

**State of California
Office of Administrative Law**

In re:
California Health Benefit Exchange

Regulatory Action:

Title 10, California Code of Regulations

Adopt sections: 6520, 6522, 6524, 6526,
6528, 6530, 6532, 6534,
6538

Amend sections:

Repeal sections:

**NOTICE OF APPROVAL OF EMERGENCY
REGULATORY ACTION**

**Government Code Sections 100504, 11346.1,
and 11349.6**

OAL Matter Number: 2018-0410-03

OAL Matter Type: Emergency Readopt (EE)

The California Health Benefit Exchange (Exchange) submitted this emergency readoption action to amend regulations governing the application, eligibility, and enrollment in the Exchange's Small Business Health Options Program (SHOP). Amendments to the SHOP regulations reflect changes in state and federal law, modify requirements to reflect best practices in the program, and clean up language for improved clarity and understanding.

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

This emergency regulatory action is effective on 4/20/2018 and will expire on 10/2/2018. The Certificate of Compliance for this action is due no later than 10/1/2018.

Date: April 20, 2018



**Richard L. Smith
Senior Attorney**

For: Debra M. Cornez
Director

Original: Peter Lee, Executive Director
Copy: Faviola Ramirez-Adams

NOTICE PUBLICATION/REGULATIONS SUBMISSION

(See instructions on reverse)

For use by Secretary of State only

STD. 400 (REV. 01-2013)

OAL FILE NUMBERS	NOTICE FILE NUMBER	REGULATORY ACTION NUMBER	EMERGENCY NUMBER
	Z-		2018-0410-03EE

For use by Office of Administrative Law (OAL) only

ENDORSED - FILED
In the office of the Secretary of State
of the State of California

APR 20 2018

1:37pm

2018 APR 10 P 4:31

OFFICE OF
ADMINISTRATIVE LAW

NOTICE

REGULATIONS

AGENCY WITH RULEMAKING AUTHORITY
California Health Benefit Exchange

AGENCY FILE NUMBER (if any)

A. PUBLICATION OF NOTICE (Complete for publication in Notice Register)

1. SUBJECT OF NOTICE		TITLE(S)	FIRST SECTION AFFECTED	2. REQUESTED PUBLICATION DATE
3. NOTICE TYPE ☐ Notice re Proposed Regulatory Action ☐ Other		4. AGENCY CONTACT PERSON	TELEPHONE NUMBER	FAX NUMBER (Optional)
OAL USE ONLY	ACTION ON PROPOSED NOTICE ☐ Approved as Submitted ☐ Approved as Modified ☐ Disapproved/Withdrawn		NOTICE REGISTER NUMBER	PUBLICATION DATE

B. SUBMISSION OF REGULATIONS (Complete when submitting regulations)

1a. SUBJECT OF REGULATION(S) Application, Eligibility, and Enrollment in the Shop Exchange	1b. ALL PREVIOUS RELATED OAL REGULATORY ACTION NUMBER(S) See attached
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2. SPECIFY CALIFORNIA CODE OF REGULATIONS TITLE(S) AND SECTION(S) (Including title 26, if toxics related)

SECTION(S) AFFECTED (List all section number(s) individually. Attach additional sheet if needed.)	ADOPT	6520, 6522, 6524, 6526, 6528, 6530, 6532, 6534, 6536 , 6538
	AMEND	per agency request
	REPEAL	
TITLE(S) 10		

3. TYPE OF FILING

☐ Regular Rulemaking (Gov. Code §11346)	☐ Certificate of Compliance: The agency officer named below certifies that this agency complied with the provisions of Gov. Code §511346.2-11347.3 either before the emergency regulation was adopted or within the time period required by statute.	☒ Emergency Readopt (Gov. Code, §11346.1(h))	☐ Changes Without Regulatory Effect (Cal. Code Regs., title 1, §100)
☐ Resubmittal of disapproved or withdrawn nonemergency filing (Gov. Code §511349.3, 11349.4)		☐ File & Print	☐ Print Only
☐ Emergency (Gov. Code, §11346.1(b))	☐ Resubmittal of disapproved or withdrawn emergency filing (Gov. Code, §11346.1)	☐ Other (Specify) _____	

4. ALL BEGINNING AND ENDING DATES OF AVAILABILITY OF MODIFIED REGULATIONS AND/OR MATERIAL ADDED TO THE RULEMAKING FILE (Cal. Code Regs. title 1, §44 and Gov. Code §11347.1)

5. EFFECTIVE DATE OF CHANGES (Gov. Code, §§ 11343.4, 11346.1(d); Cal. Code Regs., title 1, §100)

☐ Effective January 1, April 1, July 1, or October 1 (Gov. Code §11343.4(a))	☒ Effective on filing with Secretary of State	☐ \$100 Changes Without Regulatory Effect	☐ Effective other (Specify) _____
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6. CHECK IF THESE REGULATIONS REQUIRE NOTICE TO, OR REVIEW, CONSULTATION, APPROVAL OR CONCURRENCE BY, ANOTHER AGENCY OR ENTITY

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

7. CONTACT PERSON

Faviola Ramirez-Adams	TELEPHONE NUMBER 916-228-8668	FAX NUMBER (Optional)	E-MAIL ADDRESS (Optional) faviola.ramirezadams@covered.ca.gov
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8. I certify that the attached copy of the regulation(s) is a true and correct copy of the regulation(s) identified on this form, that the information specified on this form is true and correct, and that I am the head of the agency taking this action, or a designee of the head of the agency, and am authorized to make this certification.

SIGNATURE OF AGENCY HEAD OR DESIGNEE

DATE

3/15/18

TYPED NAME AND TITLE OF SIGNATORY

Peter V. Lee, Executive Director

For use by Office of Administrative Law (OAL) only

ENDORSED APPROVED

APR 20 2018

Office of Administrative Law

ALL PREVIOUS RELATED OAL REGULATORY ACTION NUMBER(S):

2013-0920-05E, 2014-0321-01EE, 2014-0620-06EE, 2014-0922-02EE, 2016-0926-04EE, 2016-1116-03EE, 2017-0407-02EE

§ 6520. Employer and Employee Application Requirements.

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

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

(2) The number of ~~qualified~~eligible employees ~~enrolling~~being offered enrollment in SHOP and the total number of ~~full-time and~~ full-time equivalent (FTE) employees employed by the qualified employer, as calculated in accordance with Health and Safety Code Section 1357.500(k)(3) and Insurance Code Section ~~10965.3(q)(3)~~10753(q)(3);

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

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

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

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

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

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

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

(810) Whether the qualified employer used an insurance agent and if so, the agent's name, general agency name (if applicable), CA insurance license number, the agency Federal Employer Identification Number if applicable, and whether the agent is an insurance agent certified by Covered California. If the qualified employer uses an insurance agent, the qualified employer must have that agent certify that he or she understands he or she may be subject to a civil penalty for providing false information under Health and Safety Code Section 1389.8 and Insurance Code Section 10119.3.

(911) Information about the qualified employer's qualified employees, in the employee application in subdivision (d);

~~(1012)~~ The employer's offer of health insurance coverage, which includes:

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

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

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

(D) If applicable, the employer's contribution rate to each of its qualified employee's employer-sponsored Group Dental Plan premiums pursuant to Section 6522(h).

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

(13) New qualified employer application submissions are due five days prior to the requested effective date. Completed submissions received after this date will carry an effective date no earlier than the first of the following month unless the qualified employer submits a signed CCSB New Business Late Submission Acknowledgement Form (Rev. 3/18), hereby incorporated by reference. Exceptions for exceptional circumstances will be considered on a case-by-case basis.

(b) To participate in the SHOP, an employer must attest to the following:

(1) That the business has 100 or fewer full-time or FTE employees and has a principal business address in California;

(2) That all qualified full-time employees of this business will be offered SHOP coverage;

(3) That the business has at least one employee who is not the owner or business partner, or the spouse of the owner or business partner;

(4) That the employer is signing the application under penalty of perjury, which means all information contained in the qualified employer application is true and correct to the best of the qualified employer's knowledge;

(5) That the employer knows that he or she may be subject to penalties under federal law if he or she intentionally provides false or untrue information pursuant to 45 CFR Section 155.285 (September 6, 2016), hereby incorporated by reference;

(6) That the employer knows that the information will only be used to determine eligibility and facilitate enrollment for health coverage and will otherwise be kept private as required by federal and state law;

(7) That any waiting period established by the qualified employer complies with 42 U.S.C. Section 300gg-7, 45 CFR Section 155.725 (December 22, 2016), hereby incorporated by reference, and applicable state law, including Section 10198.7 of the California Insurance Code and Section 1357.51 of the California Health and Safety Code, and all qualified employees have complied with the qualified employer's waiting period;

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

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

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

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

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

(13) That the qualified employer understands that once coverage in a QHP is approved by the SHOP, changes to the coverage cannot be implemented until the qualified employer's annual election of coverage period pursuant to Section 6526, except to the extent the qualified employer exercises the right to change coverage with the same issuer within the first 30 days of the effective date of coverage pursuant to Section 6528(f), Health and Safety Code 1357.504(d), and Insurance Code Section 10753.06.5(d);

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

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

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

(17) That the qualified employer understands that the attestations in this section are subject to audit by the SHOP at any time; and

(18) That the qualified employer agrees to maintain compliance with the attestations in this section in order to continue eligibility for coverage through the SHOP.

(c) A qualified employer must provide the SHOP with its most recent Quarterly Contribution Return and Report of Wages (Form DE-9C), as filed with the California Employment Development Division, on which the qualified employer must identify on the face of the form whether each employee listed on the DE-9C is a full-time employee, part-time eligible employee, ineligible employee and whether the employee is

still employed by the qualified employer. If there is not sufficient space on the face of the Form DE-9C for the qualified employer to add the required information, the qualified employer may attach additional sheets of paper to the Form DE-9C as necessary. A qualified employer must provide the SHOP with additional or other documents in the following circumstances:

- (1) For a qualified employer who is a sole proprietor in business less than three (3) months, a California business license or Fictitious Business Name Filing and a DE-9C or payroll records for 30 days;
- (2) For a qualified employer who is a sole proprietor who is in business three (3) months or more, a DE-9C. If the owner is not listed as earning wages on the DE-9C and wishes to enroll for coverage, a current IRS Form 1040 Schedule C Profit or Loss From Business (Sole Proprietorship) or, if a Form 1040 Schedule C is not available, a California business license or Fictitious Business Name filing may be substituted;
- (3) For a qualified employer who is a corporation in business less than three (3) months, Articles of Incorporation, filed and stamped by the Secretary of State, and a Statement of Information or corporate meeting minutes listing all officers' names and a DE-9C or payroll records for 30 days;
- (4) For a qualified employer who is a corporation in business three (3) months or more, a DE-9C, and, if officers who are not listed on DE-9C enroll for coverage, a Statement of Information;
- (5) For a qualified employer who is a partnership in business less than three (3) months, a Partnership Agreement, a Federal Tax Identification appointment letter, and a DE-9C or payroll records for 30 days;
- (6) For a qualified employer who is a partnership in business three (3) months or more, a DE-9C and a current IRS Form 1065 Schedule K-1, if the partners are not listed on DE-9C and want to enroll for coverage. If an IRS Form 1065 Schedule K-1 is not yet available, the Partnership Agreement and the Federal Tax Identification appointment letter can be substituted;
- (7) For a qualified employer who is a limited partnership in business less than three (3) months, a Partnership Agreement, a Federal Tax Identification appointment letter, and a DE-9C or payroll records for 30 days;
- (8) For a qualified employer who is a limited partnership in business three (3) months or more, a DE-9C. If ~~General Partners~~ general partners are not listed on DE-9C and wish to enroll in coverage, then a current IRS Form 1065 Schedule K-1. If an IRS Form 1065 Schedule K-1 is not available, the Partnership Agreement and a Federal Tax Identification appointment letter can be substituted. Limited partners are not eligible for coverage unless they appear on a DE-9C;
- (9) For a qualified employer who is a limited liability partnership in business less than three (3) months, a Partnership Agreement or a Federal Tax Identification appointment letter, and a DE-9C or payroll records for 30 days;
- (10) For a qualified employer who is a limited liability partnership in business three (3) months or more, a DE-9C. If partners are not listed on the DE-9C and wish to enroll in coverage, then a current IRS Form 1065 Schedule K-1. If the IRS Form 1065 Schedule K-1 is not yet available, the Partnership Agreement and the Federal Tax Identification appointment letter can be substituted;

(11) For a qualified employer who is a limited liability company in business less than three (3) months, Articles of Organization with the Operating Agreement or the Statement of Information and a DE-9C or payroll records for 30 days; ~~and~~

(12) For a qualified employer who is a limited liability company in business three (3) months or more, a DE-9C. If managing members are not listed as earning wages on the DE-9C and wish to enroll for coverage, a current IRS Form 1065 Schedule K-1 for a partnership or IRS Form 1040 Schedule C for a sole proprietorship. If an IRS Form 1065 Schedule K-1 is not yet available, a Statement of Information or Articles of Organization with the Operating Agreement may be substituted; and

(13) For a qualified employer who was previously insured outside of the SHOP, the SHOP may waive or alter any additional documentation submission requirements in Section 6520(c)(1) - (12), if as determined by the SHOP on a case-by-case basis, the proof of coverage is sufficient to satisfy these requirements.

(d) To participate in the SHOP, a qualified employee must submit the following information to the SHOP:

(1) The employer's business name, ~~principal business address~~, and business phone number;

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

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

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

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

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

~~(B) The start date of any prior Cal-COBRA or COBRA continuation coverage; and~~

~~(C) The remaining months of eligibility for continuation coverage.~~

(4) If the qualified employer is offering coverage for dependents and the employee elects to offer his or her dependents coverage, the marital or domestic partnership status of the qualified employee;

(5) If the qualified employer is offering coverage for spouses, registered domestic partners, or non-registered domestic partners, and/or dependent children, and the employee elects to offer his or her dependents coverage, then information about the qualified employee's spouse, registered domestic partner, or non-registered partner, and/or dependent children, which includes:

(A) The first and last name of each spouse, registered domestic partner, or non-registered domestic partner, and/or each dependent child, their relationship to the qualified employee, SSN or taxpayer identification number, date of birth, age, gender, home address, and mailing address (if different from home address); and

(B) Whether the qualified employee would like to enroll a dependent who is a disabled child pursuant to Section 599.500 of Title 2 of the California Code of Regulations; ~~and~~

(6) The name of the QHP and dental plan, if applicable, selected by the qualified employee and dependents.

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

(1) Agree to mandatory arbitration if the QHP selected by the employee requires arbitration, which would require the employee and his or her dependents to arbitrate all claims relating to his or her QHP;

(2) Disclose whether the employee used an insurance agent and, if so, the agent's name, general agency name (if applicable), and whether the agent is an insurance agent certified by Covered California. If the employee uses an insurance agent, the employee must have that agent certify that he or she understands he or she may be subject to a civil penalty for providing false information under Health and Safety Code Section 1389.8 and Insurance Code Section 10119.3.

(3) Sign the application under penalty of perjury, that all information contained in the employee application is true and correct to the best of the employee's knowledge.

(4) Acknowledge that the employee understands that he or she may be subject to penalties under federal law if he or she intentionally provides false or untrue information pursuant to 45 CFR Section 155.285.

(f) If a qualified employee declines coverage, the employee must sign the declination of coverage, which is part of the application, and state other sources of coverage, if any.

(g) The SHOP must keep all information received pursuant to this section private in accordance with applicable federal and state privacy and security laws pursuant to 45 CFR Section 155.260 (September 6, 2016), hereby incorporated by reference, and the Information Practices Act of 1977 (Cal. Civ. Code, commencing with Section 1798). The SHOP may not provide to the qualified employer any information collected on the employee application with respect to the qualified employees or dependents of qualified employees, other than the name, address, birth date, and plan selection of the spouse or dependent. The SHOP may only share information from an employee application with the QHP or employer that is strictly necessary for the purposes of eligibility and enrollment. Information obtained by the SHOP pursuant to this section may not be used for purposes other than eligibility determinations and enrollment in health coverage through the SHOP.

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

§ 6522. Eligibility Requirements for Enrollment in the SHOP.

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

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

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

(3) Either -

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

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

(4) Meets the following minimum participation rules:

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

~~(1) However, if the qualified employer pays 100 percent of the qualified employees' QHP premiums or the qualified employer only employs one to three eligible employees, then all eligible employees not~~ waiving coverage per Section 6522(4)(B) of the qualified employer must enroll in health insurance coverage through the SHOP.

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

(5) Meets the following group contribution rule:

(A) A qualified employer must contribute to each of its qualified employees' QHP premiums, a minimum of 50 percent of the lowest cost premium for employee-only coverage in the level of coverage selected by the qualified employer pursuant to Section 6520(a)(10)(C), or a lesser minimum percent that may be determined by prevailing market practice through a SHOP survey of market practices. The contribution rate will be published on the CCSB website.

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

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

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

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

~~(e) The~~ A qualified employee is eligible to enroll his or her dependent spouse or non-registered, registered domestic partner, non-registered domestic partners, and/or dependent children of the

qualified employees, if offered health insurance coverage, whose dependent eligibility has been verified by the SHOP, if the offer from the qualified employer, are eligible to select a QHP through the SHOP, includes an offer of dependent coverage.

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

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

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

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

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

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

Note: Authority: Section 100504, Government Code. Reference: Sections 100502 and 10503, Government Code; and 45 CFR Sections 147.104, 155.705, 155.710, 155.715 and 155.720.

§ 6524. Verification Process for Enrollment in the SHOP.

~~(a)~~ Verification of Eligibility

~~(1a)~~ The SHOP shall verify or obtain information as provided in this section to determine whether an employer, employee or dependent meets the eligibility requirements specified in Section 6522 prior to allowing an employer to offer health insurance coverage to its employees or a qualified employee to select a QHP through the SHOP.

~~(2b)~~ For purposes of verifying employee eligibility, the SHOP must:

~~(A1)~~ Verify that the employee has been identified by the qualified employer as an employee being offered health insurance coverage by the qualified employer;

~~(B2)~~ Accept the information attested to by the employee under Section 6520 unless the information is inconsistent with the qualified employer-provided information; and

~~(C3)~~ Collect only the minimum information necessary for verification of eligibility and enrollment in accordance with the eligibility requirements in Section 6522.

~~(b)~~ Inconsistencies

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

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

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

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

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

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

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

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

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

(D) If, after the 30-day period described in subdivision (b)(2)(C) of this section, the SHOP has not received satisfactory documentary evidence to support the employee's application or resolve the inconsistency, the SHOP must provide written notice to the employee of its denial of eligibility in accordance with subdivision (~~de~~) of this section.

(~~ed~~) Notification of Employer Eligibility

~~(1)~~ The SHOP must provide written notice to an employer applying to participate in the SHOP whether the employer is eligible in accordance with Section 6522 and the employer's right to appeal such determination pursuant to Section 6542(c).

(~~de~~) Notification of Employee Eligibility

~~(1)~~ The SHOP must provide written notice to an employee seeking to enroll in a QHP offered through the SHOP of the determination by the SHOP whether the employee is eligible in accordance with Section 6522(d) and the employee's right to appeal such eligibility determination pursuant to Section 6542(c).

Note: Authority: Section 100504, Government Code. Reference: Sections 100502 and 10503, Government Code; and 45 CFR Sections 155.715 and 155.720.

§ 6526. Qualified Employer Election of Coverage Periods.

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

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

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

(d) A qualified employer may only change its offer of health insurance coverage, including making changes to the reference plan, to its qualified employees, as described in Section 6520(a)(10), during the qualified employer's annual election period. The qualified employer's annual election period is at least ~~1020~~ days, beginning on the day the SHOP sends written notice of the annual employer election period, which the SHOP must send at least ~~3060~~ days prior to the completion of the employer's plan year.

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

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

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

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

Note: Authority: Section 100504, Government Code. Reference: Sections 100502 and 10503, Government Code; and 45 CFR Sections 147.104, 155.705, 155.720, 155.725 and 156.285.

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

(a) A qualified employee may enroll in a QHP or change his or her QHP only during the initial employee open enrollment period and annual employee open enrollment period described in this section or during a special enrollment period as described in Section 6530.

(b) Subject to subdivision (e) of this section, a qualified employee's initial employee open enrollment period begins the day his or her employer submits all of the information required in Section 6520 and the SHOP has determined that the employer is a qualified employer.

(c) Subject to subdivision (e) of this section, the annual employee open enrollment period begins the day after his or her qualified employer's annual election period has ended.

(d) The initial and annual employee open enrollment period is at least 20 days.

(e) Beginning January 1, 2014, the SHOP shall provide to qualified employers, a written annual employee open enrollment period notification for each qualified employee 60 days prior to the ~~employee's annual open enrollment~~ end of the qualified employer's plan year and after that employer's annual election period.

(f) Qualified employers may allow qualified employees to make a change to their selected QHP after the effective date of coverage during the first thirty (30) days of the new plan year, provided that the newly selected QHP is offered by the same issuer.

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

(~~g~~g) If a qualified employee does not enroll in a different QHP during his or her annual employee open enrollment period, ~~that~~ the qualified employee will remain in the QHP selected in the previous year unless:

- (1) The qualified employee terminates his or her coverage from the QHP in accordance with Section 6538(b), or
- (2) The QHP is no longer available to the qualified employee.

(~~g~~h) Notwithstanding subdivision (~~g~~f)(2), if the qualified employee's current QHP is not available, the qualified employee shall be enrolled in a QHP offered by the same QHP issuer at the same metal tier that is the most similar to the qualified employee's current QHP, as determined by the SHOP on a case-by-case basis.

(i) If the issuer of the QHP in which the qualified employee is currently enrolled is no longer available, or if another QHP is not available from the current QHP issuer in the same metal tier, the qualified employee may be enrolled in the lowest cost QHP offered by a different QHP issuer in the same metal tier as the qualified employee's current QHP, as determined by the SHOP on a case-by-case basis.

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

(ik) Waiting periods in the SHOP are calculated beginning on the date the employee becomes a qualified employee who is otherwise eligible for coverage, regardless of when a qualified employer notifies the SHOP about a newly qualified employee.

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

Note: Authority: Section 100504, Government Code. Reference: Sections 100502 and 10503, Government Code; and 45 CFR Sections 147.104, 155.720, 155.725 and 156.285.

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

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

(b) A qualified employee, or his or her dependent, may enroll in a QHP or change QHPs during special enrollment periods outside of the initial and annual open enrollment periods in the following situations:

(1) A qualified employee, or his or her dependent, either:

(A) Loses Minimum Essential Coverage (MEC), as specified in subdivision (de) of this section. The date of the loss of MEC shall be:

1. The date of the last day the qualified employee, or his or her dependent, would have coverage under his or her previous plan or coverage; or

2. If a loss of MEC occurs due to a QHP decertification, the date of the notice of decertification as described in 45 CFR Section 155.1080(e)(2);

(B) Loses pregnancy-related coverage described under Section 1902(a)(10)(A)(i)(IV) and (a)(10)(A)(ii)(IX) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(i)(IV), (a)(10)(A)(ii)(IX)) and Section 14005.18 of the Welfare and Institutions Code. The date of the loss of coverage is the last day the consumer would have pregnancy-related coverage; or

(C) Loses Medi-Cal coverage for the medically needy, as described under section 1902(a)(10)(C) of the Social Security Act and Section 14005.21 of the Welfare and Institutions Code, only once per calendar year. The date of the loss of coverage is the last day the consumer would have medically needy coverage;

(2) A qualified employee gains a dependent or becomes a dependent through marriage or entry into domestic partnership, birth, adoption, placement for adoption, placement in foster care, assumption of a parent-child relationship, or through a child support order or other court order;

(3) The enrollee loses a dependent or is no longer considered a dependent through divorce or legal separation as defined by State law in the State in which the divorce or legal separation occurs, or if the enrollee, or his or her dependent, dies.

(4) The qualified employee's, or his or her dependent's, enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, misconduct, or inaction of an officer, employee, or agent of the Exchange or HHS, its instrumentalities, or a non-

Exchange entity providing enrollment assistance or conducting enrollment activities, as evaluated and determined by the Exchange. In such cases, the Exchange shall take necessary actions to correct or eliminate the effects of such error, misrepresentation, inaction, or misconduct. For purposes of this provision, misconduct, as determined by the Exchange, includes the failure to comply with applicable standards under this title, or other applicable federal or state laws;

(5) ~~An enrollee, or his or her dependent,~~ adequately demonstrates to the Exchange, with respect to QHPs offered through the Exchange, or to the applicable regulator, with respect to health plans offered outside the Exchange, as determined by the Exchange on a case-by-case basis, that the health plan QHP in which he or she is enrolled, substantially violated a material provision of its contract in relation to the enrollee or his or her dependents;

(6) An enrollee, qualified employee, or enrollee, or his or her dependent, gains access to new QHPs as a result of a permanent move and either-

(A) Had MEC as described in 26 CFR Section 1.5000A-1(b) (December 26, 2013), hereby incorporated by reference, for one or more days during the 60 days preceding the permanent move; or

(B) Was living outside of the United States or in a United States territory at the time of the permanent move; ~~or~~

~~(67)~~ The qualified employee, or his or her dependent, was released from incarceration;

~~(8)~~ The qualified employee or his or her dependent, ~~or~~ is a member of the reserve forces of the United States military returning from active duty or a member of the California National Guard returning from active duty service under Title 32 of the United States Code;

~~(79)~~ A qualified employee who is an Indian, as defined by Section 4 of the Indian Health Care Improvement Act (25 U.S.C. Section 1603(c)), and his or her dependent who is enrolled or is enrolling in a QHP through an Exchange on the same application as the qualified employee, may enroll in a QHP or change from one QHP to another one time per month;

~~(810)~~ A qualified employee, or ~~her~~ his or her dependent, demonstrates to the Exchange, in accordance with guidelines issued by HHS and as determined by the Exchange on a case-by-case basis, that the individual meets other exceptional circumstances. Such circumstances may include, but are not limited to, the following ~~circumstances~~:

(A) If a child who has been determined ineligible for Medi-Cal and CHIP, and for whom a party other than the party who expects to claim him or her as a tax dependent is required by court order to provide health insurance coverage for the child, the child shall be eligible for a special enrollment period if otherwise eligible for enrollment in a QHP;

~~(B) A qualified employee or dependent was receiving services from a contracting provider under another health benefit plan, as defined in Section 1399.845(f) of the Health and Safety Code or Section 10965(f) of the Insurance Code, for one of the conditions described in Section 1373.96(c) of the Health and Safety Code and that provider is no longer participating in the health benefit plan;~~

(11C) A qualified employee or his or her dependent demonstrates to the Exchange, with respect to health benefit plans offered through the Exchange, or to the applicable regulator, with respect to health benefit plans offered outside the Exchange, that he or she did not enroll in a health benefit plan during the immediately preceding enrollment period available to the employee or dependent because he or she was misinformed that he or she was covered under MEC;

(12) A qualified employee, or his or her dependent, is receiving services from a contracting provider under a health benefit plan, as defined in Section 1399.845(f) of the Health and Safety Code or Section 10965(f) of the Insurance Code, for one of the conditions described in Section 1373.96(c) of the Health and Safety Code or section 10133.56(a) of the Insurance Code, and that provider is no longer participating in the health benefit plan.

(913) A qualified employee, or his or her dependent, loses eligibility for coverage under a Medi-Cal plan under title XIX of the Social Security Act or a state child health plan under title XXI of the Social Security Act;

(1014) A qualified employee, or his or her dependent, becomes eligible for assistance, with respect to health insurance coverage under a SHOP, under a Medi-Cal plan (including any waiver or demonstration project conducted under or in relation to such a plan).

(15) A qualified employee, or his or her dependent, is a victim of domestic abuse or spousal abandonment, as specified in 26 CFR Section 1.36B-2 (b)(2)(ii) through (v) (July 26, 2017), hereby incorporated by reference, is enrolled in MEC, and seeks to enroll in coverage separate from the perpetrator of the abuse or abandonment. A dependent of a victim of domestic abuse or spousal abandonment who is on the same application as the victim may enroll in coverage at the same time as the victim.

(16) A qualified employee or dependent —

(A) Applies for coverage on the Exchange during the annual open enrollment period or due to a qualifying event, is assessed by the Exchange as potentially eligible for Medi-Cal or the Children's Health Insurance Program (CHIP), and is determined ineligible for Medi-Cal or CHIP by the State Medi-Cal or CHIP agency either after open enrollment has ended or more than 60 days after the qualifying event; or

(B) Applies for coverage at the State Medi-Cal or CHIP agency during the annual open enrollment period, and is determined ineligible for Medi-Cal or CHIP after open enrollment has ended.

(17) The qualified employee, or his or her dependent, adequately demonstrates to the Exchange that a material error related to plan benefits, service area, or premium influenced the qualified employee's or dependent's decision to purchase a QHP through the Exchange.

(c) A qualified employee, or his or her dependent, who experiences one of the situations described in subdivision (ab) of this section has:

(1) 30 days from the date of the event described in paragraphs (b)(1)-(812) and (b)(15)-(17) of that subdivision in this section to select a QHP through the SHOP.

(2) 30 days from the date of the event described in paragraphs (b)(11) or (g)(1) of this section to select coverage for the qualified employee or his or her eligible dependents in a QDP through the SHOP.

(23) 60 days from the date of the event described in paragraphs (b)(913) and (b)(1014) of that subdivision in this section to select a QHP through the SHOP.

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

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

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

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

1. Legal separation;

2. Divorce;

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

4. Death of an employee;

5. Termination of employment;

6. Reduction in the number of hours of employment; and

7. Any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing;

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

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

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

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

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

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

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

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

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

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

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

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

(B) Subject to Section 10384.17 of the Insurance Code and Section 1365 of the Health and Safety Code, Termination of coverage due to a carrier demonstrating fraud or an intentional misrepresentation of material fact under the terms of the policy by the policyholder, contractholder, or employer for cause, such as the making of a fraudulent claim or an intentional misrepresentation of a material fact in connection with a plan.

(f) If requested by a QHP or SHOP, an employee or a dependent of an employee who experiences a triggering event that gives rise to a special enrollment period pursuant to this section must provide verification of the triggering event to SHOP for review.

(g) A qualified employee or his or her dependent may enroll in a QDP during a special enrollment period outside of the initial and annual open enrollment periods in the following situations:

(1) Loss of eligibility for dental insurance coverage. Loss of eligibility for dental insurance coverage shall be consistent with any of following situations specified in subdivisions (b)(11) or (e)(1)-(3) of this section. The date of the loss of dental coverage shall be the date of the last day the qualified employee, or his or her dependent, would have coverage under his or her previous plan or coverage.

(2) Loss of eligibility for dental insurance coverage does not include termination or loss of dental insurance coverage due to any of the situations specified in subdivisions (e)(4)(A)-(B).

(3) A qualified employee, or his or her dependent, loses eligibility for pediatric dental coverage subsequent to turning nineteen (19) years of age and wishes to continue dental coverage under a standalone dental plan offered by a QDP in the SHOP;

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

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

Note: Authority: Section 100504, Government Code. Reference: Sections 100502 and 10503, Government Code; 26 CFR Section 54.9801-2, 45 CFR Sections 147.104, 155.420, 155.725 and 156.285; Sections 1357.503 and 1399.849, Health and Safety Code; and Sections 10753.05 and, 10753.063.5, and 10965.3 Insurance Code.

§ 6532. Employer Payment of Premiums.

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

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

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

(b) Once coverage is effective, the SHOP will send invoices to qualified employers on the 15th of ~~the~~each month, or the following business day if the 15th falls on a weekend or holiday, for health insurance coverage for the following month. ~~Payment must be delivered to the SHOP or postmarked by the last day of the invoicing month.~~

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

(2) After the first invoice, the qualified employer must make a monthly premium payment of no less than 85 percent of the total balance due, including any amounts past due, by the due date on the invoice.

(c) If a qualified employer makes a payment for less than the full amount due, the payment will be allocated by the total percentage paid across all amounts due for health and dental benefits, if any.

(d) In any month after a qualified employer has paid its initial month's premium, if a qualified employer does not pay its premium pursuant to subdivision (b) of this section, the SHOP will, on the day following the due date of the invoice, mail a notice of delinquency to the qualified employer that shows the past due balance, informs the qualified employer of the any applicable grace period pursuant to Section 10273.4(a)(1) of the California Insurance Code and Section 1365(a)(1) of the California Health and Safety

Code, states the effective date of termination if payment is not received during the grace period, provides instructions for making the premium payment necessary in order to maintain coverage in force, and provides notice of the qualified employer's right to request review of the cancellation by the applicable regulator appeal.

(e) In any month after a qualified employer has paid its initial month's premium, if a qualified employer does not pay its premium pursuant to subdivision (b), the SHOP may apply a late penalty fee pursuant to the terms in the Covered California group supplement agreement with the employer.

(fe) If a qualified employer makes a premium payment via check that is returned unpaid for any reason the SHOP shall apply a \$25.00 insufficient funds fee.

(f) If a qualified employer has been terminated pursuant to Section 6538(a), then the group may request to be reinstated in the same coverage in which it was last enrolled within 30 days after the effective date of termination. Past due premiums, if any, must be paid before a group may be reinstated without a lapse in coverage.

(g) A qualified employer terminated due to non-payment of premium in Section 6538(c) may request to be reinstated in the same coverage in which it was last enrolled within 30 days after the effective date of termination. Past due premiums, if any, must be paid before a group may be reinstated without a lapse in coverage.

(h) A qualified employer may not reinstate coverage 31 or more days following the effective date of termination and may only reinstate once during the 12-month period beginning at the time of their original effective date or from their most recent renewal date, whichever is more recent. Exceptions will be considered on a case-by-case basis.

(i) Terminated groups seeking to reapply for coverage 31 or more days following the effective date of termination shall be considered a new group with an effective date consistent with the provisions of this Section and Section 6520 (a)(13).

(j) Collections for delinquent accounts payable will be performed as per State Accounting Manual (SAM) section 8776.6 (non-employee accounts receivable).

Note: Authority: Section 100504, Government Code. Reference: Sections 100502 and 10503, Government Code; and 45 CFR Sections 155.705, 155.720 and 156.285.

§ 6534. Coverage Effective Dates for Special Enrollment Periods.

(a) Except as specified in subdivision (b) of this section, coverage effective dates for special enrollment periods for a QHP or QDP selection received by the Exchange from a qualified employee:

(1) Shall be no later than the first day of the following month for applications received between the first and fifteenth day of any month, or

(2) Shall be no later than the first day of the second following month for applications received between the sixteenth and last day of any month.

(b) Special coverage effective dates shall apply to the following situations:

(1) In the case of birth, adoption, placement for adoption, ~~or placement in foster care, and assumption of a parent-child relationship,~~ coverage is effective for that enrollee on the date of birth, adoption, placement for adoption, ~~or placement in foster care, or assumption of a parent-child relationship,~~ or on the first day of the following month if requested by the enrollee;

(2) In the case of marriage, domestic partnership or where a qualified employee loses Minimum Essential Coverage, as described in Section 6530(b)(1), coverage is effective for that qualified employee or dependent on the first day of the month following the date the request for special enrollment is received ~~of the marriage, domestic partnership, or loss of MEC;~~ and

(3) In the case of a qualified employee or dependent eligible for a special enrollment period as described in Section 6530(b)(4) and 6530(b)(5), the coverage is effective on either

(A) The date of the event that triggered the special enrollment period under Section 6530(b)(4) or 6530(b)(5), or

(B) In accordance with subdivision (a) of this section, whichever is the least financially burdensome on the enrollee, as determined by the Exchange.

Note: Authority: Section 100504, Government Code. Reference: Sections 100502 and 10503, Government Code; and 45 CFR Sections 155.725 and 156.285.

§ 6538. Disenrollment and Termination.

(a) A qualified employer may terminate coverage during the plan year for all its qualified employees and their dependents covered by the employer group health plan at the end of each month, in accordance with at least a 30-day notice to the SHOP, as fully set forth in subdivision (e) of this section. If a qualified employer terminates coverage through the SHOP, the SHOP must:

(1) Ensure that each QHP terminates the coverage of the qualified employer's qualified employees and their dependents enrolled in the QHP through the SHOP; and

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

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

(c) The SHOP may initiate termination of a qualified employee's coverage in a QHP or a dependent's coverage in a QHP, and shall permit a QHP issuer to terminate such coverage provided that the QHP issuer makes reasonable accommodations for all individuals with disabilities (as defined by the Americans with Disabilities Act) and complies with any and all requirements for cancellations, rescissions, and nonrenewals pursuant to Health and Safety Code section 1365 and Insurance Code sections 10273.4 and 10273.7 and relevant state regulations before terminating coverage for such individuals, under the following circumstances:

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

- (2) The qualified employer fails to pay premiums for coverage, as specified in Section 6532, and anythe applicable grace period, as provided in 10 CCR § 2274.53 and 28 CCR § 1300.65, has been exhausted;
- (3) The qualified employee's or the qualified employee's dependent coverage is rescinded by the QHP issuer in compliance with Health and Safety Code Section 1389.21 or California Insurance Code Sections 10384.17 and 10273.7;
- (4) The QHP terminates or is decertified as described in 45 CFR Section 155.1080 (May 29, 2012), hereby incorporated by reference, except for those eligible for enrollment in a similar plan as determined by the SHOP, on a case-by-case basis, pursuant to Section 6528(g);
- (5) The qualified employee changes from one QHP to another QHP during an annual employee open enrollment period or special enrollment period in accordance with Sections 6528 and 6530;
- (6) Upon the death of the qualified employee or a dependent of a qualified employee;
- (7) The qualified employee chooses not to remain enrolled in the QHP at open enrollment. This election would only be effective for the new plan year and coverage in the current QHP would remain uninterrupted through the end of the current plan year;
- (8) The qualified employee is no longer an employee or a dependent; ~~and~~
- (9) The qualified employee is newly eligible for Medi-Cal or CHIP, but only if the qualified employee or dependent requests coverage to be terminated; and
- (10) The qualified employer is ineligible to participate in the SHOP because it has lost its eligibility pursuant to Section 6522.
- (d) If a QHP issuer terminates coverage pursuant to subdivision (c)(2) and ~~(34)~~ of this section, the QHP issuer must comply with Sections 10273.4, 10273.7, and 10384.17 of the California Insurance Code and Section 1365 of the California Health and Safety Code, and implementing relevant state regulations.

(e) Effective Dates of Termination

- (1) In the case of a termination in accordance with subdivision (a) of this section, the last day of coverage shall be:
 - (A) The end of the month in which the qualified employer provided notice of termination, if the qualified employer provides at least a 30-day notice to the SHOP; or notice to the SHOP on or before the fifteenth of the month, or on a case-by-case basis an earlier date upon agreement between the QHP and the SHOP; or
 - (B) If the qualified employer does not provide at least a 30-day notice to the SHOP on or before the fifteenth of the month, the last day of the month following the month in which the qualified employer gave notice of termination or, on a case-by-case basis, an earlier date upon agreement between the QHP and the SHOP.
- (2) In the case of a termination in accordance with subdivision (b) of this section, the effective date of termination shall be 14 days after the date of the request or the date requested by the qualified employee, whichever is later, or upon agreement between the QHP and the qualified employee.;

- (A) No sooner than the last day of the month in which the SHOP receives the request.
- (B) On a date in a subsequent month specified by the employee as long as that date is the last day of the month, or
- (C) On a case-by-case basis, an earlier date upon agreement between the QHP and SHOP.
- (D) In no case will the effective date of termination be a date other than the last day of the month.

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

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

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

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

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

(8) In the case of a termination in accordance with subdivision (c)(6) of this section, the last day of coverage shall be the date of death.

(9) In the case of a termination in accordance with subdivision (c)(7) of this section, the last day of coverage shall be the last day of the qualified employer's plan year.

(10) In the case of a termination in accordance with subdivision (c)(8) of this section, the last day of coverage shall be the last day of the month in which the employee or dependent ceased being an employee or dependent.

(11) In the case of a termination in accordance with subdivision (c)(9), the effective date of termination of coverage shall be the day before such other coverage begins.

(f) If a qualified employee's coverage or the coverage of a qualified employee's dependent is terminated pursuant to subdivision (b) of this section, the SHOP shall ~~promptly~~ provide the qualified employee or qualified employee's dependent with a notice of termination of coverage that includes the termination effective date and reason for termination.

(g) Notice of Termination

(1) Except as provided in subdivision (g)(3) of this section, if any enrollee's coverage or enrollment through the SHOP is terminated due to non-payment of premiums or due to a loss of the enrollee's

eligibility to participate in the SHOP, including where an enrollee loses his or her eligibility because a qualified employer has lost its eligibility, the SHOP must notify the enrollee of the termination. Such notice must include the termination effective date and reason for termination, and must be sent within three (3) business days if an electronic notice is sent, and within five (5) business days if a mailed hard copy notice is sent.

(2) Except as provided in subdivision (g)(3) of this section, if an employer group's coverage or enrollment through the SHOP is terminated due to non-payment of premiums or, where applicable, due to a loss of the qualified employer's eligibility to offer coverage through the SHOP, the SHOP must notify the employer of the termination. Such notice must include the termination effective date and reason for termination, and must be sent within three (3) business days if an electronic notice is sent, and within five (5) business days if a mailed hard copy notice is sent.

(3) Where state law requires a QHP issuer to send the notices described in subdivisions (g)(1) and (g)(2) of this section, a SHOP is not required to send such notices.

(4) When a primary subscriber and his or her dependents live at the same address, a separate termination notice need not be sent to each dependent at that address, provided that the notice sent to each primary subscriber at that address contains all required information about the termination for the primary subscriber and his or her dependents at that address.

Note: Authority: Section 100504, Government Code. Reference: Sections 100502 and 10503, Government Code; and 45 CFR Sections 155.720, 155.725, 155.735 and 156.285.



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Important information about your Covered California for Small Business Application

NEW BUSINESS LATE SUBMISSION ACKNOWLEDGEMENT

Your request to enroll with Covered California for Small Business has been received past the new business submission deadline date of 5 business days prior to requested effective date. It is important to note the following delays may occur:

- Approval of group policy
- Verification of eligibility with the carriers
- ID cards will be received 7-10 business days after approval

Please work with the carrier directly to verify eligibility and benefits.

To ensure expedient coverage please note the following:

- All required documentation must be completed and sent in by the **late submission deadline**, of no later than 5 business days after the requested effective date. Failure to do so will cause your group to be effective 1st of month following original requested date.
- Enrollment information **is not** effectuated until payment is received and posted to your account.

☐ I understand that by completing this form and meeting the submission requirements our desired effective date will be granted, we will not be able to change or delay our effective date after group approval.

Company Name

Requested Effective Date

Signature of Business Owner/Authorized Company Officer Title

Print Name

Date

Agent Signature

Date

ELECTRONIC CODE OF FEDERAL REGULATIONS

e-CFR data is current as of April 18, 2018

Title 26 → Chapter I → Subchapter A → Part 1 → §1.36b-2

Title 26: Internal Revenue
PART 1—INCOME TAXES**§1.36B-2 Eligibility for premium tax credit.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(iii) *Eligibility for months during a plan year—(A) Failure to enroll in plan.* An employee or related individual may be eligible for minimum essential coverage under an eligible employer-sponsored plan for a month during a plan year if the employee or related individual could have enrolled in the plan for that month during an open or special enrollment period for the plan year. If an enrollment period relates to coverage for not only the upcoming plan year (or the current plan year in the case of an

enrollment period other than an open enrollment period), but also coverage in one or more succeeding plan years, this paragraph (c)(3)(iii)(A) applies only to eligibility for the coverage in the upcoming plan year (or the current plan year in the case of an enrollment period other than an open enrollment period).

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

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

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

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

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

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

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

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

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

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

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

- (i) The employee may not opt to receive the amount as a taxable benefit;
 - (ii) The employee may use the amount to pay for minimum essential coverage; and
 - (iii) The employee may use the amount exclusively to pay for medical care, within the meaning of section 213.
- (7) *Opt-out arrangements.* [Reserved]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

minimum essential coverage under X's plan for July through December 2014.

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

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

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

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

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

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

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

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

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