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AMENDED IN ASSEMBLY APRIL 8, 2010

CALIFORNIA LEGISLATURE—2009—10 REGULAR SESSION

ASSEMBLY BILL

No. 1602

**Introduced by Assembly Member John A. Pérez
(Principal coauthors: Assembly Members Bass and Monning)**

January 5, 2010

~~An act to add Title 22 (commencing with Section 100500) to the Government Code, to amend Sections 1357.06, 1357.51, and 1373 of, and to add Sections 1346.2 and 1367.001 to, the Health and Safety Code, and to amend Sections 10198.7, 10277, and 10708 of, and to add Sections 10112.1 and 10112.2 to, the Insurance~~ *An act to add Sections 100502, 100503, 100504, 100505, 100506, 100507, 100520, 100521, and 100522 to the Government Code, to add Section 1366.6 to the Health and Safety Code, and to add Section 10112.3 to the Insurance Code, relating to health care coverage, and making an appropriation therefor.*

LEGISLATIVE COUNSEL'S DIGEST

AB 1602, as amended, John A. Pérez. Health care coverage.

~~(1) Existing~~

Existing law provides various programs to provide health care coverage to persons with limited financial resources, including the

Medi-Cal program and the Healthy Families Program. *Existing law provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of its provisions a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance.*

Existing law, the federal Patient Protection and Affordable Care Act (PPACA), requires each state to, by January 1, 2014, establish an American Health Benefit Exchange that facilitates the purchase of qualified health plans by qualified individuals and qualified small employers, as specified, and meets certain other requirements.

This bill would enact the California Patient Protection and Affordable Care Act. ~~The bill would create the California Health Benefit Exchange (the Exchange) in state government to be governed by an executive board with 5 members, including the Secretary of California Health and Human Services and 4 other members appointed by the Governor and the Legislature. The bill, and would, contingent on the enactment of SB 900, which would create the California Health Benefit Exchange (the Exchange), specify the powers and duties of the board governing the Exchange relative to determining eligibility for enrollment in the Exchange and arranging for coverage with under qualified health plans, and would require the board to facilitate the purchase of qualified health plans through the Exchange by qualified individuals and qualified small employers by January 1, 2014. The bill would prohibit a carrier that is not participating in the Exchange from offering a catastrophic plan, as defined, in the individual market. The bill would create the California Health Trust Fund as a continuously appropriated fund and would enact other related provisions.~~

The bill would impose various requirements on participating plans and insurers and, commencing January 1, 2014, on nonparticipating plans and insurers, as specified. Because a willful violation of these requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program.

~~The bill would require the Director of the Department of Managed Health Care and the Insurance Commissioner to review an Internet portal developed by the United States Department of Health and Human Services and to jointly develop and maintain an electronic clearinghouse of coverage available in the individual and small group markets if the federal Internet portal does not adequately achieve certain purposes.~~

~~(2) Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service~~

~~plans by the Department of Managed Health Care and makes a willful violation of that act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law requires every health care service plan contract that provides for termination of coverage of a dependent child upon the attainment of the limiting age for dependent children to also provide that attainment of the limiting age shall not terminate the coverage of a child under certain conditions. Existing law establishes similar requirements for group health insurance policies that provide coverage of dependent children.~~

~~This bill would prohibit the limiting age in group or individual contracts or policies from being less than 26 years of age for dependent children covered by those plan contracts and insurance policies.~~

~~The bill would modify certain of the requirements applicable to group or individual health care service plan contracts and health insurance policies issued, amended, renewed, or delivered on or after September 23, 2010, consistent with requirements of the federal Patient Protection and Affordable Care Act. The bill would prohibit lifetime limits on the dollar value of benefits and would authorize annual limits on the dollar value of benefits only in specified circumstances. The bill would require coverage, and prohibit cost-sharing requirements applicable to enrollees or insureds, for certain health care benefits. The bill would also prohibit preexisting condition exclusions for enrollees or insureds under 19 years of age.~~

~~Because a willful violation of these requirements with respect to a health care service plan would be a crime, the bill would impose a state-mandated local program.~~

~~(3) The~~

~~The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.~~

~~This bill would provide that no reimbursement is required by this act for a specified reason.~~

~~Vote: majority. Appropriation: yes. Fiscal committee: yes. State-mandated local program: yes.~~

The people of the State of California do enact as follows:

- 1 SECTION 1. This act shall be known and may be cited as the
- 2 California Patient Protection and Affordable Care Act.

1 SEC. 2. It is the intent of the Legislature to enact the necessary
 2 statutory changes to California law in order to ~~be~~ *establish an*
 3 *American Health Benefit Exchange in California and its*
 4 *administrative authority in a manner that is* consistent with the
 5 federal Patient Protection and Affordable Care Act (Public Law
 6 111-148), as amended by the federal Health Care and Education
 7 Reconciliation Act of 2010 (Public Law 111-152), hereafter the
 8 federal act. In doing so, it is the intent of the Legislature to do all
 9 of the following:

- 10 (a) Reduce the number of uninsured Californians by creating
 11 an organized, transparent marketplace for Californians to purchase
 12 affordable, quality health care coverage, to claim available federal
 13 tax credits and cost-sharing subsidies, and to meet the personal
 14 responsibility requirements imposed under the federal act.
- 15 (b) Strengthen the health care delivery system.
- 16 (c) Guarantee the availability and renewability of health care
 17 coverage through the private health insurance market to qualified
 18 individuals and qualified small employers.
- 19 (d) Require that health care service plans and health insurers
 20 issuing coverage in the individual and small employer markets
 21 compete on the basis of price, quality, and service, and not on risk
 22 selection.
- 23 (e) Meet the requirements of the federal act *and all applicable*
 24 *federal guidance and regulations.*

25 ~~SEC. 3. Title 22 (commencing with Section 100500) is added~~
 26 ~~to the Government Code, to read:~~

27
 28 ~~TITLE 22. CALIFORNIA HEALTH BENEFIT EXCHANGE~~

29
 30 ~~100500. For purposes of this division, the following definitions~~
 31 ~~shall apply:~~

- 32 (a) ~~“Board” means the board described in subdivision (a) of~~
 33 ~~Section 100501.~~
- 34 (b) ~~“Carrier” means either a private health insurer holding a~~
 35 ~~valid outstanding certificate of authority from the Insurance~~
 36 ~~Commissioner or a health care service plan, as defined under~~
 37 ~~subdivision (f) of Section 1345 of the Health and Safety Code,~~
 38 ~~licensed by the Department of Managed Health Care.~~
- 39 (c) ~~“Exchange” means the California Health Benefit Exchange~~
 40 ~~established by Section 100501.~~

1 ~~(d) “Federal act” means the federal Patient Protection and~~
2 ~~Affordable Care Act (Public Law 111-148), as amended by the~~
3 ~~federal Health Care and Education Reconciliation Act of 2010~~
4 ~~(Public Law 111-152).~~

5 ~~(e) “Fund” means the California Health Trust Fund established~~
6 ~~by Section 100520.~~

7 ~~(f) “SHOP Program” means the Small Business Health Options~~
8 ~~Program established by subdivision (m) of Section 100502.~~

9 ~~100501. (a) There is in state government the California Health~~
10 ~~Benefit Exchange, an independent public entity, which shall be~~
11 ~~known as the Exchange. The Exchange shall be governed by an~~
12 ~~executive board consisting of five members who are residents of~~
13 ~~California. Of the members of the board, two shall be appointed~~
14 ~~by the Governor, one shall be appointed by the Senate Committee~~
15 ~~on Rules, and one shall be appointed by the Speaker of the~~
16 ~~Assembly. The Secretary of California Health and Human Services~~
17 ~~or his or her designee shall serve as a voting, ex officio member~~
18 ~~of the board.~~

19 ~~(b) Members of the board, other than an ex officio member,~~
20 ~~shall be appointed for a term of four years. Vacancies shall be~~
21 ~~filled by appointment for the unexpired term.~~

22 ~~(c) Each person appointed to the board shall have demonstrated~~
23 ~~and acknowledged expertise in at least two of the following areas:~~

24 ~~(1) Individual health care coverage.~~

25 ~~(2) Small group health care coverage.~~

26 ~~(3) Health benefits plan administration.~~

27 ~~(4) Health care finance.~~

28 ~~(5) Administering a public or private health care delivery system.~~

29 ~~(6) Health plan purchasing.~~

30 ~~(d) Each member of the board shall have the responsibility and~~
31 ~~duty to meet the requirements of this act and the federal act, to~~
32 ~~serve the public interest of the individuals and small businesses~~
33 ~~seeking health care coverage through the Exchange, and to ensure~~
34 ~~the operational well-being and fiscal solvency of the Exchange.~~

35 ~~(e) In making appointments to the board, the appointing~~
36 ~~authorities shall take into consideration the cultural, ethnic, and~~
37 ~~geographical diversity of the state so that the board’s composition~~
38 ~~reflects the communities of California.~~

39 ~~(f) A member of the board or of the staff of the Exchange shall~~
40 ~~not be employed by, a consultant to, a member of the board of~~

1 ~~directors of, affiliated with, an agent of, or otherwise a~~
2 ~~representative of, a carrier or other insurer, an agent or broker, a~~
3 ~~health care provider, or a health care facility or health clinic while~~
4 ~~serving on the board and during the first year following his or her~~
5 ~~service on the board. A board member shall not receive~~
6 ~~compensation for his or her service on the board but may receive~~
7 ~~a per diem and reimbursement for travel and other necessary~~
8 ~~expenses, as provided in Section 103 of the Business and~~
9 ~~Professions Code, while engaged in the performance of official~~
10 ~~duties of the board.~~

11 ~~(g) No member of the board shall make, participate in making,~~
12 ~~or in any way attempt to use his or her official position to influence~~
13 ~~the making of any decision that he or she knows or has reason to~~
14 ~~know will have a reasonably foreseeable material financial effect,~~
15 ~~distinguishable from its effect on the public generally, on him or~~
16 ~~her or a member of his or her immediate family, or on either of~~
17 ~~the following:~~

18 ~~(1) Any source of income, other than gifts and other than loans~~
19 ~~by a commercial lending institution in the regular course of~~
20 ~~business on terms available to the public without regard to official~~
21 ~~status aggregating two hundred fifty dollars (\$250) or more in~~
22 ~~value provided to, received by, or promised to the member within~~
23 ~~12 months prior to the time when the decision is made.~~

24 ~~(2) Any business entity in which the member is a director,~~
25 ~~officer, partner, trustee, employee, or holds any position of~~
26 ~~management.~~

27 ~~(h) There shall not be any liability in a private capacity on the~~
28 ~~part of the board or any member of the board, or any officer or~~
29 ~~employee of the board, for or on account of any act performed or~~
30 ~~obligation entered into in an official capacity, when done in good~~
31 ~~faith, without intent to defraud, and in connection with the~~
32 ~~administration, management, or conduct of this title or affairs~~
33 ~~related to this title.~~

34 ~~(i) The board shall hire an executive director to organize,~~
35 ~~administer, and manage the operations of the Exchange. The~~
36 ~~executive director shall serve at the pleasure of the board.~~

37 ~~(j) The board shall be subject to the Bagley-Keene Open Meeting~~
38 ~~Act (Article 9 (commencing with Section 11120) of Chapter 1 of~~
39 ~~Part 1 of Division 3 of Title 2), except that the board may hold~~

1 closed sessions when considering matters related to litigation,
2 personnel, contracting, and rates.

3 ~~(k) The board shall apply for planning and establishment grants~~
4 ~~made available to the Exchange pursuant to Section 1311 of the~~
5 ~~federal act. If an executive director has not been hired under~~
6 ~~subdivision (i) when the United States Secretary of Health and~~
7 ~~Human Services makes the initial planning and establishment~~
8 ~~grants available, the California Health and Human Services Agency~~
9 ~~shall, upon request of the board, submit the initial application for~~
10 ~~planning and establishment grants to the United States Secretary~~
11 ~~of Health and Human Services. If a majority of the board has not~~
12 ~~been appointed when the United States Secretary of Health and~~
13 ~~Human Services makes the initial planning and establishment~~
14 ~~grants available, the California Health and Human Services Agency~~
15 ~~shall submit the initial application for planning and establishment~~
16 ~~grants to the United States Secretary of Health and Human~~
17 ~~Services. The board shall be responsible for using the funds~~
18 ~~awarded by the United States Secretary of Health and Human~~
19 ~~Services for the planning and establishment of the Exchange,~~
20 ~~consistent with subdivision (b) of Section 1311 of the federal act.~~

21 ~~100502. The board shall, at a minimum, do all of the following~~
22 ~~SEC. 3. Section 100502 is added to the Government Code, to~~
23 ~~read:~~

24 ~~100502. The board shall, at a minimum, do all of the following~~
25 ~~to implement Section 1311 of the federal act:~~

26 (a) Implement procedures for the certification, recertification,
27 and decertification, consistent with guidelines established by the
28 United States Secretary of Health and Human Services, of health
29 plans as qualified health plans. The board shall require health plans
30 seeking certification as qualified health plans to do all of the
31 following:

32 (1) Submit a justification for any premium increase prior to
33 implementation of the increase. The plans shall prominently post
34 that information on their Internet Web sites. The board shall take
35 this information, and the information and the recommendations
36 provided to the board by the Department of Insurance or the
37 Department of Managed Health Care under paragraph (1) of
38 subdivision (b) of Section 2794 of the federal Public Health Service
39 Act, into consideration when determining whether to make the
40 health plan available through the Exchange. The board shall take

1 into account any excess of premium growth outside the Exchange
2 as compared to the rate of that growth inside the Exchange,
3 including information reported by the Department of Insurance
4 and the Department of Managed Health Care.

5 (2) (A) Make available to the public and submit to the board,
6 the United States Secretary of Health and Human Services, and
7 the Insurance Commissioner or the Department of Managed Health
8 Care, as applicable, accurate and timely disclosure of the following
9 information:

- 10 (i) Claims payment policies and practices.
 - 11 (ii) Periodic financial disclosures.
 - 12 (iii) Data on enrollment.
 - 13 (iv) Data on disenrollment.
 - 14 (v) Data on the number of claims that are denied.
 - 15 (vi) Data on rating practices.
 - 16 (vii) Information on cost sharing and payments with respect to
17 any out-of-network coverage.
 - 18 (viii) Information on enrollee and participant rights under Title
19 I of the federal act.
 - 20 (ix) Other information as determined appropriate by the United
21 States Secretary of Health and Human Services.
- 22 (B) The information required under subparagraph (A) shall be
23 provided in plain language, as defined in subparagraph (B) of
24 paragraph (3) of subdivision (e) of Section 1311 of the federal act.
- 25 (3) Permit individuals to learn, in a timely manner upon the
26 request of the individual, the amount of cost sharing, including,
27 but not limited to, deductibles, copayments, and coinsurance, under
28 the individual's plan or coverage that the individual would be
29 responsible for paying with respect to the furnishing of a specific
30 item or service by a participating provider. At a minimum, this
31 information shall be made available to the individual through an
32 Internet Web site and through other means for individuals without
33 access to the Internet.
- 34 (b) Provide for the operation of a toll-free telephone hotline to
35 respond to requests for assistance.
 - 36 (c) Maintain an Internet Web site through which enrollees and
37 prospective enrollees of qualified health plans may obtain
38 standardized comparative information on those plans.

1 (d) Assign a rating to each qualified health plan offered through
2 the Exchange in accordance with the criteria developed by the
3 United States Secretary of Health and Human Services.

4 (e) Utilize a standardized format for presenting health benefits
5 plan options in the Exchange, including the use of the uniform
6 outline of coverage established under Section 2715 of the federal
7 Public Health Service Act.

8 (f) Inform individuals of eligibility requirements for the
9 Medi-Cal program, the Healthy Families Program, or any
10 applicable state or local public program and, if, through screening
11 of the application by the Exchange, the Exchange determines that
12 an individual is eligible for any such program, enroll that individual
13 in the program.

14 (g) Establish and make available by electronic means a
15 calculator to determine the actual cost of coverage after the
16 application of any premium tax credit under Section 36B of the
17 Internal Revenue Code of 1986 and any cost-sharing reduction
18 under Section 1402 of the federal act.

19 (h) Grant a certification attesting that, for purposes of the
20 individual responsibility penalty under Section 5000A of the
21 Internal Revenue Code of 1986, an individual is exempt from the
22 individual requirement or from the penalty imposed by that section
23 because of either of the following:

24 (1) There is no affordable qualified health plan available through
25 the Exchange or the individual's employer covering the individual.

26 (2) The individual meets the requirements for any other
27 exemption from the individual responsibility requirement or
28 penalty.

29 (i) Transfer to the Secretary of the Treasury all of the following:

30 (1) A list of the individuals who are issued a certification under
31 subdivision (h), including the name and taxpayer identification
32 number of each individual.

33 (2) The name and taxpayer identification number of each
34 individual who was an employee of an employer but who was
35 determined to be eligible for the premium tax credit under Section
36 36B of the Internal Revenue Code of 1986 because of either of the
37 following:

38 (A) The employer did not provide minimum essential coverage.

39 (B) The employer provided the minimum essential coverage
40 but it was determined under subparagraph (C) of paragraph (2) of

1 subsection (c) of Section 36B of the Internal Revenue Code of
2 1986 to either be unaffordable to the employee or not provide the
3 required minimum actuarial value.

4 (3) The name and taxpayer identification number of each
5 individual who notifies the Exchange under paragraph (4) of
6 subsection (b) of Section 1411 of the federal act that they have
7 changed employers and of each individual who ceases coverage
8 under a qualified health plan during a plan year and the effective
9 date of that cessation.

10 (j) Provide to each employer the name of each employee of the
11 employer described in paragraph (2) of subdivision (i) who ceases
12 coverage under a qualified health plan during a plan year and the
13 effective date of that cessation.

14 (k) Perform duties required of, or delegated to, the Exchange
15 by the United States Secretary of Health and Human Services or
16 the Secretary of the Treasury related to determining eligibility for
17 premium tax credits, reduced cost sharing, or individual
18 responsibility exemptions.

19 (l) Establish the navigator program in accordance with
20 subdivision (i) of Section 1311 of the federal act. Any entity chosen
21 by the Exchange as a navigator shall do all of the following:

22 (1) Conduct public education activities to raise awareness of
23 the availability of qualified health plans.

24 (2) Distribute fair and impartial information concerning
25 enrollment in qualified health plans, and the availability of
26 premium tax credits under Section 36B of the Internal Revenue
27 Code of 1986 and cost-sharing reductions under Section 1402 of
28 the federal act.

29 (3) Facilitate enrollment in qualified health plans.

30 (4) Provide referrals to any applicable office of health insurance
31 consumer assistance or health insurance ombudsman established
32 under Section 2793 of the federal Public Health Service Act, or
33 any other appropriate state agency or agencies, for any enrollee
34 with a grievance, complaint, or question regarding his or her health
35 plan, coverage, or a determination under that plan or coverage.

36 (5) Provide information in a manner that is culturally and
37 linguistically appropriate to the needs of the population being
38 served by the Exchange.

39 (m) Establish the Small Business Health Options Program,
40 separate from the activities of the board related to the individual

1 market, to assist qualified small employers in facilitating the
2 enrollment of their employees in qualified health plans offered
3 through the Exchange in the small-~~group~~ *employer* market in a
4 manner consistent with paragraph (2) of subdivision (a) of Section
5 1312 of the federal act.

6 ~~100503. In addition to meeting the minimum requirements of~~
7 *SEC. 4. Section 100503 is added to the Government Code, to*
8 *read:*

9 *100503. In addition to meeting the minimum requirements of*
10 *Section 1311 of the federal act, the board shall do all of the*
11 *following:*

12 (a) Determine the criteria and process for eligibility, enrollment,
13 and disenrollment of enrollees and potential enrollees in the
14 Exchange *and coordinate that process with the state and local*
15 *government entities administering other health care coverage*
16 *programs, including the State Department of Health Care Services,*
17 *the Managed Risk Medical Insurance Board, and California*
18 *counties, in order to ensure consistent eligibility and enrollment*
19 *processes and seamless transitions between coverage.*

20 (b) Develop processes to coordinate with the county entities
21 that administer eligibility for the Medi-Cal program and the entity
22 that determines eligibility for the Healthy Families Program,
23 including, but not limited to, processes for case transfer, referral,
24 and enrollment in the Exchange of individuals applying for
25 assistance to those entities, if allowed or required by federal law.

26 (c) Determine the minimum requirements a health plan must
27 meet to be considered for participation in the Exchange as a
28 qualified health plan, and the standards and criteria for selecting
29 qualified health plans to be offered through the Exchange. In the
30 course of selectively contracting for health care coverage offered
31 to qualified individuals and qualified small employers through the
32 Exchange, the board shall seek to contract with carriers to provide
33 health insurance choices that offer the optimal choice, value,
34 quality, and service.

35 (d) Provide, in each region of the state, a choice of qualified
36 health plans at each of the five levels of coverage contained in
37 subdivisions (d) and (e) of Section 1302 of the federal act.

38 (e) Require, as a condition of participation in the Exchange,
39 carriers to fairly and affirmatively offer, market, and sell in the
40 Exchange *at least one product within each of the five levels of*

1 coverage contained in subdivisions (d) and (e) of Section 1302 of
 2 the federal act. *The board may require carriers to offer additional*
 3 *products within each of those five levels of coverage. This*
 4 *subdivision shall not apply to a carrier that solely offers*
 5 *supplemental coverage in the Exchange under paragraph (10) of*
 6 *subdivision (a) of Section 100504.*

7 (f) Require, as a condition of participation in the Exchange,
 8 carriers that sell any products outside the Exchange to do both of
 9 the following:

10 (1) Fairly and affirmatively offer, market, and sell all products
 11 made available to individuals in the Exchange to individuals
 12 purchasing coverage outside the Exchange.

13 (2) Fairly and affirmatively offer, market, and sell all products
 14 made available to small employers in the Exchange to small
 15 employers purchasing coverage outside the Exchange.

16 (g) Determine when an enrollee’s coverage commences and the
 17 extent and scope of coverage.

18 (h) Provide for the processing of applications and the enrollment
 19 and disenrollment of enrollees.

20 (i) Determine and approve cost-sharing provisions for qualified
 21 health plans.

22 (j) *Establish uniform billing and payment policies for qualified*
 23 *health plans offered in the Exchange to ensure consistent*
 24 *enrollment and disenrollment activities for individuals enrolled*
 25 *in the Exchange.*

26 ~~(j)~~

27 (k) Undertake activities necessary to market and publicize the
 28 availability of health care coverage and federal subsidies through
 29 the Exchange. The board shall also undertake outreach and
 30 enrollment activities that seek to assist enrollees and potential
 31 enrollees with enrolling and reenrolling in the Exchange in the
 32 least burdensome manner, including populations that may
 33 experience barriers to enrollment, such as the disabled and those
 34 with limited English language proficiency.

35 ~~(k)~~

36 (l) Select and set performance standards and compensation for
 37 navigators selected under subdivision (l) of Section 100502.

38 ~~(l)~~

39 (m) Employ necessary staff.

- 1 ~~(m) Assess a charge, at the lowest possible rate, on the qualified~~
2 ~~health plans offered by carriers to support the development,~~
3 *(n) Assess a charge on the qualified health plans offered by*
4 *carriers that is reasonable and necessary to support the*
5 *development, operations, and prudent cash management of the*
6 *Exchange. This charge shall not affect the requirement under*
7 *Section 1301 of the federal act that carriers charge the same*
8 *premium rate for each qualified health plan whether offered inside*
9 *or outside the Exchange.*
- 10 ~~(n)~~
11 *(o) Authorize expenditures, as necessary, from the California*
12 *Health Trust Fund to pay program expenses to administer the*
13 *Exchange.*
- 14 ~~(o)~~
15 *(p) Keep an accurate accounting of all activities, receipts, and*
16 *expenditures, and annually submit to the United States Secretary*
17 *of Health and Human Services a report concerning that accounting.*
- 18 ~~(p)~~
19 *(q) Maintain enrollment and expenditures to ensure that*
20 *expenditures do not exceed the amount of revenue in the fund, and*
21 *if sufficient revenue is not available to pay estimated expenditures,*
22 *institute appropriate measures to ensure fiscal solvency.*
- 23 ~~(q)~~
24 *(r) Exercise all powers reasonably necessary to carry out the*
25 *powers and responsibilities expressly granted or imposed by this*
26 *act, and comply with the duties, responsibilities, and requirements*
27 *of this act and the federal act.*
- 28 ~~(r)~~
29 *(s) Consult with stakeholders relevant to carrying out the*
30 *activities under this title, including, but not limited to, all of the*
31 *following:*
- 32 *(1) Health care consumers who are enrolled in health plans.*
 - 33 *(2) Individuals and entities with experience in facilitating*
34 *enrollment in health plans.*
 - 35 *(3) Representatives of small businesses and self-employed*
36 *individuals.*
 - 37 *(4) The Director of Health Care Services.*
 - 38 *(5) Advocates for enrolling hard-to-reach populations.*
- 39 ~~(s)~~

1 (t) Facilitate the purchase of qualified health plans in the
2 Exchange by qualified individuals and qualified small employers
3 no later than January 1, 2014.

4 (†)

5 (u) Report, or contract with an independent entity to report, to
6 the Legislature by December 1, 2018, on whether to adopt the
7 option in paragraph (3) of subdivision (c) of Section 1312 of the
8 federal act to merge the individual and small-group employer
9 markets. In its report, the board shall provide information, based
10 on at least two years of data from the Exchange, on the potential
11 impact on rates paid by individuals and by small employers in a
12 merged individual and small-group employer market, as compared
13 to the rates paid by individuals and small employers if a separate
14 individual and small-group employer market is maintained. A
15 report made pursuant to this paragraph shall be submitted pursuant
16 to Section 9795.

17 (‡)

18 (v) With respect to the SHOP Program, collect premiums and
19 administer all other necessary and related tasks, including, but not
20 limited to, enrollment and plan payment, in order to make the
21 offering of employee plan choice as simple as possible for qualified
22 small employers.

23 (¶)

24 (w) Require carriers participating in the Exchange to
25 immediately notify the Exchange, under the terms and conditions
26 established by the board when an individual is or will be enrolled
27 in or disenrolled from any qualified health plan offered by the
28 carrier.

29 (⌘)

30 (x) Ensure that the Exchange provides oral interpretation services
31 in any language for individuals seeking coverage through the
32 Exchange and makes available a toll-free telephone number for
33 the hearing and speech impaired. The board shall ensure that
34 written information made available by the Exchange is presented
35 in a plainly worded, easily understandable format and made
36 available in prevalent languages.

37 ~~100504. (a) The board may do the following:~~

38 *SEC. 5. Section 100504 is added to the Government Code, to*
39 *read:*

40 *100504. (a) The board may do the following:*

1 (1) With respect to individual coverage made available in the
2 Exchange, collect premiums and assist in the administration of
3 subsidies.

4 (2) Enter into contracts.

5 (3) Sue and be sued.

6 (4) Receive and accept gifts, grants, or donations of moneys
7 from any agency of the United States, any agency of the state, any
8 municipality, county, or other political subdivision of the state.

9 (5) Receive and accept gifts, grants, or donations from
10 individuals, associations, private foundations, or corporations,
11 subject to the adoption by the board at a public meeting of conflict
12 of interest provisions.

13 (6) Adopt rules and regulations, as necessary. Until January 1,
14 2016, any necessary rules and regulations may be adopted as
15 emergency regulations in accordance with the Administrative
16 Procedure Act (Chapter 3.5 (commencing with Section 11340) of
17 Part 1 of Division 3 of Title 2). The adoption of these regulations
18 shall be deemed to be an emergency and necessary for the
19 immediate preservation of the public peace, health and safety, or
20 general welfare.

21 (7) Collaborate with the State Department of Health Care
22 Services *and the Managed Risk Medical Insurance Board*, to the
23 extent possible, to allow an individual the option to remain enrolled
24 with his or her carrier and provider network in the event the
25 individual experiences a loss of eligibility of premium tax credits
26 and becomes eligible for the Medi-Cal program or the Healthy
27 Families Program, or loses eligibility for the Medi-Cal program
28 or the Healthy Families Program and becomes eligible for premium
29 tax credits through the Exchange.

30 (8) Share information with relevant state departments, consistent
31 with the confidentiality provisions in Section 1411 of the federal
32 act, necessary for the administration of the Exchange.

33 (9) Require carriers participating in the Exchange to make
34 available to the Exchange and regularly update an electronic
35 directory of contracting health care providers so that individuals
36 seeking coverage through the Exchange can search by health care
37 provider name to determine which health plans in the Exchange
38 include that health care provider in their network. The board may
39 also require a carrier to provide regularly updated information to
40 the Exchange as to whether a health care provider is accepting

1 new patients for a particular health plan. The Exchange may
 2 provide an integrated and uniform consumer directory of health
 3 care providers indicating which carriers the providers contract with
 4 and whether the providers are currently accepting new patients.
 5 The Exchange may also establish methods by which health care
 6 providers may transmit relevant information directly to the
 7 Exchange, rather than through a carrier.

8 *(10) Make available supplemental coverage for enrollees of the*
 9 *Exchange to the extent permitted by the federal act, provided that*
 10 *no General Fund money is used to subsidize the cost of that*
 11 *coverage.*

12 (b) The Exchange shall only collect information from individuals
 13 or designees of individuals necessary to administer the Exchange
 14 and consistent with Section 1411 of the federal act.

15 *(c) The Exchange shall have the authority to offer standardized*
 16 *products.*

17 ~~100505. A carrier that is not participating in the Exchange shall~~
 18 ~~not offer, market, or sell a catastrophic plan, as defined in~~
 19 ~~subdivision (e) of Section 1302 of the federal act, in the individual~~
 20 ~~market.~~

21 ~~100520. (a) The California Health Trust Fund is hereby~~
 22 *SEC. 6. Section 100505 is added to the Government Code, to*
 23 *read:*

24 *100505. The board shall establish and use a competitive*
 25 *process to select participating carriers and any other contractors*
 26 *under this title. Any contract entered into pursuant to this title*
 27 *shall be exempt from Chapter 2 (commencing with Section 10100)*
 28 *of Division 2 of the Public Contract Code, and shall be exempt*
 29 *from the review or approval of any division of the Department of*
 30 *General Services.*

31 *SEC. 7. Section 100506 is added to the Government Code, to*
 32 *read:*

33 *100506. (a) The board shall establish an appeal process for*
 34 *prospective and current enrollees of the Exchange that complies*
 35 *with all requirements of the federal act concerning the role of a*
 36 *state Exchange in facilitating federal appeals of Exchange-related*
 37 *determinations. In no event shall the scope of those appeals be*
 38 *construed to be broader than the requirements of the federal act.*
 39 *Once the federal regulations concerning appeals have been issued*
 40 *in final form by the United States Secretary of Health and Human*

1 *Services, the board may establish additional requirements related*
2 *to appeals.*

3 *(b) The board shall not be required to provide an appeal if the*
4 *subject of the appeal is within the jurisdiction of the Department*
5 *of Managed Health Care pursuant to the Knox-Keene Health Care*
6 *Service Plan Act of 1975 (Chapter 2.2 (commencing with Section*
7 *1340) of Division 2 of the Health and Safety Code) and its*
8 *implementing regulations, or within the jurisdiction of the*
9 *Department of Insurance pursuant to the Insurance Code and its*
10 *implementing regulations.*

11 *SEC. 8. Section 100507 is added to the Government Code, to*
12 *read:*

13 *100507. (a) Notwithstanding any other provision of law, the*
14 *Exchange shall not be subject to licensure or regulation by the*
15 *Department of Insurance or the Department of Managed Health*
16 *Care.*

17 *(b) Carriers that contract with the Exchange shall have a license*
18 *or certificate of authority from, and shall be in good standing with,*
19 *their respective regulatory agencies.*

20 *SEC. 9. Section 100520 is added to the Government Code, to*
21 *read:*

22 *100520. (a) The California Health Trust Fund is hereby*
23 *created in the State Treasury for the purpose of this title.*
24 *Notwithstanding Section 13340, all moneys in the fund shall be*
25 *continuously appropriated without regard to fiscal year for the*
26 *purposes of this title. Any moneys in the fund that are unexpended*
27 *or unencumbered at the end of a fiscal year may be carried forward*
28 *to the next succeeding fiscal year.*

29 *(b) Notwithstanding any other provision of law, moneys*
30 *deposited in the fund shall not be loaned to, or borrowed by, any*
31 *other special fund or the General Fund, or a county general fund*
32 *or any other county fund.*

33 *(c) The board of the California Health Benefit Exchange shall*
34 *establish and maintain a prudent reserve in the fund.*

35 *(d) The board or staff of the Exchange shall not utilize any funds*
36 *intended for the administrative and operational expenses of the*
37 *Exchange for staff retreats, promotional giveaways, excessive*
38 *executive compensation, or promotion of federal or state legislative*
39 *or regulatory modifications.*

1 (e) Notwithstanding Section 16305.7, all interest earned on the
2 moneys that have been deposited into the fund shall be retained
3 in the fund and used for purposes consistent with the fund.

4 *SEC. 10. Section 100521 is added to the Government Code, to*
5 *read:*

6 *100521. The state shall not be liable beyond the assets of the*
7 *fund for any obligations incurred, or liabilities sustained, in the*
8 *operation of the Exchange.*

9 *SEC. 11. Section 100522 is added to the Government Code, to*
10 *read:*

11 *100522. The Exchange shall not make expenditures that exceed*
12 *the amount of available moneys in the fund.*

13 *SEC. 12. Section 1366.6 is added to the Health and Safety*
14 *Code, to read:*

15 *1366.6. (a) For purposes of this section, the following*
16 *definitions shall apply:*

17 (1) “Exchange” means the California Health Benefit Exchange
18 established in Title 22 (commencing with Section 100500) of the
19 Government Code.

20 (2) “Federal act” means the federal Patient Protection and
21 Affordable Care Act (Public Law 111-148), as amended by the
22 federal Health Care and Education Reconciliation Act of 2010
23 (Public Law 111-152), and any amendments to, or regulations or
24 guidance issued under, those acts.

25 (3) “Qualified health plan” has the same meaning as that term
26 is defined in Section 1301 of the federal act.

27 (4) “Small employer” has the same meaning as that term is
28 defined in Section 1357.

29 (b) Health care service plans participating in the Exchange
30 shall fairly and affirmatively offer, market, and sell in the Exchange
31 at least one product within each of the five levels of coverage
32 contained in subdivisions (d) and (e) of Section 1302 of the federal
33 act. The board established under Section 100501 of the
34 Government Code may require plans to sell additional products
35 within each of those levels of coverage. This subdivision shall not
36 apply to a plan that solely offers supplemental coverage in the
37 Exchange under paragraph (10) of subdivision (a) of Section
38 100504 of the Government Code.

1 (c) Health care service plans participating in the Exchange that
2 sell any products outside the Exchange shall do both of the
3 following:

4 (1) Fairly and affirmatively offer, market, and sell all products
5 made available to individuals in the Exchange to individuals
6 purchasing coverage outside the Exchange.

7 (2) Fairly and affirmatively offer, market, and sell all products
8 made available to small employers in the Exchange to small
9 employers purchasing coverage outside the Exchange.

10 (d) Commencing January 1, 2014, a health care service plan
11 shall, with respect to plan contracts that cover hospital, medical,
12 or surgical expenses, only sell the five levels of coverage contained
13 in subdivisions (d) and (e) of Section 1302 of the federal act, except
14 that a health care service plan that does not participate in the
15 Exchange shall, with respect to plan contracts that cover hospital,
16 medical, or surgical benefits, only sell the four levels of coverage
17 contained in subdivision (d) of Section 1302 of the federal act.

18 (e) Commencing January 1, 2014, a health care service plan
19 that does not participate in the Exchange shall, with respect to
20 plan contracts that cover hospital, medical, or benefits, offer the
21 standardized products for qualified health plans offered in the
22 Exchange. This subdivision shall not be construed to prohibit the
23 plan from offering other products provided that it complies with
24 subdivision (d).

25 SEC. 13. Section 10112.3 is added to the Insurance Code, to
26 read:

27 10112.3. (a) For purposes of this section, the following
28 definitions shall apply:

29 (1) "Exchange" means the California Health Benefit Exchange
30 established in Title 22 (commencing with Section 100500) of the
31 Government Code.

32 (2) "Federal act" means the federal Patient Protection and
33 Affordable Care Act (Public Law 111-148), as amended by the
34 federal Health Care and Education Reconciliation Act of 2010
35 (Public Law 111-152), and any amendments to, or regulations or
36 guidance issued under, those acts.

37 (3) "Qualified health plan" has the same as that term is defined
38 in Section 1301 of the federal act.

39 (4) "Small employer" has the same meaning as that term is
40 defined in Section 10700.

1 **(b)** *Health insurers participating in the Exchange shall fairly*
2 *and affirmatively offer, market, and sell in the Exchange at least*
3 *one product within each of the five levels of coverage contained*
4 *in subdivisions (d) and (e) of Section 1302 of the federal act. The*
5 *board established under Section 100501 of the Government Code*
6 *may require insurers to sell additional products within each of*
7 *those levels of coverage. This subdivision shall not apply to an*
8 *insurer that solely offers supplemental coverage in the Exchange*
9 *under paragraph (10) of subdivision (a) of Section 100504 of the*
10 *Government Code.*

11 **(c)** *Health insurers participating in the Exchange that sell any*
12 *products outside the Exchange shall do both of the following:*

13 **(1)** *Fairly and affirmatively offer, market, and sell all products*
14 *made available to individuals in the Exchange to individuals*
15 *purchasing coverage outside the Exchange.*

16 **(2)** *Fairly and affirmatively offer, market, and sell all products*
17 *made available to small employers in the Exchange to small*
18 *employers purchasing coverage outside the Exchange.*

19 **(d)** *Commencing January 1, 2014, a health insurer, with respect*
20 *to policies that cover hospital, medical, or surgical benefits, may*
21 *only sell the five levels of coverage contained in subdivisions (d)*
22 *and (e) of Section 1302 of the federal act, except that a health*
23 *insurer that does not participate in the Exchange may, with respect*
24 *to policies that cover hospital, medical, or surgical benefits only*
25 *sell the four levels of coverage contained in subdivision (d) of*
26 *Section 1302 of the federal act.*

27 **(e)** *Commencing January 1, 2014, a health insurer that does*
28 *not participate in the Exchange shall, with respect to policies that*
29 *cover hospital, medical, or surgical expenses, offer the*
30 *standardized products for qualified health plans offered in the*
31 *Exchange. This subdivision shall not be construed to prohibit the*
32 *insurer from offering other products provided that it complies with*
33 *subdivision (d).*

34 **SEC. 14.** *No reimbursement is required by this act pursuant*
35 *to Section 6 of Article XIII B of the California Constitution because*
36 *the only costs that may be incurred by a local agency or school*
37 *district will be incurred because this act creates a new crime or*
38 *infraction, eliminates a crime or infraction, or changes the penalty*
39 *for a crime or infraction, within the meaning of Section 17556 of*
40 *the Government Code, or changes the definition of a crime within*

1 *the meaning of Section 6 of Article XIII B of the California*
2 *Constitution.*

3 *SEC. 15. This act shall become operative only if Senate Bill*
4 *900 of the 2009–10 Regular Session is also enacted and becomes*
5 *operative.*

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**All matter omitted in this version of the bill
appears in the bill as amended in the
Senate, August 2, 2010. (JR11)**

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