Notice Published March 30, 2018

NOTICE OF PROPOSED RULEMAKING
CALIFORNIA CODE OF REGULATIONS, TITLE 10, CHAPTER 12, ARTICLE 6
ADOPT SECTIONS 6520, 6522, 6524, 6526, 6528, 6530, 6532, 6534, 6536 AND 6538

The California Health Benefit Exchange/Covered California (the Exchange) Board proposes to adopt the regulations described below after considering all comments, objections, and recommendations regarding the proposed action.

PUBLIC HEARING

The Exchange has not scheduled a public hearing on this proposed action. However, the Exchange will hold a hearing if it receives a written request for a public hearing for any interested person, or his or her authorized representative, no later than 15 days before the close of the written comment period.

WRITTEN COMMENT PERIOD

Any interested person, or his or her authorized representative, may submit written comments relevant to the proposed regulatory action to the Exchange. The written comment period closes at **5:00 p.m. on May 14, 2018.** The Exchange will consider only comments received at the Exchange's office by that time. Submit written comments to:

Faviola Ramirez-Adams, Regulations Analyst
California Health Benefit Exchange (Covered California)
1601 Exposition Blvd.
Sacramento, CA 95815

Comments may also be submitted by facsimile (FAX) at 916-403-4468 or by e-mail to regulations@covered.ca.gov.

AUTHORITY AND REFERENCE

Government Code Section 100504(a)(6) authorizes the California Health Benefit Exchange/Covered California (the Exchange) Board to adopt rules and regulations, as necessary. The proposed regulations implement, interpret, and make specific Government Code Sections 100503, 100504 and 100506; and Title 45 of the Code of Federal Regulations, Section 155.740.

INFORMATIVE DIGEST/POLICY STATEMENT OVERVIEW

Documents to be incorporated by reference:

None

Summary of Existing Laws

The federal Patient Protection and Affordable Care Act (ACA) required each state to establish an American Health Benefit Exchange that makes available qualified health plans (QHPs) to qualified individuals and small employers by January 1, 2014. In 2010, the legislature enacted the California Patient Protection and Affordable Care Act (California Government Code Section 100500 et seq.), which established the Exchange (AKA Covered California). Covered California is California's competitive marketplace where consumers and small businesses can shop for and purchase affordable QHPs certified by the Exchange. Additionally, the Exchange is the only place where consumers and small employers can receive tax credits to lower the costs of health insurance, if eligible.

On September 30, 2013 the California Health Benefit Exchange ("Covered California" or "Exchange") adopted emergency regulations found at Title 10, California Code of Regulations (CCR), Chapter 12, Article 6, Sections 6520, 6522, 6524, 6526, 6528, 6530, 6532, 6534, 6536, and 6538. Readoption of these emergency regulations took place on April 1, June 30, October 2, 2014, September 30 and November 28, 2016, and April 17, 2017. These emergency regulations are in effect and established the Exchange's policies regarding the Small Business Health Option Program's (AKA SHOP or Covered California for Small Business) policies and procedures for eligibility determination and redetermination, enrollment in qualified health plans, and termination of coverage.

The proposed regulations implement, interpret, and make specific the requirements in state and federal law. The proposed action is specifically in furtherance of California Government Code Section 100504 which instructs the Exchange to establish policies and procedures for eligibility determination and redetermination, enrollment in qualified health plans, and termination of coverage for prospective and current enrollees of the Exchange that complies with federal law. Additionally, Title 45, Section 155.700 et seq. of the Code of Federal Regulations (CFR) requires states establishing a SHOP to provide policies and procedures for eligibility determination and redetermination, enrollment in qualified health plans, and termination of coverage processes for the SHOP.

The Exchange is now proposing to make permanent those emergency regulations at 10 CCR § 6520, 6522, 6524, 6526, 6528, 6530, 6532, 6534, 6536, and 6538, with amendments.

Summary of the Effect of the Proposed Regulation

The proposed regulations make permanent previously readopted emergency regulations, with amendments, of the SHOP policies and procedures for eligibility determination and redetermination, enrollment in qualified health plans, and termination of coverage processes. The proposed regulatory action would permanently establish employee and employer rights

and responsibilities with respect to SHOP policies and procedures for eligibility determination and redetermination, enrollment in qualified health plans, and termination of coverage.

Evaluation of Inconsistency/Incompatibility with Existing State Regulations

After an evaluation of current regulations, the Exchange has determined that these proposed regulations are not inconsistent or incompatible with any existing regulations. While several California statutes and regulations govern health insurance and notably include provisions affecting the Exchange in the Government Code, the Insurance Code, and the Health & Safety Code, the Exchange has determined these are the only regulations that concern policies and procedures for eligibility determination and redetermination, enrollment in qualified health plans, and termination of coverage in the SHOP Exchange.

Anticipated Benefits of the Proposed Regulation

Anticipated benefits of the proposed action include nonmonetary benefits to the protection of public health and safety, worker safety, the environment, the prevention of discrimination, or the promotion of fairness or social equity. This includes:

- Providing structure for the Exchange to give predictability and clear standards to the public and qualified health plan issuers now and into the future.
- Establishing clear guidelines for the public regarding eligibility, enrollment, and termination of SHOP coverage.
- Aligning California's regulations with the federal act and complying with state law.
- Providing increased health care access to the public in California; and
- Ultimately, helping to save lives and increase the health of the public in California.

DISCLOSURES REGARDING THE PROPOSED ACTION

The Exchange has made the following initial determinations:

Matters Prescribed by Statute Applicable to the Agency or to Any Specific Regulation or Class of Regulations

None.

Mandate on Local Agencies and School Districts

None. The Executive Director of the California Health Benefit Exchange has determined that this proposed regulatory action does not impose a mandate on local agencies or school districts.

Cost To Any Local Agency or School District Which Must Be Reimbursed In Accordance With Government Code Sections 17500 Through 17630

None. This proposal does not impose costs on any local agency or school district for which reimbursement would be required pursuant to Part 7 (commencing with Section 17500) of Division 4 of the Government Code.

Costs or Savings to State Agencies

The proposal results in additional costs to the California Health Benefit Exchange, which became financially self-sustaining in 2016. The proposal does not result in any costs or savings to any other state agency.

Costs or Savings in Federal Funding to the State

The proposal results in additional costs to the California Health Benefit Exchange, which, via dollars from QHP participation fees, became financially self-sustaining in 2016.

Other Nondiscretionary or Savings Imposed on Local Agencies

None. This proposal does not impose other nondiscretionary costs or savings on local agencies.

Significant Effect on Housing Costs

None.

Effect on Small Business

The proposal results in an effect on participating small businesses with 1-100 employees statewide by providing them with policies and procedures for eligibility determination and redetermination, enrollment in qualified health plans, and termination of coverage in the small business marketplace for health insurance through the Exchange. There are no jobs created or eliminated from this proposal.

Significant, Statewide Adverse Economic Impact Directly Affecting Business, Including the Ability of California Businesses to Compete With Businesses in Other States

None.

Cost Impacts on a Representative Private Person or Business

While the total statewide dollar costs to businesses or individuals over the lifetime of the proposed regulation is unknown. The agency is not aware of any cost impacts a representative private person or business would necessarily incur in reasonable compliance with the proposed action.

Results of the Economic Impact Assessment/Analysis

The Exchange concludes regarding the proposed regulations that it is:

(1) **unlikely** that the proposal will create or eliminate any jobs in the State;
(2) **unlikely** that the proposal will create or eliminate businesses within the State;
(3) **unlikely** that the proposal will impact the expansion of businesses currently doing business in California; and
(4) **likely** that the health and welfare of consumers will benefit from the proposed regulation.

Benefits of the Proposed Action

Anticipated benefits including nonmonetary benefits to the protection of public health and safety, worker safety, the environment, the prevention of discrimination, or the promotion of fairness or social equity, from this proposed regulatory action are:

- Providing structure for the Exchange to give predictability and clear standards to the public and qualified health plan issuers now and into the future.
- Establishing clear guidelines for the public regarding eligibility, enrollment, and termination of SHOP coverage. Aligning California's regulations with the federal act and complying with state law.
- Providing increased health care access to the public in California; and
- Ultimately, helping to save lives and increase the health of the public in California.

CONSIDERATION OF ALTERNATIVES

In accordance with Government Code section 11346.5, subdivision (a)(13), the Board must determine that no reasonable alternative it considered or that has otherwise been identified and brought to the attention of the agency would be more effective in carrying out the purpose for which the action is proposed, or would be as effective and less burdensome to affected private persons than the proposed action, or would be more cost-effective to affected private persons and equally effective in implementing the statutory policy or other provision of law.

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

CONTACT PERSONS

Inquiries concerning the proposed administrative action may be directed to:

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

The backup contact person for inquiries concerning the proposed administrative action may be directed to:

Brandon Ross
Assistant General Counsel
California Health Benefit Exchange (Covered California)
1601 Exposition Blvd.
Sacramento, CA 95815
Telephone: (916) 228-8281

Please direct request for copies of the proposed text of the regulations, the Initial Statement of Reasons, the modified text of the regulations, if any, or other information upon which the rulemaking is based to Faviola Ramirez-Adams at the above contact information.

AVAILABILITY OF STATEMENT OF REASONS, TEXT OF PROPOSED REGULATIONS AND RULEMAKING FILE

The Exchange will have the entire rulemaking file available for inspection and copying throughout the rulemaking process at its office at the above address. As of the date of this notice is published in the Notice Register, the rulemaking file consists of this notice, the proposed text of the regulation and the Initial Statement of Reasons. Copies may be obtained by contacting Faviola Ramirez-Adams at the address or phone number listed above.

AVAILABILITY OF CHANGED OR MODIFIED TEXT

After holding the hearing, if requested, and considering all timely and relevant comments received, the Exchange may adopt the proposed regulations substantially as described in this notice. If the Exchange makes modifications which are sufficiently related to the originally proposed text, it will make the modified text to the public at least 15 days before the Exchange adopts the regulations as revised. Please send requests for copies of any modified regulations to the attention of Faviola Ramirez-Adams at the address indicated above. The Exchange will accept written comments on the modified regulations for 15 days after the date on which they are made available.

AVAILABILITY OF THE FINAL STATEMENT OF REASONS

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

AVAILABILITY OF DOCUMENTS ON THE INTERNET

Copies of the Notice of Proposed Rulemaking, the Initial Statement of Reasons and the proposed text of the regulations in underline can be accessed through our website at www.healthexchange.ca.gov/regulations.

INITIAL STATEMENT OF REASONS FOR
APPLICATION, ELIGIBILITY, AND ENROLLMENT IN THE SHOP EXCHANGE
OF THE CALIFORNIA HEALTH BENEFIT EXCHANGE
CALIFORNIA CODE OF REGULATIONS, TITLE 10, CHAPTER 12, ARTICLE 6
ADOPT SECTION 6520 THROUGH 6538

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

SUMMARY OF THE PROPOSED REGULATIONS:

The proposed regulations seek to clarify and make specific the California Health Benefit Exchange's policies and procedures for eligibility determination and redetermination, enrollment in qualified health plans, and termination of coverage through the Small Business Health Options Program (SHOP) a.k.a. Covered California for Small Business (CCSB). The regulations provide small employers and employees with eligibility requirements to qualify and sign up for health insurance coverage through the SHOP Exchange. The regulations will also provide the standards and requirements applicable to QHP issuers participating in the SHOP Exchange.

This proposed regulatory action will make permanent Sections 6520, 6522, 6524, 6526, 6528, 6530, 6532, 6534, 6536, 6538 of Title 10 of the California Code of Regulations (C.C.R.) related to the SHOP of the California Health Benefit Exchange.

AUTHORITY AND BACKGROUND
Under the federal Patient and Protection and Affordable Care Act (PPACA), each state was required, by January 1, 2014, to establish an American Health Benefit Exchange that makes available qualified health plans (QHPs) to qualified individuals and small employers. Existing state law, the California Patient Protection and Affordable Care Act, established the California Health Benefit Exchange within state government. Gov. Code § 100500 et seq. The law requires the Exchange to establish a Small Business Health Options Program (SHOP) (AKA "Covered California for Small Business"). Gov. Code § 100502(m). It further requires the Exchange to establish the criteria and process for eligibility determination, enrollment, and disenrollment of enrollees and potential enrollees in the Exchange's Small Business Health Options Program. Gov. Code § 100503(a).

In March 2010, President Obama signed federal health reform legislation entitled the Patient Protection and Affordable Care Act (Affordable Care Act). The Affordable Care Act creates state-based health insurance exchanges. The purpose of state health insurance exchanges is to make health insurance more affordable and easier to

purchase for small business and individuals. Under the Affordable Care Act, states may choose to operate their own exchanges or participate in a multi-state exchange. If a state elects to operate its own exchange, that state is required, by January 1, 2014, to establish an American Health Benefit Exchange that makes available qualified health plans to qualified individuals and small employers.

California chose to operate its own exchange, now known as the “Exchange” or "Covered California." The Exchange's vision is to improve the health of all Californians by assuring their access to affordable, high quality health care. The Exchange’s mission is to increase the number of insured Californians, improve health care quality, lower costs, and reduce health disparities through an innovative, competitive marketplace that empowers consumers to choose the health plan and providers that give them the best value.

In 2010, the California legislature enacted Gov. Code Section 100500 et seq., which established the Exchange. The Exchange is a competitive marketplace where consumers and small businesses can shop for and purchase affordable, quality insurance coverage. Gov. Code Section 100500(a) established that the Exchange shall be governed by an executive board (“the Board”). Gov. Code Section 100504(a)(6) specifically authorizes the Board to adopt rules and regulations, as necessary. It is pursuant to that statutory authority that the Exchange proposes this permanent regulatory proposal.

Gov. Code Section 100502(m) requires the Exchange to establish a Small Business Health Options Program (SHOP) where small employers and employees can purchase quality, affordable health insurance. The Exchange is further required to establish the criteria and process for eligibility determination, enrollment, and disenrollment of enrollees and potential enrollees in the Exchange’s Small Business Health Options Program. (Gov. Code, Section 100503(a)).

These regulations implement and make specific statutory requirements in Gov. Code Section 100502(m) to identify and define the standard plan designs that carriers are required to offer inside and outside of the Exchange. It is the intent of the Exchange that these regulations are consistent with applicable laws and guidance related to the offering of products inside and outside of the Exchange.

THE PROBLEM

Existing state and federal law, the federal Patient Protection and Affordable Care Act (ACA) and the California Affordable Care Act led to the establishment of the California Health Benefit Exchange as the sole marketplace in the state where qualified individuals and small businesses would be able to receive tax credits and cost share reductions to purchase coverage through Exchange-certified qualified health plans (QHPs). State and federal law required the Exchange to facilitate the purchase of QHPs through the Exchange by January 1, 2014.More specifically, the California enabling legislation requires the Exchange to establish the criteria and process for eligibility determination, enrollment, and disenrollment of enrollees and potential enrollees in the Exchange.

(Gov. Code, § 100503(a).) The eligibility determination, enrollment, and disenrollment procedures are not only required by federal and state law, but they are fundamental for administering the Exchange on an ongoing basis. The adoption of these regulations will help provide an avenue for small business employees to gain access to health insurance. Establishing a process through which small business employers can purchase coverage for their employees will expand access to quality and affordable health insurance, thereby effectuating the intent of the Affordable Care Act.

PURPOSES, BROAD OBJECTIVES AND BENEFITS

The broad purpose of this proposed regulatory action is to establish the Exchange's policies and procedures for eligibility determination and redetermination, enrollment in qualified health plans, termination of coverage through the Exchange, and appeals process in the SHOP.

Specifically, the Exchange's proposed regulatory action will provide the necessary criteria for the enrollment functions of the SHOP, requirements for participation by employers and employees, and additional standards specific to the SHOP for health plans offering coverage. Establishing requirements with respect to application, eligibility, and enrollment will facilitate a standardized system through which small business employers can clearly understand their SHOP options to bring quality and affordable health coverage to their employees. In turn, these proposed regulations will expand access to health care and improve the health and welfare of thousands of California residents.

Objectives:

The broad objectives of this proposed regulatory action are to:

- Provide structure for the Exchange and give predictability and clear standards for the SHOP to small employers, their employees and dependents, and qualified health plan issuers.

- Specifically provide the public with the eligibility requirements to qualify for federal tax subsidies through the SHOP Exchange

- Establish the criteria and process for eligibility determination, enrollment, and disenrollment of employers, their enrollees and potential enrollees in the SHOP Exchange.

- Establish an appeals process for prospective and current employers and enrollees of the Exchange and thereby provide due process to applicants denied insurance or with other appealable rights. More specifically, this action includes clear guidelines for the public to request and receive a fair hearing.

- Achieve State compliance with the federal act.

- Administer the SHOP Exchange eligibility determination, enrollment, and disenrollment procedures of the ACA transparently, systematically, and predictably for the public on an ongoing basis.

- Reduce health care costs and provide increased and quality health care to the employees and their dependents of small employers in California.

Benefits:

Anticipated benefits of the proposed regulatory action, including nonmonetary benefits to the protection of public health and safety, worker safety, the environment, the prevention of discrimination, or the promotion of fairness or social equity, are:

- Making quality health care available to thousands of small business employers and their employees in California;

- Providing structure for the Exchange to give predictability and clear standards to the public and qualified health plan issuers now and into the future;

- Providing the public with clear standards and eligibility requirements to qualify for federal tax subsidies through the SHOP Exchange;

- Establishing the criteria and process for eligibility determination, enrollment, and disenrollment of enrollees and potential enrollees in the SHOP Exchange;

- Aligning California's regulations with the federal act and complying with state law;

- Reducing health care costs for Californians;

- Providing increased health care access to the public in California; and

- Ultimately, helping to save lives and increase the health of the public in California.

CONSISTENCY AND COMPATIBILITY WITH EXISTING STATE REGUATIONS*:*

The Exchange has evaluated whether the proposed regulations are inconsistent or incompatible with existing state laws and regulations. This evaluation included a review of the laws that regulate the Exchange and specifically those statutes and regulations related to health insurance in general. Exchange staff also conducted an internet search of other state agency regulations.

Several California statutes and regulations govern health insurance, most notably those provisions are codified in certain provisions of the Health and Safety Code and the

Insurance Code. No known statute or regulation conflicts with this proposed regulatory proposal. Some compatible statutes, including those in federal law such as the Patient Protection and Affordable Care Act (ACA), Employee Retirement Income Security Act of 1974 (ERISA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) provide additional requirements that may affect the Exchange's SHOP operations. The Exchange is in conformity with applicable requirements. All statutes identified have been reviewed and are compatible with this proposal. Additionally, the proposed regulatory text has identified authorities being implemented or made specific through the proposal.

DETAILED DISCUSSION OF THE SPECIFIC PURPOSE, RATIONALE AND PROBLEM ADDRESSED FOR EACH REGULATION PROPOSED FOR AMENDMENT, ADOPTION OR REPEAL:

Article 6. Application, Eligibility, and Enrollment in the SHOP Exchange Sections 6520, 6522, 6524, 6526, 6528, 6530, 6532, 6534, 6538, and 6540 of Title 10 of the California Code of Regulations (C.C.R.)

Authority Cited in this Regulatory Proposal: Government Code Section 100504.

References Cited in this Regulatory Proposal: Government Code Sections 100502, 100503, and 100504; 45 C.F.R. Parts 155 and 156.

Pursuant to its authorities, the Exchange proposes to permanently adopt Article 6 of Title 10, Investment, Chapter 12, and the regulations contained in that Article. The detailed discussion of the specific purpose, rationale, problems addressed, and statement of reasons for Article 5 and the sections within that Article is as follows:

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

Article 6 in its entirety, implements, clarifies, and makes specific the eligibility requirements for small employers and employees to enroll in a qualified health plan (QHP) through the SHOP Exchange. It details the processes to apply for, enroll, and terminate coverage in the SHOP Exchange, including steps necessary to seek an eligibility determination or redetermination. This article is necessary to provide small business employers, employees and the public with the standards and guidelines to request and receive an eligibility determination for enrollment in a QHP through the Exchange. This article is also necessary to provide the standards and requirements for QHP issuers regarding enrollment of small employers and employees in the QHPs and termination of coverage through the SHOP Exchange. This entire Article is also necessary to implement federal requirements in 45 CFR 155.730.

§ 6520. Employer and Employee Application Requirements

Section 6520 in its entirety, clarifies and makes specific all the required elements and declarations that the applicant must provide in the application in order for the SHOP Exchange to determine the applicants' eligibility for enrollment. This is necessary to provide the employer groups with clear standards and guidelines on how to complete and submit an application for coverage through the SHOP Exchange, and to comply with mandatory federal requirements specified in 45 CFR Section 155.730.

Section 6520(a) in its entirety clarifies and makes specific the application criteria required to enroll in the SHOP Exchange. This is necessary to provide the public with guidance on what information is required to participate in SHOP. This is also necessary to comply with mandatory federal requirements specified in 45 CFR Section 155.730(a) and 155.730(b).

Section 6520(a)(1) specifies and clarifies that an employer must submit all information necessary to identify the employer, including business and fictitious name, federal and state identification numbers, type of organization, Standard Industry Classification (SIC) code, primary business address, business and mailing addresses. Business name, fictitious name and State employer identification number are necessary to identify the business. Business location is necessary to determine eligibility of the employer and the premium rates applicable to the employer's qualified employees. SIC Code is necessary to better target employers in the SHOP marketplace. Mailing and billing address information is necessary for mailing of documents and billings. The Exchange requires the organization type to better target their SHOP marketplace. This is also necessary to comply with mandatory federal requirements specified in 45 CFR Section 155.730(b)(1).

Section 6520(a)(2) requires the total number of eligible employees being offered enrollment in SHOP and total number of full time equivalent (FTE) employees employed. This is necessary to determine whether the employer is eligible for the SHOP Exchange. This is also necessary to comply with the federal requirement specified in 45 CFR Section 155.730(b)(2), Health and Safety Code Section 1357.500(k)(3) and Insurance Code Section 10753(q)(3).

Section 6520(a)(3) requires an employer to specify whether it has employed 20 or more employees for 20 or more weeks in the current or preceding calendar year. This is necessary information for QHPs to determine primary and secondary payer status for health care services delivered to enrollees with respect to Medicare payments to health care service providers.

Section 6520(a)(4) requires the employer to advise whether or not they are extending an offer of coverage to dependents or non-registered domestic partners of the employee. This information is necessary to determine whether the employee's dependents and/or non-registered domestic partners are eligible to participate in the SHOP Exchange and be included on the Employer's SHOP policy.

Section 6520(a)(5) desired insurance coverage effective date is required and necessary to establish the Employer's desired effective date for health insurance coverage. Without this information the SHOP Exchange would not know when to instruct QHPs to commence coverage and when to invoice the employer..

Section 6520(a)(6) requires employer to advise whether they are subject to COBRA or Cal-COBRA. This information is necessary to determine whether the Employer is subject to COBRA or Cal-COBRA continuation coverage regulations and to assist SHOP in determining who is responsible for the administration of continuation benefits in the event that an employee qualifies for them. SHOP will administer Cal-COBRA benefits and the Employer is responsible for administering Federal COBRA benefits.

Section 6520(a)(7) requires the employer to advise if they are currently offering coverage to their employees, and, if so, through which issuer. This information is necessary for SHOP to better understand the current health insurance market for small businesses and identify shifts in that market to better serve employers and their employees. One of the goals of the PPACA is to increase the number of small employers providing health care coverage to employees. Having this information from qualified employers will help the Exchange know if the goal is being met.

Section 6520(a)(8) requires the employer to advise if they intend to claim the Small Business Health Care Tax Credit. This information is necessary for SHOP to better understand the current health insurance market and drivers leading to employer participation in the SHOP.

Section 6520(a)(9) requires the name and contact information of the employer's primary contact and the employer's business owner or authorized company officer. This information is necessary so the SHOP Exchange knows who to contact regarding the employer's policy and how to contact that person. In addition, the information regarding the employer's business owner or authorized company officer is necessary to comply with the SHOP's on-line employer portal requirement to insure only authorized personnel have access to this portal.

Section 6520(a)(10) requires the employer to state whether it used a certified insurance agent, the agent's name, the 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. It is necessary to identify which agent and general agency, if applicable, assisted and advised the employer with decision making and the completion of the employer application in order to correctly associate the employer with the agent and general agency for the purposes of commission remittance. This section also requires the employer to have the agent certify that he or she understands that he or she may be subject to civil penalty for providing false information under Health and Safety Code 1389.8 and Insurance Code 10119.3. This is necessary to remind the agent of their duty and to compel the agent to provide accurate information to the employer, and to give the employer recourse in the event that the agent provides inaccurate information.

Section 6520(a)(11) requires that the employer provide information about their qualified employees that are eligible to apply for coverage under the employer's application. The required information is specified in subsection 6520(d). Having this information is necessary so the SHOP can review the employer-provided information about the qualified employees and compare it to the information provided in the employer's reconciled Quarterly Contribution Return and Report of Wages (Form DE-9C), to aid in determining if the qualified employer meets the minimum participation required for eligibility in the SHOP.

Section 6520(a)(12) requires employer's premium contribution amount for employees, metal tier and reference plan selection. This is necessary to inform the SHOP of the employer's premium contribution, metal tier and reference plan so the SHOP can correctly calculate employer contribution dollar amounts for each enrolled employee and their dependents and know what metal tier employees can chose from.

Section 6520(a)(12)(A) requires health premium contribution amount for employees . This is necessary for the employer to provide their premium contribution amount for employees so that the SHOP can correctly determine how much of the employees' health insurance premium will be paid by the employer and how much of the health insurance premium the employee will pay.

Section 6520(a)(12)(B) requires health premium contribution amount for spouse, non-registered domestic partner or dependent children, if applicable. This is necessary to determine how much of the dependents' insurance premium amounts will be paid by the employer and how much of those amounts will be paid by the employee.

Section 6520(a)(12)(C) requires employer to choose health insurance metal tier, or tiers, and reference plan. This is necessary for the employer to provide their metal tier selection and QHP reference plan because the employer's premium contribution is based on their QHP metal tier and reference plan selection. This is also necessary to determine the dollar amount of the employees' health insurance premium paid by the employer and the dollar amount paid by the employee, respectively. .

Section 6520(a)(12)(D) requires the employer to advise if they will offer infertility benefits to their qualified employees. It is necessary for the SHOP to know this so the appropriate plans and correct premium amounts can be provided to employees for their review and selection.

Section 6520(a)(13) clarifies and makes specific that 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. Exceptions for exceptional circumstances will be considered on a case-by-case basis. It is important for new qualified employers and their agents to know application deadlines and their

associated effective dates of coverage so they can plan their offer of coverage to their eligible employees and their eligible dependents accordingly. In addition, it is important for new qualified employers and their agents to know that if they submit their application subsequent to the deadline but wish to have an effective date the first of the following month, as opposed to the first of the second month following the submission date, they can do so by completing and submitting the CCSB New Business Late Submission Acknowledgement Form. This form has the new qualified employer acknowledge that, due to their late submission, delays in enrollments for their qualified employees' selected QHPs may occur.

Section 6520(b) in its entirety clarifies and makes specific the employer attestations required for SHOP participation. This is necessary for the employer to attest to the fact that the information provided on the application is accurate to the best of their knowledge and the possible consequences for intentionally providing inaccurate information. This is also necessary for the employer to acknowledge all rules and requirements required to enroll in and maintain health insurance coverage through SHOP as well as acknowledge applicable state and federal laws.

Section 6520(b)(1) advises that the employer attest that their business has 100 or fewer full time equivalent employees and has a principal business address in California. The employer must attest to these since they are requirements for eligibility in the SHOP and there is no method for SHOP to verify this information other than through a full audit of the employer's records.

Section 6520(b)(2) advises that the employer attest that all qualified full-time employees are offered SHOP coverage. The employer must attest to this since it is a requirement for eligibility and there is no means by which SHOP can independently verify this.

Section 6520(b)(3) advises that the employer attest that the business has at least one employee who is not an owner, business partner, or spouse of either. The employer must attest to this since it is a requirement for eligibility and there is no method for SHOP to verify this information other than through a full audit of the employer's records.

Section 6520(b)(4) advises the employer that they are signing the application under penalty of perjury that all information in the application is true and correct to the best of the employer's knowledge. This is necessary for the employer to acknowledge that they are required to provide accurate information to the best of their knowledge or face possible criminal charges. Signature under penalty of perjury is required for the SHOP Exchange application consistent with the requirements of the Individual Exchange application. The penalty of perjury provision was deemed necessary following extensive stakeholder consultation to protect against fraud in Exchange health insurance programs and ensure the authenticity of information provided.

Section 6520(b)(5) advises the employer that the employer knows that he or she may be subject to civil penalties under federal law if he or she intentionally provides false or

untrue information. This is necessary to specify that the employer acknowledges that they are required to provide accurate information to the best of their knowledge or face possible civil action.

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

Section 6520(b)(7) advises the employer that any employer-based waiting period complies with 42 U.S.C.§ 300gg-7 and applicable state law, and that all qualified employees have completed the qualified employer's waiting period. This section is necessary to advise employers that they may establish employee waiting periods but that they must be complaint with applicable State and Federal Law and if the employer has established waiting periods, that the employees he or she is offering coverage to have satisfied those waiting periods.

Section 6520(b)(8) advises that the employer must obtain the consent of every qualified employee listed on the application to include their personally identifiable information on the application. This is necessary to ensure that the employer takes appropriate actions to obtain their employees' permission to provide their personally identifiable information to the SHOP.

Section 6520(b)(9) ensures the employer understands that discrimination based on race, color, national origin, religion, gender 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 is prohibited. This is necessary to alert the employer that discrimination specified in the regulation, the Health and Safety Code, and the Insurance Code is prohibited by the Exchange and all eligible full-time employees made an offer of coverage.

Section 6520(b)(10) ensures that the employer understands that the SHOP will not consider the qualified employer approved for health insurance coverage until the SHOP has received the first month's premium payment, which cannot be less than 85 percent of the total amount due. This is necessary to advise the employer it must remit payment for the entire invoiced amount, and no less than 85 percent of the total amount due, in order to effectuate health insurance coverage. This is necessary to allow for the first payment to be as much as 15 percent less than the total amount due which may happen, for example, when the employer's initial list of qualified employees is unintentionally incorrect. Without this subdivision, the employer may think that coverage has commenced even though it has not paid the invoice.

Section 6520(b)(11) ensures that the employer is made aware of the requirement to continue to make the monthly premium payments each month by the invoice due date, and which cannot be less than 85 percent of the total amount due, including past due amounts, in order to maintain eligibility for SHOP. This section is necessary because,

pursuant to 45 CFR 155.735, failure to timely pay the monthly premium could result in the termination of SHOP coverage.

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

Section 6520(b)(13) this section ensures that the employer understands that once coverage in a QHP is approved, changes to coverage cannot be made until the employer's next annual election period pursuant to Section 6526, with the exception that the employer may 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). This is necessary to ensure that the employer understands that once coverage in a QHP is approved, they may only make changes within the first 30 days of coverage, or at their next annual election period.

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

Section 6520(b)(15) advises the employer that once employer and employee information is transmitted to the selected QHP, the coverage effective date cannot be changed nor can the coverage be terminated until after the first month of coverage. This is necessary to advise the employer that they cannot make a change to their effective date of coverage, and, separately, they cannot terminate the coverage until after the first month. It is important that the employer knows this information so he or she can 1) request the correct date for commencement of coverage, and 2) understand that once employer and enrollee information is transmitted to QHPs, coverage cannot be terminated by the employer for any of his or her qualified employees or their dependents before the end of the first month.

Section 6520(b)(16) advises the employer that he or she must inform its qualified employees of the availability of child and family dental plans and that qualified employees may choose to enroll in a dental plan only, even if the qualified employee does not choose to enroll in a QHP. This is necessary to ensure that the employer knows all options available to employees, and that it is his or her responsibility to inform qualified employees of this availability.

Section 6520(b)(17) advises the employer that the attestations are subject to audit by the SHOP at any time. It is important that the employer be aware that it may be necessary to verify the accuracy and truthfulness of the information it provided to the SHOP.

Section 6520(b)(18) ensures the employer agrees to maintain compliance with the requirements in this section in order to continue eligibility for coverage through the SHOP. This is necessary to advise the employer that it must continue to comply with all of the requirements in this section or risk loss of SHOP coverage.

Section 6520(c) in its entirety, clarifies and makes specific the requirement of the employer to 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 (EDD). This section also clarifies the employer requirement to identify whether each employee on the DE-9C is a full-time employee, part-time eligible employee, ineligible employee or if the employee still works for the employer. This section advises the employer to provide the required information on the Form DE-9C, and explains that they may attach additional sheets of paper to the DE-9C form, if necessary. This section also advises the qualified employer of the additional documents required by SHOP based on their business entity type and length of time in business. This section is necessary to provide guidance to the employer regarding the documents required by the SHOP to identify and establish the eligibility of the business, as well as identify eligible employees. This subdivision is also necessary so that the SHOP can verify that only eligible small employers and their eligible employees enroll in coverage through the SHOP Exchange.

Section 6520(c)(1) requires a sole proprietor in business less than three (3) months to provide a California business license or Fictitious Business Name Filing and a DE-9C or payroll records for 30 days. This is necessary to provide the employer guidance on the documents required by the SHOP to establish eligibility of their business, as well as identify the business and eligible employees. This is also necessary to verify that the employer and employees are actually eligible to enroll in coverage through the SHOP Exchange.

Section 6520(c)(2) requires a sole proprietor in business three (3) months or more to provide 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, or, if a Form 1040 Schedule C is not available, a California business license

or Fictitious Business Name filing may be substituted. This is necessary to provide a sole proprietor guidance on the documents required by the SHOP to identify and establish eligibility of their business and, if the business owner wishes to enroll for coverage, establish eligibility to do so..,

Section 6520(c)(3) requires a corporation in business less than three (3) months to provide 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. This is necessary to provide the employer guidance on the documents required by the SHOP to establish eligibility of their business, as well as identify the business and eligible employees. This is also necessary to verify that the employer and employees are actually eligible to enroll in coverage through the SHOP Exchange.

Section 6520(c)(4) requires a corporation in business three (3) months or more to provide a DE-9C, and if officers are not listed on the DE-9C and enroll for coverage, a Statement of Information. This is necessary to provide the employer guidance on the documents required by the SHOP to establish eligibility of their business, as well as identify the business and eligible employees. This is also necessary to verify that the employer and employees are actually eligible to enroll for coverage through the SHOP Exchange.

Section 6520(c)(5) requires a partnership in business less than three (3) months to provide a Partnership Agreement, a Federal Tax Identification appointment letter and a DE-9C, or payroll records for 30 days. This is necessary to provide the employer guidance on the documents required by the SHOP to establish eligibility of their business, as well as identify the business and eligible employees. This is also necessary to verify that the employer and employees are actually eligible to enroll in coverage through the SHOP Exchange.

Section 6520(c)(6) requires a partnership in business three (3) months or more to provide a DE-9C and a current IRS Form 1065 Schedule K-1, if partners are not listed on the DE-9C and want to enroll for coverage. If IRS Form 1065 Schedule K-1 is not available, the Partnership Agreement and Federal Tax Identification appointment letter can be substituted. This is necessary to provide the employer guidance on the documents required by the SHOP to establish eligibility of their business, as well as identify the business and eligible employees. This is also necessary to verify that the employer and employees are actually eligible to enroll in coverage through the SHOP Exchange.

Section 6520(c)(7) requires a limited partnership in business less than three (3) months to provide a Partnership Agreement, a Federal Tax Identification appointment letter and a DE-9C or payroll records for 30 days. This is necessary to provide the employer guidance on the documents required by the SHOP to establish eligibility of their business, as well as identify the business and eligible employees. This is also

necessary to verify that the employer and employees are actually eligible to enroll in coverage through the SHOP Exchange.

Section 6520(c)(8) requires a limited partnership in business three (3) months or more to provide a DE-9C. If general partners are not listed on the DE-9C and wish to enroll in coverage, they must provide 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. This section also advises employers that limited partners are not eligible for coverage unless they appear on the DE-9C. This is necessary to provide the employer guidance on the documents required by the SHOP to establish eligibility of their business, as well as identify the business and eligible employees. This is also necessary to verify that the employer and employees are actually eligible to enroll in coverage through the SHOP Exchange.

Section 6520(c)(9) requires a limited liability partnership in business less than three (3) months to provide a Partnership agreement or a Federal Tax Identification appointment letter and a DE-9C, or payroll records for 30 days. This is necessary to provide the employer guidance on the documents required by the SHOP to establish eligibility of their business, as well as identify the business and eligible employees. This is also necessary to verify that the employer and employees are actually eligible to enroll in coverage through the SHOP Exchange.

Section 6520(c)(10) requires a limited liability partnership in business three (3) months or more to provide a DE-9C. If partners are not listed on the DE-9C and wish to enroll in coverage, a current IRS Form 1065 Schedule K-1 must be provided. If the IRS Form 1065 Schedule K-1 is not available, the Partnership Agreement and the Federal Tax Identification appointment letter can be substituted. This is necessary to provide the employer guidance on the documents required by the SHOP to establish eligibility of their business, as well as identify the business and eligible employees. This is also necessary to verify that the employer and employees are actually eligible to enroll in coverage through the SHOP Exchange.

Section 6520(c)(11) requires a limited liability company in business less than three (3) months to provide Articles of Organization with the Operating Agreement, or the Statement of Information and a DE-9C, or payroll records for 30 days. This is necessary to provide the employer guidance on the documents required by the SHOP to establish eligibility of their business, as well as identify the business and eligible employees. This is also necessary to verify that the employer and employees are actually eligible to enroll in coverage through the SHOP Exchange.

Section 6520(c)(12) requires a limited liability company in business three (3) months or more to provide 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 must be provided. If the IRS Form 1065 Schedule K-1 is not available, a Statement of Information, or Articles of Organization with the Operating Agreement may be substituted. This is necessary to

provide the employer guidance on the documents required by the SHOP to establish eligibility of their business, as well as identify the business and eligible employees. This is also necessary to verify that the employer and employees are actually eligible to enroll in coverage through the SHOP Exchange as a small business group.

Section 6520(c)(13) specifies that for qualified employers who were previously insured outside of the SHOP, the SHOP may waive or alter the additional document requirements in Sections 6520(c)(1)-(12) if the SHOP determines, on a case-by-case basis, the proof of that prior coverage is sufficient to determine eligibility. This is necessary to allow the SHOP the flexibility to decrease the burden on employers to provide documentation that can establish eligibility for SHOP coverage if the SHOP determines those additional requirements are unnecessary.

Section 6520(d) in its entirety, clarifies and makes specific the information that a qualified employee must provide in order to participate in the SHOP. This is necessary to advise the employee of the information required by the SHOP to determine eligibility, identify the employee, and dependents if applicable, and provide contact and mailing address information.

Section 6520(d)(1) requires name and phone number of employee's employer. This information is necessary to match the employee to the employer.

Section 6520(d)(2) requires employee's first and last name, taxpayer identification number, date of birth, home and mailing address, phone number, email address and if the employee is newly hired. The employee's mailing address, email address and telephone number are necessary for mailing documents and contacting the employee if there are questions regarding his or her application. The employee's taxpayer identification number is a unique identifier that is necessary to ensure the integrity of that employee's record in both SHOP and QHP administrative systems. It is necessary to know if the employee is newly hired in order to aid in the review of the employer's DE-9C. An employee who is newly hired is unlikely to appear in the employer's most recent DE-9C.

Section 6520(d)(3)(i) – (iii) requires the employee to state if he or she is applying for Cal-COBRA or COBRA continuation coverage, and if so, (i) if that coverage is currently in effect or, (ii) if the employee has had a qualifying event that renders the employee eligible to apply for continuation coverage, and, (iii) if applicable, the effective date of continuation coverage, the nature of the qualifying event that triggered continuation coverage eligibility and the date of the qualifying event. It is necessary to a) know if an employee's continuation coverage is already in effect so the SHOP can ensure that the qualified beneficiary does not experience a gap in coverage because the SHOP will know that all of the continuation coverage application timeline requirements have already been met, and, b) in the case of an employee who has recently experienced a qualifying event and is applying for continuation coverage, the SHOP needs to be able to track the timing of the receipt of the application vs. the date of the qualifying event as well as the timing of receipt of the premium for the first month of coverage in order to

confirm eligibility, and, c) in the case where continuation coverage is currently in effect, the effective date of coverage and in both cases, the date and type of qualifying event are necessary to determine the continuation coverage termination date.

Section 6520(d)(4) requires the employee to state their marital or domestic partnership status if the employer is offering coverage for dependents and the employee elects to include his or her dependents under their coverage. This information is necessary to identify and include a dependent on the employee's policy and to determine if that dependent is eligible to be added to the employee's policy.

Section 6520(d)(5) clarifies and specifies that if the 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 domestic partner and/or dependent children is required. This is necessary to advise the employee of the dependent information required in order to add a dependent to their policy.

Section 6520(d)(5)(A) requires the employee to provide the first and last name of their 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). This information is necessary to identify the enrollee as a dependent of the qualified employee, to enable SHOP to verify dependent eligibility, to enable the SHOP to send coverage documents and information about coverage to the enrolling dependent, and to determine which QHPs, based on home residence, are available to the dependent for coverage.

Section 6520(d)(5)(B) requires the employee to state if he or she is enrolling a dependent who is a disabled child pursuant to Section 599.500 of Title 2 of the California Code of Regulations. SHOP needs to know this information to advise the employee of the guidelines for establishing a disabled child as a dependent and to determine the dependent's continued eligibility as a child dependent upon attaining the age of 26 years.

Section 6520(d)(6) requires the employee to provide the name of the QHP and dental plan, if applicable, selected by the qualified employee and dependents. This information is necessary to ensure that the SHOP enrolls a qualified employee and dependents in the correct QHP and dental plan, if applicable.

Section 6520(e) in its entirety, clarifies and makes specific the qualified employee attestations required for SHOP participation. This is necessary to advise the employee of these requirements, that they must provide true and correct information and that the information provided on the application will only be shared with a QHP or employer for eligibility and enrollment purposes.

Section 6520(e)(1) requires an employee to acknowledge that they agree to arbitration if the QHP they select requires arbitration. This is necessary in the event that the employee enrolls in a QHP that uses mandatory binding arbitration to resolve disputes. State law, Health and Safety Code section 1363.1, requires notice of binding arbitration to be included in the application for insurance coverage and this requirement will ensure that the employee is aware of the requirement and the rights he or she is waiving by agreeing to binding arbitration.

Section 6520(e)(2) This section captures agent information that allows the Exchange and the Department of Insurance to monitor the participation of licensed insurance agents who facilitate enrollments in the SHOP Exchange. It is also necessary to require agents to acknowledge their understanding that federal and state law provides sanctions for agents that give false information in the application process.

Section 6520(e)(3) requires the employee to sign the application under penalty of perjury, and all information included in the application is true and correct to the best of the employee's knowledge. This is necessary in order to notice the employee that he or she may be subject to penalties under state law for perjury if he or she intentionally provides false or untrue information. Perjury is a felony pursuant to California Penal Code section 126.

Section 6520(e)(4) this section advises the applying employee that in addition to sanctions under state law, he or she is subject to civil penalties under federal law for providing false information in the application process. This is necessary to serve as fair notice to the person seeking coverage and also to act as a deterrent to the use of false information.

Section 6520(f) requires the employee sign the declination of coverage and to provide other sources of coverage if they are declining coverage offered by their employer. This is necessary in the event that an employee experiences a qualifying event that would trigger a special enrollment period, such as the loss or gain of health insurance coverage at a future date. This is also necessary to determine whether an employer meets the minimum participation requirement to be eligible to participate in the SHOP Exchange (some of the other sources of coverage count as valid waivers in the minimum participation requirement determination).

Section 6520(g) states that SHOP may not provide any information provided on the employee application to the employer with respect to the qualified employee or dependents of employees other than the name, address, birthdate and QHP selection of the qualified employee and their dependents. 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. All information received on the application is private in accordance with applicable federal and state privacy and security laws pursuant to 45 CFR 155.260 and the California Information Practices Act of 1977 (California Civil Code section 1798 et seq.). This is necessary to ensure that the SHOP uses an employee's personal information only to facilitate eligibility and enrollment in

the SHOP Exchange, thereby preventing unnecessary disclosure of personal information.

Section 6522 Eligibility Requirements for Enrollment in the SHOP

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

Section 6522(a) in its entirety, clarifies and makes specific all employer eligibility requirements for enrollment in SHOP. This is necessary to advise the employer of all eligibility requirements for enrollment in the SHOP. This is also necessary to comply with requirements of 45 CFR Section 155.710(b).

Section 6522(a)(1) clarifies that a small employer must meet the definition of a small employer as defined in Section 6410 which incorporates state and federal law. This is necessary to provide the employer with a reference for the definition of a small employer pursuant to state and federal law (45 CFR 155.20; Health and Safety Code section 1357.500(k) and Insurance Code section 10753(g)) since only those employers who meet this definition can be eligible to purchase coverage through the SHOP.

Section 6522(a)(2) clarifies that a small employer, in order to be an qualified small employer, must elect to offer all eligible full-time employees coverage in a QHP through the SHOP. This is necessary to inform the employer that if they elect to obtain coverage through the SHOP, they must extend an offer of coverage, at a minimum, to all full-time employees. This is also necessary to comply with 45 CFR Section 155.710(b)(2).

Section 6522(a)(3)(A) and (B) clarifies that the employer must have its principal business address in California and offer coverage to all of its full-time employees through the SHOP in California or offer coverage to each eligible employee through the SHOP serving that employee's primary worksite. This is necessary to advise an employer the requirement regarding the primary business location and extension of coverage eligibility requirement for the SHOP. This is also necessary to comply with, and is substantially identical to, 45 CFR Section 155.710(b)(i) and 155.710(b)(ii).

Section 6522(a)(4) in its entirety, clarifies the minimum employee participation rules. This is necessary to ensure that the employer is aware of the minimum employee participation requirement for eligibility in the SHOP.

Section 6522(a)(4)(A) clarifies and makes specific the SHOP minimum employee participation rules in order for the employer to be eligible to participate in the SHOP. It also clarifies that the SHOP may decrease the minimum participation rate required for eligibility as determined via a SHOP survey of prevailing market practices. The 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 CCSB

website. The participation rate provision is necessary to ensure that the employer is aware of the minimum employee participation requirements for eligibility in the SHOP. The minimum participation requirement itself is necessary to ensure that the financial risk of insuring sick enrollees is balanced by the enrollment of healthy enrollees, and is a common business requirement in the small group health insurance market outside of the SHOP Exchange as well. Without minimum participation requirements, there is a higher risk that only sick enrollees will enroll in QHPs thus increasing the cost to provide insurance coverage in the marketplace. However, market practices can shift to accurately reflect risk based upon prevailing market conditions at the time and a lower participation requirement may be necessary. SHOP will assess such market shifts and decrease the participation requirement accordingly and with notice provided to issuers as stated and published.

Section 6522(a)(4)(B) clarifies and makes specific when a qualified employee waives an employer's offer of coverage due to the qualified employee's enrollment in coverage through another employer, an employee's union, Medicaid pursuant to 42 U.S.C § 1396 et seq., or Medicare pursuant to 42 U.S.C. § 1395 et seq., or any other federal or state health care program other than coverage through a QHP sold in the Individual Exchange, that the employee is not counted in calculating compliance with Section 6522(a)(4)(A) above. This is necessary to advise the employer that there are certain valid waivers to the minimum employee participation rule and that they still meet participation requirements when an employee presents with a valid waiver. Coverage through a QHP sold in the Individual Exchange is not considered a valid waiver because it is not employer sponsored coverage.

Section 6522(a)(5) in its entirety, clarifies the SHOP employer group contribution rule. This is necessary to advise the employer of their minimum contribution amount in order to be eligible for the SHOP. It is also necessary to maintain a balanced risk pool in the SHOP marketplace since the more an employer contributes towards employees' premiums, the greater the likelihood that healthy, low-risk individuals will enroll. This is absolutely necessary for the SHOP Exchange to remain a competitive option for employer-sponsored health insurance coverage.

Section 6522(a)(5)(A) clarifies and makes specific the minimum employer contribution requirement to be applied toward premium costs for all qualified employees. It also clarifies that the SHOP may decrease the minimum employee premium contribution required for eligibility as determined via a SHOP survey of prevailing market practices. This is necessary to advise the employer of the minimum contribution requirement for the employee-only coverage in the level of coverage selected by the qualified employer pursuant to Section 6520(a)(12)(A) and (B). However, common market practices can shift to lower employee premium contribution requirements based upon prevailing market conditions which can be beneficial to small employers while maintaining an appropriate risk balance. SHOP will assess such market shifts and decrease the minimum contribution requirement if necessary to remain competitive with the small group market outside of the SHOP.

Section 6522(a)(6) requires that a qualified employer who wishes to offer his or her employees infertility benefits, must do so in accordance with CA Health and Safety Code Section 1374.55 and CA Insurance Code Section 10119.6. By law, it is required and necessary to notify the employer of its options to offer employee infertility benefits and that certain rules apply to such an offer of benefits based upon 1) the number of employees employed by the employer and, 2) the type of coverage the employee choses for health care coverage: either a health maintenance organization (HMO) or a preferred provider organization (PPO). This is provision is necessary to ensure the SHOP is in compliance with state law.

Section 6522(b) clarifies and makes specific an exception to the minimum participation and employer contribution requirements as stated in Section 6522(a)(4)(A) and Section 6522(a)(5)(A) that are required by federal law. This is necessary to ensure SHOP compliance with federal law and advise an employer who is otherwise eligible for the SHOP pursuant to the criteria in section 6522, but unable to meet the above participation and contribution requirements, pursuant to 45 CFR 147.104(B), that it may apply for coverage during a special annual enrollment period. That period begins on November 15 and extends to December 15 of the calendar year for a January 1 effective date. The exact dates of the special annual enrollment period are mandated by 45 CFR 147.104(b)(1)(i)(B).

Section 6522(c) clarifies and makes specific that pursuant to 45 CFR 155.710(d), an employer who ceases to be a small employer solely by reason of an increase in employees shall continue to be eligible for SHOP as long as the employer meets all other eligibility criteria and maintains continuous SHOP coverage. This is necessary for the SHOP to comply with a federal requirement and to advise the employer that as long as they maintain continuous coverage in the SHOP and comply with all other requirements for continued eligibility, their coverage will not terminate solely due to an increase in employees that no longer makes them a small employer according to the SHOP's definition of a small employer. This is also necessary to ensure that employees remain covered when a small employer experiences business growth. The possibility of a small business employer becoming ineligible for the SHOP due to an increased number of employees would be a disincentive for business growth.

Section 6522(d) specifies that all qualified employees whose eligibility has been verified by the SHOP may enroll in a QHP through the SHOP. This is necessary to comply with federal requirements in 45 CFR 155.710. This provision expressly confers that right to qualified employees.

Section 6522(e) specifies that a qualified employee is eligible to enroll his or her dependent spouse, registered domestic partner, non-registered domestic partner, 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. . This is necessary to comply with federal requirements in 45 CFR 155.710.

Section 6522(f) requires the SHOP to allow an employer who meets the criteria of a qualified employer as described in subdivision (a) of this section but whose principal business address is not in California, to offer coverage to his or her eligible employees whose primary worksite is in the SHOP's service area. This is necessary to allow qualified employers to offer affordable, quality health care coverage to all eligible employees, even if the employer's principal business address is outside of California, as long as that employer has employees whose primary worksite address is in the SHOP's service area. It is also necessary to comply with 45 CFR 155.710(b).

Section 6522(g) requires that a qualified employer immediately notify the SHOP of any change to their principal business location and, if the new location is in a different geographic rating area in California, the SHOP will apply a new geographic rating factor to the employer's premium upon renewal, and not before. It is necessary for an employer to notify the SHOP of any change in primary business location immediately to ensure SHOP has the correct information for renewal documents and other document creation.

Section 6524 Verification Process for Enrollment in the SHOP

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

Section 6524(a) requires the SHOP to verify that an employer, employee, or dependent meets the eligibility requirements specified in Section 6522 prior to allowing an employer to offer health insurance coverage to its employees or to allow an employee to select a QHP through the SHOP. Verification is necessary to ensure the SHOP provides health coverage only to eligible employers, employees, and dependents. Without verification requirements, some ineligible employers, employees, and dependents may potentially be enrolled in coverage through the SHOP. Enumerated verification processes protect the SHOP against instances of mistake or even fraud committed by the submission of inaccurate or misleading information by employers or employees and properly notifies employers of these processes.

Section 6524(b) in its entirety, specifies how the SHOP will verify employee eligibility. This is necessary to advise the employer and employee of the SHOP's eligibility verification handling procedure.

Section 6524(b)(1) instructs the SHOP to verify that the employee has been identified by the qualified employer as an employee being offered health insurance coverage by the qualified employer. This is a required step in the employee eligibility verification

process. Verification is necessary to ensure the SHOP provides health coverage only to eligible people. Without verification requirements, some ineligible employees could be enrolled in coverage through the SHOP as a result of submitting inaccurate information. It is also necessary to make it clear that for eligibility purposes such information from the employer and employee must be consistent. In addition, it is necessary to comply with 45 CFR Section 155.715(b)(1).

Section 6524(b)(2) requires the SHOP to accept the information attested to by the employee under Section 6520 unless that information is inconsistent with the employer-provided information. This provision also informs the employer and employee that attestations made by them in Section 6520 will not require additional documentary proof unless inconsistencies are detected. This is necessary for the SHOP to be in compliance with federal regulations at 45 CFR 155.715(b)(1), and to inform the employer and employee of the SHOP's eligibility verification handling procedures. This is also necessary to specify that for eligibility purposes the information from the employer and employee must be consistent.

Section 6524(b)(3) instructs the SHOP to only collect the minimum information necessary for verification of eligibility. This is in accordance with the eligibility requirements in Section 6522. This is necessary to advise the employer and employee that the SHOP will only collect the minimum information necessary to determine the employer and employee are eligible for coverage in the SHOP. This is also necessary to prevent unnecessary disclosure of personal information.

Section 6524(c) in its entirety, clarifies and specifies how the SHOP will handle employer and employee inconsistencies with the information provided to the SHOP. This is necessary to advise the employer and employee of the SHOP's verification of inconsistency procedure.

Section 6524(c)(1) clarifies and specifies how the SHOP will proceed in handling employer information which is inconsistent with the eligibility requirements in Section 6522. This is necessary to advise the employer of the SHOP's eligibility inconsistency handling procedure.

Section 6524(c)(1)(A) clarifies that the SHOP will make a reasonable effort to identify and address the causes of inconsistencies, such as considering that an inconsistency may be due to a typographical or clerical error. This is necessary to determine whether the inconsistency is problematic to eligibility. Without a reasonable effort to identify causes of inconsistencies, an inconsistency due to a clerical error could cause an eligible employer, employee or dependent to be denied coverage through the SHOP.

Section 6524(c)(1)(B) advises that the SHOP will provide written notice to the employer if an inconsistency is discovered. This is necessary to notify the employer of the SHOP's inconsistency handling procedure and ensure the employer is notified of the inconsistency in order to have an opportunity to make corrections and avoid a delay in effectuation of health care coverage.

Section 6524(c)(1)(C) advises the employer that in the event that an inconsistency is discovered, a written notice described in Section 6524(c) will provide the employer with a 30 day period to provide documentary evidence to support the employer's application or resolve the inconsistency. This is necessary to advise the employer that they will be given a 30 day period to respond and resolve inconsistencies discovered by the SHOP. A 30-day period is necessary because it is a reasonable amount of time for an employer to gather and present documentary evidence to resolve the inconsistency, It is also necessary to be compliant with 45 CFR Section 155.715(d).

Section 6524(c)(1)(D) instructs the employer that if they are unable to provide satisfactory documentation to resolve the inconsistency within the 30-day period as described in Section 6524(c) the SHOP will provide written notice to the employer of its denial of eligibility and the employer's right to appeal this eligibility determination. This is necessary to advise the employer of the SHOP's denial of eligibility notification requirement if an inconsistency is not resolved. This section is also necessary to advise the employer of their right to appeal a denial of eligibility. Providing written notice to the employer of the denial of eligibility is necessary to ensure that the employer is put on notice that eligibility has been denied. Additionally, notifying the employer of the right to appeal such a determination pursuant to Section 6542(c) is necessary to ensure that recourse is available to an eligible employer who is unable to resolve an inconsistency by providing satisfactory documentary evidence within 30 days. It is also necessary to be compliant with 45 CFR Section 155.715(d).

Section 6524(c)(2) clarifies and specifies how the SHOP will proceed in handling employee information which is inconsistent with the information provided by the employee's employer. This is necessary to advise the employee of the SHOP's information inconsistency handling procedure.

Section 6524(c)(2)(A) clarifies that the SHOP will make a reasonable effort to identify and address the causes of inconsistencies, such as considering that an inconsistency may be due to a typographical or clerical error. This is necessary to determine whether the inconsistency is problematic to eligibility. Without a reasonable effort to identify causes of inconsistencies, an inconsistency due to a clerical error could cause an eligible employee to be denied coverage through the SHOP. It is also necessary to be compliant with 45 CFR Section 155.715(d).

Section 6524(c)(2)(B) requires the SHOP to provide written notice to the employee if they are unable to substantiate the employee's status. This is necessary to advise the employee of the SHOP's information inconsistency handling procedure. This is also necessary to ensure the employee is notified of the inconsistency in order to have an opportunity to make corrections. It is also necessary to be compliant with 45 CFR Section 155.715(d).

Section 6524(c)(2)(C) advises the employee that in the event that an inconsistency is discovered, a written notice described in Section 6524(c) will provide the employee with a 30-day period to provide documentary evidence to support the employee's application

and resolve the inconsistency. This is necessary to advise the employee that they will be given a 30-day period to respond and resolve inconsistencies discovered by the SHOP. A 30-day period is necessary because it is a reasonable amount of time for an employee to gather and present documentary evidence to resolve the inconsistency, It is also necessary to be compliant with 45 CFR Section 155.715(d).

Section 6524(c)(2)(D) advises the employee that if they are unable to provide satisfactory documentation to resolve the inconsistency within the 30-day period as described in Section 6524(c), the SHOP will provide written notice to the employee of its denial of eligibility and the employee's right to appeal this eligibility determination. This section is necessary to advise the employee of their right to appeal a denial of eligibility. Providing written notice to the employee of the denial of eligibility is necessary to ensure that the employee is put on notice that eligibility has been denied. Additionally, notifying the employee of the right to appeal such a determination is necessary to ensure that recourse is available to an eligible employee who is unable to resolve an inconsistency by providing satisfactory documentary evidence within 30 days. It is also necessary to be compliant with 45 CFR Section 155.715(d).

Section 6524(d) requires the SHOP to notify the employer whether the employer is eligible and the employer's right to appeal a denial of eligibility. This is necessary to inform the employer of the SHOP's eligibility determination and the employer's right to appeal if denied eligibility in compliance with 45 CFR 155.715(e).

Section 6524(e) requires the SHOP to notify the employee of eligibility and the employee's right to appeal a denial of eligibility. This is necessary to inform the employee of the SHOP's eligibility determination and the employee's right to appeal if denied eligibility in compliance with 45 CFR 155.715(f).

Section 6526 Qualified Employer Election of Coverage Periods

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

Section 6526(a) clarifies and specifies that a qualified employer who is not already participating in the SHOP may elect to offer health insurance coverage through the SHOP to its qualified employees at any time during the calendar year by submitting the information specified in Section 6520. This is necessary to advise a qualified employer who wishes to participate in the SHOP but is not already doing so, that he or she may apply to do so at any time during the year, and that unlike the individual marketplace, there is no specific open enrollment period in the SHOP.

Section 6526(b) clarifies and specifies the timeframe in which a qualified employer that does not meet the minimum participation or contribution requirements in Section 6522(a)(4) and 6522(a)(5), but meets all remaining eligibility criteria, may elect to offer health insurance coverage through the SHOP. This is necessary to meet guaranteed availability requirements under federal law in 45 CFR 147.104 which require the SHOP to allow an employer that does not meet the minimum participation or contribution requirements to sign up for coverage during the annual special enrollment period of from November 15 to December 15 of each year.

Section 6526(c) clarifies and specifies that the employer's plan year is 12 months and that the employer's plan year and the employees' plan year will have the same 12-month plan period beginning on, as the group subscriber, the employer's effective date of coverage. This provision is necessary to clarify that a plan year is determined by the employer's effective date of coverage, as newly hired employees who begin their employment after an employer's initial enrollment period may mistakenly believe that their plan year will follow their effective date of coverage.

Section 6526(d) clarifies and specifies that the employer may only change its offer of health insurance coverage, including making changes to the employer's reference plan, to employees during the employer's annual election period. This section also clarifies and specifies the length of the employer's annual election period and when the employer's election period can begin. This is necessary to advise an employer when they may change their offer of coverage to employees and the timeframe in which they may make those changes. Requiring an annual employer election period to be at least 20 days is necessary to give employers enough time to review additional options and return employer selection that may have become available to them since their last enrollment period and to submit desired changes to the coverage being offered to their employees for the following plan year to the SHOP. Sending written notice of the annual employer election period at least 60 days prior to the completion of the employer's current plan year is necessary to give employers a reasonable amount of time to investigate and consider alternative coverage options for the next plan year. The employer election period timeframe is consistent with standard industry practice. Additionally, the 60-day renewal period notification is consistent with state law requirements to notify groups of any rate and coverage changes at least 60 days prior to the effective date of those changes.

Section 6526(e) clarifies that 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. It is necessary for employers to understand that if the reference plan used during the current plan year to calculate the employee portion of the premium payment is not available in the new plan year, the employer must take action to select a new reference plan. The SHOP will not make such a selection for the employer or on the employer's behalf.

Section 6526(f) clarifies that 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. The auto-selected reference plan selected by the SHOP will be the lowest cost plan in the qualified employer's selected metal tier. Additionally, the contribution rate applied to the new reference plan will be the employer's same contribution rate as in the current plan year. It is important that employers understand and know that if the reference plan they chose for the current plan year is no longer available to them in their upcoming plan year and they take no action to select a new reference plan, the SHOP will auto-select a new reference plan for them. By auto-selecting a new reference plan on behalf of the employer, the SHOP is able to continue coverage for the employer's qualified employees and their dependents so they do not experience a lapse in coverage due to the inaction of the qualified employer.

§ 6528. Initial and Annual Enrollment Periods for Qualified Employees

Section 6528, in its entirety, specifies the period of time when an employee may enroll in or change to a different QHP, known as the initial or annual employee open enrollment period. This is necessary to provide the employee and the public with clear standards on the permissible timeframes for an employee to enroll in coverage through a QHP. This section is also necessary to establish timeframes in compliance with federal requirements specified in 45 CFR Section 155.725.

Section 6528(a) clarifies and makes specific that the only time that an employee may enroll in a QHP or change a QHP is during the enrollment periods identified in this section. This is necessary to provide employees with clear guidance on when he or she may enroll in coverage through a QHP. This is also necessary to comply with the federal requirement to provide for a specified enrollment period specified in 45 CFR Section 155.725(e).

Section 6528(b) clarifies and makes specific that the employee's initial open enrollment period does not begin until their employer has submitted all of the information required in Section 6520 and the SHOP has determined that the employer is a qualified employer. This is necessary to provide employees with clear guidance as to when they may begin to enroll in coverage through a QHP and that process cannot begin until the SHOP has made the determination that the employer is a qualified employer.

Section 6528(c) clarifies and makes specific the exact time period in which an employee's annual open enrollment period begins, which is the day after the employer's annual election period ends. This is necessary to provide the employee with clear guidance as to when he or she may begin to re-enroll or enroll in coverage through a different QHP. An employee must wait until after the employer annual election period has ended because he or she cannot make the decision to enroll or re-enroll through a QHP until the employer has determined what changes, if any, he or she is making to the offer of health care coverage to employees and their dependents. This subdivision is also necessary to comply with 45 CFR Section 155.725(e) which requires the SHOP Exchange to establish annual open enrollment periods for employees.

Section 6528(d) specifies that the initial and annual enrollment period for qualified employees is a minimum of 20 days. It is necessary to inform employees of the timeframe they have available to them to make health coverage decisions. A minimum of 20 days is a reasonable timeframe and aligned with common industry practice.

Section 6528(e) requires the SHOP Exchange to provide qualified employers with a written annual employee open enrollment period notification for each qualified employee at least 60 days prior to the end of the employer's plan year and after the end of the employer's annual election period. It is necessary to timely provide employers with open enrollment information for their employees so they can review the information and timely distribute it to their employees to insure employees have notice of, and start planning for their annual open enrollment period prior to the start of that period as required in 45 CFR Section 155.725(f). It is also necessary to not begin annual employee open enrollment until after the annual employer election period so employees can be informed of any changes their employer made to his or her offer of coverage.

Section 6528(f) specifies that a qualified employee can make a change to his or her selected QHP during the first thirty days of their new plan year and select a different QHP provided that the newly selected QHP is offered by the same QHP issuer. It is important that employees know that they have the ability to make a change to the QHP they selected during their open enrollment, without experiencing a qualifying event that affords them a special enrollment right, as long as it is done within the first thirty days of the new plan year. This gives them additional flexibility to make the best selection for their needs. However, any change they wish to make can only be within the same issuer. This conforms with current industry practice and with state law.

Section 6528(f)(1) specifies that an employee request to make a plan selection change after the first day of their new plan year will become effective retroactively to the first day of the new plan year if SHOP receives the request for the change by the fifteenth day of the first month of the new plan year, unless the employer requests an effective date of the first of the following month. It is important for employers and employees to know that the effective date of the requested change is dependent upon the timeframe of the receipt of the request to SHOP.

Section 6528(f)(2) specifies that an employee request to make a plan selection change after the first day of their new plan year will become effective on the first day of the second month of the new plan year if SHOP receives the request for the change between the sixteenth day and the thirtieth day of the first month of the new plan year, 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. It is important for employers and employees to know that the effective date of the requested change is dependent upon the timeframe of the receipt of the request to SHOP.

Section 6528(g), 6528(g)(1) and (g)(2) clarify and make specific what will happen if an employee does not renew coverage or change QHPs during the annual enrollment

period. This subdivision, in its entirety, clarifies that the employee will remain enrolled in the same QHP as he or she was enrolled, unless one of two things occur, which are specified in subparagraphs one and two of subdivision (f). These subdivisions clarify that unless the employee terminates coverage in the QHP, or the QHP is no longer available to the employee, the employee will remain enrolled in that QHP. These provisions are necessary because in many instances, an employee will take no action during his or her annual enrollment period and will expect that his or her coverage will continue with the same QHP. This is how the market operates today and this requirement is necessary to ensure that employees do not unknowingly lose coverage through a QHP by their inaction. Furthermore, this subdivision and subparagraphs are required by 45 CFR Section 155.725(i).

Section 6528(h) specifies and makes clear what will happen if a qualified employee's current QHP is not available to them in the following plan year and the employee takes no action during his or her open enrollment period. In that instance, the qualified employee will be enrolled in a QHP offered by the same QHP issuer at the same metal tier that is most similar to the qualified employee's current QHP, as determined by the SHOP, on a case-by case basis. It is necessary to inform employees how the SHOP will respond to their inaction and assign their coverage for the following plan year if the employee takes no action during their annual open enrollment period and their current QHP is no longer available to them. This is how the market operates today and this requirement is necessary to ensure that employees do not unknowingly lose coverage through a QHP by their inaction.

Section 6528(i) specifies and makes clear what will happen if a qualified employee's current QHP is not available to them in the following plan year because the issuer is no longer participating in the SHOP or if another QHP is not available from the current QHP issuer in the same metal tier, and the employee takes no action during his or her open enrollment period. If the QHP in which an enrollee is currently enrolled is no longer available for either reason, the enrollee may be enrolled in the lowest cost QHP offered by a different QHP issuer that is available to the enrollee through the SHOP at the same metal tier, as determined by the SHOP on a case-by-case basis. It is necessary to inform employees how the SHOP will respond to their inaction and may assign their coverage for the following plan year if the employee takes no action during their annual open enrollment period and the issuer of their current QHP is either no longer participating in the SHOP or another QHP is not available from their current QHP issuer in the same metal tier.

Section 6528(j) specifies the clarifies what will happen when an employee becomes qualified for coverage outside of the initial open enrollment period, annual open enrollment period, or a special enrollment period, such as newly hired employees who are hired outside of the initial or annual open enrollment period. This subdivision is necessary for new hires and other newly qualified employees to be able to enroll in coverage through a QHP. Without this provision, an employee would have to wait until

the next enrollment period before he or she could enroll in coverage. Additionally, this provision is required pursuant to 45 CFR Section 155.725(g).

Section 6528(k) specifies that prior to the end of the employer's annual election period, the employer must report any changes to the initial employer application information in Section 6520(a)(3). It is necessary for SHOP to know if the employer has employed 20 or more employees during 20 or more weeks in the prior calendar year in order for SHOP to know if that employer is subject to federal COBRA or Cal-COBRA regulations. If the employer is subject to federal COBRA regulations, the employer is responsible for the administration of those benefits. If the employer is subject to Cal-COBRA regulations, the SHOP is responsible for the administration of those benefits.

§ 6530. Special Enrollment Periods for Qualified Employees and Dependents

Section 6530, in its entirety, specifies the events that would allow an employee to enroll in or change coverage to a different QHP outside of the initial and annual open enrollment periods. This is necessary to comply with federal and state law and to provide the employees with clear standards on when they can enroll or change coverage outside of the initial and annual enrollment periods

Section 6530(a) requires that the SHOP provide special enrollment periods during which certain qualified employees or dependents of qualified employees may enroll in QHPs and QDPs and enrollees may change QHPs. It is necessary to make clear that the SHOP has this obligation to enrollees so enrollees understand under which circumstances they may be eligible for a special enrollment period and when that special enrollment period starts.

Section 6530(b) and (b)(1) clarifies and makes specific that an employee or his or her dependent, may enroll in a QHP, or an enrollee may change from one QHP to another, during special enrollment periods only if one of the qualifying life events specified in this subdivision occurs. This subdivision is necessary to provide the employees with clear standards and guidelines as to the qualifying life events that will trigger a special enrollment period, and to comply with the federal requirements specified in 45 CFR Section 155.725(e).

Section 6530(b)(1)(A) specifies that if a qualified employee or dependent loses Minimum Essential Coverage, then he or she is eligible for a special enrollment period. This is necessary to comply with mandatory federal requirements set forth at 45 CFR Sections 155.725(j)(2)(i) and 155.420(d)(1)(i).

Section 6530(b)(1)(A) 1. specifies and makes clear that the date of the loss of MEC is the date of the last day the qualified employee or his or her dependent would have coverage under his or her previous plan. It is necessary to clarify for enrollees the date of the loss of MEC so they know and can calendar the time they are provided for their

special enrollment period so they don't inadvertently fail to enroll during this period and forfeit the opportunity. Also, this is necessary to comply with mandatory federal requirements set forth at 45 CFR Sections 155.725(j)(2)(i) and 155.420(d)(1)(i).

Section 6530(b)(1)(A) 2. specifies and makes clear that the date of the loss of MEC, if due to a QHP decertification, is the date of the notice of decertification as described in 45 CFR Section 155.1080(e)(2). It is necessary to clarify for enrollees the date of the loss of MEC so they know and can calendar the time they are provided for their special enrollment period and don't inadvertently fail to enroll during this period and forfeit the opportunity.

Section 6530(b)(1)(B) specifies that if a qualified employee or his or her dependent loses pregnancy-related coverage described in Section 1902(a)(10)(A)(i)(IV) and (a)(10)(ii)(IX) of the Social Security Act (42 U.S.C.1396(a)(10)(i)(IV), (a)(10)(ii)(IX) and Section 14005.18 of the Welfare and Institutions Code, the date of the loss of coverage is the last day the enrollee would have pregnancy-related coverage. It is necessary to clarify for enrollees the date of the loss of pregnancy-related coverage so they know and can calendar the time they are provided for their special enrollment period and don't inadvertently fail to enroll during this period and forfeit the opportunity. Also, this is necessary to comply with the mandatory federal requirement set forth at 45 CFR Section 155.420(d)(1)(iii).

Section 6530(b)(1)(C) specifies that if a qualified employee loses eligibility for coverage under a 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, they will be eligible for a special enrollment period only once per calendar year. The date of the loss of coverage is the last day the consumer would have medically needy coverage. It is necessary to clarify for enrollees the date of the loss of medically needy coverage so they know and can calendar the time they are provided for their special enrollment period and don't inadvertently fail to enroll during this period and forfeit the opportunity. This is also necessary to comply with mandatory federal requirements set forth at 45 CFR Section 155.725(j)(2)(ii) and Section155.420(d)(1)(iv).

Section 6530(b)(2) specifies that if 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, then he or she is eligible for a special enrollment period. It is necessary to specify for enrollees the life events that give rise to a special enrollment right so they know that such an event allows them to make changes to their current coverage option, including the selection of a different QHP. This is necessary to comply with mandatory federal requirements set forth at 45 CFR Sections 155.725(j)(2)(i) and 155.420(d)(2).

Section 6530(b)(3) specifies that if an 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, then he or she is eligible for a special enrollment period. It is necessary to explain and clarify that enrollees who experience divorce, legal separation or death of a dependent have the right to a special enrollment period in which they may select a different coverage option, including the selection of a different QHP. This is also necessary to comply with mandatory federal requirements set forth at 45 CFR Sections 155.725(j)(2)(i) and 155.420(d)(2)(ii)

Section 6530(b)(4) specifies that if a 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 or its instrumentalities or a non-Exchange entity providing enrollment assistance or conducting enrollment activities, as evaluated and determined by the Exchange, then the qualified employee or the dependent is eligible for a special enrollment period. It is necessary to allow an enrollee who is enrolled in a QHP, or not enrolled in a QHP, because a mistake or an act of misconduct occurred, to get enrolled in a QHP of their choice to correct the wrong. This is also necessary to comply with mandatory federal requirements set forth at 45 CFR Sections 155.725(j)(2)(i) and 155.420(d)(4).

Section 6530(b)(5) specifies that if an enrollee adequately demonstrates to the Exchange, with respect to health plans offered through the Exchange, or to the applicable regulator, with respect to health plans offered outside the Exchange, that the QHP in which he or she is enrolled, substantially violated a material provision of its contract in relation to the qualified employee or his or her dependents, then he or she is eligible for a special enrollment period. It is necessary to allow an enrollee who is enrolled in a QHP that has materially violated its contract to get enrolled in a different QHP of their choice. This is also necessary to comply with mandatory federal requirements set forth at 45 CFR Sections 155.725(j)(2)(i) and 155.420(d)(5).

Section 6530(b)(6) specifies that if a qualified employee, or his or her dependent, gains access to new QHPs as a result of a permanent move , then he or she is eligible for a special enrollment period. It is necessary to provide an enrollee who gains access to new QHPs because of a permanent move with a special enrollment period because this is a reasonable life circumstance to give rise to this right. This is also necessary to comply with mandatory federal requirements set forth at 45 CFR Sections 155.725(j)(2)(i) and 155.420(d)(7).

Section 6530(b)(7) specifies that if a qualified employee, or his or her dependent, was released from incarceration, then he or she is eligible for a special enrollment period. It is necessary to provide an enrollee who has been released from incarceration with a special enrollment period because that person no longer has access to health care services provided to them while incarcerated. This is a reasonable life circumstance to give rise to this right. This is also necessary to comply with mandatory federal requirements set forth at 45 CFR Sections 155.725(j)(2)(i) and 155.420(d)(7).

Section 6530(b)(8) specifies that if a 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, then he or she is eligible for a special enrollment period. It is necessary to provide an enrollee who is returning from active duty with a special enrollment period because that person no longer has access to health care coverage provided to them by the military. This is a reasonable life circumstance to give rise to this right. This is also necessary to comply with mandatory federal requirements set forth at 45 CFR Sections 155.725(j)(2)(i) and 155.420(d)(7).

Section 6530(b)(9) specifies that 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 QHP one time per month. This is necessary to comply with mandatory federal requirements set forth at 45 CFR Sections 155.725(j)(2)(i) and 155.420(d)(8).

Section 6530(b)(10) specifies that a special enrollment right occurs if 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 include, but are not limited to, those circumstances described in Sections 6530(10)(A) and (B) below. It is necessary to describe these circumstances so employees and their dependents have a clear understanding of what some of these exceptional circumstances are and that they give rise to their right to a special enrollment period. It is also necessary to comply with mandatory federal requirements set forth at 45 CFR Section 155.725(j)(2)(i), Section 155.420(d)(2)(i), Section 155.420(d)(4) and Section 1399.845(f) of the Health and Safety Code or Section 10965(f) of the Insurance Code.

Section 6530(b)(10)(A) specifies that 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. This is necessary to give the qualified dependent the opportunity to enroll in a QHP and for the Exchange to be in compliance with the court order.

Section 6530(b)(10)(B) specifies that if 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 pan 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 Minimum Essential Coverage, then he or she is eligible for a special enrollment period. This is necessary to ensure that a qualified employee or dependent has an opportunity to obtain health insurance through the SHOP despite being misinformed that he or she

was covered under Minimum Essential Coverage. Members of the general public often lack technical knowledge about health insurance coverage and must rely on others for guidance. It would be a disservice to deny a qualified employee or dependent the opportunity to enroll in coverage through the SHOP if he or she did not enroll in the preceding enrollment period because he or she was misinformed.

Section 6530(b)(11) specifies that if 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, then that enrollee is eligible for a special enrollment period. It is necessary to provide this right to an enrollee under these circumstances so he or she has the opportunity to continue to receive services with their current provider if that provider is a contracting provider under a different QHP available to the enrollee through the SHOP. It is also necessary to provide this opportunity to comply with Health and Safety Code and Insurance Code regulations.

Section 6530(b)(12) specifies that if 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, then he or she is eligible for a special enrollment period. This is necessary to comply with mandatory federal requirements set forth at 45 CFR Section 155.725(j)(2)(ii).

Section 6530(b)(13) specifies that if a qualified employee or dependent becomes eligible for assistance, with respect to health insurance coverage under a SHOP, under a Medi-Cal plan (including any waiver or demonstration project conducted under or in relation to such a plan), then he or she is eligible for a special enrollment period in the SHOP. This is necessary to comply with mandatory federal requirements set forth at 45 CFR Section 155.725(j)(2)(iii).

Section 6530(b)(14) specifies that if a qualified employee, or his or her dependent, is a victim of domestic abuse or spousal abandonment, as specified in 26 CFR Section 1.36B-2 (b)(2)(ii) through (v), is enrolled in MEC, and seeks to enroll in coverage separate from the perpetrator of the abuse or abandonment, then he or she is eligible for a special enrollment period. 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. It is necessary to provide enrollees in these circumstances with a special enrollment period because these are reasonable life circumstances to give rise to this right. It is also necessary to comply with mandatory federal requirements set forth in 45 CFR Section 155.725(j)(2)(i),

Section 6530(b)(15)(i) and (ii) specify that a qualified employee, or his or her dependent, applies for coverage on the Exchange during the annual open enrollment period, or due to a qualifying event, and is assessed by the Exchange as eligible for Medi-Cal or the Children's Health Insurance Program (CHIP), and put into one of those

programs, only to be later determined to be ineligible, is given the opportunity to enroll in other health coverage through a special enrollment period. It is important that enrollees who find themselves in either of these similar situations have the opportunity to enroll for coverage through the SHOP under a special enrollment period because their inability to do so during their annual open enrollment period or because of a qualifying event is not through any fault of their own. They should not be denied coverage or experience a gap in coverage due to these circumstances that are beyond their control.

Section 6530(b)(16) specifies that a qualified employee, or his or her dependent, who demonstrates to the Exchange that a material error related to plan benefits, service area, or premium, influenced the qualified employee's or dependent's decision to purchase a QHP through the Exchange should be eligible for a special enrollment period. It is important to allow enrollees who have chosen health coverage under a QHP based upon erroneous information in these three areas be allowed to choose a different QHP under a special enrollment period to allow them to make a selection that best suits their health care needs since they were not allowed to do so originally.

Section 6530(b)(17) specifies that if a 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), that employee and his or her dependent, will be provided with a special enrollment period to select a different QHP if they so choose. It is important that employees and their dependents know and understand that any of the other qualifying events identified in the specified sections of both the California Health and Safety Code and the California Insurance Code will trigger this right for their SHOP coverage. Additional triggering events may be adopted into state law that would apply to SHOP coverage. Including this provision will ensure consumers are able to enroll in a QHP through the SHOP as soon as those state laws become effective and ensure the SHOP program is in compliance with state law.

Section 6530(c) specifies that an employee or his or her dependent has a time limit in which to apply for coverage if they experience any of the life events that trigger a special enrollment period described in subdivision (b) of this section. It is necessary to inform enrollees of this time period so they do not inadvertently fail to submit their application for coverage and thereby forfeit the opportunity to enroll in a QHP during their special enrollment period.

Section 6530(c)(1) clarifies and makes specific that an employee or his or her dependent has 30 days from the date of the event described in paragraphs (b)(1) - (11) and (b)(14) – (16) of this section to select a QHP through the SHOP. It is necessary and important to inform employees and their dependents of the time limit for making a QHP selection during their special enrollment period since an inadvertent failure to make this selection in this timeframe would result in forfeiture of the enrollment right. This subdivision is also necessary to comply with, and is substantially identical to, 45 CFR 155.725(j)(3)(i).

Section 6530(c)(2) clarifies and makes specific that an employee or his or her dependent has 30 days from the date of the event described in paragraph (g)(1) of this section to select coverage for a qualified employee or his or her eligible dependents in a QDP through the SHOP. It is necessary and important to inform employees and their dependents of the time limit for making a QDP selection during their special enrollment period since an inadvertent failure to make this selection in this timeframe would result in forfeiture of the enrollment right.

Section 6530(c)(3) clarifies and makes specific that an employee or his or her dependent has 60 days from the date of the event described in paragraphs (b)(12), (b)(13), and (b)(17) of this section to select coverage for a qualified employee or his or her eligible dependent in a QHP through the SHOP. It is necessary and important to inform employees and their dependents of the time limit for making a QHP selection during their special enrollment period since an inadvertent failure to make this selection in this timeframe would result in forfeiture of the enrollment right. This subdivision is also necessary to comply with, and is substantially identical to, 45 CFR 155.725(j)(3)(ii).

Section 6530(d) clarifies and makes specific that dependents of an employee are only eligible for a special enrollment period if the employer of the employee actually offers coverage for the dependents of its employees. This is necessary to clarify that the employer is not required to provide coverage to dependents and if such coverage is not provided that dependents could not enroll in coverage even if they did have a triggering event that would open up a special enrollment period. This subdivision is also necessary to comply with, and is substantially identical to, 45 CFR 155.725(j)(4).

Section 6530(e), including subdivisions (1), (2), and (3) and their subparagraphs, specifies what events or circumstances are considered “loss of MEC” and what events or circumstances are not. These are necessary to comply with, and are substantively identical to, the federal requirements referenced in 45 CFR Section 155.725(j)(6), which incorporates 45 CFR 155.420(e). The federal rule in Section 155.420(e) does not list the circumstances that give rise to the loss of MEC; rather, it only cites to the IRS regulation specified in 26 CFR Section 54.9801-6(a) (3) (i) through (iii) that includes those circumstances. The SHOP Exchange specifies those circumstances in subdivisions (e)(1) – (3) and their subparagraphs of this section to provide employers and their qualified employees and dependents with more clarity and a single source of information.

Section 6530(e)(4)(A) and (B) clarify that the loss of MEC, as specified in subdivision (b)(1) of this section, do not include termination due to the employee’s or dependent’s failure to pay premiums on a timely basis, including COBRA premiums, or, the termination of coverage for cause, such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan. It is important and necessary to insure enrollees are informed of the circumstances under which a loss of MEC does not give rise to a special enrollment period. This is also necessary to comply with mandatory federal requirements set forth at 45 CFR Section 155.420(e)(1).

Section 6530(f) allows SHOP or QHP issuers, upon request, to require verification if an employee or dependent reports experiencing a triggering event that would allow him or her to enroll in coverage in a QHP during a special enrollment period. This is necessary so that employees know they may have to provide verification of the triggering event and also necessary to allow QHP issuers to verify whether an employee actually experienced a triggering event. Because of guaranteed issue and open enrollment periods, employees are only allowed to enroll in coverage during open enrollment periods. Allowing employees to enroll at other times of the year would mean that an employee could wait until he or she needed medical care to purchase coverage. This would dramatically skew the risk pool for QHP issuers and cause a rise of premiums for the market as a whole.

Section 6530(g) in its entirety, clarifies that 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. It is necessary to inform enrollees that special enrollment periods exist for dental coverage as well as medical coverage.

Section 6530(g)(1) specifies that the loss of eligibility for dental insurance coverage shall be consistent with any of the situations specified in subdivisions (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. It is necessary to inform enrollees of the circumstances that give rise to a special enrollment right for dental coverage so they know they have the opportunity to continue dental coverage without a gap..

Section 6530(g)(2) specifies that the 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) of this section. It is important and necessary to delineate for enrollees the circumstances which do not give rise to a special enrollment period for dental coverage.

Section 6530(g)(3) specifies that a qualified employee or his or her dependent will be eligible for a special enrollment period if they experience a loss of eligibility for pediatric dental coverage subsequent to turning nineteen (19) years of age and wish to continue dental coverage under a standalone dental plan offered by a QDP in the SHOP. It is necessary to inform enrollees that losing pediatric dental coverage because they are no longer young enough to be considered a pediatric dental enrollee would give rise to a special enrollment right for dental coverage so they know they have the opportunity to continue dental coverage without a gap.

Section 6530(h) clarifies that the effective dates of coverage for a special enrollment are determined using the provisions of Section 6534. It is necessary to direct consumers to the correct area to find this information so that they can be fully informed in all aspects of special enrollment periods.

Section 6530(i) notes a limitation that qualified employees will not be able to enroll under a special enrollment period unless the employer group meets any applicable minimum participation rules under Section 6522(a)(4). It is important and necessary to remind employees that employer eligibility regarding minimum participation requirements is a necessary condition for their eligibility to enroll under that employer.

§ 6532. Employer Payment of Premiums

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

Section 6532(a) specifies that 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. This subdivision is necessary to inform employers as to the timing of their initial payment for coverage and how they will be informed of the amount due and that they are required to remit payment for the total amount due for all of their employers who are to be covered under their benefit plan.

Section 6532(a)(1) specifies that 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. This subdivision is necessary to provide employers with clear standards regarding the minimum amount of payment required from the employer and when that payment must be received by the Exchange in order to effectuate coverage for that employer's employees on the date the employer requested in their application for coverage through the SHOP.

Section 6532(a)(2) specifies that if a qualified employer's first payment does not meet the requirements in subdivision (a)(1) of this section, the SHOP will cancel the application of that qualified employer and the applications of that employer's qualified employees. This is necessary to provide employers with a clear understanding of the consequences of not making full and timely payment on the initial invoice.

Section 6532(b) specifies how invoicing will be done after the employer has made its first payment and coverage is effective for its employees who enrolled in coverage through the SHOP Exchange. It is necessary to differentiate what will happen in this circumstance when coverage is already effective because there are operational differences once coverage has become effective. This subdivision is necessary to inform employers when ongoing invoices will be sent. Without this subdivision the SHOP Exchange could not invoice the employers for the coverage and QHP issuers could not provide coverage to the employer's employees.

Section 6532(b)(1) specifies and makes clear that a qualified employer's monthly premium payment must be delivered to the SHOP or postmarked by the last day of the invoicing month. This subdivision is necessary to inform employers of the due date for premium payments once coverage is effectuated so that they know what to expect and can adjust their operations, if necessary, to accommodate this requirement.

Section 6532(b)(2) specifies and makes clear that 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. This subdivision is necessary to inform employers regarding the amount of premium payment that the Exchange must timely receive for coverage to continue so that they know what to expect and can adjust their operations, if necessary, to accommodate this requirement.

Section 6532(c) clarifies what will happen when an employer makes a payment for less than the full amount of the invoice and premiums are owed to both health and dental benefits. The regulation specifies that the payment will be allocated by the total percentage paid across all amounts due for health and dental benefits, if any. This is a very common occurrence in the small group market today and therefore it is necessary to clarify what will happen in these circumstances.

Section 6532(d) specifies what will happen when an employer fails to make its premium payment pursuant to subdivision (b) of this section and certain rights the employer has if it fails to make a timely premium payment. This is necessary to inform the employer of the consequences of failing to pay its premium amount due by the due date. This subdivision is also necessary to comply with Insurance Code Section 10273.4(a)(1) and Health and Safety Code Section 1365(a)(1), which require certain notices be sent to the employer regarding delinquencies and grace periods prior to coverage being terminated for nonpayment of premium as well as the employer's right to request a review of a cancellation, should one occur, by the applicable regulator. This subdivision ensures that employers are fully aware of the consequences of not paying the premium amount due by the due date.

Section 6532(e) specifies that if a qualified employer makes a premium payment via check that is returned unpaid for any reason, the SHOP will apply a $25.00 insufficient funds fee. This subdivision is necessary to inform employers of the consequences of having insufficient funds in their payment account to cover the amount of their premium payment so that they know what to expect and can adjust their operations, if necessary, to avoid this fee.

Section 6532(f) specifies that 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. It is necessary to inform employers that even though the coverage for their

employees has been terminated at the employer's request, they still have the opportunity to have that coverage reinstated with no gap in coverage for their qualified employees and their dependents if the employer makes that request within the stated time frame.

Section 6532(g) specifies that if a qualified employer has been terminated pursuant to Section 6538(c)(2) 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. It is necessary to inform employers that even though the coverage for their employees has been terminated due to non-payment of premium, they still have the opportunity to have that coverage reinstated with no gap in coverage for their qualified employees and their dependents if the employer pays past amounts due within the stated time frame.

Section 6532(h) specifies that a qualified employer may not reinstate coverage if the request for reinstatement is received by the SHOP 31 or more days following the effective date of termination. Further, a qualified employer 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. It is necessary to inform employers of the consequences when SHOP does not receive a timely reinstatement request. Without this information, employers may fail to take advantage of this opportunity to reinstate coverage for his or her employees which could result in a gap in coverage.

Section 6532(i) specifies that 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). It is necessary to inform employers who have been terminated and who wish to resume SHOP coverage for their employees that doing so 31 or more days past the termination effective date will require them to apply for that coverage as a new group. This will result in the necessity for new applications for the employer and all qualified employees and a gap in coverage for qualified employees and their eligible dependents.

Section 6532(j) specifies that the SHOP will perform collection procedures for delinquent accounts payable and will do so as per State Accounting Manual (SAM) section 8776.6 (non-employee accounts receivable). It is important for employers to understand that SHOP will pursue collection on delinquent accounts and will do so in accordance with the State Accounting Manual so employers have a reference and know what to expect.

§ 6534. Coverage Effective Dates for Special Enrollment Periods

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

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

Section 6534(a)(1) specifies that the coverage effective dates for special enrollment periods for a QHP or QDP selection received by the Exchange from a qualified employee will be no later than the first day of the following month for applications received between the first and the fifteenth day of any month. This subdivision is necessary to provide clarity to employees on when their coverage will be effective when providing the Exchange with their selections by the fifteenth of the month. This section is also necessary to comply with, and are substantively identical to, the federal requirements specified in 45 CFR Section 155.420(b).

Section 6534(a)(2) specifies that the coverage effective dates for special enrollment periods for a QHP or QDP selection received by the Exchange from a qualified employee will be no later than the first day of the second following month for applications received between the sixteenth and last day of any month. This subdivision is necessary to provide clarity to employees on when their coverage will be effective when providing the Exchange with their selections between the sixteenth and the last day of the month. This section is also necessary to comply with, and are substantively identical to, the federal requirements specified in 45 CFR Section 155.420(b).

Section 6534(b) in its entirety, specifies the coverage effective dates for certain triggering events that give rise to a special enrollment period. Federal law treats the triggering events in this subdivision different than all of the other triggering events and specifies different coverage effective dates for different triggering events. For clarity purposes, this subdivision outlines these special triggering events rather than simply citing to federal law. Therefore, this subdivision is necessary to comply with, and is substantially identical to, the requirement in 45 CFR 155.420(b)(2).

Sections 6534(b)(1) specifies and makes clear that in case of birth, adoption, placement for adoption, or placement in foster care, coverage is effective for that enrollee on the date of birth, adoption, placement for adoption, or placement in foster care, or on the first day of the following month if requested by the enrollee. It is important and necessary for the employee to know and understand that their newly acquired child dependent will have health coverage on the day of the event that made them an eligible dependent unless the employee choses to have that coverage begin on the first day of the following month. It is also important for the employee to know and understand that they have this choice available to them since choosing to have the coverage begin on the first day of the month following the acquisition of a new child dependent could result in premium savings for one month since issuers are required to provide coverage for newly acquired child dependents of adult enrollees for the first 30 days after the acquisition under the terms and conditions of the adult enrollee's coverage.

Section 6534(b)(2) specifies and makes clear that 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 by the SHOP. It is important and necessary for the employee to know and understand that their newly acquired dependent cannot have coverage begin until the first day of the month following the receipt date of the request. Likewise, it is equally important for employees to know and understand that a loss of MEC will result in a new coverage effective date the first of the month following the receipt date. In all of these instances, employees need to know and understand when new coverage begins to avoid misunderstandings that could result in health care services being delivered that are not yet covered by the issuer.

Section 6534(b)(3) in its entirety, specifies the coverage effective dates for a qualified employee or his or her dependent when the enrollment or non-enrollment in a QHP was done in error, as described in Section 6530(b)(4), and also in the case when an enrollee, or his or her dependent, demonstrates to the Exchange that the QHP in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee. It is necessary to inform employees in these specific circumstances when the effective date of new coverage is to avoid misunderstandings that could result in either unnecessary delays in seeking health care services or health care services being delivered that are not yet covered by the issuer.

Section 6534(b)(3)(A) specifies and makes clear that coverage is effective on either the date of the event that triggered the special enrollment period under Section 6530(b)(4) or 6530(b)(5) or the date that is described in Section 6534(b)((3)(B) below. It is necessary and important to inform employees what the effective date of coverage is for these triggering events. Enrollees need to know when coverage begins to avoid misunderstandings that could result in either unnecessary delays in seeking health care services or health care services being delivered that are not yet covered by the issuer.

Section 6534(b)(3)(B) specifies and makes clear that the effective date of coverage for an employee or his or her dependent who experiences a triggering event that gives rise to a special enrollment period as described in Section 6530(b)(4) or 6530(b)(5) will be the date of the triggering event, as described above, or the date that is least financially burdensome on the enrollee, as determined by the Exchange. The Exchange will determine if it is more advantageous to the enrollee to have coverage effective on the date of the triggering event, or to apply the timing in subsection (a) of this section. Items the Exchange would consider in making the determination would include the amount of out-of-pocket expenses the enrollee may have incurred, if any, for health care treatment subsequent to the triggering event, or, if no health care services were rendered to the enrollee, if premium amounts are due back to the enrollee for coverage they paid for but should not have. It is important and necessary for enrollees to know and understand that the Exchange will correct these types of errors and do an analysis on the financial impact of these errors to determine the date of coverage that is the most financially advantageous to the enrollee.

§ 6536. Covered Effective Dates for Qualified Employees

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

Section 6536(a) specifies the effective date of coverage for QHPs selected by employees during the initial open enrollment period. This subdivision is necessary to provide clarity to employees that their coverage will become effective based upon when their employer pays the group's premium as required in subdivision 6520(b)(10). This is also necessary to inform the employer of the cutoff date to be eligible to receive the first of the following month effective date in the SHOP, as requested. This cutoff allows the SHOP to avoid the unnecessary administrative complications associated with partial month coverage such as prorated premium payments for both the employer and employee, partial month eligibility and remittance to QHPs and partial month commission payments to agents and general agencies. It is also consistent with carrier practices in the small group market and aligns the SHOP with common industry practice.

Section 6536(b) specifies the effective date of coverage for QHPs selected by employees during their annual open enrollment period. This subdivision is necessary to provide clarity to employees that, if their employer has elected to renew its offer of coverage on the Exchange during the employer annual election period, coverage will be effective on the first day of the employer's subsequent plan year, with no gap in coverage between plan years. This is necessary to ensure continuous coverage and comply with federal law requirements in 45 CFR 155.725(b) that establishes a 12-month plan year beginning on the employer's effective date of coverage in the SHOP.

Section 6536(c) specifies the effective date of coverage for QHPs selected by a newly qualified employee. Newly qualified employees are those employees who were not hired or otherwise not eligible to purchase coverage during an open enrollment period. This subdivision is necessary to provide clarity to those newly hired employees on when their coverage will become effective, which is the first day of the following month in which they became a qualified employee. It is necessary to begin coverage on the first day of the month to avoid the potential complications associated with partial month coverage such as prorated premium payments for both the employer and employee, partial month eligibility and remittance to QHPs and partial month commission payments to agents and general agencies. By beginning eligibility for newly qualified employees on the first of the following month in which they became a qualified employee, the SHOP is also aligned with common industry practices in the small group market.

Section 6538 Disenrollment and Termination

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

Section 6538(a) clarifies and makes specific the standard employer-initiated termination procedure for the SHOP as required by 45 CFR 155.735 that 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 provided that the employer has given notice to the SHOP on or before the 15th day of any month. If notice is given after the 15th of the month, the SHOP may terminate the coverage or enrollment on the last day of the following month. It also codifies the SHOP's responsibilities to ensure the employer's QHP coverage is terminated for all enrollees covered by the employer group health plan, as requested by the employer. This subdivision is necessary to advise the employer how and when to request termination of all enrollees' coverage through the SHOP, and the SHOP's responsibility to ensure coverage is terminated, as requested by the employer. The timing of the notice requirement to the SHOP is necessary to give the SHOP and subsequently, the affected QHPs, reasonable time to process the termination of coverage. This requirement also aligns the SHOP with the requirements for the Federally-facilitated SHOPS as set forth in 45 CFR 155.735(b)(2).

Section 6538(a)(1) clarifies and makes specific the SHOP's responsibility to ensure that each QHP terminates an employer's employees and their dependents enrolled in a QHP through SHOP. This is necessary to ensure the consistent application of the requested termination across all QHPs in which the employer's enrollees are enrolled. Because of the SHOP's unique employee-choice model, enrollees may be enrolled in several different QHPs offered by several different issuers and it is necessary for the SHOP to apply the group termination rule consistently across each affected QHP.

Section 6538(a)(2) clarifies and makes specific the SHOP's requirement to provide notification of the effective date of termination to each of the employer's employees enrolled in a QHP through the SHOP within fifteen days of receiving notice from the employer in subdivision(a). This section also specifies that notification must provide employees with information on other potential sources of coverage including access to the Individual Marketplace through the Exchange. Providing notice of termination to employees within fifteen days of the employer notification of termination to the SHOP is necessary to allow the SHOP adequate time to process the request, prepare employee notices, and timely inform employees that their coverage will be terminated, giving them an opportunity to obtain information and potentially seek coverage from another source before their coverage with the SHOP terminates.

Section 6538(b) clarifies the requirement that the employer must request the SHOP terminate an employee's or a dependent's coverage upon receiving a written request from the qualified employee. This is necessary to advise the employer that they must request termination of employee coverage with the SHOP if a written request to terminate is received from an employee. Since employers are the holders of the coverage policy and are solely responsible for the payment of premiums, any notice to terminate the coverage of an employee who wishes to terminate his or her coverage under the employer's policy for any reason, must come from the employer. Allowing the information to come directly from the employee, leaving the employer out of the information loop, will result in inaccurate administration of the policy. This also provides notice to employees that requests to terminate coverage be in writing to ensure that employers respect and effectuate employee coverage termination decisions.

Section 6538(c) clarifies that the SHOP may initiate termination of a qualified employee's coverage in a QHP or a dependent's coverage in a QHP for specific reasons as listed below. This section also clarifies and specifies that the QHP must make reasonable accommodations for all individuals with disabilities and that the QHP complies with all requirements for cancellations, rescissions and non-renewals before terminating coverage for such individuals. This is necessary to advise an employer when and for what reasons the SHOP and QHP may initiate termination of an employee and employee's dependents' QHP coverage.

Section 6538(c)(1) clarifies that the SHOP may terminate QHP coverage for an employee or dependent that is no longer eligible for coverage in a QHP. This is necessary to advise the employer and employer that coverage for an employee or dependent that is no longer eligible for coverage must be terminated as eligibility is a requirement for coverage in a QHP.

Section 6538(c)(2) clarifies that the SHOP may terminate QHP coverage if a qualified employer fails to pay premiums for coverage and any applicable grace period, as provided in 10 CCR § 2274.53 and 28 CCR § 1300.65 has been exhausted. This is necessary to advise the employer that failure to pay premium may result in termination of QHP coverage. This is also necessary because a QHP requires funding, through premium payments, in order to provide coverage. Without premium payments, QHPs cannot provide coverage.

Section 6538(c)(3) clarifies that the SHOP may terminate employee or employee's dependent coverage if coverage is rescinded by the QHP in compliance with Health and Safety Code Section 1389.21 or California Insurance Code Section 10384.17. This is necessary to advise an employer and employee that SHOP may terminate QHP coverage for acts of fraud or intentional misrepresentation on the part of the enrollee. The SHOP and the QHP must be allowed to terminate coverage if an employee or an employee's dependent has performed an act or practice constituting fraud or made an intentional misrepresentation of material fact as prohibited by the terms of the policy.

Section 6538(c)(4) clarifies that the SHOP may terminate an employee or employee's dependent coverage if the QHP terminates or is decertified as described in 45 CFR §155.1080. The date of "May 29, 1012" is added to this section to specify the date of the CFR that is cited and referenced in this paragraph. This is necessary to advise an employer and employee that termination or decertification of a QHP may result in termination of QHP coverage. This is also necessary because if a QHP terminates or is decertified, then it is no longer in compliance with minimum certification standards. The SHOP must have the ability to terminate coverage so that enrollees may pursue health coverage options from certified QHPs.

Section 6538(c)(5) clarifies that the SHOP may terminate QHP coverage if an employee changes from one QHP to another during an annual open enrollment or special enrollment period in accordance with Sections 6528 and 6530. This is necessary to advise the employer and employee that QHP coverage will terminate when an employee changes to another QHP. This prevents the possibility that an employee or dependent has coverage under two different QHPs under a single employer's policy. This is also necessary to ensure that qualified employees can freely move from one QHP to another during an annual employee open enrollment period or special enrollment period.

Section 6538(c)(6) clarifies that the SHOP may terminate QHP coverage upon the death of a qualified employee or dependent of qualified employee. This is necessary to advise the employer and employee that QHP coverage will terminate upon the death of an enrollee. This is also necessary because neither the SHOP nor a QHP can provide coverage to someone who has died and premium payments should cease to be collected accordingly.

Section 6538(c)(7) clarifies that the SHOP may terminate QHP coverage if an employee chooses not to remain enrolled in the QHP during open enrollment. This is necessary to ensure that qualified employees have the option to disenroll from a QHP during open enrollment and that coverage will terminate at the end of the employee's current plan year. This is necessary to be consistent with small group annual election period rules that allow employees to disenroll from their current QHP and enroll in a new QHP, with an effective date the first day of the new plan year, during the annual employee election period.

Section 6538(c)(8) clarifies that the SHOP may terminate QHP coverage if an employee is no longer employed with the qualified employer. This is necessary to advise the employer and employee that QHP coverage will terminate if employee is no longer employed with employer. This is also necessary because an employee must be employed by a qualified employer in order to be eligible for non-continuation coverage through the SHOP.

Section 6538(c)(9) clarifies that the SHOP may terminate coverage if an employee is newly eligible for Medi-Cal or CHIP, but the employee or dependent must request termination of QHP coverage through the SHOP. This is necessary to advise the

employer and employee that QHP coverage will terminate in this situation upon receiving written request from the employee or dependent. This is also necessary because the qualified employee must have the option to either stay enrolled in the QHP or enroll in Medi-Cal or CHIP, if eligible.

Section 6538(c)(10) clarifies that the SHOP may terminate QHP coverage for all of the employees and their dependents of a qualified employer if that qualified employer is no longer eligible to participate in the SHOP because it has lost its eligibility pursuant to Section 6522. This is necessary because once a qualified employer has lost its eligibility to purchase or maintain coverage through the SHOP, the SHOP must terminate the coverage of all of the covered enrollees since employer eligibility is a requirement to obtain and/or maintain that coverage for employees and their dependents.

Section 6538(d) clarifies and specifies that if the QHP insurer initiates termination of a qualified employee's coverage in a QHP or a dependent's coverage in a QHP because an employer fails to pay premiums or if the QHP terminates or is decertified, the QHP 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. This is necessary to advise the employer and employee that the QHP must comply with relevant state regulations when terminating coverage due to non-payment of premiums or due to QHP termination or decertification. Complying with these regulations is necessary to provide protections to employees in the form of requirements that the QHP must meet before termination is effective.

Section 6538(e) clarifies effective dates of termination for QHP coverage. This is necessary to advise employer and employee when termination in a QHP will be effective based on the situation.

Section 6538(e)(1) clarifies effective date of termination of QHP coverage if termination is requested by an employer as specified in Section 6538(a). This is necessary to provide the SHOP with adequate processing time and to advise employer and employee when termination in a QHP will be effective, including via notice to employees, upon receiving employer's request to terminate coverage.

Section 6538(e)(1)(A) clarifies that if an employer provides notice of termination on or before the fifteenth day of any month, the termination date will be the end of the month in which the employer provided notice of termination of coverage to ,the SHOP, or on a case-by-case basis, an earlier date upon agreement between the QHP and the SHOP. This is necessary to advise employer and employee when termination in a QHP will be effective in this situation. This is also necessary to give the SHOP reasonable time to process the notice of termination and provide termination information to QHPs who must properly terminate employee and dependent coverage.

Section 6538(e)(1)(B) clarifies that if an employer does not provide the SHOP with notice of termination on or before the fifteenth day of the month, the termination will take place on the last day of the month following the month in which the qualified

employer provided notice of termination , or, on a case-by-case basis, an earlier date upon agreement between the QHP and the SHOP.. This is necessary to advise employer and employee when termination in a QHP will be effective in this situation. This is also necessary to give the SHOP reasonable time to process the notice of termination and provide termination information to QHPs who must properly terminate employee and dependent coverage.

Section 6538(e)(2)(A), (B), (C) and (D). clarifies that with respect to a termination request from an employer to terminate coverage of an employee or dependent because of a written request received from the employee, (A) the effective date of termination shall be no sooner than the last day of the month in which the SHOP receives the request, (B) unless the employee or dependent requests a termination date for a month subsequent to the notice month, or, (C) on a case-by-case basis, an earlier date as long as both the QHP issuer and the SHOP agree to that date. In these cases, the effective date of termination will be the last day of the requested month. This is necessary to advise employer and employee when termination in a QHP will be effective in these situations and that (D) in no case will the effective date of termination be a date other than the last day of the month. It is necessary to restrict effective dates of termination to the last day of the month in order to avoid the complications associated with partial month coverage such as prorated premium payments for both the employer and employee, partial month eligibility and remittance to QHPs and partial month commission payments to agents and general agencies.

Section 6538(e)(3) clarifies that in the event of termination due to an employee or employee's dependent no longer being eligible for coverage, termination shall be the last day of the month in which eligibility of the employee or employee's dependent ceased. This is necessary to advise employer and employee when termination in a QHP will be effective in this situation. Specifying that termination shall be the last day of the month in which eligibility ceased is necessary to ensure that the employee or employee's dependent has coverage through the end of the month, since an alternative form of coverage may not begin until the beginning of the following month.

Section 6538(e)(4) clarifies that in the event that an employer fails to pay premiums for coverage, termination shall be the last day of the grace period consistent with Section 102734 of the California Insurance Code and Section 1365 of the California Health and Safety Code and implementing state regulations. This is necessary to advise employers and employees when termination in a QHP will become effective in this situation. Requiring a grace period is necessary to comply with applicable laws to provide an opportunity for an employer to make a payment by the last day of the grace period in order to maintain coverage, even after the employer has failed initially to make a timely premium payment.

Section 6538(e)(5) clarifies that in the event that a QHP rescinds coverage of an employee or an employee's dependent, the last day of coverage shall be the day prior to the day the fraud or intentional misrepresentation of material fact occurred. This is necessary to advise employer and employee when termination in a QHP will be

effective in this situation in compliance with state law in Health and Safety Code Section 1389.21 and California Insurance Code Section 10384.17. This is also necessary to not extend the coverage duration to employees or dependents who performed an act or practice constituting fraud or made an intentional misrepresentation of material fact as prohibited by the terms of the policy. Employees and dependents should not benefit from coverage at all if obtaining coverage was the result of fraud or misrepresentation.

Section 6538(e)(6) clarifies that the last day of coverage in event that a QHP terminates or is decertified shall be the day before the QHP terminates or is decertified, 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. This is necessary to advise the employer and employee when termination in a QHP will be effective in this situation. Requiring the last day of coverage to be the later of the day before the QHP terminates or is decertified, or the day the issuer has met the requirements in Health and Safety Code 1365(a)(5) and (6) or Insurance Code 10273.4(d) or (e), is necessary to ensure that the QHP being terminated or decertified covers the employees as long as possible until coverage is no longer feasible.

Section 6538(e)(7) clarifies that the last day of coverage in the event that an employee changes from one health plan to another shall be the last day before the effective date of coverage in the new QHP. This is necessary to advise employer and employee when termination in a QHP will be effective in this situation. This is also necessary to ensure that the qualified employee remains covered during the process of changing from one health plan to another with no gap in coverage.

Section 6538(e)(8) clarifies that the last day of coverage upon the death of an employee or an employee's dependent shall be the date of death. This is necessary to advise the employer and employee the effective date of the QHP termination. This is also necessary because a QHP does not provide coverage to an individual once deceased and the QHP would cease billing for coverage according to the date of death.

Section 6538(e)(9) clarifies that the last day of coverage for an employee that chooses not to remain enrolled in a QHP at open enrollment shall be the last day of the employer's plan year. This is necessary to advise employer and employee when termination in a QHP will be effective in this situation. This is also necessary to ensure that the QHP continues coverage through the end of the employer's plan year. Even though the employee chooses not to remain enrolled in the QHP for the following plan year, he or she should expect to be covered through the end of this plan year in alignment with small group market rules that require a 12-month plan year cycle.

Section 6538(e)(10) clarifies that the last day of coverage for an employee that is no longer an employee or dependent that no longer qualifies as a dependent is the last day of the month in which the employee or dependent ceased being an employee or dependent. This is necessary to advise employer and employee when termination in a QHP will be effective in this situation. This is also necessary because an employer cannot be expected to provide coverage to someone who is not an employee or an

employee’s dependent beyond their legally permissible eligibility under state and federal law.

Section 6538(e)(11) clarifies that the last day of coverage for an employee that is newly eligible for Medi-Cal or CHIP shall be the day before such other coverage begins but only if the employee or dependent requests termination of QHP coverage. This is necessary to advise the employer and employee when termination in a QHP will be effective in this situation. This is also necessary to ensure that the qualified employee or dependent remains covered during the process of changing health insurance coverage and experiences no gap in coverage.

Section 6538(f) clarifies that if an employee’s coverage or the coverage of a qualified employee’s dependent is terminated following an employer’s request to the SHOP based upon receipt of a qualified employee’s written request to terminate, 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. Informing the qualified employee or dependent of the termination effective date is necessary to provide confirmation to the employee or dependent that the request for termination was received by the SHOP and acted upon

Section 6538(g) clarifies, in its entirety, the SHOP’s responsibility to provide termination notices to qualified employers and qualified employees with information regarding the termination. It is necessary that both employers and employees know that they will receive written confirmation of the loss of health insurance coverage.

Section 6538(g)(1) specifies that if any enrollee's coverage 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. It is necessary to provide specific termination information to enrollees so they have a clear understanding of the exact date when their coverage ceases and the reason for the termination of coverage. It is also necessary to ensure that enrollees receive this information in a timely manner so they can pursue alternative health insurance coverage to avoid a gap in coverage. More time is provided to the SHOP to provide mailed notices than electronic notices due to the additional administrative actions required with mailed notices. This subdivision is necessary for clarity to ensure all SHOP termination procedures are captured in this regulation. It is substantially similar to requirements in 45 CFR 155.735(g).

Section 6538(g)(2) specifies that 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. It is necessary to provide specific termination information to qualified employers so they have a clear understanding of the exact date when the coverage for their qualified employees and their dependents ceases and the reason for the termination. If the reason for the termination is reversible, such as for non-payment of premiums, knowing this reason gives the employer the opportunity to remit outstanding balances and reinstate the coverage. It is also necessary to ensure that employers receive this information in a timely manner so they can either take the necessary actions to reinstate the coverage or, alternatively, to pursue alternative health insurance coverage for qualified employees and their dependents to avoid a gap in coverage. More time is provided to the SHOP to provide mailed notices than electronic notices due to the additional administrative actions required with mailed notices. This subdivision is necessary for clarity to ensure all SHOP termination procedures are captured in this regulation. It is substantially similar to requirements in 45 CFR 155.735(g).

Section 6538(g)(3) clarifies that 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. It is necessary to provide this information to employers and employees so that they know from which entity to expect such notice and they don't inadvertently ignore a notice because they didn't expect one from that entity. This subdivision is necessary for clarity to ensure all SHOP termination procedures are captured in this regulation. It is substantially similar to requirements in 45 CFR 155.735(g).

Section 6538(g)(4) specifies that 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. It is necessary to provide this information to employees and dependents so they do not expect to receive separate notices of termination for each dependent at the same address and understand that the information contained in that notice applies to all enrollees at that address and that they do not inadvertently ignore that information for some enrollees. This subdivision is necessary for clarity to ensure all SHOP termination procedures are captured in this regulation. It is substantially similar to requirements in 45 CFR 155.735(g).

ECONOMIC IMPACT ASSESSMENT/ANALYSIS

Anticipated benefits, including nonmonetary benefits, to the protection of public health and safety, worker safety, the environment, the prevention of discrimination, or the promotion of fairness or social equity, from this proposed regulatory action are:

- Making quality health care available to all Californians;

- Providing structure for the Exchange to give predictability and clear standards to the public and qualified health plan issuers now, and into the future;
- Providing the public with clear standards and eligibility requirements to qualify for federal tax subsidies through the Exchange;
- Establishing the criteria and process for eligibility determination, enrollment, and disenrollment of enrollees and potential enrollees in the Exchange;
- Establishing an appeals process for prospective and current enrollees of the Exchange, and thereby providing due process to applicants denied insurance or with other appealable rights. More specifically, this action includes clear guidelines for the public to request and receive a fair hearing;
- Aligning California's regulations with the federal act and complying with state law;
- Reducing health care costs for Californians;
- Providing increased health care access to the public in California; and
- Ultimately, helping to save lives and increase the health of the public in California.

EVIDENCE SUPPORTING FINDING OF NO SIGNIFICANT STATEWIDE ADVERSE ECONOMIC IMPACT DIRECTLY AFFECTING BUSINESS

Background, Assumptions and Calculations:

To be eligible for a Federal Tax Credit, a Small Business must cover at least 50 percent of the cost of single (not family) health care coverage for each of their eligible employees. They must also have fewer than 25 full-time equivalent employees (FTEs). Those employees must have average wages of less than $50,000 per year.
For tax years 2010-2013, there is a sliding-scale tax credit of up to 35 percent of the employer's eligible premium expenses. Employers with 10 or fewer full-time equivalent employees and paying annual average wages of $25,000 or less qualify for the maximum credit. For tax-exempt employers, the same employee and wage requirements apply, but the maximum tax credit is 25 percent of eligible premium expenses.

Beginning in 2014, the maximum tax credit increases to 50 percent of premium expenses and coverage must be purchased from a state health insurance exchange. The maximum tax credit for tax-exempt employers increases to 35 percent in 2014.
In 2016, businesses with up to 100 employees can apply for health insurance coverage for their workers through Covered California. That is an increase from 2015, when only businesses with fewer than 50 workers could apply for coverage through the Covered California exchange.

Employers with 25 or fewer full-time equivalent employees, who cover half the cost of their monthly premiums and other factors may qualify for federal tax credits, but only if they enroll through Covered California for Small Business.
Over 2 million small employers provide health insurance to employees in California. While only 4,300 of those businesses used CCSB, the program provides greater choice for employers. While enrollment is still lower than expected, the program has continued to grow each year. In spring 2017, the federal government reported that SHOP had enrolled 232,698 employees from 27,205 firms. Of this total, over 80 percent were enrolled through state-run SHOP programs. The number of businesses electing the tax credit has not been released[1].

Number of Small Businesses Eligible for the Tax Credit

The information below is from a survey performed by Field Research Corporation, an independent research organization based in San Francisco. The survey was conducted by telephone during the period of April 16 – May 6, 2012 for Kaiser Permanente and the Small Business Majority. 368 small business owners (2-50 employees) participated in the survey. The small businesses were regionally stratified, random samples of small businesses from Dun and Bradstreet listings in the Northern and Southern CA regions.

- About six in ten of the California small business owners surveyed are currently eligible for the health reform law's tax credit based on their number of employees and the average annual wages these employees are paid.
- Three quarters of those eligible for the tax credit, representing 37% of all eligible small business owners, did not currently offer health insurance to their employees and therefore wouldn't benefit from the credit. Just 3% of all California small business owners eligible for the tax credit said they know that their company is eligible for it, of whom, just 2% are taking advantage of it.

The statistics below are from a study performed for Families USA and the Small Business Majority**.** The study, conducted by The Lewin Group, was to estimate the number of firms that are eligible for the small business health care tax credit under the Affordable Care Act in tax year 2011.

- More than 375,000 small businesses in California (70.1 percent of California businesses with fewer than 25 workers) are eligible for tax credits to help with the cost of health coverage for their workers for the 2011 tax year.
- More than two in five (42.2 percent) of small businesses that are eligible for this tax credit are eligible for the maximum tax credit when they file their 2011 taxes.
- More than 2.4 million Californians are employed by a small business that is eligible for a tax credit for the 2011 tax year.

[1] The Commonwealth Fund, Talking SHOP: Revisiting the Small-Business Marketplaces in California and Colorado, http://www.commonwealthfund.org/publications/fund-reports/2017/jul/talking-shop-small-business-marketplaces-california-colorado (July 2017).

A. Potential Costs to Businesses Resulting from the Proposed Amendment:

The proposed regulations seek to clarify and make specific the California Health Benefit Exchange's policies and procedures for eligibility determination and redetermination, enrollment in qualified health plans, and termination of coverage through the Small Business Health Options Program (SHOP) a.k.a. Covered California for Small Business (CCSB). The regulations provide small employers and employees with eligibility requirements to qualify and sign up for health insurance coverage through the SHOP Exchange. The regulations will also provide the standards and requirements applicable to QHP issuers participating in the SHOP Exchange.

The proposal specifies and makes clear that the effective date of coverage for an employee or his or her dependent who experiences a triggering event, or the date that is least financially burdensome on the enrollee, as determined by the Exchange. This proposal has been circulated to and reviewed by affected parties including businesses and qualified health plans. No comments regarding the economic impact of the proposal were received.

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

B. The creation of new businesses or the elimination of existing businesses within the State of California.

The proposed regulatory package is not expected to impact the creation or elimination of businesses for the reasons stated above.

C. The expansion of businesses currently doing business within the State of California.

The proposal is not expected to impact the expansion of businesses in California because the proposed regulations will provide small employer and employees with clear standards and eligibility requirements to qualify for health insurance coverage through SHOP.

D. The benefits of the regulation to the health and welfare of California residents, worker safety, and the State's environment.

The Exchange is committed to improving the consumer experience for the CCSB program. The proposed regulations have a number of benefits which are tied to the Exchange's overall mission. Additionally, the proposed regulations will clarify the employer and employee application requirements, eligibility requirements for the program, verification process for enrollment, qualified employer election of coverage

periods, initial and annual enrollment for qualified employees, employer payment of premiums, special enrollment coverage effective dates, and disenrollment and termination. Providing structure for the Exchange to give predictable, clear standards to CCSB participants currently enrolled in the program prospectively.

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

The Board considered the following alternatives during the review of the CCSB regulations.

1. *Whether to require 85% remittance of the amount invoiced for premium due to CCSB to effectuate or continue coverage?*

Alternative: Require 100% of the invoiced amount be remitted to CCSB to effectuate or continue coverage.

Reasoning for rejecting: Frequently employer groups make changes to the number of employees covered under their group plan because of changes in employee eligibility throughout the month. Employees leave employment or have changes to their hours that make them ineligible for coverage under the group plan, so they should no longer be included in the invoice. Often, invoices are generated for the following month before the employer informs CCSB of a termination that should be effective on the last day of the current month. These changes have an impact on premium due for the following month (as opposed to amount invoiced) that the employer attempts to mitigate by making an adjustment to the invoiced amount to derive the actual amount due. It is common industry practice to allow employers some leeway in their monthly invoiced premium payment to account for these as yet unaccounted for terminations to insure all of their employees do not lose coverage for an employer-adjusted remittance that would get rectified in the following month by a CCSB adjustment. To date, there is a very low percentage of employer groups who do not remit premium as invoiced. This practice is, by far, the exception rather than the rule.

2. *Whether to allow employees and their dependents to purchase dental-only coverage through CCSB?*

Alternative: Require employees to purchase medical coverage as a condition for the purchase of dental coverage.

Reasoning for rejecting: Employees who decline medical coverage from their employer often do so because they have that coverage from another source, such as a spouse's employer. However, that other source may not offer dental coverage, which is an important employee benefit. Allowing employees of CCSB-covered groups to purchase dental-only coverage for themselves and their dependents closes that gap for employees in that situation.

Application, Eligibility, and Enrollment in the Shop Exchange

§ 6520. Employer and Employee Application Requirements.

(a) A qualified employer who is eligible to purchase coverage from a Qualified Health Plan (QHP) for its 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) 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, 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 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 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 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; and

(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.

(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:

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

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

(iii) 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; and

(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 1389.8 and Insurance Code 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.

(f) If a qualified employee declines coverage, the employee must sign the declination of coverage 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: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; and 45 CFR Sections 155.705, 155.715, 155.730 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 CCSB website.

(1) If the qualified employer pays 100 percent of the qualified employees' QHP premiums, then all eligible employees not waiving coverage per 6522(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)(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 CA Health and Safety Code Section 1374.55 and CA 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.

Note: Authority: Section 100504, Government Code. Reference: Sections 100502 and 10503, 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 (b)(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 (b)(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 (c) 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 (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 (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 (d) 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: Section 100504, Government Code. Reference: Sections 100502 and 10503, 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 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 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)(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: Section 100504, Government Code. Reference: Sections 100502 and 10503, 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 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 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) 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: Section 100504, Government Code. Reference: Sections 100502 and 10503, 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).

(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 health plans offered through the Exchange, or to the applicable regulator, with respect to health plans offered outside the Exchange, that the QHP in which he or she is enrolled, substantially violated a material provision of its contract in relation to the 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: 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; or

(B) 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.

(11) 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.

(12) 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.

(13) 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).

(14) A qualified employee, or his or her dependent, is a victim of domestic abuse or spousal abandonment, as specified in 26 CFR Section 1.36B-2 (b)(2)(ii) through (v), is enrolled in MEC, and seeks to enroll in coverage separate from the perpetrator of the abuse or abandonment. 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.

(15) A qualified employee or dependent—

(i) 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

(ii) 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.

(16) 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.

(17) 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)(14)-(16) 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)(11) 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)(12), (b)(13), and (b)(17) 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;

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.

(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 (d)(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 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 (e)(1)-(3) or (b)(11) 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: Section 100504, Government Code. Reference: Sections 100502 and 10503, Government Code; 26 CFR Section 54.9801-2, 45 CFR Sections 147.104, 155.420, 155.725 and 156.285;

Sections 1357.503 and 1399.849, Health and Safety Code; and Sections 10753.05 and 10753.063.5, 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: Section 100504, Government Code. Reference: Sections 100502 and 10503, 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: Section 100504, Government Code. Reference: Sections 100502 and 10503, 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: Section 100504, Government Code. Reference: Sections 100502 and 10503, 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 section 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, or

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

(C) Or 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: Section 100504, Government Code. Reference: Sections 100502 and 10503, Government Code; and 45 CFR Sections 155.720, 155.725, 155.735 and 156.285.

STATE OF CALIFORNIA — DEPARTMENT OF FINANCE

ECONOMIC AND FISCAL IMPACT STATEMENT (REGULATIONS AND ORDERS)

STD. 399 (REV. 12/2013)

ECONOMIC IMPACT STATEMENT

DEPARTMENT NAME	CONTACT PERSON	EMAIL ADDRESS	TELEPHONE NUMBER
California Health Benefit Exchange	Gabriela Ventura	Gabriela.Ventura@covered	(916) 228-8477

DESCRIPTIVE TITLE FROM NOTICE REGISTER OR FORM 400	NOTICE FILE NUMBER
SHOP Eligibility and Enrollment Regulations	Z

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

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

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

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

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

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

3. Enter the total number of businesses impacted: 5,889

Describe the types of businesses (Include nonprofits): Small business with 1-100 employees and third party administrator.

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

4. Enter the number of businesses that will be created: N/A eliminated: N/A

Explain: N/A

5. Indicate the geographic extent of impacts:
- [x] Statewide
- [ ] Local or regional (List areas): _____

6. Enter the number of jobs created: N/A and eliminated: N/A

Describe the types of jobs or occupations impacted: Nearly all types of occupations employed by firms with 1-100 employees.

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

If YES, explain briefly: N/A

STATE OF CALIFORNIA — DEPARTMENT OF FINANCE

ECONOMIC AND FISCAL IMPACT STATEMENT
(REGULATIONS AND ORDERS)

STD. 399 (REV. 12/2013)

ECONOMIC IMPACT STATEMENT (CONTINUED)

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

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

   a. Initial costs for a small business: $ See 1 (d) below. Annual ongoing costs: $ _____ Years: _____

   b. Initial costs for a typical business: $ See 1 (d) below. Annual ongoing costs: $ _____ Years: _____

   c. Initial costs for an individual: $ See 1 (d) below. Annual ongoing costs: $ _____ Years: _____

   d. Describe other economic costs that may occur: Participating in the Small Business Health Options Program (SHOP) is strictly voluntary.

2. If multiple industries are impacted, enter the share of total costs for each industry: $0

3. If the regulation imposes reporting requirements, enter the annual costs a typical business may incur to comply with these requirements. *Include the dollar costs to do programming, record keeping, reporting, and other paperwork, whether or not the paperwork must be submitted.* $ 0

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

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

   Number of units: _____

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

   Explain the need for State regulation given the existence or absence of Federal regulations: Gov. Code Section 100502(m) requires the Exchange to establish a Small Business Health Options Program (SHOP).

   Enter any additional costs to businesses and/or individuals that may be due to State - Federal differences: $ 0

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

1. Briefly summarize the benefits of the regulation, which may include among others, the health and welfare of California residents, worker safety and the State's environment: The proposed regulations will provide the small employer and employees with clear standards and eligibility requirements to qualify for and sign up for health insurance coverage through SHOP.

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

   Explain: Gov. Code Section 100502(m) requires the Exchange to establish a Small Business Health Options Program (SHOP).

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

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

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

1. List alternatives considered and describe them below. If no alternatives were considered, explain why not: Require 100% of the invoiced amount be remitted to CCSB to effectuate or continue coverage instead of 85%. Require employees to purchase medical coverage as a condition for the purchase of dental coverage.

ECONOMIC IMPACT STATEMENT (CONTINUED)

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

Regulation: Benefit: $ Insignificant Cost: $ Insignificant

Alternative 1: Benefit: $ Insignificant Cost: $ Insignificant

Alternative 2: Benefit: $ Insignificant Cost: $ Insignificant

3. Briefly discuss any quantification issues that are relevant to a comparison of estimated costs and benefits for this regulation or alternatives: Alt #1A very low number of employer groups pay less than full binder payment. Alt #2 Employees who decline coverage already have coverage from another source.

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

Explain: N/A

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

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

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

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

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

Alternative 1:

Alternative 2:

(Attach additional pages for other alternatives)

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

Regulation: Total Cost $ Cost-effectiveness ratio: $

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

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

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

☐ YES ☒ NO

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

5. Briefly describe the following:

The increase or decrease of investment in the State: N/A

The incentive for innovation in products, materials or processes: N/A

The benefits of the regulations, including, but not limited to, benefits to the health, safety, and welfare of California residents, worker safety, and the state's environment and quality of life, among any other benefits identified by the agency: Making high quality health care available to all Californians, and providing increased education and access to health care coverage.

STATE OF CALIFORNIA — DEPARTMENT OF FINANCE

ECONOMIC AND FISCAL IMPACT STATEMENT
(REGULATIONS AND ORDERS)

STD. 399 (REV. 12/2013)

FISCAL IMPACT STATEMENT

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

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

$ _____

☐ a. Funding provided in _____

Budget Act of _____ or Chapter _____, Statutes of _____

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

Fiscal Year: _____

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

$ _____

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

☐ a. Implements the Federal mandate contained in _____

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

Case of: _____ vs. _____

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

Date of Election: _____

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

Local entity(s) affected: _____

_____

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

Authorized by Section: _____ of the _____ Code;

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

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

☐ 3. Annual Savings. (approximate)

$ _____

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

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

☐ 6. Other. Explain _____

_____

STATE OF CALIFORNIA — DEPARTMENT OF FINANCE

ECONOMIC AND FISCAL IMPACT STATEMENT
(REGULATIONS AND ORDERS)

STD. 399 (REV. 12/2013)

FISCAL IMPACT STATEMENT (CONTINUED)

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

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

$ _____

It is anticipated that State agencies will:

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

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

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

$ _____

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

☒ 4. Other. Explain Covered California would incur est. costs of $15.3M in FY17-18, $15.7M in FY18-19, and $16.1M in FY19-20.

Please refer to Attachment II. There is no impact to the General Fund.

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

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

$ _____

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

$ _____

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

☐ 4. Other. Explain _____

FISCAL OFFICER SIGNATURE	DATE
[signature]	1-4-18

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

AGENCY SECRETARY	DATE
[signature]	3/21/18

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

DEPARTMENT OF FINANCE PROGRAM BUDGET MANAGER	DATE