Regulations Table of Contents
Application, Eligibility, and Enrollment Process for the Individual Exchange

TITLE 10. INVESTMENT
CHAPTER 12. CALIFORNIA HEALTH BENEFIT EXCHANGE (§6400 ET SEQ.)

California Code of Regulations

Title 10. Investment

Chapter 12. California Health Benefit Exchange (§ 6400 et seq.)

Add Section 6408:

Article 2. Abbreviations and Definitions

§ 6408. Abbreviations.

The following abbreviations shall apply to this article:

ACO	Accountable Care Organization
APTC	Advance Payments of Premium Tax Credit
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CalHEERS	California Healthcare Eligibility, Enrollment, and Retention System
CFR	Code of Federal Regulations
CHIP	Children's Health Insurance Program
CSR	Cost-Sharing Reduction
DHCS	Department of Health Care Services
DHS	U.S. Department of Homeland Security
EPO	Exclusive Provider Organization
FPL	Federal Poverty Level
FQHC	Federally-Qualified Health Center
HEDIS	Health Effectiveness Data and Information Set
HHS	U.S. Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104–191)
HMO	Health Maintenance Organization
HAS	Health Savings Account
IAP	Insurance Affordability Program
IPA	Independent Practice Association
IRC	Internal Revenue Code of 1986
IRS	Internal Revenue Services
LEP	Limited English Proficient

MAGI	Modified Adjusted Gross Income
MEC	Minimum Essential Coverage
POS	Point of Service
QHP	Qualified Health Plan
SHOP	Small Business Health Options Program
SSA	Social Security Administration
SSN	Social Security Number
TIN	Taxpayer Identification Number
USC	United States Code

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100501, 100502, and 100503, Government Code; 45 CFR Sections 155.20 and 155.300.

Amend Section 6410:

§ 6410. Definitions.

As used in this Chapter, the following terms shall mean:

340B Entity: A "covered entity" as defined in Public Health Service Act Section 340B(a)(4), 42 U.S.C. 256b(a)(4).

Accountable Care Organization (ACO): A voluntary group of physicians, hospitals and other health care providers that are willing to assume responsibility and some financial risk for the care of a clearly defined patient population attributed to them on the basis of patients' use of primary care services. Characteristics of an ACO may include robust use of electronic health record infrastructure, defined quality metrics including outcomes, shared savings formulas affecting reimbursement, coordinated care requirements or pay for performance reimbursement components.

Alternate Benefit Plan Design: A QHP proposed benefit plan design which features different cost-sharing requirements than the Exchange's Standardized Qualified Health Plan Designs.

Adoption Taxpayer Identification Number (ATIN): An ATIN as defined in 26 CFR § 301.6109-3(a).

Advance Payments of Premium Tax Credit (APTC): Payment of the tax credits authorized by 26 U.S.C. 36B and its implementing regulations, which are provided on an advance basis to an eligible individual enrolled in a QHP through an Exchange in accordance with Section 1412 of the Affordable Care Act.

Affordable Care Act (ACA): The federal Patient Protection and Affordable Care Act of 2010 (Pub.L. 111–148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Pub.L. 111–152).

Agent or Broker: A person or entity licensed by the State as an agent, broker or insurance producer.

Annual Open Enrollment Period: The period each year during which a qualified individual may enroll or change coverage in a QHP through the Exchange, as specified in Section 6502 of Article 5 of this chapter.

Applicable Children's Health Insurance Program (CHIP) MAGI–based Income Standard: The applicable income standard as defined at 42 CFR § 457.310(b)(1), as applied under the State plan adopted in accordance with title XXI of the Social Security Act, or waiver of such plan and as certified by the State CHIP Agency in accordance with 42 CFR § 457.348(d), for determining eligibility for child health assistance and enrollment in a separate child health program.

Applicable Medi-Cal Modified Adjusted Gross Income (MAGI)-based income standard: The same standard as "applicable modified adjusted gross income standard," as defined at 42 CFR § 435.911(b), as applied under the State plan adopted in accordance with title XIX of the Social Security Act, or waiver of such plan, and as certified by the DHCS in accordance with 42 CFR § 435.1200(b)(2) for determining eligibility for Medi-Cal.

Applicant: An applicant means:

(a) An individual who is seeking eligibility for him or herself through an application submitted to the Exchange, excluding those individuals seeking eligibility for an exemption from the shared responsibility payment for not maintaining minimum essential coverage pursuant to Section 6454 of Article 4 of this chapter, or transmitted to the Exchange by an agency administering an insurance affordability program for at least one of the following:

(i) Enrollment in a QHP through the Exchange; or

(ii) Medi-Cal, Healthy Families Program, and the BHP, if applicable.

(b) An employer or employee seeking eligibility for enrollment in a QHP through the SHOP, where applicable.

Application Filer: An applicant; an adult who is in the applicant's household, as defined in 42 CFR § 435.603(f), or family, as defined in 26 U.S.C. 36B(d) and 26 CFR § 1.36B-1(d); an authorized representative; or if the applicant is a minor or incapacitated, someone acting responsibly for an applicant; excluding those individuals seeking eligibility for an exemption pursuant to Section 6454 of Article 4 of this chapter.

Authorized Representative: Any person or entity who has been designated, in writing, by the applicant to act on his/her behalf or individuals who have appropriate power of attorney or legal conservatorship.

Benefit Plan Requirements: Coverage that provides for all of the following as under 45 CFR § 156.20:

(a) The essential health benefits as described in Section 1302(b) of the Affordable Care Act;

(b) Cost-sharing limits as described in Section 1302(c) of the Affordable Care Act; and

(c) A bronze, silver, gold, or platinum level of coverage as described in Section 1302(d) of the Affordable Care Act, or is a catastrophic plan as described in Section 1302(e) of the Affordable Care Act.

Benefit Year: A calendar year for which a health plan provides coverage for health benefits.

Bidder: A Health Insurance Issuer seeking to enter into a Qualified Health Plan contract.

Board: The Board of the California Health Benefit Exchange, established by Government Code 100500.

Consumer Assessment of Healthcare Provider (CAHPS): ~~Consumer Assessment of Healthcare Providers and Systems.~~ The Consumer Assessment of Healthcare Providers and Systems (CAHPS) program is a multi-year initiative of the Agency for Healthcare Research and Quality (AHRQ) to support and promote the assessment of consumers' experiences with health care. CAHPS develops surveys that are taken by hospitals, health plans, and home health agencies and are designed to measure patient experience with these entities.

California Health Eligibility, Enrollment and Retention System (CalHEERS): The California Healthcare Eligibility, Enrollment and Retention System, created pursuant to Government Code 100502 and 100503, as well as 42 U.S.C. 18031, to enable enrollees and prospective enrollees of QHPs to obtain standardized comparative information on the QHPs as well as apply for eligibility, enrollment, and reenrollment in the Exchange.

California Health Benefit Exchange or Exchange: The entity established pursuant to Government Code 100500. The Exchange also does business as and may be referred to as “Covered California.”

Catastrophic Plan: A health plan described in Section 1302(e) of the Affordable Care Act.

Certified QHP: Any QHP that is selected by the Exchange and has entered into a contract with the Exchange for the provision of health insurance coverage for enrollees who purchase health insurance coverage through the Individual and/or Small Business Health Options Program (SHOP) Exchanges.

Cost-share or Cost-sharing: Any expenditure required by or on behalf of an enrollee with respect to receipt of Essential Health Benefits; such term includes deductibles, coinsurance, copayments, or similar charges, but excludes premiums, balance billing amounts for non-network providers, and spending for non-covered services.

Cost-Sharing Reduction (CSR): Reductions in cost-sharing for an eligible individual enrolled in a silver level plan in the Exchange or for an individual who is an Indian enrolled in a QHP in the Exchange.

Day: A calendar day unless a business day is specified.

Educated Health Care Consumer: An individual as defined in Section 1304(e) of the Affordable Care Act.

Eligible Employer-sponsored Plan: A plan as defined in Section 5000A(f)(2) of IRC (26 U.S.C. § 5000A(f)(2)).

Employee: An individual as defined in Section 2791 of the Public Health Service Act (42 U.S.C. 300gg-91).

Employer: A person as defined in Section 2791 of the Public Health Service Act (42 U.S.C. 300gg-91), except that such term includes employers with one or more employees. All persons treated as a single employer under subsection (b), (c), (m), or (o) of Section 414 of IRC (26 U.S.C. § 414) are treated as one employer.

Employer Contributions: Any financial contributions towards an employer sponsored health plan, or other eligible employer-sponsored benefit made by the employer including those made by salary reduction agreement that is excluded from gross income.

Enrollee: A qualified individual or qualified employee enrolled in a QHP.

Exclusive Provider Organization (EPO): An Exclusive Provider Organization, as defined in California Code of Regulations, title 10, Section 2699.6000(r).

Essential Community Providers: Providers that serve predominantly low-income, medically underserved individuals, as defined in 45 C.F.R. 156.235.

Essential Health Benefits: The benefits listed in 42 U.S.C. 18022, Health and Safety Code 1367.005, and Insurance Code 10112.27.

Evidence-Based Medicine: The conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients.

Exchange Evaluation Team: The team selected by the Exchange to conduct the QHP bid response evaluation by consensus and assess whether the response is responsive and may proceed to the evaluation of the response.

Exchange Service Area: The entire geographic area of the State of California.

Executive Director: The Executive Director of the Exchange.

Federally-Qualified Health Center (FQHC): Federally-Qualified Health Center has the same meaning as that term is defined in Section 1905(l)(2)(B) of the Social Security Act (42 U.S.C. 1396d(l)(2)(B)).

Federal Poverty Level (FPL): The most recently published Federal poverty level, updated periodically in the Federal Register by the Secretary of Health and Human Services under the authority of 42 U.S.C. § 9902(2), as of the first day of the annual open enrollment period for coverage in a QHP through the Exchange, as specified in Section 6502 of Article 5 of this chapter.

Geographic Service Area: A defined geographic area within the State of California that a proposed QHP proposes to serve and is approved by the applicable State Health Insurance Regulator to serve.

Grandfathered Health Plan: A health plan as defined in 45 CFR § 147.140.

Group Health Plan: A group health plan within the meaning of 45 CFR § 146.145(a).

Health Insurance Coverage: Coverage as defined in 45 CFR § 144.103.

Health Insurance Issuer: Health Insurance Issuer has the same meaning as that term is defined in 42 U.S.C. 300gg-91 and 45 C.F.R. 144.103. Also referred to as “Health Issuer” or “Issuer.”

Health Maintenance Organization (HMO): A Health Care Service Plan (as that term is defined in Health & Safety Code 1345) holding a current license from and in good standing with the California Department of Managed Health Care.

Health plan: A plan as defined in Section 1301(b)(1) of the Affordable Care Act.

Health Effectiveness Data and Information Set (HEDIS): ~~Health Effectiveness Data and Information Set, a~~A set of managed care performance measures developed and maintained by the National Committee for Quality Assurance.

Health Savings Account (HSA): Health Savings Account, as defined in 26 U.S.C. 223.

Independent Practice Association (IPA): An IPA is a legal entity organized and directed by physicians in private practice to negotiate contracts with Health Insurance Issuers on their behalf.

Insurance Affordability Program (IAP): A program as defined in 42 CFR § 435.4.

Indian: An Indian, as defined in Section 4(d) of the Indian Self–Determination and Education Assistance Act (Pub.L. 93– 638), means a person who is a member of an Indian tribe.

Indian Tribe: An Indian tribe, as defined in Section 4(e) of the Indian Self– Determination and Education Assistance Act (Pub.L. 93–638), means any Indian tribe, band, nation, or other organized group or community, including any Alaska Native village or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act (85 Stat. 688) [43 U.S.C. § 1601 et seq.], which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

Individual and Small Business Health Options Program (SHOP) Exchanges: The programs administered by the Exchange pursuant to California Government Code § 100500 et seq. (2010 Cal. Stat. 655 (AB 1602) and 2010 Cal. Stat. 659 (SB 900)), 42 U.S.C. 18031(b) of the federal Patient Protection Affordable Care Act and other applicable laws to furnish and to pay for health insurance plans for Qualified Individuals and Qualified Employers.

Individual Market: A market as defined in Section 1304(a)(2) of the Affordable Care Act.

Ineligible Bidder: A prospective Bidder who is not in good standing with the applicable State Health Insurance Regulator, or does not meet the qualifications for consideration as a Qualified Health Plan under this Chapter, or has not provided complete responses or conforming responses to the QHP solicitation.

Initial Open Enrollment Period: The initial period in which Qualified Individuals may enroll in QHPs, from October 1, 2013 to March 31, 2014, subject to 45 C.F.R. 155.410(b).

Internet Web Portal: The web portal made available through a link on the Exchange's website, www.healthexchange.ca.gov, through which the Exchange will make the Solicitation available electronically and which can be accessed directly at https://www.proposaltech.com/app.php/login.

Large Employer: Beginning before January 1, 2016, an employer who, in connection with a group health plan with respect to a calendar year and a plan year, employed an average of at least 51 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year. Effective for plan years beginning on or after January 1, 2016, the number of employees shall be determined using the method set forth in section 4980H(c)(2) of IRC (26 U.S.C. § 4980H(c)(2)).

Lawfully Present: a non-citizen individual as defined in 42 CFR § 435.4.

Level of Coverage: One of four standardized actuarial values and the catastrophic level of coverage as defined in 42 U.S.C. 18022(d) and (e).

MAGI-based income: Income as defined in 42 CFR § 435.603(e).

Medical Group: A group of physicians and other health care providers who have organized themselves to provide services to a defined patient population or contract with a Health Issuer or hospital.

Minimum Essential Coverage (MEC): Coverage as defined in Section 5000A(f) of IRC (26 U.S.C. § 5000A(f)) and in 26 CFR § 1.36B-2(c).

Minimum Value: Minimum value, when used to describe coverage in an eligible employer-sponsored plan, means that the plan meets the requirements with respect to coverage of the total allowed costs of benefits set forth in Section 36B(c)(2)(C)(ii) of IRC (26 U.S.C. § 36B(c)(2)(C)(ii)) and in 26 CFR § 1.36B-2(c)(3)(vi).

Modified Adjusted Gross Income (MAGI): Income as defined in Section 36B(d)(2)(B) of IRC (26 U.S.C. § 36B(d)(2)(B)) and in 26 CFR § 1.36B-1(e)(2).

Network or Provider Network: The collection of Providers who have entered into contracts with a Health Insurance Issuer which govern payment and other terms of the business relationship between the Health Insurance Issuer and the Providers. Provider Networks are integral to an Issuer's proposed QHPs.

Non-citizen: An individual who is not a citizen or national of the United States, in accordance with Section 101(a)(3) of the Immigration and Nationality Act.

~~POS: Point of Service as defined in Health & Safety Code 1374.60.~~

Patient-Centered Medical Home: a team-based model of care led by a personal physician who provides continuous and coordinated care throughout a patient's lifetime to maximize health outcomes.

Plan Year: A consecutive 12 month period during which a health plan provides coverage for health benefits. A plan year may be a calendar year or otherwise.

Plain Language: Language that the intended audience, including individuals with limited English proficiency, can readily understand and use because that language is concise, well-organized, and follow other best practices of plain language writing.

Point of Service (POS): Point of Service as defined in Health & Safety Code 1374.60.

Preferred Provider Organization (PPO): A network of medical doctors, hospitals, and other health care providers who have contracted with a Health Insurance Issuer to provide health care at reduced rates to the Issuer's insureds or enrollees.

Provider or Network Provider: An appropriately credentialed or licensed individual, facility, agency, institution, organization or other entity that has a written agreement with a proposed QHP Bidder for the delivery of health care services.

QHP Issuer: A Health Insurance Issuer whose proposed QHP has been selected and certified by the Exchange for offering to Qualified Individuals and Qualified Employers purchasing health insurance coverage through the Exchange

Qualified employee: An individual who is employed by a qualified employer and has been offered health insurance coverage by such qualified employer through the SHOP.

Qualified Employer: Qualified Employer has the same meaning as that term is defined in 42 U.S.C. 18032(f)(2) and 45 C.F.R. 155.710.

Qualified Health Plan (QHP): Qualified Health Plan (QHP) has the same meaning as that term is defined in Patient Protection and Affordable Care Act Section 1301, 42 U.S.C. 18021. If a Standalone Dental Plan is offered through the Exchange, another health plan offered through the Exchange shall not fail to be treated as a QHP solely because the plan does not offer coverage of benefits offered through the standalone plan under 42 U.S.C. 18022(b)(1)(J).

Qualified Health Plan Solicitation or Solicitation: The California Health Benefit Exchange 2012-2013 Initial Qualified Health Plan Solicitation to Health Issuers and Invitation to Respond, as amended December 28, 2012.

Qualified Individual: Qualified Individual is an individual who meets the requirements of 42 U.S.C. 18032(f)(1) and 45 C.F.R. 155.305(a).

Qualifying coverage in an eligible employer-sponsored plan: Coverage in an eligible employer-sponsored plan that meets the affordability and minimum value standards specified in Section 36B(c)(2)(C) of IRC (26 U.S.C. § 36B(c)(2)(C)) and in 26 CFR § 1.36B-2(c)(3).

Quality Assurance: Processes used by proposed QHPs to monitor and improve the quality of care provided to enrollees.

Rating Region: The geographic regions for purposes of rating defined in Health & Safety Code 1357.512 and Insurance Code 10753.14.

Reasonably compatible: The difference or discrepancy between the information that the Exchange obtained through electronic data sources, provided by the applicant, or other information in the records of the Exchange and an applicant's attestation does not impact the eligibility of the applicant, including the amount of advance payments of the premium tax credit or category of cost-sharing reductions.

SHOP: A Small Business Health Options Program operated by the Exchange through which a qualified employer can provide its employees and their dependents with access to one or more QHPs.

SHOP Plan Year: A 12-month period beginning with the Qualified Employer's effective date of coverage.

Small employer: An employer as defined in Section 1357.500(k) of California Health and Safety Code.

Small group market: A group market as defined in Section 1304(a)(3) of the Affordable Care Act.

Special enrollment period: A period during which a qualified individual or enrollee who experiences certain qualifying events, as specified in Section 6504(a) of Article 5 of this chapter, may enroll in, or change enrollment in, a QHP through the Exchange outside of the initial and annual open enrollment periods.

Solicitation Official: The Exchange's single point of contact for the Solicitation.

Standalone Dental Plan: A plan providing limited scope dental benefits as defined in 26 U.S.C. 9832(c)(2)(A), including the pediatric dental benefits meeting the requirements of 42 U.S.C. 18022(b)(1)(J).

Standardized QHP Benefit Design(s): Benefit plan designs that the Board determines to be standard pursuant to Government Code 100504(c), as described in Solicitation Section II.B.1.

State Health Insurance Regulators: The Department of Managed Health Care and California Department of Insurance.

State Mandates: Health care benefits required to be covered by California statutes.

Tax dependent: A dependent as defined in Section 152 of IRC (26 U.S.C. § 152).

Tax filer: An individual, or a married couple, who indicates that he, she, or the couple expects:

(a) To file an income tax return for the benefit year, in accordance with 26 U.S.C. §§ 6011, 6012, and implementing regulations;

(b) If married (within the meaning of 26 CFR § 1.7703–1), to file a joint tax return for the benefit year;

(c) That no other taxpayer will be able to claim him, her, or the couple as a tax dependent for the benefit year; and

(d) That he, she, or the couple expects to claim a personal exemption deduction under Section 151 of IRC on his or her tax return for one or more applicants, who may or may not include himself or herself and his or her spouse.

Telemedicine: The ability of physicians and patients to connect via technology other than through virtual interactive physician/patient capabilities, especially enabling rural and out-of-area patients to be seen by specialists remotely.

Two-Tiered Network: A benefit design with two in-network benefit levels. Standard plan cost-share is applied to most cost-effective network with higher cost-share allowed for more expensive in-network choice. Actuarial value is based on likely overall use of tiered networks.

Value-Based Insurance Design: Value-Based Benefit Design includes explicit use of plan incentives to encourage enrollee adoption of one or more of the following: appropriate use of high-value services, including certain prescription drugs and preventive services and use of high-performance providers who adhere to evidence-based treatment guidelines.

NOTE: Authority: Sections 100502, 100503, 100504, and 100505, Government Code. Reference: Sections 100501, 100502, 100503, and 100505, Government Code; 45 CFR Sections 155.20 and 155.300.

California Code of Regulations

Title 10. Investment

Chapter 12. California Health Benefit Exchange (§ 6400 et seq.)

Article 4. General Provisions.

§ 6450. Meaning of Words.

Words shall have their usual meaning unless the context or a definition clearly indicates a different meaning. "Shall" means mandatory. "May" means permissive. "Should" means suggested or recommended.

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100501, 100502, and 100503, Government Code.

§ 6452. Accessibility and Readability Standards.

(a) All applications, including the single streamlined application described in Section 6470 of Article 5 of this chapter, forms, notices, and correspondence provided to the applicants and enrollees by the Exchange and QHP issuers shall conform to the standards outlined in paragraphs (b) and (c) of this section.

(b) Information shall be provided to applicants and enrollees in plain language, as defined in Section 6410 of Article 2 of this chapter, and all written correspondence shall also:

(1) Be formatted in such a way that it can be understood at the ninth-grade level;

(2) Not contain technical language beyond an ninth-grade level or print smaller than 12 point; and

(3) Not contain language that minimizes or contradicts the information being provided.

(c) Information shall be provided to applicants and enrollees in a manner that is accessible and timely to:

(1) Individuals living with disabilities through the provision of auxiliary aids and services at no cost to the individual, including accessible Web sites, 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:

(A) Oral interpretation or written translations; and

(B) Taglines in non-English languages indicating the availability of language services.

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

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; 45 C.F.R. Sections 155.20 and 155.205.

§ 6454. Exemption from Individual Responsibility.

"Reserved."

California Code of Regulations

Title 10. Investment

Chapter 12. California Health Benefit Exchange (§ 6400 et seq.)

Article 5. Application, Eligibility, and Enrollment Process for the Individual Exchange

§ 6470. Application.

(a) The Exchange shall use a single, streamlined application [placeholder to specify the name and date version of the single, streamlined application] to determine eligibility and to collect information necessary for:

(1) Enrollment in a QHP;
(2) APTC;
(3) CSR; and
(4) MAGI Medi-Cal or CHIP.

(b) To apply for any of the programs listed in paragraph (a) of this section, an applicant or an application filer shall submit all information, documentation, and declarations required on the single, streamlined application.

(c) The applicant shall sign and date the following declaration:

"I certify (or declare) under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

This means that I have understood all the questions on this application and provided true and correct answers to such questions to the best of my knowledge. Where I do not have personal knowledge of an answer, I have made every reasonable attempt to verify (or confirm) the information with someone who has personal knowledge of the answer.

I acknowledge that if I am not truthful, I know that there may be a civil and/or criminal penalty for perjury (under California Penal Code Section 126, perjury is punishable by imprisonment for up to four years).

I know that all information disclosed on this application will be used to determine eligibility of every person applying for health insurance on this application. The information will be kept private as required by federal and California law.

I agree to notify Covered California by ______________________ within ___ days if anything changes from and is different than what I have provided for each person applying for health insurance on this application.

By entering my full name below, I agree that this digital signature shall have the same force and effect as if I signed this application by my own hand.

________________ ____________________________________

Date and Place Electronic Signature”

(d) An application filer may file an application through one of the following channels:

(1) The Exchange’s Internet website;
(2) Telephone;
(3) Mail; or
(4) In person.

(e) The Exchange shall accept an application and make an eligibility determination for an applicant seeking an eligibility determination at any point in time during the year.

(f) “Reserved” [Placeholder to add acknowledgement that applicant consents for us to hit the hub with their SSN to verify their information, such as citizenship, and to obtain their tax data for the benefit year they are applying for].

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; 45 C.F.R. §§ 155.310, 155.405.

§ 6472. Eligibility Requirements for Enrollment in a QHP through the Exchange.

(a) An applicant shall meet the requirements of this section, regardless of the applicant’s eligibility for APTC or CSR. For purposes of this section, an applicant includes all individuals listed on the application who are seeking enrollment in a QHP through the Exchange.

(b) An applicant who has a SSN shall provide his or her SSN to the Exchange.

(c) An applicant shall be a citizen or national of the United States, or a non-citizen who is lawfully present in the United States, and is reasonably expected to be a citizen, national, or a non-citizen who is lawfully present for the entire period for which enrollment is sought.

(d) An applicant shall not be incarcerated, other than incarceration pending the disposition (judgment) of charges.

(e) An applicant shall meet one of the following applicable residency standards:

(1) For an individual who is age 21 and over, is not living in an institution as defined in Title 22, Division 3, Sections 50047 through 50052.5, is capable of indicating intent, and is

not receiving Supplemental Security Income/State Supplemental Program payments as defined in Title 22, Division 3, Section 50095, the service area of the Exchange of the individual is the service areas of the Exchange in which he or she is living and:

(A) Intends to reside, including without a fixed address; or

(B) Has entered with a job commitment or is seeking employment (whether or not currently employed).

(2) For an individual who is under the age of 21, is not living in an institution as defined in in Title 22, Division 3, Sections 50047 through 50052.5, is not eligible for Medi-Cal based on receipt of assistance under title IV–E of the Social Security Act, is not receiving Supplemental Security Income/State Supplemental Program payments as defined in Title 22, Division 3, Section 50095, the Exchange service area of the individual is:

(A) The service area of the Exchange in which he or she resides, including without a fixed address; or

(B) The service area of the Exchange of a parent or caretaker, established in accordance with paragraph (e)(1) of this section, with whom the individual resides.

(3) For an individual who is not described in paragraphs (e)(1) or (2) of this section, the Exchange must apply the residency requirements described in Title 22, Division 3, Section 50320 with respect to the service area of the Exchange.

(4) Special rule for tax households with members in multiple Exchange service areas.

“Reserved.”

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; 45 C.F.R. § 155.305.

§ 6474. Eligibility Requirements for APTC and CSR.

(a) Those individuals who apply to receive APTC and CSR shall meet the eligibility requirements of this section in addition to the requirements of Section 6472.

(b) For purposes of this section, household income has the meaning given the term in Section 36B(d)(2) of IRC (26 U.S.C. § 36B(d)(2)) and in 26 C.F.R. § 1.36B-1(e).

(c) Eligibility for APTC.

(1) A tax filer shall be eligible for APTC if:

(A) Tax filer is expected to have a household income of greater than or equal to 100 percent but not more than 400 percent of the FPL for the benefit year for which coverage is requested; and

(B) One or more applicants for whom the tax filer expects to claim a personal exemption deduction on his or her tax return for the benefit year, including the tax filer and his or her spouse:

i. Meets the requirements for eligibility for enrollment in a QHP through the Exchange, as specified in Section 6472;

ii. Is not eligible for MEC, with the exception of coverage in the individual market, in accordance with section 36B(c)(2)(B) and (C) of IRC (26 U.S.C. § 36B(c)(2)(B), (C)) and 26 C.F.R. § 1.36B-2(c); and

iii. Is enrolled in a QHP through the Exchange.

(2) A non-citizen tax filer who is lawfully present and ineligible for Medi-Cal by reason of immigration status shall be eligible for APTC if:

(A) Tax filer meets the requirements specified in paragraph (c)(1) of this section, except for paragraph (c)(1)(A);

(B) Tax filer is expected to have a household income of less than 100 percent of the FPL for the benefit year for which coverage is requested; and

(C) One or more applicants for whom the tax filer expects to claim a personal exemption deduction on his or her tax return for the benefit year, including the tax filer and his or her spouse, is a non-citizen who is lawfully present and ineligible for Medi-Cal by reason of immigration status, in accordance with section 36B(c)(1)(B) of IRC (26 U.S.C. § 36B(c)(1)(B)) and in 26 C.F.R. § 1.36B-2(b)(5).

(3) Tax filer shall not be eligible for APTC if:

(A) HHS notifies the Exchange, as part of the verification process described in Sections 6482 through 6486, that APTC was made on behalf of the tax filer (or either spouse if the tax filer is a married couple) for a year for which tax data would be used to verify household income and family size in accordance with Section 6482(d) and (e);

(B) Tax filer (or his or her spouse) did not comply with the requirement to file an income tax return for that year, as required by 26 U.S.C. §§ 6011, 6012, and implementing regulations; and

(C) The APTC was not reconciled for that period.

(4) The APTC amount shall be calculated in accordance with section 36B of IRC (26 U.S.C. § 36B) and 26 C.F.R. § 1.36B-3.

(5) An application filer shall provide the SSN of a tax filer who is not an applicant only if an applicant attests that the tax filer has a SSN and filed a tax return for the year for which tax data would be used to verify household income and family size.

(d) Eligibility for CSR.

(1) An applicant shall be eligible for CSR if he or she:

(A) Meets the eligibility requirements for enrollment in a QHP through the Exchange, as specified in Section 6472;

(B) Meets the requirements for APTC, as specified in paragraph (c) of this section; and

(C) Is expected to have a household income that does not exceed 250 percent of the FPL for the benefit year for which coverage is requested.

(2) The Exchange may only provide CSR to an enrollee who is not an Indian if he or she is enrolled through the Exchange in a silver-level QHP, as defined by section 1302(d)(1)(B) of the Affordable Care Act.

(3) The Exchange shall use the following eligibility categories for CSR when making eligibility determinations under this section:

(A) An individual who is expected to have a household income:

i. Greater than or equal to 100 percent of the FPL and less than or equal to 150 percent of the FPL for the benefit year for which coverage is requested, or

ii. Less than 100 percent of the FPL for the benefit year for which coverage is requested, if he or she is eligible for APTC under paragraph (c)(2) of this section;

(B) An individual is expected to have a household income greater than 150 percent of the FPL and less than or equal to 200 percent of the FPL for the benefit year for which coverage is requested; and

(C) An individual who is expected to have a household income greater than 200 percent of the FPL and less than or equal to 250 percent of the FPL for the benefit year for which coverage is requested.

(4) If an enrollment in a QHP under a single family policy covers two or more individuals, the Exchange shall deem the individuals under such family policy to be collectively eligible only for the last category of eligibility listed below for which all the individuals covered by the family policy would be eligible:

(A) Not eligible for CSR;
(B) Section 6494(a)(3) and (4) – Special CSR eligibility standards and process for Indians regardless of income;
(C) Paragraph (d)(3)(C) of this section;
(D) Paragraph (d)(3)(B) of this section;
(E) Paragraph (d)(3)(A) of this section; and
(F) Section 6494(a)(1) and (2) – Special CSR eligibility standards and process for Indians with household incomes under 300 percent of FPL.

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; 45 C.F.R. § 155.305.

§ 6476. Eligibility Determination Process

(a) An applicant may request an eligibility determination only for enrollment in a QHP through the Exchange.

(b) An applicant's request for an eligibility determination for an IAP shall be deemed a request for all IAPs.

(c) The following special rules relate to APTC.

(1) An enrollee may accept less than the full amount of APTC for which he or she is determined eligible.

(2) To be determined eligible for APTC, a tax filer shall make the following attestations as applicable:

(A) He or she will file an income tax return for the benefit year, in accordance with 26 U.S.C. §§ 6011, 6012, and implementing regulations;

(B) If married (within the meaning of 26 CFR 1.7703–1), he or she will file a joint tax return for the benefit year;

(C) No other taxpayer will be able to claim him or her as a tax dependent for the benefit year; and

(D) He or she will claim a personal exemption deduction on his or her tax return for the applicants identified as members of his or her family, including the tax filer and his or her spouse, in accordance with Section 6482(d).

(d) If the Exchange determines an applicant eligible for Medi-Cal or CHIP, the Exchange shall notify DHCS and transmit all information from the records of the Exchange to DHCS, promptly and without undue delay [placeholder for data/records transmittal timeline], that is necessary for DHCS to provide the applicant with coverage.

(e) An applicant's eligibility shall be determined promptly and without undue delay [placeholder for application processing timeline].

(f) Upon making an eligibility determination, the Exchange shall implement the eligibility determination under this section for enrollment in a QHP through the Exchange, APTC, and CSR as follows:

(1) For an initial eligibility determination, in accordance with the dates specified in Section 6502(c) and (f) and Section 6504(g) and (h), as applicable; or

(2) For a redetermination, in accordance with the dates specified in Section 6496(k), (l) and (m) and Section 6498(l), as applicable.

(g) The Exchange shall provide timely [placeholder for specific timeline for providing notice] written notice to an applicant of any eligibility determination made in accordance with this article.

(h) The Exchange shall notify an employer that an employee has been determined eligible for APTC and CSR upon determination that an employee is eligible for APTC and CSR. Such notice shall:

(1) Identify the employee;

(2) Indicate that the employee has been determined eligible for APTC and CSR;

(3) Indicate that, if the employer has 50 or more full-time employees, the employer may be liable for the tax penalty assessed under section 4980H of IRC; and

(4) Notify the employer of the right to appeal the determination.

(i) If an applicant who is determined eligible for enrollment in a QHP does not select a QHP within his or her enrollment periods, specified in Sections 6502 and 6504, and seeks a new enrollment period:

(1) Prior to the date on which his or her eligibility would have been redetermined in accordance with Section 6498 had he or she enrolled in a QHP:

(A) The applicant shall attest as to whether information affecting his or her eligibility has changed since his or her most recent eligibility determination before his or her eligibility shall be determined for an enrollment period; and

(B) Any changes the applicant reports shall be processed in accordance with the procedures specified in Section 6496.

(2) On or after the date on which his or her eligibility would have been redetermined in accordance with Section 6498 had he or she enrolled in a QHP, the applicant's eligibility for an enrollment period shall be determined in accordance with the procedures specified in Section 6498.

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; 45 C.F.R. § 155.310.

§ 6478. Verification Process Related to Eligibility Requirements for Enrollment in a QHP through the Exchange.

(a) The Exchange shall verify or obtain information as provided in this section to determine whether an applicant meets the eligibility requirements specified in Section 6472 relating to the eligibility requirements for enrollment in a QHP through the Exchange.

(b) Verification of SSN.

(1) For any individual who provides his or her SSN to the Exchange, the Exchange shall transmit the SSN and other identifying information to HHS, which will submit it to the SSA.

(2) If the Exchange is unable to verify an individual's SSN through the SSA, the Exchange shall follow the procedures specified in Section 6492, except that the Exchange shall provide the individual with a period of 90 days from the date on which the notice described in Section 6492(a)(2)(A) is received for the applicant to provide satisfactory documentary evidence or resolve the inconsistency with the SSA. The date on which the notice is received means five days after the date on the notice, unless the individual demonstrates that he or she did not receive the notice within the five-day period.

(c) Verification of citizenship, status as a national, or lawful presence.

(1) For an applicant who attests to citizenship and has a SSN, the Exchange shall transmit the applicant's SSN and other identifying information to HHS, which will submit it to the SSA.

(2) For an applicant who has documentation that can be verified through the DHS and who attests to lawful presence, or who attests to citizenship and for whom the Exchange cannot substantiate a claim of citizenship through the SSA, the Exchange shall transmit information from the applicant's documentation and other identifying information to HHS, which will submit necessary information to the DHS for verification.

(3) For an applicant who attests to citizenship, status as a national, or lawful presence, and for whom the Exchange cannot verify such attestation through the SSA or the DHS, the Exchange shall follow the inconsistencies procedures specified in Section 6492, except that the Exchange shall provide the applicant with a period of 90 days from the date on which the notice described in Section 6492 (a)(2)(A) is received for the applicant to provide satisfactory documentary evidence or resolve the inconsistency with the SSA or the DHS, as applicable. The date on which the notice is received means five days after the date on the notice, unless the applicant demonstrates that he or she did not receive the notice within the five-day period

(d) Verification of residency.

(1) The Exchange shall verify an applicant's attestation that he or she meets the residency standards of Section 6472(e) as follows:

(A) Except as provided in paragraphs (d)(2) and (3) of this section, accept his or her attestation without further verification; or

(B) Examine HHS-approved electronic data sources that are available to the Exchange.

(2) If information provided by an applicant regarding residency is not reasonably compatible with other information provided by the individual or in the records of the Exchange, the Exchange shall examine information in HHS-approved data sources that are available to the Exchange.

(3) If the information in such data sources is not reasonably compatible with the information provided by the applicant, the Exchange shall follow the procedures specified in Section 6492. Evidence of immigration status may not be used to determine that an applicant is not a resident of the Exchange service area.

(e) Verification of incarceration status.

(1) The Exchange shall verify an applicant's attestation that he or she meets the requirements of 6472(b) by:

(A) Relying on any HHS-approved electronic data sources that are available to the Exchange; or

(B) Except as provided in paragraph (e)(2) of this section, if a HHS-approved data source is unavailable, accepting the applicant's attestation without further verification.

(2) If an applicant's attestation is not reasonably compatible with information from HHS-approved data sources described in paragraph (e)(1)(A) of this section or other information provided by the applicant or in the records of the Exchange, the Exchange shall follow the inconsistencies procedures specified in Section 6492.

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; 45 C.F.R. § 155.315.

§ 6480. Verification of Eligibility for MEC other than through an Eligible Employer-Sponsored Plan Related to Eligibility Determination for APTC and CSR.

(a) The Exchange shall verify whether an applicant is eligible for MEC other than through an eligible employer-sponsored plan, Medi-Cal, or CHIP, using information obtained from the HHS.

(b) The Exchange shall verify whether an applicant has already been determined eligible for coverage through Medi-Cal or CHIP, using information obtained from the DHCS.

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100502, 100503, and 100504, Government Code; 45 C.F.R. § 155.320.

§ 6482. Verification of Family Size and Household Income Related to Eligibility Determination for APTC and CSR.

(a) For purposes of this section, "family size" and "household income" have the meanings given the terms in Section 36B(d)(1) and (2) of IRC (26 U.S.C. § 36B(d)(1)) and in 26 C.F.R. § 1.36B-1(d), (e).

(b) For all individuals whose income is counted in calculating a tax filer's household income, in accordance with section 36B(d)(2) of IRC (26 U.S.C. § 36B(d)(2)) and 26 C.F.R. § 1.36B-1(e), and for whom the Exchange has a SSN or a TIN, the Exchange shall request tax return data regarding MAGI and family size from HHS.

(c) If the identifying information for one or more individuals does not match a tax record on file with the IRS, the Exchange shall proceed in accordance with the procedures specified in Section 6492.

(d) An applicant's family size shall be verified in accordance with the following procedures.

(1) An applicant shall attest to the individuals that comprise a tax filer's family for APTC and CSR.

(2) If an applicant attests that the information described in paragraph (b) of this section represents an accurate projection of a tax filer's family size for the benefit year for which coverage is requested, the tax filer's eligibility for APTC and CSR shall be determined based on the family size data in paragraph (b) of this section.

(3) Except as specified in paragraph (d)(4) of this section, the tax filer's family size for APTC and CSR shall be verified by accepting an applicant's attestation without further verification if:

(A) The data described in paragraph (b) of this section is unavailable; or

(B) The applicant attests that a change in family size has occurred, or is reasonably expected to occur, and so the data described in paragraph (b) of this section does not represent an accurate projection of the tax filer's family size for the benefit year for which coverage is requested.

(4) If Exchange finds that an applicant's attestation of a tax filer's family size is not reasonably compatible with other information provided by the application filer for the family or in the records of the Exchange, with the exception of the data described in paragraph (b) of this section, the applicant's attestation shall be verified using data obtained through other electronic data sources. If such data sources are unavailable or information in such data sources is not reasonably compatible with the applicant's attestation, the applicant shall provide additional documentation requested by the Exchange to support the attestation, in accordance with Section 6492.

(e) An applicant's annual household income shall be verified in accordance with the following procedures.

(1) The annual household income of the family described in paragraph (d)(1) shall be computed based on the tax return data described in paragraph (b) of this section.

(2) An applicant shall attest to a tax filer's projected annual household income.

(3) If an applicant's attestation indicates that the information described in paragraph (e)(1) of this section represents an accurate projection of the tax filer's household income for the benefit year for which coverage is requested, the tax filer's eligibility for APTC and CSR shall be determined based on the household income data in paragraph (e)(1) of this section.

(4) If the data described in paragraph (b) of this section is unavailable, or an applicant attests that a change in household income has occurred, or is reasonably expected to occur, and so it does not represent an accurate projection of the tax filer's household income for the benefit year for which coverage is requested, the applicant shall attest to the tax filer's projected household income for the benefit year for which coverage is requested.

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; 45 C.F.R. § 155.320.

§ 6484. Verification Process for Increases in Household Income Related to Eligibility Determination for APTC and CSR.

(a) Except as provided in paragraph (b) of this section, the Exchange shall accept the applicant's attestation for the tax filer's family without further verification if:

(1) An applicant attests, in accordance with Section 6482(e)(2), that a tax filer's annual household income has increased, or is reasonably expected to increase, from the data described in Section 6482(e)(1) for the benefit year for which the applicant(s) in the tax filer's family are requesting coverage; and

(2) The Exchange has not verified the applicant's MAGI-based income through the process specified in Section 6488(e) to be within the applicable Medi-Cal or CHIP MAGI–based income standard.

(b) If the Exchange finds that an applicant's attestation of a tax filer's annual household income is not reasonably compatible with other information provided by the application filer or available to the Exchange in accordance with Section 6488(d), the applicant's attestation shall be verified using data the Exchange obtained through electronic data sources.

(c) If the data sources described in paragraph (b) of this section are unavailable or information in such data sources is not reasonably compatible with the applicant's attestation, the applicant shall provide additional documentation requested by the Exchange to support the attestation, in accordance with Section 6492.

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; 45 C.F.R. § 155.320.

§ 6486. Alternate Verification Process for APTC and CSR Eligibility Determination for Decreases in Annual Household Income or If Tax Return Data Is Unavailable.

(a) A tax filer's annual household income shall be determined based on the alternate verification procedures described in paragraphs (b) and (c) of this section if:

(1) An applicant attests to projected annual household income in accordance with Section 6482(e)(2);

(2) The tax filer does not meet the criteria specified in Section 6484;

(3) The applicants in the tax filer's family have not established MAGI-based income, through the process specified in Section 6488(e), that is within the applicable MAGI-based income standard; and

(4) One of the following conditions is met:

(A) The IRS does not have tax return data that may be disclosed under Section 6103(l)(21) of IRC (26 U.S.C. § 6102(l)(21)) for the tax filer that is at least as recent as the calendar year two years prior to the calendar year for which APTC and CSR would be effective;

(B) The applicant attests that the tax filer's applicable family size has changed, or is reasonably expected to change (or the members of the tax filer's family have changed, or are reasonably expected to change), for the benefit year for which the applicants in his or her family are requesting coverage;

(C) The applicant attests that a change in circumstances has occurred, or is reasonably expected to occur, and so the tax filer's annual household income has decreased, or is reasonably expected to decrease, from the data described in Section 6482(b) for the benefit year for which the applicants in his or her family are requesting coverage;

(D) The applicant attests that the tax filer's filing status has changed, or is reasonably expected to change, for the benefit year for which the applicants in his or her family are requesting coverage; or

(E) An applicant in the tax filer's family has filed an application for unemployment benefits.

(b) If a tax filer qualifies for an alternate verification process based on the requirements specified in paragraph (a) of this section and the applicant's attestation to projected annual household income, as described in Section 6482(e)(2), is no more than ten percent below the annual household income computed in accordance with Section 6482(e)(1), the applicant's attestation shall be accepted without further verification.

(c) If a tax filer qualifies for an alternate verification process based on the requirements specified in paragraph (a) of this section and the applicant's attestation to projected annual household income, as described in Section 6482(e)(2), is greater than ten percent below the annual household income computed in accordance with Section 6482(e)(1), or if the tax data described in Section 6482(b) is unavailable:

(1) The applicant's attestation of the tax filer's projected annual household income for the tax filer shall be verified by:

(A) Using annualized data from the MAGI-based income sources specified in Section 6488(d);

(B) Using other HHS-approved electronic data sources; or

(C) Following the procedures specified in Section 6492(a)(1) through (4) if electronic data are unavailable or do not support an applicant's attestation;

(2) The applicant shall not be eligible for APTC~~,~~ or CSR, ~~MAGI Medi-Cal, or CHIP~~ if:

(A) An applicant has not responded to a request for additional information from the Exchange following the 90-day period described in paragraph (c)(1)(C) of this section; and

(B) The data sources specified in Sections 6482(b) and 6488(d) indicate that an applicant in the tax filer's family is eligible for Medi-Cal or CHIP.

(3) If, at the conclusion of the period specified in paragraph (c)(1)(C) of this section, the Exchange remains unable to verify the applicant's attestation, the Exchange shall:

(A) Determine the applicant's eligibility based on the information described in Section 6482(e)(1);

(B) Notify the applicant of such determination in accordance with the notice requirements specified in Section 6476(g); and

(C) Implement such determination in accordance with the effective dates specified in Section 6496(k) through (m).

(4) If, at the conclusion of the period specified in paragraph (c)(1)(C) of this section, the Exchange remains unable to verify the applicant's attestation for the tax filer and the information described in Section 6482(e)(1) is unavailable, the Exchange shall:

(A) Determine the tax filer ineligible for APTC and CSR;

(B) Notify the applicant of such determination in accordance with the notice requirements specified in Section 6476(g); and

(C) Discontinue any APTC and CSR in accordance with the effective dates specified in Section 6496(k) through (m).

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; 45 C.F.R. § 155.320.

§ 6488. Verification Process for MAGI-Based Medi-Cal and CHIP.

"Reserved."

§ 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.

"Reserved."

6492**§ 6492. Inconsistencies.**

(a) Except as otherwise specified in this Article, for an applicant whose attestations are inconsistent with the data obtained by the Exchange from available data sources, or for whom the Exchange cannot verify information required to determine eligibility for enrollment in a QHP, or for APTC and CSR, including when electronic data is required in accordance with this section but not available, the Exchange:

(1) Shall make a reasonable effort to identify and address the causes of such inconsistency, including through typographical or other clerical errors, by contacting the application filer to confirm the accuracy of the information submitted by the application filer;

(2) If unable to resolve the inconsistency through the process described in paragraph (a)(1) of this section, shall:

(A) Provide notice to the applicant regarding the inconsistency; and

(B) Provide the applicant with a period of 90 days from the date on which the notice described in paragraph (a)(2)(A) of this section is sent to the applicant to either present satisfactory documentary evidence through the channels available for the submission of an application, as described in Section 6470(d), except by telephone, or otherwise resolve the inconsistency.

(3) May extend the period described in paragraph (a)(2)(B) of this section for an applicant if the applicant demonstrates that a good faith effort has been made to obtain the required documentation during the period.

(4) During the period described in paragraph (a)(2)(B) of this section, shall:

(A) Proceed with all other elements of eligibility determination using the applicant's attestation, and provide eligibility for enrollment in a QHP if an applicant is otherwise qualified; and

(B) Ensure that APTC and CSR are provided within this period on behalf of an applicant who is otherwise qualified for such payments and reductions, as described in Section 6474, provided that the tax filer attests to the Exchange that he or she understands that any APTC paid on his or her behalf are subject to reconciliation.

(5) If, after the period described in paragraph (a)(2)(B) of this section, the Exchange remains unable to verify the attestation, shall:

(A) Determine the applicant's eligibility based on the information available from the data sources specified in Sections 6478 through 6492, unless such applicant qualifies for the exception provided under paragraph (b) of this section, and notify the applicant of such determination in accordance with the notice requirements specified in Section 6476(g), including notice that the Exchange is unable to verify the attestation; and

(B) Effectuate the determination specified in paragraph (a)(5)(A) of this section no earlier than 10 days after and no later than 30 days after the date on which the notice in paragraph (a)(5)(A) of this section is sent.

(b) The Exchange shall provide an exception, on a case-by-case basis, to accept an applicant's attestation as to the information which cannot otherwise be verified and the applicant's explanation of circumstances as to why the applicant does not have documentation if:

(1) An applicant does not have documentation with which to resolve the inconsistency through the process described in paragraph (a)(2) of this section because such documentation does not exist or is not reasonably available;

(2) The Exchange is unable to otherwise resolve the inconsistency for the applicant; and

(3) The inconsistency is not related to citizenship or immigration status.

(c) An applicant shall not be required to provide information beyond the minimum necessary to support the eligibility and enrollment processes of the Exchange, Medi-Cal, and CHIP.

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100502, 100503, and 100504, Government Code; 45 C.F.R. § 155.315.

§ 6494. Special Eligibility Standards and Verification Process for Indians.

(a) An Indian applicant's eligibility for CSR shall be determined based on the following procedures.

(1) An Indian applicant shall be eligible for CSR if he or she:

(A) Meets the eligibility requirements specified in Sections 6472 and 6474(c);

(B) Is expected to have a household income, as defined in section 36B(d)(2) of IRC (26 U.S.C. § 36B(d)(2)) and in 26 C.F.R. § 1.36B-1(e), that does not exceed 300 percent of the FPL for the benefit year for which coverage is requested; and

(C) Is enrolled in a QHP through the Exchange.

(2) If an Indian applicant meets the eligibility requirements of paragraph (a)(1):

(A) Such applicant shall be treated as an eligible insured; and

(B) The QHP issuer shall eliminate any cost-sharing under the plan.

(3) Regardless of an Indian applicant's income and the requirement of Section 6476(b) to request an eligibility determination for all IAPs, such applicant shall be eligible for CSR if the individual is:

(A) Enrolled in a QHP through the Exchange; and

(B) Furnished an item or service directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or through referral under contract health services.

(4) If an Indian applicant meets the requirements of paragraph (a)(3) of this section, the QHP issuer:

(A) Shall eliminate any cost-sharing under the plan for the item or service specified in paragraph (a)(3)(B); and

(B) Shall not reduce the payment to any such entity for the item or service specified in paragraph (a)(3)(B) by the amount of any cost-sharing that would be due from the Indian but for subparagraph (A).

(b) An Indian applicant's attestation that he or she is an Indian shall be verified by:

(1) Using any relevant documentation verified in accordance with Section 6492;

(2) Relying on any HHS-approved electronic data sources that are available to the Exchange; or

(3) If HHS-approved data sources are unavailable, an individual is not represented in available data sources, or data sources are not reasonably compatible with an applicant's attestation:

(A) Following the procedures specified in Section 6492; and

(B) Verifying documentation provided by the applicant that meets the following requirements for satisfactory documentary evidence of citizenship or nationality:

i. Except as provided in subclause (ii), a document issued by a federally recognized Indian tribe evidencing membership or enrollment in, or affiliation with, such tribe (such as a tribal enrollment card or certificate of degree of Indian blood).

ii. With respect to those federally recognized Indian tribes located within States having an international border whose membership includes individuals who are not citizens of the United States, such other forms of documentation (including tribal documentation, if appropriate) that HHS has determined to be satisfactory documentary evidence of citizenship or nationality.

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; 45 C.F.R. § 155.350.

§ 6496. Eligibility Redetermination during a Benefit Year.

(a) The Exchange shall redetermine the eligibility of an enrollee in a QHP through the Exchange during the benefit year if it receives and verifies new information reported by an enrollee or identifies updated information through the data matching described in paragraph (g) of this section.

(b) Except as specified in paragraphs (c) and (d) of this section, an enrollee, or an application filer on behalf of the enrollee, shall report any change of circumstances with respect to the eligibility standards specified in Sections 6472 and 6474 within 30 days of such change. Changes shall be reported through any of the channels available for the submission of an application, as described in Section 6470(d).

(c) An enrollee who has not requested an eligibility determination for IAPs shall not be required to report changes that affect eligibility for IAPs.

(d) An enrollee who experiences a change in income that is less than 10 percent of the income used in the enrollee's most recent eligibility determination is not required to report such a change.

(e) The reported changes shall be verified in accordance with the process specified in Sections 6478 through 6492 before such information shall be used in an eligibility determination.

(f) The Exchange shall provide electronic notifications to an enrollee who has elected to receive electronic notifications, unless he or she has declined to receive notifications under this paragraph, regarding the requirements for reporting changes and the enrollee's opportunity to report any changes as described in paragraph (d) of this section.

(g) The Exchange shall examine available data sources on a semiannual basis to identify the following changes of circumstances:

(1) Death; and

(2) Eligibility determinations for Medicare, Medi-Cal, or CHIP.

(h) For verification of the enrollee-reported data, the Exchange shall:

(1) Redetermine the enrollee's eligibility in accordance with the standards specified in Sections 6472 and 6474;

(2) Notify the enrollee regarding the determination, in accordance with the requirements specified in Section 6476(g); and

(3) Notify the enrollee's employer, as applicable, in accordance with the requirements specified in Section 6476(h).

(i) For verification of updated information that the Exchange identifies through semiannual data matching not regarding income, family size, and family composition, the Exchange shall:

(1) Notify the enrollee regarding the updated information, as well as the enrollee's projected eligibility determination after considering such information;

(2) Allow an enrollee 30 days from the date of the notice described in paragraph (i)(1) to notify the Exchange that such information is inaccurate;

(3) If the enrollee responds contesting the updated information, proceed in accordance with Section 6492; and

(4) If the enrollee does not respond within the 30-day period specified in paragraph (i)(2), proceed in accordance with paragraphs (h)(1) and (2) of this section.

(j) For verification of updated information that the Exchange identifies through semiannual data matching regarding income, family size, and family composition, the Exchange shall:

(1) Follow procedures described in paragraph (i)(1) and (2) of this section;

(2) If the enrollee responds confirming the updated information or providing more up to date information, proceed in accordance with paragraphs (h)(1) and (2) of this section; and

(3) If the enrollee does not respond within the 30-day period specified in paragraph (i)(2) of this section, maintain the enrollee's existing eligibility determination without considering the updated information.

(k) Except as specified in paragraphs (l) or (m) of this section, the Exchange shall implement changes resulting from a redetermination under this section on the first day of the month following the date of the redetermination notice described in paragraph (h)(2) of this section.

(l) Changes captured through a redetermination on or after the sixteenth day of any month shall be effective on the first day of the month after the month specified in paragraph (k) of this section.

(m) In the case of a redetermination that results in an enrollee being ineligible to continue his or her enrollment in a QHP through the Exchange:

(1) The enrollee’s QHP coverage through the Exchange shall be terminated, as specified in Section 6506(b)(1); and

(2) The Exchange shall maintain the enrollee’s eligibility for enrollment in a QHP without APTC and CSR until the effective dates of the termination of coverage, as specified in Section 6506(d)(3).

(n) In the case of a redetermination that results in a change in the amount of APTC for the benefit year, the Exchange shall recalculate the amount of APTC in such a manner as to:

(1) Account for any APTC already made on behalf of the tax filer for the benefit year for which information is available to the Exchange, such that the recalculated APTC amount is projected to result in total APTC for the benefit year that correspond to the tax filer's total projected APTC for the benefit year, calculated in accordance with Section 36B of IRC (26 U.S.C. § 36B) and 26 C.F.R. § 1.36B-3; and

(2) Ensure that the APTC provided on the tax filer's behalf is equal to or greater than zero and is calculated in accordance with Section 36B(b) of IRC (26 U.S.C. § 36B(b)) and 26 C.F.R 1.36B-3(d).

(o) In the case of a redetermination that results in a change in CSR, the Exchange shall determine an individual eligible for the category of CSR that corresponds to his or her expected annual household income for the benefit year, subject to the special rule for family policies set forth in Section 6474(d)(4).

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; 45 C.F.R. § 155.330.

§ 6498. Annual Eligibility Redetermination.

(a) Except as specified in paragraph (d) of this section, the Exchange shall redetermine the eligibility of an enrollee in a QHP through the Exchange on an annual basis in accordance with the timing described in paragraph (f) of this section.

(b) To conduct an annual redetermination, the Exchange shall have on file an active authorization from an enrollee to obtain updated tax return information described in paragraph (c) of this section. This authorization shall be for a period of no more than five years based on a single authorization, provided that an individual may:

(1) Decline to authorize the Exchange to obtain updated tax return information; or

(2) Authorize the Exchange to obtain updated tax return information for up to five years; and

(3) Discontinue, change, or renew his or her authorization at any time.

(c) If an enrollee requested an eligibility determination for IAPs on the original application, in accordance with Section 6476(a) and (b), and the Exchange has an active authorization to obtain tax data as a part of the annual redetermination process, the Exchange shall request:

(1) Updated tax return information through HHS, as described in Section 6482(b) and (c); and

(2) Data regarding MAGI-based income, as described in Section 6488(d).

(d) If an enrollee requested an eligibility determination for IAPs on the original application, in accordance with Section 6476(a) and (b), and the Exchange does not have an active authorization to obtain tax data as a part of the annual redetermination process, the Exchange:

(1) Shall notify the enrollee in accordance with the timing described in paragraph (f) of this section; and

(2) Shall not proceed with the redetermination process described in paragraphs (e) and (g) through (m) of this section until such authorization has been obtained or the enrollee withdraws his or her request for an eligibility determination for IAPs.

(e) The Exchange shall provide an enrollee with an annual redetermination notice with a pre-populated form that includes:

(1) Data obtained under paragraph (c) of this section, if applicable;

(2) Data used in the enrollee's most recent eligibility determination; and

(3) The enrollee's projected eligibility determination for the following year, after considering any updated information described in paragraph (e)(1) of this section, including, if applicable, the amount of any APTC and the level of any CSR or eligibility for Medi-Cal or CHIP.

(f) For eligibility redeterminations under this section, the Exchange shall provide the annual redetermination notice, as specified in paragraph (e) of this section, and the notice of annual open enrollment period, as specified in Section 6502(e), through a single, coordinated notice.

(g) An enrollee, or an application filer on behalf of the enrollee, shall report to the Exchange any changes with respect to the information listed in the notice described in paragraph (e) of this section within 30 days from the date of the notice, using any of the channels available for the submission of an application, as described in Section 6470(d).

(h) The Exchange shall verify any information reported by an enrollee under paragraph (g) of this section using the processes specified in Sections 6478 through 6492, prior to using such information to determine eligibility.

(i) An enrollee, or an application filer on behalf of the enrollee, shall sign and return the notice described in paragraph (e) of this section. If an enrollee does not sign and return the notice described in paragraph (e) of this section within the 30-day period specified in paragraph (g) of this section, the Exchange shall proceed in accordance with the procedures specified in paragraph (j) of this section.

(j) After the 30-day period specified in paragraph (g) of this section has elapsed, the Exchange shall:

(1) Redetermine the enrollee's eligibility in accordance with the standards specified in Sections 6472 and 6474 using the information provided to the individual in the notice specified in paragraph (e), as supplemented with any information reported by the enrollee and verified by the Exchange in accordance with paragraphs (g) and (h) of this section;

(2) Notify the enrollee in accordance with the requirements specified in Section 6476(g); and

(3) If applicable, notify the enrollee's employer, in accordance with the requirements specified in Section 6476(h).

(k) If an enrollee reports a change with respect to the information provided in the notice specified in paragraph (e) of this section that the Exchange has not verified as of the end of the 30-day period specified in paragraph (g) of this section, the Exchange shall redetermine the enrollee's eligibility after completing verification, as specified in paragraph (h) of this section.

(l) A redetermination under this section shall be effective on the first day of the coverage year following the year in which the Exchange provided the notice in paragraph (e) of this section, or in accordance with the rules specified in Section 6496(k) through (m), whichever is later.

(m) If an enrollee remains eligible for coverage in a QHP upon annual redetermination, such enrollee shall remain in the QHP selected the previous year unless he or she terminates coverage from such plan, including termination of coverage in connection with enrollment in a different QHP, in accordance with Section 6506.

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; 45 C.F.R. § 155.335.

§ 6500. Enrollment of Qualified Individuals into QHPs.

(a) A qualified individual may enroll in a QHP (and an enrollee may change QHPs) only during, and in accordance with the coverage effective dates related to, the following periods:

(1) The initial open enrollment period, as specified in Section 6502;

(2) The annual open enrollment period, as specified in Section 6502; or

(3) A special enrollment period, as specified in Section 6504, for which the qualified individual has been determined eligible.

(b) For purposes of this section, enrollment shall be deemed complete when the applicant's coverage is effectuated, which shall occur when the QHP issuer receives the applicant's initial premium payment in full and by the due date.

(c) The Exchange shall accept a QHP selection from an applicant who is determined eligible for enrollment in a QHP in accordance with Section 6472, and shall:

(1) Notify the applicant of her or his initial premium payment methodology options, if applicable, and of the requirement that the applicant's initial premium payment shall be received in full and by the due date by the QHP issuer in order for the applicant's coverage to be effectuated, as specified in paragraph (b) of this section;

(2) Notify the QHP issuer that the individual is a qualified individual and of the applicant's selected QHP and premium payment methodology option, if applicable;

(3) Transmit to the QHP issuer information necessary to enable the issuer to enroll the applicant promptly and without undue delay [placeholder for data transmittal timeline]; and

(4) Transmit eligibility and enrollment information to HHS promptly and without undue delay [placeholder for data transmittal timeline].

(d) The Exchange shall maintain records of all enrollments in QHPs through the Exchange.

(e) The Exchange shall reconcile enrollment information with QHP issuers and HHS no less than once a month.

(f) A QHP issuer shall accept enrollment information specified in paragraph (c) of this section consistent with the privacy and security requirements established by the Exchange in accordance with 45 CFR § 155.260 and in an electronic format that is consistent with 45 CFR § 155.270, and shall:

(1) Acknowledge receipt of enrollment information transmitted from the Exchange in accordance with the standards established by the Exchange;

(2) Enroll a qualified individual during the periods specified in paragraph (a) of this section;

(3) Abide by the effective dates of coverage established by the Exchange in accordance with Section 6502(c) and (f) and Section 6504(g) and (h);

(4) Notify the Exchange of the issuer's timely receipt of a qualified individual's initial premium payment and his or her effective date of coverage;

(5) Notify a qualified individual of his or her effective date of coverage upon the timely receipt of the individual's initial premium payment; and

(6) Provide new enrollees an enrollment information package that is compliant with accessibility and readability standards specified in Section 6452 of Article 4 of this chapter.

(g) If an applicant initiates enrollment directly with a QHP issuer for enrollment through the Exchange, the QHP issuer shall either:

(1) Direct the individual to file an application with the Exchange, or

(2) Assist the applicant, upon the applicant's request, to apply for and receive an eligibility determination for coverage through the Exchange through the Exchange Internet Web site.

(h) A QHP issuer shall follow the premium payment process established by the Exchange.

(i) A QHP issuer shall reconcile enrollment and premium payment files with the Exchange no less than once a month.

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; 45 C.F.R. §§ 155.400, 156.260, and 156.265.

§ 6502. Initial and Annual Open Enrollment Periods.

(a) A qualified individual shall enroll in a QHP, or an enrollee shall change QHPs, only during the initial open enrollment period, as specified in paragraph (b) of this section, the annual open enrollment period, as specified in paragraph (d) of this section, or a special enrollment period, as described in Section 6504, for which the qualified individual has been determined eligible.

(b) The initial open enrollment period begins October 1, 2013 and extends through March 31, 2014.

(c) Regular coverage effective dates for initial open enrollment period for a QHP selection received by the Exchange from a qualified individual:

(1) On or before December 15, 2013, shall be January 1, 2014;

(2) Between the first and fifteenth day of any subsequent month during the initial open enrollment period, shall be the first day of the following month; and

(3) Between the sixteenth and last day of the month for any month between December 2013 and March 31, 2014, shall be the first day of the second following month.

(d) Annual open enrollment period for benefit years beginning on or after January 1, 2015, begins October 15 and extends through December 7 of the preceding calendar year.

(e) Beginning 2014, the Exchange shall provide a written annual open enrollment notification to each enrollee no earlier than September 1 and no later than September 30.

(f) For a qualified individual who has made a QHP selection during the annual open enrollment period, the coverage effective date shall be the first day of the following benefit year.

(g) The initial premium payment shall be made by a qualified individual and received by the QHP issuer by the end of the month prior to the coverage effective dates specified in paragraphs (c) and (f) of this section.

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; 45 C.F.R. § 155.410.

§ 6504. Special Enrollment Periods.

(a) A qualified individual may enroll in a QHP, or an enrollee may change QHP, during special enrollment periods only if one of the following triggering events occurs:

(1) A qualified individual or dependent loses MEC, as specified in paragraph (b) of this section;

(2) A qualified individual gains a dependent or becomes a dependent through marriage, birth, adoption, or placement for adoption;

(3) An individual who was not previously a citizen, national, or lawfully present individual gains such status;

(4) A qualified individual's enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Exchange or HHS, or its instrumentalities as evaluated and determined by the Exchange. In such cases, the Exchange shall take necessary actions to correct or eliminate the effects of such error, misrepresentation, or inaction;

(5) An enrollee adequately demonstrates to the Exchange that the QHP in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee;

(6) An enrollee is determined newly eligible or newly ineligible for APTC or has a change in eligibility for CSR;

(7) An individual whose existing coverage through an eligible employer-sponsored plan will no longer be affordable or provide minimum value, as described in section 36B(c)(2)(C) of IRC (26 U.S.C. § 36B(c)(2)(C)) and in 26 C.F.R. § 1.36B-2(c)(3)(v) and (vi), for his or her employer's upcoming plan year is determined newly eligible for APTC. Such individual may access this special enrollment period prior to the end of his or her coverage through such eligible employer-sponsored plan;

(8) A qualified individual or enrollee gains access to new QHPs as a result of a permanent move, which shall also apply to individuals who are released from incarceration; and

(9) A qualified individual who is an Indian, as defined in Section 6410 of Article 2 of this chapter, may enroll in a QHP or change from one QHP to another one time per month.

(b) Loss of MEC, as specified in paragraph (a)(1) of this section, includes:

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

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

i. Legal separation,
ii. Divorce,
iii. Cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan),
iv. Death of an employee,
v. Termination of employment,
vi. Reduction in the number of hours of employment, and
vii. Any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing;

(B) Loss of eligibility for coverage through Medicare, Medi-Cal, or other government-sponsored health care programs;

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

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

(E) A situation in which an individual incurs a claim that would meet or exceed a lifetime limit on all benefits; and

(F) A situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual.

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

(3) Exhaustion of COBRA continuation coverage, meaning that such coverage ceases:

(A) Due to the failure of the employer or other responsible entity to remit premiums on a timely basis;

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

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

(c) Loss of MEC, as specified in paragraph (a)(1) of this section, does not include termination or loss due to:

(1) Failure to pay premiums on a timely basis, including COBRA premiums prior to expiration of COBRA coverage; or

(2) Termination of coverage for cause, such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with a plan.

(d) A qualified individual or an enrollee shall provide adequate information and evidentiary documentation to the Exchange to demonstrate that the individual or the enrollee meets at least one of the triggering events specified in paragraph (a) of this section.

(e) The Exchange shall verify any information or documentation provided by an applicant or an enrollee under paragraph (d) of this section in accordance with the process specified in Sections 6478 through 6492 before such information shall be used to determine eligibility for a special enrollment period.

(f) A qualified individual or enrollee shall have 60 days from the date of one of the triggering events specified in paragraph (a) of this section to select a QHP.

(g) Except as specified in paragraph (h) of this section, regular coverage effective dates for special enrollment period for a QHP selection received by the Exchange from a qualified individual:

(1) Between the first and fifteenth day of any month, shall be the first day of the following month; and

(2) Between the sixteenth and last day of any month, shall be the first day of the second following month.

(h) Special coverage effective dates shall apply to the following situations.

(1) In the case of birth, adoption or placement for adoption:

(A) The coverage shall be effective on the date of birth, adoption, or placement for adoption; and

(B) APTC and CSR, if applicable, are not effective until the first day of the following month, unless the birth, adoption, or placement for adoption occurs on the first day of the month; and

(2) In the case of marriage, or in the case where a qualified individual loses MEC, as described in paragraph (a)(1) of this section, the coverage shall be effective on the first day of the following month.

(i) The initial premium payment shall be made by a qualified individual and received by the QHP issuer by the end of the month prior to the coverage effective dates specified in paragraphs (f), (g) and (h) of this section.

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; 45 C.F.R. § 155.420.

§ 6506. Termination of Coverage in a QHP.

(a) An enrollee may terminate his or her coverage in a QHP, including as a result of the enrollee obtaining other MEC, with appropriate notice to the Exchange.

(b) The Exchange may initiate termination of an enrollee's coverage in a QHP, and shall permit a QHP issuer to terminate such coverage, provided that the issuer makes reasonable accommodations for all individuals with disabilities (as defined by the Americans with Disabilities Act) before terminating coverage for such individuals, under the following circumstances:

(1) The enrollee is no longer eligible for coverage in a QHP through the Exchange;

(2) The enrollee fails to pay premiums for coverage, as specified in paragraph (c) of this section, and:

(A) The three-month grace period required for individuals receiving APTC has been exhausted, as described in paragraph (c)(2) and (3) of this section; or

(B) Any other grace period not described in paragraph (b)(2)(A) of this section has been exhausted;

(3) The enrollee's coverage is rescinded by the QHP issuer because the enrollee has made a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan;

(4) The QHP terminates or is decertified as described in 45 CFR § 155.1080; or

(5) The enrollee changes from one QHP to another during an annual open enrollment period or special enrollment period in accordance with Sections 6502 and 6504.

(c) In the case of termination of enrollee's coverage due to non-payment of premium, as specified in paragraph (b)(2) of this section, a QHP issuer shall:

(1) Provide the enrollee, who is delinquent on premium payment, with notice of such payment delinquency;

(2) Provide a grace period of three consecutive months if an enrollee receiving APTC has previously paid at least one full month's premium during the benefit year;

(3) During the grace period specified in paragraph (c)(2):

(A) Pay all appropriate claims for services rendered to the enrollee during the first month of the grace period and may pend claims for services rendered to the enrollee in the second and third months of the grace period;

(B) Notify the Exchange and HHS of such non-payment;

(C) Notify providers of the possibility for denied claims when an enrollee is in the second and third months of the grace period; and

(D) Continue to collect APTC on behalf of the enrollee from the IRS; and

(4) If an enrollee receiving APTC exhausts the three-month grace period specified in paragraph (c)(2) of this section without paying all outstanding premiums:

(A) Terminate the enrollee's coverage on the effective date described in paragraph (d)(4) of this section, provided that the QHP issuer meets the notice requirements specified in paragraph (e)(1) and (2) of this section; and

(B) Return APTC paid on behalf of such enrollee for the second and third months of the grace period.

(d) If an enrollee's coverage in a QHP is terminated for any reason, the following effective dates for termination of coverage shall apply.

(1) For purposes of this paragraph, reasonable notice is defined as 14 days from the requested effective date of termination.

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

(A) The termination date specified by the enrollee, if the enrollee provides reasonable notice;

(B) Fourteen days after the termination is requested by the enrollee, if the enrollee does not provide reasonable notice; or

(C) On a date determined by the enrollee's QHP issuer, if the enrollee's QHP issuer is able to effectuate termination in fewer than 14 days and the enrollee requests an earlier termination effective date; or,

(D) If the enrollee is newly eligible for Medi-Cal or CHIP, the day before such coverage begins.

(3) In the case of a termination in accordance with paragraph (b)(1) of this section, the last day of coverage shall be the last day of the month following the month in which the notice described in Section 6496(h)(2) is sent by the Exchange unless the individual requests an earlier termination effective date per paragraph (a) of this section.

(4) In the case of a termination in accordance with paragraph (b)(2)(A) of this section, the last day of coverage shall be the last day of the first month of the three-month grace period.

(5) In the case of a termination in accordance with paragraph (b)(2)(B) of this section, the last day of coverage shall be consistent with existing California laws regarding grace periods.

(6) In the case of a termination in accordance with paragraph (b)(5) of this section, the last day of coverage in an enrollee's prior QHP shall be the day before the effective date of coverage in his or her new QHP.

(e) If an enrollee's coverage in a QHP is terminated for any reason, the QHP issuer shall:

(1) Provide the enrollee with a notice of termination of coverage that includes the reason for termination and the Exchange-approved appeals language at least 30 days prior to the last day of coverage, consistent with the effective date established by the Exchange in accordance with paragraph (d) of this section;

(2) Notify the Exchange of the termination effective date and reason for termination; and

(3) Maintain records of termination of coverage in accordance with the Exchange standards.

(f) If an enrollee's coverage in a QHP is terminated for any reason, the Exchange shall:

(1) Send termination information to the QHP issuer and HHS promptly and without undue delay [placeholder for specified timeline]; and

(2) Retain records of termination of coverage in order to facilitate audit functions.

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; 45 C.F.R. §§ 155.430 and 156.270.

§ 6508. Appeals of Eligibility Determinations for the Exchange Participation.

"Reserved."

NOTE: A separate Article will be designated for appeals of eligibility determinations through the Exchange.