

AMENDED IN ASSEMBLY MARCH 11, 2013

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

**ASSEMBLY BILL**

**No. 710**

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**Introduced by Assembly Member Pan**

February 21, 2013

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An act to amend Section ~~1385.01~~ of the Health and Safety Code, and to amend Section ~~10181~~ of the Insurance Code *100503* of the Government Code, relating to health care coverage, and making an appropriation therefor.

LEGISLATIVE COUNSEL'S DIGEST

AB 710, as amended, Pan. ~~Review of rate increases: California Health Benefit Exchange. Exchange: multiemployer plans.~~

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. 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 provides that, for the purposes of provisions relating to review of rate increases by health care service plan contracts and health insurance policies, specified definitions shall

~~apply.~~ Existing law creates the continuously appropriated California Health Trust Fund, which consists of charges on the qualified health plans offered by carriers to support the development, operations, and prudent cash management of the Exchange.

~~This bill would add the definition of “Exchange” to those provisions:~~

~~This bill would, to the extent permitted by federal law, require the board to also facilitate the purchase of qualified health plans through the Exchange by multiemployer plans, as defined, no later than July 1, 2014. By expanding the purpose for which moneys in the California Health Trust Fund may be used, this bill would make an appropriation.~~

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

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

1 SECTION 1. Section 100503 of the Government Code is  
2 amended to read:

3 100503. In addition to meeting the minimum requirements of  
4 Section 1311 of the federal act, the board shall do all of the  
5 following:

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

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

20 (c) Determine the minimum requirements a carrier must meet  
21 to be considered for participation in the Exchange, and the  
22 standards and criteria for selecting qualified health plans to be  
23 offered through the Exchange that are in the best interests of  
24 qualified individuals and qualified small employers. The board  
25 shall consistently and uniformly apply these requirements,

1 standards, and criteria to all carriers. In the course of selectively  
2 contracting for health care coverage offered to qualified individuals  
3 and qualified small employers through the Exchange, the board  
4 shall seek to contract with carriers so as to provide health care  
5 coverage choices that offer the optimal combination of choice,  
6 value, quality, and service.

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

10 (e) Require, as a condition of participation in the Exchange,  
11 carriers to fairly and affirmatively offer, market, and sell in the  
12 Exchange at least one product within each of the five levels of  
13 coverage contained in subdivisions (d) and (e) of Section 1302 of  
14 the federal act. The board may require carriers to offer additional  
15 products within each of those five levels of coverage. This  
16 subdivision shall not apply to a carrier that solely offers  
17 supplemental coverage in the Exchange under paragraph (10) of  
18 subdivision (a) of Section 100504.

19 (f) (1) Require, as a condition of participation in the Exchange,  
20 carriers that sell any products outside the Exchange to do both of  
21 the following:

22 (A) Fairly and affirmatively offer, market, and sell all products  
23 made available to individuals in the Exchange to individuals  
24 purchasing coverage outside the Exchange.

25 (B) Fairly and affirmatively offer, market, and sell all products  
26 made available to small employers in the Exchange to small  
27 employers purchasing coverage outside the Exchange.

28 (2) For purposes of this subdivision, “product” does not include  
29 contracts entered into pursuant to Part 6.2 (commencing with  
30 Section 12693) of Division 2 of the Insurance Code between the  
31 Managed Risk Medical Insurance Board and carriers for enrolled  
32 Healthy Families beneficiaries or contracts entered into pursuant  
33 to Chapter 7 (commencing with Section 14000) of, or Chapter 8  
34 (commencing with Section 14200) of, Part 3 of Division 9 of the  
35 Welfare and Institutions Code between the State Department of  
36 Health Care Services and carriers for enrolled Medi-Cal  
37 beneficiaries.

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

1 (h) Provide for the processing of applications and the enrollment  
2 and disenrollment of enrollees.

3 (i) Determine and approve cost-sharing provisions for qualified  
4 health plans.

5 (j) Establish uniform billing and payment policies for qualified  
6 health plans offered in the Exchange to ensure consistent  
7 enrollment and disenrollment activities for individuals enrolled in  
8 the Exchange.

9 (k) Undertake activities necessary to market and publicize the  
10 availability of health care coverage and federal subsidies through  
11 the Exchange. The board shall also undertake outreach and  
12 enrollment activities that seek to assist enrollees and potential  
13 enrollees with enrolling and reenrolling in the Exchange in the  
14 least burdensome manner, including populations that may  
15 experience barriers to enrollment, such as the disabled and those  
16 with limited English language proficiency.

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

19 (m) Employ necessary staff.

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

25 (2) (A) The board shall set the salaries for the exempt positions  
26 described in paragraph (1) and subdivision (i) of Section 100500  
27 in amounts that are reasonably necessary to attract and retain  
28 individuals of superior qualifications. The salaries shall be  
29 published by the board in the board's annual budget. The board's  
30 annual budget shall be posted on the Internet Web site of the  
31 Exchange. To determine the compensation for these positions, the  
32 board shall cause to be conducted, through the use of independent  
33 outside advisors, salary surveys of both of the following:

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

36 (ii) Other relevant labor pools.

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

1 (C) The Department of Human Resources shall review the  
2 methodology used in the surveys conducted pursuant to  
3 subparagraph (A).

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

9 (n) Assess a charge on the qualified health plans offered by  
10 carriers that is reasonable and necessary to support the  
11 development, operations, and prudent cash management of the  
12 Exchange. This charge shall not affect the requirement under  
13 Section 1301 of the federal act that carriers charge the same  
14 premium rate for each qualified health plan whether offered inside  
15 or outside the Exchange.

16 (o) Authorize expenditures, as necessary, from the California  
17 Health Trust Fund to pay program expenses to administer the  
18 Exchange.

19 (p) Keep an accurate accounting of all activities, receipts, and  
20 expenditures, and annually submit to the United States Secretary  
21 of Health and Human Services a report concerning that accounting.  
22 Commencing January 1, 2016, the board shall conduct an annual  
23 audit.

24 (q) (1) Annually prepare a written report on the implementation  
25 and performance of the Exchange functions during the preceding  
26 fiscal year, including, at a minimum, the manner in which funds  
27 were expended and the progress toward, and the achievement of,  
28 the requirements of this title. This report shall be transmitted to  
29 the Legislature and the Governor and shall be made available to  
30 the public on the Internet Web site of the Exchange. A report made  
31 to the Legislature pursuant to this subdivision shall be submitted  
32 pursuant to Section 9795.

33 (2) In addition to the report described in paragraph (1), the board  
34 shall be responsive to requests for additional information from the  
35 Legislature, including providing testimony and commenting on  
36 proposed state legislation or policy issues. The Legislature finds  
37 and declares that activities including, but not limited to, responding  
38 to legislative or executive inquiries, tracking and commenting on  
39 legislation and regulatory activities, and preparing reports on the  
40 implementation of this title and the performance of the Exchange,

1 are necessary state requirements and are distinct from the  
2 promotion of legislative or regulatory modifications referred to in  
3 subdivision (d) of Section 100520.

4 (r) Maintain enrollment and expenditures to ensure that  
5 expenditures do not exceed the amount of revenue in the fund, and  
6 if sufficient revenue is not available to pay estimated expenditures,  
7 institute appropriate measures to ensure fiscal solvency.

8 (s) Exercise all powers reasonably necessary to carry out and  
9 comply with the duties, responsibilities, and requirements of this  
10 ~~act~~ *title* and the federal act.

11 (t) Consult with stakeholders relevant to carrying out the  
12 activities under this title, including, but not limited to, all of the  
13 following:

14 (1) Health care consumers who are enrolled in health plans.

15 (2) Individuals and entities with experience in facilitating  
16 enrollment in health plans.

17 (3) Representatives of small businesses and self-employed  
18 individuals.

19 (4) The State Medi-Cal Director.

20 (5) Advocates for enrolling hard-to-reach populations.

21 (u) Facilitate the purchase of qualified health plans in the  
22 Exchange by qualified individuals and qualified small employers  
23 no later than January 1, 2014, *and, to the extent permitted by*  
24 *federal law, by multiemployer plans, as defined in Section 3(37)*  
25 *of the federal Employee Retirement Income Security Act of 1974*  
26 *(29 U.S.C. Sec. 1001 et seq.), no later than July 1, 2014.*

27 (v) Report, or contract with an independent entity to report, to  
28 the Legislature by December 1, 2018, on whether to adopt the  
29 option in paragraph (3) of subdivision (c) of Section 1312 of the  
30 federal act to merge the individual and small employer markets.  
31 In its report, the board shall provide information, based on at least  
32 two years of data from the Exchange, on the potential impact on  
33 rates paid by individuals and by small employers in a merged  
34 individual and small employer market, as compared to the rates  
35 paid by individuals and small employers if a separate individual  
36 and small employer market is maintained. A report made pursuant  
37 to this subdivision shall be submitted pursuant to Section 9795.

38 (w) With respect to the SHOP Program, collect premiums and  
39 administer all other necessary and related tasks, including, but not  
40 limited to, enrollment and plan payment, in order to make the

1 offering of employee plan choice as simple as possible for qualified  
2 small employers.

3 (x) Require carriers participating in the Exchange to immediately  
4 notify the Exchange, under the terms and conditions established  
5 by the board, when an individual is or will be enrolled in or  
6 disenrolled from any qualified health plan offered by the carrier.

7 (y) Ensure that the Exchange provides oral interpretation  
8 services in any language for individuals seeking coverage through  
9 the Exchange and makes available a toll-free telephone number  
10 for the hearing and speech impaired. The board shall ensure that  
11 written information made available by the Exchange is presented  
12 in a plainly worded, easily understandable format and made  
13 available in prevalent languages.

14 ~~SECTION 1. Section 1385.01 of the Health and Safety Code~~  
15 ~~is amended to read:~~

16 ~~1385.01. For purposes of this article, the following definitions~~  
17 ~~shall apply:~~

18 ~~(a) "Exchange" means the California Health Benefit Exchange~~  
19 ~~created by Section 100500 of the Government Code.~~

20 ~~(b) "Large group health care service plan contract" means a~~  
21 ~~group health care service plan contract other than a contract issued~~  
22 ~~to a small employer, as defined in Section 1357, 1357.500, or~~  
23 ~~1357.600.~~

24 ~~(c) "Small group health care service plan contract" means a~~  
25 ~~group health care service plan contract issued to a small employer,~~  
26 ~~as defined in Section 1357, 1357.500, or 1357.600.~~

27 ~~(d) "PPACA" means Section 2794 of the federal Public Health~~  
28 ~~Service Act (42 U.S.C. Sec. 300gg-94), as amended by the federal~~  
29 ~~Patient Protection and Affordable Care Act (Public Law~~  
30 ~~(111-148)), and any subsequent rules, regulations, or guidance~~  
31 ~~issued under that section.~~

32 ~~(e) "Unreasonable rate increase" has the same meaning as that~~  
33 ~~term is defined in PPACA.~~

34 ~~SEC. 2. Section 10181 of the Insurance Code is amended to~~  
35 ~~read:~~

36 ~~10181. For purposes of this article, the following definitions~~  
37 ~~shall apply:~~

38 ~~(a) "Exchange" means the California Health Benefit Exchange~~  
39 ~~created by Section 100500 of the Government Code.~~

1 (b) “Large group health insurance policy” means a group health  
2 insurance policy other than a policy issued to a small employer,  
3 as defined in Section 10700, 10753, or 10755.

4 (c) “Small group health insurance policy” means a group health  
5 insurance policy issued to a small employer, as defined in Section  
6 10700, 10753, or 10755.

7 (d) “PPACA” means Section 2794 of the federal Public Health  
8 Service Act (42 U.S.C. Sec. 300gg-94), as amended by the federal  
9 Patient Protection and Affordable Care Act (Public Law 111-148),  
10 and any subsequent rules, regulations, or guidance issued pursuant  
11 to that law.

12 (e) “Unreasonable rate increase” has the same meaning as that  
13 term is defined in PPACA.