State of California
Office of Administrative Law

In re:
California Health Benefit Exchange

Regulatory Action:

Title 10, California Code of Regulations

Adopt sections:
Amend sections: 6520, 6522, 6524, 6526, 6528, 6530, 6532, 6534, 6538, 6542, 6550
Repeal sections:

AMENDED NOTICE OF APPROVAL OF EMERGENCY REGULATORY ACTION

Government Code Sections 11346.1 and 11349.6

OAL Matter Number: 2021-0827-02

OAL Matter Type: Emergency (E)

This emergency action amends regulations for the Small Business Health Options Program (SHOP) regarding employer and employee application requirements, eligibility and enrollment requirements and processes, premium payments, availability of employer and employee options for metal tiers and associated health plans, application standard, the employee minimum participation rate, and administrative processes. This is a deemed emergency pursuant to Government Code section 100504(a)(6)(A).

OAL approves this emergency regulatory action pursuant to sections 11346.1 and 11349.6 of the Government Code.

This emergency regulatory action is effective on 9/7/2021 and will expire on 9/8/2026. The Certificate of Compliance for this action is due no later than 9/7/2026.

Date: September 7, 2021

Mark Storm
Senior Attorney

For: Kenneth J. Pogue
Director

Original: Peter Lee, Executive Director
Copy: Courtney Leadman

State of California
Office of Administrative Law

In re:
California Health Benefit Exchange

Regulatory Action:

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Date: September 7, 2021

Mark Storm
Senior Attorney

For: Kenneth J. Pogue
Director

Original: Peter Lee, Executive Director
Copy: Courtney Leadman

STATE OF CALIFORNIA–OFFICE OF ADMINISTRATIVE LAW

NOTICE PUBLICATION/REGULATIONS SUBMISSION

EMERGENCY

STD. 400 (REV. 10/2019)

For use by Secretary of State only

ENDORSED - FILED
in the office of the Secretary of State
of the State of California
SEP 07 2021
1:23 PM

OAL FILE NUMBERS	NOTICE FILE NUMBER	REGULATORY ACTION NUMBER	EMERGENCY NUMBER
	Z-	2021-0827-02 E	

For use by Office of Administrative Law (OAL) only

OFFICE OF ADMIN. LAW
2021 AUG 27 PM 12:53

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	TITLE(S)	FIRST SECTION AFFECTED	2. REQUESTED PUBLICATION DATE

3. NOTICE TYPE	4. AGENCY CONTACT PERSON	TELEPHONE NUMBER	FAX NUMBER (Optional)
☐ Notice re Proposed Regulatory Action ☐ Other			

OAL USE ONLY	ACTION ON PROPOSED NOTICE	NOTICE REGISTER NUMBER	PUBLICATION DATE
	☐ Approved as Submitted ☐ Approved as Modified ☐ Disapproved/ Withdrawn		

B. SUBMISSION OF REGULATIONS (Complete when submitting regulations)

1a. SUBJECT OF REGULATION(S): SHOP Eligibility and Enrollment

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

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:

AMEND: 6520, 6522, 6524, 6526, 6528, 6530, 6532, 6534, 6538, 6542, and 6550

TITLE(S): 10

REPEAL:

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))
- ☐ 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. 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))
- ☒ 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

- ☐ Department of Finance (Form STD. 399) (SAM §6660)
- ☐ Fair Political Practices Commission
- ☐ State Fire Marshal
- ☐ Other (Specify)

7. CONTACT PERSON	TELEPHONE NUMBER	FAX NUMBER (Optional)	E-MAIL ADDRESS (Optional)
Courtney Leadham	(916) 281-2562		courtney.leadham@covered.ca.g

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: 8/19/21

TYPED NAME AND TITLE OF SIGNATORY: Peter Lee, Executive Director

For use by Office of Administrative Law (OAL) only

ENDORSED APPROVED

SEP 07 2021

Office of Administrative Law

Title 10. Investment

Chapter 12. California Health Benefit Exchange

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

§ 6520. Employer and Employee Application Requirements.

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

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

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

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

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

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

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

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

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

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

(10) Whether the qualified employer used an insurance agent and if so, the agent's name, general agency name (if applicable), CA insurance license number, the agency Federal Employer Identification Number if applicable, and whether the agent is an insurance agent certified by Covered California. If the qualified employer uses an insurance agent, the qualified employer must have that agent certify that he or she 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~~health coverage or dental coverage, and the health reference plan or dental reference plan which includes:

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

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

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

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

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

(13) New qualified employer application submissions are due five days prior to the requested effective date. Completed submissions received after this date will carry an effective date no earlier than the first of the following month unless the qualified employer submits a signed CCSB New Business Late Submission Acknowledgement

Form (Rev. 3/18), 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 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~~health coverage or dental coverage and will otherwise be kept private as required by federal and state law;

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

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

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

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

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

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

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

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

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

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

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

(17) That the qualified employer 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 five days prior to the requested effective date:

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

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

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

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

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

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

(4) If the qualified employer is offering coverage for dependents and the employee elects to offer his or her 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 names ~~of the QHP and dental plan~~of the health plans and dental plans, if applicable, selected by the qualified employee and dependents.

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

(1) Agree to mandatory arbitration if the QHP Issuer selected by the employee requires arbitration, which would require the employee and his or her 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~~ health plan or dental plan selection of the spouse or dependent. The SHOP may only share information from an employee application with the QHP Issuer or employer that is strictly necessary for the purposes of eligibility and enrollment. Information obtained by the SHOP pursuant to this section may not be used for purposes other than eligibility determinations and enrollment in ~~health coverage~~health or dental coverage through the SHOP

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

§ 6522. Eligibility Requirements for Enrollment in the Shop.

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

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

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

(3) Either -

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

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

(4) Meets the following minimum participation rules:

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

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

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

(5) Meets the following group contribution rule:

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

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

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

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

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

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

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

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

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

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

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

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

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

§ 6524. Verification Process for Enrollment in the Shop.

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

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

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

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

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

(c) Inconsistencies

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

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

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

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

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

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

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

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

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

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

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

(d) Notification of Employer Eligibility

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

(e) Notification of Employee Eligibility

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

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

§ 6526. Qualified Employer Election of Coverage Periods.

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

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

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

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

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

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

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

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

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

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

(a) A qualified employee may enroll in a QHP or change his or her 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 QHP issuer.

(1) Requests to the SHOP to make changes to ~~plan~~ QHP selection received on the first through the fifteenth day of the month after the effective date shall become

retroactively effective to the first day of the month, unless the employer requests an effective date of the first of the following month.

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

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

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

in the same metal tier as the qualified employee's current ~~QHP~~health plan, as determined by the SHOP on a case-by-case basis.

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

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

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

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

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

(b) A qualified employee, or his or her 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 health 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 Medi-Cal 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~~Issuer of the health coverage or

dental coverage 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.

(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 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 health coverage under a Medi-Cal plan under title XIX of the Social Security Act or a state child health plan under title XXI of the Social Security Act.

(14) A qualified employee, or his or her 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~~ a QHP 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~~ a QHP at the same time as the victim.

(16) A qualified employee or dependent -

(A) Applies for health 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 health 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)-(11) and (b)(15)-(18) of that subdivision in this section to select a QHP through the SHOP.

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

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

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

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

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

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

1. Legal separation;

2. Divorce;

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

4. Death of an employee;

5. Termination of employment; and

6. Reduction in the number of hours of employment;

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

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

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

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

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

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

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

(B) When the individual no longer resides, lives, or works in the service area of an HMO or similar program (whether or not within the choice of the individual) and there is no other COBRA continuation coverage available to the individual; or

(C) When the individual incurs a claim that would meet or exceed a lifetime limit on all benefits and there is no other COBRA continuation coverage available to the individual.

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

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

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

(f) If requested by a QHP Issuer or SHOP, an employee or a dependent of an employee who experiences a triggering event that gives rise to a special enrollment

period pursuant to this section must provide verification of the triggering event to SHOP for review.

(g) A qualified employee or his or her 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 dental 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 Issuer in the SHOP;

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

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

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

and 1399.849, Health and Safety Code; and Sections 10753.05, 10753.063.5 and 10965, Insurance Code.

§ 6532. Employer Payment of Premiums.

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

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

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

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

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

(2) After the first invoice, the qualified employer must make a monthly premium payment ~~of no less than 85 percent~~ of 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~~health coverage and dental coverage, 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 that is returned ~~unpaid~~ for any reason, the SHOP shall apply a $25.00 insufficient funds fee. If a qualified employer makes a second premium payment that is returned unpaid for any reason within six months of the prior returned payment, the qualified employer shall submit premium payment and the insufficient funds fee for returned payment in the form of a cashier's check or money order. This requirement to make monthly premium payments in the form of a cashier's check or money order shall continue for a period of 12 months beginning with the first of the month following the last paid-through date. If premium payment is not submitted in one of these two forms, the qualified employer group may be subject to termination for non-payment of premium as described in Section

6538(c)(2). If payment is returned for insufficient funds, it will be considered non-payment for the invoiced month of coverage and triggers the 30 day Grace Period.

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

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

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

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

Insurance Code sections 10273.4 and 10273.7 and relevant state regulations before terminating coverage for such individuals, under the following circumstances:

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

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

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

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

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

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

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

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

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

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

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

(e) Effective Dates of Termination

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

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

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

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

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

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

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

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

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

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

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

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

(7) In the case of a termination in accordance with subdivision (c)(5) of this section, the last day of coverage in an enrollee's prior QHP shall be the day before the effective date of coverage in his or her 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~~ 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 10503, Government Code; and 45 CFR Sections 155.720, 155.725, 155.735, 155.1080 and 156.285.

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

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

Appeal record: The appeal decision, all papers and requests filed in the proceeding, and, if a hearing was held, the transcript or recording of hearing testimony or an official report containing the substance of what happened at the hearing and any exhibits introduced at the hearing.

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

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

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

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

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

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

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

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

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

Vacate: To set aside a previous action.

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

§ 6542. General Eligibility Appeals Requirements for Shop.

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

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

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

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

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

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

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

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

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

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

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

(d) The SHOP and appeals entity shall:

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

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

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

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

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

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

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

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

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

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

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

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

(1) An explanation of the appeals process;

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

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

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

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

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

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

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

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

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

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

(m) The appeals entity shall ensure that all data exchanges that are part of the appeals process, comply with the Federal and State privacy and security standards specified in 45 CFR Section 155.260 and the Information Practices Act of 1977 (Cal. Civ. Code, § 1798 et seq.) and are in an electronic format that is consistent with 45 CFR Section 155.270.

(n) Both the SHOP and the appeals entity shall provide the appellant with the opportunity to review his or her entire eligibility file, including all papers, requests, documents, and relevant information in the SHOP's possession at any time from the date on which an appeal request is filed to the date on which the appeal decision is issued.

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

§ 6544. Informal Resolution.

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

(b) Upon receipt of a valid appeal request, the SHOP shall:

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

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

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

(d) If the appeal advances to hearing:

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

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

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

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

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

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

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

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

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

§ 6546. Dismissals of Appeals.

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

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

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

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

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

(1) The reason for the dismissal; and

(2) An explanation of how the appellant may show good cause as to why the dismissal should be vacated in accordance with subdivision (d) of this section.

(c) If an appeal is dismissed, the appeals entity shall, within 15 business days from the date of the dismissal, provide notice of the dismissal to the SHOP.

(d) The appeals entity may vacate a dismissal and proceed with the appeal if the appellant makes a written request within 30 calendar days of the date of the notice of the dismissal showing good cause why the dismissal should be vacated.

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

§ 6548. Hearing Requirements.

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

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

(c) The hearing shall be conducted:

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

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

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

(4) By telephone, video conference, or in person, in accordance with the California Department of Social Services' Manual of Policies and Procedures Section 22-045.1.

(d) The appeals entity shall provide the appellant with the opportunity to:

(1) Review his or her appeal record, including all documents and records to be used by the appeals entity at the hearing, at least two (2) business days before the date of the hearing as well as during the hearing;

(2) Bring witnesses to testify;

(3) Establish all relevant facts and circumstances;

(4) Present an argument without undue interference;

(5) Question or refute any testimony or evidence, including the opportunity to confront and cross-examine adverse witnesses; and

(6) Be represented by an appeals representative.

(e) The appeals entity shall consider the information used to determine the appellant's eligibility as well as any additional, relevant evidence presented during the course of the appeals process, including at the hearing.

(f) The appeals entity shall review the appeal de novo and shall consider all relevant facts and evidence presented during the appeal process.

(g) Postponements and continuances shall be conducted in accordance with the California Department of Social Services' Manual of Policies and Procedures Section 22-053.

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

§ 6550. Expedited Appeal Process.

(a) An appellant shall have the right to request an expedited appeals process from the appeals entity where there is an immediate need for ~~health services~~health coverage or dental coverage because a standard appeal could jeopardize the appellant's life or health, or ability to attain, maintain, or regain maximum function.

(b) If the appeals entity denies a request for an expedited appeal, it shall:

(1) Handle the appeal request under the standard appeals process and issue the appeal decision in accordance with Section 6552; and

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

(A) The reason for the denial;

(B) An explanation that the appeal request will be administered pursuant to the standard appeals process; and

(C) An explanation of the appellant's rights under the standard appeals process.

(c) If the appeals entity grants a request for an expedited appeal, it shall:

(1) Ensure a hearing date is set on an expedited basis;

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

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

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

(3) Within three (3) business days from the date on which the appellant's request for an expedited appeal is granted, provide notice via secure electronic interface to the SHOP, specifying that the appellant's request for an expedited appeal is granted and a hearing will be set on an expedited basis.

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

§ 6552. Appeal Decisions.

(a) The appeals decisions shall:

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

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

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

(4) Summarize the facts relevant to the appeal;

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

(6) Provide information about judicial review available to the appellant pursuant to Section 1094.5 of the California Code of Civil Procedure.

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

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

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

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

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

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

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