1500-1 ADDED 10/15
Background to Affordable Care Act and Covered California

The Patient Protection and Affordable Care Act (Pub. L. 111–148) was enacted on March 23, 2010. The Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152), which amended and revised several provisions of the Patient Protection and Affordable Care Act, was enacted on March 30, 2010. The two statutes collectively are commonly referred to as the "Affordable Care Act" or "ACA."

California has created the California Health Benefit Exchange, called "Covered California," which offers a choice of health plans, establishes common rules regarding offering and pricing of insurance, and provides information to consumers. It serves as a one-stop shop where applicants are assessed for eligibility for the various programs, purchase private insurance and enroll in the plan of their choice.

(26 C.F.R. §1.36B-1(b) and 45 C.F.R. § 155.20; Gov't Code §§ 100500-100503.)

1500-2 ADDED 10/15
CalHEERS

The California Healthcare, Eligibility, Enrollment and Retention System (CalHEERS) is an automated system jointly managed by the Department of Health Care Services (DHCS) and Covered California. CalHEERS is designed to handle all applications for healthcare benefits, including all Medi-Cal programs, Advanced Payments of Premium Tax Credit (APTC) and Cost-Sharing Reduction (CSR) for enrollment into a Qualified Health Plan (QHP) through Covered California, and unsubsidized enrollment into a QHP through Covered California.

(Welf. & Inst. Code, § 14015.5, subd. (f)(2); Cal. Code Regs, tit. 10, § 6410.)

1500-3 MOVED 5/16
Insurance Affordability Program (IAP)

[MOVED TO 1522-2A]

1505-1 ADDED 10/15
MAGI Medi-Cal Eligibility, Adults 19 to 64

Medi-Cal coverage without a share of cost is provided to individuals who meet the Medi-Cal non-financial eligibility criteria, who are age 19 to 64, and who have Modified Adjusted Gross Income (MAGI) at or below 138% of the Federal Poverty Level (FPL) (5% disregard added to the 133% FPL limit), provided the individuals are not entitled to, or enrolled in, Medicare benefits under Part A or B.

(42 U.S.C. § 1396a(a)(10)(A)(i)(VIII); 42 C.F.R. §§ 435.119, 435.603(d)(4); 45 C.F.R. § 155.305(c); Welf. & Inst. Code, § 14005.64, subd. (b).)

1505-2 ADDED 10/15
MAGI Medi-Cal Eligibility for Children, including OTLIC

Children under age 19 in a family with household Modified Adjusted Gross Income (MAGI) up to 266% of the Federal Poverty Level (FPL) are eligible for Medi-Cal benefits with no share of cost. Depending on the age and income of the child, a child may receive MAGI Medi-Cal under the Optional Targeted Low-Income Children (OTLIC) program, which is a part of MAGI Medi-Cal for children. Premiums of $13 per child, up to a maximum of $39 per family, apply for children ages 1-19 with household MAGI income between 160% and 266% of the Federal Poverty Level.

(42 U.S.C. §§ 1396a(a)(10)(A)(ii)(XIV), 1396a(r)(2); 1396d(u)(2)(B); &1397jj(b); Welf. & Inst. Code, § 14005.26; Cal. State Plan Amend. CA-13-005 (November 1, 2013); Cal. Dept. of Health Care Svcs., All County Welf. Director's Lett. (ACWDL) No. 14-15 (March 28, 2014), attaching DHCS ACA Medicaid and Exchange AID CODE List, version 1.0 (January 31, 2014); ACWDL No. 14-21 (April 21, 2014).)

1505-3 ADDED 10/15
APTC and CSR

For those requiring financial assistance who do not qualify for full-scope Medi-Cal benefits with no share of cost, or for other Minimum Essential Coverage, the Affordable Care Act offers the following:

1) Tax Credits (Advance Payments of Premium Tax Credit (APTC)) lower the cost of insurance premiums for taxpayers with household Modified Adjusted Gross Incomes (MAGI) of 100% to 400% of the federal poverty level, provided the taxpayers meet other eligibility requirements. APTC can be immediately applied to the premiums of health plans offered through Covered California, lowering the monthly premium cost.

(26 U.S.C. § 36B(b); 42 U.S.C. § 18082; 26 C.F.R. § 1.36B-4(a); 45 C.F.R. § 155.305(f)(1).)

2) Cost-Sharing Reduction (CSR) reduces the amount of non-premium health care expenses, such as copayments and deductibles, that an individual or family has to pay to receive health benefits. CSR is available for those with household incomes between 100% and 250% of the federal poverty level, provided they enroll in a silver level Qualified Health Plan and meet other eligibility requirements.

(42 U.S.C. §§ 18022(c) & 18071; 45 C.F.R. § 155.305(g).)

1510-1 ADDED 10/15

Requirement for Minimum Essential Coverage, Penalties for Months Without Coverage

For each month beginning after 2013, a non-exempt individual must ensure that the individual and any non-exempt dependents are covered under Minimum Essential Coverage for such month. The Internal Revenue Service imposes penalties on taxpayers for each month that they do not have Minimum Essential Coverage, unless the taxpayer qualifies for and obtains an exemption. For example, an individual is exempt from penalties if such non-covered period is for a continuous period of less than three months.

(26 U.S.C. § 5000A; 26 C.F.R. §§ 1.5000A-1, 1.5000A-3.)

1510-2 ADDED 10/15

Definition of Minimum Essential Coverage

Minimum Essential Coverage includes

(1) Specified government-sponsored programs;

(2) Eligible employer-sponsored plans;

(3) Plans in the individual market, including Qualified Health Plans offered by Covered California;

(4) Grandfathered health plans; and

(5) Other coverage recognized by the Department of Health and Human Services as Minimum Essential Coverage.

(26 U.S.C. § 5000A(f)(1); 26 C.F.R. §§ 1.36B-2(c) & 1.5000A-2.)

1510-3 ADDED 10/15

Employees and Relatives are Eligible for MEC Based on Employer-Sponsored Plans If Plans are Affordable for Employees and Provide Minimum Value; No MEC During Waiting Period

The term "eligible employer-sponsored plan" means, with respect to any employee, a group health plan or group health insurance coverage offered by an employer to the employee which is

(A) a governmental plan (within the meaning of section 2791(d)(8) of the Public Health Service Act); or

(B) any other plan or coverage offered in the small or large group market within a State.

For purposes of eligibility for Advance Payments of Premium Tax Credit (APTC), an employee who may enroll in an eligible employer sponsored plan, and a related individual who may enroll in the employer sponsored plan because of a relationship to the employee, are eligible for Minimum Essential Coverage (MEC) under the plan for any month only if the plan is affordable and provides minimum value.

An eligible employer sponsored plan is affordable for an employee if the portion of the annual premium the employee must pay for self-only coverage does not exceed the required contribution percentage (9.5% as of 2015) of the applicable taxpayer's household income for the taxable year.

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 (9.5% as of 2015).

An eligible employer sponsored plan provides minimum value only if the plan's share of the total allowed costs of benefits provided to the employee under the plan is at least 60%.

An employee, or related individual, is not eligible for MEC under an eligible employer-sponsored plan during a required waiting period before the coverage becomes effective.

(26 U.S.C. § 5000A(f)(2); 26 C.F.R. §§1.36B-2(c)(3), 1.36B-2T(c)(3)(v)(C), 1.36B-6.)

1510-3A ADDED 5/16

COBRA or Retirement Coverage is MEC Only If Individual Enrolls

Former employees (including retirees) and their relatives who are enrolled in eligible employer-sponsored coverage or in continuation coverage that employers are required to offer under federal or State law (commonly known as COBRA), have Minimum Essential Coverage (MEC) for the months in which they are enrolled.

(26 C.F.R. §1.36B-2(c)(3)(iv).)

1510-3B ADDED 5/16

MEC Includes Full-Scope MAGI Medi-Cal; Restricted-Scope Medi-Cal, or Medi-Cal with Share of Cost is not MEC

Minimum Essential Coverage (MEC) includes full-scope MAGI Medi-Cal, which has no share of cost.

Restricted-scope Medi-Cal, including Medi-Cal that is limited to treatment of emergency medical conditions, is not considered MEC.

Medi-Cal that requires the beneficiary to pay a share of cost or a “spend-down” amount is not MEC.

(26 U.S.C. 5000A(f)(1)(A); 26 C.F.R. § 1.5000A-2(b)(1) & (2); Department of Health & Human Services, Centers for Medicare & Medicaid Services, “Minimum Essential Coverage,” SHO # 14-002 (Nov. 7, 2014).)

1510-4 ADDED 10/15

MEC Includes Medicare Part A for most Individuals

“Minimum Essential Coverage (MEC)” includes coverage under Medicare Part A for most individuals. The rules about whether and when Medicare Part A qualifies as Minimum Essential Coverage differ, depending on whether the individual is eligible for Medicare Part A with or without a premium and whether the individual chooses to enroll in Medicare Part A.

1. Individuals eligible for Medicare Part A with no premium:

An individual who is eligible for Medicare Part A with no premium is treated as eligible for Minimum Essential Coverage (MEC), whether or not the individual enrolls in Medicare Part A. The date when the individual is treated as eligible for MEC depends on whether or not the eligible individual chooses to enroll in Medicare Part A with no premium:

   a. Individual who enrolls in Medicare Part A with no premium:

An individual who enrolls in Medicare Part A without a premium is treated as having MEC as of the first day of the first full month the individual may receive benefits under Medicare Part A, which may be several months after the individual turned age 65, depending on when the individual completed the administrative requirements to enroll.

b. Individual who does not enroll in Medicare Part A with no premium:

An individual who is eligible for Medicare Part A with no premium, but does not enroll, is treated as eligible for MEC on the first day of the fourth calendar month after the date that established eligibility (usually the first day of the fourth month after turning 65). This "fourth calendar month" rule applies only to those who were eligible to enroll in Medicare Part A with no premium but did not enroll.

2. Individuals eligible for Medicare Part A, but must pay a premium:

An individual who is eligible to enroll in Medicare Part A but is required to pay a premium is not treated as eligible for MEC if the individual chooses not to enroll in Medicare Part A.

However, if an individual chooses to enroll in Medicare Part A, even if the individual is required to pay a premium, the individual is treated as having MEC upon enrollment in Medicare Part A. Therefore, an individual who is enrolled in Medicare Part A is ineligible for APTC, even if the individual is paying a premium for the Medicare Part A.

(26 U.S.C. § 5000A(f)(1)(A)(i); 26 C.F.R. §§ 1.36B-2(c)(2)(i), (ii) & (vi), 1.5000A-2(b)(1)(i); US Centers for Medicare and Medicaid, "Frequently Asked Questions Regarding Medicare and the Marketplace, August 1, 2014," Answer A6, at <https://www.cms.gov/Medicare/Eligibility-and-Enrollment/Medicare-and-the-Marketplace/Downloads/Medicare-Marketplace_Master_FAQ_8-28-14_v2.pdf> [as of May 27, 2016]; Covered California, Individuals with Medicare, "Medicare Factsheet," p.2, <http://www.coveredca.com/individuals-and-families/special-circumstances/individuals-on-medicare/> [as of May 27, 2016].)

1510-5 ADDED 10/15

Exemptions from Maintaining Minimum Essential Coverage

The following persons are exempt from the penalty for failure to maintain Minimum Essential Coverage:

(1) a person with a religious conscience exemption;

(2) a member of a health care sharing ministry;

(3) an exempt non-citizen, defined as an individual who is not a U.S. citizen or U.S. national and is either

a) A nonresident alien (within the meaning of 26 U.S.C. § 7701(b)(1)(B)); or

b) An individual who is not lawfully present (within the meaning of 45 C.F.R. § 155.20).

(4) an incarcerated individual;

(5) an individual who cannot afford coverage (an individual is without affordable coverage if for any month the individual's required contribution (determined on an annual basis) for coverage for the month exceeds 8% of the individual's household income for the taxable year);

(6) individuals with income below the filing threshold;

(7) members of Indian tribes;

(8) those determined by the Department of Health and Human Services to have suffered a hardship; and

(9) individuals with a short coverage gap (a continuous period of less than three months).

(26 U.S.C. § 5000A(d) & (e); 26 C.F.R. § 1.5000A-3.)

1510-5A ADDED 6/16

Hardship Exemption for Anyone Below the Tax Filing Threshold

Any individual below the tax filing threshold is entitled to a hardship exemption, regardless of whether they file a return and regardless of whether they claim a dependent. This exemption may be claimed through the tax filing process, but individuals who are eligible for this exemption and do not file tax returns will be exempt without having to take any further action. If an individual qualifies for this exemption, the exemption applies to the individual, the individual's spouse (if filing jointly or if no return is filed), and anyone the individual claims or could have claimed as a dependent.

(45 CFR 155.605(e)(1); Department Of Health & Human Services, Centers for Medicare & Medicaid Services, Center for Consumer Information & Insurance Oversight, "Shared Responsibility Guidance – Filing Threshold Hardship Exemption" (September 18, 2014), at <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Filing-Threshold-Exemption-Guidance-9-18-14.pdf> [as of January 16, 2016].)

1510-6 ADDED 10/15

Ineligible for APTC and CSR if Eligible for Full-Scope MAGI Medi-Cal, Medicare Part A or Other MEC

An individual who is eligible for full-scope MAGI Medi-Cal, Medicare Part A, or other Minimum Essential Coverage (MEC) (with the exception of coverage in the individual market) is not eligible for Advance Payments of Premium Tax Credit (APTC) or Cost-Sharing Reduction (CSR) assistance.

Restricted-scope Medi-Cal, including Medi-Cal that is limited to treatment of emergency medical conditions, is not MEC.

Medi-Cal that requires the beneficiary to pay a share of cost or a "spend-down" amount is not MEC.

(26 U.S.C. §§ 36B(b)(1), (c)(2)(B), 5000A(f)(1)(A)(i); 26 C.F.R. §§ 1.36B-2(a)(2), (c), 1.5000A-2(b)(1) & (2); 45 C.F.R. § 155.305(f)(1)(ii)(B); Cal. Code Regs, tit. 10, § 6474, subd. (c)(1)(B); "Minimum Essential Coverage," Department of Health & Human Services, Centers for Medicare & Medicaid Services, SHO# 14-002 (Nov. 7, 2014).)

1510-6A ADDED 5/16

Effect of Retroactive Eligibility Determination for MAGI Medi-Cal on Eligibility for APTC

When an individual is enrolled in a Covered California Qualified Health Plan (QHP) and is receiving with Advance Payments of Premium Tax Credit (APTC), and when that QHP enrollee is determined to be retroactively eligible for MAGI Medi-Cal, the retroactive Medi-Cal eligibility determination does not make the QHP enrollee retroactively ineligible for APTC. Instead, for purposes of APTC eligibility, the MAGI Medi-Cal eligibility is treated as Minimum Essential Coverage, and the QHP enrollee becomes ineligible for APTC, on the first day of the first calendar month after the date of the notice approving the QHP enrollee for MAGI Medi-Cal.

For example:

In November 2014, Taxpayer F enrolls in a Covered California Qualified Health Plan for 2015 and receives APTC. F loses her part-time employment and on April 10, 2015 applies for MAGI Medi-Cal. On May 15, 2015, a notice is issued informing F that she has been approved for MAGI Medi-Cal and that her MAGI Medi-Cal coverage is effective retroactively as of April 1, 2015. For purposes of F's eligibility for APTC, F is treated as eligible for Minimum Essential Coverage beginning on June 1, 2015, the first day of the first calendar month after the May 15, 2015 Medi-Cal approval notice. Thus, F remains eligible for APTC through May 31, 2015.

(26 C.F.R. §1.36B-2(c)(2)(iv) & (vi) (Example 4).)

1515-1 ADDED 10/15

Definition of Qualified Health Plan

A Qualified Health Plan (QHP) is a plan that is offered through and certified by Covered California as meeting the standards in the federal Affordable Care Act regulations, which include the requirement that the plan must provide essential health benefits packages. An essential health benefits package must cover at least the following 10 categories of benefits:

(1) Ambulatory patient services.
(2) Emergency services.
(3) Hospitalization.
(4) Maternity and newborn care.
(5) Mental health and substance use disorder services, including behavioral health treatment.
(6) Prescription drugs.
(7) Rehabilitative and habilitative services and devices.
(8) Laboratory services.
(9) Preventive and wellness services and chronic disease management.
(10) Pediatric services, including oral and vision care.

(26 U.S.C. § 36B(c)(3)(A); 42 U.S.C. §§ 18021(a); 18022(a) & (b); 18031(c); 26 C.F.R. 1.36B-1(c); 45 C.F.R. §§ 155.20,156.20,156.110; Gov. Code §§ 100501(g),100502(a); Cal. Code Regs, tit. 10, § 6410.)

1515-2 ADDED 10/15

Levels of Coverage

Each Qualified Health Plan (QHP) is certified to be a Bronze, Silver, Gold, Platinum, or catastrophic plan, depending on the level of coverage provided.

(42 U.S.C. § 18022(d); 42 C.F.R. § 156.140; Health & Saf. Code, §§ 1367.008, 1367.009; Ins. Code, §§ 10112.295, 10112.297; Cal. Code Regs, tit. 10, § 6410.)

1515-3 ADDED 10/15

Definition of Catastrophic Qualified Health Plan

Catastrophic Qualified Health Plans (QHPs) do not provide benefits, except for a minimum of three primary care visits per year, until a high deductible has been met. Catastrophic QHPs are available only to individuals who have not attained the age of 30 before the beginning of the plan year, or who have received a certificate of exemption from the Minimum Essential Coverage requirement based on hardship or coverage being unaffordable.

(26 U.S.C. § 5000A(e); 42 U.S.C. § 18022(e); 45 C.F.R. §§ 155.20, 155.305(h), 156.155(a); Health & Saf. Code, § 1367.008(c); Ins. Code, § 10112.295(c); Cal. Code Regs, tit. 10, § 6410.)

1515-4 ADDED 10/15

Covered California Must Determine Applicant's Eligibility for Catastrophic QHP

Covered California must determine an applicant eligible for enrollment in a catastrophic Qualified Health Plan (QHP) if the applicant

(A) has not attained the age of 30 before the beginning of the plan year; or

(B) has a certification in effect for any plan year that the applicant is exempt from the requirement to maintain Minimum Essential Coverage (MEC) because:

(1) the applicant is without affordable coverage (applicant is without affordable coverage if for any month the applicant's required contribution (determined on an annual basis) for coverage exceeds 8% of the applicant's household income for the taxable year; or

(2) the applicant is determined by the Department of Health and Human Services (HHS) to have suffered a hardship with respect to the capability to obtain coverage under a qualified health plan.

An applicant who has been denied an exemption certification must appeal to the HHS.

(26 U.S.C. § 5000A(e)(1) & (5); 42 U.S.C. § 18082(b)(1)(B); 45 C.F.R. § 155.305(h); Cal. Code Regs., tit. 10, §§ 6472(f)(1); 6602(b); Cal. Dept. of Social Svcs., All County Lett. (ACL) No. 14-14 (Feb. 7, 2014) pp. 6-7.)

1515-5 ADDED 10/15
HHS Retains Jurisdiction over Exemption Eligibility Determination Appeals

The State Hearings Division (SHD) has jurisdiction over all appeals regarding eligibility determination, redetermination, and timeliness of Covered California coverage or grants of federal tax credits or federal subsidies, *except* for appeals of an eligibility determination and redetermination for an exemption. Exemption appeals will be handled by the Department of Health and Human Services (HHS).

(Cal. Code Regs, tit. 10, § 6602, subd. (b); Cal. Dept. of Social Svcs., All County Lett. (ACL) No. 14-14 (Feb. 7, 2014) pp. 6-7.)

1515-6 ADDED 10/15

APTC Not Available for Catastrophic QHP

Advance Payments of Premium Tax Credit (APTC) shall not be available to support enrollment in a catastrophic Qualified Health Plan (QHP) through Covered California.

(26 U.S.C. § 36B(b)(2) & (c)(3)(A); 26 C.F.R. § 1.36B-1(c); Cal. Code Regs., tit. 10, § 6472, subd. (f)(2).)

1521-1 ADDED 10/15
One Application to Collect Information and Determine Eligibility

A Single, Streamlined Application (SSApp) must be used to determine eligibility and to collect information necessary for enrollment in all Insurance Affordability Programs (IAP), including Modified Adjusted Gross Income (MAGI) Medi-Cal, Non-MAGI Medi-Cal, Advance Payments of Premium Tax Credit (APTC) and Cost-Sharing Reduction (CSR) subsidies, as well as unsubsidized coverage into a Qualified Health Plan (QHP) through Covered California. However, counties continue to accept application forms in existence prior to January 1, 2014 and ask applicants for additional information or supplemental forms needed to complete the eligibility determination.

(42 U.S.C. § 18083(a) & (b); 42 C.F.R. § 435.907(b); 45 C.F.R. § 155.405(a), (b); Welf. & Inst. Code, § 15926, subd. (c); Cal. Code Regs, tit. 10, § 6470, subd. (a); Medi-Cal Eligibility Divis. Info. Lett. (MEDIL) No. I 13-12 (Sept. 16, 2013) p. 2; Cal. Dept. of Social Svcs., All County Lett. (ACL) No. 14-14 (Feb. 7, 2014) p. 5; Cal. Dep't of Health Care Services, All County Welf. Directors' Lett. (ACWDL) No. 15-34 (Oct. 28, 2015).)

1522-1 ADDED 10/15

Insurance Affordability Program (IAP)

The term "Insurance Affordability Program" means one of the following:

(1) The Medi-Cal program;

(2) The Optional Targeted Low-Income Children (OTLIC) program;

(3) A Qualified Health Plan (QHP) through Covered California with Advance Payments of Premium Tax Credit (APTC); or

(4) A QHP through Covered California with Cost-Sharing Reduction (CSR).

(42 C.F.R. § 435.4; 42 U.S.C. §§ 1396a(a)(10)(A)(ii)(XIV), 1396a(r)(2), 1396d(u)(2)(B) & 1397jj(b); Gov't Code § 100501.1; Welf. & Inst. Code, §§ 14005.26,14057; Cal. State Plan Amdt. CA-13-005 (November 1, 2013).)

1522-1A ADDED 10/15
Applicants Who Seek Any IAPs Must Be Evaluated for All IAPs

An applicant's request for an eligibility determination for one Insurance Affordability Program (IAP) is deemed a request for all IAPs, including Modified Adjusted Gross Income (MAGI) Medi-Cal, Non-MAGI Medi-Cal, Advance Payments of Premium Tax Credit (APTC) and Cost Sharing Reduction (CSR) subsidies. An applicant is not permitted to request an eligibility determination for less than all IAPs. If an applicant requests any of the IAPs, the applicant must be evaluated for all IAPs.

(42 U.S.C. § 18083 (a); 45 C.F.R. § 155.310(b); Cal. Code Regs, tit. 10, § 6476, subd. (b).)

1522-2 ADDED 10/15
Applicant Option to Apply for a QHP without Seeking IAP

An applicant may request an eligibility determination for enrollment in a Covered California Qualified Health Plan (QHP), without also seeking a determination of eligibility for an Insurance Affordability Program (IAP).

(45 C.F.R. § 155.310(b); Cal. Code Regs., tit. 10, § 6476, subd. (a).)

1523-1 ADDED 10/15
Application Methods

Individuals may apply for healthcare benefits by mail, fax, telephone, online, or in person at county offices or with certified assisters. Individuals may submit their applications either to the

county or to Covered California. The county must accept quick-sort phone transfers from Covered California.

(42 U.S.C. § 18083(b)(1); 45 C.F.R. § 155.405(c)(2); Welf. & Inst. Code, § 15926, subd. (b); Cal. Code Regs., tit. 10, § 6470, subd. (j); Medi-Cal Eligibility Divis. Info. Lett. (MEDIL) No. I 13-12 (September 16, 2013) p. 3.)

1523-2 ADDED 10/15
Application Timing

Covered California must accept an application and make an eligibility determination for an applicant seeking an eligibility determination at any point in time during the year.

(45 C.F.R. § 155.310(c); Cal. Code Regs, tit. 10, § 6470, subd. (k).)

1523-3 ADDED 10/15
Application Content

An applicant must provide the information, documentation, and declarations required on the Single, Streamlined Application (SSApp) and sign and date the application under penalty of perjury. Electronic, including telephonically recorded, signatures and handwritten signatures transmitted via any electronic transmission must be accepted. The information, documentation and declaration required are set forth in the California Code of Regulations, title 10, section 6470, subdivisions (c), (d) and (e). Covered California, the counties, or any other entity accepting and processing applications may not require an applicant to provide any forms, documents, or other information or undergo verification that is duplicative or otherwise unnecessary.

(42 U.S.C. §§ 18081(b) & 18083(b)(2); 42 C.F.R. § 435.907(e), (f); Welf. & Inst. Code, § 15926, subd. (h)(1); Cal. Code Regs, tit. 10, § 6470, subds. (b)-(e).)

1523-4 ADDED 10/15
No Additional Information Required Unless Information is Inconsistent or Insufficient for Eligibility Determination

Covered California must not request additional information or paperwork from an applicant who has completed the Single, Streamlined Application (SSApp) unless the information provided on the application is inconsistent with electronic data obtained for verification purposes or the information is otherwise insufficient to determine eligibility.

(42 U.S.C. § 18083(b)(2); 42 C.F.R. § 435.907(e); 45 C.F.R. § 155.315(i).)

1523-5 ADDED 10/15
No Information from Non-Applicants Regarding Citizenship or Immigration Status

Covered California may not request information about citizenship or immigration status of an individual who is not seeking coverage for himself or herself on any application or supplemental form.

(45 C.F.R. § 155.310(a)(2); Welf. & Inst. Code, § 15926, subd. (c)(4)(B).)

1523-6 ADDED 10/15
Non-Applicant's SSN May be Required to Verify Non-Applicant's Income

Covered California must require an applicant with a Social Security Number (SSN) to provide such a number. Covered California, however, must not require a SSN of an individual who is not seeking coverage for himself or herself on the application or supplemental form, unless the individual is a tax filer whose tax data would be used for verification of the applicant household's income and family size.

(45 C.F.R. §§ 155.305(f)(6); 155.310(a)(3); Welf. & Inst. Code, § 15926, subd. (c)(4)(B); Cal. Code Regs, tit. 10, § 6470, subd. (c).)

1524-1 ADDED 10/15
Notice of Incomplete Application

If an applicant or application filer submits an incomplete application that does not include sufficient information for Covered California to conduct an eligibility determination for enrollment in a QHP or IAPs, where applicable, Covered California must do the following:

1. Provide the applicant notice indicating that information necessary to complete an eligibility determination is missing, specifying the missing information, and providing instructions on how to provide the missing information.

2. Provide the applicant with a period of 90 calendar days from the date on which the notice is sent to the applicant, or until the end of an enrollment period, whichever date is earlier, but in no event less than 30 calendar days from the date of the notice, to provide the information needed to complete the application to Covered California.

3. During the period in which the applicant must submit the missing information, Covered California must not proceed with the applicant's eligibility determination or provide advance payments of the premium tax credit or cost-sharing reductions, unless the applicant or application filer has provided sufficient information to determine his or her eligibility for enrollment in a QHP through Covered California, in which case Covered California must make such a determination for enrollment in a QHP.

4. If the applicant fails to provide the requested information within the specified time period, Covered California must provide notice of denial to the applicant, including notice of appeals rights.

(45 C.F.R. § 155.310(k); Cal. Code Regs., tit. 10, § 6470, subd. (l).)

1524-2 ADDED 10/15
Timelines for Covered California to Determine Eligibility and Provide Written Notice of Eligibility Determination

Covered California must determine an applicant's eligibility within 10 calendar days from the date it receives the applicant's complete paper application. This timeline does not apply to eligibility determinations for applications submitted online, which occur real time, if administratively feasible.

Covered California must provide the applicant a written notice of eligibility determination within five business days from the date of the eligibility determination.

(45 C.F.R. § 155.310(e), (g); Cal. Code Regs., tit. 10, § 6476, subds. (f), (h).)

1524-3 ADDED 10/15
Covered California Must Provide Written Notice, Including Notice of Appeal Procedures, at the Time of Application and When Sending Notices of Eligibility Determination and Redetermination

Covered California must provide notice of appeal procedures at the time that the applicant submits an application and when Covered California sends a notice of eligibility determination and redetermination. Such notices must contain the following information:

(1) An explanation of the action reflected in the notice, including the effective date of the action;

(2) Any factual bases upon which the decision was made;

(3) Citations to, or identification of, the relevant regulations supporting the action;

(4) Contact information for available customer service resources, including local legal aid and welfare rights offices; and

(5) An explanation of appeal rights, which must contain the following information:

a. A description of the procedures by which the applicant or enrollee may request an appeal, including an expedited appeal;

b. Information on the applicant's or enrollee's right to represent himself or herself, or to be represented by legal counsel or another representative;

c. Information on how to obtain a legal aid referral or free legal help;

d. An explanation that all hearings shall be conducted by telephone, video conference, or in person, in accordance with the California Department of Social Services' Manual of Policies and Procedures, section 22-045;

e. An explanation of the circumstances under which the appellant's eligibility may be maintained or reinstated pending an appeal decision, as provided in title 10 of the California Code of Regulations, section 6608; and

f. An explanation that an appeal decision for one household member may result in a change in eligibility for other household members and that such a change shall be handled as a redetermination of eligibility for all household members in accordance with the standards specified in sections 6472 and 6474.

(45 C.F.R. §§ 155.230, 155.355; Cal. Code Regs., tit. 10, §§ 6454, subd. (a), 6604.)

1525-1 ADDED 10/15

Covered California to Transmit Applications to Counties in Three Business Days

Covered California will make an initial determination of Modified Adjusted Gross Income (MAGI) Medi-Cal eligibility. If Covered California determines an applicant eligible for MAGI Medi-Cal, including the Optional Targeted Low-Income Children Program (OTLICP), Covered California must notify and transmit to the applicant's resident county all information that is necessary for the county to provide the applicant with the coverage. Covered California must transmit the information to the county within three business days from the date of the eligibility determination.

(45 C.F.R. § 155.310(d)(3); Welf. & Inst. Code, § 14015.5, subd. (c); Cal. Code Regs., tit. 10, § 6476, subds. (e), (f).)

1525-2 ADDED 10/15

Applications that Covered California Must Forward to Counties

Covered California must forward to the counties the applications from the following individuals for eligibility determinations:

1. Individuals excepted from MAGI methodology:

    a. Individual is aged 65 or older;

    b. Individual is blind or disabled when the individual is not eligible under MAGI;

    c. Individual is enrolled in Medicare, but only for the purpose of determining eligibility for Medicare Savings Programs, including Qualified Medicare Beneficiary, Specified Low-Income Medicare Beneficiary and Qualified Individual; and

    d. Individual is requesting Long-Term Care (LTC) or Home and Community Based Waiver services or resides in LTC facility.

2. Individuals found income eligible for APTCs, but not income eligible for MAGI-based Medi-Cal, and indicated on the single streamlined application potential eligibility for Medi-Cal on a basis other than MAGI:

    a. Individual is aged 65 years old or older;

    b. Individual is blind or disabled; and

    c. Individual claims blindness or a disability, for purposes of submitting a disability determination package.

3. Individuals found MAGI Medi-Cal eligible, but indicated on the application a basis other than MAGI and request an eligibility determination on a basis other than MAGI; and

4. Individuals, who request a full Medi-Cal determination.

(Welf. & Inst. Code, § 15926, subd. (h)(2); Medi-Cal Eligibility Divis. Info. Lett. (MEDIL) No. I 13-12 (September 16, 2013) pp. 5-6.)

1525-3 ADDED 10/15

No Break in Coverage

During the processing of an application, renewal, or a transition due to a change in circumstances, the county and Covered California must ensure that all Insurance Affordability Program (IAP) applicants and recipients, who meet all program eligibility requirements and comply with all necessary requests for information, move between programs without any breaks in coverage. During the process, the county and Covered California must not require applicants and recipients to provide any forms, documents, or other information or undergo verification that is duplicative or otherwise unnecessary. The individual must be informed about how to obtain information on the status of his or her application, renewal, or transfer to another program at any time, and the information must be promptly provided when requested.

(Welf. & Inst. Code, § 15926, subd. (h)(1).)

1531-1 ADDED 10/15

Enrollment Periods

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

(1) The initial open enrollment period;

(2) An annual open enrollment period; or

(3) A special enrollment period for which the qualified individual has been determined eligible.

(45 C.F.R. § 155.410(b); Cal. Code Regs., tit. 10, § 6500, subd. (a).)

1532-1 ADDED 10/15

Initial Open Enrollment Period for 2014 Coverage

The initial open enrollment period began on October 1, 2013 and extended through March 31, 2014.

(45 C.F.R. § 155.410(b); Cal. Code Regs., tit. 10, § 6502, subd. (b).)

1532-2 ADDED 10/15

2014 Coverage Effective Dates Based on Initial Enrollment Period

The regular coverage effective dates for the initial open enrollment period for a Qualified Health Plan (QHP) selection received by Covered California from a qualified individual shall be as follows:

1. For a QHP selection received by Covered California on or before December 23, 2013, the coverage effective date shall be January 1, 2014;

2. For a QHP selection received between December 24, 2013 and December 31, 2013, the coverage effective date shall be February 1, 2014.

3. For a QHP selection received between the first and fifteenth day of the month for any month between January 2014 and March 31, 2014, the coverage effective date shall be the first day of the following month;

4. For a QHP selection received between the sixteenth and last day of the month for any month between January 2014 and March 31, 2014, the coverage effective date shall be the first day of the second following month.

Coverage must be effectuated on the above dates, provided the qualified individual pays, in full, the initial net premium (premium reduced by the APTC amount for which Covered California has determined the individual eligible) by the premium due date, and the QHP issuer receives the payment on or before the premium due date.

(45 C.F.R. §§ 155.400(e), 155.410(c); Cal. Code Regs., tit. 10, § 6502, subds. (c) & (g).)

1532-3 ADDED 10/15

2015 Annual Open Enrollment Period

The annual open enrollment period for the benefit year beginning on January 1, 2015, began on November 15, 2014 and was extended through February 22, 2015.

(45 C.F.R. § 155.410(e)(1); Cal. Code Regs., tit. 10, § 6502, subd. (d)(1); Covered California Procedure Task Guide SC.207.2 (Feb. 19, 2015) p.1 [Covered California Document].)

1532-4 ADDED 10/15

2015 Coverage Effective Dates Based on Annual Open Enrollment Period

The coverage effective dates for the benefit year beginning on January 1, 2015 for a Qualified Health Plan (QHP) selection received by Covered California from a qualified individual shall be as follows:

1. For a QHP selection received by Covered California from November 15, 2014 through December 15, 2014, the coverage effective date shall be January 1, 2015.

2. For a QHP selection received by Covered California from December 16, 2014 through January 15, 2015, the coverage effective date shall be February 1, 2015.

3. For a QHP selection received by Covered California from January 16, 2015 through February 15, 2015, the coverage effective date shall be March 1, 2015.

Coverage must be effectuated on the above dates, provided the qualified individual pays, in full, the initial net premium (premium reduced by the APTC amount for which Covered California has determined the individual eligible) by the premium due date, and the QHP issuer receives the payment on or before the premium due date.

(45 C.F.R. §§ 155.400(e), 155.410(f)(1); Cal. Code Regs., tit. 10, § 6502, subds. (f)(1), (g).)

1532-5 ADDED 10/15

2016 Annual Open Enrollment Period

The annual open enrollment period for the benefit year beginning on January 1, 2016, began on November 1, 2015 and extended through January 31, 2016.

(45 C.F.R. § 155.410(e)(2); Cal. Code Regs., tit. 10, § 6502, subd. (d)(2).)

1532-6 ADDED 10/15

2016 Coverage Effective Dates Based on Annual Open Enrollment Period

The coverage effective dates for the benefit year beginning on January 1, 2016 for a Qualified Health Plan (QHP) selection received by Covered California from a qualified individual shall be as follows:

1. For a QHP selection received by Covered California from November 1, 2015 through December 15, 2015, the coverage effective date shall be January 1, 2016.

2. For a QHP selection received by Covered California from December 16, 2015 through January 15, 2016, the coverage effective date shall be February 1, 2016.

3. For a QHP selection received by Covered California from January 16, 2016 through January 31, 2016, the coverage effective date shall be March 1, 2016.

Coverage must be effectuated on the above dates, provided the qualified individual pays, in full, the initial net premium (premium reduced by the APTC amount for which Covered California has determined the individual eligible) by the premium due date, and the QHP issuer receives the payment on or before the premium due date.

(45 C.F.R. §§ 155.400(e), 155.410(f)(2); Cal. Code Regs., tit. 10, § 6502, subds. (f)(2), (g).)

1533-1 ADDED 10/15

Triggering Events for Special Enrollment Periods

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

(1) A qualified individual, or his or her dependent, loses Minimum Essential Coverage (MEC), which includes:

a) Loss of eligibility for coverage, including but not limited to

i) Loss of eligibility for coverage as a result of

(1) Legal separation;

(2) Divorce or dissolution of domestic partnership;

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

(4) Death of an employee;

(5) Termination of employment; or

(6) Reduction in the number of hours of employment.

ii) Loss of eligibility for coverage through Medicare, Medi-Cal or other government-sponsored health care programs, other than programs specified as not MEC under title 26 of the Code of Federal Regulations, section 1.5000A-2(b)(1)(ii).

iii) Loss of coverage because an individual no longer resides, lives, or works in the service area of a HMO or similar program in the individual market (whether or not within the choice of the individual).

iv) Loss of coverage because an individual no longer resides, lives, or works in the service area of a HMO or similar program in the group market (whether or not within the choice of the individual).

v) An individual incurs a claim that would meet or exceed a lifetime limit on all benefits.

vi) Loss of coverage because a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual.

b) Termination of employer contributions to employee's or dependent's coverage that is not COBRA continuation coverage; and

c) Exhaustion of COBRA continuation coverage, for any reason other than either failure of the individual to pay premiums on a timely basis, or for cause, such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan. An individual is considered to have exhausted COBRA continuation coverage if such coverage ceases:

i) Due to failure of the employer or other responsible entity to pay premiums timely;

ii) 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

iii) 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.

(2) A qualified individual, or his or her dependent, is enrolled in non-calendar year health insurance coverage, even if the qualified individual or his or her dependent has the

option to renew such coverage; the date of the loss of coverage is the last day of the plan or policy year;

(3) A qualified individual, or his or her dependent, loses Medi-Cal coverage for pregnancy-related services;

(4) A qualified individual, or his or her dependent, loses Medi-Cal coverage for medically needy;

(5) A qualified individual gains a dependent or becomes a dependent through marriage or entry into domestic partnership, birth, adoption, placement for adoption, or placement in foster care, or through a child support order or other court order;

(6) Loses a dependent or is no longer considered a dependent through divorce, legal separation, or dissolution of domestic partnership as defined by state law in the state in which the divorce, legal separation, or dissolution of domestic partnership occurs, or if the enrollee, or his or her dependent, dies;

(7) A qualified individual gains a dependent or becomes a dependent through marriage, birth, adoption, placement for adoption, placement in foster care, or through a child support order or other court order;

(8) A qualified individual loses a dependent or is no longer considered a dependent through divorce, legal separation, or dissolution of domestic partnership, or his or he dependent, dies;

(9) A qualified individual, or his or her dependent, who was not previously a citizen, national, or lawfully present individual gains such status;

(10) A qualified individual'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 Covered California or the Department of Health and Human Services, its instrumentalities, or a non-Covered California entity providing enrollment assistance or conducting enrollment activities. For purposes of this provision, misconduct includes the failure to comply with applicable standards under title 10 of the California Code of Regulations or other applicable Federal or State laws;

(11) An enrollee, or his or her dependent, adequately demonstrates that the QHP in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee;

(12) An enrollee, or his or her dependent enrolled in the same QHP, is determined newly eligible or newly ineligible for APTC or has a change in eligibility for CSR;

(13) A qualified individual, or his or her dependent, who is enrolled in an eligible employer-sponsored plan is determined newly eligible for APTC because such individual is ineligible for qualifying coverage in an eligible employer-sponsored plan, including as a result of his or her employer discontinuing or changing available coverage within the next 60 days, provided such individual is allowed to terminate existing coverage.

(14) A qualified individual or enrollee, or his or her dependent, gains access to new QHPs as a result of a permanent move, including individuals released from incarceration;

(15) A qualified individual who is an Indian may enroll in a QHP or change from one QHP to another one time per month;

(16) A qualified individual or enrollee, or his or her dependent, demonstrates to Covered California, on a case-by-case basis, that the individual meets other exceptional circumstances, including, but not limited to

a) An individual with a certificate of exemption for hardship is no longer eligible for a hardship exemption within a coverage year;

b) An individual with a certificate of exemption reports a change regarding the eligibility standards for exemption and the individual is no longer eligible for an exemption;

c) He or she is a child, ineligible for Medi-Cal and OTLIC, and for whom a party other than the party who expects to claim the child as a tax dependent is required by court order to provide health insurance coverage for the child, provided the child is otherwise eligible for enrollment in a QHP; or

d) He or she is a victim of domestic abuse or spousal abandonment, as specified in 26 C.F.R. § 1.36B-2T(b)(2)(ii)-(v);

(17) A qualified individual or enrollee, or his or her dependent, was receiving services from a contracting provider under another health benefit plan, and that provider is no longer participating in the health benefit plan, and the qualified individual, enrollee or dependent seeks to complete care for one of the following conditions: an acute condition, a serious chronic condition, pregnancy, terminal illness, infant care from birth to 36 months, and surgery or other procedure that was recommended and documented by the provider to occur within 180 days;

(18) A qualified individual being released from incarceration;

(19) A qualified individual who is a member of the United States military reserve forces or the California National Guard returning from active duty;

(20) A qualified individual who demonstrates that he or she did not enroll in a health benefit plan during the immediately preceding enrollment period available to the individual because he or she was misinformed that he or she was covered under MEC;

(21) Any other triggering events listed in the Health and Safety Code, section 1399.849, subdivision (d)(1) and the Insurance Code, section 10965.3, subdivision (d)(1).

(45 C.F.R. §§ 155.420(d), 155.605(g)(1), 155.620(b); 26 C.F.R. § 1.5000A-2(b)(1)(ii); Health & Saf. Code, § 1399.849, subd. (d)(1); Ins. Code, § 10965.3, subd. (d)(1); Cal. Code Regs., tit. 10, §§ 6502, 6504, subds. (a), (b), (c).)

1533-2 ADDED 10/15

Effective Date of Loss of MEC

The effective date of loss of Minimum Essential Coverage (MEC) by an individual shall be

(1) The last day the qualified individual or his or her dependent would have coverage under his or her previous plan or coverage; or

(2) If the loss occurs due a QHP decertification, the date of notification of the decertification.

(45 C.F.R. §§ 155.420(d)(1)(i); 155.1080(e)(2); Cal. Code Regs., tit. 10, § 6504, subd. (a)(1)(A).)

1533-3 ADDED 10/15

Special Enrollment Periods Triggered by an Error, Misconduct, or Breach of Contract

A qualified individual may enroll in a Qualified Health Plan (QHP), or an enrollee may change QHPs, during special enrollment periods only if a triggering event occurs, which includes the following:

(1) Error, Misrepresentation, Misconduct or Inaction by Covered California, Covered California Agent, or Non-Covered California Entity Providing Enrollment Assistance

A qualified individual'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 Covered California or the Department of Health and Human Services, its instrumentalities, or a non-Covered California entity providing enrollment assistance or conducting enrollment activities. For purposes of this provision, misconduct includes the failure to comply with applicable standards under title 10 of the California Code of Regulations or other applicable Federal or State laws.

(2) QHP Issuer's Breach of Contract

An enrollee, or his or her dependent, adequately demonstrates to Covered California that the QHP in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee.

(45 C.F.R. § 155.420(d)(4) & (5); Cal. Code Regs., tit. 10, § 6504, subds. (a)(4) &(5).)

1533-4 ADDED 10/15

One-Time Special Enrollment Period, February 23, 2015 – April 30, 2015, for Individuals Learning of Tax Penalty

From February 23, 2015 through April 30, 2015, individuals are eligible for special enrollment based on learning of the tax penalty for not having Minimum Essential Coverage.

(Covered California Procedure Task Guide SC.207.2 (Feb. 19, 2015) p.1 [Covered California Document].)

1533-5 ADDED 10/15

Failure to Pay Premiums or Termination of Coverage for Cause Do Not Trigger Special Enrollment

Loss of coverage, for purposes of triggering a special enrollment period, does not include voluntary termination of coverage or loss due to failure to pay premiums timely, including COBRA premiums prior to exhaustion of COBRA coverage, or termination of coverage for cause, such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with a plan.

(45 C.F.R. § 155.420(e); Cal. Code Regs., tit. 10, § 6504, subd. (c).)

1533-6 ADDED 10/15

Individuals Who Qualify for Special Enrollment Have 60 Days or 120 Days to Select a QHP

An individual who qualifies for a special enrollment period has 60 days from the date of the triggering event to select a Qualified Health Plan (QHP). But the individual will have 60 days before and after the triggering event, 120 days, to select a QHP, under the following circumstances:

(1) A qualified individual or his or her dependent who loses coverage due to loss of MEC, expiration of non-calendar year health insurance coverage, losing Medi-Cal for pregnancy-related services, or losing Medi-Cal for medically needy, shall have 60 days before and after the date (120 days) of the loss of coverage to select a QHP.

(2) A qualified individual who is enrolled in an eligible employer-sponsored plan and will lose eligibility for qualifying coverage in an eligible employer-sponsored plan within the next 60 days shall have 60 days before and after (120 days) the loss of eligibility for qualifying coverage in an eligible employer-sponsored plan to select a QHP.

(45 C.F.R. § 155.420(c); Cal. Code Regs., tit. 10, § 6504, subd. (f).)

1533-7 ADDED 10/15

Regular and Special Coverage Effective Dates for Special Enrollment Periods

A. Regular Coverage Effective Dates for a Special Enrollment Period

The regular coverage effective dates for a special enrollment period for a Qualified Health Plan (QHP) selection received by Covered California from a qualified individual shall be as follows:

1. For a QHP selection received by Covered California between the first and fifteenth day of any month, the coverage effective date shall be the first day of the following month;

2. For a QHP selection received by Covered California between the sixteenth and last day of any month, the coverage effective date shall be the first day of the second following month.

B. Special Coverage Effective Dates

The special coverage effective dates for special enrollment periods are as follows:

1. In the case of birth, adoption, placement for adoption, or placement in foster case, the coverage shall be effective either:

    a. On the date of birth, adoption, placement for adoption, or placement in foster care; or

    b. On the first day of the month following the date of birth, adoption, placement for adoption, or placement in foster care, at the option of the qualified individual or the enrollee.

2. In the case of marriage or entry into domestic partnership, the coverage and APTC and CSR, if applicable, shall be effective on the first day of the month following plan selection.

3. In the case where a qualified individual, or his or her dependent, loses coverage due to loss of MEC, expiration of non-calendar year health insurance coverage, losing Medi-Cal for pregnancy-related services, losing Medi-Cal for medically needy, or because a qualified individual, or his or her dependent, who is enrolled in an eligible employer-sponsored plan is determined newly eligible for APTC because such individual is ineligible for qualifying coverage in an eligible employer-sponsored plan; the coverage and APTC and CSR, if applicable, shall be effective:
    a. On the first day of the month following the loss of coverage if the plan selection is made on or before the date of the loss of coverage; or
    b. On the first day of the month following plan selection if the plan selection is made after the date of the loss of coverage.
4. If a qualified individual or enrollee is eligible for a special enrollment period because of errors or misconduct of Covered California, Covered California's agent, or a non-Covered California entity providing enrollment assistance; or a QHP issuer's breach of contract; or exceptional circumstances, the coverage shall be effective on an appropriate date, including a retroactive date, determined on a case-by-case basis based on the circumstances of the special enrollment period.

5. In a situation where a qualified individual gains or becomes a dependent through a child support order or other court order, the coverage shall be effective either:

    a. On the date the court order is effective; or

    b. In accordance with the regular coverage effective dates, at the option of the qualified individual or the enrollee.

6. If a qualified individual loses a dependent or is no longer considered a dependent because an enrollee or his or her dependent dies, the coverage shall be effective on the first day of the month following the plan selection.

Coverage must be effectuated on the above dates, provided

(1) the individual pays the initial premium payment in full, reduced by the APTC amount he or she is determined eligible for by Covered California, by the premium payment due date. In cases of retroactive enrollment dates, the initial premium shall mean the sum of the premiums for the aggregate period of coverage for which the individual is applying and determined eligible by Covered California; and

(2) The applicable QHP issuer receives such payment on or before such due date.

(45 C.F.R. § 155.420(b); Cal. Code Regs., tit. 10, § 6504, subds. (g), (h), (i).)

1533-8 ADDED 10/15

Qualified Individual or Enrollee Must Attest to Special Enrollment Triggering Event Under Penalty of Perjury

A qualified individual or an enrollee shall attest under penalty of perjury that he or she meets at least one of the triggering events for special enrollment. Covered California shall inform the qualified individual or the enrollee that pursuant to title 45 Code of Federal Regulations section 155.285, the Department of Health and Human Services (HHS) may impose civil money penalties of up to $25,000.00 on the qualified individual or the enrollee if he or she

(1) fails to provide the correct information requested by Covered California due to his or her negligence or disregard of the federal or State rules or regulations related to Covered California with negligence and disregard as follows:

a) "Negligence" includes any failure to make a reasonable attempt to provide accurate, complete, and comprehensive information; and

b) "Disregard" includes any careless, reckless, or intentional disregard for any federal or State rules or regulations related to Covered California; or

(2) knowingly and willfully provides false or fraudulent information requested by Covered California, where “knowingly and willfully” means the intentional provision of information that the person knows to be false, i.e. fraudulent.

Covered California shall accept the qualified individual's or the enrollee's attestation without further verification.

(26 U.S.C. § 6662; 45 C.F.R. § 155.285; Cal. Code Regs., tit. 10, § 6504, subd. (d).)

1533-9 ADDED 10/15

Covered California’s Duties to Applicant, QHP Issuer, and HHS When Applicant Selects QHP

Covered California must accept a Qualified Health Plan (QHP) selection from an applicant who is determined eligible for enrollment in a QHP and must

(1) notify the applicant of her or his initial premium payment method options and of the requirement that the applicant’s initial premium payment shall be received in full by the QHP issuer on or before the premium due date in order for the applicant’s coverage to be effectuated;

(2) notify the QHP issuer that the individual is a qualified individual and of the applicant's selected QHP and premium payment method option;

(3) transmit to the QHP issuer information necessary to enable the issuer to enroll the applicant within three business days from the date Covered California obtains the information; and

(4) transmit eligibility and enrollment information to the Department of Health and Human Services (HHS) promptly and without undue delay.

(45 C.F.R. § 155.400(a), (b); Cal. Code Regs., tit. 10, § 6500, subd. (b).)

1534-1 ADDED 10/15

Covered California's Duties to Applicant when Applicant Selects QHP

Covered California must accept a Qualified Health Plan (QHP) selection from an applicant who is determined eligible for enrollment in a QHP and must notify the applicant of her or his initial premium payment method options and of the requirement that the applicant's initial premium payment shall be received in full by the QHP issuer on or before the premium due date in order for the applicant's coverage to be effectuated.

(45 C.F.R. § 155.400(a), (b); Cal. Code Regs., tit. 10, § 6500, subd. (b)(1).)

1534-2 ADDED 10/15

Covered California's Duty to Notify QHP Issuer When Applicant Selects QHP

When an applicant who is determined eligible for enrollment selects a Qualified Health Plan (QHP), Covered California is required to notify the QHP issuer that the individual is a qualified individual and of the applicant's selected QHP and premium payment method option. Covered California is also required to transmit to the QHP issuer information necessary to enable the issuer to enroll the applicant within three business days from the date when Covered California obtains the information.

(Cal. Code Regs., tit. 10, § 6500, subds. (b)(2) & (3).)

1534-3 ADDED 10/15

Covered California's Duty to Notify HHS When Applicant Selects QHP

When an applicant who is determined eligible for enrollment selects a Qualified Health Plan (QHP), Covered California is required to transmit eligibility and enrollment information to the federal Department of Health and Human Services (HHS) promptly and without undue delay, in a manner and timeframe as specified by HHS.

(45 C.F.R. §§ 155.340(a)(1) & 155.400(b)(1); Cal. Code Regs., tit. 10, § 6500, subd. (b)(4).)

1534-4 ADDED 10/15

Duties of QHP Issuer When Applicant Selects QHP

A QHP issuer must accept enrollment information consistent with federal and state standards and must

(1) acknowledge receipt of enrollment information transmitted from Covered California upon receipt of such information;

(2) enroll a qualified individual during the applicable enrollment period;

(3) notify a qualified individual of his or her premium due date;

(4) abide by the effective dates of coverage established by Covered California;

(5) notify Covered California of the issuer's timely receipt of a qualified individual's initial premium payment and his or her effective date of coverage;

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

(7) provide new enrollees an enrollment information package that is compliant with Covered California's accessibility and readability standards.

(45 C.F.R. § 156.265; Cal. Code Regs., tit. 10, § 6500, subd. (e).)

1534-5 ADDED 10/15

Duties of QHP Issuer If Applicant Requests Assistance

If an applicant requests assistance from a QHP issuer for enrollment through Covered California, the QHP issuer must either

(1) direct the individual to file an application with Covered California; or

(2) assist the applicant, upon the applicant's request, to apply for and receive an eligibility determination for coverage through Covered California through CalHEERS, provided the QHP issuer

(A) complies with federal and State privacy and security standards;

(B) complies with federal consumer assistance standards;

(C) informs the applicant of the availability of other QHP products offered through Covered California and describes how to access the Covered California web site; and

(D) complies with the requirements for plan-based enrollers.

(45 C.F.R. § 156.1230; Cal. Code Regs., tit. 10, § 6500, subd. (f).)

1540-1 ADDED 10/15

Qualified Health Plan – Eligibility

To be eligible to enroll in a Covered California Qualified Health Plan (QHP), an applicant must be

(1) a citizen or national of the United States or a non-citizen who is lawfully present and is reasonably expected to be a citizen, national, or a non-citizen who is lawfully present for the entire period for which enrollment is sought;

(2) not incarcerated; and

(3) a California resident. For an individual age 21 or over, capable of indicating intent, the individual's Exchange service area is the service area where the individual is living and intends to reside, including without a fixed address, or has entered a job commitment or is seeking employment. Covered California may not deny or terminate an individual's eligibility for enrollment in a QHP if the individual meets the California residency standard but for a temporary absence and intends to return when the purpose of the absence has been accomplished.

(45 C.F.R. § 155.305(a); Cal. Code Regs, tit. 10, § 6472, subds. (a), (c), (d), (e).)

1540-2 ADDED 10/15

Applicant may Enroll in Covered California QHP with His or Her Dependents

An applicant may enroll in a Covered California Qualified Health Plan (QHP) along with his or her dependents. For purposes of enrollment in a QHP, "dependent" means a qualified individual's or enrollee's spouse or registered domestic partner, and child until the attainment of age 26 (regardless of his or her school attendance), unless the child is disabled.

(45 C.F.R. § 147.120; Health & Saf. Code, §§ 1399.845, subd. (b), 1399.847 & 1399.849, subd. (a); Cal. Code Regs, tit. 10, § 6410.)

1540-3 ADDED 10/15

Health Plan Issuers, Including Covered California QHP Issuers, Offering Coverage for Dependent Children Must Make Such Coverage Available for the Children until Age 26

A health plan issuer (including a Qualified Health Plan (QHP) issuer) that makes available dependent coverage of children must make such coverage available for the children until attainment of age 26, unless the child is disabled. A child is disabled if the child is incapable of self-support because of a physical or mental disability which existed continuously from a date prior to attainment of age 26.

An issuer must treat a child as a dependent based solely on the relationship between the child and the primary subscriber, and not based on any other factors, such as financial dependency, the presence or absence of the child's residency with the primary subscriber or with any other person, student status, employment, eligibility for other coverage, or any combination thereof.

(45 C.F.R. § 147.20; Gov. Code, § 22775; Health & Saf. Code, §§ 1399.845, subd. (a), 1399.849, subd. (a)(1); Cal. Code Regs, tit. 2, §§ 599.500, subds. (n)–(p) & 599.501, subds. (f) and (g).)

1540-4 ADDED 10/15

Special Qualified Health Plan Enrollment Rule for Tax Households with Members in Multiple Exchange Service Areas

(1) Except in the case of tax dependents described in paragraph (2), below, if all members of a tax household are not within the same Exchange service area, any member of the tax household may enroll in a Qualified Health Plan (QHP) through any of the Exchanges for which one of the tax filers meets the residency standard.

(2) If both spouses in a tax household enroll in a QHP through the same Exchange, a tax dependent may only enroll in a QHP through that Exchange, or through the Exchange that serves the area in which the dependent meets a residency standard.

(45 C.F.R § 155.305(a)(3)(iv); Cal. Code Regs, tit. 10, § 6472, subd. (e)(4).)

1540-5 ADDED 10/15

Unlawful to Issue Health Insurance Policy to a Person Entitled to Benefits Under Medicare Part A or Enrolled in Medicare part B; Unlawful to Refuse to Renew Policy If Enrollee Later Becomes Eligible for Medicare

It is unlawful for a person to sell or issue a health insurance policy to an individual entitled to benefits under Medicare part A or enrolled in Medicare part B (including an individual electing a Medicare + Choice plan) with knowledge that the policy duplicates health benefits to which the individual is otherwise entitled.

If, however, an individual is already enrolled in a health insurance policy and later becomes eligible for Medicare, federal law prohibits nonrenewing or terminating the original insurance policy on the basis of the Medicare eligibility. Medicare eligibility or entitlement is not a basis for nonrenewal or termination of an individual's health insurance coverage in the individual market, which includes a Covered California Qualified Health Plan. An individual who is enrolled in a Covered California Qualified Health Plan and later becomes eligible for Medicare must notify Covered California or the Covered California health plan issuer if he or she wishes to terminate the Covered California Qualified Health Plan upon becoming eligible for Medicare.

(42 U.S.C. § 1395ss(d)(1)(3)(A)(i)(I); 45 C.F.R. § 147.106(h)(2).)

1540-6 ADDED 10/15

Enrollee's Duty to Report Changes in Circumstances

An enrollee, or application filer on behalf of an enrollee, must report any change of circumstances with respect to the eligibility standards within 30 days of such change. An enrollee, however, who has a change in income that does not impact the amount of the

enrollee's Advance Payments of Premium Tax Credit (APTC) or the level of Cost-Sharing Reduction (CSR) is not required to report such a change.

(45 C.F.R. § 155.330(b); Cal. Code Regs., tit. 10, § 6496, subds. (b), (d).)

1541-1 ADDED 10/15

Enrollee may Initiate Termination by Notifying Covered California or QHP – Type of Termination Dictates Termination Effective Dates

1. Termination Process for Prospective Terminations and Terminations based on Enrolling in New QHP under Special Enrollment

An enrollee may terminate his or her coverage in a Qualified Health Plan (QHP) through Covered California, including as a result of the enrollee obtaining other Minimum Essential Coverage (MEC), by notifying Covered California or the QHP issuer. The last day of coverage shall be as follows:

(A) The termination date specified by the enrollee, if the enrollee provides notice 14 days before the requested effective date of termination;

(B) Fourteen days after the termination is requested by the enrollee, if the enrollee does not notice 14 days before the requested effective date of termination;

(C) On a date on or after the date on which the termination is requested by the enrollee, subject to the determination of the enrollee's QHP issuer, if the enrollee's QHP issuer agrees to effectuate termination in fewer than 14 days, and the enrollee requests an earlier termination effective date;

(D) If the enrollee is newly eligible for full-scope Medi-Cal (including OTLIC), the last day of the month during which the enrollee is determined eligible for full-scope Medi-Cal (including OTLIC); or

(E) For terminations that occur because the enrollee changes from one QHP to another during open or special enrollment, the last day of coverage in the prior QHP shall be the day before the effective date of coverage in the new QHP; the last day of coverage in the prior QHP and the effective date of coverage in the new QHP may be retroactive dates if the enrollee was granted special enrollment pursuant to title 10 of the California Code of Regulations, subdivisions (a)(4), (a)(5) or (a)(10).

2. Enrollee may Terminate Plan Retroactively under some Circumstances

Covered California shall permit an enrollee to retroactively terminate or cancel his or her coverage or enrollment in a QHP if the enrollee demonstrates to Covered California that

(A) the enrollee attempted to terminate the coverage or enrollment in a QHP and experienced a technical error that did not allow the enrollee to terminate his or her coverage or enrollment through Covered California, and requests retroactive termination within 60 days after he or she discovered the technical error;

(B) the enrollment in a QHP through Covered California was unintentional, inadvertent, or erroneous and was the result of the error or misconduct of an officer, employee, or agent of Covered California or HHS, its instrumentalities, a QHP issuer, or a non-Covered California entity providing enrollment assistance or conducting enrollment activities. Such enrollee must request cancellation within 60 days of discovering the unintentional, inadvertent, or erroneous enrollment. For purposes of this provision, misconduct includes the failure to comply with applicable standards under this title, or other applicable Federal or State requirements as determined by Covered California; or

(C) the enrollment in the QHP was without knowledge or consent by any third party, including third parties who have no connection with Covered California, and requests cancellation within 60 days of discovering of the enrollment.

3. Retroactive Termination Dates Depend on Type of Termination

The effective dates for retroactive terminations shall be as follows:

(A) For a termination based on technical error, as described in paragraph 2(A), the termination date shall be no sooner than 14 days after the date that the enrollee can demonstrate he or she contacted Covered California to terminate the coverage or enrollment through Covered California, unless the QHP issuer agrees to an earlier effective date as set forth in paragraph 1(C).

(B) For a termination or cancellation based on error or misconduct, as described in paragraph 2(B), or a termination based on the enrollee having been enrolled without his or her knowledge or consent, as described in paragraph 2(C), the cancellation or termination date shall be the original coverage effective date or a later date, as determined appropriate by Covered California on a case by case basis, based on the circumstances of the cancellation or termination.

4. Covered California Duties when QHP is Terminated Retroactively

In cases of retroactive termination dates, Covered California shall ensure that

(A) the enrollee receives the APTC and CSR for which he or she is determined eligible;

(B) the enrollee is refunded any excess premiums paid or out-of-pocket payments made by or for the enrollee for covered benefits and services, including prescription drugs, incurred after the retroactive termination date;

(C) the enrollee's premium and cost sharing are adjusted to reflect the enrollee's obligations under the new QHP; and

(D) Consistent with 45 CFR Section 156.425(b), in the case of a change in the level of CSR (or a QHP without CSR) under the same QHP issuer during a benefit year, any cost sharing paid by the enrollee under the previous level of CSR (or a QHP without CSR) for that benefit year is taken into account in the new level of CSR for purposes of calculating cost sharing based on aggregate spending by the individual, such as for deductibles or for the annual limitations on cost sharing.

(45 C.F.R. §§ 155.430(b)(1) & (d)(1)-(2), (8)-(10), (12); Cal. Code Regs, tit. 10, § 6506, subds. (a)(1), (4) & (d)(1)-(4), (9)-(11).)

1541-2 ADDED 10/15

Household Member, Authorized Representative, or Other Individual Shall be Permitted to Initiate Termination of Deceased's Coverage; Last Day of Coverage Is Date of Enrollee's Death

An individual, including an enrollee's authorized representative, shall be permitted to report the death of an enrollee to Covered California for purposes of initiating termination of the enrollee's coverage in accordance with the following requirements:

(A) The individual shall be at least 18 years old.

(B) If the individual reporting the death is the application filer, the enrollee's authorized representative, or anyone in the household of the deceased who was included in the initial application, he or she shall be permitted to initiate termination of the deceased's coverage.

(C) If the individual reporting the death is *not* the application filer, the enrollee's authorized representative, or anyone in the household of the deceased who was included in the initial application, he or she shall submit satisfactory documentation of death to Covered California before he or she can initiate termination of the deceased's coverage. Satisfactory documentation may include a copy of a death certificate, obituary, medical record, power of attorney, proof of executor, or proof of estate. The documentation or an attached cover note shall provide the following information:

1. Full name of the deceased;

2. Date of birth of the deceased;

3. Covered California application ID or case number (if known) of the deceased;

4. Social Security Number (if known) of the deceased; and

5. Contact information for the person submitting the documentation, including full name, address, and phone number.

In the case of a termination due to the enrollee's death, the last day of coverage is the date of death.

(45 C.F.R. § 155.430(b)(3); Cal. Code Regs., tit. 10, § 6506, subds. (a)(3) & (d)(8).)

1541-3 ADDED 10/15

Enrollee may Choose to Remain Enrolled in QHP without APTC or CSR if He or She Becomes Eligible for Other MEC; Covered California Must Redetermine and Terminate if Enrollee does not Choose to Remain Enrolled

At the time of plan selection, an enrollee may choose to remain enrolled in a Qualified Health Plan (QHP) without Advance Payments of Premium Tax Credit (APTC) and/or Cost Sharing Reduction (CSR) if he or she becomes eligible for other Minimum Essential Coverage (MEC) and the enrollee does not request termination in accordance with title 10 of the California Code of Regulations, section 6506, subdivision (a)(1). If the enrollee does not choose to remain enrolled in a QHP in such a situation, Covered California must initiate termination of his or her enrollment in the QHP upon completion of the redetermination process specified in section 6496.

(45 C.F.R. §§ 155.330, 155.430(b)(1)(ii); Cal. Code Regs., tit. 10, §§ 6496, 6506, subd. (a)(2).)

1541-4 ADDED 10/15

Covered California or QHP Issuer May Initiate Termination Under Specified Circumstances

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

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

(2) The enrollee fails to pay premiums, after having exhausted applicable grace periods;

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

(4) The QHP terminates or is decertified;

(5) The enrollee changes from one QHP to another during an annual open enrollment period or special enrollment period; or

(6) Any other reason for termination of coverage described in title 45 of the Code of Federal Regulations section 147.106. These reasons include the following:

(A) The QHP issuer is ceasing to offer coverage in the market; and

(B) For network plans, there is no longer any enrollee under the QHP who lives, resides, or works in the service area of the QHP issuer (or in the area for which the issuer is authorized to do business);

(45 C.F.R. sections 147.106 & 155.430(b)(2); Cal. Code Regs, tit. 10, § 6506, subd. (b).)

1541-5 ADDED 10/15

QHP Issuer Must Provide Enrollee with Notice of Payment Delinquency and Must Provide Written Notice within Five Business Days from the Date of Termination of a QHP (with or without APTC)

If an enrollee is delinquent on premium payment, the Qualified Health Plan (QHP) issuer must provide the enrollee with notice of the delinquency.

If a QHP issuer terminates an enrollee's coverage or enrollment in a QHP

A. because the enrollee is no longer eligible for coverage in a QHP through Covered California;

B. for nonpayment of premiums; or

C. because the enrollee made a fraudulent claim or an intentional misrepresentation of a material fact in connection with the QHP;

the QHP issuer must provide the enrollee, within five business days from the date of the termination, with a written notice of termination of coverage that includes

1. the termination effective date;

2. the reason for termination; and

3. notice of appeals rights provided under title 10 of the California Code of Regulations, section 6604, including a right to a Covered California appeal to the California Department of Social Services (CDSS) State Hearings Division (SHD).

(45 C.F.R. §§ 155.430(d); 156.270(b)(1) & (f); Cal. Code Regs, tit. 10, § 6506 subds. (c)(1), (d) & (e)(1).)

1541-6 ADDED 10/15

Amended to Remove

DMHC Reqs (CM)

12/15<u>Termination Process for Non-Payment of Premiums, Enrollee Receiving APTC; Enrollee Must Be Reinstated if Enrollee Pays All Premiums Due Prior to the End of the Grace Period</u>

1. Overview of Process

In the event of non-payment of premium by an enrollee, a Qualified Health Plan (QHP) issuer must

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

(B) provide a grace period of three months for an enrollee, who when failing to timely pay premiums, is receiving Advanced Payments of Premium Tax Credit (APTC);

(C) during the three-month grace period provided for enrollees who are receiving APTC and who have previously paid at least one full month's premium during the benefit year, the QHP issuer shall

a. pay all appropriate claims for services rendered to the enrollee during the first month of the grace period and may pay claims for services rendered to the enrollee in the second and third months of the grace period;

b. notify Covered California and the Department of Health and Human Services (HHS) of such non-payment;

c. notify providers of the possibility for denied claims when an enrollee is in the second and third months of the grace period;

d. continue to collect APTC on behalf of the enrollee from the IRS; and

e. comply with any other applicable State laws and regulations relating to the grace period.

(45 C.F.R. §§ 155.430 & 156.270; Cal. Code Regs, tit. 10, § 6506, subd. (c).)

2. QHP Issuer shall Terminate Coverage if Enrollee Receiving APTC Exhausts Three-Month Grace Period without Paying all Outstanding Premiums

If an enrollee receiving APTC exhausts the three-month grace period without paying all outstanding premiums, a QHP issuer shall:

(A) Terminate the enrollee's coverage effective the last day of the first month of the 3-month grace period, provided that the QHP issuer complies with the following notice requirements:

(1) The QHP issuer shall provide the enrollee, within five business days from the date of the termination, with a written notice of termination of coverage that includes:

a. The termination effective date;

b. The reason for termination; and

c. The notice of appeal rights, in accordance with the requirements specified in title 10 of the California Code of Regulations, section 6604, including the right to a Covered California appeal to the California Department of Social Services (CDSS) State Hearings Division (SHD).

(2) The QHP issuer shall notify Covered California of the termination effective date and reason for termination.

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

The QHP issuer shall also comply with the following additional requirements:

(C) The QHP issuer shall abide by the regulations on termination of coverage effective dates, which specify that the last day of coverage shall be the last day of the first month of the three-month grace period.

(D) The QHP issuer shall maintain electronic records of termination of coverage, including audit trails and the reason codes for the termination, for a minimum of 10 years.

(45 C.F.R. §§ 155.430 & 156.270; Cal. Code Regs, tit. 10, § 6506, subds. (c) & (e).)

1541-7 ADDED 10/15

Amended to Remove DMHC Reqs (CM)

12/18Termination Process for Non-Payment of Premiums if Enrollee is Not Receiving APTC; Reinstatement Required if Enrollee Pays Premiums When Due

1. Overview of Process

For an enrollee who is not receiving Advance Payments of Premium Tax Credit (APTC), Covered California may initiate termination of the enrollee's coverage in a Qualified Health Plan (QHP), and shall permit a QHP issuer to terminate such coverage, if the enrollee fails to pay premiums for coverage.

In the event of non-payment of premium by an enrollee, a QHP issuer must provide the enrollee, who is delinquent on premium payment, with notice of such payment delinquency.

(45 C.F.R. §§ 155.430 & 156.270; Cal. Code Regs, tit. 10, § 6506, subds. (b)(2)(B) & (c).)

2. QHP Issuer May Terminate Coverage if Enrollee Does Not Pay All Outstanding Premiums

If an enrollee's coverage in a QHP is terminated because the QHP issuer did not receive the past due amount from the enrollee, the QHP issuer shall

A. provide the enrollee, within five business days from the date of the termination, with a written notice of termination of coverage that includes

i. the termination effective date;

ii. the reason for termination; and

iii. the notice of appeal rights, in accordance with the requirements specified in Section 6604 of Article 7 of this chapter, including the right to a Covered California appeal to the California Department of Social Services (CDSS) State Hearings Division.

B. notify Covered California of the termination effective date and reason for termination;

C. maintain electronic records of termination of coverage, including audit trails and reason codes for termination, for a minimum of ten years.

(45 C.F.R. §§ 155.430 & 156.270; Cal. Code Regs, tit. 10, § 6506, subds. (b)(2)(B), (c), (e).)

1541-8 ADDED 10/15

Effective Dates of Terminations Initiated by Covered California or the QHP Issuer

For a termination that occurs because the enrollee is no longer eligible for coverage in a Qualified Heath Plan (QHP), the last day of coverage shall be the last day of eligibility, unless the enrollee requests an earlier termination date.

For terminations that occur because of non-payment of premiums

A. if the enrollee was eligible for a three-month grace period, because the enrollee was receiving Advance Payments of Premium Tax Credits (APTC) and had paid at least one full month's premium during the benefit year, the last day of coverage shall be the last day of the first month of the three-month grace period.

B. if an enrollee was not eligible for the three-month APTC grace period, coverage may be cancelled prospectively only after the end of the 30-day grace period.

For terminations that occur because the enrollee changes from one QHP to another during an annual open enrollment period, or special enrollment period, 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, including any retroactive enrollments effectuated under title 10 of the California Code of Regulations, section 6504, subdivision (h)(4) when an enrollee is granted a special enrollment period to change QHPs with a retroactive coverage effective date.

(45 C.F.R. § 155.430(d); Cal. Code Regs, tit. 10, § 6506, subd. (d); Cal. Code Regs, tit. 28, § 1300.65, subds. (a)(5) & (c)(3)(A).)

1542-1 ADDED 10/15

Definition of PTC and APTC

Payments of Premium Tax Credit (PTC) are payment(s) of tax credits authorized by section 36B of the Internal Revenue Code (26 U.S.C. § 36B). PTC may be provided in advance to an eligible individual enrolled in a Qualified Health Plan (QHP) through Covered California: Advance Payments of Premium Tax Credit (APTC).

(42 U.S.C. § 18081; Cal. Code Regs., tit. 10, § 6410; Cal. Dept. of Social Svcs., All County Lett. (ACL) No. 14-14 (Feb. 7, 2014) p. 2.)

1542-1A ADDED

5/16Definition of Tax Filer

Tax filer means an individual, or a married couple, who attests that he, she, or the couple expects to file a tax return for the benefit year and that if married, will file jointly with spouse,

unless subject to an exemption to filing a joint tax return. Tax filer further attests that no other taxpayer will claim the individual or couple as a tax dependent for the benefit year and that the individual or couple expects to claim a personal exemption deduction for one or more applicants.

(Cal. Code Regs, tit. 10, § 6410.)

1542-2 ADDED 10/15

Eligibility for APTC

A tax filer shall be eligible for Advanced Payments of Premium Tax Credit (APTC) if

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

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

(1) meets the requirements for eligibility for enrollment in a QHP, that is not a catastrophic plan, through Covered California;

(2) is not eligible for MEC, with the exception of coverage in the individual market; and

(3) is enrolled in a QHP, that is not a catastrophic plan, through Covered California.

(26 U.S.C. § 36B(c); 26 C.F.R. § 1.36B-2; Cal. Code Regs., tit. 10, §§ 6474, subd. (c), 6472.)

1542-2A ADDED 5/16

Non-Citizens Lawfully Present with Income between 100% and 400% FPL are Eligible for APTC/CSR to the Same Extent as Other Individuals

Non-citizens lawfully present in the United States with incomes between 100% and 400% of the Federal Poverty Level (FPL) are eligible for Advance Payments of Premium Tax Credit (APTC) and Cost-Sharing Reduction (CSR) to the same extent as other lawfully present individuals.

(45 C.F.R. §§ 155.305(a)(1), (f)(1)(ii)(A), (g)(1)(i)(A); Cal. Code Regs., tit. 10, §§ 6472(c) & 6474(c)(1)(B) & (d)(1)(A).)

1542-3 ADDED 10/15

[Redacted]

1542-3A ADDED 5/16

Special Rules for Non-Citizens Lawfully Present with Income below 100% FPL

Non-citizen tax filers who are lawfully present in the United States, who have income below 100% of the Federal Poverty Level (FPL), but who are not eligible for Medi-Cal due to their immigration status, are not subject to the minimum 100% FPL requirement to be eligible for Advance Payments of Premium Tax Credit (APTC). These non-citizens may receive APTC if they meet all other APTC eligibility requirements.

If a taxpayer with income less than 100% of the FPL is eligible for APTC under this special rule for non-citizens lawfully present who are not eligible for Medi-Cal, the taxpayer's actual household income for the taxable year is used to compute the premium assistance amount.

(26 U.S.C. § 36B(c)(1)(B); 26 CFR §§ 1.36B-2(b)(5) & (7); 45 C.F.R. § 155.305(f)(2); Cal. Code Regs., tit. 10, § 6474, subd. (c)(2).)

1542-4 ADDED 10/15

Taxpayer May Choose to Have Premium Tax Credit Paid in Advance (APTC) to QHP or Receive Tax Credit at Time of Tax Filing

A taxpayer may choose from among several options for receiving premium tax credits. The taxpayer may choose to have the federal government pay the tax credit directly to his or her Covered California Qualified Health Plan (QHP) on a monthly basis, reducing the net premiums that the taxpayer must pay each month to the QHP. Alternatively, the taxpayer may choose to pay the full or partial cost of his or her QHP premium each month, and receive the remaining tax credit in the form of a tax refund when he or she files the federal tax return. A Covered California enrollee may choose to have Covered California pay the health plan less than the full amount of the tax credit for which Covered California determines him or her eligible, and the enrollee may seek the remainder of the tax credit when he or she files his federal income tax return for the benefit year.

(42 U.S.C. § 18082(c)(2)(A); 26 C.F.R. §§ 1.36B-1(j), 1.36B-4(a); Cal. Code Regs, tit. 10 , § 6476, subd (d)(1).)

1542-5 ADDED 10/15

APTC Subject to Reconciliation

A taxpayer must reconcile the amount of APTC on the taxpayer's income tax return for a taxable year. A taxpayer whose premium tax credit for the taxable year exceeds the taxpayer's APTC may receive the excess as an income tax refund. On the other hand, a taxpayer whose APTC payments for the taxable year exceed the taxpayer's premium tax credit for the taxable year owes the excess as an additional tax liability.

(26 U.S.C. § 36B(f); 26 C.F.R. § 1.36B-4(a); Cal Code Regs, tit. 10 , § 6410.)

1542-5A ADDED 5/16

Covered California's Duty to Provide 1095-A Form

Covered California is required to furnish a 1095-A form to each individual for whom Covered California provided a Qualified Health Plan (QHP) with or without Advance Payments of Premium Tax Credit (APTC) during a tax year. Covered California provides APTC by paying

the credit to the individual's health plan issuer during the year, to reduce the net cost of the individual's monthly health insurance premiums. At the end of the year, Covered California must provide the individual with a 1095-A Form showing the amount of APTC that Covered California provided during the year, so that when the individual files his or her federal income tax return, the individual can reconcile the amount of tax credits to which they are entitled with the amount of advance tax credits that they received during the tax year. A Covered California consumer may request a Dispute Form 1095-A if the consumer believes that information on the 1095-A form is incorrect.

(26 C.F.R. §1.36B-5; IRS, Form 1095-A, Health Insurance Marketplace Statement (September 28, 2015), at <https://www.irs.gov/uac/about-form-1095-a> [as of May 27, 2016]; Covered California, "What is Form 1095-A?," at <http://www.coveredca.com/members/form-1095-a/> [as of May 27, 2016].)

1542-5B ADDED 5/16

Tax Filer Not Eligible for APTC If Tax Filer Received APTC in Prior Year and did Not Reconcile

A tax filer shall not be eligible for Advance Payments of Premium Tax Credit (APTC) for a benefit year if the Department of Health and Human Services (HHS) notifies Covered California, as part of the verification process, that APTC was provided to the tax filer in a prior year and the tax filer did not file a tax return for the prior year and did not reconcile APTC for the prior year.

(45 C.F.R. § 155.305(f)(4); Cal Code Regs, tit. 10 , § 6474(c)(3); Department Of Health & Human Services, Centers for Medicare & Medicaid Services, Center for Consumer Information & Insurance Oversight, "Guidance on Annual Eligibility Redeterminations and Re-enrollments for Marketplace Coverage for 2016" (April 22, 2015), pp. 4-5, at <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/annual-redeterminations-for-coverage-42215.pdf> [as of May 26, 2016].)

1542-6 ADDED 10/15

Taxpayer Eligible for Premium Tax Credit Only If Enrolled in Covered California QHP

A taxpayer is eligible for premium tax credits (APTC, or tax credits at the time of filing the tax return) only if the tax filer, the tax filer's spouse, or one or more of the tax filer's tax dependents is (or was) enrolled in a Covered California Qualified Health Plan (QHP) for the months for which the tax filer seeks the tax credit.

(26 U.S.C. § 36b(c)(2); 45 C.F.R. § 155.305(f)(3).)

1542-7 ADDED 10/15

Family Size/Tax Household for APTC/CSR

Eligibility for APTC and CSR is based on the applicant taxpayer's family size and income.

(26 U.S.C. § 36B(b)(2); 42 U.S.C. § 18071(c); 45 C.F.R. § 155.305(f), (g); Cal. Code Regs., tit. 10, § 6474, subds. (c), (d).)

1542-8 ADDED 10/15

Family Size

A taxpayer's family size equals the number of individuals for whom the taxpayer may claim a deduction under federal tax law (26 U.S.C. § 151). The taxpayer may claim deductions for him or herself, spouse, and dependents who are not claimed as dependents by other taxpayers. Dependents are the taxpayer's qualifying children and qualifying relatives.

(26 U.S.C. §§ 36B(d)(1), 151(a); 26 C.F.R. §§ 1.36B-1(d), (f), 1.36B-2(b)(3); Cal. Code Regs., tit. 10, § 6482, subd. (a).)

1543-1 ADDED 10/15

Who Taxpayers May Claim as Dependents

Dependents are the taxpayer's qualifying children and qualifying relatives.

(26 U.S.C. §§ 151, 152.)

1543-2 ADDED 10/15

Qualifying Child

A taxpayer's qualifying child means an individual

(1) who is the taxpayer's natural child, adopted child, stepchild, foster child, brother, sister, stepbrother, stepsister, half-brother, half-sister, or one of their descendants;

(2) who lives with the taxpayer for more than one-half of the taxable year;

(3) who is under age 19, or under age 24 (if a full time student), at the close of the calendar year in which the taxable year begins, and younger than the tax filer (and the taxpayer's spouse, if married filing jointly); these age requirements are deemed met for individuals who are permanently and totally disabled, as defined in federal law;

(4) who has not provided over one-half of such individual's own support for the taxable year;

(5) who has not filed a joint tax return with the individual's spouse in that taxable year; and

(6) who is a U.S. citizen or national, U.S. resident alien, or a resident of Canada or Mexico.

(26 U.S.C. § 152(a), (b), (c); 26 C.F.R. §§ 1.152-1, 1.152-2(a).)

1543-3 ADDED 10/15

Special Qualifying Child Rule for Individuals with Disability

If at any time during the taxable year, an individual is permanently and totally disabled, as defined under federal tax law (26 U.S.C. § 22(e)(3)), that individual is deemed to have met the age criteria for a qualifying child.

(26 U.S.C. § 152(c)(3)(B).)

1543-4 ADDED 10/15

Parent and Non-Parent Taxpayers Who Can Claim the Qualifying Child

When two or more taxpayers can claim a deduction for a child, that child will be considered a qualifying child and dependent of the taxpayer who is the child's parent. If the child's parent is deceased or unknown, the child will be considered a qualifying child and dependent of the taxpayer with the highest adjusted gross income in the taxable year.

(26 U.S.C. § 152(c)(4)(A).)

1543-5 ADDED 10/15

Parent Taxpayer That Can Claim the Qualifying Child When Two Parents May Claim the Child

When two parents may claim the child, the child will be considered a qualifying child and dependent of the parent with whom the child lives for the longest period of time during the taxable year. If the child lives with both parents equally, the child will be considered a qualifying child and dependent of the parent with the highest adjusted gross income.

(26 U.S.C. § 152(c)(4)(B); 26 C.F.R. § 1.152-4(a).)

1543-6 ADDED 10/15

Custodial Parent's Release of Claim to Exemption

A custodial parent with whom the child lives the longest during the taxable year may release the claim to exemption by signing IRS Form 8332 (Release/Revocation of Release of Claim to Exemption for Child by Custodial Parent) and declaring the intent to not claim the qualifying child as a dependent. The non-custodial parent must attach the form to his or her tax return for the taxable year.

(26 U.S.C. § 152(e); 26 C.F.R. § 1.152-4(b).)

1543-7 ADDED 10/15

Qualifying Relative

A taxpayer's qualifying relative and dependent means an individual:

(1) who is the taxpayer's

a. child or a descendant of a child;

b. brother, sister, stepbrother, or stepsister;

c. father or mother, or an ancestor of either;

d. stepfather or stepmother;

e. son or daughter of a brother or sister of the taxpayer;

f. brother or sister of the father or mother of the taxpayer;

g. son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, or sister-in-law; or

h. anyone, other than the taxpayer's spouse, who lives with the taxpayer during the entire taxable year and is a member of the taxpayer's household (may include the taxpayer's unmarried same sex partner and registered domestic partner);

(2) whose gross income during the taxable year is less than the exemption amount ($4,000 for calendar year 2015); this amount does not include income that an individual with a disability earns from a sheltered workshop where the individual receives medical care;

(3) for whom the taxpayer has provided over one-half of such individual's support for the taxable year;

(4) who is not any taxpayer's qualifying child;

(5) who has not filed a joint tax return with the individual's spouse in that taxable year; and

(6) who is a U.S. citizen or national, U.S. resident alien, or a resident of Canada or Mexico.

(26 U.S.C. § 152(a), (b), (d); 26 C.F.R. §§ 1.152-1, 1.152-2(a).)

1543-8 ADDED 10/15

Domestic Partners Not Dependents for APTC and CSR Eligibility, Unless They Meet "Qualifying Relative" Test

Domestic partners are not dependents for purposes of APTC and CSR eligibility determinations; except, under certain circumstances, "anyone" who meets the test for being a qualifying relative may be claimed as a dependent on a federal tax return.

(26 U.S.C. §§ 36B(d)(1), 151(a), 152; 26 C.F.R. §§ 1.152-1, 1.152-2(a); Cal. Code Regs., tit. 10, § 6410.)

1543-9 ADDED 10/15

Family Size, Individuals Exempt from Penalty for Failing to Maintain MEC

A taxpayer's family size may include individuals, who are not subject to or are exempt from the minimum essential health care coverage requirement.

(26 C.F.R. § 1.36B-1(d).)

1543-10 ADDED 10/15

Rules for Individuals Not Lawfully Present in the U.S.

A taxpayer's family size does not include a dependent not lawfully present in the U.S.

(26 U.S.C. § 36B(e)(1)(B)(i)(I); 26 C.F.R. § 1.36B-3(l)(1).)

1544-1 ADDED 10/15

Requirement for Married Couples to File Joint Returns, Unless an Exception Applies

If a couple is considered married for tax return filing purposes, they must file a joint tax return for the benefit year to be eligible for APTC, unless they meet an exception for victims of domestic abuse or spousal abandonment.

(26 U.S.C. § 36B(c)(1)(C); 26 C.F.R. §§ 1.36B-2(b)(2), 1.36B-4(b)(3), 1.36B-2T ; Cal. Code Regs, tit. 10, § 6476, subd. (d)(2).)

1544-2 ADDED 10/15

Temporary Exception to Joint Tax Return Requirement for Individuals Considered Married

In taxable years beginning January 1, 2014 through July 24, 2017, a married taxpayer, who is considered married for tax return filing purposes but files a tax return separately from the spouse, satisfies the APTC joint filing requirement if the taxpayer

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

(2) is unable to file a joint return because the taxpayer is a victim of domestic abuse or spousal abandonment; and

(3) certifies on the return that the taxpayer meets the criteria of a victim of domestic abuse or spousal abandonment.

(26 C.F.R. § 1.36B-2T(b)(2)(ii).)

1544-3 ADDED 10/15

Domestic Abuse (Temporary Exception) to Joint Filing Requirement

For purposes of determining whether a taxpayer meets the criteria for an exception to the joint tax return requirement, 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.

(26 C.F.R. § 1.36B-2T(b)(2)(iii).)

1544-4 ADDED 10/15

Spousal Abandonment (Temporary Exception) to Joint Filing Requirement

For purposes of determining whether a taxpayer meets the criteria for an exception to the joint tax return requirement, a taxpayer is a victim of spousal abandonment for a taxable year if the taxpayer is unable to locate his or her spouse after reasonable diligence.

(26 C.F.R. § 1.36B-2T(b)(2)(iv).)

1544-5 ADDED 10/15

Three-Year Limit for Joint Return Exception (Temporary Exception)

A married taxpayer filing separately may meet the criteria for an exception to the joint tax return requirement based on domestic abuse or spousal abandonment for only three consecutive taxable years.

(26 C.F.R. § 1.36B-2T(b)(2)(v).)

1544-6 ADDED 10/15

No Joint Return Requirement for Individuals Not Considered Married

A married individual who is not considered married within the meaning of title 26 of the United States Code section 7703 does not need to file a joint tax return to be eligible for APTC and/or CSR.

(26 U.S.C. §§ 2(b)(1), 36B(c)(1)(C), 7703(b); 26 C.F.R. §§ 1.2-2(b)-(e), 1.36B-2(b)(2), 1.36B-4(b)(3), 1.36B-2T, 1.7703-1(b); Cal. Code Regs, tit. 10, § 6476, subd. (d)(2).)

1545-1 ADDED 10/15

Marital Status Determined at the End of Tax Year, Except If Spouse Dies

The determination of whether an individual is married is made as of the close of the taxable year. If, however, a taxpayer's spouse dies during the taxable year, the determination is made as of the time of the death.

(26 U.S.C. § 7703(a)(1).)

1545-2 ADDED 10/15

Married but Separated

An individual is considered married even though living apart from the spouse unless legally separated under a decree of divorce or separate maintenance.

(26 U.S.C. § 7703(a)(2).)

1545-3 ADDED 10/15

Not Considered Married

A married individual is not considered married for tax purposes if,

1. the individual files a separate return;

2. the individual maintains as his or her home a household that constitutes for more than one-half of the taxable year the principal place of residence of a dependent child with respect to whom such individual is entitled to a deduction for the taxable year;

3. the individual furnishes over one-half of the cost of maintaining such household during the taxable year; and

4. during the last six months of the taxable year, the individual's spouse is not a member of the individual's household.

(26 U.S.C. §§ 2(c), 7703(b).)

1545-4 ADDED 10/15

Head of Household

An individual shall be considered the head of a household if the individual is unmarried or considered as not married for tax return filing purposes at the close of the taxable year; is not a surviving spouse; and

1. the individual files a separate return;

2. the individual maintains as his or her home a household that constitutes for more than one-half of the taxable year the principal place of residence of a dependent child with respect to whom such individual is entitled to a deduction for the taxable year, but not if such child is married at the close of the taxable year; or the principle place or residence of any other person who is a dependent of the taxpayer, if the taxpayer is entitled to a deduction for that person for the taxable year, including the father or mother of the taxpayer;

3. the individual maintains the household and contributes over half of the cost of maintaining the household during the taxable year; and

4. during the last six months of the taxable year, the individual's spouse is not a member of the individual's household.

(26 U.S.C. § 2(b)(1), (c); 26 C.F.R. § 1.2-2(b)-(e).)

1545-5 ADDED 10/15

Limitations on Head of Household Filing Status – Nonresident Alien Individual

An individual shall not be considered to be a head of a household if at any time during the taxable year the individual is a non-resident alien.

(26 U.S.C. § 2(b)(3)(A); 26 C.F.R. § 1.2-2(b)(6).)

1545-6 ADDED 10/15

Limitations on Head of Household Filing Status – Nonresident Alien Spouse

For purposes of determining head of household status, an individual is not considered married at the close of the taxable year if at any time during the taxable year the individual's spouse is a nonresident alien.

(26 U.S.C. § 2(b)(2)(B); 26 C.F.R. § 1.2-2(b)(5).)

1546-1 ADDED 10/15

Household Income

An applicant family's annual household income is computed based on tax return data for all individuals whose income is counted in calculating a tax filer's or an applicant's household income as follows:

1. The taxpayer's modified adjusted gross income, plus
2. The aggregate modified adjusted gross incomes of all other individuals who were
    a. taken into account in determining the taxpayer's family size; and
    b. required to file a tax return for the taxable year.

(26 U.S.C. § 36B(d)(2)(A); 26 C.F.R. § 1.36B-1(e); Cal. Code Regs., tit. 10, § 6482, subd. (a).)

1546-2 ADDED 10/15

Tax Filing Thresholds – Individuals Claimed as Dependents

A U.S. citizen or resident alien who is claimed as a dependent by another taxpayer must file an income tax return if the annual income met the relevant threshold, as shown below.

1) Use only taxable portions of income to determine filing threshold: When determining whether a tax dependent must file a tax return, compare the ***taxable*** portion of the dependent's earned, unearned, and gross income to the tax filing table for dependents. IRS rules define these terms as follows:
    a) Unearned income includes taxable interest, ordinary dividends, and capital gain distributions. It also includes unemployment compensation, *taxable* social security benefits, pensions, annuities, and distributions of unearned income from a trust.
    b) Earned income includes salaries, wages, tips, professional fees, and *taxable* scholarship and fellowship grants.
    c) Gross income is the total of the unearned and earned income.
2) Social Security benefits received by dependents: If a dependent receives social security benefits that are ***not taxable***, the dependent has zero unearned income, because the IRS only counts "taxable" social security as "unearned income." Most of the time, the social security benefits received by a dependent who is applying for MAGI Medi-Cal are not taxable. If a dependent's social security benefits are not taxable, do not consider the dependent's social security benefits when reviewing the tax filing table.

3) Tax dependent status: The IRS tax filing table for dependents includes a cautionary reminder that if a person's gross income was $3,950 for 2014 or $4,000 for 2015 or more, that person usually cannot be claimed as a dependent unless the person meets the requirements to be a "qualifying child" (including the requirement to be under age 19, or under age 24 if a student, unless the child is disabled). For example, if a child is over these age limits and is not disabled, a parent cannot claim the child as a dependent under the "qualifying child" rules. However, the parent may claim the child as a dependent under the "qualifying relative" rules, but *only if* the child's gross income was less than $3,950 for 2014 or $4,000 for 2015 and *also* if the parent and child meet the other requirements for "qualifying relative" status. For details, see Exemptions for Dependents (IRS publication 501, p. 11 et. seq.).

4) Different filing rules apply, depending on marital status, age, and whether dependent is blind: The IRS provides different filing thresholds depending on whether a dependent is single or married, over or under age 65, or blind. In MAGI Medi-Cal hearings, most dependents are single, under age 65, and not blind.

(26 U.S.C. § 6012; 26 U.S.C. § 86 (rules for determining whether social security benefits are taxable); 26 C.F.R. § 1.1-1; IRS Publication 501, *Exemptions, Standard Deduction, and Filing Information for Use in Preparing 2014 Returns* (2014), Table 2, at <http://www.irs.gov/uac/About-Publication-501> [as of Aug. 12, 2015].)

1546-3 ADDED 10/15

2014 Tax Filing Thresholds – Individuals Claimed as Tax Dependents

For 2014, the tax filing thresholds for individuals claimed as tax dependents by another taxpayer are as follows:

1) Single Dependent, Under Age 65, not Blind:

   i) The individual must file a tax return if **any** of the following apply:
      (1) Unearned income was more than $1,000;

      (2) Earned income was more than $6,200;

      (3) Gross income was more than the larger of

         (a) $1,000, or

         (b) Earned income (up to $5,850) plus $350.

2) Single Dependent, Age 65 or Older, or Blind:

   i) The individual must file a tax return if **any** of the following apply:
      (1) Unearned income was more than $2,550 ($4,100 if 65 or older **and** blind);

      (2) Earned income was more than $7,750 ($9,300 if 65 or older **and** blind);

      (3) Gross income was more than the larger of

(a) $2,550 ($4,100 if 65 or older **and** blind), or

(b) Earned income (up to $5,850) plus $1,900 ($3,450 if 65 or older **and** blind).

3) Married Dependent, Under Age 65, not Blind:

i) The individual must file a tax return if **any** of the following apply:
(1) Gross income was at least $5 and spouse files a separate return and itemizes deductions.

(2) Unearned income was more than $1,000;

(3) Earned income was more than $6,200;

(4) Gross income was more than the larger of

(a) $1,000, or

(b) Earned income (up to $5,850) plus $350.

4) Married Dependent, Age 65 or Older, or Blind:

i) The individual must file a tax return if **any** of the following apply:
(1) Gross income was at least $5 and spouse files a separate return and itemizes deductions.

(2) Unearned income was more than $2,200 ($3,400 if 65 or older **and** blind);

(3) Earned income was more than $7,400 ($8,600 if 65 or older **and** blind);

(4) Gross income was more than the larger of

(a) $2,200 ($3,400 if 65 or older **and** blind), or

(b) Earned income (up to $5,850) plus $1,550 ($2,750 if 65 or older **and** blind).

(26 U.S.C. § 6012; 26 C.F.R. § 1.1-1; IRS Publication 501, *Exemptions, Standard Deduction, and Filing Information for Use in Preparing 2014 Returns* (2014), Table 2, at <http://www.irs.gov/uac/About-Publication-501> [as of Aug. 12, 2015].)

1546-3A ADDED 5/16

2015 Tax Filing Thresholds – Individuals Claimed as Tax Dependents

For 2015, the tax filing thresholds for individuals claimed as tax dependents by another taxpayer are as follows:

1) Single Dependent, Under Age 65, not Blind:

i) The individual must file a tax return if **any** of the following apply:
(1) Unearned income was more than $1,050;

(2) Earned income was more than $6,300;

(3) Gross income was more than the larger of

(a) $1,050, or

(b) Earned income (up to $5,950) plus $350.

2) Single Dependent, Age 65 or Older, or Blind:

i) The individual must file a tax return if **any** of the following apply:
(1) Unearned income was more than $2,600 ($4,150 if 65 or older **and** blind);

(2) Earned income was more than $7,850 ($9,400 if 65 or older **and** blind);

(3) Gross income was more than the larger of

(a) $2,600 ($4,150 if 65 or older **and** blind), or

(b) Earned income (up to $5,950) plus $1,900 ($3,450 if 65 or older **and** blind).

3) Married Dependent, Under Age 65, not Blind:

i) The individual must file a tax return if **any** of the following apply:

(1) Gross income was at least $5 and spouse files a separate return and itemizes deductions.

(2) Unearned income was more than $1,050;

(3) Earned income was more than $6,300;

(4) Gross income was more than the larger of

(a) $1,050, or

(b) Earned income (up to $5,950) plus $350.

4) Married Dependent, Age 65 or Older, or Blind:

i) The individual must file a tax return if **any** of the following apply:
(1) Gross income was at least $5 and spouse files a separate return and itemizes deductions.

(2) Unearned income was more than $2,300 ($3,550 if 65 or older **and** blind);

(3) Earned income was more than $7,550 ($8,800 if 65 or older **and** blind);

(4) Gross income was more than the larger of

(a) $2,300 ($3,550 if 65 or older **and** blind), or

(b) Earned income (up to $5,950) plus $1,600 ($2,850 if 65 or older **and** blind).

(26 U.S.C. § 6012; 26 C.F.R. § 1.1-1; IRS Publication 501, Exemptions, Standard Deduction, and Filing Information for Use in Preparing 2014 Returns (December 29, 2015), Table 2, at <http://www.irs.gov/uac/About-Publication-501> [as of February 25, 2016].)

1546-4 ADDED 10/15

Modified Adjusted Gross Income Definition for APTC and CSR

Modified Adjusted Gross Income for APTC and CSR means starting with an individual's Adjusted Gross Income (determined based on tax filing rules), and then "modifying" the Adjusted Gross Income by adding the following three types of income:

(1) Foreign earned income excluded from gross income as permitted under federal tax law (26 U.S.C. § 911(a));

(2) ax exempt interest; and

(3) Non-taxable social security retirement, survivors and disability benefits, and tier 1 railroad retirement benefits.

Although the "MAGI" modification only adds an individual's non-taxable social security retirement, survivors and disability benefits, and tier 1 railroad retirement benefits, the MAGI income calculation will always include 100% of an individual's social security retirement, survivors and disability benefits, and tier 1 railroad retirement benefits, because the taxable social security benefits are included in the individual's Adjusted Gross Income, and the non-taxable social security benefits are added as the "modification" to the Adjusted Gross Income.

(26 U.S.C. § 36B (d)(2)(B); 26 C.F.R. § 1.36B-1(e)(2); Cal. Code Regs, tit. 10, § 6410.)

1546-5 ADDED 10/15

Adjusted Gross Income (AGI), General Definition

Adjusted Gross Income (AGI) means "gross income," as defined in tax rules, minus certain deductions that tax rules allow a taxpayer to take before calculating the "Adjusted Gross Income" line on the tax return. These Adjusted Gross Income deductions are taken before the taxpayer takes his or her Schedule A deductions or Standard Deduction.

Thus, the first step in calculating Adjusted Gross Income is to determine the taxpayer's "Gross Income," using tax rules. The next step is to determine whether the taxpayer is entitled to take any of the Adjusted Gross Income deductions.

(26 U.S.C. §§ 62, 162(l), 164(f); 26 C.F.R. § 1.62-1(c); IRS Form 1040 Instructions for 2014, pp. 30-37, at <http://www.irs.gov/pub/irs-pdf/i1040.pdf > [as of August 13, 2015].)

1546-6 ADDED 10/15

Gross Income - General

MAGI Medi-Cal eligibility is based on Modified Adjusted Gross Income, which uses "Adjusted Gross Income" as its starting point. The starting point for determining "Adjusted Gross Income" is to determine an individual's "Gross Income," as defined in tax rules.

Tax rules define "Gross Income" as income that is not exempt from tax.

Gross Income includes compensation for services (i.e. fees, wages, commissions, and fringe benefits), gross business or partnership income, rental income, financial gain from exchange of property, royalties, interest, dividend, annuities, alimony, pension, distribution from a life insurance, estate or trust, unemployment benefits, and tax refunds.

(26 U.S.C. §§ 61, 85; 26 C.F.R. § 1.61-1; *Hyde v. Commission* (2011) Tax Court Memo 2011-104, 101 T.C.M. (CCH) 1502; IRS Publication 501, *Exemptions, Standard Deduction, and Filing Information for Use in Preparing 2015 Returns* (2015), Table. 1, at <http://www.irs.gov/uac/About-Publication-501> [as of February 25, 2016].)

1546-6A ADDED 5/16

Gross Income - Gifts and Inheritances

As a general rule, gross income does not include the value of property acquired by gift, bequest or inheritance. If, however, the property received produces income such as interest, dividends or rents, this income is taxable.

(26 U.S.C. § 102(a) & (b); IRS Publication 525 – Main Content, at <https://www.irs.gov/publications/p525/ar02.html> [as of February 25, 2016].)

1546-6B ADDED 5/16

Compensation for Injuries or Sickness Compensation for Injuries or Sickness from Active Services in the Armed Forces

Gross income does not include amounts received as a pension, annuity or similar allowance for personal injuries or sickness arising from active services in the armed forces of any country.

(26 U.S.C. § 104(a)(4).)

1546-7 ADDED 10/15

Gross Income - Self-Employment Income

Income from self-employment is calculated based on the taxpayer's net business profit (or loss), as shown on the Schedule C (calculated by reducing gross revenue from self-employment by allowable deductible expenses) or other applicable schedules.

(26 U.S.C. § 1402(a); IRS Form 1040, Schedule C, at <http://www.irs.gov/pub/irs-pdf/f1040sc.pdf> [as of September 3, 2015]; IRS Form 1040, Instructions, at <www.irs.gov/pub/irs-pdf/i1040gi.pdf> [as of September 3, 2015].)

1546-8 ADDED 10/15

Gross Income - Social Security Benefits

If it has been determined that an individual's income must be included when determining the household income, then the *total* amount of the individual's social security retirement, survivors and disability benefits, and tier 1 railroad retirement benefits, will always be included in calculating that individual's *Modified* Adjusted Gross Income, since the *total* MAGI calculation includes *both* taxable and non-taxable Social Security benefits.

When it is necessary to determine the *taxable* portion (*gross income* portion) of an individual's social security benefits, the following federal tax rule is used:

Gross income includes social security retirement, survivors and disability benefits, and tier one railroad retirement benefits, only in the following circumstances:

(1) The social security beneficiary was married, lived with the spouse at any time during the taxable year, but filing separately; or

(2) One half of the social security beneficiary's social security benefits plus other gross income and any tax exempt interest is more than $25,000 (for calendar years 2014 and 2015) ($32,000 if married filing jointly).

(26 U.S.C. § 86; *Maki v. Commissioner* (1996) Tax Court Memo 1996-209, RIA TC Memo P 96209, 71 T.C.M. (CCH) 2933; IRS Publication 915, "Social Security and Equivalent Railroad Retirement Benefits" (August 5, 2015), at <https://www.irs.gov/uac/about-publication-915> [as of May 27, 2016].)

1546-9 ADDED 10/15

Gross Income - Workers' Compensation

Gross income does not include workers' compensation. Workers' compensation for purposes of this paragraph does not include retirement plan benefits received based on age, length of service, or prior contributions to the plan, even if the retirement was due to an occupational sickness or injury.

(26 U.S.C. § 104; 26 C.F.R. § 1.104-1(b); IRS Publication 17 (November 26, 2013) p. 53; IRS Publication 525 – Main Content, at <https://www.irs.gov/publications/p525/ar02.html> [as of February 25, 2016].)

1546-10 ADDED 10/15

Gross Income - Veteran's Benefits

Veterans' benefits paid under any law, regulation, or administrative practice, administered by the Department of Veterans Affairs (VA) are not included in gross income. The following amounts paid to veterans or their families are not taxable:

1. Education, training, and subsistence allowances.

2. Disability compensation and pension payments for disabilities paid either to veterans or their families.

3. Grants for homes designed for wheelchair living.

4. Grants for motor vehicles for veterans who lost their sight or the use of their limbs.

5. Veterans' insurance proceeds and dividends paid either to veterans or their beneficiaries, including the proceeds of a veteran's endowment policy paid before death.

6. Interest on insurance dividends you leave on deposit with the VA.

7. Benefits under a dependent-care assistance program.

8. The death gratuity paid to a survivor of a member of the Armed Forces who died after September 10, 2001.

9. Payments made under the compensated work therapy program.

10. Any bonus payment by a state or political subdivision because of service in a combat zone.

Military pensions and disability benefits, however, are included in gross income, if they are:

1. Retirement benefits based on age or years of service; and

2. Disability pension benefits based on years of service, except when the pension qualifies for exclusion for service-connected disability.

(26 U.S.C. §§ 104, 122, 134; IRS Publication 17 (2014) pp. 51-53; IRS Publication 525 (2014) pp. 15-16, at <https://www.irs.gov/publications/p525/ar02.html > [as of February 25, 2016].)

1546-11 ADDED 10/15

Gross Income - Child Support

Gross income does not include child support.

(26 U.S.C. § 71(c).)

1546-12 ADDED 10/15

Gross Income - IHSS Wages Included; WPCS Wages Are Excluded

Generally, an applicant's IHSS wages are taxable gross income and therefore are included in Modified Adjusted Gross Income (MAGI).

An applicant's wages from providing personal care services are excluded from the applicant's MAGI under California Department of Health Care Services Medi-Cal Eligibility Divis. Info. Lett. (MEDIL) No. 15-03 and federal tax law (26 U.S.C. § 131) when all three conditions are met:

(1) The applicant receives wages through the Waiver Personal Care Services (WPCS) program for providing personal care services to a Medi-Cal beneficiary who is a waiver participant.

a. A provider under WPCS receives Time Reports showing the hours approved under WPCS. Providers who also receive wages through an In Home Supportive Services (IHSS) program receive two Time Reports: one from IHSS and one from WPCS. (WAIVER PERSONAL CARE SERVICES FREQUENTLY ASKED QUESTIONS Department of Health Care Services In-Home Operations Branch, p. 3, at <http://www.dhcs.ca.gov/services/ltc/Documents/WPC_Frequently_Asked_Questions.pdf> [as of August 11, 2015].)

(2) The applicant and the WPCS recipient live in the same home.

(3) The applicant's exempt wages are for providing personal care services to no more than 5 WPCS recipients age 19 or above, or 10 WPCS recipients under age 19.

(26 U.S.C. §§ 36B(d)(2)(B), 131; Internal Revenue Bulletin: 2014-4, January 21, 2014, Notice 2014–7, Foster care payment, Medicaid waivers <http://www.irs.gov/irb/2014-4_IRB/ar06.html#d0e425> [as of August 11, 2015]; Cal. Dept. Health Care Svcs., Medi-Cal Eligibility Div. Info. Lett. (MEDIL) No. 15-03 (Jan. 27, 2015).)

1546-13 ADDED 10/15

Gross Income - Constructive Receipt of Income

Although the taxpayer may not have the income in his or her possession, the taxpayer has constructively received it in the taxable year during which the income is made available so that the taxpayer may access the income during that taxable year. The taxpayer, however, has not constructively received the income if the taxpayer cannot access the income, or if the access is subject to substantial limitations.

(26 C.F.R. § 1.451-2(a).)

1546-13A ADDED 10/15

Gross Income, Treatment of California State Disability Income

California State Disability Income (SDI) is not treated as taxable income, unless the disability insurance benefits are paid as a substitution for Unemployment Insurance benefits.

If the disability insurance benefits are paid as a substitution for Unemployment Insurance benefits, then the disability insurance benefits are taxable, because Unemployment Insurance benefits are taxable income.

(26 USC §§ 104(a)(3) & 105(e); 26 CFR §§ 1.104-1(d) & 1.105-5; Cal. Unemployment Insurance Code §§ 984, 2601, 2603, 2653, 2901; Cal. Employment Development Dept., FAQ - Disability Insurance (DI) Benefits, at <http://www.edd.ca.gov/Disability/FAQ_DI_Benefits.htm> [as of May 27, 2016].)

1546-13B ADDED 10/15

Gross Income, Treatment of Disability Benefits Received under a Private Disability Insurance Policy

If an individual receives disability benefits under a private disability insurance policy that the individual paid for with his or her own funds, the amounts that the individual receives under that disability policy are usually excluded from gross income. The following rules apply to determining whether some or all of the benefits received under a private disability insurance policy are taxable income:

- If the individual paid the entire cost of the disability insurance policy with his or her own funds, and the income used to pay for the disability policy was taxed, then none of the benefits received under the policy are taxable income.

- If the individual paid the entire cost of the disability insurance policy with his or her own funds, but the individual paid the premiums through a cafeteria plan, and the individual did *not* include the amount of the premiums paid for the disability insurance policy as taxable income, then the premiums are considered paid for by the employer, and the disability benefits received under the policy are fully taxable.

- If both the individual and the employer paid the premiums for the disability insurance policy, then the amount of disability benefits attributable to the employer's premium payments is reported as income.

(26 U.S.C. §§ 104 & 105; 26 C.F.R. §§ 1.104-1(d) & 1.105-5; IRS, Life Insurance & Disability Insurance Proceeds, at <https://www.irs.gov/Help-&-Resources/Tools-&-FAQs/FAQs-for-Individuals/Frequently-Asked-Tax-Questions-&-Answers/Interest,-Dividends,-Other-Types-of-Income/Life-Insurance-&-Disability-Insurance-Proceeds/Life-Insurance-&-Disability-Insurance-Proceeds-1> [as of May 27, 2016].)

1546-14 ADDED 10/15

Adjusted Gross Income (AGI) - Deductions

Adjusted Gross Income (AGI) means gross income minus the following deductions:

(1) Educator expenses up to $250;

(2) Certain business expenses of reservists, performing artists, and fee-basis government officials;

(3) Losses from sale or exchange of property;

(4) Deductions attributable to expenses related to production of rental income and to depletion and depreciation of improvement related to mines, oil and gas wells, other natural deposits, and timber;

(5) Deductions of life tenants and income beneficiaries of property;

(6) Pension, profit-sharing, and annuity plans of self-employed individuals;

(7) Qualified retirement savings;

(8) Penalty on early withdrawal of savings (excluding the 10% early distribution penalty that applies to any distribution from retirement account that occurs before age 59.5);

(9) Alimony paid;

(10) Reforestation expenses;

(11) Certain required repayment of supplemental unemployment compensation benefits;

(12) Jury duty pay remitted to the employer;

(13) Deduction for clean-fuel vehicle and refueling property;

(14) Moving expenses;

(15) Archer MSAs (Medical Savings Accounts);

(16) Student loan interest deduction of up to $2,500;

(17) Qualified college tuition and related expenses up to $4,000 in taxable year;

(18) Health saving account deduction;

(19) Costs involving discrimination suits;

(20) Attorneys' fees relating to awards to whistleblowers;

(21) Deductible part of self-employment tax; and

(22) Self-employment health insurance deduction.

(26 U.S.C. §§ 62, 162(l), 164(f); 26 C.F.R. § 1.62-1(c); IRS Form 1040 Instructions for 2014, pp. 30-37, at < http://www.irs.gov/pub/irs-pdf/i1040.pdf > [as of August 13, 2015]; IRS Publication 970, pp. 37-43, at <www.irs.gov/pub/irs-pdf/p970.pdf> [as of September 4, 2015].)

1546-15 ADDED 10/15

AGI – Moving Expense Deduction

A taxpayer may deduct moving expenses if

1. new employment is at least 50 miles farther from the taxpayer's old home than previous employment; or if the taxpayer was not previously employed, new employment must be at least 50 miles from the old home; and

2. the taxpayer works full time for at least 30 weeks during the 12-month period following the move.

(26 U.S.C. § 62(a)(15); 26 C.F.R. § 1.62-1(c).)

1547-1 ADDED 10/15

APTC/CSR Determinations Must Use FPL in Effect on First Day of Open Enrollment Period

When determining eligibility for APTC and CSR, the applicable Federal Poverty Level (FPL) is the most recently published poverty guideline in effect as of the first day of the annual open enrollment period for coverage in a Qualified Health Plan (QHP) during that calendar year.

(26 U.S.C. § 36B(d)(3); 42 U.S.C. 9902(2); 26 C.F.R. § 1.36B-1(h); 45 C.F.R. § 155.300(a); Cal. Code Regs., tit. 10, § 6502; 78 Fed.Reg. 5182 (Jan. 24, 2013).)

1547-2

ADDED 10/15

APTC/CSR Determinations for Coverage During 2014 Must Use 2013 FPL

For eligibility determinations of any Qualified Health Plan (QHP) offered through Covered California for coverage during a calendar year, the applicable Federal Poverty Level (FPL) is the most recently published poverty guideline in effect as of the first day of the annual open enrollment period for coverage during that calendar year.

For determinations of coverage effective during 2014, the 2013 FPL guidelines must be used, because the first day of open enrollment for 2014 coverage was November 15, 2013.

The 2013 FPL chart is as follows:

Federal Poverty Level Guidelines 2013

Federal Poverty Guidelines 2013 (Rounded up to the nearest dollar)	
	ANNUAL FPL
MAGI Household Size	100% FPL
1	$11,490
2	$15,510
3	$19,530
4	$23,550
Each Add'l	$4,020

(26 U.S.C. § 36B(d)(3); 42 U.S.C. 9902(2); 26 C.F.R. § 1.36B-1(h); 45 C.F.R. § 155.300(a);

Cal. Code Regs., tit. 10, § 6502; 78 Fed.Reg. 5182 (Jan. 24, 2013).)

1547-3

ADDED 10/15

APTC/CSR Determinations for Coverage During 2015 Must Use 2014 FPL

For eligibility

determinations of any Qualified Health Plan (QHP) offered through Covered California for coverage during a calendar year, the applicable Federal Poverty Level (FPL) is the most recently published poverty guideline in effect as of the first day of the annual open enrollment period for coverage during that calendar year.

For determinations of coverage effective during 2015, the 2014 FPL guidelines must be used, because the first day of open enrollment for 2015 coverage was November 15, 2014.

The 2014 FPL chart is as follows:

Federal Poverty Guidelines 2014 (Rounded up to the nearest dollar)	
	ANNUAL FPL
MAGI Household Size	100% FPL
1	$11,670
2	$15,730
3	$19,790
4	$23,850

Each Add'l	$4,060

(26 U.S.C. § 36B(d)(3); 42 U.S.C. 9902(2); 26 C.F.R. § 1.36B-1(h); 45 C.F.R. § 155.300(a);

Cal. Code Regs., tit. 10, § 6502; 79 Fed.Reg. 3593 (Jan. 22, 2014); Cal. Dept. of Health Care Svcs., All County Welf. Director's Lett. (ACWDL) No. 14-04 (February 19, 2014).)

1547-4

ADDED 10/15

APTC/CSR Determinations for Coverage During 2016 Must Use 2015 FPL

For eligibility determinations of any Qualified Health Plan (QHP) offered through Covered California for coverage during a calendar year, the applicable Federal Poverty Level (FPL) is the most recently published poverty guideline in effect as of the first day of the annual open enrollment period for coverage during that calendar

year.

For determinations of coverage effective during 2016, the 2015 FPL guidelines must be used, because the first day of open enrollment for 2016 coverage was November 15, 2015.

The 2015 FPL chart is as follows:

Federal Poverty Guidelines 2015 (Rounded up to the nearest dollar)	
	ANNUAL FPL
MAGI Household Size	100%
1	$11,770
2	$15,930
3	$20,090
4	$24,250
Each Add'l	$4,160

(26 U.S.C. § 36B(d)(3); 42 U.S.C. 9902(2); 26 C.F.R. § 1.36B-1(h); 45 C.F.R. § 155.300(a);

Cal. Code Regs., tit. 10, § 6502; Cal. Dept. of Health Care Svcs., All County Welf. Directors' Lett. (ACWDL) No. 15-14 (March 11, 2015).)

1547-5 ADDED 10/15

Special FPL Rules for Individuals Not Lawfully Present in the U.S.

When determining the Federal Poverty Level (FPL) for a tax household with individuals not lawfully present in the U.S., Covered California must consider the following:

(1) the tax household's family size does not include individuals not lawfully present; and

(2) the tax household's income is equal to the sum of the household income, which includes the income of the individuals not lawfully present, and the following fraction:

   a. the numerator - the poverty line for the family size, not including the individuals not lawfully present; and

   b. the denominator - the poverty line for the family size, including the individuals not lawfully present.

(26 U.S.C. § 36B(e)(1)(B); 26 C.F.R. § 1.36B-3(l).)

1548-1 ADDED 10/15

Calculation of APTC

Title 26 of the United States Code section 36B (section 36B) and title 26 of the Code of Federal Regulations section 1.36B-3 outline the steps used to calculate a taxpayer's health insurance premium assistance amount, as follows:

A. FPL

Section 36B(b) requires the taxpayer's income to be compared to the Federal Poverty Level (FPL), to determine the taxpayer's percent of the FPL.

B. Percent of Income Required to be Spent on Health Insurance Premiums

Section 36B(b)(3)(A) requires the taxpayer to spend a certain percentage of his income on health insurance, known as the "applicable percentage." This applicable percentage shall be calculated by applying a sliding scale to the table set forth in Section 36B(b)(3)(A)(i).

The Internal Revenue Service adjusts the applicable percentage table annually. The applicable percentage tables are as follows:

Applicable Percentage Table for Benefit Year 2014

Household income percentage of Federal Poverty Level	Initial percentage	Final percentage
Less than 133%	2.0	2.0
At least 133% but less than 150%	3.0	4.0
At least 150% but less than 200%	4.0	6.3
At least 200% but less than 250%	6.3	8.05

At least 250% but less than 300%	8.05	9.5
At least 300% but less than 400%	9.5	9.5

Applicable Percentage Table for Benefit Year 2015

Household income percentage of Federal Poverty Level	Initial percentage	Final percentage
Less than 133%	2.01	2.01
At least 133% but less than 150%	3.02	4.02
At least 150% but less than 200%	4.02	6.34
At least 200% but less than 250%	6.34	8.10
At least 250% but less than 300%	8.10	9.56
At least 300% but less than 400%	9.56	9.56

Applicable Percentage Table for Benefit Year 2016

Household income percentage of Federal Poverty Level	Initial percentage	Final percentage
Less than 133%	2.03	2.03
At least 133% but less than 150%	3.05	4.07
At least 150% but less than 200%	4.07	6.41
At least 200% but less than 250%	6.41	8.18
At least 250% but less than 300%	8.18	9.66
At least 300% but less than 400%	9.66	9.66

C. Monthly Premium Assistance Amount

Once a taxpayer's applicable premium percentage has been calculated, section 36B(b)(2)(B) requires the taxpayer's monthly health insurance premium assistance to be calculated as follows:

1. Multiply the applicable premium percentage times the taxpayer's household income for the taxable year.

2. Divide this result by 12, to calculate the taxpayer's monthly premium contribution.

3. Find the monthly premium cost for the second lowest cost silver plan available to the taxpayer in the taxpayer's rating area.

4. Subtract the taxpayer's monthly premium contribution (the result in step two) from the monthly premium cost used in step three, as follows:

   Monthly premium for second lowest cost silver plan *minus* the taxpayer's monthly premium contribution *equals* the monthly premium assistance available to the taxpayer.

D. Benefit Year Premium Assistance Credit Amount

Add the monthly premium assistance amounts for each month during which the taxpayer is eligible for assistance to calculate the total premium assistance credit amount available to the taxpayer for the taxable year.

(26 U.S.C. § 36B(b); 26 C.F.R. §§ 1.36B-3; 1.36B-3T; Internal Revenue Bulletin 2014-33, Rev. Proc. 2014-37 (Aug. 11, 2014), at <https://www.irs.gov/irb/2014-33_IRB/ar09.html> [as of May 26, 2016]; Internal Revenue Bulletin 2014-50, Rev. Proc. 2014-62 (Dec. 8, 2014), at <https://www.irs.gov/irb/2014-50_IRB/ar11.html> [as of May 26, 2016].)

1548-2 ADDED 10/15

[Redacted; Duplicate of 1547-5]

1548-3 ADDED 10/15

[Redacted; Duplicate of 1542-3]

1548-4 ADDED 10/15

Allocation of APTC to Household Members Enrolled in Multiple Plans

Individuals in a tax filer's household may enroll in multiple health plans.

When individuals in one tax household enroll in multiple plans, the tax household's APTC shall be allocated among the QHP policies as follows:

1. The APTC shall be apportioned based on the number of enrollees covered under the QHP, weighted by the age of the enrollees, using the default uniform age rating curve established by the Secretary of HHS under title 45 of the Code of Federal Regulations section 147.102(e);

2. The portion allocated to any single QHP policy shall not exceed the portion of the QHP's adjusted monthly premium properly allocated to essential health benefits; and

3. If the portion of the APTC allocated to a QHP exceeds the portion of the same QHP's adjusted monthly premium properly allocated to essential health benefits, the remainder shall be allocated evenly among all other QHPs in which individuals in the tax filers' tax households are enrolled.

(26 C.F.R. § 1.36B-3 (e), (f) (see examples 6 and 10); Cal. Code Regs., tit. 10, § 6500, subd. (i).)

1548-5 ADDED 10/15

APTC Not Available for Catastrophic QHP

APTC shall not be available to support enrollment in a catastrophic QHP through Covered California.

(45 C.F.R. § 155.305(f)(3); Cal. Code Regs., tit. 10, § 6472(f)(2).)

1548-6 ADDED 10/15

[Redacted; Duplicate of 1542-3]

1549-1 ADDED 10/15

Definition of Cost-Sharing

"Cost-sharing" means any expenditure that a health plan enrollee must pay to receive essential health benefits. The term includes deductibles, coinsurance, copayments, or similar charges. It excludes premiums, balance billing amounts for non-network providers, and spending for non-covered services.

(42 U.S.C. § 18022(c)(3); 45 C.F.R. § 155.20 (2014); Welf. & Inst. Code, § 14102, subd. (d)(1); Cal. Code Regs, tit. 10, § 6410.)

1549-2 ADDED 10/15

Definition of CSR

"Cost-Sharing Reduction" means "reduction in cost sharing for an eligible individual enrolled in a silver level plan in [Covered California] or for an individual who is an Indian enrolled in a Qualified Health Plan in [Covered California]."

(45 C.F.R. § 155.20; Cal. Code Regs, tit. 10, § 6410.)

1549-3 ADDED 10/15

CSR Eligibility

To qualify for Cost-Sharing Reduction (CSR), the applicant must

1. be eligible for enrollment in a Qualified Health Plan (QHP) through Covered California;
2. meet the eligibility requirements for Advance Payments of Premium Tax Credit (APTC);
3. have a household income that is not expected to exceed 250% of the Federal Poverty Level (FPL) for the benefit year for which coverage is requested (or 300% of the FPL if the applicant is an Indian); and
4. be enrolled in at least a silver level QHP, unless the applicant is an Indian.

(42 U.S.C. § 18071(b) & (c); 45 C.F.R. §§ 155.305(g)(1) & 155.350(a); Cal. Code Regs, tit. 10, §§ 6474, subd. (d) & 6494.)

1549-4 ADDED 10/15

Eligible for CSR If Eligible for APTC, Even If Not Receiving APTC

To be eligible for CSR, an individual must *meet* APTC eligibility requirements. The individual, however, does not have to *receive* APTC if the monthly premium for the benchmark health plan (second lowest silver plan) is equal or lower than the individual's required monthly contribution, which is determined by the APTC calculation set forth under title 26 of the United States Code section 36B.

(42 U.S.C. § 18071(b)(1), (c)(2); 45 C.F.R. § 155.305(g)(1); Cal. Code Regs, tit. 10, § 6474, subd. (d).)

1549-5 ADDED 10/15

CSR for Individuals Between 100% and 250% FPL

For individuals, who are eligible for CSR and have incomes between 100% and 250% of the FPL, their health plan's share of the total benefit costs will increase from 70%, as required for a "silver" level plan, as follows:

1. For individuals with household income between 100 to 150% of the FPL, the health plan's share of the total benefit costs increases to 94%;

2. For individuals with household income between 151 to 200% of the FPL, the health plan's share of the total benefit costs increases to 87%; and

3. For individuals with household income between 201 to 250% of the FPL, the health plan's share of the total benefit costs increases to 73%.

(42 U.S.C. § 18071(c)(1)(B), (c)(2); 45 C.F.R. § 155.305(g)(2); Cal. Code Regs, tit. 10, § 6474, subd. (d)(3).)

1549-6 ADDED 10/15

Family Members in Multiple Tax Households

Family members can be in different tax households but enroll in a single QHP together. In such cases, Covered California will determine each tax household's CSR eligibility separately. When two or more family members in different tax households enroll in a single family policy, these family members are collectively eligible only for the CSR level for which all individuals covered by the policy would be eligible. If one member is ineligible for CSR, then other family members enrolled in the same family policy are also ineligible.

(45 C.F.R. § 155.305(g)(3); Cal. Code Regs, tit. 10, § 6474, subd. (d)(4).)

1550-1 ADDED 10/15

Indians Eligible for CSR with Income Less Than 300% of the FPL

The health plan issuer must eliminate any cost sharing under the plan for members of an Indian tribe, as defined under title 25 of the Unites States Code section 450b(d) and (e), who have income below 300% of the FPL, who meet the eligibility requirements for enrolling in a Qualified Health Plan (QHP) and for APTC, and who are enrolled in a QHP. The Indian tribe members

may be enrolled in a bronze, silver, gold, or platinum level plan and receive the Cost-Sharing Reduction (CSR).

(42 U.S.C. § 18071(d)(1); 45 C.F.R. §§ 155.305(g)(1)(ii), 155.350(b); Cal. Code Regs, tit. 10, §§ 6474, subd. (d)(2), 6494, subd. (a).)

1550-2 ADDED 10/15

Indians Eligible for CSR If Services Provided Directly by the Indian Health Providers

Regardless of income, members of an Indian tribe are eligible for Cost-Sharing Reduction (CSR) if they receive health items or services directly from the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization.

(42 U.S.C. § 18071(d)(2); 45 C.F.R. § 155.350(b); Cal. Code Regs, tit. 10, § 6494, subds. (a)(3), (a)(4).)

1550-3 ADDED 10/15

Special CSR Rules for Non-Citizens Lawfully Present with Income below 100% FPL

Non-citizens lawfully present in the United States with incomes between 100% and 250% of the Federal Poverty Level (FPL) are eligible for Cost-Sharing Reduction (CSR) to the same extent as other individuals.

Non-citizens lawfully present in the U.S., who have income below 100% of the FPL, but who are not eligible for Medi-Cal due to their immigration status, are eligible for CSR if they meet all other the CSR eligibility requirements, even if they do not meet the requirement to have income between 100% and 250% of the FPL.

If an individual with income less than 100% of the FPL is eligible for CSR under this special rule for non-citizens lawfully present who are not eligible for Medi-Cal, the individual shall be treated as having household income equal to 100% for purposes of applying the CSR eligibility rules.

(26 U.S.C. § 36B(c)(1)(B); 42 U.S.C. § 18071(b); 45 C.F.R. §& 155.305(f)(2) & (g); Cal. Code Regs., tit. 10, § 6474, subds. (c)(2) & (d).)

1560-1 ADDED 10/15

Definition of “Reasonably Compatible”

For purposes of eligibility determinations, Covered California must consider information obtained through electronic data sources, information provided by the applicant, or other information in Covered California’s records to be reasonably compatible with the applicant’s attestation if the difference or discrepancy does not impact the applicant’s eligibility, including the amount of Advance Payments of Premium Tax Credit (APTC) or the level of Cost-Sharing Reduction (CSR).

(45 C.F.R. § 155.300(d); Cal. Code Regs, tit. 10, § 6410.)

1560-2 ADDED 10/15

Information Enrollees Must Provide Regarding Status as Citizen, National, or Lawfully Present

Each individual seeking to be enrolled in a Qualified Health Plan (QHP) must provide the following information:

1. For an enrollee whose eligibility is based on an attestation of citizenship, the enrollee must provide the enrollee's Social Security Number.

2. For an enrollee whose eligibility is based on an attestation of the enrollee's immigration status, the enrollee must provide the enrollee's Social Security Number (if applicable) and such identifying information with respect to the enrollee's immigration status as the Department of Health and Human Services (HHS) determines appropriate.

(42 U.S.C. § 18081(b)(2) Cal. Code Regs., tit. 10, § 6478, subd. (c).)

1560-3 ADDED 10/15

Covered California Must Verify Eligibility

Covered California must verify or obtain information to determine whether an applicant meets the eligibility requirements to enroll in a Qualified Health Plan (QHP) through Covered California.

(45 C.F.R. § 155.315(a); Cal. Code Regs, tit. 10, § 6478, subd. (a).)

1561-1 ADDED 10/15

Validation of Social Security Number, Step One: Transmission to HHS and SSA

For any individual who provides his or her Social Security Number to Covered California, Covered California must transmit the Social Security Number and other identifying information to the Department of Health and Human Services, which will then submit it to the Social Security Administration.

(45 C.F.R. § 155.315(b)(1); Cal. Code Regs, tit. 10, § 6478, subd. (b)(1).)

1561-2 ADDED 10/15

Validation of Social Security Number, Step Two: Process If SSA Cannot Verify SSN, or if Individual is Deceased

If Covered California is unable to verify an individual's Social Security Number through the Social Security Administration (SSA), or if the SSA indicates that the individual is deceased, Covered California must notify the individual and give the individual 90 days from the date the individual receives the notice to provide satisfactory documentary evidence or resolve the inconsistency with the SSA.

(45 C.F.R. sec. 155.315(b)(2); Cal. Code Regs, tit. 10, § 6478, subd. (b)(2).)

1562-1 ADDED 10/15

Verification of Citizenship, Status as a National, or Lawful Presence: Verification with Records from the Social Security Administration

For an applicant who attests to citizenship and has a Social Security Number, Covered California must transmit the applicant's Social Security Number and other identifying information to the Department of Health and Human Services, which will then submit it to the Social Security Administration.

(45 C.F.R. sec. 155.315(c)(1); Cal. Code Regs, tit. 10, § 6478, subd. (c)(1).)

1562-2 ADDED 10/15

Verification of Citizenship, Status as a National, or Lawful Presence: Verification with Records from the Department of Homeland Security

For an applicant who has documentation that can be verified through the Department of Homeland Security (DHS) and who attests to lawful presence, or who attests to citizenship and for whom Covered California cannot substantiate a claim of citizenship through the Social Security Administration, Covered California must transmit information from the applicant's documentation and other identifying information to the Department of Health and Human Services (HHS), which will submit necessary information to Department of Homeland Security (DHS) for verification.

(45 C.F.R. § 155.315(c)(2); Cal. Code Regs, tit. 10, § 6478, subd. (c)(2).)

1562-3 ADDED 10/15

Verification of Citizenship, Status as a National, or Lawful Presence: Inconsistencies and Inability to Verify Information

For an applicant who attests to citizenship, status as a national, or lawful presence, and for whom Covered California cannot verify such attestation through the Social Security Administration (SSA) or the Department of Homeland Security (DHS), Covered California must notify the individual and give the individual 90 days from the date the individual receives the notice to provide satisfactory documentary evidence or resolve the inconsistency with the SSA or DHS, as applicable.

(45 C.F.R. sec. 155.315(c)(3); Cal. Code Regs, tit. 10, § 6478, subd. (c)(3).)

1563-1 ADDED 10/15

Verification of Residency, Accept Attestation If Reasonably Compatible

If information provided by an applicant regarding residency is reasonably compatible with other information provided by the individual or in the records of Covered California, Covered California must accept the applicant's attestation that he or she meets the requirements for residency in the service area of Covered California.

(45 C.F.R. § 155.315(d)(1); Cal. Code Regs, tit. 10, § 6478, subd. (d)(1).)

1563-2 ADDED 10/15

Verification of Residency, Examine Data If Information is Not Reasonably Compatible

If information provided by an applicant regarding residency is not reasonably compatible with other information provided by the individual or in the records of Covered California, Covered California must examine information in data sources that are available to Covered California and which have been approved by the Department of Health and Human Services.

(45 C.F.R. § 155.315(d)(3); Cal. Code Regs, tit. 10, § 6478, subd. (d)(2).)

1563-3 ADDED 10/15

Verification of Residency, Follow Inconsistency Procedures If Data is Not Reasonably Compatible

If information provided by an applicant regarding residency is not reasonably compatible with the information in data sources that are available to Covered California and which have been approved by the Department of Health and Human Services, Covered California must follow procedures to (1) make reasonable efforts to identify and address the causes of such inconsistency, and (2) give the applicant 90 days to present documentary evidence or otherwise resolve the inconsistency.

(45 C.F.R. sec. 155.315(d)(4); Cal. Code Regs, tit. 10, § 6478, subd. (d)(3).)

1563-4 ADDED 10/15

Verification of Residency, Prohibition Against Using Evidence of Immigration Status

Evidence of immigration status may not be used to determine that an applicant is not a resident of a Covered California service area.

(45 C.F.R. § 155.315(d)(4); Cal. Code Regs, tit. 10, § 6478, subd. (d)(3).)

1564-1 ADDED 10/15

Verification of Family Size - Attestation

An applicant’s family size shall be verified in accordance with the following procedures:

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

2. If an applicant attests that the information based on the applicant's tax return represents an accurate projection of a tax filer's family size for the benefit year for which coverage is requested, the tax filer's eligibility for APTC and CSR shall be determined based on that information.

3. The tax filer's family size for APTC and CSR shall be verified by accepting an applicant's attestation without further verification if

a. the information based on tax return is unavailable; or

b. the applicant attests that a change in family size has occurred, or is reasonably expected to occur, so the tax return does not represent an accurate projection of the tax filer's family size for the benefit year for which coverage is requested.

4. If an applicant's attestation of a tax filer's family size is not reasonably compatible with other information provided by the application filer for the family or in the records of Covered California, with the exception of tax data, the attestation shall be verified using data from other electronic data sources. If such data sources are unavailable or information in such sources is not reasonably compatible with the attestation, Covered California shall give the applicant 90 days to provide additional documentation to support the attestation.

(45 C.F.R. § 155.320(c); Cal. Code Regs., tit. 10, § 6482, subd. (d).)

1564-2 ADDED 10/15

Covered California's Duty to Request Tax Return and Social Security Benefits Data from Federal Agencies

For all individuals whose income is counted in calculating a tax filer's or an applicant's household income, and for whom Covered California has a Social Security Number, Covered California must request tax return data regarding Modified Adjusted Gross Income and family size from the Secretary of the Treasury, and data regarding Social Security benefits from the Commissioner of Social Security, by transmitting identifying information to the Department of Health and Human Services.

(45 C.F.R. § 155.320(c)(1)(i); Cal. Code Regs, tit. 10, § 6482, subd. (b).)

1564-3 ADDED 10/15

Covered California's Duty to Follow Inconsistency Procedures If Identifying Information for an Individual Does Not Match Tax Records

If the identifying information for one or more individuals does not match a tax record on file with the Secretary of the Treasury, Covered California must make a reasonable effort to identify and address the causes of such inconsistency.

(45 C.F.R. § 155.320(c)(1)(ii); Cal. Code Regs, tit. 10, §§ 6482, subd. (c) & 6492, subd. (a)(1).)

1564-4 ADDED 10/15

Income Verification Steps

The applicant's annual household income shall be verified using the following procedures:

1. Covered California must use tax return data to compute the annual household income for an applicant's family for all individuals whose income is counted in calculating an applicant's household income.

2. An applicant must attest to a tax filer's projected annual household income.

3. If the applicant's attestation indicates that the income shown on the tax returns represents an accurate projection of the tax filer's household income for the benefit year for which coverage is requested, the tax filer's eligibility for Advance Payments of Premium Tax Credit (APTC) and Cost-Sharing Reduction (CSR) shall be determined based on the household income shown on the tax data.

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

(45 C.F.R. § 155.320(c)(3)(ii); Cal. Code Regs, tit. 10, § 6482, subd. (e).)

1564-5 ADDED 10/15

Attestation of Income Increase Reasonably Compatible with Data

Except where an applicant's attestation is not reasonably compatible with other information, or where electronic data is not available to Covered California , Covered California must accept an applicant's attestation regarding the tax filer's annual household income without further verification if

1. an applicant attests that a tax filer's annual household income for the benefit year for which the applicants in the tax filer's family are requesting coverage has increased, or is reasonably expected to increase, from the income computed based on the tax return data of the previous taxable year; and

2. Covered California has verified that that the applicant's MAGI income is not within the applicable Medi-Cal or Optional Targeted Low-Income Children (OTLIC) Program MAGI-based income standard.

    a. MAGI Medi-Cal income standard for adults ages 19 to 64 is 138% or lower; and

    b. MAGI income for OTLIC Program for children ages 18 and lower is 266% or lower.

(45 C.F.R. § 155.320(c)(3)(iii); Cal. Code Regs, tit. 10, § 6484, subd. (a).)

1564-6 ADDED 10/15

Attestation of Income Increase Not Reasonably Compatible or Data Unavailable

If Covered California finds that an applicant's attestation of a tax filer's projected annual household income is not reasonably compatible with other information provided by the

application filer or available to Covered California, the applicant's attestation shall be verified using data Covered California obtained through available electronic data sources.
If electronic data is not available, or if information in electronic data sources is not reasonably compatible with the applicant's attestation, the applicant must provide additional documentation requested by Covered California to support the attestation. Covered California must also make reasonable efforts to identify and address the causes of such inconsistency.

(45 C.F.R. § 155.320(c)(3)(iii); Cal. Code Regs, tit. 10, §§ 6484, subds. (b) & (c), 6492, subd. (a)(1).)

1564-7 ADDED 10/15

Criteria for Using Alternate Verification Process for APTC and CSR Eligibility Determinations for Decreases in Income or If Tax Return Data is Unavailable

A tax filer's annual household income shall be determined based on the alternate verification procedures if the following circumstances are met:

(1) An applicant attests to projected annual household income;

(2) The tax filer does not meet the criteria specified in title 10 of the California Code of Regulations, section 6484, with respect to the verification process for increases in income;

(3) Covered California has verified that the MAGI income of the applicants in the tax filer's family is not within the applicable Medi-Cal or Optional Targeted Low-Income Children Program MAGI income standard; and

(4) One of the following conditions is met:

(A) The IRS does not have tax return data that may be disclosed for the tax filer that is at least as recent as the calendar year two years prior to the calendar year for which Advance Payments of Premium Tax Credit (APTC) and Cost-Sharing Reduction (CSR) would be effective;

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

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

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

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

(45 C.F.R. § 155.320(c)(3)(iv); Cal. Code Regs, tit. 10, §§ 6486, subds. (a), (b), (c), 6484.)

1564-8 ADDED 10/15

Applicant's Attestation Accepted if Projected Income Decrease is No More Than 10%

If a tax filer qualifies for an alternate verification process, and the applicant's attestation to projected annual household income is no more than 10% below the annual household income computed based on tax return data, the applicant's attestation shall be accepted without further verification.

(45 C.F.R. § 155.320(c)(3)(v); Cal. Code Regs, tit. 10, § 6486, subd. (b).)

1564-9 ADDED 10/15

Alternate Verification Process If Projected Income Decrease is Greater Than 10% or If Tax Return Data is Unavailable

If a tax filer qualifies for an alternate verification process, and the applicant's attestation to projected annual household income is greater than 10% below the annual household income computed based on tax return data, or if tax return data is unavailable, the applicant's attestation of the tax filer's projected annual household income for the tax filer shall be verified by

1. using annualized data from Modified Adjusted Gross Income (MAGI)-based income sources, including the IRS, the Social Security Administration, the Employment Development Department, the Department of Health Care Services, and other state agencies that administer public assistance programs

2. using other electronic data sources approved by the Department of Health and Human Services (HHS); or

3. following Covered California's procedures to (1) make reasonable efforts to identify and address the causes of such inconsistency, and (2) give the applicant 90 days to present documentary evidence or otherwise resolve the inconsistency.

(45 C.F.R. 155.320(c)(3)(vi)(D); 42 C.F.R. 435.948(a); Cal. Code Regs, tit. 10, § 6486, subd. (c)(1).)

1564-10 ADDED 10/15

Failure to Respond to Request for Information Results in APTC/CSR Ineligibility

In the alternative verification process for income decreases greater than 10% or when tax return data is unavailable, the applicant shall not be eligible for Advance Payments of Premium Tax Credits (APTC) or Cost Sharing Reductions (CSR) if

1. the applicant has not responded to Covered California's request for additional information to resolve the inconsistency within 90 days from the date when Covered California notified the applicant of the inconsistency; and

2. tax return data and data from sources including the IRS, the Social Security Administration, the Employment Development Department, the Department of Health Care Services, and other state agencies that administer public assistance programs indicate that an applicant in the tax filer's family is eligible for Medi-Cal or the Optional Targeted Low-Income Children's program, other than the restricted Medi-Cal coverage of pregnancy-related services.

(45 CFR 155.320(c)(3)(vi)(E); 42 C.F.R. 435.948(a); Cal. Code Regs, tit. 10, § 6486, subd. (c)(2).)

1564-11 ADDED 10/15

Covered California's Action If Unable to Verify Attestation and Tax Data is Available

If, after 90 days from the date Covered California notified the applicant of an inconsistency, Covered California remains unable to verify the applicant's attestation, Covered California must

1. determine the applicant's eligibility based on tax return data;

2. provide written notice to the applicant of such determination within five business days from the date of the determination; and

3. implement such determination with the effective dates specified in title 10 of the California Code of Regulations, section 6496, subdivisions (k) through (n).

(45 CFR 155.320(c)(3)(vi)(F); 42 C.F.R. 435.948(a); Cal. Code Regs, tit. 10, § 6486, subd. (c)(3).)

1564-12 ADDED 10/15

Covered California's Action If Unable to Verify Attestation and Tax Data is Not Available

If, after 90 days from the date Covered California notified the applicant of an inconsistency, Covered California remains unable to verify the applicant's attestation for the tax filer and tax return data is unavailable, Covered California, must

1. determine the tax filer ineligible for APTC and CSR;

2. provide written notice to the applicant of such determination within five business days from the date of the determination; and

3. discontinue any APTC and CSR on in title 10 of the California Code of Regulations, section 6496, subdivisions (k) through (n).

(45 CFR 155.320(c)(3)(vi)(G); 42 C.F.R. 435.948(a); Cal. Code Regs, tit. 10, § 6486, subd. (c)(4).)

1564-13 ADDED 10/15

Procedures for Handling Inconsistencies

When an applicant's attestations are inconsistent with the data obtained by Covered California from available data sources, or for whom Covered California cannot verify information required to determine eligibility for enrollment in a QHP, or for APTC and CSR, including when electronic data is required, but it is not reasonably expected that the data will be available within one day, Covered California must make a reasonable effort to identify and address the causes of such inconsistency, including through typographical or other clerical errors, by contacting the application filer to confirm the accuracy of the information submitted by the application filer.

If still unable to resolve the inconsistency, Covered California must provide the applicant 90 days to either present satisfactory documentary evidence or otherwise resolve the inconsistency. This period can be extended applicant if the applicant demonstrates that a good faith effort has been made to obtain the required documentation during the period. During this period, Covered California must

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

b. ensure that APTC and CSR are provided within this period on behalf of an applicant who is otherwise qualified for such payments and reductions, provided the tax filer attests to Covered California that he or she understands that any APTC paid on his or her behalf are subject to reconciliation.

(45 C.F.R. § 155.315(f); Cal. Code Regs, tit. 10, §§ 6492, subd. (a) & (b), 6478, subd. (d), 6480.)

1564-14 ADDED 10/15

Case-by-Case Exceptions to Accept Attestations

Covered California must provide an exception, on a case-by-case basis, to accept an applicant’s attestation as to the information which cannot otherwise be verified and the applicant’s explanation of circumstances as to why the applicant does not have documentation, if,

1. an applicant does not have documentation with which to resolve the inconsistency because such documentation does not exist or is not reasonably available;

2. Covered California is unable to otherwise resolve the inconsistency; and

3. the inconsistency is not related to citizenship or immigration status.

(45 C.F.R. § 155.315(g); Cal. Code Regs, tit. 10, § 6492, subd. (b).)

1564-14A ADDED 10/15

Covered California Must Verify Eligibility for MEC, Other than Through Employer-Sponsored Plan, by Obtaining Information from HHS and DHCS

Covered California must verify whether an applicant is eligible for Minimum Essential Coverage (MEC) other than through an eligible employer-sponsored plan, Medi-Cal, or CHIP, using information obtained from the Department of Health and Human Services (HHS).

Covered California must verify whether an applicant has already been determined eligible for coverage through Medi-Cal or CHIP, using information obtained from the Department of Health Care Services (DHCS).

(45 C.F.R. § 155.320(b)(1); Cal. Code Regs. tit. 10, § 6480.)

1565-1 Added

5/16Eligibility Redetermination During Benefit Year – Enrollee Reports New Information

A. Redetermination Process when Enrollee Reports New Information

Covered California shall redetermine the eligibility of an enrollee in a Qualified Health Plan (QHP) through Covered California during the benefit year if it receives and verifies new information reported by an enrollee. Covered California shall notify the enrollee of the redetermination, and notify the enrollee's employer, as applicable.

B. Implementation Dates for Redeterminations when Enrollee Reports New Information

The implementation effective dates based the redetermination shall be as follows:

1. For changes resulting from an appeal decision, the date specified in the appeal decision;

2. For redeterminations affecting enrollment or premiums only

    a. on the first day of the month following the date on which Covered California is notified of the change, if Covered California is notified of the change by the 15th of the month; or

    b. on the first day of the second month following the date on which Covered California is notified of the change, if Covered California is notified of the change after the 15th of the month;

3. For birth, adoption, marriage, domestic partnership, loss of Minimum Essential Coverage (MEC), special enrollment, material violation of contact by a QHP, court order related to gaining a dependent and becoming a dependent, and death, and the dates as outlined in California Code of Regulations, title 10, section 6504, subdivision (h); and

4. for redeterminations affecting all other eligibility determinations,

a. on the first day of the month following the date of the Covered California notice of redetermination after verifying enrollee-reported updates, if Covered California issues the redetermination notice the 15th of the month; or

b. on the first day of the second month following the date of the Covered California notice of redetermination after verifying enrollee-reported updates, if Covered California issues the redetermination notice after the 15th of the month.

C. Recalculation of APTC and CSR following Redetermination

1. Recalculation of APTC

In the case of a redetermination that results in a change in the amount of Advance Payments of Premium Tax Credit (APTC) for the benefit year, Covered California must recalculate the amount of APTC in such a manner as to account for any APTC already made on behalf of the tax filer for the benefit year for which information is available to Covered California, such that the recalculated APTC amount is projected to result in total APTC for the benefit year that correspond to the tax filer's total projected APTC for the benefit year, calculated in accordance with title 26 of the Code of Federal Regulations, section 1.36B-3.

2. Recalculation of CSR

In the case of a redetermination that results in a change in a change in Cost-Sharing Reduction (CSR), Covered California shall determine an individual eligible for the category of CSR that corresponds to his or her expected annual household income for the benefit year, subject to the rule for family policies set forth in title 10 of the California Code of Regulations, section 6474(d)(4).

(45 C.F.R. § 155.330; Cal. Code Regs, tit. 10, § 6496.)

1565-2 Added

5/16<u>Eligibility Redetermination During Benefit Year Based on Covered California's Semiannual Identification of Updated Information Through Data Matching</u>

(1) Covered California must Conduct Semiannual Data Matching

Covered California must examine available data sources on a semiannual basis to identify the following changes of circumstances:

(A) Death; and

(B) For enrollees receiving Advance Payments of Premium Tax Credits (APTC) or Cost-Sharing Reductions (CSRs), eligibility determinations for Medicare, Medi-Cal, or CHIP.

(2) <u>Covered California must Follow Notification and Redetermination Processes if Covered California Identifies Updated Information</u>

If Covered California identifies updated information through semiannual data matching regarding death or eligibility for Medicare, Medi-Cal or CHIP, Covered California must:

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

(B) Allow an enrollee 30 days from the date of the notice to notify Covered California that such information is inaccurate;

(C) If the enrollee responds contesting the updated information, proceed in accordance with the inconsistency resolution process as outlined in title 10 of the California Code of Regulations, section 6492; and

(D) If the enrollee does not respond within the 30-day period, proceed with redetermination based on the updated information and notify the enrollee.

(3) Implementation Dates for Redeterminations following Data Matching

The implementation effective dates based the redetermination shall be as follows:

(A) for changes resulting from an appeal decision, the date specified in the appeal decision;

(B) for redeterminations affecting enrollment or premiums only:

a. on the first day of the month following the date on which Covered California is notified of the change, if Covered California is notified of the change by the 15th of the month; or

b. on the first day of the second month following the date on which Covered California is notified of the change, if Covered California is notified of the change after the 15th of the month;

(C) for birth, adoption, marriage, domestic partnership, loss of MEC, special enrollment, material violation of contact by a QHP, court order related to gaining a dependent and becoming a dependent, and death, and the dates outlined in section 6504, subdivision (h); and

(D) for redeterminations affecting all other eligibility determinations,

a. on the first day of the month following the date of the Covered California notice of redetermination, if Covered California issues the redetermination notice the 15th of the month; or

b. on the first day of the second month following the date of the Covered California notice of redetermination, if Covered California issues the redetermination notice after the 15th of the month.

(4) Recalculation of APTC and CSR following Redetermination

(A) Recalculation of Advance Payments of Premium Tax Credit

In the case of a redetermination that results in a change in the amount of APTC for the benefit year, Covered California must recalculate the amount of APTC in such a manner as to account

for any APTC already made on behalf of the tax filer for the benefit year for which information is available to Covered California, such that the recalculated APTC amount is projected to result in total APTC for the benefit year that correspond to the tax filer's total projected APTC for the benefit year, calculated in accordance with title 26 of the Code of Federal Regulations, section 1.36B-3.

(B) Recalculation of Cost-Sharing Reductions

In the case of a redetermination that results in a change in a change in CSR, Covered California shall determine an individual eligible for the category of CSR that corresponds to his or her expected annual household income for the benefit year, subject to the rule for family policies set forth in title 10 of the California Code of Regulations, section 6474(d)(4).

(45 C.F.R. § 155.330; Cal. Code Regs, tit. 10, § 6496.)

1565-3 Added

5/16Annual Eligibility Redetermination Process for Enrollee who Requested IAPs and did not Provide Authorization for Covered California to Check Tax Records

If an enrollee or qualified individual who requested eligibility determination for Insurance Affordability Programs does not have an active authorization on file for Covered California to obtain tax return information, Covered California must redetermine eligibility each year and renew enrollment using the following process:

1. Covered California must notify the enrollee or the qualified individual at least 30 days before Covered California sends the annual redetermination notice, explaining that unless the enrollee authorizes Covered California to obtain the updated tax return information, his or her premium assistance (APTC) and Cost Sharing Reduction (CSR) will end on the last day of the current benefit year, and Covered California will renew his or her coverage in a Qualified Health Plan for the following benefit year without APTC and CSR.

2. After at least 30 days has passed after Covered California notified the individual of the requirement to provide authorization for Covered California to obtain tax return information, if the enrollee or qualified individual has not provided authorization for Covered California to obtain tax return information, Covered California must redetermine eligibility only for enrollment in a Qualified Health Plan, and must not proceed with a redetermination for Insurance Affordability Programs. Covered California must then provide an annual redetermination notice that includes the following information:

    a. The enrollee's or qualified individual's projected eligibility determination for the following year, notifying the enrollee or qualified individual of the eligibility determination for enrollment in a Qualified Health Plan, without Insurance Affordability Programs; and

    b. Prescribed explanations about the redetermination process, open enrollment dates, and instructions about how to report changes, as specified in title 10 of the California Code of Regulations, section 6498, subdivisions (e)(1) (notice for qualified individuals who are not currently enrolled in a Qualified Health Plan) or

(e)(2) (notice for current enrollees who have requested an eligibility determination for Insurance Affordability Programs), as modified by the requirements that apply to an enrollee or qualified individual who did not provide tax authorization.

3. A current enrollee or a qualified individual must complete the renewal process within 30 days from the date of the annual redetermination notice, using the processes specified in title 10 of the California Code of Regulations, section 6498(i)(1)-(3).

4. After the 30-day period for the enrollee or qualified individual to respond to the annual redetermination notice has elapsed, Covered California must redetermine the enrollee's or the qualified individual's eligibility using the information provided to the enrollee or qualified individual in the annual redetermination notice, as supplemented with any information that the enrollee or qualified individual reported to Covered California, after Covered California verified the information reported by the enrollee or qualified individual.

   Covered California shall renew an enrollee's coverage for the following year, using the process described in step 5, below, except that Covered California will not provide Advance Payments of Premium Tax Credit or Cost-Sharing Reductions if the enrollee did not provide tax authorization.

   Covered California shall notify the enrollee or qualified individual of the redetermined eligibility, and shall notify an enrollee of the renewed enrollment, by providing written notice within five business days from the date of the eligibility redetermination.

5. If the enrollee remains eligible for enrollment in a Qualified Health Plan through Covered California upon annual redetermination, and he or she does not terminate coverage, including terminating coverage in connection with voluntarily selecting a different Qualified Health Plan in accordance with title 10 of the California Code of Regulations, section 6506, Covered California shall renew the enrollee's coverage in a plan that Covered California chooses using the hierarchy specified in title 10 of the California Code of Regulations, section 6498, subdivision (l), or, if this section conflicts with federal rules, using the hierarchy specified in title 45 of the Code of Federal Regulations, section 155.335(j).

(45 C.F.R. § 155.335; Cal. Code Regs, tit. 10, § 6498.)

1565-4 Added

5/16<u>Annual Eligibility Redetermination Process for Enrollee who Requested IAPs and Provided Authorization for Covered California to Check Tax Records</u>

If the enrollee or qualified individual requested an eligibility determination for Insurance Affordability Programs and has an active authorization on file for Covered California to obtain tax return information, Covered California must redetermine eligibility each year and renew enrollment using the following process:

1. Covered California must request updated income information, using the following processes:

a. Covered California must request updated tax return information and data regarding social security benefits through the federal Department of Health and Human Services, using the process specified in title 10 of the California Code of Regulations, section 6482(b); and

b. Covered California must request updated income data from available State data sources, such as the Franchise Tax Board and the Employment Development Department.

2. Covered California must provide an annual redetermination notice to enrollees and qualified individuals that includes the following information:

   a. The enrollee's or qualified individual's projected eligibility determination for the following year, after considering any updated income information that Covered California obtained from state and federal data sources, including, if applicable, the amount of any advance payments of premium tax credit and the level of any cost sharing reductions, or eligibility for Medi-Cal or CHIP; and

   b. Prescribed explanations about the redetermination process, open enrollment dates, the processes that apply to Advance Payments of Premium Tax Credit and Cost-Sharing Reductions, and instructions about how to report changes, as specified in title 10 of the California Code of Regulations, section 6498, subdivisions (e)(1) (notice for qualified individuals who are not currently enrolled in a Qualified Health Plan) or (e)(2) (notice for current enrollees who have requested an eligibility determination for Insurance Affordability Programs), as appropriate.

3. A current enrollee or a qualified individual must complete the renewal process within 30 days from the date of the annual redetermination notice, using the processes specified in title 10 of the California Code of Regulations, section 6498(i)(1)-(3).

4. If the enrollee or qualified individual provides Covered California with updated information, Covered California must verify any information reported by the enrollee or qualified individual, before using such information to redetermine eligibility.

5. After the 30-day period for the enrollee or qualified individual to respond to the annual redetermination notice has elapsed, Covered California must redetermine the enrollee's or the qualified individual's eligibility using the information provided to the enrollee or qualified individual in the annual redetermination notice, as supplemented with any information that the enrollee or qualified individual reported to Covered California, after Covered California verified the information reported by the enrollee or qualified individual.

6. Covered California shall renew an enrollee's coverage for the following year, using the process described in step 5, below.

   Covered California shall notify the enrollee or qualified individual of the redetermined eligibility, and shall notify an enrollee of the renewed enrollment, by providing written notice within five business days from the date of the eligibility redetermination.

7. If the enrollee remains eligible for enrollment in a Qualified Health Plan through Covered California upon annual redetermination, and he or she does not terminate coverage, including terminating coverage in connection with voluntarily selecting a different Qualified Health Plan in accordance with title 10 of the California Code of Regulations, section 6506, Covered California shall renew the enrollee's coverage in a plan that Covered California chooses using the hierarchy specified in title 10 of the California Code of Regulations, section 6498, subdivision (l), or, if this section conflicts with federal rules, using the hierarchy specified in title 45 of the Code of Federal Regulations, section 155.335(j).

(45 C.F.R. § 155.335; Cal. Code Regs, tit. 10, § 6498.)

1565-5 Added

5/16Annual Eligibility Redetermination Process for Enrollee who Requested Enrollment in QHP but did not Request IAPs

If the enrollee or qualified individual requested enrollment in a Covered California Qualified Health Plan, but did not request an eligibility determination for Insurance Affordability Programs, Covered California must redetermine eligibility each year and renew enrollment using the following process:

1. Covered California must provide an annual redetermination notice to enrollees and qualified individuals that includes the following information:

    a. The enrollee's or qualified individual's projected eligibility determination for the following year, and

    b. Prescribed explanations about the redetermination process, open enrollment dates, and instructions about how to report changes, as specified in title 10 of the California Code of Regulations, section 6498, subdivisions (e)(1) (notice for qualified individuals who are not currently enrolled in a Qualified Health Plan) or (e)(3) (notice for current enrollees who have not requested an eligibility determination for Insurance Affordability Programs), as appropriate.

2. A current enrollee or a qualified individual must complete the renewal process within 30 days from the date of the annual redetermination notice, using the processes specified in title 10 of the California Code of Regulations, section 6498(i)(1)-(3).

3. If the enrollee or qualified individual provides Covered California with updated information, Covered California must verify any information reported by the enrollee or qualified individual, before using such information to redetermine eligibility.

4. After the 30-day period for the enrollee or qualified individual to respond to the annual redetermination notice has elapsed, Covered California must redetermine the enrollee's or the qualified individual's eligibility using the information provided to the enrollee or qualified individual in the annual redetermination notice, as supplemented with any information that the enrollee or qualified individual reported to Covered California, after Covered California verified the information reported by the enrollee or qualified individual.

Covered California shall renew an enrollee's coverage for the following year, using the process described in step 5, below.

Covered California shall notify the enrollee or qualified individual of the redetermined eligibility, and shall notify an enrollee of the renewed enrollment, by providing written notice within five business days from the date of the eligibility redetermination.

5. If the enrollee remains eligible for enrollment in a Qualified Health Plan through Covered California upon annual redetermination, and he or she does not terminate coverage, including terminating coverage in connection with voluntarily selecting a different Qualified Health Plan in accordance with title 10 of the California Code of Regulations, section 6506, Covered California shall renew the enrollee's coverage in a plan that Covered California chooses using the hierarchy specified in title 10 of the California Code of Regulations, section 6498, subdivision (l), or, if this section conflicts with federal rules, using the hierarchy specified in title 45 of the Code of Federal Regulations, section 155.335(j).

(45 C.F.R. § 155.335; Cal. Code Regs, tit. 10, § 6498.)

1570-1 ADDED 10/15

Appeal Rights for Applicants and Enrollees

An applicant or enrollee must have the right to appeal any action or inaction related to the individual's eligibility for or enrollment in a Qualified Health Plan (QHP), including the following:

(1) All eligibility determinations and redeterminations by Covered California, including the amount of Advanced Payments of Premium Tax Credit (APTC) and the level of Cost-Sharing Reduction (CSR);

(2) An eligibility determination for an exemption (heard by the Department of Health and Human Services);

(3) Covered California's failure to provide a timely eligibility determination or redetermination; and

(4) A denial of a request to vacate a dismissal made by the California Department of Social Services, State Hearings Division.

(45 C.F.R. § 155.505(b); Gov. Code, 100506.1; Cal. Code Regs., tit. 10, § 6602, subd. (a).)

1570-2 ADDED 10/15

California Department of Social Services, State Hearings Division, Hears Appeals Arising Out of Covered California Application and Enrollment Process and Medi-Cal

Covered California and the California Department of Social Services have entered into an Inter-Agency (IA) Agreement that authorizes the State Hearings Division (SHD) to conduct hearings based on consumer appeals that arise out of the Covered California application and enrollment process. The SHD will be handling all applicant appeals regarding eligibility, redetermination

and timeliness of Covered California grants of federal tax credits or federal subsidies. The SHD will also continue to handle all Medi-Cal appeals, including MAGI Medi-Cal appeals, through the IA Agreement with the Department of Health Care Services.

(45 C.F.R. § 155.505(c); Gov. Code, § 100506.3; Cal. Code Regs., tit. 10, §§ 6600 & 6602, subd. (b); Cal. Dept. of Social Svcs., All County Lett. (ACL) No. 14-14 (Feb. 7, 2014) pp. 6-8.)

1570-3 ADDED 10/15

HHS Hears Exemption Appeals

The U.S. Department of Health and Human Services (HHS) hears appeals of an eligibility determination for an exemption. These appeals are not heard by the California Department of Social Services (CDSS), State Hearings Division (SHD).

(45 C.F.R. § 155.625(b); Cal. Code Regs., tit. 10, § 6602, subd. (b); Cal. Dept. of Social Svcs., All County Letter (ACL) No. 14-14 (Feb. 7, 2014) pp. 6-7.)

1571-1 ADDED 10/15

Covered California Must Provide Written Notice, Including Notice of Appeal Procedures, at Time of Application and When Sending Notices of Eligibility Determination and Redetermination

Covered California must provide notice of appeal procedures at the time the applicant submits an application and when Covered California sends a notice of eligibility determination and redetermination. Such notices must contain the following information:

(1) An explanation of the action reflected in the notice, including the effective date of the action;

(2) Any factual bases upon which the decision was made;

(3) Citations to, or identification of, the relevant regulations supporting the action;

(4) Contact information for available customer service resources, including local legal aid and welfare rights offices; and

(5) An explanation of appeal rights, which must contain the following information:

a. A description of the procedures by which the applicant or enrollee may request an appeal, including an expedited appeal;

b. Information on the applicant's or enrollee's right to represent himself or herself, or to be represented by legal counsel or another representative;

c. Information on how to obtain a legal aid referral or free legal help;

d. An explanation that all hearings shall be conducted by telephone, video conference, or in person, in accordance with the California Department of Social Services' Manual of Policies and Procedures, section 22-045;

e. An explanation of the circumstances under which the appellant's eligibility may be maintained or reinstated pending an appeal decision, as provided in in title 10 of the California Code of Regulations, section 6608; and

f. An explanation that an appeal decision for one household member may result in a change in eligibility for other household members and that such a change shall be handled as a redetermination of eligibility for all household members in accordance with the standards specified in sections 6472 and 6474.

(45 C.F.R. §§ 155.230, 155.355; Cal. Code Regs., tit. 10, §§ 6454, subd. (a), 6604.)

1572-1 ADDED 10/15

SHD Administrative Law Judges Determine Validity of Appeals and Good Cause for Untimely Appeal Requests and Continuances

A California Department of Social Services' State Hearings Division (SHD) Administrative Law Judge shall determine, on a case-by-case basis,

A. the validity of all appeals requests received by Covered California, the SHD, or the counties; and

B. whether good cause exists, including, but not limited to, good cause for an untimely appeal request and continuance.

"Good cause" means as a substantial and compelling reason beyond the party's control, considering the length of the delay, the diligence of the party making the request, and the potential prejudice to the other party. The inability of a person to understand an adequate and language-compliant notice, alone, shall not constitute good cause.

(Welf. & Inst. Code, § 10951; Cal. Code Regs., tit. 10, §6602, subd. (c).)

1572-2 ADDED 10/15

SHD Must Determine Appeal Valid if Appeal meets Timeliness Requirements and Addresses Appealable Issue; SHD Must Dismiss Appeal if Not Valid

The California Department of Social Services' State Hearings Division (SHD) shall consider an appeal request valid if it is submitted in accordance with the timeliness requirements of title 10 of the California Code of Regulations, section 6606, subdivision (c) and if the appeal addresses an appealable issue in accordance with section 6602, subdivision (a).

The SHD shall dismiss an appeal if the appellant fails to submit a valid appeal request without good cause.

(45 C.F.R. §§155.520(a)(4), (b) & (c), 155.505(b); Cal. Code Regs., tit. 10, §§ 6602, subd. (a), 6606, subds. (b) & (c), 6610, subd. (a)(3).)

1572-3 ADDED 10/15

Applicant or Enrollee Must Appeal Within 90 Days, or 180 Days with Good Cause

Covered California and the State Hearings Division (SHD) shall allow an applicant or enrollee to request an appeal within 90 days of the date of the notice of eligibility determination, unless the SHD determines that there is good cause, as defined in section 10951 of the Welfare and Institution Code, for filing the appeals request beyond the 90-day period. No appeal filing timeline shall be extended for good cause for more than 180 days after the date of the notice of eligibility determination. If the last day of the filing period falls on a Saturday, Sunday, or holiday, as defined in Government Code, section 6700, the filing period shall be extended to the next business day, in accordance with Government Code, section 6707.

Good Cause means as a substantial and compelling reason beyond the party's control, considering the length of the delay, the diligence of the party making the request, and the potential prejudice to the other party. The inability of a person to understand an adequate and language-compliant notice, in and of itself, shall not constitute good cause.

Covered California must allow an appellant to appeal within a timeframe consistent with the California Department of Social Services' requirements for submitting appeal requests, which include the application of principles of equity jurisdiction as provided by law".

(45 C.F.R. 155.520(b); Gov. Code, § 100506.4, subd. (a)(1); Welf. & Inst. Code, § 10951(a) & (b); Cal. Code Regs., tit. 10 § 6606, subd. (c).)

1573-1 ADDED 10/15

SHD Must Send Written Acknowledgement of Valid Appeal to Appellant Within Five Business Days

Within five business days from the date on which the valid appeal request is received, the California Department of Social Services' (CDSS') State Hearings Division (SHD) shall send written acknowledgment to the appellant of the receipt of his or her valid appeal request, including but not limited to:

A. Information regarding the appellant's opportunity for informal resolution prior to the hearing;

B. Information regarding the appellant's eligibility pending appeal;

C. An explanation that any APTC paid on behalf of the tax filer pending appeal is subject to reconciliation under title 26 of the United States Code, section 36B(f) and title 26 of the Code of Federal Regulations, section 1.36B-4; and

D. An explanation that the appellant shall have the opportunity to review his or her entire eligibility file, including information on how an income determination was made and all papers, requests, documents, and relevant information in the possession of the entity that made the decision that is the subject of the appeal at any time from the date on which an appeal request is filed to the date on which the appeal decision is issued.

(45 C.F.R. §155.520(d)(1); Gov. Code, § 100506.4, subd. (d)(1); Cal. Code Regs., tit. 10 § 6606, subd. (e)(1).)

1573-2 ADDED 10/15

SHD Must Send Written Notice of Invalid Appeal to Appellant Within Five Business Days

Upon receipt of an appeal request that is determined not valid, unless the California Department of Social Services' (CDSS') State Hearings Division (SHD) determines that there is good cause for such a failure, a SHD's Presiding Administrative Law Judge, or other Administrative Law Judge, as delegated by a Presiding Administrative Law Judge, must

(1) within five business days from the date on which the appeal request is received, send written notice to the appellant informing him or her

(A) that the appellant's appeal request has not been accepted;

(B) the nature of the defect in the appeal request; and

(C) that, if the defect is curable, the appellant may cure the defect and resubmit the appeal request within 30 calendar days from the date on which the invalid appeal request is received; and

(2) treat as valid an amended appeal request that meets the requirements for a valid appeal.

(45 C.F.R. §155.520(d)(2); Cal. Code Regs., tit. 10 § 6606, subd. (f).)

1574-1 ADDED 10/15

Covered California and State Hearings Division Must Accept Appeal Requests Submitted Through Multiple Methods

Covered California and the State Hearings Division must accept appeal requests submitted through any of the following methods:

(1) Covered California's Internet Web site;
(2) Telephone;
(3) Facsimile;
(4) Mail; or
(5) In person.

(45 C.F.R. § 155.520(a); Gov. Code, § 100506.4, subd. (b); Cal. Code Regs., tit. 10, § 6606, subd. (a).)

1575-1 ADDED 10/15

Appellant May Represent Himself or Herself or Use an Authorized Representative

The appellant may represent himself or herself or be represented by legal counsel, or may authorize a person or organization (including a relative, friend, or another spokesperson) to represent him or her at any time during the application and appeal process, including during the informal resolution process.

The appellant must be permitted to designate an authorized representative by telephone, mail, in person, through the internet, or through other commonly available electronic means. The claimant/appellant must provide a signature when designating an authorized representative; electronic, including telephonically recorded, signatures and handwritten signatures transmitted via any electronic transmission must be accepted.

(45 C.F.R. § 155.505(e); Gov. Code, § 100506.4, subd. (f); Cal. Code Regs., tit. 10, §§ 6470, subd. (j); 6508, subds. (a), (b); 6602, subd. (e).)

1576-1 ADDED 10/15

Covered California Must Provide Appellant Opportunity to Review Entire Eligibility File at Any Time from Date Appeal Request is Filed to Date Appeal Decision is Issued

Covered California must provide the appellant with the opportunity to review his or her entire eligibility file, including all papers, requests, documents, and relevant information in Covered California's possession at any time from the date on which an appeal request is filed to the date on which the appeal decision is issued.

(45 C.F.R. § 155.550(a); Cal. Code Regs., tit. 10, § 6602, subd. (j).)

1576-2 ADDED 10/15

SHD Must Provide Appellant Opportunity to Review Appeal Record Before and During Hearing

The California Department of Social Services' (CDSS') State Hearings Division (SHD) must provide the appellant with the opportunity to review his or her appeal record, including all documents and records to be used by the SHD at the hearing, at least two business days before the date of the hearing as well as during the hearing.

(45 C.F.R. §155.535(d)(1); Gov. Code, § 100506.4, subd. (h)(6); Cal. Code Regs., tit. 10, § 6614, subd. (d)(1).)

1577-1 ADDED 10/15

Covered California Must Continue Appellant's Eligibility Status Pending Appeal of Redetermination

If an appellant files a valid appeal of a semi-annual or annual redetermination, Covered California must continue to consider the appellant eligible for enrollment in a Qualified Health Plan (QHP), Advance Payments of Premium Tax Credit (APTC), and Cost-Sharing Reduction (CSR), as applicable, in accordance with the level of eligibility immediately before the redetermination being appealed, provided the appellant accepts eligibility pending the appeal and agrees to make his or her premium payments in full, reduced by the APTC amount he or she is determined eligible for by Covered California, by the applicable payment due dates.

(45 C.F.R. §155.525; Gov. Code, § 100506.5; Cal. Code Regs, tit. 10, § 6608; Cal. Dept. of Social Svcs., All County Lett. (ACL) No. 14-14 (Feb. 7, 2014) pp. 7-8.)

1578-1 ADDED 10/15

Dual Cases, Responsibility to Notify Other Agencies

During the informal resolution process, prior to the hearing, the entity that made the determination being appealed (county, Department of Health Care Services, or Covered California) must determine whether a dual agency appeal is required to resolve the matter at the hearing and notice the other agencies if not already included.

(Gov. Code, § 100506.4, subds. (g)(1), (g)(8)(C).)

1578-2

Dual Cases, Role of County and Covered California Representatives, Presentation of Evidence

Whenever possible, in a dual case the County Hearing Representative will present the MAGI Medi-Cal or the Non-MAGI Med-Cal case and the Covered California Hearings Representative will present the Covered California case in the same hearing. Covered California and the counties may work cooperatively in presenting evidence at the hearing.

(Cal. Dept. of Social Svcs., All County Lett. (ACL) No. 14-14 (Feb. 7, 2014) p. 18.)

1579-1 ADDED 10/15

Informal Resolution Process

Prior to the hearing, a representative of the entity that made the eligibility or enrollment determination being appealed (county, Department of Health Care Services, or Covered California) must contact the appellant or the appellant's representative and offer to discuss the determination with the appellant if he or she agrees. This discussion is known as the "informal resolution process."

The appellant's right to a hearing shall be reserved. The appellant may proceed with his or her appeal if the appellant is dissatisfied with the outcome of the informal resolution process. The appellant or the authorized representative may withdraw the hearing request voluntarily or may agree to a conditional withdrawal that shall list the agreed-upon conditions that the appellant and Covered California, county, or the State Department of Health Care Services or its designee must meet.

If the appeal advances to a hearing, the appellant shall not be required to provide duplicative information or documentation that he or she previously provided during the application, redetermination, enrollment, or informal resolution process.

The informal resolution process shall not delay the timeline for a hearing.

The informal resolution process is voluntary and neither an appellant's participation nor nonparticipation in the informal resolution process shall affect the right to a hearing.

If the appellant is satisfied with the outcome of the informal resolution process and conditionally withdraws his or her appeal request and the appeal does not advance to a hearing, within five business days from the date of the outcome of the informal resolution, Covered California shall

A. notify the appellant of:

   (1) the outcome of the informal resolution, including a plain language description of the effect of such outcome on the appellant's appeal and eligibility; and

   (2) the effective date of such outcome, if applicable; and

B. Covered California must provide a copy of the conditional withdrawal agreement signed by the appellant or the appellant's authorized representative and Covered California and instructions on how to submit his or her conditional withdrawal request to the State Hearings Division (SHD).

(45 C.F.R. § 155.535(a); Gov. Code, § 100506.4, subd. (g); Cal. Code Regs., tit. 10, § 6612.)

1580-1 ADDED 10/15

SHD Administrative Judges Conduct "De Novo" Evidentiary Hearings

The hearing shall be an evidentiary hearing where the appellant may present evidence, bring witnesses to testify, establish all relevant facts and circumstances, present an argument without undue interference, and question or refute any testimony or evidence, including, but not limited to, the opportunity to confront and cross-examine adverse witnesses, if any.

State Hearings Division (SHD) Administrative Law Judges (ALJs) must consider the information used to determine the appellant's eligibility, as well as any additional relevant evidence presented during the appeal process, including at the hearing.

SHD ALJs must review the record "de novo" and must consider all relevant facts and evidence presented during the appeal. This standard of "de novo" review means that the SHD has authority to issue its own decision based on the evidence produced during the hearing process.

(45 C.F.R. § 155.535(e) & (f). Gov. Code, § 100506.4, subds. (h)(4) & (7); Cal. Code Regs., tit. 10, § 6614, subds. (e), (f); Cal. Dept. of Social Svcs., All County Lett. (ACL) No. 14-14 (Feb. 7, 2014) p. 15.)

1581-1 ADDED 10/15

Covered California and County Representatives have Authority to Stipulate

The representatives for Covered California and the County have authority at the state hearing to make binding agreements and stipulations on behalf of the parties they are representing.

(Cal. Dept. of Social Svcs., Manual of Policy and Proced., § 22-073.37.)

1582-1 ADDED 10/15

SHD Must Maintain an Expedited Appeals Process

The California Department of Social Services' (CDSS') State Hearings Division (SHD) must establish and maintain an expedited appeals process for an appellant to request an expedited appeals process where there is an immediate need for health services because a standard appeal could jeopardize the appellant's life, health, or ability to attain, maintain, or regain maximum function.

If an expedited appeal is granted, the decision shall be issued as expeditiously as reasonably possible and no later than five business days from the close of the hearing record.
If an expedited appeal is denied, the SHD shall notify the appellant within three days by telephone or through other commonly available secure electronic means, to be followed by a notice in writing, within five working days of the denial of an expedited appeal. If an expedited appeal is denied, the appeal shall be handled through the standard appeal process.

(45 C.F.R. § 155.540(a); Gov. Code, § 100506.4, subd. (a)(2); Cal. Code Regs., tit. 10, §§ 6616, subd. (a), 6618, subd. (b)(2); Cal. Dept. of Social Svcs., All County Lett. (ACL) No. 14-14 (Feb. 7, 2014) pp. 14-15.)

1583-1 ADDED 10/15

Implementation Date of Hearing Decision May be Prospective or Retroactive, at Appellant's Option

Appeal decisions shall state the effective date of the decision.

Upon receiving the appeal decision described in title 10 of the Code of California Regulations, section 6618(b), Covered California shall promptly, but no later than 30 days from the date of the appeal decision:

(1) Implement the appeal decision effective, at the option of the appellant:

(A) Prospectively, (i) on the date specified in the appeal decision, or (ii) on the date requested by the appellant; or

(B) Retroactively, to the coverage effective date the appellant did receive or would have received if the appellant had enrolled in coverage under the incorrect eligibility determination that is the subject of the appeal; and

(2) Redetermine the eligibility of household members who have not appealed their own eligibility determinations but whose eligibility may be affected by the appeal decision, in accordance with the standards specified in Section 6472 and 6474 of title 10 of the California Code of Regulations.

(45 C.F.R. § 155.545(a)(5), (c); Cal. Code Regs., tit. 10, §§ 6618(a) & 6618(c).)

1583-2 ADDED 10/15

[Redacted combined with 1583-1]

1584-1 ADDED 10/15

Administrative Law Judges Have Authority to Dismiss Appeals Withdrawn by Appellants

Administrative Law Judges have authority to dismiss appeals withdrawn by appellants.

(45 C.F.R. § 155.530(a) & (b); Cal. Code Regs., tit. 10, § 6610; Cal. Dept. of Social Svcs., All County Lett. (ACL) No. 14-14 (Feb. 7, 2014) pp. 11-12.)

1584-2 ADDED 10/15

Appeal Dismissed If Appellant Unconditionally Withdraws Appeal in Writing

The State Hearings Division (SHD) shall dismiss an appeal if the appellant unconditionally withdraws the appeal request in writing prior to the hearing date.

(45 C.F.R. § 155.530(a); Cal. Code Regs., tit. 10, § 6610, subd. (a)(1); Cal. Dept. of Social Svcs., All County Lett. (ACL) No. 14-14 (Feb. 7, 2014) p. 11.)

1584-3 ADDED 10/15

Appeal Dismissed If Appellant Unconditionally Withdraws Appeal Verbally and Does Not Object to Withdrawal After State Hearings Division Sends Written Confirmation

An unconditional withdrawal shall be accepted by telephone if the following requirements are met:

1. The appellant's statement and telephonic signature made under penalty of perjury shall be recorded in full; and

2. The State Hearings Division (SHD) shall provide the appellant with a written confirmation documenting the telephonic interaction. If the appellant has verbally withdrawn his or her appeal request prior to the hearing, and such withdrawal is unconditional, the SHD shall send the appellant a written confirmation of the withdrawal within five business days from the date on which the appellant's verbal withdrawal is received. The written confirmation must include

    a. the reason for dismissal;

    b. an explanation of the dismissal's effect on the appellant's eligibility; and

    c. an explanation of how the appellant may show good cause why the dismissal should be vacated.

The written confirmation shall serve as the appellant's written withdrawal and the appeal shall be dismissed unless the appellant notifies the SHD, in writing or verbally, within 15 days of the date of the written confirmation, that the appellant has not withdrawn the appeal request.

(45 C.F.R. § 155.530(a) & (b); Cal. Code Regs., tit. 10, § 6610, subds. (a)(1)(B) & (D), (b); Cal. Dept. of Social Svcs., All County Letter No. 14-14 (Feb. 7, 2014) p. 12.)

1584-4 ADDED 10/15

<u>Appeal Dismissed If Appellant Conditionally Withdraws Appeal in Writing (Which Can Include Telephonic Signature If Recorded and Under Penalty of Perjury)</u>

The State Hearings Division (SHD) shall dismiss an appeal if the appellant conditionally withdraws the appeal request in writing prior to the hearing date, in accordance with the following procedure:

> A request to withdraw a hearing based on a conditional withdrawal must be accompanied by the agreement signed (faxed or telephonic signature is allowed) by the appellant and Covered California or the county, as part of the informal resolution process. The agreement must specify what Covered California or the county is re-reviewing and the actions to be taken, after review, with sufficient detail that the obligations of the appellant and/or Covered California and/or the county are clear. The written agreement must be signed by all parties and received by the SHD prior to the hearing.

Upon receipt of the signed conditional withdrawal, the hearing date, if any, shall be vacated.

The actions of both parties under the conditional withdrawal agreement shall be completed within 30 calendar days of the date on the agreement. Upon the satisfactory completion of the actions of the appellant and Covered California under the conditional withdrawal agreement, the SHD shall dismiss the appeals request unless the hearing request is reinstated based on a reinstatement request made within 90 calendar days, or 180 calendar days with good cause.

A conditional withdrawal shall be accepted by telephone if the following requirements are met:

1. The appellant's statement and telephonic signature made under penalty of perjury shall be recorded in full; and

2. The State Hearings Division shall provide the appellant with a written confirmation documenting the telephonic interaction.

(45 C.F.R. § 155.530(a) & (b); Cal. Code Regs., tit. 10, § 6610, subds. (a)(1)(C) & (D); Cal. Dept. of Social Svcs., All County Lett. (ACL) No. 14-14 (Feb. 7, 2014) pp. 11-12.)

1584-5 ADDED 10/15

Appeal Dismissed If Appellant Fails to Appear at Hearing without Good Cause

The California Department of Social Services' (CDSS') State Hearings Division (SHD) shall dismiss an appeal if the appellant fails to appear at a scheduled hearing without good cause.

(45 C.F.R. § 155.530(a)(2); Cal. Code Regs., tit. 10, § 6610, subd. (a)(2); Cal. Dept. of Social Svcs. Manual of Policies and Proceds., § 22-054.22; Cal. Dept. of Social Svcs., All County Lett. (ACL) No. 14-14 (Feb. 7, 2014) p. 13.)

1584-6 ADDED 10/15

Appeal Dismissed If Appellant Dies While Appeal Pending, Unless Appeal Affects Other Household Members or Representative Can Carry-On Appeal

The California Department of Social Services' (CDSS') State Hearings Division (SHD) shall dismiss an appeal if the appellant dies while the appeal is pending, unless the appeal affects the remaining member(s) of the deceased's household or the appeal can be carried forward by a representative of the deceased's estate, or by an heir of the deceased if the decedent's estate is not in probate.

(45 C.F.R.§155.530(a)(4); Cal. Code Regs., tit. 10, § 6610, subd. (a)(4); Cal. Dept. of Social Svcs. Manual of Policies and Proceds., § 22-004.4; Cal. Dept. of Social Svcs., All County Lett. (ACL) No. 14-14 (Feb. 7, 2014) p. 13.)

1584-7 ADDED 10/15

SHD Must Provide Appellant with Written Notice of Dismissal

If an appeal is dismissed, the California Department of Social Services' (CDSS') State Hearings Division shall provide written notice to the appellant within five business days from the date of the dismissal. This notice shall include:

(1) The reason for the dismissal;

(2) An explanation of the dismissal's effect on the appellant's eligibility; and

(3) An explanation of how the appellant may show good cause as to why the dismissal should be vacated.

(45 C.F.R. §155.530(b); Cal. Code Regs., tit. 10, § 6610, subd. (b); Cal. Dept. of Social Svcs., All County Lett. (ACL) No. 14-14 (Feb. 7, 2014) p. 13.)

1584-8 ADDED 10/15

SHD Must Vacate Dismissal If Appellant Shows Good Cause

The California Department of Social Services' (CDSS') State Hearings Division (SHD) must vacate a dismissal and proceed with the appeal if the appellant makes a written request within 30 calendar days of the date of the notice of the dismissal showing good cause why the dismissal should be vacated.

(45 C.F.R. §155.530(d)(1); Cal. Code Regs., tit. 10, § 6610, subd. (d)(1); Cal. Dept. of Social Svcs., All County Lett. (ACL) No. 14-14 (Feb. 7, 2014) p. 13.)

1584-9 ADDED 10/15

SHD Must Provide Written Notice to Appellant if Request to Vacate Dismissal is Denied

The California Department of Social Services' (CDSS') State Hearings Division (SHD) must provide written notice of the denial of a request to vacate a dismissal to the appellant within five business days from the date of such denial, if the request is denied.

(45 C.F.R. §155.530(d)(2); Cal. Code Regs., tit. 10, § 6610, subd. (d)(2); Cal. Dept. of Social Svcs., All County Lett. (ACL) No. 14-14 (Feb. 7, 2014) p. 13.)

1584-10 ADDED 10/15

Appellants May Appeal to the HHS upon Exhaustion of the SHD Appeals Process

If the appellant disagrees with the appeal decision of the California Department of Social Services' (CDSS') State Hearings Division (SHD), he or she may make an appeal request to the U.S. Department of Health and Human Services' (HHS') appeals entity within 30 days of the date of the SHD's notice of appeal decision or notice of denial of a request to vacate a dismissal.

(45 C.F.R. §§ 155.505(c)(2)(i), 155.520(c); Cal. Code Regs., tit. 10, §§ 6602, subd. (d), 6606 subd. (d); Cal. Dept. of Social Svcs., All County Lett. (ACL) No. 14-14 (Feb. 7, 2014) p. 16.)

1585-1

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