of the proposed penalty;

(v) An explanation of the person's right to a hearing under any applicable administrative hearing process;

(vi) A statement that failure to request a hearing within 60 calendar days after the date of issuance printed on the notice permits the assessment of the proposed penalty; and

(vii) Information explaining how to file a request for a hearing and the address to which the hearing request must be sent.

(2) The person may request a hearing before an ALJ on the proposed penalty by filing a request in accordance with the procedure to file an appeal specified in paragraph (f) of this section.

(e) *Failure to request a hearing.* If the person does not request a hearing within 60 calendar days of the date of issuance printed on the notice described in paragraph (d) of this section, HHS may impose the proposed civil money penalty.

(1) HHS will notify the person in writing of any penalty that has been imposed, the means by which the person may satisfy the penalty, and the date on which the penalty is due.

(2) A person has no right to appeal a penalty with respect to which the person has not timely requested a hearing in accordance with paragraph (d) of this section.

(f) *Appeal of proposed penalty.* Subject to paragraph (e)(2) of this section, any person against whom HHS proposed to impose a civil money penalty may appeal that penalty in accordance with the rules and procedures outlined at 45 CFR part 150, subpart D, excluding §§150.461, 150.463, and 150.465.

(g) *Enforcement authority*—(1) *HHS.* HHS may impose civil money penalties up to the maximum amounts specified in paragraph (d) of this section for any of the violations described in paragraph (a) of this section.

(2) *OIG.* In accordance with the rules and procedures of 42 CFR part 1003, and in place of imposition of penalties by CMS, the OIG may impose civil money penalties for violations described in paragraph (a)(1)(ii) of this section.

(h) *Settlement authority.* Nothing in this section limits the authority of HHS to settle any issue or case described in the notice furnished in accordance with §155.285(d) or to compromise on any penalty provided for in this section.

(i) *Limitations.* No action under this section will be entertained unless commenced, in accordance with §155.285(d), within 6 years from the date on which the violation occurred.

[79 FR 30346, May 27, 2014, as amended at 81 FR 61581, Sept. 6, 2016]

(ii) The amounts newly made available under such integrated HRAs for the current year are accounted for.

(d) *Use of state-specific standard population for the calculation of AV.* Beginning in 2015, if submitted by the State and approved by HHS, a state-specific data set will be used as the standard population to calculate AV in accordance with paragraph (a) of this section. The data set may be approved by HHS if it is submitted in accordance with paragraph (e) of this section and:

(1) Supports the calculation of AVs for the full range of health plans available in the market;

(2) Is derived from a non-elderly population and estimates those likely to be covered by private health plans on or after January 1, 2014;

(3) Is large enough that: (i) The demographic and spending patterns are stable over time; and (ii) Includes a substantial majority of the State's insured population, subject to the requirement in paragraph (d)(2) of this section;

(4) Is a statistically reliable and stable basis for area-specific calculations; and (5) Contains claims data on health care services typically offered in the then-current market.

(e) *Submission of state-specific data.* AV will be calculated using the default standard population described in paragraph (f) of this section, unless a data set in a format specified by HHS that can support the use of the AV Calculator as described in paragraph (a) of this section is submitted by a State and approved by HHS consistent with paragraph (d) of this section by a date specified by HHS.

(f) *Default standard population.* The default standard population for AV calculation will be developed and summary statistics, such as in continuance tables, will be provided by HHS in a format that supports the calculation of AV as described in paragraph (a) of this section.

§ 156.140 Levels of coverage.

(a) *General requirement for levels of coverage.* AV, calculated as described in § 156.135 of this subpart, and within a de minimis variation as defined in paragraph (c) of this section, determines whether a health plan offers a bronze, silver, gold, or platinum level of coverage.

(b) *The levels of coverage* are:

(1) *A bronze health plan* is a health plan that has an AV of 60 percent.

(2) *A silver health plan* is a health plan that has an AV of 70 percent.

(3) *A gold health plan* is a health plan that has an AV of 80 percent.

(4) *A platinum health plan* is a health plan that has as an AV of 90 percent.

(c) *De minimis variation.* The allowable variation in the AV of a health plan that does not result in a material difference in the true dollar value of the health plan is ±2 percentage points.

§ 156.145 Determination of minimum value.

(a) *Acceptable methods for determining MV.* An employer-sponsored plan provides minimum value (MV) if the percentage of the total allowed costs of benefits provided under the plan is no less than 60 percent. An employer-sponsored plan may use one of the following methods to determine whether the percentage of the total allowed costs of benefits provided under the plan is not less than 60 percent.

(1) The MV Calculator to be made available by HHS and the Internal Revenue Service. The result derived from the calculator may be modified under the rules in paragraph (b) of this section.

(2) Any safe harbor established by HHS and the Internal Revenue Service.

(3) A group health plan may seek certification by an actuary to determine MV if the plan contains non-standard features that are not suitable for either of the methods described in paragraphs (a)(1) or (2) of this section. The determination of MV must be made by a member of the American Academy of Actuaries, based on an analysis performed in accordance with generally accepted actuarial principles and methodologies.

(4) Any plan in the small group market that meets any of the levels of coverage, as described in § 156.140 of this subpart, satisfies minimum value.

(b) *Benefits that may be counted towards the determination of MV.* (1) In the event that a group health plan uses the

issuer notifies a qualified employee enrolled in a QHP through the SHOP of the effective date of his or her coverage.

(2) For plan years beginning on or after January 1, 2017, the SHOP must ensure that a QHP issuer notifies an enrollee enrolled in a QHP through the SHOP of the effective date of his or her coverage.

(3) When a primary subscriber and his or her dependents live at the same address, a separate notice of the effective date of coverage 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 coverage effective date for the primary subscriber and his or her dependents at that address.

(f) *Records.* The SHOP must receive and maintain for at least 10 years records of enrollment in QHPs, including identification of—

(1) Qualified employers participating in the SHOP; and

(2) Qualified employees enrolled in QHPs.

(g) *Reconcile files.* The SHOP must reconcile enrollment information and employer participation information with QHPs on no less than a monthly basis.

(h) *Employee termination of coverage from a QHP.* If any employee terminates coverage from a QHP, the SHOP must notify the employee's employer.

(i) *Reporting requirement for tax administration purposes.* The SHOP must report to the IRS employer participation, employer contribution, and employee enrollment information in a time and format to be determined by HHS.

[77 FR 18464, Mar. 27, 2012, as amended at 80 FR 10869, Feb. 27, 2015]

§ 155.725 Enrollment periods under SHOP.

(a) *General requirements.* The SHOP must ensure that enrollment transactions are sent to QHP issuers and that such issuers adhere to coverage effective dates in accordance with this section.

(b) *Rolling enrollment in the SHOP.* The SHOP must permit a qualified employer to purchase coverage for its small group at any point during the year. The employer's plan year must consist of the 12-month period beginning with the qualified employer's effective date of coverage, unless the plan is issued in a State that has elected to merge its individual and small group risk pools under section 1312(c)(3) of the Affordable Care Act, in which case the plan year will end on December 31 of the calendar year in which coverage first became effective.

(c) *Annual employer election period.* The SHOP must provide qualified employers with a standard election period prior to the completion of the employer's plan year and before the annual employee open enrollment period, in which the qualified employer may change its participation in the SHOP for the next plan year, including—

(1) The method by which the qualified employer makes QHPs available to qualified employees pursuant to §155.705(b)(2) and (3);

(2) The employer contribution towards the premium cost of coverage;

(3) The level of coverage offered to qualified employees as described in §155.705(b)(2) and (3); and

(4) The QHP or QHPs offered to qualified employees in accordance with §155.705.

(d) *Annual employer election period notice.* The SHOP must provide notification to a qualified employer of the annual election period in advance of such period.

(e) *Annual employee open enrollment period.* (1) The SHOP must establish a standardized annual open enrollment period for qualified employees prior to the completion of the applicable qualified employer's plan year and after that employer's annual election period.

(2) Qualified employers in a Federally-facilitated SHOP must provide qualified employees with an annual open enrollment period of at least one week.

(f) *Annual employee open enrollment period notice.* The SHOP must provide notification to a qualified employee of the annual open enrollment period in advance of such period.

(g) *Newly qualified employees.* (1) In a State Exchange that does not use the Federal platform for SHOP functions, the following rules apply with respect

to enrollment and coverage effective dates for newly qualified employees.

(i) The SHOP must provide an employee who becomes a qualified employee outside of the initial or annual open enrollment period an enrollment period beginning on the first day of becoming a qualified employee. A newly qualified employee must have at least 30 days from the beginning of his or her enrollment period to select a QHP. The enrollment period must end no sooner than 15 days prior to the date that any applicable employee waiting period longer than 45 days would end if the employee made a plan selection on the first day of becoming eligible.

(ii) The effective date of coverage for a QHP selection received by the SHOP from a newly qualified employee must always be the first day of a month, and must generally be determined in accordance with paragraph (h) of this section, unless the employee is subject to a waiting period consistent with §147.116 of this subchapter, in which case the effective date may be on the first day of a later month, but in no case may the effective date fail to comply with §147.116 of this subchapter.

(iii) Waiting periods in the SHOP are calculated beginning on the date the employee becomes a qualified employee who is otherwise eligible for coverage, regardless of when a qualified employer notifies the SHOP about a newly qualified employee.

(2) In a Federally-facilitated SHOP or in a State Exchange that uses the Federal platform for SHOP functions, the following rules apply with respect to enrollment and coverage effective dates for newly qualified employees.

(i) The SHOP must provide an employee who becomes a qualified employee outside of the initial or annual open enrollment period with a 30-day enrollment period beginning on the date the qualified employer notifies the SHOP about the newly qualified employee. Qualified employers must notify the SHOP about a newly qualified employee on or before the thirtieth day after the day that the employee becomes a newly qualified employee.

(ii) The effective date of coverage for a QHP selection received by the SHOP from a newly qualified employee is the first day of the month following plan selection, unless the employee is subject to a waiting period consistent with §147.116 of this subchapter and paragraph (g)(2)(iii) of this section, in which case the effective date will be on the first day of the month following the end of the waiting period, but in no case may the effective date fail to comply with §147.116 of this subchapter. If a newly qualified employee's waiting period ends on the first day of a month and the employee has already made a plan selection by that date, coverage must take effect on that date. If a newly qualified employee makes a plan selection on the first day of a month and any applicable waiting period has ended by that date, coverage must be effective on the first day of the following month. If a qualified employer with variable hour employees makes regularly having a specified number of hours of service per period, or working full-time, a condition of employee eligibility for coverage offered through the SHOP, any measurement period that the qualified employer elects to use under §147.116(c)(3)(i) to determine whether an employee meets the applicable eligibility conditions with respect to coverage offered through the SHOP must not exceed 10 months, beginning on any date between the employee's start date and the first day of the first calendar month following the employee's start date.

(iii) Waiting periods in the SHOP are calculated beginning on the date the employee becomes a qualified employee who is otherwise eligible for coverage, regardless of when a qualified employer notifies the SHOP about a newly qualified employee, and must not exceed 60 days in length. Waiting periods must be 0, 15, 30, 45 or 60 days in length.

(h) *Initial and annual open enrollment effective dates.* (1) The SHOP must establish effective dates of coverage for qualified employees enrolling in coverage for the first time, and for qualified employees enrolling during the annual open enrollment period described in paragraph (e) of this section.

(2) For a group enrollment received by the Federally-facilitated SHOP from a qualified employer at the time of an initial group enrollment or renewal:

(i) Between the first and fifteenth day of any month, the Federally-facilitated SHOP must ensure a coverage effective date of the first day of the following month unless the employer opts for a later effective date within a quarter for which small group market rates are available.

(ii) Between the 16th and last day of any month, the Federally-facilitated SHOP must ensure a coverage effective date of the first day of the second following month unless the employer opts for a later effective date within a quarter for which small group market rates are available.

(i) *Renewal of coverage.* (1) If a qualified employee enrolled in a QHP through the SHOP remains eligible for enrollment through the SHOP in coverage offered by the same qualified employer, the SHOP may provide for a process under which the employee will remain in the QHP selected the previous year, unless—

(i) The qualified employee terminates coverage from such QHP in accordance with standards identified in §155.430;

(ii) The qualified employee enrolls in another QHP if such option exists; or

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

(2) The SHOP may treat a qualified employer offering coverage through the SHOP as offering the same coverage under §155.705(b)(3) at the same level of contribution under §155.705(b)(11) unless:

(i) The qualified employer is no longer eligible to offer such coverage through the SHOP;

(ii) The qualified employer elects to offer different coverage or a different contribution through the SHOP;

(iii) The qualified employer withdraws from the SHOP; or

(iv) In the case of a qualified employer offering a single QHP, the single QHP is no longer available through the SHOP.

(j)(1) *Special enrollment periods.* 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 enrollees may change QHPs.

(2) The SHOP must provide a special enrollment period for a qualified employee or dependent of a qualified employee who:

(i) Experiences an event described in §155.420(d)(1) (other than paragraph (d)(1)(ii)), or experiences an event described in §155.420(d)(2), (4), (5), (7), (8), (9), (10), (11), or (12);

(ii) Loses eligibility for coverage under a Medicaid plan under title XIX of the Social Security Act or a State child health plan under title XXI of the Social Security Act; or

(iii) Becomes eligible for assistance, with respect to coverage under a SHOP, under such Medicaid plan or a State child health plan (including any waiver or demonstration project conducted under or in relation to such a plan).

(3) A qualified employee or dependent of a qualified employee who experiences a qualifying event described in paragraph (j)(2) of this section has:

(i) Thirty (30) days from the date of a triggering event described in paragraph (j)(2)(i) of this section to select a QHP through the SHOP; and

(ii) Sixty (60) days from the date of a triggering event described in paragraph (j)(2)(ii) or (iii) of this section to select a QHP through the SHOP;

(4) A dependent of a qualified employee is not eligible for a special election period if the employer does not extend the offer of coverage to dependents.

(5) The effective dates of coverage for special enrollment periods are determined using the provisions of §155.420(b).

(6) Loss of minimum essential coverage is determined using the provisions of §155.420(e).

(7) Notwithstanding anything to the contrary in §155.420(d), §155.420(a)(4) and (d)(2)(i)(A) do not apply to special enrollment periods in the SHOP.

(k) *Limitation.* Qualified employees will not be able to enroll unless the employer group meets any applicable minimum participation rate implemented under §155.705(b)(10).

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