

AMENDED IN ASSEMBLY JANUARY 6, 2014

CALIFORNIA LEGISLATURE—2013—14 REGULAR SESSION

ASSEMBLY BILL

No. 369

Introduced by Assembly Member Pan

February 14, 2013

An act to amend Section ~~100503~~ of the Government Code, 1373.96 of the Health and Safety Code, and to amend Section 10133.56 of the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 369, as amended, Pan. ~~California Health Benefit Exchange report~~. Continuity of care.

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 the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan, with some exceptions, to provide for the completion of covered services by a terminated provider or a nonparticipating provider for enrollees who were receiving services from the provider for one of the specified conditions at the time of the contract termination or at the time a newly covered enrollee's coverage became effective. Existing law requires a health insurer, with some exceptions, to provide for the completion of covered services by a terminated provider for insureds who were receiving services from the provider for one of the specified conditions at the time of the policy termination.

Under the federal Patient Protection and Affordable Care Act (PPACA), each state is required, by January 1, 2014, to establish an

American Health Benefit Exchange that makes available qualified health plans to qualified individuals and small employers. Existing state law establishes the California Health Benefit Exchange (Exchange) within state government, specifies the powers and duties of the board governing the Exchange, and requires the board to facilitate the purchase of qualified health plans through the Exchange by qualified individuals and small employers by January 1, 2014. ~~Existing law requires the board to report, or contract with an independent entity to report, to the Legislature by December 1, 2018, on whether to adopt the option under the PPACA to merge the individual and small employer insurance markets.~~

~~This bill would instead require the board or the independent entity to make this report to the Legislature by March 1, 2019.~~

This bill would require a health insurer to arrange for the completion of covered services by a nonparticipating provider at the request of a newly covered insured under a group insurance policy. The bill would require a health care service plan and a health insurer to arrange for the completion of covered services by a nonparticipating provider for a newly covered enrollee and a newly covered insured under an individual health care service plan contract or insurance policy whose prior coverage was terminated between January 1, 2013, and March 31, 2014, inclusive.

Because a willful violation of these provisions by a health care service plan would, in part, be a crime, this bill would impose a state-mandated local program.

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: no. Fiscal committee: ~~no~~-yes.
State-mandated local program: ~~no~~-yes.

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

- 1 SECTION 1. Section 1373.96 of the Health and Safety Code
- 2 is amended to read:
- 3 1373.96. (a) A health care service plan shall at the request of
- 4 an enrollee, provide the completion of covered services as set forth

1 in this section by a terminated provider or by a nonparticipating
2 provider.

3 (b) (1) The completion of covered services shall be provided
4 by a terminated provider to an enrollee who at the time of the
5 contract's termination, was receiving services from that provider
6 for one of the conditions described in subdivision (c).

7 (2) The completion of covered services shall be provided by a
8 nonparticipating provider to a newly covered enrollee who, at the
9 time his or her coverage became effective, was receiving services
10 from that provider for one of the conditions described in
11 subdivision (c).

12 (c) The health care service plan shall provide for the completion
13 of covered services for the following conditions:

14 (1) An acute condition. An acute condition is a medical
15 condition that involves a sudden onset of symptoms due to an
16 illness, injury, or other medical problem that requires prompt
17 medical attention and that has a limited duration. Completion of
18 covered services shall be provided for the duration of the acute
19 condition.

20 (2) A serious chronic condition. A serious chronic condition is
21 a medical condition due to a disease, illness, or other medical
22 problem or medical disorder that is serious in nature and that
23 persists without full cure or worsens over an extended period of
24 time or requires ongoing treatment to maintain remission or prevent
25 deterioration. Completion of covered services shall be provided
26 for a period of time necessary to complete a course of treatment
27 and to arrange for a safe transfer to another provider, as determined
28 by the health care service plan in consultation with the enrollee
29 and the terminated provider or nonparticipating provider and
30 consistent with good professional practice. Completion of covered
31 services under this paragraph shall not exceed 12 months from the
32 contract termination date or 12 months from the effective date of
33 coverage for a newly covered enrollee.

34 (3) A pregnancy. A pregnancy is the three trimesters of
35 pregnancy and the immediate postpartum period. Completion of
36 covered services shall be provided for the duration of the
37 pregnancy.

38 (4) A terminal illness. A terminal illness is an incurable or
39 irreversible condition that has a high probability of causing death
40 within one year or less. Completion of covered services shall be

1 provided for the duration of a terminal illness, which may exceed
2 12 months from the contract termination date or 12 months from
3 the effective date of coverage for a new enrollee.

4 (5) The care of a newborn child between birth and age 36
5 months. Completion of covered services under this paragraph shall
6 not exceed 12 months from the contract termination date or 12
7 months from the effective date of coverage for a newly covered
8 enrollee.

9 (6) Performance of a surgery or other procedure that is
10 authorized by the plan as part of a documented course of treatment
11 and has been recommended and documented by the provider to
12 occur within 180 days of the contract's termination date or within
13 180 days of the effective date of coverage for a newly covered
14 enrollee.

15 (d) (1) The plan may require the terminated provider whose
16 services are continued beyond the contract termination date
17 pursuant to this section to agree in writing to be subject to the same
18 contractual terms and conditions that were imposed upon the
19 provider prior to termination, including, but not limited to,
20 credentialing, hospital privileging, utilization review, peer review,
21 and quality assurance requirements. If the terminated provider
22 does not agree to comply or does not comply with these contractual
23 terms and conditions, the plan is not required to continue the
24 provider's services beyond the contract termination date.

25 (2) Unless otherwise agreed by the terminated provider and the
26 plan or by the individual provider and the provider group, the
27 services rendered pursuant to this section shall be compensated at
28 rates and methods of payment similar to those used by the plan or
29 the provider group for currently contracting providers providing
30 similar services who are not capitated and who are practicing in
31 the same or a similar geographic area as the terminated provider.
32 Neither the plan nor the provider group is required to continue the
33 services of a terminated provider if the provider does not accept
34 the payment rates provided for in this paragraph.

35 (e) (1) The plan may require a nonparticipating provider whose
36 services are continued pursuant to this section for a newly covered
37 enrollee to agree in writing to be subject to the same contractual
38 terms and conditions that are imposed upon currently contracting
39 providers providing similar services who are not capitated and
40 who are practicing in the same or a similar geographic area as the

1 nonparticipating provider, including, but not limited to,
2 credentialing, hospital privileging, utilization review, peer review,
3 and quality assurance requirements. If the nonparticipating provider
4 does not agree to comply or does not comply with these contractual
5 terms and conditions, the plan is not required to continue the
6 provider's services.

7 (2) Unless otherwise agreed upon by the nonparticipating
8 provider and the plan or by the nonparticipating provider and the
9 provider group, the services rendered pursuant to this section shall
10 be compensated at rates and methods of payment similar to those
11 used by the plan or the provider group for currently contracting
12 providers providing similar services who are not capitated and
13 who are practicing in the same or a similar geographic area as the
14 nonparticipating provider. Neither the plan nor the provider group
15 is required to continue the services of a nonparticipating provider
16 if the provider does not accept the payment rates provided for in
17 this paragraph.

18 (f) The amount of, and the requirement for payment of,
19 copayments, deductibles, or other cost sharing components during
20 the period of completion of covered services with a terminated
21 provider or a nonparticipating provider are the same as would be
22 paid by the enrollee if receiving care from a provider currently
23 contracting with or employed by the plan.

24 (g) If a plan delegates the responsibility of complying with this
25 section to a provider group, the plan shall ensure that the
26 requirements of this section are met.

27 (h) This section shall not require a plan to provide for
28 completion of covered services by a provider whose contract with
29 the plan or provider group has been terminated or not renewed for
30 reasons relating to a medical disciplinary cause or reason, as
31 defined in paragraph (6) of subdivision (a) of Section 805 of the
32 Business and Profession Code, or fraud or other criminal activity.

33 (i) This section shall not require a plan to cover services or
34 provide benefits that are not otherwise covered under the terms
35 and conditions of the plan contract. ~~This~~ *Except as provided in*
36 *subdivision (k), this* section shall not apply to a newly covered
37 enrollee covered under an individual subscriber agreement who is
38 undergoing a course of treatment on the effective date of his or
39 her coverage for a condition described in subdivision (c).

1 ~~(j) This section shall not apply to a newly covered enrollee who~~
 2 ~~is offered an out-of-network option or to a newly covered enrollee~~
 3 ~~who had the option to continue with his or her previous health plan~~
 4 ~~or provider and instead voluntarily chose to change health plans.~~

5 ~~(k)~~

6 (j) The provisions contained in this section are in addition to
 7 any other responsibilities of a health care service plan to provide
 8 continuity of care pursuant to this chapter. Nothing in this section
 9 shall preclude a plan from providing continuity of care beyond the
 10 requirements of this section.

11 (k) (1) *A health care service plan shall, at the request of a newly*
 12 *covered enrollee under an individual health care service plan*
 13 *contract, arrange for the completion of covered services by a*
 14 *nonparticipating provider for one of the conditions described in*
 15 *subdivision (c) if the newly covered enrollee meets both of the*
 16 *following:*

17 (A) *The newly covered enrollee’s prior coverage was terminated*
 18 *between January 1, 2013, and March 31, 2014, inclusive.*

19 (B) *At the time his or her coverage became effective, the newly*
 20 *covered enrollee was receiving services from that provider for one*
 21 *of the conditions described in subdivision (c).*

22 (2) *A violation of this subdivision does not constitute a crime*
 23 *under Section 1390.*

24 (l) The following definitions apply for the purposes of this
 25 section:

26 (1) “Individual provider” means a person who is a licentiate, as
 27 defined in Section 805 of the Business and Professions Code, or
 28 a person licensed under Chapter 2 (commencing with Section
 29 1000) of Division 2 of the Business and Professions Code.

30 (2) “Nonparticipating provider” means a provider who is not
 31 contracted with a health care service plan. *A nonparticipating*
 32 *provider does not include a terminated provider.*

33 (3) “Provider” shall have the same meaning as set forth in
 34 subdivision (i) of Section 1345.

35 (4) “Provider group” means a medical group, independent
 36 practice association, or any other similar organization.

37 (5) “Terminated provider” *means a provider whose contract*
 38 *to provide services to enrollees is terminated or not renewed by*
 39 *the plan or one of the plan’s contracting provider groups.*

1 *SEC. 2. Section 10133.56 of the Insurance Code is amended*
2 *to read:*

3 10133.56. (a) A health insurer that enters into a contract with
4 a professional or institutional provider to provide services at
5 alternative rates of payment pursuant to Section 10133 shall, at
6 the request of an insured, arrange for the completion of covered
7 services by a terminated provider, if the insured is undergoing a
8 course of treatment for any of the following conditions:

9 (1) An acute condition. An acute condition is a medical
10 condition that involves a sudden onset of symptoms due to an
11 illness, injury, or other medical problem that requires prompt
12 medical attention and that has a limited duration. Completion of
13 covered services shall be provided for the duration of the acute
14 condition.

15 (2) A serious chronic condition. A serious chronic condition is
16 a medical condition due to a disease, illness, or other medical
17 problem or medical disorder that is serious in nature and that
18 persists without full cure or worsens over an extended period of
19 time or requires ongoing treatment to maintain remission or prevent
20 deterioration. Completion of covered services shall be provided
21 for a period of time necessary to complete a course of treatment
22 and to arrange for a safe transfer to another provider, as determined
23 by the health insurer in consultation with the insured and the
24 terminated provider and consistent with good professional practice.
25 Completion of covered services under this paragraph shall not
26 exceed 12 months from the contract termination date.

27 (3) A pregnancy. A pregnancy is the three trimesters of
28 pregnancy and the immediate postpartum period. Completion of
29 covered services shall be provided for the duration of the
30 pregnancy.

31 (4) A terminal illness. A terminal illness is an incurable or
32 irreversible condition that has a high probability of causing death
33 within one year or less. Completion of covered services shall be
34 provided for the duration of a terminal illness, which may exceed
35 12 months from the contract termination date.

36 (5) The care of a newborn child between birth and age 36
37 months. Completion of covered services under this paragraph shall
38 not exceed 12 months from the contract termination date.

1 (6) Performance of a surgery or other procedure that has been
2 recommended and documented by the provider to occur within
3 180 days of the contract's termination date.

4 (b) The insurer may require the terminated provider whose
5 services are continued beyond the contract termination date
6 pursuant to this section, to agree in writing to be subject to the
7 same contractual terms and conditions that were imposed upon
8 the provider prior to termination, including, but not limited to,
9 credentialing, hospital privileging, utilization review, peer review,
10 and quality assurance requirements. If the terminated provider
11 does not agree to comply or does not comply with these contractual
12 terms and conditions, the insurer is not required to continue the
13 provider's services beyond the contract termination date.

14 (c) Unless otherwise agreed upon between the terminated
15 provider and the insurer or between the terminated provider and
16 the provider group, the agreement shall be construed to require a
17 rate and method of payment to the terminated provider, for the
18 services rendered pursuant to this section, that are the same as the
19 rate and method of payment for the same services while under
20 contract with the insurer and at the time of termination. The
21 provider shall accept the reimbursement as payment in full and
22 shall not bill the insured for any amount in excess of the
23 reimbursement rate, with the exception of copayments and
24 deductibles pursuant to subdivision (e).

25 (d) Notice as to the process by which an insured may request
26 completion of covered services pursuant to this section shall be
27 provided in any insurer evidence of coverage and disclosure form
28 issued after March 31, 2004. An insurer shall provide a written
29 copy of this information to its contracting providers and provider
30 groups. An insurer shall also provide a copy to its insureds upon
31 request.

32 (e) The payment of copayments, deductibles, or other
33 cost-sharing components by the insured during the period of
34 completion of covered services with a terminated provider shall
35 be the same copayments, deductibles, or other cost-sharing
36 components that would be paid by the insured when receiving care
37 from a provider currently contracting with the insurer.

38 (f) If an insurer delegates the responsibility of complying with
39 this section to its contracting entities, the insurer shall ensure that
40 the requirements of this section are met.

1 (g) For the purposes of this section, the following terms have
2 the following meanings:

3 (1) “Provider” means a person who is a licentiate as defined in
4 Section 805 of the Business and Professions Code or a person
5 licensed under Chapter 2 (commencing with Section 1000) of
6 Division 2 of the Business and Professions Code.

7 (2) “*Provider group*” includes a medical group, independent
8 practice association, or any other similar organization.

9 (3) “*Nonparticipating provider*” means a provider who does
10 not have a contract with an insurer to provide services to insureds.
11 A nonparticipating provider does not include a terminated
12 provider.

13 ~~(2)~~
14 (4) “Terminated provider” means a provider whose contract to
15 provide services to insureds is terminated or not renewed by the
16 insurer or one of the insurer’s contracting provider groups. ~~A~~
17 ~~terminated provider is not a provider who voluntarily leaves the~~
18 ~~insurer or contracting provider group.~~

19 ~~(3) “Provider group” includes a medical group, independent~~
20 ~~practice association, or any other similar organization.~~

21 (h) This section shall not require an insurer or provider group
22 to provide for the completion of covered services by a provider
23 whose contract with the insurer or provider group has been
24 terminated or not renewed for reasons relating to medical
25 disciplinary cause or reason, as defined in paragraph (6) of
26 subdivision (a) of Section 805 of the Business and Professions
27 Code, or fraud or other criminal activity.

28 (i) This section shall not require an insurer to cover services or
29 provide benefits that are not otherwise covered under the terms
30 and conditions of the insurer contract.

31 (j) The provisions contained in this section are in addition to
32 any other responsibilities of insurers to provide continuity of care
33 pursuant to this chapter. Nothing in this section shall preclude an
34 insurer from providing continuity of care beyond the requirements
35 of this section.

36 (k) (1) *A health insurer shall, at the request of a newly covered*
37 *insured under a group insurance policy, arrange for the completion*
38 *of covered services by a nonparticipating provider for one of the*
39 *conditions described in subdivision (a).*

1 (2) A health insurer shall, at the request of a newly covered
 2 insured under an individual insurance policy, arrange for the
 3 completion of covered services by a nonparticipating provider for
 4 one of the conditions described in subdivision (a) if the newly
 5 covered insured meets both of the following:

6 (A) The newly covered insured’s prior coverage was terminated
 7 between January 1, 2013, and March 31, 2014.

8 (B) At the time his or her coverage became effective, the newly
 9 covered insured was receiving services from that provider for one
 10 of the conditions described in subdivision (a).

11 (3) (A) The insurer may require a nonparticipating provider
 12 whose services are continued pursuant to this section for a newly
 13 covered insured to agree in writing to be subject to the same
 14 contractual terms and conditions that are imposed upon currently
 15 participating providers providing similar services who are
 16 practicing in the same or a similar geographic area as the
 17 nonparticipating provider, including, but not limited to,
 18 credentialing, hospital privileging, utilization review, peer review,
 19 and quality assurance requirements. If the nonparticipating
 20 provider does not agree to comply or does not comply with these
 21 contractual terms and conditions, the insurer is not required to
 22 continue the provider’s services.

23 (B) Unless otherwise agreed upon by the nonparticipating
 24 provider and the insurer or by the nonparticipating provider and
 25 the provider group, the services rendered pursuant to this section
 26 shall be compensated at rates and methods of payment similar to
 27 those used by the insurer or the provider group for currently
 28 participating providers providing similar services who are
 29 practicing in the same or a similar geographic area as the
 30 nonparticipating provider. Neither the insurer nor the provider
 31 group is required to continue the services of a nonparticipating
 32 provider if the provider does not accept the payment rates provided
 33 for in this paragraph. The provider shall accept the reimbursement
 34 as payment in full and shall not bill the insured for any amount in
 35 excess of the reimbursement rate, with the exception of copayments
 36 and deductibles pursuant to subdivision (e).

37 SEC. 3. No reimbursement is required by this act pursuant to
 38 Section 6 of Article XIII B of the California Constitution because
 39 the only costs that may be incurred by a local agency or school
 40 district will be incurred because this act creates a new crime or

1 *infraction, eliminates a crime or infraction, or changes the penalty*
2 *for a crime or infraction, within the meaning of Section 17556 of*
3 *the Government Code, or changes the definition of a crime within*
4 *the meaning of Section 6 of Article XIII B of the California*
5 *Constitution.*

6 ~~SECTION 1. Section 100503 of the Government Code is~~
7 ~~amended to read:~~

8 ~~100503. In addition to meeting the minimum requirements of~~
9 ~~Section 1311 of the federal act, the board shall do all of the~~
10 ~~following:~~

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

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

25 ~~(c) Determine the minimum requirements a carrier must meet~~
26 ~~to be considered for participation in the Exchange, and the~~
27 ~~standards and criteria for selecting qualified health plans to be~~
28 ~~offered through the Exchange that are in the best interests of~~
29 ~~qualified individuals and qualified small employers. The board~~
30 ~~shall consistently and uniformly apply these requirements,~~
31 ~~standards, and criteria to all carriers. In the course of selectively~~
32 ~~contracting for health care coverage offered to qualified individuals~~
33 ~~and qualified small employers through the Exchange, the board~~
34 ~~shall seek to contract with carriers so as to provide health care~~
35 ~~coverage choices that offer the optimal combination of choice,~~
36 ~~value, quality, and service.~~

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

1 ~~(e) Require, as a condition of participation in the Exchange,~~
 2 ~~carriers to fairly and affirmatively offer, market, and sell in the~~
 3 ~~Exchange at least one product within each of the five levels of~~
 4 ~~coverage contained in subdivisions (d) and (e) of Section 1302 of~~
 5 ~~the federal act. The board may require carriers to offer additional~~
 6 ~~products within each of those five levels of coverage. This~~
 7 ~~subdivision shall not apply to a carrier that solely offers~~
 8 ~~supplemental coverage in the Exchange under paragraph (10) of~~
 9 ~~subdivision (a) of Section 100504.~~

10 ~~(f) (1) Require, as a condition of participation in the Exchange,~~
 11 ~~carriers that sell any products outside the Exchange to do both of~~
 12 ~~the following:~~

13 ~~(A) 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 ~~(B) 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 ~~(2) For purposes of this subdivision, “product” does not include~~
 20 ~~contracts entered into pursuant to Part 6.2 (commencing with~~
 21 ~~Section 12693) of Division 2 of the Insurance Code between the~~
 22 ~~Managed Risk Medical Insurance Board and carriers for enrolled~~
 23 ~~Healthy Families beneficiaries or contracts entered into pursuant~~
 24 ~~to Chapter 7 (commencing with Section 14000) of, or Chapter 8~~
 25 ~~(commencing with Section 14200) of, Part 3 of Division 9 of the~~
 26 ~~Welfare and Institutions Code between the State Department of~~
 27 ~~Health Care Services and carriers for enrolled Medi-Cal~~
 28 ~~beneficiaries.~~

29 ~~(g) Determine when an enrollee’s coverage commences and the~~
 30 ~~extent and scope of coverage.~~

31 ~~(h) Provide for the processing of applications and the enrollment~~
 32 ~~and disenrollment of enrollees.~~

33 ~~(i) Determine and approve cost-sharing provisions for qualified~~
 34 ~~health plans.~~

35 ~~(j) Establish uniform billing and payment policies for qualified~~
 36 ~~health plans offered in the Exchange to ensure consistent~~
 37 ~~enrollment and disenrollment activities for individuals enrolled in~~
 38 ~~the Exchange.~~

39 ~~(k) Undertake activities necessary to market and publicize the~~
 40 ~~availability of health care coverage and federal subsidies through~~

1 the Exchange. The board shall also undertake outreach and
2 enrollment activities that seek to assist enrollees and potential
3 enrollees with enrolling and reenrolling in the Exchange in the
4 least burdensome manner, including populations that may
5 experience barriers to enrollment, such as the disabled and those
6 with limited English language proficiency.

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

9 (m) Employ necessary staff.

10 (1) The board shall hire a chief fiscal officer, a chief operations
11 officer, a director for the SHOP Exchange, a director of Health
12 Plan Contracting, a chief technology and information officer, a
13 general counsel, and other key executive positions, as determined
14 by the board, who shall be exempt from civil service.

15 (2) (A) The board shall set the salaries for the exempt positions
16 described in paragraph (1) and subdivision (i) of Section 100500
17 in amounts that are reasonably necessary to attract and retain
18 individuals of superior qualifications. The salaries shall be
19 published by the board in the board's annual budget. The board's
20 annual budget shall be posted on the Internet Web site of the
21 Exchange. To determine the compensation for these positions, the
22 board shall cause to be conducted, through the use of independent
23 outside advisors, salary surveys of both of the following:

24 (i) Other state and federal health insurance exchanges that are
25 most comparable to the Exchange.

26 (ii) Other relevant labor pools.

27 (B) The salaries established by the board under subparagraph
28 (A) shall not exceed the highest comparable salary for a position
29 of that type, as determined by the surveys conducted pursuant to
30 subparagraph (A).

31 (C) The Department of Human Resources shall review the
32 methodology used in the surveys conducted pursuant to
33 subparagraph (A).

34 (3) The positions described in paragraph (1) and subdivision (i)
35 of Section 100500 shall not be subject to otherwise applicable
36 provisions of the Government Code or the Public Contract Code
37 and, for those purposes, the Exchange shall not be considered a
38 state agency or public entity.

39 (n) Assess a charge on the qualified health plans offered by
40 carriers that is reasonable and necessary to support the

1 development, operations, and prudent cash management of the
2 Exchange. This charge shall not affect the requirement under
3 Section 1301 of the federal act that carriers charge the same
4 premium rate for each qualified health plan whether offered inside
5 or outside the Exchange.

6 ~~(o) Authorize expenditures, as necessary, from the California
7 Health Trust Fund to pay program expenses to administer the
8 Exchange.~~

9 ~~(p) Keep an accurate accounting of all activities, receipts, and
10 expenditures, and annually submit to the United States Secretary
11 of Health and Human Services a report concerning that accounting.
12 Commencing January 1, 2016, the board shall conduct an annual
13 audit.~~

14 ~~(q) (1) Annually prepare a written report on the implementation
15 and performance of the Exchange functions during the preceding
16 fiscal year, including, at a minimum, the manner in which funds
17 were expended and the progress toward, and the achievement of,
18 the requirements of this title. This report shall be transmitted to
19 the Legislature and the Governor and shall be made available to
20 the public on the Internet Web site of the Exchange. A report made
21 to the Legislature pursuant to this subdivision shall be submitted
22 pursuant to Section 9795.~~

23 ~~(2) In addition to the report described in paragraph (1), the board
24 shall be responsive to requests for additional information from the
25 Legislature, including providing testimony and commenting on
26 proposed state legislation or policy issues. The Legislature finds
27 and declares that activities including, but not limited to, responding
28 to legislative or executive inquiries, tracking and commenting on
29 legislation and regulatory activities, and preparing reports on the
30 implementation of this title and the performance of the Exchange,
31 are necessary state requirements and are distinct from the
32 promotion of legislative or regulatory modifications referred to in
33 subdivision (d) of Section 100520.~~

34 ~~(r) Maintain enrollment and expenditures to ensure that
35 expenditures do not exceed the amount of revenue in the fund, and
36 if sufficient revenue is not available to pay estimated expenditures,
37 institute appropriate measures to ensure fiscal solvency.~~

38 ~~(s) Exercise all powers reasonably necessary to carry out and
39 comply with the duties, responsibilities, and requirements of this
40 title and the federal act.~~

- 1 ~~(t) Consult with stakeholders relevant to carrying out the~~
2 ~~activities under this title, including, but not limited to, all of the~~
3 ~~following:~~
- 4 ~~(1) Health care consumers who are enrolled in health plans.~~
 - 5 ~~(2) Individuals and entities with experience in facilitating~~
6 ~~enrollment in health plans.~~
 - 7 ~~(3) Representatives of small businesses and self-employed~~
8 ~~individuals.~~
 - 9 ~~(4) The State Medi-Cal Director.~~
 - 10 ~~(5) Advocates for enrolling hard-to-reach populations.~~
- 11 ~~(u) Facilitate the purchase of qualified health plans in the~~
12 ~~Exchange by qualified individuals and qualified small employers~~
13 ~~no later than January 1, 2014.~~
- 14 ~~(v) Report, or contract with an independent entity to report, to~~
15 ~~the Legislature by March 1, 2019, on whether to adopt the option~~
16 ~~in paragraph (3) of subdivision (c) of Section 1312 of the federal~~
17 ~~act to merge the individual and small employer markets. In its~~
18 ~~report, the board shall provide information, based on at least two~~
19 ~~years of data from the Exchange, on the potential impact on rates~~
20 ~~paid by individuals and by small employers in a merged individual~~
21 ~~and small employer market, as compared to the rates paid by~~
22 ~~individuals and small employers if a separate individual and small~~
23 ~~employer market is maintained. A report made pursuant to this~~
24 ~~subdivision shall be submitted pursuant to Section 9795.~~
- 25 ~~(w) With respect to the SHOP Program, collect premiums and~~
26 ~~administer all other necessary and related tasks, including, but not~~
27 ~~limited to, enrollment and plan payment, in order to make the~~
28 ~~offering of employee plan choice as simple as possible for qualified~~
29 ~~small employers.~~
- 30 ~~(x) Require carriers participating in the Exchange to immediately~~
31 ~~notify the Exchange, under the terms and conditions established~~
32 ~~by the board, when an individual is or will be enrolled in or~~
33 ~~disenrolled from any qualified health plan offered by the carrier.~~
- 34 ~~(y) Ensure that the Exchange provides oral interpretation~~
35 ~~services in any language for individuals seeking coverage through~~
36 ~~the Exchange and makes available a toll-free telephone number~~
37 ~~for the hearing and speech impaired. The board shall ensure that~~
38 ~~written information made available by the Exchange is presented~~
39 ~~in a plainly worded, easily understandable format and made~~
40 ~~available in prevalent languages.~~

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