



Notice Published September 6, 2019

NOTICE OF PROPOSED RULEMAKING

CALIFORNIA CODE OF REGULATIONS, TITLE 10, CHAPTER 12, ARTICLE 12 ADOPT SECTIONS 6900, 6901, 6902, 6903, 6904, 6905, 6906, 6907, and 6908

The Board of Directors for the California Health Benefit Exchange (hereinafter referred to as the “Exchange”) proposes to adopt the regulation 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 on **October 21, 2019**. The Exchange will consider only comments received at the Exchange’s office by that time. Submit written comments to:

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

Comments may also be submitted by facsimile (FAX) at 916-228-8321 or by e-mail to regulations@covered.ca.gov.

AUTHORITY AND REFERENCE

Government Code Section 100504(a)(6) authorizes the Board of Directors for the Exchange to adopt rules and regulations, as necessary. The proposed regulations implement, interpret, and make specific Government Code Sections 100502 and 100503; and Title 45 of the Code of Federal Regulations, Sections 155.205 and 156.260.

INFORMATIVE DIGEST/POLICY STATEMENT OVERVIEW

Summary of Existing Laws

In March 2010, President Obama signed federal health reform legislation called the Patient Protection and Affordable Care Act (ACA). It created the opportunity for each state to establish a state-based health insurance exchange to implement the ACA. California chose to operate an exchange that is commonly known as known as "Covered California." For purposes of this Notice, Covered California will be referred to as the "Exchange." 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 their health plan.

State law also specifies the powers and duties of the executive board of the Exchange. Government Code Section 100504(a)(6) authorizes the Exchange's Board of Directors to adopt rules and regulations, as necessary. The Exchange proposes this permanent rulemaking in furtherance of its rulemaking authority to implement, interpret and make specific state and federal laws.

Currently, there some emergency regulations that establish and regulate the Medi-Cal Managed Care Plan Enroller program. Those regulations outline the requirements for the application to apply to the program and the fingerprinting and background check process.

Summary of the Effect of the Proposed Regulation

These regulations pertain to the Exchange's Medi-Cal Managed Care Plan Enrollment Assistance Program. The broad purpose of this proposed regulatory action is to: (1) complete Certificate of Compliance requirements for Sections 6902, 6903, and 6904; (2) adopt Sections 6900, 6901, 6901, 6905, 6906, 6807, and 6908; and (3) make minor edits that ensure clarity and accuracy.

Anticipated Benefits of the Proposed Regulation

The anticipated benefits of this proposed regulation include:

- Complete the Certificate of Compliance requirement for emergency regulations;
- Adopt previously expired regulations;
- Make minor clarifying edits to remove some ambiguity and accommodate stakeholder requests; and
- Ensure compliance with federal auditing requirements.

Evaluation of Inconsistency/Incompatibility with Existing State Regulations

After an evaluation of current regulations, the Exchange determined that these proposed regulations are not inconsistent or incompatible with any existing regulations. In Articles 8, 9, and 11, there are several regulations pertaining to the roles and responsibilities of Certified Enrollers, such as Certified Enrollment Counselors, Certified Application Counselors, and Plan-Based Enrollers. The proposed regulations governing Medi-Cal Managed Care Plan Enrollers do not conflict with any other regulations governing other Certified Enrollers.

Documents to be incorporated by reference:

26 CFR Section 1.36B-2(c)(3)(v) and (vi), (July 26, 2017)
42 CFR Section 435.603(f), (November 30, 2016)
45 CFR Section 155.205(d), (December 22, 2016)
45 CFR Section 155.220, (December 22, 2016)
45 CFR Section 155.260, (September 6, 2016)

Documents Relied Upon:

None.

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 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 Exchange but will have no impact on other agencies or the State General Fund. The Exchange is currently completely funded by assessments on premiums charged by Qualified Health Plans.

Other Nondiscretionary or Savings Imposed on Local Agencies

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

Costs or Savings in Federal Funding to the State

The proposal will not result in costs or savings in federal funding to the state.

Significant Effect on Housing Costs

None.

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

None.

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.

Effect on Small Business

This proposed regulation is not expected to create or expand small business within the State of California. The current MMCPE/MMCP program has been operating since

2012. Considering that many regulations in this package currently exist as emergency regulations, there are no anticipated effects on small businesses.

Cost Impacts on a Representative Private Person or Business

The Exchange is not aware of any cost impacts that a representative private person or business would necessarily incur in reasonable compliance with the proposed action.

CONSIDERATION OF ALTERNATIVES

In accordance with Government Code Section 11346.5(a)(13), the Exchange must determine that no reasonable alternative considered or that has otherwise been identified and brought to the attention of the Exchange would be more effective in carrying out the purpose for which this action is proposed, 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 effectuating the purpose of the statute and applicable federal regulations. This proposed action is the most effective in effectuating the purpose of the statute and applicable federal regulations.

CONTACT PERSONS

Inquiries concerning the proposed administrative action may be directed to:

Faviola Adams
Regulations Coordinator
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:

Brian Kearns
Attorney
California Health Benefit Exchange (Covered California)
1601 Exposition Blvd.
Sacramento, CA 95815
Telephone: (916) 228-8843

Please direct 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 Annalisa Franco 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 Annalisa Franco at the address or phone number listed above.

AVAILABILITY OF CHANGED OR MODIFIED TEXT

After holding a 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 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 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 <https://hbex.coveredca.com/regulations>.



INITIAL STATEMENT OF REASONS

CALIFORNIA CODE OF REGULATIONS, TITLE 10, CHAPTER 12, ARTICLE 12 ADOPT SECTIONS 6900, 6901, 6902, 6903, 6904, 6905, 6906, 6907, and 6908

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

BACKGROUND

In March 2010, President Obama signed federal health reform legislation called the Patient Protection and Affordable Care Act (ACA). It created the opportunity for each state to establish a state-based health insurance exchange to implement the ACA. California chose to operate an exchange that is commonly known as known as “Covered California.” For purposes of this Initial Statement of Reasons, Covered California will be referred to as the “Exchange.” 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 their health plan.

State law also specifies the powers and duties of the executive board of the Exchange. Government Code Section 100504(a)(6) authorizes the Exchange’s Board of Directors to adopt rules and regulations, as necessary. The Exchange proposes this permanent rulemaking in furtherance of its rulemaking authority to implement, interpret and make specific state and federal laws. Specifically, this rulemaking package is intended to: (1) complete Certificate of Compliance requirements for Sections 6902, 6903, and 6904; (2) adopt Sections 6900, 6901, 6901, 6905, 6906, 6807, and 6908; and (3) make minor edits that ensure clarity and accuracy.

PROBLEM STATEMENT

Since 2014, the Exchange has significantly relied upon Certified Enrollers to facilitate enrollment of consumers into Qualified Health Plans (QHPs). Certified Enrollers include Certified Enrollment Counselors, Certified Application Counselors, Medi-Cal Managed

Care Plan Enrollers, Agents, and Plan-Based Enrollers. Certified Enrollers account for over half of the Exchange's enrollments every year, so it is important for the Exchange to foster a mutually beneficial relationship with each type of Enroller. Each counselor affiliates with an entity in order to provide enrollment assistance. Medi-Cal Managed Care Plan Enrollers (MMCPEs) affiliate with Medi-Cal Managed Care Plans (MMCPs) and perform enrollment assistance on behalf of the Entity. For purposes of this Initial Statement of Reasons, Medi-Cal Managed Care Plan Enrollers and Medi-Cal Managed Care Plans will be referred to as **MMCPEs** and **MMCPs**, respectively.

MMCPs are entities that contract with the Department of Health Care Services (DHCS) to provide health care services to enrolled Medi-Cal beneficiaries. MMCPEs are individual counselors who affiliate with MMCPs to enroll consumers into Medi-Cal. They also enroll a small number of individuals into Exchange plans.

The proposed rulemaking package makes permanent existing emergency regulations regarding MMCPEs and MMCPs. These regulations set forth the requirements for the application to apply to the program and the fingerprinting and background check process. This package also adopts Sections 6900, 6901, 6901, 6905, 6906, 6807, and 6908. These sections were previously emergency regulations but have expired. They outline definitions; eligibility requirements; training topics and procedures; roles and responsibilities; conflict of interest rules; and suspension/revocation processes.

ANTICIPATED BENEFITS

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 high quality health care available to all Californians;
- Providing structure for the Exchange to give predictable, clear standards to the public and to MMCPs/MMCPEs both now and prospectively;
- Establishing a uniform process for MMCP/MMCPE certification;
- Providing increased access to and education about health care coverage to the public in California.

PURPOSE AND NECESSITY

The broad purpose of this proposed regulatory action is to: (1) complete Certificate of Compliance requirements for Sections 6902, 6903, and 6904; (2) adopt Sections 6900, 6901, 6905, 6906, 6807, and 6908; and (3) make minor edits that ensure clarity and accuracy.

Pursuant to its authorities, the Exchange proposes to permanently adopt certain regulations as follows:

Section 6900:

This section clarifies and makes specific the definitions for certain terms used throughout Article 12. This is necessary because certain terms have specified meanings in state and federal regulations. Section 6900 ensures that these terms are consistently used throughout Article 12.

Section 6900 was previously an emergency regulation that expired on April 27, 2018. This rulemaking package makes minor citation changes to the previously filed emergency regulation. Other than these changes, the proposed regulations are identical to the regulations that expired in April 27, 2018.

Authorized Contact: “Authorized Contact” is a term unique to the Exchange. Therefore, defining the term is necessary to ensure that the affected public understands this term as it is used in these regulations.

Certified Medi-Cal Managed Care Plan: Defining “Certified Medi-Cal Managed Care Plan” provides clarity to this Article as the term is used throughout. It is a term unique to the Exchange. This definition is necessary to ensure that those regulated by this Article, consumers, and other interested parties understand the role of Certified Medi-Cal Managed Care Plans and to whom these regulations apply.

Certified Medi-Cal Managed Care Plan Enroller or Enroller: Defining “Certified Medi-Cal Managed Care Plan Enroller” provides clarity to this Article so that entities wishing to become Certified Medi-Cal Managed Care Plan Enroller understand the eligibility rules. “Certified Medi-Cal Managed Care Plan Enroller” is a term unique to the Exchange.

Consumer Assistance: Defining “Consumer Assistance” provides clarity to these regulations and informs individuals and entities carrying out consumer assistance functions of their duties. Defining “Consumer Assistance” is necessary to ensure consistency with federal regulations set out in 45 C.F.R. § 155.205.

Medi-Cal Managed Care Plan: Defining “Medi-Cal Managed Care Plan” provides clarity to this Article as it is used throughout this Article. This definition is also particularly important for describing the entities eligible to become certified and perform the duties as set forth in this Article.

Primary Contact: “Primary Contact” is a term unique to the Exchange. The primary contact will be the appointed liaison with the Exchange. Defining this term is necessary to ensure that applicants know how to complete their application and whom to select to be the liaison with the Exchange.

Section 6901:

This section outlines the requirements for becoming an MMCP. It is necessary to define the population who can become certified and perform the duties as set forth in this Article. It was previously an emergency regulation that expired on April 27, 2018. This rulemaking package makes minor grammatical changes to the previous emergency regulation. Other than these changes, the proposed regulations are identical to those that expired in April 2018.

Section 6902:

This section sets forth the requirements for the application for qualified entities interested in performing services as a MMCP. Section 6902 is an active emergency regulation. This rulemaking package makes no changes to the existing language.

Section 6902(a)(1) – (5) outlines the submission procedures, review process, and application content for participation in the MMCP program. Subdivisions (a)(1)-(5) specify the process that must be followed to submit an application and become certified. This section is necessary to guide interested individuals through the application process. This section also informs applicants that they must not only complete training, but also within 30 days of submitting the agreement and proof of insurance.

Applicants must submit an executed agreement which conforms to the roles and responsibilities as set forth in Section 6906. This is necessary to ensure that participants are knowledgeable and prepared to carry out the functions of the program. The submission of an agreement is necessary to ensure that participants are on notice of their required functions and are legally bound to perform those functions in conformance with these regulations.

Applicants must also submit proof of general liability insurance of a minimum value of \$1,000,000.00 per occurrence with the Exchange to be listed as an additional insured and evidence of workers compensation coverage. This is required to protect and indemnify the Exchange from litigation exposure that may arise due to the conduct and events arising from, or involving MMCPs and/or its employees. The one million dollar amount is consistent with guidance received by the Office of Risk Management, a division of the Department of General Services.

Entities who complete the application and training requirements will be given a Certified Medi-Cal Managed Care Plan Number. This number assists Covered California in monitoring and tracking the MMCPE. MMCPE must designate an individual to take the training requirements outlined in Section 6905. The training is necessary to ensure that the MMCPE can fulfill the requirements of the program. The 30-day deadline incentivizes the MMCPE to complete its training requirements in a timely fashion so that it can service consumers as soon as possible.

Section 6902(b)(1)-(2) require the organization's full and legal name. This is necessary to identify the applicant. The Exchange must be advised of the applicant's legal name so that agreements and correspondence will legally bind and address the proper name of the applicant.

Section 6902(b)(3) requires the applicant's primary contact's email address. This is necessary so that the Exchange can communicate and send correspondence via email to the applicant's primary contact. This form of communication will allow for efficiency and timeliness in conducting communication related to the MMCP program.

Section 6902(b)(4)-(5) require documentation of the applicant's primary and secondary phone number. This is necessary to ensure the Exchange has correct contact information on file for its records so that the Exchange can communicate with the applicant's authorized representative throughout the application process and if selected, communicate regarding participation in the MMCP program.

Section 6902(b)(6)-(9) require the applicant's Federal Employment Identification Number, State Tax Identification Number, status as a Medi-Cal Managed Care Plan, and identification of the type of program. This information is necessary to confirm the applicant's eligibility to participate in the program and to confirm that the applicant can fully perform the work without violating any conflict of interest rules.

Section 6902(b)(10) requires the applicant to certify that it will comply with Section 6907, which identifies the conflict of interest standards. This certification is necessary to ensure that applicants can and will comply with all conflict of interest rules. The Exchange cannot certify organizations that are incapable of complying with the conflict of interest rules.

Section 6902(b)(11) requires the applicant to attest that it will serve families of mixed immigration status. This is necessary because the Exchange relies on MMCPs to engage with diverse and hard-to-reach populations, including families of mixed immigration status.

Section 6902(b)(12) requires the applicant to attest that it will service individuals with disabilities. This is necessary because the Exchange relies on MMCPs to engage with diverse and hard-to-reach populations, including individuals with disabilities.

Section 6902(b)(13)(A)-(H) requires the applicant to provide contact information for both its primary sites and any sub-sites. It also requires the applicant to provide its hours of operation. This information is necessary for administrative purposes. It allows the Exchange to communicate with the organization. The Exchange also makes this information available to the public so consumers can directly contact MMCPs for assistance.

Section 6902(b)(14) requires the Authorized Contact to certify that the application contains information that is true and correct. This ensures that the applicants provide accurate information. The Exchange can only certify qualified organizations. The decision to certify is solely based on the information provided in the application, so it is essential for applicants to supply truthful information.

Section 6902(b)(15)(A)-(C) It requires the MMCPs to provide any additional information that the Exchange can consider when reviewing the application. It also requires the applicant to identify its certification number if the Exchange has certified it in another program. This allows MMCP applicants to be fairly considered for the program and ensure that they can fully perform the duties without violating the conflicts of interest.

Section 6903

This section sets forth the requirements for the application for qualified individuals interested in performing services as a MMCPE. Section 6903 is an active emergency regulation. This rulemaking package makes no changes to the existing language.

Section 6903(a)(1)(A) broadly outlines the documents that MMCPE applicants must submit to the Exchange. This is necessary to provide the individual with clear guidance on what information the Exchange must collect in order to properly determine the individual's eligibility to become an MMCPE. The submission of an agreement is necessary to ensure that applicants are on notice of their required functions and are legally bound to perform those functions in conformance with the applicable regulations.

Section 6903(a)(1)(B) identifies the requirements that applicants must complete within 90 calendar days after submitting the appropriate paperwork. Applicants must submit their fingerprinting images and disclose criminal convictions/administrative actions. This information is necessary as it allows the Exchange to make an individualized assessment of the individual's fitness eligibility to become an MMCPE, as required by Government Code Section 1043.

All applicants must complete training as a condition to certification. This is necessary to ensure that individuals are knowledgeable and prepared to carry out the duties and functions of an MMCPE. Applicants must also pass a certification exam administered by the Exchange.

Section 6903(a)(2) requires the Exchange to certify individuals who complete the requirements of Section 6904, pass the fingerprinting and criminal record check, and have no administrative actions taken against them which are substantially related to the qualifications, functions, or duties of the specific position sought. This is necessary to inform applicants all requirements which must be satisfied before the Exchange must issue a certification.

Section 6903(b) outlines the requirements for an MMCPE application. This is necessary to inform applicants of the required information to complete an MMCPE application.

Section 6903(b)(1) requires the applicant's name, e-mail address, and primary phone number. require the organization's full and legal name. This is necessary to identify the applicant. The Exchange must be advised of the applicant's legal name so that agreements and correspondence will legally bind and address the proper name of the applicant. This section also requires the applicant's e-mail address and phone number. This is necessary so that the Exchange can communicate and send correspondence via email to the applicant regarding certification and any updates to the program.

Section 6903(b)(2) requires an applicant's Driver's License Number or Identification Number issued by the California Department of Motor Vehicles. This is necessary for the Exchange to confirm the applicant's age. MMCPEs must be at least 18 years old.

Section 6903(b)(3) – (4) require applicants to identify the languages that they can speak and write. This is necessary to ensure the applicants can serve target populations in their preferred language. This also allows the Exchange to monitor its compliance with 45 C.F.R. § 155.205(c).

Section 6903(b)(5) requires the applicant to submit their fingerprinting images and disclose criminal convictions/administrative actions. This information is necessary as it allows the Exchange to make an individualized assessment of the individual's fitness eligibility to become an MMCPE, as required by Government Code Section 1043.

Section 6903(b)(6)(A) requires the applicant to certify that they will comply with the Agreement and all requirements sets forth in the Article. This ensures that the applicant can perform the MMCPE functions without violating the conflict of interest rules.

Section 6903 (b)(6)(B) requires applicants to certify that they are a natural person of not less than 18 years of age. This is necessary for the Exchange to confirm the applicant's age. MMCPEs must be at least 18 years old.

Section 6903(b)(6)(C) requires applicants to certify that the application contains information that is true and correct. This ensures that the applicants provide accurate information. The Exchange can only certify qualified individuals. The decision to certify is solely based on the information provided in the application, so it is essential for applicants to supply truthful information.

Section 6903(b)(6)(D)-(E) requires applicants to certify that they will comply with all applicable privacy and security standards, including any set forth in the agreement between the MMCP and the Exchange. This certification is necessary to confirm the applicant's willingness and ability to comply with the privacy/security rules. All MMCPEs must strictly adhere to the privacy and security rules when handling a consumer's

personally identifiable information. Failure to comply with these rules must result in immediate decertification and possible legal action.

Section 6903(b)(7) requires the applicant to sign and date the application. This is required to formalize the completion of the application process.

Section 6903(c)(1)-(5) requires the MMCP to notify the Exchange of every individual to be added or removed as an MMCPE. The notification must include the MMCP name and identification number; name and signature of the Authorized Contact; name, email, and phone number for each MMCPE to be added/removed; effective date of addition or removal; and sites individual will serve. This information is necessary to facilitate Covered California's tracking and monitoring of the MMCPE.

Section 6904

This section outlines the fingerprinting and criminal record check procedures for MMCPEs. Prior to performing work, all MMCPEs must comply with these procedures and clear the background check. This section details each step of the process as well as the appeal procedures in the event of an adverse decision.

Section 6904 is an active emergency regulation. This rulemaking package makes no changes to the language.

Section 6904(a) requires MMCPEs to comply with the background check process set forth in Subdivisions 6658 (a)-(c) in Article 8. This subdivision is needed to ensure compliance with Section 6456 of Article 4 of this Chapter and Government Code Section 1043.

Section 6904(b) provides that the Exchange will pay the background check costs incurred by individuals whose duties require fingerprinting. This subdivision is necessary to inform applicants that they will not need to assume background check costs when applying for certification.

Section 6904(c) specifies that an individual is disqualified upon receipt of a final determination from the Exchange and is ineligible to reapply for certification for two years. This allows an applicant sufficient time in order to develop evidence that would support a finding of rehabilitation, for example if an individual has had his or her record expunged. This subdivision also is necessary to reduce the workload on the Exchange of having to review multiple applications from the same individual after that individual receives a letter of rejection, while allowing the individual the opportunity to apply again in the future.

Section 6905

This section identifies all training requirements for MMCPEs. As part of the certification process, MMCPEs must complete training that covers a variety of topics. MMCPEs must also complete annual training to retain their certification status.

Section 6860 was previously an emergency regulation that expired on April 27, 2018. This rulemaking package makes no changes to the previous emergency regulation.

Section 6905(a) requires MMCPEs to comply with the training process set forth in Subdivisions 6660 of Article 8. This section sets forth the subjects about which CAEs and MMCPEs must be knowledgeable in order to carry out the duties required of them when performing enrollment assistance activities on behalf of the Exchange. This subdivision is necessary to ensure that MMCPEs have the proper training before performing any of their required duties.

Section 6905(b) provides that MMCPEs are required to pass an annual examination to maintain certification with the Exchange. This subdivision is necessary to ensure those providing consumer assistance functions remain knowledgeable of products and services offered by the Exchange.

Section 6906

This section outlines the CAC's roles and responsibilities when performing enrollment assistance.

Section 6906 was previously an emergency regulation that expired on April 27, 2017. This rulemaking package makes minor citation changes to the previously filed emergency regulation. Other than these changes, the proposed regulations are identical to the regulations that expired in April 27, 2017.

Section 6906(a)(1) requires MMCPEs to maintain expertise in eligibility, enrollment, and Exchange program specifications. This requirement is necessary to ensure that MMCPEs can accurately convey all current insurance options to consumers.

Section 6906(a)(2) requires MMCPEs to provide information and services in a fair, accurate, and impartial manner. This involves assisting consumers with submitting the eligibility application; clarify the distinctions among health coverage options, including QHPs; and help consumers make informed decisions during the health coverage selection process. This requirement is necessary to ensure consumers receive the best possible assistance when choosing the appropriate health plan for their health and financial needs.

Section 6906(a)(3) requires MMCPEs to facilitate the enrollment of individuals and employees coverage in a QHP through the Exchange and for insurance affordability programs. This is a core function for MMCPEs. The Exchange relies on MMCPEs to assist consumers with enrollment into Covered California plans and other insurance

affordability programs. This requirement is necessary to ensure that the MMCEPs can fulfill their main objective.

Section 6906(a)(4) requires MMCEPs to provide referrals to any applicable office of health insurance Consumer Assistance or health insurance ombudsman established under Section 2793 of the Public Health Service Act, 42 U.S.C. § 300gg-93, or any other appropriate State agency or agencies, for any enrollee with a grievance, complaint, or question regarding their health plan, coverage, or a determination under such plan or coverage. This is an important requirement because consumers may run into coverage issues after enrollment. Consumers could seek the MMCEPs for advice on an appeals process. MMCEPs are not trained to handle insurance disputes but are required to refer consumers to the appropriate entity who can assist the consumer. This process ensures that the consumer receives the appropriate assistance in an expedient manner.

Section 6906(a)(5) requires applicants to certify that they will comply with all applicable privacy and security standards set forth in 45 CFR § 155.260 (September 6, 2016). This requirement is necessary to confirm the applicant's willingness and ability to comply with the privacy/security rules. All MMCEPs must strictly adhere to the privacy and security rules when handling a consumer's personally identifiable information. Failure to comply with these rules must result in immediate decertification and possible legal action.

Section 6906(a)(6) requires MMCEPs to ensure that voter registration assistance is available to each consumer. This subdivision is required in order to comply with National Voter Registration Act (42 U.S.C. § 1973gg-5), Elections Code Sections 2400 et seq., and Section 6462 of Article 4.

Section 6906(a)(7) requires MMCEPs to comply with any applicable federal or state laws and regulations. This requirement is necessary to protect both consumers and the Exchange from MMCEPs who cannot comply with applicable laws. The Exchange entrusts MMCEPs to handle sensitive information when performing enrollment assistance.

Section 6906(b) requires MMCPs and MMCEPs to inform limited English proficient consumers of their right to receive language assistance services and how to obtain them. This subdivision is needed to ensure that those with limited English proficiency are made aware how to obtain language assistance services so that they can communicate effectively with a MMCP/MMCPE.

Section 6906(c) requires MMCPs and MMCEPs to ensure that their assistance is available to persons with disabilities. This section ensures that MMCEPs and MMCPs can assist all consumers from different backgrounds, especially those that may significantly rely upon health insurance to address issues related to disabilities. The

Exchange relies on MMCPs and MMCPEs to target hard-to-reach populations, so this section is essential for MMCPs and MMCPEs to fulfill their purpose.

Section 6906(d) requires MMCPs and MMCPEs to provide the same level of service to all individuals regardless of age, disability, culture, sexual orientation, or gender identity, and seek advice or experts when needed. This section is necessary to prohibit discrimination on the basis of age, disability, culture, sexual orientation, or gender identity, so that all consumers can receive the same level of service.

Section 6906(e)(1)-(3) outlines information that MMCPEs must include on each application. This information allows the Exchange to track the MMCPEs and their assistance to consumers. The Exchange will use this information if it needs to resolve any issues related to the enrollment.

Section 6906(f) notifies MMCPEs that they cannot later add the information in Section 6906(e). This is important because MMCPEs should be on notice that they must input the information while completing the application and not after the fact.

Section 6906(g) requires MMCPs and MMCPEs to wear an identification badge when providing consumer assistance. This subdivision is necessary to ensure that all consumers feel that the individuals representing the Exchange are trained and certified by the Exchange. Consumers will thus feel more trusting of the individuals with whom they work, which will foster more honest and truthful communication. Additionally, the Exchange will be better able to keep track of the individuals it has certified as MMCPEs and identify them should there be a reported issue or problem with that particular MMCPE or the MMCP.

Section 6906(h)(1) requires MMCPEs and MMCPs to refrain from having a conflict of interest as set forth in Section 6907. This cross reference to Section 6907 is needed to stress the importance of the conflict of interest principles and ensure that MMCPEs and MMCPs abide by those rules when performing enrollment assistance.

Section 6906(h)(2) prohibits MMCPs and MMCPEs from mailing consumer applications for the consumer. Mailing an application on behalf of a consumer would prolong the Counselor or Entity's exposure to the consumer's personal information, and is not necessary to fulfill their roles and responsibilities. This subdivision is necessary to avoid such exposure.

Section 6906(h)(3) prohibits MMCPEs and MMCPs from coaching a consumer to provide inaccurate information regarding their income, residency, or immigration status on his or her application to the Exchange. This is necessary to prevent fraudulent applications and inaccuracies that could result in a consumer choosing an incompatible plan.

Section 6906(h)(4) prohibits MMCPEs and MMCPs from recommending one plan or provider over another to a consumer. This subdivision is needed to ensure that

consumers pick the best plan that fits their financial and health needs. MMCPEs and MMCPs can offer assistance with plan selection, but consumers must ultimately make the informed decision.

Section 6906(h)(5) prohibits MMCPEs and MMCPs from accepting premium payments from consumers. This subdivision is necessary to ensure that MMCPs are not accessing or receiving credit card information from consumers. Accepting payment information from consumers is not part of a MMCPs required duties, and thus would give them access to personal information that they do not need access to. This subdivision is necessary to limit the amount of personal information to which a MMCP or MMCPE has access to, thus reducing the risk of misuse of this highly sensitive information.

Section 6906(h)(6) prohibits MMCPEs and MMCPs from inputting premium payment information on behalf of the consumer. This subdivision is necessary to ensure that MMCPs are not accessing or receiving credit card information from consumers. Accepting payment information from consumers is not part of a MMCP's required duties, and thus would give them access to personal information that they do not need access to. This subdivision is necessary to limit the amount of personal information to which a MMCP or MMCPE has access to, thus reducing the risk of misuse of this highly sensitive material.

Section 6906(h)(7) prohibits MMCPEs and MMCPs from paying consumer premiums or any type of consideration to or on behalf of the consumer. This subdivision is needed to ensure that MMCPEs and MMCPs are not inducing consumers to allow them to provide assistance so that they can increase their enrollment numbers. Some premium amounts may be as low as a few dollars, in which case the MMCPs would have more to gain from paying the premium on behalf of the consumer, than losing that consumer as a client.

Section 6906(h)(8) prohibits MMCPEs and MMCPs from encouraging or accepting any type of remuneration from the consumer. This prohibition promotes a chief goal of the Certified Enroller program, which is that consumers can receive free assistance from any Certified Enroller or the Covered California Service Center. Consumers should not have to pay for enrollment assistance under any circumstance.

Section 6906(h)(9) prohibits MMCPEs and MMCPs from intentionally creating multiple applications from the same household as defined in 42-C.F.R. § 435.603(f). This regulation would ensure that MMCPEs and MMCPs are not manipulating the system in order to increase their enrollment numbers.

Section 6906(h)(10) prohibits MMCPEs and MMCPs from inviting, influencing or arranging for a consumer to separate from their employer-based group health coverage if such coverage is affordable and provide minimum value. This is necessary to ensure that Counselors are not unduly influencing consumers to separate from health insurance that provides them with the appropriate coverage. Exchange plans are for

those consumers who do not have access to plans that are affordable and provide minimum value.

Section 6906(h)(11) precludes MMPCEs and MMCPs from soliciting enrollment assistance by going door-to-door or through other unsolicited means of direct contract (unless the consumer has a pre-existing relationship). This requirement protects consumers from unwarranted invasions into their personal privacy and from harassing phone calls. The Exchange recognizes that consumers should be protected from unsolicited contacts from Certified Enrollers.

Section 6906(h)(12) precludes MMCPs and MMCPs from initiating telephone calls to consumers using an automatic telephone dialing system unless the consumer has a pre-existing relationship. This requirement protects consumers from unwarranted invasions into their personal privacy and from harassing phone calls. The Exchange recognizes that consumers should be protected from unsolicited contacts from Certified Enrollers. It also ensures that MMCPs comply with state and federal laws related to robocalling.

Section 6906(i) requires MMCPs and MMCPs to report to the Exchange any subsequent arrests for which they have been released on bail or personal recognizance, criminal convictions and administrative actions to the Exchange within 30 calendar days of the date of each occurrence. This requirement is necessary to ensure that MMCPs have not committed or been accused of committing any additional substantially related crimes after becoming certified with the Exchange. This addition serves to comply with Government Code Section 1043 and regulations set forth in Section 6456 of Article 4.

Section 6906(j) requires MMCPs and MMCPs to notify the Exchange of any change in contact information for the Certified Medi-Cal Managed Care Plan or its MMCPs. This requirement allows the Exchange to maintain contact with the MMCP and its MMCPs, so it can communicate new policies, procedures, and any issues related to consumer enrollment.

Section 6907

This section sets forth the conflict of interest standards for MMCPs and MMCPs pursuant to this Article.

Section 6907 was previously an emergency regulation that expired on April 27, 2017. This rulemaking package makes minor citation changes to the previously filed emergency regulation. Other than these changes, the proposed regulations are identical to the regulations that expired in April 27, 2017.

Section 6907(a)(1) requires MMCPs and MMCPs to comply with applicable State law related to the sale, solicitation, and negotiation of insurance products, including

applicable State law related to agent, broker, and producer licensure. This requirement is necessary to protect both consumers and the Exchange from MMCPEs who cannot comply with applicable laws. The Exchange entrusts that MMCPEs and MMCPs can perform their duties in compliance with State laws related to the solicitation, sale, and negotiation of insurance products. The Exchange will not contract with MMCPEs and MMCPs that cannot apply with these laws.

Section 6907(a)(2) requires MMCPEs and MMCPs to create a written plan to remain free of conflicts of interest while performing consumer assistance activities on behalf of the Exchange. This section ensures that MMCPEs and MMCPs are aware of the conflict of interest rules and also actively take measures to prevent conflicts from occurring.

Section 6907(a)(3) requires MMCPEs and MMCPs to provide information to consumers about the full range of QHP options and insurance affordability programs for which they are eligible. This section ensures that MMCPEs and MMCPs to provide fair, accurate, and impartial information to consumers so they can make an informed decision regarding health insurance.

Section 6907(a)(4)(A) requires MMCPEs and MMCPs to disclose to the Exchange and to each consumer receiving application assistance any lines of insurance business, not covered by the restrictions on participation and prohibitions on conduct in this section, which the entity or individual intends to sell while carrying out consumer assistance functions. This section enables the Exchange to determine whether the MMCPEs and MMCPs can legally fulfill their respective duties. This section also promotes transparency as consumers will be informed of potential (but not actual) conflicts of interest when engaging with a MMCPE and MMCP. Transparency allows consumers to make informed decision when choosing a certified enroller.

Section 6907(a)(4)(B) requires MMCPEs and MMCPs to disclose any existing employment relationships, or any former employment relationships within the last five years, with any health insurance issuers or issuers of stop loss insurance, or subsidiaries of health insurance issuers or issuers of stop loss insurance, including any existing employment relationships between a spouse or domestic partner and any health insurance issuers or issuers of stop loss insurance, or subsidiaries of health insurance issuers or issuers of stop loss insurance. This section enables the Exchange to determine whether the MMCPEs and MMCPs can legally fulfill their respective duties. This section also promotes transparency as consumers will be informed of potential (but not actual) conflicts of interest when engaging with a MMCPE and MMCP. Transparency allows consumers to make informed decision when choosing a certified enroller.

Section 6907(a)(4)(C) requires MMCPEs and MMCPs to disclose any existing or anticipated financial, business, or contractual relationship with one or more health insurance issuers or issuers of stop loss insurance, or subsidiaries of health insurance issuers or issuers of stop loss insurance. This section enables the Exchange to determine whether the MMCPEs and MMCPs can legally fulfill their respective duties.

This section also promotes transparency as consumers will be informed of potential (but not actual) conflicts of interest when engaging with an MMCPE and MMCP.

Transparency allows consumers to make informed decision when choosing a certified enroller.

Section 6907(b)(1) requires MMCPEs that are licensed insurance agents to comply with 45 CFR section 155.220. All licensed agents selling Exchange plans must comply with these federal regulations and the Exchange does not have the discretion to waive them. This section has been updated to include an effective date for the cited federal regulation.

Section 6907(b)(2) requires MMCPEs that are licensed insurance agents to execute an agreement that complies with 45 CFR section 155.220. All licensed agents selling Exchange plans must comply with these federal regulations and the Exchange does not have the discretion to waive them. Additionally, the Exchange requires all agents to execute an agreement as a condition to becoming certified.

Section 6907(b)(3) prohibits MMCPEs from receiving direct or indirect consideration from any health insurance issuer or stop loss insurance issuer (other than from their own MMCP) in connection with the enrollment of any individuals in a QHP or non-QHP. The Exchange has identified such financial arrangements as a conflict of interest, because they may improperly influence how MMCPEs sell plans to consumers.

Section 6907(b)(4) prohibits MMCPEs from becoming certified as a certified insurance agent while concurrently serving as an MMCPE. The Exchange has determined that MMCPEs should only work within their respective program and cannot become certified as a certified insurance agent. Becoming certified as an agent would create a conflict of interest for MMCPEs and likely cause them to violate multiple MMCP regulations. This section has been modified to accommodate for the fact that Article 10 has expired. The reference to Article 10 has been removed.

Section 6908

This subdivision in its entirety sets forth the suspension, revocation, and appeals procedures for individuals applying or certified under this Article.

Section 6908 was previously an emergency regulation that expired on April 27, 2017. This rulemaking package makes minor citation changes to the previously filed emergency regulation. Other than these changes, the proposed regulations are identical to the regulations that expired in April 27, 2017.

Section 6908(a)(1) informs MMCPEs and MMCPs that their certification will be suspended or revoked if they fail to comply with applicable federal or state laws or regulations. This is necessary to ensure that MMCPEs and MMCPs are abiding by

applicable federal and state laws and regulations when providing services pursuant to this Article. This requirement will serve to protect the Exchange from liability stemming from any violation of the law its contractors may commit. This subdivision is necessary to give the Exchange the right to terminate the certification of individuals and entities for violations of applicable law.

Section 6908(a)(2) specifies that MMCPEs and MMCPs will be subject to suspension or revocation of certification if they have a potentially disqualifying administrative or criminal record. This is necessary to comply with Government Code Section 1043. This requirement will serve to protect the Exchange from liability stemming from any violation of the law its contractors may commit. This subdivision is necessary to give the Exchange the right to terminate the certification of individuals and entities for violations of applicable law.

Section 6908(a)(3) specifies that an MMCPE or MMCP who has received a final determination of disqualification is not eligible to reapply for certification for two years. This is necessary to ensure that the Exchange is not repeating the same workload by making determinations on individuals who have already been disqualified. The Exchange established a two-year time period to provide enough time for the disqualified individual or entity to make efforts toward rehabilitation and be eligible for another opportunity to be certified, while not being overly prohibitive.

RELIED ON DOCUMENTS

None.

ECONOMIC IMPACT ANALYSIS

Creation of Jobs

This proposed regulation is not expected to create or eliminate any jobs within the State of California. The proposed Medi-Cal Managed Care Plan Enroller and Medi-Cal Managed Care Plan regulations are intended to complete Certificate of Compliance requirements, permanently adopt certain regulations that expired in April 2017 and make minor edits that ensure clarity and address stakeholder requests. Additionally, these regulations will streamline the application process to ease the administrative burden on applicants. Therefore, no new job creation or elimination is expected to occur due to this proposed regulation.

Creation of Businesses

This proposed regulation is not expected to create or eliminate any new business within the State of California. The MMCPE and MMCP program is already in existence and the regulations makes permanent existing emergency and previously expired regulations. It

also addresses grammatical issues and update dates of the cited federal regulations for MMCPE and MMCP to participate in the program. Therefore, no new businesses are expected to form or be eliminated due to this proposed regulation.

Expansion of Businesses

This proposed regulation is not expected to expand any business within the State of California. The current MMCPE and MMCP program is already in existence. Therefore, no expansion of businesses are expected due to this proposed regulation.

Benefits

The regulations package has a number of benefits which are tied to the Exchange's overall mission. The Exchange is committed to improving the consumer experience in using a MMCPE and MMCP to obtain health insurance. These regulations ensure that the Exchange obtains only that information which is necessary to determine a MMCPE and MMCP applicant's eligibility. They also set a deadline for when MMCPEs must complete their recertification training.

DESCRIPTION OF ALTERNATIVES

In accordance with Government Code Section 11346.5(a)(13), the Exchange has determined that no reasonable alternative considered or that has otherwise been identified and brought to the attention of the Exchange would be more effective in carrying out the purpose for which this action is proposed, 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 effectuating the purpose of the statute and applicable regulations. This proposed action is the most effective in effectuating the purpose of the statute and applicable regulations.

SUPPORT FOR DETERMINATION OF NO SIGNIFICANT ADVERSE ECONOMIC IMPACT ON BUSINESS

The proposed rulemaking modifies multiple sections governing the MMCPE and MMCP application and certification process. The goal of these amendments is to make minor edits and adopt regulations that prior were emergency regulations. The proposed changes are intended to streamline the application process for individuals and entities who wish to participate in the program. The edits to sections that were previously emergency regulations will ensure clarity and address stakeholder requests. This is a benefit to both the Exchange and its MMCPE and MMCP program applicants.

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.

Title 10. Investment

Chapter 12. California Health Benefit Exchange

Article 12. Medi-Cal Managed Care Plan Enrollment Assistance

§ 6900. Definitions.

(a) For purposes of this Article, the following terms shall have the following associated meanings:

(1) Authorized Contact: The individual appointed by the Certified Medi-Cal Managed Care Plan entity to manage the agreement executed with the Exchange pursuant to this Article.

(2) Certified Medi-Cal Managed Care Plan: a Medi-Cal Managed Care Plan who has been certified pursuant to this Article.

(3) Certified Medi-Cal Managed Care Plan Enroller or Enroller: An individual that is an employee or contractor of a Certified Medi-Cal Managed Care Plan who provides enrollment assistance pursuant to this Article.

(4) Consumer Assistance: The programs and activities created under 45 C.F.R. § 155.205(d) (December 22, 2016), hereby incorporated by reference, to provide enrollment assistance to consumers.

(5) Medi-Cal Managed Care Plan: An entity contracting with the Department of Health Care Services (DHCS) to provide health care services to enrolled Medi-Cal beneficiaries under Chapter 7, commencing with section 14000, or Chapter 8, commencing with section 14200, of Division 9, Part 3, of the Welfare and Institutions Code.

(6) Primary Contact: The individual appointed by the Certified Medi-Cal Managed Care Plan to be the liaison with the Exchange.

Note: Authority cited: Sections 100502 and 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; 45 C.F.R Section 155.205.

§ 6901. Eligibility.

(a) All California Medi-Cal Managed Care Plans as defined in section 6900 are eligible to apply to become a Certified Medi-Cal Managed Care Plan with the Exchange.

Note: Authority cited: Sections 100502 and 100504, Government Code. Reference: Sections 100502 and 100503, Government Code.

§ 6902. Application.

(a) A Medi-Cal Managed Care Plan may apply to register as a Certified Medi-Cal Managed Care Plan according to the following process:

(1) The entity shall submit an application containing all information, documentation, and declarations required in subdivision (b) of this section.

(2) The application shall demonstrate that the entity is capable of carrying out at least those duties described in section 6906 and has existing relationships, or could readily establish relationships, with employers and employees, consumers (including uninsured and underinsured consumers), or self-employed individuals likely to be eligible for enrollment in a Qualified Health Plan (QHP) or an insurance affordability program.

(3) The Exchange shall review the application and, if applicable, request any additional or missing information necessary to determine eligibility.

(4) Entities who have submitted a completed application and demonstrated ability to meet the above requirements shall:

(A) Submit the following:

1. An executed agreement conforming to the Roles and Responsibilities defined in section 6906; and

2. Proof of general liability insurance with coverage of not less than \$1,000,000 per occurrence with the Exchange named as an additional insured, and workers' compensation insurance.

(5) Entities who are eligible based on their completed application and whose designee completes and passes the training requirements established pursuant to

section 6905 shall be registered as a Certified Medi-Cal Managed Care Plan by the Exchange and assigned a Certified Medi-Cal Managed Care Plan Number. If the designee fails to complete the training requirements set forth in section 6905 within 30 calendar days of completing the requirements in (a)(4)(A) of this section, the applicant shall be deregistered.

(b) A Certified Medi-Cal Managed Care Plan application shall contain the following information:

(1) Full name;

(2) Legal name;

(3) Primary e-mail address;

(4) Primary phone number;

(5) Secondary phone number;

(6) Federal Employment Identification Number;

(7) State Tax Identification Number;

(8) Identification of applicant's status as a Medi-Cal Managed Care Plan and a copy of supporting documentation;

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

(10) A certification that the applicant and all of its employees who will be acting pursuant to this Article comply with section 6907;

(11) An attestation that the entity will serve families of mixed immigration status;

(12) An attestation that the entity will serve individuals with disabilities.

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

(A) Site Location Address;

(B) Mailing Address;

(C) County;

(D) Primary Contact name;

(E) Primary e-mail address;

(F) Primary phone number;

(G) Secondary phone number; and

(H) Hours of operation.

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

(15) For each Enroller to be affiliated with the applicant:

(A) All information required by section 6903 that is not already included elsewhere in the application required by this section; and

(B) An indication of whether he or she is certified by the Exchange and, if applicable, the certification number.

Note: Authority cited: Sections 100502 and 100504, Government Code. Reference: Sections 100502 and 100503, Government Code.

§ 6903. Certified Medi-Cal Managed Care Plan Enroller Application.

(a) An individual may become a Certified Medi-Cal Managed Care Plan Enroller according to the following process:

(1) The individual shall:

(A) Submit the following:

1. All information, documentation, and declarations required in subdivision (b) of this section; and

2. An executed agreement conforming to the Roles and Responsibilities defined in section 6906.

(B) Within 90 calendar days of completing the requirements in (a)(1)(A) of this section:

1. Submit fingerprinting images in accordance with section 6904 (a);

2. Disclose to the Exchange all criminal convictions and administrative actions taken against the applicant;

3. Complete the required training established in section 6905; and

4. Pass the required certification exam pursuant to section 6660(d) of Article 8.

(2) Individuals who complete the above requirements and pass the Certified Medi-Cal Managed Care Plan Enroller Fingerprinting and Criminal Record Check described in section 6904 shall be certified as a Certified Medi-Cal Managed Care Plan Enroller by the Exchange.

(b) An individual's application to become a Certified Medi-Cal Managed Care Plan Enroller shall contain the following information:

(1) Name, e-mail address, primary and secondary phone number;

(2) Driver's License Number or Identification Number issued by the California Department of Motor Vehicles. If neither is available, the applicant may provide any other unique identifier found on an identification card issued by a federal, state, or local government agency or entity;

(3) Languages that the Certified Medi-Cal Managed Care Plan Enroller can speak;

(4) Languages that the Certified Medi-Cal Managed Care Plan Enroller can write;

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

(6) A certification by the individual that:

(A) The individual complies with the agreement required by section 6903(a)(1)(A)2. as well as all requirements as set forth in this Article, including but not limited to Section 6907;

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

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

(D) The individual will abide by all applicable privacy and security requirements, including but not limited to those set forth in the agreement between the Medi-Cal Managed Care Plan and the Exchange; and

(E) The individual will adhere to all applicable State and Federal laws and regulations.

(7) For the individual applying to become a Certified Medi-Cal Managed Care Plan Enroller, signature and date signed; and

(8) For the Authorized Contact from the Certified Medi-Cal Managed Care Plan that the individual will be affiliated with, name, signature, and date signed.

(c) A Certified Medi-Cal Managed Care Plan shall notify the Exchange of every individual to be added or removed as an affiliated Certified Medi-Cal Managed Care Plan Enroller. Such notification shall include:

(1) Name of the Certified Medi-Cal Managed Care Plan and the Certified Medi-Cal Managed Care Plan Number;

(2) Name and signature of the Authorized Contact from the Certified Medi-Cal Managed Care Plan;

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

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

(5) An indication of whether the individual is certified as a Certified Medi-Cal Managed Care Plan Enroller.

Note: Authority cited: Sections 100502 and 100504, Government Code.

Reference: Sections 100502 and 100503, Government Code.

§ 6904. Fingerprinting and Criminal Record Checks.

(a) Subdivisions 6658 (a)-(c) of Article 8 apply to individuals seeking certification pursuant to this Article.

(b) Background check costs for individuals seeking certification under this Article shall be paid by the Certified Medi-Cal Managed Care Plan.

(c) Following the receipt of a final determination pursuant to section 6658(c) that an individual is disqualified from certification, the individual shall not reapply for certification for two years.

Note: Authority cited: Sections 1043 and 100504, Government Code. Reference: Section 100502, Government Code; and Section 11105, Penal Code.

§ 6905. Training Requirements.

(a) All individuals who carry out functions pursuant to this Article shall complete training as outlined in section 6660 of Article 8.

(b) Certified Medi-Cal Managed Care Plans shall ensure that any affiliated Certified Medi-Cal Managed Care Plan Enrollers do not perform any consumer assistance functions if more than twelve months have passed since the Medi-Cal Managed Care Plan Enroller passed the certification exam in section 6660(d) of Article 8.

Note: Authority cited: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code.

§ 6906. Roles & Responsibilities.

(a) Certified Medi-Cal Managed Care Plans and Certified Medi-Cal Managed Care Plan Enrollers shall perform the following functions:

(1) Maintain expertise in eligibility, enrollment, and Exchange program specifications;

(2) Provide information and services in a fair, accurate, and impartial manner, which includes: providing information that assists consumers with submitting the eligibility application; clarifying the distinctions among health coverage options, including QHPs; and helping consumers make informed decisions during the health coverage selection process. Such information must acknowledge the existence of other health programs (i.e., Medi-Cal and Children's Health Insurance Programs);

(3) Facilitate selection of a QHP and/or insurance affordability programs;

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

(5) Comply with the privacy and security requirements in 45 C.F.R. § 155.260 (September 6, 2016), hereby incorporated by reference;

(6) Ensure that voter registration assistance is available in compliance with section 6462 of Article 4 of this Chapter; and

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

(b) To ensure that information provided as part of any Consumer Assistance is culturally and linguistically appropriate to the needs of the population being served, including individuals with limited English proficiency, a Certified Medi-Cal Managed Care Plan and its affiliated Certified Medi-Cal Managed Care Plan Enrollers shall comply with the requirements of section 6664(b)(1) through (b)(6) of Article 8.

(c) To ensure that Consumer Assistance is accessible to people with disabilities, Certified Medi-Cal Managed Care Plans and affiliated Certified Medi-Cal Managed Care Plan Enrollers shall comply with the requirements of section 6664(c)(1) through (c)(5) of Article 8.

(d) To ensure that no consumer is discriminated against, Certified Medi-Cal Managed Care Plans and Certified Medi-Cal Managed Care Plan Enrollers shall provide the same level of service to all individuals regardless of age, disability, culture, sexual orientation, or gender identity and seek advice of experts when needed.

(e) Certified Medi-Cal Managed Care Plan Enrollers shall complete the Certified Enrollment Counselor section of a consumer's application to the Exchange, including the following:

(1) Name and certification number of the Certified Medi-Cal Managed Care Plan Enroller;

(2) Name of the Certified Medi-Cal Managed Care Plan and the Certified Medi-Cal Managed Care Plan Number; and

(3) Signature and date of signature by the Certified Medi-Cal Managed Care Plan Enroller.

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

(g) Certified Medi-Cal Managed Care Plan Enrollers shall wear the badge issued by the Exchange at all times when providing assistance pursuant to this Article.

(h) The Certified Medi-Cal Managed Care Plan and Certified Medi-Cal Managed Care Plan Enroller shall never:

(1) Have a conflict of interest as defined in section 6907;

(2) Mail the paper application for the consumer;

(3) Coach the consumer to provide inaccurate information on the application regarding income, residency, immigration status and other eligibility rules;

(4) Coach or recommend one plan or provider over another;

(5) Accept any premium payments from the consumer;

(6) Input any premium payment information on behalf of the consumer;

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

(8) Induce or accept any type of direct or indirect remuneration from the consumer;

(9) Intentionally create multiple applications from the same household, as defined in 42 C.F.R. § 435.603(f) (November 30, 2016), hereby incorporated by reference;

(10) Invite, influence, or arrange for an individual whose existing coverage through an eligible employer-sponsored plan is affordable and provides minimum value, as described in 26 USC § 36B(c)(2)(C)) and in 26 C.F.R. § 1.36B-2(c)(3)(v) and (vi)

(July 26, 2017), hereby incorporated by reference, to separate from employer-based group health coverage;

(11) Solicit any consumer for application or enrollment assistance by going door-to-door or through other unsolicited means of direct contact, including calling a consumer to provide application or enrollment assistance without the consumer initiating the contact, unless the consumer has a pre-existing relationship with the individual Certified Medi-Cal Managed Care Plan Enroller or Certified Medi-Cal Managed Care Plan and other applicable State and Federal laws are otherwise complied with; or

(12) Initiate any telephone call to a consumer using an automatic telephone dialing system or an artificial or prerecorded voice, except in cases where the individual Certified Medi-Cal Managed Care Plan Enroller or Certified Medi-Cal Managed Care Plan has a relationship with the consumer and so long as other applicable State and Federal laws are otherwise complied with.

(i) Certified Medi-Cal Managed Care Plan Enrollers shall report to the Exchange any subsequent arrests for which they have been released on bail or personal recognizance and criminal convictions, in accordance with section 6456 (c) of Article 4, and administrative actions taken by any other agency, within 30 calendar days of the date of the arrest or final administrative action order.

(j) Certified Medi-Cal Managed Care Plans shall notify the Exchange of any change in Contact information for the Certified Medi-Cal Managed Care Plan or its Certified Medi-Cal Managed Care Plan Enrollers.

Note: Authority cited: Sections 100502 and 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; 26 C.F.R Section 1.36b-2; 42 C.F.R Section 435.602; 45 C.F.R Section 155.260.

§ 6907. Conflict of Interest.

(a) Certified Medi-Cal Managed Care Plan and Certified Medi-Cal Managed Care Plan Enrollers shall:

(1) Comply with applicable State law related to the sale, solicitation, and negotiation of insurance products, including applicable State law related to agent, broker, and producer licensure;

(2) Create a written plan to remain free of conflicts of interest while carrying out functions under this Article;

(3) Provide information to consumers about the full range of QHP options and insurance affordability programs for which they are eligible;

(4) Disclose to each consumer who receives application assistance from the entity or individual:

(A) Any lines of insurance business which the entity or individual intends to sell while carrying out the Consumer Assistance functions;

(B) Any existing employment relationships, or any former employment relationships within the last five years, with any health insurance issuers or issuers of stop loss insurance, or subsidiaries of health insurance issuers or issuers of stop loss insurance, including any existing employment relationships between a spouse or domestic partner and any health insurance issuers or issuers of stop loss insurance, or subsidiaries of health insurance issuers or issuers of stop loss insurance; and

(C) Any existing or anticipated financial, business, or contractual relationships with one or more health insurance issuers or issuers of stop loss insurance, or subsidiaries of health insurance issuers or issuers of stop loss insurance.

(b) Medi-Cal Managed Care Plan Enrollers who are licensed insurance agents with the California Department of Insurance shall:

(1) Comply with 45 C.F.R. section 155.220, (December 22, 2016), hereby incorporated by reference;

(2) Execute an agreement with the Exchange that complies with 45 C.F.R. section 155.220;

(3) While a Certified Medi-Cal Managed Care Plan Enroller, not receive any direct or indirect consideration from any health insurance issuer or stop loss insurance issuer, other than compensation on a salary or contractual basis from the Certified Medi-Cal Managed Care Plan, in connection with the enrollment of any individuals in a QHP or non-QHP;

(4) Not be concurrently certified as a certified insurance agent by the Exchange.

Note: Authority cited: Sections 100502 and 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; and 45 C.F.R. § 155.220.

§ 6908. Suspension and Revocation.

(a) Each of the following shall be justification for the Exchange to suspend or revoke the certification of any Certified Medi-Cal Managed Care Plan or Certified Medi-Cal Managed Care Plan Enroller:

(1) Failure to comply with all applicable federal or state laws or regulations; and
(2) A potentially disqualifying administrative action or criminal record which is substantially related to the qualifications, functions, or duties of the specific position of the entity or individual, under sections 6903 and 6904.

(b) Following the receipt of a determination pursuant to this section that disqualifies an individual or entity from certification, the entity or individual is not eligible to reapply for certification for two years.

Note: Authority cited: Sections 100502 and 100504, Government Code. Reference: Sections 100502 and 100503, Government Code.

ELECTRONIC CODE OF FEDERAL REGULATIONS

e-CFR data is current as of September 6, 2018 -[Title 26](#) → [Chapter I](#) → [Subchapter A](#) → [Part 1](#) → §1.36b-2Title 26: Internal Revenue
[PART 1—INCOME TAXES](#)**§1.36B-2 Eligibility for premium tax credit.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(iii) *Eligibility for months during a plan year—(A) Failure to enroll in plan.* An employee or related individual may be eligible for minimum essential coverage under an eligible employer sponsored plan for a month during a plan year if the employee or related individual could have enrolled in the plan for that month during an open or special enrollment period for the plan year. If an enrollment period relates to coverage for not only the upcoming plan year (or the current plan year in the case of an enrollment period other than an open enrollment period), but also coverage in one or more succeeding plan years, this paragraph (c)(3)(iii)(A) applies only to eligibility for the coverage in the upcoming plan year (or the current plan year in the case of an enrollment period other than an open enrollment period). -

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

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

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

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

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

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

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

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

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

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

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

- (i) The employee may not opt to receive the amount as a taxable benefit;
- (ii) The employee may use the amount to pay for minimum essential coverage; and -

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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ELECTRONIC CODE OF FEDERAL REGULATIONS

e-CFR data is current as of September 6, 2018 -[Title 42](#) → [Chapter IV](#) → [Subchapter C](#) → [Part 435](#) → [Subpart G](#) → §435.603

Title 42: Public Health

[PART 435—ELIGIBILITY IN THE STATES, DISTRICT OF COLUMBIA, THE NORTHERN MARIANA ISLANDS, AND AMERICAN SAMOA](#)[Subpart G—General financial Eligibility requirements and Options](#)**§435.603 Application of modified adjusted gross income (MAGI).**

(a) *Basis, scope, and implementation.* (1) This section implements section 1902(e)(14) of the Act.

(2) Effective January 1, 2014, the agency must apply the financial methodologies set forth in this section in determining the financial eligibility of all individuals for Medicaid, except for individuals identified in paragraph (j) of this section and as provided in paragraph (a)(3) of this section.

(3) In the case of determining ongoing eligibility for beneficiaries determined eligible for Medicaid coverage to begin on or before December 31, 2013, application of the financial methodologies set forth in this section will not be applied until March 31, 2014 or the next regularly scheduled renewal of eligibility for such individual under §435.916 of this part, whichever is later. -

(b) *Definitions.* For purposes of this section—

Child means a natural or biological, adopted or step child.

Code means the Internal Revenue Code.

Family size means the number of persons counted as members of an individual's household. In the case of determining the family size of a pregnant woman, the pregnant woman is counted as herself plus the number of children she is expected to deliver. In the case of determining the family size of other individuals who have a pregnant woman in their household, the pregnant woman is counted, at State option, as either 1 or 2 person(s) or as herself plus the number of children she is expected to deliver.

Parent means a natural or biological, adopted or step parent.

Sibling means natural or biological, adopted, half, or step sibling.

Tax dependent has the meaning provided in §435.4 of this part.

(c) *Basic rule.* Except as specified in paragraph (i), (j), and (k) of this section, the agency must determine financial eligibility for Medicaid based on “household income” as defined in paragraph (d) of this section.

(d) *Household income*—(1) *General rule.* Except as provided in paragraphs (d)(2) through (d)(4) of this section, household income is the sum of the MAGI based income, as defined in paragraph (e) of this section, of every individual included in the individual's household.

(2) *Income of children and tax dependents.* (i) The MAGI based income of an individual who is included in the household of his or her natural, adopted or step parent and is not expected to be required to file a tax return under section 6012(a)(1) of the Code for the taxable year in which eligibility for Medicaid is being determined, is not included in household income whether or not the individual files a tax return.

(ii) The MAGI based income of a tax dependent described in paragraph (f)(2)(i) of this section who is not expected to be required to file a tax return under section 6012(a)(1) of the Code for the taxable year in which eligibility for Medicaid is being determined is not included in the household income of the taxpayer whether or not such tax dependent files a tax return.

(3) In the case of individuals described in paragraph (f)(2)(i) of this section, household income may, at State option, also include actually available cash support, exceeding nominal amounts, provided by the person claiming such individual as a tax dependent. -

(4) Effective January 1, 2014, in determining the eligibility of an individual using MAGI based income, a state must subtract an amount equivalent to 5 percentage points of the federal poverty level for the applicable family size only to determine the eligibility of an individual for medical assistance under the eligibility group with the highest income standard using MAGI based methodologies in the applicable Title of the Act, but not to determine eligibility for a particular eligibility group.

(e) *MAGI-based income.* For the purposes of this section, MAGI based income means income calculated using the same financial methodologies used to determine modified adjusted gross income as defined in section 36B(d)(2)(B) of the Code, with the following exceptions—

(1) An amount received as a lump sum is counted as income only in the month received.

(2) Scholarships, awards, or fellowship grants used for education purposes and not for living expenses are excluded from income.

(3) *American Indian/Alaska Native exceptions.* The following are excluded from income:

(i) Distributions from Alaska Native Corporations and Settlement Trusts;

(ii) Distributions from any property held in trust, subject to federal restrictions, located within the most recent boundaries of a prior federal reservation, or otherwise under the supervision of the Secretary of the Interior;

(iii) Distributions and payments from rents, leases, rights of way, royalties, usage rights, or natural resource extraction and harvest from—

(A) rights of ownership or possession in any lands described in paragraph (e)(3)(ii) of this section; or

(B) federally protected rights regarding off reservation hunting, fishing, gathering, or usage of natural resources;

(iv) Distributions resulting from real property ownership interests related to natural resources and improvements—

(A) Located on or near a reservation or within the most recent boundaries of a prior federal reservation; or

(B) resulting from the exercise of federally protected rights relating to such real property ownership interests;

(v) Payments resulting from ownership interests in or usage rights to items that have unique religious, spiritual, traditional, or cultural significance or rights that support subsistence or a traditional lifestyle according to applicable Tribal Law or custom;

(vi) Student financial assistance provided under the Bureau of Indian Affairs education programs.

(f) *Household—(1) Basic rule for taxpayers not claimed as a tax dependent.* In the case of an individual who expects to file a tax return for the taxable year in which an initial determination or renewal of eligibility is being made, and who does not expect to be claimed as a tax dependent by another taxpayer, the household consists of the taxpayer and, subject to paragraph (f)(5) of this section, all persons whom such individual expects to claim as a tax dependent.

(2) *Basic rule for individuals claimed as a tax dependent.* In the case of an individual who expects to be claimed as a tax dependent by another taxpayer for the taxable year in which an initial determination or renewal of eligibility is being made, the household is the household of the taxpayer claiming such individual as a tax dependent, except that the household must be determined in accordance with paragraph (f)(3) of this section in the case of—

(i) Individuals other than a spouse or child who expect to be claimed as a tax dependent by another taxpayer; and

(ii) Individuals under the age specified by the State under paragraph (f)(3)(iv) of this section who expect to be claimed by one parent as a tax dependent and are living with both parents but whose parents do not expect to file a joint tax return; and

(iii) Individuals under the age specified by the State under paragraph (f)(3)(iv) of this section who expect to be claimed as a tax dependent by a non custodial parent. For purposes of this section—

(A) A court order or binding separation, divorce, or custody agreement establishing physical custody controls; or

(B) If there is no such order or agreement or in the event of a shared custody agreement, the custodial parent is the parent with whom the child spends most nights.

(3) *Rules for individuals who neither file a tax return nor are claimed as a tax dependent.* In the case of individuals who do not expect to file a federal tax return and do not expect to be claimed as a tax dependent for the taxable year in which an initial determination or renewal of eligibility is being made, or who are described in paragraph (f)(2)(i), (f)(2)(ii), or (f)(2)(iii) of this section, the household consists of the individual and, if living with the individual—

(i) The individual's spouse;

(ii) The individual's children under the age specified in paragraph (f)(3)(iv) of this section; and

(iii) In the case of individuals under the age specified in paragraph (f)(3)(iv) of this section, the individual's parents and - siblings under the age specified in paragraph (f)(3)(iv) of this section.

(iv) The age specified in this paragraph is either of the following, as elected by the agency in the State plan—

(A) Age 19; or

(B) Age 19 or, in the case of full time students, age 21.

(4) *Married couples.* In the case of a married couple living together, each spouse will be included in the household of the other spouse, regardless of whether they expect to file a joint tax return under section 6013 of the Code or whether one spouse expects to be claimed as a tax dependent by the other spouse.

(5) For purposes of paragraph (f)(1) of this section, if, consistent with the procedures adopted by the State in accordance with §435.956(f) of this part, a taxpayer cannot reasonably establish that another individual is a tax dependent of the taxpayer for the tax year in which Medicaid is sought, the inclusion of such individual in the household of the taxpayer is determined in accordance with paragraph (f)(3) of this section.

(g) *No resource test or income disregards.* In the case of individuals whose financial eligibility for Medicaid is determined in accordance with this section, the agency must not—

(1) Apply any assets or resources test; or

(2) Apply any income or expense disregards under sections 1902(r)(2) or 1931(b)(2)(C), or otherwise under title XIX of the Act, except as provided in paragraph (d)(1) of this section.

(h) *Budget period—(1) Applicants and new enrollees.* Financial eligibility for Medicaid for applicants, and other individuals not receiving Medicaid benefits at the point at which eligibility for Medicaid is being determined, must be based on current monthly household income and family size.

(2) *Current beneficiaries.* For individuals who have been determined financially eligible for Medicaid using the MAGI based methods set forth in this section, a State may elect in its State plan to base financial eligibility either on current monthly household income and family size or income based on projected annual household income and family size for the remainder of the current calendar year.

(3) In determining current monthly or projected annual household income and family size under paragraphs (h)(1) or (h)(2) of this section, the agency may adopt a reasonable method to include a prorated portion of reasonably predictable future income, to account for a reasonably predictable increase or decrease in future income, or both, as evidenced by a signed contract for employment, a clear history of predictable fluctuations in income, or other clear indicia of such future changes in income. Such future increase or decrease in income or family size must be verified in the same manner as other income and eligibility factors, in accordance with the income and eligibility verification requirements at §435.940 through §435.965, including by self attestation if reasonably compatible with other electronic data obtained by the agency in accordance with such sections.

(i) If the household income of an individual determined in accordance with this section results in financial ineligibility for Medicaid and the household income of such individual determined in accordance with 26 C.F.R. 1.36B-1(e) is below 100 percent PL, Medicaid financial eligibility will be determined in accordance with 26 C.F.R. 1.36B-1(e).

(j) *Eligibility Groups for which MAGI-based methods do not apply.* The financial methodologies described in this section are not applied in determining the Medicaid eligibility of individuals described in this paragraph. The agency must use the financial methods described in §435.601 and §435.602 of this subpart.

(1) Individuals whose eligibility for Medicaid does not require a determination of income by the agency, including, but not limited to, individuals receiving Supplemental Security Income (SSI) eligible for Medicaid under §435.120 of this part, individuals deemed to be receiving SSI and eligible for Medicaid under §435.135, §435.137 or §435.138 of this part and individuals for whom the State relies on a finding of income made by an Express Lane agency, in accordance with section 1902(e)(13) of the Act.

(2) Individuals who are age 65 or older when age is a condition of eligibility.

(3) Individuals whose eligibility is being determined on the basis of being blind or disabled, or on the basis of being treated as being blind or disabled, including, but not limited to, individuals eligible under §435.121, §435.232 or §435.234 of this part or

under section 1902(e)(3) of the Act, but only for the purpose of determining eligibility on such basis.

(4) Individuals who request coverage for long term care services and supports for the purpose of being evaluated for an eligibility group under which long term care services and supports not covered for individuals determined eligible using MAGI based financial methods are covered, or for individuals being evaluated for an eligibility group for which being institutionalized, meeting an institutional level of care or satisfying needs based criteria for home and community based services is a condition of eligibility. For purposes of this paragraph, “long term care services and supports” include nursing facility services, a level of care in any institution equivalent to nursing facility services; and home and community based services furnished under a waiver or State plan under sections 1915 or 1115 of the Act; home health services as described in sections 1905(a)(7) of the Act and personal care services described in sections 1905(a)(24) of the Act.

(5) Individuals who are being evaluated for eligibility for Medicare cost sharing assistance under section 1902(a)(10)(E) of the Act, but only for purposes of determining eligibility for such assistance.

(6) Individuals who are being evaluated for coverage as medically needy under subparts D and I of this part, but only for the purpose of determining eligibility on such basis.

(k) *Eligibility.* In the case of an individual whose eligibility is being determined under §435.214, the agency may—

(1) Consider the household to consist of only the individual for purposes of paragraph (f) of this section;

(2) Count only the MAGI based income of the individual for purposes of paragraph (d) of this section. -

(3) Increase the family size of the individual, as defined in paragraph (b) of the section, by one.

[77 17206, Mar. 23, 2012, as amended at 78 42302, July 15, 2013; 81 86456, Nov. 30, 2016]

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§155.205 Consumer assistance tools and programs of an Exchange.

(a) *Call center.* The Exchange must provide for operation of a toll free call center that addresses the needs of consumers requesting assistance and meets the requirements outlined in paragraphs (c)(1), (c)(2)(i), and (c)(3) of this section, unless it enters into a federal platform agreement through which it relies on HHS to carry out call center functions, in which case the Exchange must provide at a minimum a toll free telephone hotline to respond to requests for assistance and appropriately directs consumers to federal platform services to apply for, and enroll in, Exchange coverage.

(b) *Internet Web site.* The Exchange must maintain an up to date Internet Web site that meets the requirements outlined in paragraph (c) of this section and:

(1) Provides standardized comparative information on each available QHP, which may include differential display of standardized options on consumer facing plan comparison and shopping tools, and at a minimum includes:

(i) Premium and cost sharing information;

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

(iii) Identification of whether the QHP is a bronze, silver, gold, or platinum level plan as defined by section 1302(d) of the Affordable Care Act, or a catastrophic plan as defined by section 1302(e) of the Affordable Care Act;

(iv) The results of the enrollee satisfaction survey, as described in section 1311(c)(4) of the Affordable Care Act;

(v) Quality ratings assigned in accordance with section 1311(c)(3) of the Affordable Care Act;

(vi) Medical loss ratio information as reported to HHS in accordance with 45 C.F.R. part 158;

(vii) Transparency of coverage measures reported to the Exchange during certification in accordance with §155.1040; and

(viii) The provider directory made available to the Exchange in accordance with §156.230.

(2) Publishes the following financial information:

(i) The average costs of licensing required by the Exchange;

(ii) Any regulatory fees required by the Exchange;

(iii) Any payments required by the Exchange in addition to fees under paragraphs (b)(2)(i) and (ii) of this section;

(iv) Administrative costs of such Exchange; and

(v) Monies lost to waste, fraud, and abuse.

(3) Provides applicants with information about Navigators as described in §155.210 and other consumer assistance services, including the toll free telephone number of the Exchange call center required in paragraph (a) of this section.

(4) Allows for an eligibility determination to be made in accordance with subpart D of this part.

(5) Allows a qualified individual to select a QHP in accordance with subpart E of this part.

(6) Makes available by electronic means a calculator to facilitate the comparison of available QHPs after the application of any advance payments of the premium tax credit and any cost sharing reductions.

(7) A State based Exchange on the federal platform must at a minimum maintain an informational Internet Web site that includes the capability to direct consumers to federal platform services to apply for, and enroll in, Exchange coverage.

(c) *Accessibility.* Information must be provided to applicants and enrollees in plain language and in a manner that is accessible and timely to—

(1) Individuals living with disabilities including accessible Web sites and the provision of auxiliary aids and services at no cost to the individual in accordance with the Americans with Disabilities Act and section 504 of the Rehabilitation Act.

(2) Individuals who are limited English proficient through the provision of language services at no cost to the individual, including

(i) for all entities subject to this standard, oral interpretation.

(A) for Exchanges and QHP issuers, this standard also includes telephonic interpreter services in at least 150 languages.

(B) for an agent or broker subject to §155.220(c)(3)(i), beginning November 1, 2015, or when such entity been registered with the Exchange for at least 1 year, whichever is later, this standard also includes telephonic interpreter services in at least 150 languages.

(ii) Written translations; and

(iii) for all entities subject to this standard, taglines in non English languages indicating the availability of language services.

(A) for Exchanges and QHP issuers, this standard also includes taglines on Web site content and any document that is critical for obtaining health insurance coverage or access to health care services through a QHP for qualified individuals, applicants, qualified employers, qualified employees, or enrollees. A document is deemed to be critical for obtaining health insurance coverage or access to health care services through a QHP if it is required to be provided by law or regulation to a qualified individual, applicant, qualified employer, qualified employee, or enrollee. Such taglines must indicate the availability of language services in at least the top 15 languages spoken by the limited English proficient population of the relevant State or States, as determined in guidance published by the Secretary. If an Exchange is operated by an entity that operates multiple Exchanges, or if an Exchange relies on an entity to conduct its eligibility or enrollment functions and that entity conducts such functions for multiple Exchanges, the Exchange may aggregate the limited English proficient populations across all the States served by the entity that operates the Exchange or conducts its eligibility or enrollment functions to determine the top 15 languages required for taglines. A QHP issuer may aggregate the limited English proficient populations across all States served by the health insurance issuers within the issuer's controlled group (defined for purposes of this section as a group of two or more persons that is treated as a single employer under sections 52(a), 52(b), 414(m), or 414(o) of the Internal Revenue Code of 1986, as amended), whether or not those health insurance issuers offer plans through the Exchange in each of those States, to determine the top 15 languages required for taglines. Exchanges and QHP issuers may satisfy tagline requirements with respect to Web site content if they post a Web link prominently on their home page that directs individuals to the full text of the taglines indicating how individuals may obtain language assistance services, and if they also include taglines on any critical stand alone document linked to or embedded in the Web site. Exchanges, and QHP issuers that are also subject to §92.8 of this subtitle, will be deemed in compliance with paragraph (c)(2)(iii)(A) of this section if they are in compliance with §92.8 of this subtitle.

(B) for an agent or broker subject to §155.220(c)(3)(i), beginning when such entity has been registered with the Exchange for at least 1 year, this standard also includes taglines on Web site content and any document that is critical for obtaining health insurance coverage or access to health care services through a QHP for qualified individuals, applicants, qualified employers, qualified employees, or enrollees. A document is deemed to be critical for obtaining health insurance coverage or access to health care services through a QHP if it is required to be provided by law or regulation to a qualified individual, applicant, qualified employer, qualified employee, or enrollee. Such taglines must indicate the availability of language services in at least the top 15 languages spoken by the limited English proficient population of the relevant State or States, as determined in guidance published by the Secretary. An agent or broker subject to §155.220(c)(3)(i) that is licensed in and serving multiple States may aggregate the limited English populations in the States it serves to determine the top 15 languages required for taglines. An agent or broker subject to §155.220(c)(3)(i) may satisfy tagline requirements with respect to Web site content if it posts a Web link prominently on its home page that directs individuals to the full text of the taglines indicating how individuals may obtain language assistance services, and if it also includes taglines on any critical stand alone document linked to or embedded in the Web site.

(iv) for Exchanges, QHP issuers, and an agent or broker subject to §155.220(c)(3)(i), Web site translations.

(A) for an Exchange, beginning no later than the first day of the individual market open enrollment period for the 2017 benefit year, content that is intended for qualified individuals, applicants, qualified employers, qualified

employees, or enrollees on a Web site that is maintained by the Exchange must be translated into any non-English language that is spoken by a limited-English proficient population that reaches 10 percent or more of the population of the relevant State, as determined in guidance published by the Secretary.

(B) For a QHP issuer, beginning no later than the first day of the individual market open enrollment period for the 2017 benefit year, if the content of a Web site maintained by the QHP issuer is critical for obtaining health insurance coverage or access to health care services through a QHP, within the meaning of §156.250 of this subchapter, it must be translated into any non-English language that is spoken by a limited-English proficient population that reaches 10 percent or more of the population of the relevant State, as determined in guidance published by the Secretary.

(C) For an agent or broker subject to §155.220(c)(3)(i), beginning on the first day of the individual market open enrollment period for the 2017 benefit year, or when such entity has been registered with the Exchange for at least 1 year, whichever is later, content that is intended for qualified individuals, applicants, qualified employers, qualified employees, or enrollees on a Web site that is maintained by the agent or broker must be translated into any non-English language that is spoken by a limited-English proficient population that reaches 10 percent or more of the population of the relevant State, as determined in guidance published by the Secretary.

(3) Inform individuals of the availability of the services described in paragraphs (c)(1) and (2) of this section and how to access such services.

(d) *Consumer assistance.* (1) The Exchange must have a consumer assistance function that meets the standards in paragraph (c) of this section, including the Navigator program described in §155.210. Any individual providing such consumer assistance must be trained regarding QHP options, insurance affordability programs, eligibility, and benefits rules and regulations governing all insurance affordability programs operated in the State, as implemented in the State, prior to providing such assistance or the outreach and education activities specified in paragraph (e) of this section.

(2) The Exchange must provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under section 2793 of the Public Health Service Act, or any other appropriate State agency or agencies, for any enrollee with a grievance, complaint, or question regarding their health plan, coverage, or a determination under such plan or coverage.

(e) *Outreach and education.* The Exchange must conduct outreach and education activities that meet the standards in paragraph (c) of this section to educate consumers about the Exchange and insurance affordability programs to encourage participation.

[77 FR 18444, Mar. 27, 2012, as amended at 78 FR 42859, July 17, 2013; 80 FR 10864, Feb. 27, 2015; 81 FR 12337, Mar. 8, 2016; 81 FR 94175, Dec. 22, 2016]

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Title 45: Public Welfare

PA T 155—EXCHANGE ESTABLISHMENT STANDARDS AND OTHER RELATED STANDARDS UNDER THE AFFORDABLE CARE ACT

Subpart C—General Functions of an Exchange

§155.220 Ability of States to permit agents and brokers to assist qualified individuals, qualified employers, or qualified employees enrolling in QHPs.

(a) *General rule.* A State may permit agents and brokers to—

(1) Enroll individuals, employers or employees in any QHP in the individual or small group market as soon as the QHP is offered through an Exchange in the State;

(2) Subject to paragraphs (c), (d), and (e) of this section, enroll qualified individuals in a QHP in a manner that constitutes enrollment through the Exchange; and

(3) Subject to paragraphs (d) and (e) of this section, assist individuals in applying for advance payments of the premium tax credit and cost sharing reductions for QHPs.

(b)(1) *Web site disclosure.* The Exchange or SHOP may elect to provide information regarding licensed agents and brokers on its Web site for the convenience of consumers seeking insurance through that Exchange and may elect to limit the information to information regarding licensed agents and brokers who have completed any required Exchange or SHOP registration and training process.

(2) A Federally facilitated Exchange or SHOP will limit the information provided on its Web site regarding licensed agents and brokers to information regarding licensed agents and brokers who have completed registration and training.

(c) *Enrollment through the Exchange.* A qualified individual may be enrolled in a QHP through the Exchange with the assistance of an agent or broker if—

(1) The agent or broker ensures the applicant's completion of an eligibility verification and enrollment application through the Exchange Internet Web site as described in §155.405, or ensures that the eligibility application information is submitted for an eligibility determination through the Exchange approved web service subject to meeting the requirements in paragraphs (c) - (3)(ii) and (c)(4)(i) of this section;

(2) The Exchange transmits enrollment information to the QHP issuer as provided in §155.400(a) to allow the issuer to effectuate enrollment of qualified individuals in the QHP.

(3)(i) When an Internet Web site of the agent or broker is used to complete the QHP selection, at a minimum the Internet Web site must:

(A) Disclose and display all QHP information provided by the Exchange or directly by QHP issuers consistent with the requirements of §155.205(b)(1) and (c), and to the extent that not all information required under §155.205(b)(1) is displayed on the agent or broker's Internet Web site for a QHP, prominently display a standardized disclaimer provided by HHS stating that information required under §155.205(b)(1) for the QHP is available on the Exchange Web site, and provide a Web link to the Exchange Web site;

(B) Provide consumers the ability to view all QHPs offered through the Exchange; -

(C) Not provide financial incentives, such as rebates or giveaways;

(D) Display all QHP data provided by the Exchange;

(E) Maintain audit trails and records in an electronic format for a minimum of ten years and cooperate with any audit under this section;

() Provide consumers with the ability to withdraw from the process and use the Exchange Web site described in §155.205(b) instead at any time;

(G) or the Federally facilitated Exchange, prominently display a standardized disclaimer provided by HHS, and provide a Web link to the Exchange Web site; and

(H) Differentially display all standardized options prominently and in accordance with the requirements under §155.205(b) - (1) in a manner consistent with that adopted by HHS for display on the Federally facilitated Exchange Web site and with standards defined by HHS, unless HHS approves a deviation;

(I) Prominently display information provided by HHS pertaining to a consumer's eligibility for advance payments of the - premium tax credit or cost sharing reductions;

(J) Allow the consumer to select an amount for advance payments of the premium tax credit, if applicable, and make related attestations in accordance with §155.310(d)(2);

(K) Demonstrate operational readiness and compliance with applicable requirements prior to the agent or broker's Internet Web site being used to complete the QHP selection; and

(L) HHS may immediately suspend the agent or broker's ability to transact information with the Exchange if HHS discovers circumstances that pose unacceptable risk to Exchange operations or Exchange information technology systems until the incident or breach is remedied or sufficiently mitigated to HHS's satisfaction.

(ii) When an Internet Web site of an agent or broker is used to complete the Exchange eligibility application, at a minimum, the Internet Web site must:

(A) Comply with the requirements in paragraph (c)(3)(i) of this section;

(B) Use exactly the same eligibility application language as appears in the E Single Streamlined Application required in §155.405, unless HHS approves a deviation;

(C) Ensure that all necessary information for the consumer's applicable eligibility circumstances are submitted through the - Exchange approved web service; and

(D) Ensure that the process used for consumers to complete the eligibility application complies with all applicable Exchange standards, including §§155.230 and 155.260(b).

(4) When an agent or broker, through a contract or other arrangement, uses the Internet Web site of another agent or broker to help an applicant or enrollee complete a QHP selection in the Federally facilitated Exchange, and the agent or broker accessing the Web site pursuant to the arrangement is listed as the agent of record on the enrollment:

(i) The agent or broker who makes the Web site available must:

(A) Provide HHS with a list of agents and brokers who enter into such an arrangement to the Federally facilitated Exchange, if requested by HHS;

(B) Verify that any agent or broker accessing or using the Web site pursuant to the arrangement is licensed in the State in which the consumer is selecting the QHP; and has completed training and registration and has signed all required agreements with the Federally facilitated Exchange pursuant to paragraph (d) of this section and §155.260(b);

(C) Ensure that its name and any identifier required by HHS prominently appears on the Internet Web site and on written materials containing QHP information that can be printed from the Web site, even if the agent or broker that is accessing the Internet Web site is able to customize the appearance of the Web site;

(D) Terminate the agent or broker's access to its Web site if HHS determines that the agent or broker is in violation of the provisions of this section and/or HHS terminates any required agreement with the agent or broker;

(E) Report to HHS and applicable State departments of insurance any potential material breach of the standards in paragraphs (c) and (d) of this section, or the agreement entered into under §155.260(b), by the agent or broker accessing the Internet Web site, should it become aware of any such potential breach. An agent or broker that provides access to its Web site to complete the QHP selection or the Exchange eligibility application or ability to transact information with HHS to another agent or broker Web site is responsible for ensuring compliance with applicable requirements in paragraph (c)(3) of this section for any Web pages of the other agent's or broker's Web site that assist consumers, applicants, qualified individuals, and enrollees in applying for APTC and CS s for QHPs, or in completing enrollment in QHPs, offered in the Exchanges. -

() When an internet Web site of an agent or broker is used to complete the exchange eligibility application, obtain HHS approval verifying that all requirements in this section are met.

(ii) HHS retains the right to temporarily suspend the ability of the agent or broker making its Web site available to transact information with HHS, if HHS discovers a security and privacy incident or breach, for the period in which HHS begins to conduct an investigation and until the incident or breach is remedied to HHS' satisfaction.

(5) HHS or its designee may periodically monitor and audit an agent or broker under this subpart to assess its compliance with the applicable requirements of this section.

(d) *Agreement.* An agent or broker that enrolls qualified individuals in a QHP in a manner that constitutes enrollment through the Exchange or assists individuals in applying for advance payments of the premium tax credit and cost sharing reductions for QHPs must comply with the terms of an agreement between the agent or broker and the Exchange under which the agent or broker at least:

- (1) registers with the Exchange in advance of assisting qualified individuals enrolling in QHPs through the Exchange;
- (2) receives training in the range of QHP options and insurance affordability programs; and
- (3) Complies with the Exchange's privacy and security standards adopted consistent with §155.260.

(e) *Compliance with State law.* An agent or broker that enrolls qualified individuals in a QHP in a manner that constitutes enrollment through the Exchange or assists individuals in applying for advance payments of the premium tax credit and cost sharing reductions for QHPs must comply with applicable State law related to agents and brokers, including applicable State law related to confidentiality and conflicts of interest.

(f) *Termination notice to HHS.* (1) An agent or broker may terminate its agreement with HHS by sending to HHS a written notice at least 30 days in advance of the date of intended termination.

(2) The notice must include the intended date of termination, but if it does not specify a date of termination, or the date provided is not acceptable to HHS, HHS may set a different termination date that will be no less than 30 days from the date on the agent's or broker's notice of termination.

(3) Prior to the date of termination, an agent or broker should—

(i) Notify applicants, qualified individuals, or enrollees that the agent or broker is assisting, of the agent's or broker's intended date of termination;

(ii) Continue to assist such individuals with Exchange related eligibility and enrollment services up until the date of termination; and

(iii) Provide such individuals with information about alternatives available for obtaining additional assistance, including but not limited to the Federally facilitated Exchange Web site.

(4) When the agreement between the agent or broker and the Exchange under paragraph (d) of this section is terminated under paragraph (f) of this section, the agent or broker will no longer be registered with the Federally facilitated Exchanges, or be permitted to assist with or facilitate enrollment of qualified individuals, qualified employers or qualified employees in coverage in a manner that constitutes enrollment through a Federally facilitated Exchange, or be permitted to assist individuals in applying for advance payments of the premium tax credit and cost sharing reductions for QHPs. The agent's or broker's agreement with the Exchange under §155.260(b) will also be terminated through the termination without cause process set forth in that agreement. The agent or broker must continue to protect any personally identifiable information accessed during the term of either of these agreements with the Federally facilitated Exchanges.

(g) *Standards for termination for cause from the Federally-facilitated Exchange.* (1) If, in HHS's determination, a specific finding of noncompliance or pattern of noncompliance is sufficiently severe, HHS may terminate an agent's or broker's agreement with the Federally facilitated Exchange for cause.

(2) An agent or broker may be determined noncompliant if HHS finds that the agent or broker violated—

(i) Any standard specified under this section;

(ii) Any term or condition of the agreement with the Federally facilitated Exchanges required under paragraph (d) of this section, or any term or condition of the agreement with the Federally facilitated Exchange required under §155.260(b);

(iii) Any State law applicable to agents or brokers, as required under paragraph (e) of this section, including but not limited to State laws related to confidentiality and conflicts of interest; or

(iv) Any Federal law applicable to agents or brokers.

(3) HHS will notify the agent or broker of the specific finding of noncompliance or pattern of noncompliance made under paragraph (g)(1) of this section, and after 30 days from the date of the notice, may terminate the agreement for cause if the matter is not resolved to the satisfaction of HHS.

(4) After the period in paragraph (g)(3) of this section has elapsed and the agreement under paragraph (d) of this section is terminated, the agent or broker will no longer be registered with the Federally facilitated Exchanges, or be permitted to assist with or facilitate enrollment of a qualified individual, qualified employer, or qualified employee in coverage in a manner that constitutes enrollment through a Federally facilitated Exchange, or be permitted to assist individuals in applying for advance payments of the premium tax credit and cost sharing reductions for QHPs. The agent's or broker's agreement with the Exchange under §155.260(b)(2) will also be terminated through the process set forth in that agreement. The agent or broker must continue to protect any personally identifiable information accessed during the term of either of these agreements with the Federally facilitated Exchanges.

(5) Fraud or abusive conduct—

(i)(A) If HHS reasonably suspects that an agent or broker may have engaged in fraud, or in abusive conduct that may cause imminent or ongoing consumer harm using personally identifiable information of an Exchange enrollee or applicant or in connection with an Exchange enrollment or application, HHS may temporarily suspend the agent's or broker's agreements required under paragraph (d) of this section and under §155.260(b) for up to 90 calendar days. Suspension will be effective on the date of the notice that HHS sends to the agent or broker advising of the suspension of the agreements.

(B) The agent or broker may submit evidence in a form and manner to be specified by HHS, to rebut the allegation during this 90 day period. If the agent or broker submits such evidence during the suspension period, HHS will review the evidence and make a determination whether to lift the suspension within 30 days of receipt of such evidence. If the rebuttal evidence does not persuade HHS to lift the suspension, or if the agent or broker fails to submit rebuttal evidence during the suspension period, HHS may terminate the agent's or broker's agreements required under paragraph (d) of this section and under §155.260(b) for cause under paragraph (g)(5)(ii) of this section.

(ii) If there is a finding or determination by a Federal or State entity that an agent or broker engaged in fraud, or abusive conduct that may result in imminent or ongoing consumer harm, using personally identifiable information of Exchange enrollees or applicants or in connection with an Exchange enrollment or application, HHS will terminate the agent's or broker's agreements required under paragraph (d) of this section and under §155.260(b) for cause. The termination will be effective starting on the date of the notice that HHS sends to the agent or broker advising of the termination of the agreements.

(iii) During the suspension period under paragraph (g)(5)(i) of this section and following termination of the agreements under paragraph (g)(5)(i)(B) or (g)(5)(ii) of this section, the agent or broker will not be registered with the Federally facilitated Exchanges, or be permitted to assist with or facilitate enrollment of qualified individuals, qualified employers, or qualified employees in coverage in a manner that constitutes enrollment through a Federally facilitated Exchange, or be permitted to assist individuals in applying for advance payments of the premium tax credit and cost sharing reductions for QHPs. The agent or broker must continue to protect any personally identifiable information accessed during the term of either of these agreements with a Federally facilitated Exchange.

(6) The State department of insurance or equivalent State agent or broker licensing authority will be notified by HHS in cases of suspensions or terminations effectuated under this paragraph (g).

(h) *Request for reconsideration of termination for cause from the Federally-facilitated Exchange—(1) Request for reconsideration.* An agent or broker whose agreement with the Federally facilitated Exchange has been terminated may request reconsideration of such action in the manner and form established by HHS.

(2) *Timeframe for request.* The agent or broker must submit a request for reconsideration to the HHS reconsideration entity within 30 calendar days of the date of the written notice from HHS.

(3) *Notice of reconsideration decision.* The HHS reconsideration entity will provide the agent or broker with a written notice of the reconsideration decision within 30 calendar days of the date it receives the request for reconsideration. This decision will constitute HHS's final determination.

(i) *Use of agents' and brokers' Internet Web sites for SHOP.* For plan years beginning on or after January 1, 2015, in States that permit this activity under State law, a SHOP may permit agents and brokers to use an Internet Web site to assist qualified employers and facilitate enrollment of enrollees in a QHP through the Exchange, under paragraph (c)(3) of this section. -

(j) *Federally-facilitated Exchange standards of conduct.* (1) An agent or broker that assists with or facilitates enrollment of qualified individuals, qualified employers, or qualified employees, in coverage in a manner that constitutes enrollment through a federally facilitated Exchange, or assists individuals in applying for advance payments of the premium tax credit and cost sharing reductions for QHPs sold through a federally facilitated Exchange, must—

- (i) Have executed the required agreement under paragraph §155.260(b);
- (ii) Be registered with the federally facilitated Exchanges under paragraph (d)(1) of this section; and
- (iii) Comply with the standards of conduct in paragraph (j)(2) of this section.

(2) Standards of conduct. An individual or entity described in paragraph (j)(1) of this section must—

(i) Provide consumers with correct information, without omission of material fact, regarding the federally facilitated Exchanges, QHPs offered through the federally facilitated Exchanges, and insurance affordability programs, and refrain from marketing or conduct that is misleading (including by having a direct enrollment Web site that HHS determines could mislead a consumer into believing they are visiting *HealthCare.gov*), coercive, or discriminates based on race, color, national origin, disability, age, sex, gender identity, or sexual orientation; -

(ii) Provide the federally facilitated Exchanges with correct information under section 1411(b) of the Affordable Care Act;

(iii) Obtain the consent of the individual, employer, or employee prior to assisting with or facilitating enrollment through a federally facilitated Exchange, or assisting the individual in applying for advance payments of the premium tax credit and cost sharing reductions for QHPs;

(iv) Protect consumer personally identifiable information according to §155.260(b)(3) and the agreement described in §155.260(b)(2); and

(v) Comply with all applicable federal and State laws and regulations.

(3) If an agent or broker fails to provide correct information, he or she will nonetheless be deemed in compliance with paragraphs (j)(2)(i) and (ii) of this section if HHS determines that there was a reasonable cause for the failure to provide correct information and that the agent or broker acted in good faith.

(k) *Penalties other than termination of the agreement with the Federally-facilitated Exchanges.* (1) If HHS determines that an agent or broker has failed to comply with the requirements of this section, in addition to any other available remedies, that agent or broker—

(i) May be denied the right to enter into agreements with the federally facilitated Exchanges in future years; and

(ii) May be subject to civil money penalties as described in §155.285.

(2) HHS will notify the agent or broker of the proposed imposition of penalties under paragraph (k)(1)(i) of this section and, after 30 calendar days from the date of the notice, may impose the penalty if the agent or broker has not requested a reconsideration under paragraph (h) of this section. The proposed imposition of penalties under paragraph (k)(1)(ii) of this section will follow the process outlined under §155.285.

(l) *Application to State-Based Exchanges using a Federal platform.* An agent or broker who enrolls qualified individuals, qualified employers, or qualified employees in coverage in a manner that constitutes enrollment through an State Based Exchange using a federal platform, or assists individual market consumers with submission of applications for advance payments of the premium tax credit and cost sharing reductions through an State Based Exchange using a federal platform must comply with all applicable federally facilitated Exchange standards in this section. -

[77 18444, Mar. 27, 2012, as amended at 78 15533, Mar. 11, 2013; 78 54134, Aug. 30, 2013; 79 13837, Mar. 11, 2014; 80 - 10865, Feb. 27, 2015; 81 12338, Mar. 8, 2016; 81 94176, Dec. 22, 2016]

EDITORIAL NOTE: At 78 54134, Aug. 30, 2013, §155.220 was amended by revising (d)(3); however, the amendment could not be incorporated because there was no regulatory text provided in the amendment for (d)(3).

[Need assistance?](#)

§155.260 Privacy and security of personally identifiable information.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(iii) Take into specific consideration:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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**ECONOMIC AND FISCAL IMPACT STATEMENT
(REGULATIONS AND ORDERS)**

STD. 399 (REV. 12/2013)

ECONOMIC IMPACT STATEMENT

DEPARTMENT NAME California Health Benefit Exchange	CONTACT PERSON Brian M. Kearns	EMAIL ADDRESS Brian.Kearns@covered.ca.gov	TELEPHONE NUMBER (916) 228-8843
DESCRIPTIVE TITLE FROM NOTICE REGISTER OR FORM 400 Certified Medi-Cal Managed Care Plan Enroller Application			NOTICE FILE NUMBER 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:

- | | |
|--|---|
| <input checked="" type="checkbox"/> a. Impacts business and/or employees | <input checked="" type="checkbox"/> e. Imposes reporting requirements |
| <input type="checkbox"/> b. Impacts small businesses | <input type="checkbox"/> f. Imposes prescriptive instead of performance |
| <input checked="" type="checkbox"/> c. Impacts jobs or occupations | <input type="checkbox"/> g. Impacts individuals |
| <input type="checkbox"/> d. Impacts California competitiveness | <input type="checkbox"/> 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 estimates that the economic impact of this regulation (which includes the fiscal impact) is:
(Agency/Department)

- Below \$10 million
 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: Unknown

Describe the types of businesses (Include nonprofits): Certified Medi-Cal Managed Care Plan Enrollers (MMCPes)

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

4. Enter the number of businesses that will be created: 0 eliminated: 0

Explain: This program leverages the support of existing Medi-Cal Managed Care Plans and their employees.

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

6. Enter the number of jobs created: 0 and eliminated: 0

Describe the types of jobs or occupations impacted: Certified Enrollers affiliated with Medi-Cal Managed Care Plans who provide in-person assistance to California residents applying for coverage through Covered California

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 NO

If YES, explain briefly: _____

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: \$ 0 Annual ongoing costs: \$ 0 Years: _____
 - b. Initial costs for a typical business: \$ 0 Annual ongoing costs: \$ 0 Years: _____
 - c. Initial costs for an individual: \$ 0 Annual ongoing costs: \$ 0 Years: _____
 - d. Describe other economic costs that may occur: None

2. If multiple industries are impacted, enter the share of total costs for each industry: N/A

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.* \$ Unknown

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: CCR Title 10. Investment

Chapter 12. California Health Benefit Exchange Article 12. Medi-Cal Managed Care Plan Enrollment Assistance

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: MMCPes are staff and volunteers of Medi-Cal Managed Care Plans who provide in-person assistance to California residents applying for individual and family health coverage through Covered California.

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

Explain: _____

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

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

No additional jobs will be created.

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: _____

Alt. #1 - Do not adopt new regulations and rely on agreements.

Alt. #2 - Do not adopt new regulations & allow Medi-Cal Managed Care Plans to regulate themselves.

**ECONOMIC AND FISCAL IMPACT STATEMENT
(REGULATIONS AND ORDERS)**

STD. 399 (REV. 12/2013)

ECONOMIC IMPACT STATEMENT (CONTINUED)

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

Regulation: Benefit: \$ Unknown Cost: \$ 0

Alternative 1: Benefit: \$ Unknown Cost: \$ 0

Alternative 2: Benefit: \$ Unknown Cost: \$ 0

3. Briefly discuss any quantification issues that are relevant to a comparison of estimated costs and benefits for this regulation or alternatives: The Exchange sees the importance of ensuring that individual enrollers meet the qualifications to perform the roles of MMCPes

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: The defined application process for a MMCPes ensures well qualified and eligible individuals participate in the program which in turn helps to reduce consumer confusion during enrollment.

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 through 12 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.

**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 _____

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 Estimated impact to California Health Trust Fund is \$17,957 in FY 2018-19 for the Medi-Cal Managed Care Plan Enrollment Assistance program. There is no impact to the General Fund. See Attachment.

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

12-20-18

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

8/15/19

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

Fiscal Summary
(Dollars in thousands)

BCP No. N/A	Title Medi-Cal Managed Care Plan Regulations	Program N/A				
Personal Services	Positions	Dollars (in thousands)				
	CY BY BY + 1	CY BY BY + 1				
Total Salaries and Wages	7.0 7.0 7.0	\$11.0 \$11.6 \$12.1				
Total Staff Benefits	7.0 7.0 7.0	\$5.4 \$5.7 \$6.0				
Total Personal Services	7.0 7.0 7.0	\$16.4 \$17.3 \$18.1				
Operating Expenses and Equipment						
General Expense						
Printing						
Communications						
Postage						
Travel-In State						
Travel-Out of State						
Training						
Facilities Operations						
Utilities						
Consulting & Professional Services: Interdepartmental						
Consulting & Professional Services: External						
Data Center Services						
Information Technology						
Equipment ³						
Other/Special Items of Expense:						
<i>list your item</i>						
Standard OE&E Allocation	\$1.5	\$1.5 \$1.5				
Total Operating Expenses and Equipment	\$1.5	\$1.5 \$1.5				
Total State Operations Expenditures	\$17.9	\$18.8 \$19.6				
Fund Source	Item Number					
	Org	Ref	Fund			
General Fund						
Special Funds	4800	001	3175	\$17.9	\$18.8	\$19.6
Federal Funds						
Other Funds (Specify)						
Reimbursements						
Total Local Assistance Expenditures				\$0	\$0	\$0
Fund Source	Item Number					
	Org	Ref	Fund			
General Fund						
Special Funds	4800	001	3175			
Federal Funds						
Other Funds (Specify)						
Reimbursements						
Grand Total, State Operations and Local Assistance				\$17.9	\$18.8	\$19.6

**California Health Benefit Exchange
Regulation Package
Personal Cost Calculations**

SALARY DETAILS

Classification ^{1/}	Salary Range			Benefit Rate (Standard)	OE&E (Standard)
	Min	Mid	Max		
Staff Services Manager I	\$ 5,917	\$ 6,634	\$ 7,351	57.0%	\$ 7,241
Associate Governmental Program Analyst	\$ 4,975	\$ 5,602	\$ 6,228	57.0%	\$ 7,241
Staff Service Analyst	\$ 3,450	\$ 3,884	\$ 4,318	57.0%	\$ 7,241
SSA - Retired Annuitant	\$ 2,298	\$ 2,298	\$ 2,298	8.0%	\$ 7,241
AGPA - Retired Annuitant	\$ 2,764	\$ 2,764	\$ 2,764	8.0%	\$ 7,241

POSITION DETAILS

Classification ^{1/}	Current Year 2018-19				Budget Year 2019-20				Budget Year +1 2020-21			
	Positions ^{2/}	Months	Time Allocation ^{3/}	Month - Equivalent ^{4/}	Positions ^{2/}	Months	Time Allocation ^{3/}	Month - Equivalent ^{4/}	Positions ^{2/}	Months	Time Allocation ^{3/}	Month - Equivalent ^{4/}
Staff Services Manager I	1.0	12.0	3%	0.4	1.0	12.0	3%	0.4	1.0	12.0	3%	0.4
Associate Governmental Program Analyst	2.0	12.0	3%	0.4	2.0	12.0	3%	0.4	2.0	12.0	3%	0.4
Staff Service Analyst	2.0	12.0	3%	0.4	2.0	12.0	3%	0.4	2.0	12.0	3%	0.4
SSA - Retired Annuitant	1.0	12.0	3%	0.4	1.0	12.0	3%	0.4	1.0	12.0	3%	0.4
AGPA - Retired Annuitant	1.0	12.0	3%	0.4	1.0	12.0	3%	0.4	1.0	12.0	3%	0.4
				-				-				-
				-				-				-
Total PYs & Adjusted Months	7.0			1.8	7.0			1.8	7.0			1.8

SALARIES & BENEFITS CALCULATIONS

Classification ^{1/}	Current Year 2018-19	Budget Year 2019-20	Budget Year+1 2021-21
Staff Services Manager I	\$ 2,388	\$ 2,507	\$ 2,627
Associate Governmental Program Analyst	\$ 4,033	\$ 4,235	\$ 4,436
Staff Service Analyst	\$ 2,796	\$ 2,936	\$ 3,076
SSA - Retired Annuitant	\$ 827	\$ 868	\$ 910
AGPA - Retired Annuitant	\$ 995	\$ 1,045	\$ 1,095
Total Salaries & Wages^{5/}	\$ 11,039	\$ 11,591	\$ 12,143
Staff Benefits^{6/}	\$ 5,399	\$ 5,669	\$ 5,939
Total Salaries & Benefits	\$ 16,438	\$ 17,260	\$ 18,082

Notes:

1. Classifications provided by program.
2. Position count provided by program.
3. Time allocation provided by program, based on amount of time spent on CAC activities.
4. Month-Equivalent = Months x Time Allocation.
5. Salary calculations based on mid-step of the classifications salary range, including GSI and MSA
6. Benefit calculations based on standard benefit rate used for budgeting purposes.
7. Based on standard OE&E used for budgeting purposes and prorated based month-equivalent.
9. No contractual expenditures per program

OPERATING EXPENSE & EQUIPMENT

Classification ^{1/}	Current Year 2018-19	Budget Year 2019-20	Budget Year+1 2021-21
Staff Services Manager I	\$ 217	\$ 217	\$ 217
Associate Governmental Program Analyst	\$ 434	\$ 434	\$ 434
Staff Service Analyst	\$ 434	\$ 434	\$ 434
SSA - Retired Annuitant	\$ 217	\$ 217	\$ 217
AGPA - Retired Annuitant	\$ 217	\$ 217	\$ 217
Total OE&E (Standard)^{7/}	\$ 1,519	\$ 1,519	\$ 1,519
Total Contracts^{8/}	\$ -	\$ -	\$ -
Total OE&E & Contracts	\$ 1,519	\$ 1,519	\$ 1,519
TOTAL COST	\$ 17,957	\$ 18,779	\$ 19,601

COST BREAKDOWN BY FUNDING SOURCE

Fund	Current Year 2013-14	Budget Year 2014-15	Budget Year+1 2015-16
General Fund	\$ 17,957	\$ 18,779	\$ 19,601
Special Funds	\$ -	\$ -	\$ -
Federal Funds	\$ -	\$ -	\$ -
	\$ 17,957	\$ 18,779	\$ 19,601