COVERED CALIFORNIA POLICY AND ACTION ITEMS

April 16, 2015

COVERED CALIFORNIA 2016 PMPM

Jim Lombard, Director of Financial Management Division

PMPM RATES FOR 2016

The Board is being asked to formally set the Exchange's Per Member Per Month (PMPM) rates for 2016.

- At its March meeting, the Board was provided alternative multi-year enrollment forecasts and budgets that indicate that revenue will equal expenditures as early as FY 2017-18 under the most likely trends and while maintaining current per member per month rates.

At its May 2014 meeting, the Board adopted the recommendation to leave 2015 PMPM fees unchanged from the 2014 rates.

- Individual health plans with or without embedded dental: $13.95
- SHOP health plans with or without embedded dental: $18.60
- Stand alone pediatric dental plans: $0.83.

Based on current enrollment outlooks and budget projections no changes in these fees are being recommended for 2016.

ENROLLMENT FORECAST FOR 2014-15 AND BEYOND

For 2015-16 multi-year budget planning, three scenario's were modeled, based upon 70%, 75% and 80% enrollment of the subsidy eligible population by the end of 2018.

Scenario's were based on review of existing programs and independent estimates:

- Participation in the Healthy Families program reached 75% at the end of its first 5 years
- Over 80% of those eligible currently participate in the Women Infants & Children program
- The latest version of CalSIM estimates enrollment through the Exchange at 78% to 81% of the subsidy eligible population (Base vs. Enhanced) in 2019 (when adjusted to exclude those with unaffordable employer-sponsored coverage)

The preliminary forecast reflects the following major assumptions based on current enrollment trends:

- 80 percent of those who enroll during Open Enrollment will pay their premium
- 75 percent of those who enroll in Special Enrollment will pay their premium
- Approximately 1.5 percent of enrollees will leave the program every month and 12 percent of enrollees will leave the program at annual renewal
- Approximately 25,000 new enrollments per month will occur on average during Special Enrollment
- 85 percent of Covered California enrollees receive subsidies

The medium enrollment scenario is recommended for forecasting.

Staff performed sensitivity analysis on different retention and Medi-Cal enrollment rates and the results remained within the parameters of the three scenario's.

Revenue projections assume that the Individual and SHOP PMPMs are held steady at $13.95 and $18.60 respectively.

MULTIYEAR OUTLOOK – ENROLLMENT SCENARIOS

LOW	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19
Effectuated Enrollment *(at fiscal year end)*	1,300,000	1,366,000	1,548,000	1,689,000	1,855,000
Revenue *(cash basis)*	$ 197.4	$ 227.8	$ 250.1	$ 283.5	$ 308.7

MEDIUM	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19
Effectuated Enrollment *(at fiscal year end)*	1,300,000	1,476,000	1,667,000	1,809,000	1,978,000
Revenue *(cash basis)*	$ 197.4	$ 234.4	$ 269.2	$ 303.6	$ 329.2

HIGH	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19
Effectuated Enrollment *(at fiscal year end)*	1,300,000	1,542,000	1,807,000	1,953,000	2,102,000
Revenue *(cash basis)*	$ 197.4	$ 238.3	$ 284.8	$ 327.5	$ 352.3

Revenue dollars in millions

COVERED CALIFORNIA PMPM AND QHP PREMIUMS

Covered California Per Member Per Month Compared to Premium

The 2015 PMPM rate for individuals on average equaled 3.6 percent of premium for enrollees in the Individual Exchange. A stable PMPM level represents an effective fee cut.

	2015	2016	2017	2018	2019	2020
Average Premium (2015 actual and projected 4% annual increases thereafter)	$393	$408	$425	$442	$459	$478
PMPM	$13.95	$13.95	$13.95	$13.95	$13.95	$13.95
PMPM as Pct. of Premium	3.6%	3.4%	3.3%	3.2%	3.0%	2.9%

MULTIYEAR FINANCIAL OUTLOOK – BASED UPON MEDIUM SCENARIO

	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19
Effectuated Enrollment *(at fiscal year end)*	1,300,000	1,476,000	1,667,000	1,809,000	1,978,000
Opening Balance	$ 485.2	$ 289.6	$ 184.0	$ 143.2	$ 146.7
Individual Market Revenue	$ 194.1	$ 228.2	$ 258.8	$ 288.1	$ 313.8
SHOP Revenue	$ 3.3	$ 6.2	$ 10.3	$ 15.4	$ 15.4
Revenue *(cash basis)*	$ 197.4	$ 234.4	$ 269.2	$ 303.6	$ 329.2
Expenditures	$ 393.0	$ 340.0	$ 310.0	$ 300.0	$ 300.0
Year-End Operating Reserve	$ 289.6	$ 184.0	$ 143.2	$ 146.7	$ 175.9
Minimum number of months expenditures covered by reserve	***8.8***	***6.5***	***5.1***	***4.9***	***5.6***

Revenue, Expenditure & Reserve dollars in millions

- Revenue projections reflect maintaining assessments at $13.95 per member per month through 2019.
- The multi-year outlook assumes up to a $340 million budget in FY 2015-16, a $310 million budget in 2016-17, a $300 million budget ongoing beginning in 2017-18, and is designed to balance revenues and expenditures by FY 2017-18.*
- Provides a 6 month operating reserve throughout FY 2015-16 and approximately a 5 month operating reserve through FY 2018-19.

** Actual budget amounts are subject to the board annual budget processes.*

RECOMMENDATION FOR BOARD APPROVAL

- Per Government Code Section 100503(n), which authorizes the Board to charge per member per month fees to fund its operation, the plan year 2016 Per Member Per Month fees are submitted to the Covered California Board for approval.
- Staff recommends that the current PMPM rates be maintained through the 2016 plan year.
- Individual health plans with or without embedded dental: $13.95
- SHOP health plans with or without embedded dental: $18.60
- Resolution 2015-25

PROPOSED NAVIGATOR PROGRAM CHANGES FOR 2015/16

Mary Watanabe, Deputy Director, Sales Division

CORE ELEMENTS OF PROPOSED NAVIGATOR PROGRAM FOR 2015/16

- Maintain Navigator Program with substantial funding of approximately $5-10 million pending final budget approval.
- Navigator Grantees will provide outreach, education, enrollment assistance, renewal assistance and post-enrollment support.
- Block grant model with payments made every 2 months.
- Grantee performance monitored against performance thresholds for new enrollments and renewals will determine future funding level and continued participation.

CORE ELEMENTS OF PROPOSED NAVIGATOR PROGRAM FOR 2015/16

- Require monthly reporting of events, touches and enrollment.
- No changes to the entities eligible to participate in the Navigator Program:
  - Consideration given to whether to allow the continued participation of organizations with a self-interest in assisting consumers with enrollment, including clinics and hospitals.
  - Strong performance of these groups, particularly in reaching Latinos, led to our recommendation to let them continue to participate this year. However, we will revisit this issue next year.

CORE ELEMENTS OF PROPOSED NAVIGATOR PROGRAM FOR 2015/16

- Three year contract term with funding level determined each fiscal year to allow for long term planning and staffing.
- Future RFAs would target specific communities or geographic regions where additional enrollment resources are needed.
- Initial contract term of August 1, 2015 – June 30, 2018.
- Will not extend existing contracts due to the change in payment structure and 3-year grant term, but encourage effective Navigators to apply.
- Navigators will be the only compensated program. We anticipate that the non-compensated Certified Application Counselors will provide both enrollment and renewal assistance.

NAVIGATOR PROGRAM REQUEST FOR APPLICATION

- Seeking applications from organizations that have an existing presence and established trusted relationship with consumers in their community.
- Demonstrated ability to successfully enroll Covered California eligible consumers.
- Proposals should describe how the applicant will reach a target market, geographic region or both.
- Anticipate awarding grants in the amount of $50,000 - $500,000 with total funding pending final budget approval in June 2015.

NAVIGATOR GRANT PROGRAM TIMELINE

Activity	Date
Release Navigator Request for Application (RFA)	April 23, 2015
Applications Due	June 1, 2015
Evaluation and Selection Process	June 2, 2015 – June 30, 2015
Board Authorizes 2015-16 Navigator Funding	June 18, 2015
Grant Award Period	August 1, 2015 – June 30, 2018

NAVIGATOR PROGRAM REQUEST FOR APPLICATION

Estimated number of grants by funding level:

$5 million		
Grant Size	Number of Grants	Total Amount
$50,000	20	$1,000,000
$100,000	10	$1,000,000
$250,000	8	$2,000,000
$500,000	2	$1,000,000
Total:	**40**	**$5,000,000**

$10 million		
Grant Size	Number of Grants	Total Amount
$50,000	40	$2,000,000
$100,000	20	$2,000,000
$250,000	16	$4,000,000
$500,000	4	$2,000,000
Total:	**80**	**$10,000,000**

CERTIFIED APPLICATION COUNSELOR PROGRAM REGULATIONS (EMERGENCY ADOPTION)

Mary Watanabe, Deputy Director, Sales Division

CERTIFIED APPLICATION COUNSELOR PROGRAM REGULATIONS

Article 11 – Certified Application Counselor Program

§ 6852 – Certified Application Entities

- Clarifies that a Certified Application Entity may not concurrently be a Certified Enrollment Entity participating in the Navigator Program to allow for transition between the programs.

§ 6854 – Certified Application Entity Application

- Changed the requirement that Certified Application Entities complete training in 30 days to 90 days.

§ 6858 – Certified Application Counselor Fingerprinting and Criminal Record Checks

- Adds that the Exchange will cover the fingerprinting background check costs for individuals seeking certification until June 30, 2016.

IMPLEMENTATION PLAN

Activity	Date
Socialize new application	April 2015
Execute new agreements	May – June 2015
For existing Certified Enrollment Counselors, transfer certification, training, and background clearance records in good standing	June 2015
CAC Program begins	July 1, 2015

2016 BENEFIT DESIGN AND NETWORK RECOMMENDATIONS (DISCUSSION)

Anne Price, Director of Plan Management Division

COVERED CALIFORNIA'S PRINCIPLES FOR ACTION – 2016 PHARMACY BENEFITS

- As part of its consideration of how to meet consumers' needs regarding specialty drug coverage and access, Covered California has solicited suggestions and proposals from health plans, advocates and others on how to best address specialty drug concerns in 2016 and future years. The issue is multifaceted, involving many future unpredictable variables. Covered California believes that its decisions need to reflect the balancing of core principles:
  - As with all benefits, drug benefit designs should foster consumers getting the right care at the right time. Benefits should steer patients to the most appropriate and cost effective drugs and not result in undue financial barriers for category of members with particular conditions
  - At the same time we need to assure overall affordability of premiums including drug costs that are increasingly becoming a larger component of the total cost of healthcare, primarily driven by the introduction and continued development of high cost specialty drugs

COVERED CALIFORNIA'S PRINCIPLES FOR ACTION (CONT.)

- Preserving the plan's ability to maximize savings and control drug costs through preferred formulary tier placement, cost sharing, and manufacturer negotiations is an important factor in long term affordability
- Policies for drugs treating those facing ongoing maintenance of chronic illnesses raise different issues and may need to reflect different strategies than for drugs that have more time-limited treatment
- Given the complexity and importance of this area, Covered California should take steps informed by data, regulatory, and other factors as we learn about potential impacts on consumers and the near and long-term impact to premiums

APPROVED CHANGES TO IMPROVE TRANSPARENCY AND ACCESS IN 2016

1. Plan formularies must include at least one drug in Tiers 1 or 2 or 3 if all FDA-approved drugs in the same drug class would otherwise qualify for Tier 4 and at least 3 drugs in that class are available as FDA-approved drugs
2. Plans to have an opt out retail option for mail order (allowing consumers that want/need in-person assistance to get such service at no additional cost)
3. Plans to provide enrolled consumers an estimate of the out-of-pocket cost for specific drugs
4. Include statement on the availability of drugs not listed on the formulary
5. In tiers 1-4, the plans must include all of their formulary covered drugs used to treat HIV/AIDS, Hepatitis C, Rheumatoid Arthritis, Multiple Sclerosis, Systemic Lupus Erythematosus*
6. Exception process written clearly on formulary
7. All drugs that are covered in Tier 4 must be listed on the formulary (not just the Top 50 or highest use drugs)*
8. Dedicated pharmacy customer service line where advocates and prospective consumers can call for clarification

* Requirement #5 and requirement #7 will be replaced and updated consistent with the final federal payment notice requirement which requires health plans to publish an up-to-date, accurate and complete list of all covered drugs on its formulary list

SPECIALTY PHARMACY FOR 2016

Maximum Coinsurance for Pharmacy

- Covered California staff needs more time to make a final recommendation, but with the current information received to date we considered multiple options to modify the 2016 standard benefit designs to put a maximum ceiling for Tier 4 on the consumers' share of cost per prescription fill (Note: with the exception of the Bronze plan, Tiers 1 – 3 of all other metal plans have flat co-pays)
- Placing the maximum amount of consumer cost sharing at 1/12th of the MOOP per specialty drug fill would result in the following changes to the 2016 Standard Benefit Designs for all formulary and plan approved (through an exception process) drugs:
  - Coinsurance up to a maximum of $500 per script for Bronze on Pharmacy Tiers 1-4
  - Coinsurance up to a maximum of $500 per script for Tier 4 on Silver 70 and Silver 73 plans
  - Coinsurance up to a maximum of $200 per script for Tier 4 on Silver 87 and Silver 94 plans.
  - Coinsurance up to a maximum of $500 per script for Tier 4 on Gold plans
  - Coinsurance up to a maximum of $300 per script for Tier 4 on Platinum plans
- This change will significantly lower the financial burden for consumers that need high cost drugs and had previously been forced to spend up to their entire maximum out-of-pocket in the first one to three months of coverage

PROPOSED 2016 ACTION FOR SPECIALTY PHARMACY

- Even though this option would significantly improve the financial burden a consumer may face when prescribed a high cost drug, we want to better understand how this proposal (and potentially other proposals with lower ceilings) may impact:
    - Drug avoidance and adherence
    - Premium increases in future years
    - Additional benefit design changes that could be implemented to mitigate future cost increases
- Data provided by the contracted health plans confirmed that the immediate impact to premium is relatively small (< 1%). However, the impact to future premiums could be substantial and warrant further assessment
- Based on needing more information than we have today to make a final decision that is grounded in understanding access and long term premium affordability, we are planning to bring forth a final recommendation to the board in May

ADDITIONAL RECOMMENDED UPDATES TO 2016 APPROVED BENEFIT DESIGNS: TIERED NETWORKS

Covered California recommends the following clarifying language regarding carriers' requirements when the carrier has a second tier for non-preferred providers that has higher cost-sharing for consumers:

- For 2016, a carrier may offer a plan with two "in-network" tiers if the lowest-cost tier, (Tier 1), network complies with the cost-sharing requirements in the standard benefit plan design, meets state network adequacy and timeliness standards as applied by the applicable regulator, and the carrier demonstrates that the two in-network tiers are in the best interest of the consumer as determined by Covered California on a case-by-case basis, based on premium stability, price, quality, choice and value. For non-Qualified Health Plans, the applicable regulator will determine if the plan's network meets regulatory requirements
- This policy will be reviewed for 2017 and carriers should plan to have only "single" tiers

ADDITIONAL RECOMMENDED UPDATES TO 2016 APPROVED BENEFIT DESIGNS: TIERED NETWORKS

This allowance is a benefit to consumers if they should end up receiving services in a Tier 2 in-network facility, however, the following will be required of the carrier if they have this type of network in 2016

- A carrier must have a primary hospital tier (Tier 1) where the hospital network meets the cost-sharing requirements in the standard benefit plan design, meets Covered California requirements for impact on premium stability, quality, choice and value, and meets state network adequacy standards as applied by the applicable regulator
- A carrier may have a second hospital tier (Tier 2) where the carrier has cost-sharing requirements that are different than the standard benefit plan design if the carrier can demonstrate that the Tier 2 network is in the best interest of the consumer as determined by Covered California
- The Tier 2 network cannot be used to meet state network adequacy and timely access standards as applied by the applicable regulator
- The Tier 2 network cannot be displayed or communicated as the primary hospital network (Tier 1) and the higher cost-sharing that may be associated with the Tier 2 facilities must be clearly called out and communicated to consumers
- Consistent with regulatory requirements, consumers that receive care at a Tier 2 facility as a result of an emergency or certain circumstances where an authorization has been approved, benefits will be applied consistent with the standard benefit plan design which will be the same as Tier 1 benefits
- Any consumer cost-sharing at both Tier 1 and Tier 2 facilities, must apply to the consumers deductible and maximum out of pocket

INDIVIDUAL ELIGIBILITY AND ENROLLMENT REGULATIONS (EMERGENCY RE-ADOPTION)

Thien Lam, Director of Eligibility and Enrollment

PROPOSED ELIGIBILITY AND ENROLLMENT REGULATIONS

Regulation Section	Summary
§ 6410. Definitions	Added or Amended Definitions: "**Cancellation of Enrollment**" means specific type of termination action that ends a qualified individual's enrollment on or before the coverage effective date resulting in enrollment through the Exchange never having been effective with the QHP. **"Enrollee"** means a person who is enrolled in a QHP and who is a recipient of services from the QHP. It also means the dependent of a qualified employee enrolled in a QHP through the SHOP, and any other person who is enrolled in a QHP through the SHOP, consistent with applicable law and the terms of the group health plan. If at least one employee enrolls in a QHP through the SHOP, "enrollee" also means a business owner enrolled in a **"Preferred Provider Organization"** (PPO) means a health insurance issuer's or carrier's insurance policy that offers covered health care services provided by a network of providers who are contracted with the issuer or carrier ("in-network") and providers who are not part of the provider network ("out-of-network"). Typically, the issuer's or carrier's coverage of benefits provided by out-of-network providers is lower than the issuer's or carrier's coverage of in-network providers. QHP through the SHOP, or the dependent of a business owner enrolled in a QHP through the SHOP. "**Reinstatement of Enrollment**" means a correction of an erroneous termination of coverage or cancellation of enrollment action and results in restoration of an enrollment with no break in coverage. "**Termination of Coverage**" means an action taken after a coverage effective date that ends an enrollee's coverage through the Exchange for a date after the original coverage effective date, resulting in a period during which the individual was enrolled in coverage through the Exchange.

PROPOSED ELIGIBILITY AND ENROLLMENT REGULATIONS

Regulation Section	Summary
§ 6478. Verification Process Related to Eligibility Requirements for Enrollment in a QHP through the Exchange § 6478(b)(2) and (3) **§ 6492. Inconsistencies.** § 6492(a)(2)(B)	Updated Timeframe/Additional language: If the Exchange is unable to verify an individual's Social Security Number (SSN) through the Social Security Administration (SSA), the Exchange shall provide the individual with a period of **95*** days from the date of the inconsistency notice for the applicant to provide satisfactory documentary evidence. If the Exchange is unable to verify an individual's attestation to their SSN, citizenship, status as a national, or lawful presence, through SSA or the U.S. Department of Homeland Security, the Exchange shall provide the individual with a period of **95*** days from the date of the inconsistency notice for the applicant to provide satisfactory documentary evidence. ***Unless, determined on case-by-case basis that consumer did not receive the notice within 5 days of the notice date. Then, the consumer shall have 90 days from the date of receipt.
§ 6482. Verification of Family Size and Household Income Related to Eligibility Determination for APTC and CSR. § 6482(d)(5) and (e)(4)(B)	Additional Language: The Exchange shall verify that neither Advanced Premium Tax Credit (APTC) nor Cost-Sharing Reductions (CSR) is being provided on behalf of an individual using information obtained by transmitting identifying information specified by Health and Human Services (HHS) to HHS. The tax filer's eligibility for APTC and CSR shall be determined based on the projected household income to which the tax filer attests.
§ 6490. Verifications of Enrollment in an Eligible Employer-Sponsored Plan and Eligibility for Qualifying Coverage in an Eligible Employer-Sponsored Plan Related to Eligibility Determination for APTC and CSR. § 6490 (e)	Updated Timeframe: For eligibility determinations for APTC and CSR that are effective before January 1, **2016**, the Exchange shall accept an applicant's attestation regarding enrollment in an eligible employer-sponsored plan and eligibility for qualifying coverage in an eligible employer-sponsored plan for the benefit year for which coverage is requested without further verification.

PROPOSED ELIGIBILITY AND ENROLLMENT REGULATIONS

Regulation Section	Summary
§ 6500. Enrollment of Qualified Individuals into QHPs. § 6504. (a)(1)(B), (a)(2)(A) and (B), and (a)(4)	Modified language: Effectuate coverage upon receipt of a full initial premium payment from the applicant on or before the premium payment due date. In cases of retroactive enrollment dates, the initial premium shall mean the sum of the premiums for the aggregate period of coverage for which the individual is applying and determined eligible by the Exchange.
§ 6504. Special Enrollment Periods. § 6504. (a)(1)(B), (a)(2)(A) and (B), and (a)(4)	Modified language: A qualified individual may enroll in a Qualified Health Plan (QHP), or an enrollee may change from one QHP to another, during special enrollment periods only if one of the following triggering events occurs: • A qualified individual or his or her dependent: Is enrolled in any non-calendar year group health plan or individual health insurance coverage, even if the qualified individual or his or her dependent has the option to renew such coverage. The date of the loss of coverage shall be the **last day of the plan or policy year**. • A qualified individual: Gains a dependent or becomes a dependent through marriage or entry into domestic partnership, birth, adoption, placement for adoption, or placement in foster care, or **through a child support order or other court order**; or Loses a dependent or is no longer considered a dependent through **divorce or legal separation** as defined by State law in the State in which the divorce or legal separation occurs, or if the enrollee, or his or her dependent, dies. • A qualified individual's, or his or her dependent's, enrollment or non-enrollment in a Qualified Health Plan is: Unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, **misconduct**, or inaction of an officer, employee, or agent of the Exchange or Health and Human Services, its instrumentalities, **or a non-Exchange entity providing enrollment assistance** or conducting enrollment activities For purposes of this provision, misconduct includes the failure to comply with applicable standards under this title, or other applicable Federal or State laws, as determined by the Exchange.

PROPOSED ELIGIBILITY AND ENROLLMENT REGULATIONS

Regulation Section	Summary
§ 6504. Special Enrollment Periods. § 6504. (h)(1)(A) and (B),(h)(5)(A) and (B), (h)(6) ***CONTINUED***	Modified language: In the case of birth, adoption, placement for adoption, or placement in foster care, the coverage shall be effective either: • On the date of birth, adoption, placement for adoption, or placement in foster care; or • On the first day of the month following the date of birth, adoption, placement for adoption, or placement in foster care, at the option of the qualified individual or the enrollee. New Language: In the case of a court order, the coverage shall be effective either: • On the date the court order is effective; or • During the regular Special Enrollment effective dates at the option of the qualified individual or the enrollee. If an enrollee or his or her dependent dies, the coverage shall be effective on the first day of the month following the plan selection.
§ 6506. Termination of Coverage in a QHP. § 6506. (a)(1)-(3)	New Language: Enrollee-initiated terminations shall be conducted in accordance with the following process: • An enrollee may choose to remain enrolled in a Qualified Health Plan (QHP) at the time of plan selection if he or she becomes eligible for other Minimum Essential Coverage and the enrollee does not request termination, the Exchange shall initiate termination of his or her enrollment in the QHP upon completion of the redetermination process.

PROPOSED ELIGIBILITY AND ENROLLMENT REGULATIONS

Regulation Section	Summary
§ 6506. Termination of Coverage in a QHP. § 6506. (a)(1)-(3) and (c)(3)(A) ***CONTINUED***	New language: Enrollee-initiated terminations shall be conducted in accordance with the following process: • An individual, including an enrollee's authorized representative, shall be permitted to report the death of an enrollee to the Exchange for purposes of initiating termination of the enrollee's coverage. The individual shall be 18 years old. If the individual reporting the death is the application filer, the enrollee's authorized representative, or anyone in the household of the deceased who was included in the initial application, he or she shall be permitted to initiate termination of the deceased's coverage. Modified language: In the case of termination of enrollee's coverage due to non-payment of premium, a Qualified Health Plan (QHP) issuer shall: • Comply with any applicable State laws and regulations regarding the grace period. New Language: In the case of a enrollee initiated termination, the last day of coverage shall be: • The retroactive termination date requested by the enrollee, if specified by applicable State laws.

PROPOSED ELIGIBILITY AND ENROLLMENT REGULATIONS

Regulation Section	Summary
§ 6506. Termination of Coverage in a QHP. § 6506. (d)(9)(A)-(D) ***CONTINUED***	A new subdivision added (with existing language): In cases of retroactive termination dates, the Exchange shall ensure that: • The enrollee receives the Advanced Premium Tax Credit (APTC) and Cost-Sharing Reductions (CSR) for which he or she is determined eligible; • The enrollee is refunded any excess premiums paid or out-of-pocket payments made by or for the enrollee for covered benefits and services, including prescription drugs, incurred after the retroactive termination date; • The enrollee's premium and cost sharing are adjusted to reflect the enrollee's obligations under the new QHP; and • In the case of a change in the level of CSR under the same QHP issuer during a benefit year, any cost sharing paid by the enrollee under the previous level of CSR for that benefit year is taken into account in the new level of CSR for purposes of calculating cost sharing based on aggregate spending by the individual, such as for deductibles or for the annual limitations on cost sharing.

PROPOSED ELIGIBILITY AND ENROLLMENT REGULATIONS

Regulation Section	Summary
§ 6608. Eligibility Pending Appeal § 6608. (b)	Modified Language: • If the tax filer or appellant, as applicable, accepts eligibility pending an appeal and agrees to make his or her premium payments in full, reduced by the APTC amount he or she is determined eligible for by the Exchange, by the applicable payment due dates, the Exchange shall continue the appellant's eligibility for enrollment in a QHP, APTC, and CSR, as applicable, in accordance with the level of eligibility immediately before the redetermination being appealed.

§ 6622. Employer Appeals Process
§ 6622. (a) and (b)
	New Language:
	
	• Employer Appeal Process:
	
	  • An employer, in response to the notice sent by Covered California, which notifies the employer that an employee qualified for APTC or CSR, may appeal a determination that the employer does not provide Minimum Essential Coverage through an employer-sponsored plan or that the employer does provide such coverage but it is not affordable coverage with respect to an employee.
	
	  • An employer who seeks an appeal shall request such an appeal directly to Health and Human Services (HHS) in accordance with the process established by HHS.