April 3, 2013

Mr. Peter Lee, Director
Ms. Thien Lam, Deputy Director Eligibility and Enrollment
Mr. David Panush, Director of Government Relations
Covered California

Re: Proposed regulations governing eligibility and enrollment for the Individual Exchange

Dear Mr. Lee, Ms. Lam and Mr. Panush:

Thank you for the opportunity to review and comment on the Exchange's proposed eligibility and enrollment regulations for the Individual Exchange (Covered California) dated March 21, 2013. On behalf of the undersigned, we submit these group comments, which are attached.

While we have a number of comments to the draft proposed regulations, we wanted to call to your attention two areas that we believe violate federal law:

- Requiring an applicant to pay premiums to the QHP before enrollment is effectuated (§6500(b)); and
- Allowing an insurer to assist with eligibility, which would give insurers private information about income and health status that should be kept out of the hands of insurers until after people are enrolled (§6500(g)).

In addition, there are a number of provisions that are of concern, including:

- Preventing someone eligible for traditional Medi-Cal from being enrolled in MAGI Medi-Cal and having Exchange emergency regulations govern Medi-Cal eligibility rules (§6486);
- Creating barriers for non-applicants, such as requiring them to provide SSNs; and
- Providing for electronic verification of residency instead of just relying on self-attestation (§6478).

We look forward to seeing a revised draft that addresses our comments and would welcome the opportunity to meet with you regarding these important regulations. We also note that several sections are marked as "reserved" and look forward to having the opportunity to review language in these areas as well.

Thank you for your consideration of our comments. For further information, contact Elizabeth Landsberg (916) 282-5118 or Julie Silas (415) 431-6747.

Sincerely,

Richard Konda, Asian Law Alliance
Doreena Wong, Asian Pacific American Legal Center
Cary Sanders, California Pan Ethnic Health Network
James Crouch, California Rural Indian Health Board
Deven McGraw, Center for Democracy & Technology
Michelle Stillwell-Parvensky, Childrens Defense Fund - California
Mike Odeh, Children Now
Kevin Aslanan, Coalition for California Welfare Rights Organizations
Sonya Vazquez, Community Health Councils, Inc.
Julie Silas, Consumers Union
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Beth Capell, Health Access
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Anne Donnelly, Project Inform
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Masen Davis, Transgender Law Center
Elizabeth Landsberg, Western Center on Law and Poverty

Consumer Advocate Comments on the Proposed Exchange Eligibility and Enrollment Regulations

April 3, 2013

Section and Issue	Comments
6410. Definitions	The proposed definition of Authorized Representative requires designation in writing. This should be broadened to allow an online signature to be sufficient to designate an AR. We appreciate the definition of "reasonable compatibility" to state that information is compatible when the difference or discrepancy between applicant's attestation and the Exchange's records does not impact the eligibility of the applicant. The definition of CalHEERS should include reference to California Welfare and Institutions Code §15926. Ad to this section a definition for LEP that states, "Limited-English-Proficient (LEP) means person who speaks English less than very well." The Definition of non-citizen is the same as the one in the proposed federal rule at 155.300. Since HHS has not issued the final rule on definitions, we recommend California's regulations include reference to 155.300 in case there are any changes. Similarly, the definition of special enrollment period should include citation to the federal definition. We recommend you add a definition of "TAX IDENTIFICATION NUMBER (TIN)" to include SSN, ITIN, ATIN.
6452. Accessibility and Readability Standards	The readability level identified in (b) for the eligibility and enrollment system should be set no higher than 6th grade level, not a 9th grade level as proposed. 6th grade is the level used by Medi-Cal and there will be many with low literacy levels applying for coverage and receiving notices. Overall, we are concerned that these regulations appear to confine the broader legal right to accommodations and accessibility to purely matter of receiving information, and we want to make sure that they address reasonable accommodations and the operation of non-discrimination in the context of redeterminations, appeals, applicable timelines, etc. ALL of the Exchange's and QHPs' policies and procedures could be the subject of a request for a reasonable modification by a person with a disability or Limited-English-Proficiency if the policy

	or procedure constitutes barrier for that individual. We recommend the following specific changes: (a) All applications, including but not limited to the single streamlined application described in Section 6470 of Article 5 of this chapter, forms, notices, correspondence, outreach and education materials, appeals, redeterminations or applicable timelines provided to the applicants and enrollees by the Exchange and QHP issuers shall conform to the standards outlined in paragraphs (b) and (c) of this section in accordance with 45 C.F.R. 155.205(c), 155.230, and 156.250. (c) should specify that "Information shall be provided to, and collected from, applicants and enrollees in a manner that is accessible and timely" since people will have to interact with the Exchange and QHPs and not just passively receive information. (c)(1) is overly narrow and tracks the language of federal disability rights laws only with respect to communication access. Moreover, it does not make sense to mention accessible web sites and then omit mention of section 508 of the Rehabilitation Act. Instead, we urge the following language: "Individuals with disabilities through the provision of reasonable accommodations and policy modifications, including auxiliary aids and services, at n cost to the individual, including accessible Web sites in accordance with the Americans with Disabilities Act of 1990 and Sections 50 and 508 of the Rehabilitation Act and applicable provisions of state law." (c)(2) Individuals who are Limited-English-Proficient through the provision of language services at no cost to the individual in accordance with Title VI of the Office of Civil Rights 1964 and all other relevant provisions of federal and state law. (A) Oral interpretation in any language or written translations at a minimum in the Medi-Cal Managed Care threshold languages; and (B) Taglines in at least 15 non-English languages indicating the availability of language services. We believe subsection (c)(3) should refer to the services "described in paragraphs (**c**)(1) and (2) rather than (**b**)(1) and (2). We also urge that these accessibility and readability standards be monitored and enforced over time and that the regulations address the method of enforcement.

6470. Application	We are concerned about (a) defining the "single streamlined application" to exclude non-MAGI. While federal law allows the state to create a "supplemental" or "alternative" form for those potentially eligible for non-MAGI Medi-Cal, we would prefer to have non-MAGI populations addressed in this provision as having their information collected and eligibility determined by the single, streamlined application and supplemented with additional information, as needed. Though this provision is about the Exchange determination since the Exchange will be doing a screen for non-MAGI Medi-Cal along with doing an assessment for MAGI Medi-Cal, that should be acknowledged here. We are concerned about codifying the penalty of perjury language in regulation. Any proposed language that describes what it means to sign something under the penalty of perjury should be evaluated for readability and tested with consumers. Moreover, the language as proposed is unclear - are applicants/enrollees required to notify of ***any*** changes or just changes that are relevant to eligibility? As it is currently drafted, applicants/enrollees have a legal obligation to report any changes, which could be quite onerous. Section (b) should be revised to allow partial applications to be submitted. As currently drafted, it requires applicants to submit "all" information required on single, streamlined application. We understood that applicants will be able to fill out partial application and get follow-up assistance, which would not be allowed under the proposed rules as drafted. Subsection (d) should add the following specifics about the channels for application: (2) Telephone through the Exchange call center or an assister (4) In person at county office or with an assister
6472. Eligibility Requirements for Enrollment in QHP through the Exchange	In subsection (a), it does not work to say an applicant is an individual "seeking enrollment in QHP." As Exchange staff has pointed out, consumers don't walk around with a sign that they are at 137% or 139% FPL. Anyone applying for subsidized coverage, whether they think they are eligible for Medi-Cal or an Exchange QHP should be considered an applicant. Subsection (c) refers to lawfully present eligibility. We recommend striking the phrase "is reasonably expected to be a" and "for the entire period for which enrollment is sought." This is the statutory definition but it is unnecessary as individuals with lawful status don't lose the status from month to month and also rarely from year

	to year. Any change in status can be reported as part of normal change reporting requirements or at annual redetermination. If lawfully present at time of application, the applicant should be provided continuous eligibility for that period unless there is information to the contrary from the beneficiary or from the Department of Homeland Security. NILC provided similar comments to HHS for the federal definition. Since HHS's proposed rule is the same, we recommend adding a cite to 45 CFR 155.305(a)(1) for this eligibility rule which may change when HHS's final rule comes out. Subsection (e) sets forth the residency requirements and appears to mirror the federal regulation at 4 CFR 155.305(a)(3). However, (e)(2), describing certain individuals under 2 for whom alternate requirements apply, omits the phrase "is not emancipated." We assume this is an oversight and request that it be added in.
6474. Eligibility Requirements for APTC and CSR	We recognize that the language in 6474(c)(1) mirrors language in 45 CFR 155.305(f), but have some concerns about the use of the term "tax filer" instead of "applicant" in (c)(1)(A), wherein it states that the "tax filer" must have household income of 100%-400% to be eligible for APTC. With all the possible permutations of families and households, we believe that there are situations where the focus should be o the "applicant's" income, rather than the income of the tax filer's household. We believe the language here may warrant further clarification. Subsections (c)(2) and (c)(2)(C) provide that lawfully present immigrants may not be excluded from the Exchange if ineligible for Medi-Cal. Both provisions should be changed to "not eligible for <u>full-scope</u> Medi-Cal" because people can get "limited scope" Medi-Cal (i.e., emergency and pregnancy-related care). (c)(2)(B): revise 100% FPL to 138% FPL. Immigrants ineligible for Medicaid due to immigration status should be eligible for APTC if their income is below the Medi-Cal income rule of 138% FPL. The calculation for APTC starts at 100% FPL and so there is special rule for immigrants whose income is below 100% FPL for actual calculation of the APTC. However, as this is the eligibility rule section, income of tax filer should be at 138% FPL or below. As drafted subsection (c)(5) requires the applicant to give the SSN of the non-applicant tax filer if the filer has an SSN and filed for the relevant tax year. Wouldn't the SSN of the applicant be sufficient to find the tax filer's SSN? The concern here is that making the applicant provide the SSN of the non- applicant filer could create barriers for many applicants, e.g. applicants who don't know what the SSN is, would experience significant delay in trying to get it, or who can't get the non-app filer's SSN, or for whom requesting it could be dangerous due to domestic violence, etc.

	If (c)(5) continues to request the non-applicant's SSN, there should be a requirement that the application filer be notified that his/her SSN will be used ONLY for purposes of income verification and cannot be shared for any other purposes other than eligibility determination. See 1411(g) of the AC and WIC § 10850 (confidentiality).
647 Eligibility Determination Process	If subsection (a) is meant that an applicant may apply only for unsubsidized coverage in a QHP that is fine but should be more clearly stated and specifically say "unsubsidized" or something similar. If, on the other hand, this subsection is meant to say that an applicant can request an eligibility determination for a QHP and not for Medi-Cal, that is not permissible because people are only eligible for Exchange subsidies if they are not eligible for Medi-Cal. A applicant could conceivably decide after receiving an eligibility determination not to enroll in Medi-Cal, but they must have an eligibility determination for both Medi-Cal and APTC. We support subsection (b) which says that an application for an IAP should be deemed a request for all IAPs. This is important as most consumers will not know when they apply what they are eligible for. We also support in (c)(1) that an enrollee can accept less than the full amount of APTC. Applicants should be informed of this at the time of application and redetermination and we urge that this disclosure be included in the regulations. Subsection (d) governs transmittal of information when the Exchange makes Medi-Cal or CHIP eligibility determination. We recommend several changes. First, this should include transmittal of potential eligibility for non-MAGI Medi-Cal in addition to MAGI Medi-Cal and CHIP since the application will have questions to screen for non-MAGI Medi-Cal. Second, those consumers determined eligible for MAGI Medi-Cal or CHIP through the Exchange should actually be enrolled in coverage and be able to choose and enroll into plan and that information as well as the eligibility record should be transferred. Lastly, we seek clarification whether the information will actually be transferred to the counties or to MEDS. We recommend the following changes to the language: (d) If the Exchange determines an applicant eligible for <u>MAGI</u> Medi-Cal or CHIP,<u>or potentially eligible for non-MAGI Medi-Cal,</u> the Exchange shall <u>enroll the applicant eligible for MAGI Medi-Cal or CHIP, as applicable and</u> notify DHCS <u>and the county</u> and transmit all information from the records of the Exchange to <u>DHCS and the county</u>, promptly and without undue delay [placeholder for data/records transmittal timeline], that is necessary for DHCS to provide the applicant with coverage. In subsection (e) and other places where there are processing timeframes we recommend that the language read, "(e) An applicant's eligibility <u>shall be granted in real time, meaning within minutes."</u>

	In subsection (g), consistent with federal regulations, this should be a combined notice that advises about eligibility for all MAGI IAPs as well as potential eligibility for non-MAGI Medi-Cal. In terms of timeframe for the notice we urge that if issued electronically, the notices be issued realtime and if issued through regular mail, it be sent the same business day. Subsection (g) refers to provision of timely "*written* notice." We urge that there be a separate section of the regulations regarding notices and that consumers be able to select their preferred method(s) of communication, including being able to get communication through secure email, regular mail or both. We also hope CalHEERS will include the ability to send text reminders.
647 Verification Process Related to Eligibility Requirements for Enrollment in QHP through the Exchange (b) verification of SSN (c) verification of citizenship or lawful presence (d) verification of residency (e) verification of incarceration	We recommend revising "any individual" to "applicant" in 6478(b)(1). SSNs should only be required and verified of APPLICANTS. Use of SSN for an application filer for income verification purposes should not be subject to the general verification of SSN as it's not being provided for any other purpose (such as ID). Also, verification of SSN as proposed by HHS in the recent proposed rule lacks sufficient due process protections so we recommend waiting until HHS issues the final rule on this before adding it to California's guidance. Subsection (c)(2) seems to assume that all lawfully present immigrants will have to present paper documentation which will then be verified with DHS. The ACA, however, permits verification using the immigrant's A number instead. Sub (c)(2) should be amended accordingly. Paper documentations should be required only if the A# verification process is not successful. We recommend revising (c)(2)to read as follows: "For an applicant who attests to being a non-citizen or national with lawful presence and for applicants attesting citizenship who cannot be verified through SSA, the Exchange shall request from the applicant only the information that is strictly necessary to verify status through DHS. Verification of status can be electronically done without requiring the applicant to provide paper documentation of status. Only the information strictly necessary to perform verification of status shall be transmitted by the Exchange to DHS. If the Exchange cannot verify status through SSA or DHS, the Exchange shall follow the inconsistencies procedures at Section 6492." We recommend adding a procedure in 6478(c) where citizenship status is verified by California vital statistics if the first match by SSA is unsuccessful and BEFORE going to inconsistency procedure at (c)(3). We recommend ensuring there is a procedure for obtaining paper documentation of citizenship/immigration status as part of verification procedure BEFORE getting to inconsistency procedures. There will be lawfully

	present immigrants who d not have an A# to provide but can provide documents at the time of application to document their status. The verification process should allow for that before moving to inconsistency procedure. In (c)(3) if an applicant provides proof of immigration status/attests to lawful presence and is in the inconsistency process, Section 1137d of the SSA and Ruiz v. Kizer as well as California Welfare and Institutions Code § 15926 (f)(6) require the applicant be aided (aid paid pending) during the reasonable opportunity period. This may need to work differently in terms of enrollment in the Exchange, but if there are medical bills between date of application and during the reasonable opportunity period for immigration status, there should be clarification about who will pay for those expenses. We support the acceptance of self-attestation for proof of residency, which is allowable under federal regulations. However, as written, the regulation is ambiguous in this regard. To make it clear, paragraph 6478(d)(1)(B) should be eliminated altogether, and the "or" after paragraph (d)(1)(A) should be deleted. Further, verification beyond attestation of residency should only be necessary if other information in the record is not reasonably compatible with the attestation, as set forth in (d)(2) and (d)(3). It would also help clarify if the same framing for the reference to 6492 were framed the same in all subparagraphs of (d). We prefer the framing in (d)(3), i.e., "the inconsistencies procedures specified in section 6492." We support the portion of (d)(3) which states that evidence of immigration status may not be used to determine residency. These are two distinct criteria and it is important to clarify that immigration status information is not determinative of residency. We recommend making that a separate subsection to make it clear that it is not an eligibility requirement in determining residency. We recommend striking "evidence of immigration status" and revising requirement as follows: "Any evidence related to immigration status cannot be used to determine an applicant's residency consistent with 4 CFR 435.956(c)(2)."
648 Verification of Eligibility for MEC other than through an Eligible Employer-Sponsored Plan Related to Eligibility Determination for APTC and CSR	

648 Verification of Family Size and Household Income Related to Eligibility Determination for APTC and CSR	The intended verification process for family size, as set forth in paragraphs (b) and (d), is not clear. As written, it appears that an applicant will have to attest to current family size [(d)(1)] and then attest again to the information that is obtained by the Exchange from the HHS data hub, from past tax returns, represents an accurate projection for the future [(d)(2)]. We believe that a second attestation is not necessary if the family's original attestation is consistent with the verification data (i.e., there has been no change from the prior tax return). There would only be the necessity for further inquiries if there is some inconsistency, in which case the procedures in (3)(B) and (4) could then be followed. We recommend adding an explicit reference to allowing self-declaration of income if the applicant attests there are no data sources available BEFORE moving into the inconsistency process.
648 Verification Process for Increases in Household Income Related to Eligibility Determination for APTC and CSR	While this section rightly refers to the inconsistency process in 6492, it is missing an important provision that is stated in 6492. As currently drafted, section 6484 would allow the Exchange to immediately require documentation when there is an inconsistency ("the application shall provide additional documentation..."). This provision should follow the federal rules (Section 155.315(f)(1)) to state that the Exchange must first 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. Additional language should be added to reflect the federal rules.
648 Alternate Verification Process for APTC and CSR Eligibility Determination for Decreases in Annual Household Income or If Tax Return Data Is Unavailable	We have grave concerns about subsection (c)(2)which states that an applicant is ineligible for APTC, CSR, MAGI Medi-Cal or CHIP if they haven't responded to the request for information within the 90 day period or the data sources indicate that an applicant in the tax filer's family is eligible for Medi-Cal or CHIP. First, we oppose Exchange regulations governing Medi-Cal or CHIP eligibility. While we understand that with the joint application the Exchange will sometimes make Medi-Cal eligibility determinations and counties will sometimes make eligibility determinations regarding APTCs and CSRs, and that the MAGI rules engine will reside in the CalHEERS system, Medi-Cal eligibility is governed by federal Medicaid law and state Medi-Cal law - NOT emergency regulations promulgated by the Exchange. Second, due to the drafting of this section it says in (2) that "the applicant shall not be eligible for . . . Medi-Cal or CHIP if: . . . (B) the data sources . . . indicate that an applicant in the tax filer's family is eligible for Medi-Cal or CHIP." This is nonsensical to say they are not eligible for Medi-Cal if they are eligible for Medi-Cal or CHIP. Perhaps it means non-MAGI Medi-Cal but this should be clarified. Once again, we recommend allowing self-declaration of household income for APT/CSR if the applicant attests there are no data sources available or tax return information is unavailable from the applicant or application filer, before moving into the inconsistency process.

648 Verification Process for MAGI-Based Medi-Cal and CHIP	The language regarding the Alternate verification plan in § 6486 refers to this section but it is currently "reserved" so we cannot review it.
649 Verifications of Enrollment in an Eligible Employer-Sponsored Plan and Eligibility for Qualifying Coverage in an Eligible Employer-Sponsored Plan Related to Eligibility Determination for APTC and CSR	"Reserved"
649 Inconsistencies	Subsection (a)(1) rightly requires that the Exchange try to resolve any inconsistencies between what the applicant filled out in her or his application and what the data electronically verified showed – both by checking for typographical or other clerical errors and contacting the applicant. We urge that this be augmented in several ways. First, if the Exchange contacts the applicant who explained the discrepancy that should be sufficient to resolve the inconsistency. Further, this section should only apply to inconsistencies that are material to the eligibility determination or the administration of the case. Language should be included that specifies that an applicant shall be contacted and given an opportunity to resolve any inconsistencies during the course of completing their application, where ever possible, including during an online, service center, telephonic, or in person application. We urge that (a)(1) be amended as follows: (1) Shall make a reasonable effort to identify and address the causes of such inconsistency, including through typographical or other clerical errors, by contacting the application filer <u>to explain the alleged inconsistencies and</u> confirm the accuracy of the information submitted by the application filer; We urge that (a)(2) be amended to facilitate the applicant sending in information by offering to accept documents electronically or send pre-paid envelope for the applicant to mail the needed document.

	We urge that (c) be revised to "An applicant shall not be required to provide information beyond what is strictly ~~the minimum~~ necessary to support the eligibility and enrollment processes of the Exchange, Medi-Cal, and CHIP."
649 Special Eligibility Standards and Verification Process for Indians	
649 Eligibility Redetermination during a Benefit Year	We see the Exchange proposes taking the federal option of using a 10% threshold income changes to determine what changes are reportable. We urge that the enrollee be given notice at the time their APTC is calculated as to what this 10% amount is for their family/the individual. It would be tailored to each account, based on the information that was used to determine eligibility. A more exact approach would be to tell the individual at eligibility determination the precise amount of income that would take them to a higher or lower level of APTC or CSR and require that they report the specific level of change. We support the approach in subsections (n) and (o) regarding APTC reconciliation and CSR changes. We agree that if the redetermination indicates a change in the APTC for the benefit year, the Exchange should calculate the new APTC level, taking into account what has already been paid out, so the applicant isn't stuck at reconciliation time owing back some of the tax credit. We would urge that this section also state that if it looks like the enrollee's annual income is going to require them to pay back some of the APTC they already received, they should be notified so they can plan ahead.
6498 Annual Eligibility Redetermination	The proposed regulations would have an authorization from enrollees to obtain tax information for "up to five years" whereas the federal provision says they can authorize "for fewer than five years." We oppose requiring applicants and enrollees to give five-year authorization in order to qualify for coverage. Rather, the Exchange should provide notice to enrollees yearly upon their redetermination that they have the right to terminate the authorization to obtain updated tax return information or to authorize it for less than five years. Subsection (c)(1) refers to requesting tax return information and (c)(2) refers to requesting data regarding MAGI-based income. As these overlap it would be helpful to more specifically lay out the difference. Again, we note a reference to section 6488 which we have not yet seen language for. It is not clear in subsection (d)(1) what the Exchange shall notify the enrollee regarding. This should be clarified.

	We support sending enrollees pre-populated redetermination forms. In (f), the redetermination notice should also include tailored information with the dollar amount for what 10% of income would be for this family and the duty to report increases in income. (g) requires an enrollee to report changes within 3 days, but this is not included as something required in the notice. This should be added to the notice to ensure enrollees understand it.
Administration of APTCs and CSRs	We note that the proposed California regulations do not include a section of the federal regulations that deal with administration of the APTCs and CSRs including the processes for notifying QHPs, applicant, etc. about APTCs and CSRs. Section 155.340. We think it would be useful for California to promulgate a parallel section.
650 Enrollment of Qualified Individuals into QHPs	6500(b): The Federal rules on effective coverage dates for initial open enrollment and annual open enrollment make no mention of paying premiums to the QHP before enrollment is effectuated. Such a requirement violates federal law. The federal regulations base effective coverage dates for initial open enrollment and annual open enrollment from the time the ***enrollee selects a QHP.*** Se Section 155.410(c) and Section 155.410(f), both of which tie "effective coverage dates" to the date when the QHP selection is received by the Exchange, not to the date when the premium is paid. Accordingly, effective coverage dates are "the first day of the following benefit year for a qualified individual who has ***made a QHP selection***..." Nowhere in the federal law do the rules permit enrollment to be conditioned on the "QHP issuer [receiving] the applicant's initial premium payment in full and by the due date." As currently drafted, the proposed California regulations would violate federal law. California cannot condition enrollment in the Exchange on proof of premium payment to the QHP issuer. Subsection 6500(b) should be deleted and replaced with language that reflects the federal rules: "For purposes of this section, enrollment shall be deemed complete when the applicant's coverage is effectuated, which shall occur when the qualified individual has made a QHP selection." All other language in (c)(1), (f)(4), and (f)(5) that reference initial premium payments as part of the enrollment effectuation process, should similarly be stricken. §6500(c)(3): Information submitted by an applicant to determine eligibility for the Exchange, APTCs, CRS, or insurance affordability programs should not be shared with the QHP (for example, income information, SSN, immigration status). Only information necessary for enrollment should be shared with the QHP. §6500(c)(3) should specify that only that information necessary to facilitate enrollment in the QHP should be sent. §6500(f): We are pleased to see language requiring QHP issuers to receive enrollment information consistent with federal Exchange regulations; however, it is critical that there be limits on the amount of enrollment

	information sent to QHP issuers, as noted in our comments to 6500(c)(3). Once information is in the hands of the QHP issuer, it will be much more difficult (if not impossible) to adequately protect it against subsequent inappropriate use. 6500(g): The federal rules state that the QHP issuer has to: "(i) Direct the individual to file an application with the Exchange in accordance with § 155.310, or (ii) Ensure the applicant received an eligibility determination for coverage through the Exchange through the Exchange Internet Web site. " (Section 156.265(b)(2)(i) and (ii). At n place in the federal rules is the QHP allowed to "assist the applicant" to apply for and receive an eligibility determination. As stated explicitly in the preamble to the federal rules, it is important that applicant's eligibility information is in no way shared with QHP issuers: "These provisions ensure that ***the applicant's information is collected only by the Exchange and thus firewalled from issuers*** and agents and brokers and accordingly protected." (Page 18425 of the Federal Rules.) [emphasis added] §6500(g)(2) should be deleted as proposed and revised to reflect what is permitted under the federal rules to read: "(ii) Ensure the applicant received an eligibility determination for coverage through the Exchange through the Exchange Internet Web site." Moreover, the Exchange should expressly prohibit health plans from serving as assistors. Health plans who are contacted for information about applying for coverage should refer the individual to the Exchange.
650 Initial and Annual Open Enrollment Periods	
650 Special Enrollment Periods	While proposed "triggering events" leading to a special enrollment track the federal regulations, they must be modified to comply with state law by including domestic partnership in addition to marriage and the special enrollment periods required under AB 108 of 201 and SBx1 2/ABx1 of 2013, e.g. release from incarceration. We support the provision in (a)(7) whereby there is a special enrollment period if employer-sponsored coverage is n longer affordable or n longer provides minimum value. We urge that COBRA also be included in this so that if COBRA coverage becomes unaffordable or does not provide minimum coverage the individual could enroll in Exchange coverage. Subsection (c) would need to be amended to achieve this. We urge you to add losing AIM among the public program losses for qualifying for special enrollment in (b)(1)(B).

	Subsections (d) and (e) summarize the process for an individual to show they had triggering event entitling them to a special enrollment period, i.e. present documentation of the event to the Exchange and they verify it. No timeframe for a decision is provided and under (f) and the individual only gets 60 days from the date of the triggering event to pick a QHP. To address this, we recommend either add deadline for the Exchange's decision or amend (f) to say 60 days "from the date the individual receives written notice that the Exchange concurs that the triggering event has occurred." We commend the clear statement in (h)(1)(A) that coverage begins on the date of birth for newborn. But are very concerned about (B), which says the APTC/CSR don't begin until the following month. The subsidies should also be effective as of o the newborn's DOB. Newborns of mothers with Medi-Cal are covered – not just eligible – as of the DOB. AIM infants are also covered as of the DOB, and AIM is a program that uses health plans exclusively (no fee for service), and even though the newborn may eventually be enrolled into Medi-Cal (if family income in the birth month was at or below 250% FPL) or into the residual Healthy Families program (if family income in the birth month was 250-300% FPL). The infants of mothers with Exchange coverage should also be eligible for subsidized coverage as of the DOB. This is a critical time for coverage, especially for newborns with extensive health care needs (e.g., premature births) but also for healthy newborns, all of whom need well-baby visits and other preventive care in the birth month.
650 Termination of Coverage in a QHP	The regulations should require that notices of termination inform applicants/enrollees of the consequences of non-payment including the APTC being returned if the consumer does not pay during the grace period. We recommend that when an individual is terminated from coverage in a QHP, they be advised about eligibility for Medi-Cal or AIM. During transitions between programs including from Exchange to Medi-Cal or AIM, the Exchange must attempt to have such transition occur without break in coverage pursuant to California Welfare & Institutions Code §15926(h)(2).
650 Appeals of Eligibility Determinations for the Exchange Participation)	"Reserved"