

AMENDED IN ASSEMBLY MARCH 21, 2013

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

**ASSEMBLY BILL**

**No. 1180**

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**Introduced by Assembly Member Pan**

February 22, 2013

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An act to ~~amend Section 100503 of the Government Code~~ *repeal and add Sections 1399.805 and 1399.811 of the Health and Safety Code, and to repeal and add Sections 10901.3 and 10901.9 of the Insurance Code, relating to health care coverage.*

LEGISLATIVE COUNSEL'S DIGEST

AB 1180, as amended, Pan. ~~California Health Benefit Exchange.~~  
*Health care coverage: HIPAA rates.*

*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 Insurance Commissioner. Existing law requires a health care service plan or a health insurer offering individual plan contracts or individual insurance policies to fairly and affirmatively offer, market, and sell certain individual contracts and policies to all federally eligible defined individuals, as defined, in each service area in which the plan or insurer provides or arranges for the provision of health care services. Existing law prohibits the premium for those policies and contracts from exceeding the premium paid by a subscriber of the California Major Risk Medical Insurance Program who is of the same age and resides in the same geographic region as the federally eligible defined individual, as specified.*

*This bill would instead prohibit the premium for those policies and contracts from exceeding the premium for a specified plan offered in the individual market through the California Health Benefit Exchange in the rating area in which the individual resides. Because a willful violation of the bill's requirements by a health care service plan would be a crime, the 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.*

~~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 makes available qualified health plans to qualified individuals and small employers. PPACA also authorizes the establishment of a basic health program under which a state may, if specified criteria are met, enter into contracts to offer one or more standard health plans providing a minimum level of essential health benefits to eligible individuals instead of offering those individuals coverage through an exchange. PPACA also establishes annual limits on deductibles for employer-sponsored plans and defines bronze, silver, gold, and platinum levels of coverage for the nongrandfathered individual and small group markets.~~

~~Existing law establishes the California Health Benefit Exchange (Exchange) to facilitate the purchase of qualified health plans through the Exchange by qualified individuals and qualified small employers by January 1, 2014. Existing law requires carriers participating in the Exchange that sell products outside the Exchange to offer, market, and sell all products made available to individuals and small employers through the Exchange to individuals and small employers purchasing coverage outside the Exchange. Existing law requires an individual or small group health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2014, to cover essential health benefits, as defined.~~

~~This bill would make technical, nonsubstantive changes to those provisions:~~

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 1399.805 of the Health and Safety Code~~  
2 ~~is repealed.~~  
3     ~~1399.805. (a) (1) After the federally eligible defined~~  
4 ~~individual submits a completed application form for a plan contract,~~  
5 ~~the plan shall, within 30 days, notify the individual of the~~  
6 ~~individual's actual premium charges for that plan contract, unless~~  
7 ~~the plan has provided notice of the premium charge prior to the~~  
8 ~~application being filed. In no case shall the premium charged for~~  
9 ~~any health care service plan contract identified in subdivision (d)~~  
10 ~~of Section 1366.35 exceed the following amounts:~~  
11     ~~(A) For health care service plan contracts that offer services~~  
12 ~~through a preferred provider arrangement, the average premium~~  
13 ~~paid by a subscriber of the Major Risk Medical Insurance Program~~  
14 ~~who is of the same age and resides in the same geographic area as~~  
15 ~~the federally eligible defined individual. However, for federally~~  
16 ~~qualified individuals who are between the ages of 60 and 64,~~  
17 ~~inclusive, the premium shall not exceed the average premium paid~~  
18 ~~by a subscriber of the Major Risk Medical Insurance Program who~~  
19 ~~is 59 years of age and resides in the same geographic area as the~~  
20 ~~federally eligible defined individual.~~  
21     ~~(B) For health care service plan contracts identified in~~  
22 ~~subdivision (d) of Section 1366.35 that do not offer services~~  
23 ~~through a preferred provider arrangement, 170 percent of the~~  
24 ~~standard premium charged to an individual who is of the same age~~  
25 ~~and resides in the same geographic area as the federally eligible~~  
26 ~~defined individual. However, for federally qualified individuals~~  
27 ~~who are between the ages of 60 and 64, inclusive, the premium~~  
28 ~~shall not exceed 170 percent of the standard premium charged to~~  
29 ~~an individual who is 59 years of age and resides in the same~~  
30 ~~geographic area as the federally eligible defined individual. The~~  
31 ~~individual shall have 30 days in which to exercise the right to buy~~  
32 ~~coverage at the quoted premium rates.~~  
33     ~~(2) A plan may adjust the premium based on family size, not~~  
34 ~~to exceed the following amounts:~~  
35     ~~(A) For health care service plans that offer services through a~~  
36 ~~preferred provider arrangement, the average of the Major Risk~~  
37 ~~Medical Insurance Program rate for families of the same size that~~

1 reside in the same geographic area as the federally eligible defined  
2 individual.

3 ~~(B) For health care service plans identified in subdivision (d)~~  
4 ~~of Section 1366.35 that do not offer services through a preferred~~  
5 ~~provider arrangement, 170 percent of the standard premium charged~~  
6 ~~to a family that is of the same size and resides in the same~~  
7 ~~geographic area as the federally eligible defined individual.~~

8 ~~(b) When a federally eligible defined individual submits a~~  
9 ~~premium payment, based on the quoted premium charges, and that~~  
10 ~~payment is delivered or postmarked, whichever occurs earlier,~~  
11 ~~within the first 15 days of the month, coverage shall begin no later~~  
12 ~~than the first day of the following month. When that payment is~~  
13 ~~neither delivered or postmarked until after the 15th day of a month,~~  
14 ~~coverage shall become effective no later than the first day of the~~  
15 ~~second month following delivery or postmark of the payment.~~

16 ~~(e) During the first 30 days after the effective date of the plan~~  
17 ~~contract, the individual shall have the option of changing coverage~~  
18 ~~to a different plan contract offered by the same health care service~~  
19 ~~plan. If the individual notified the plan of the change within the~~  
20 ~~first 15 days of a month, coverage under the new plan contract~~  
21 ~~shall become effective no later than the first day of the following~~  
22 ~~month. If an enrolled individual notified the plan of the change~~  
23 ~~after the 15th day of a month, coverage under the new plan contract~~  
24 ~~shall become effective no later than the first day of the second~~  
25 ~~month following notification.~~

26 *SEC. 2. Section 1399.805 is added to the Health and Safety*  
27 *Code, to read:*

28 *1399.805. (a) After the federally eligible defined individual*  
29 *submits a completed application form for a plan contract, the plan*  
30 *shall, within 30 days, notify the individual of the individual's actual*  
31 *premium charges for that plan contract, unless the plan has*  
32 *provided notice of the premium charge prior to the application*  
33 *being filed. In no case shall the premium charged for any health*  
34 *care service plan contract identified in subdivision (d) of Section*  
35 *1366.35 exceed the premium for the second lowest cost silver plan*  
36 *of the individual market in the rating area in which the individual*  
37 *resides which is offered through the California Health Benefit*  
38 *Exchange established under Title 22 (commencing with Section*  
39 *100500) of the Government Code, as described in Section*  
40 *36B(b)(3)(B) of Title 26 of the United States Code.*

1 (b) When a federally eligible defined individual submits a  
2 premium payment, based on the quoted premium charges, and that  
3 payment is delivered or postmarked, whichever occurs earlier,  
4 within the first 15 days of the month, coverage shall begin no later  
5 than the first day of the following month. When that payment is  
6 neither delivered nor postmarked until after the 15th day of a  
7 month, coverage shall become effective no later than the first day  
8 of the second month following delivery or postmark of the payment.

9 (c) During the first 30 days after the effective date of the plan  
10 contract, the individual shall have the option of changing coverage  
11 to a different plan contract offered by the same health care service  
12 plan. If the individual notified the plan of the change within the  
13 first 15 days of a month, coverage under the new plan contract  
14 shall become effective no later than the first day of the following  
15 month. If an enrolled individual notified the plan of the change  
16 after the 15th day of a month, coverage under the new plan  
17 contract shall become effective no later than the first day of the  
18 second month following notification.

19 SEC. 3. Section 1399.811 of the Health and Safety Code is  
20 repealed.

21 ~~1399.811. Premiums for contracts offered, delivered, amended,~~  
22 ~~or renewed by plans on or after January 1, 2001, shall be subject~~  
23 ~~to the following requirements:~~

24 ~~(a) The premium for new business for a federally eligible defined~~  
25 ~~individual shall not exceed the following amounts:~~

26 ~~(1) For health care service plan contracts identified in~~  
27 ~~subdivision (d) of Section 1366.35 that offer services through a~~  
28 ~~preferred provider arrangement, the average premium paid by a~~  
29 ~~subscriber of the Major Risk Medical Insurance Program who is~~  
30 ~~of the same age and resides in the same geographic area as the~~  
31 ~~federally eligible defined individual. However, for federally~~  
32 ~~qualified individuals who are between the ages of 60 to 64 years,~~  
33 ~~inclusive, the premium shall not exceed the average premium paid~~  
34 ~~by a subscriber of the Major Risk Medical Insurance Program who~~  
35 ~~is 59 years of age and resides in the same geographic area as the~~  
36 ~~federally eligible defined individual.~~

37 ~~(2) For health care service plan contracts identified in~~  
38 ~~subdivision (d) of Section 1366.35 that do not offer services~~  
39 ~~through a preferred provider arrangement, 170 percent of the~~  
40 ~~standard premium charged to an individual who is of the same age~~

1 and resides in the same geographic area as the federally eligible  
2 defined individual. However, for federally qualified individuals  
3 who are between the ages of 60 to 64 years, inclusive, the premium  
4 shall not exceed 170 percent of the standard premium charged to  
5 an individual who is 59 years of age and resides in the same  
6 geographic area as the federally eligible defined individual.

7 (b) The premium for in force business for a federally eligible  
8 defined individual shall not exceed the following amounts:

9 (1) For health care service plan contracts identified in  
10 subdivision (d) of Section 1366.35 that offer services through a  
11 preferred provider arrangement, the average premium paid by a  
12 subscriber of the Major Risk Medical Insurance Program who is  
13 of the same age and resides in the same geographic area as the  
14 federally eligible defined individual. However, for federally  
15 qualified individuals who are between the ages of 60 and 64 years,  
16 inclusive, the premium shall not exceed the average premium paid  
17 by a subscriber of the Major Risk Medical Insurance Program who  
18 is 59 years of age and resides in the same geographic area as the  
19 federally eligible defined individual.

20 (2) For health care service plan contracts identified in  
21 subdivision (d) of Section 1366.35 that do not offer services  
22 through a preferred provider arrangement, 170 percent of the  
23 standard premium charged to an individual who is of the same age  
24 and resides in the same geographic area as the federally eligible  
25 defined individual. However, for federally qualified individuals  
26 who are between the ages of 60 and 64 years, inclusive, the  
27 premium shall not exceed 170 percent of the standard premium  
28 charged to an individual who is 59 years of age and resides in the  
29 same geographic area as the federally eligible defined individual.  
30 The premium effective on January 1, 2001, shall apply to in force  
31 business at the earlier of either the time of renewal or July 1, 2001.

32 (c) The premium applied to a federally eligible defined  
33 individual may not increase by more than the following amounts:

34 (1) For health care service plan contracts identified in  
35 subdivision (d) of Section 1366.35 that offer services through a  
36 preferred provider arrangement, the average increase in the  
37 premiums charged to a subscriber of the Major Risk Medical  
38 Insurance Program who is of the same age and resides in the same  
39 geographic area as the federally eligible defined individual.

1 ~~(2) For health care service plan contracts identified in~~  
2 ~~subdivision (d) of Section 1366.35 that do not offer services~~  
3 ~~through a preferred provider arrangement, the increase in premiums~~  
4 ~~charged to a nonfederally qualified individual who is of the same~~  
5 ~~age and resides in the same geographic area as the federally defined~~  
6 ~~eligible individual. The premium for an eligible individual may~~  
7 ~~not be modified more frequently than every 12 months.~~

8 ~~(3) For a contract that a plan has discontinued offering, the~~  
9 ~~premium applied to the first rating period of the new contract that~~  
10 ~~the federally eligible defined individual elects to purchase shall~~  
11 ~~be no greater than the premium applied in the prior rating period~~  
12 ~~to the discontinued contract.~~

13 *SEC. 4. Section 1399.811 is added to the Health and Safety*  
14 *Code, to read:*

15 *1399.811. Premiums for contracts offered, delivered, amended,*  
16 *or renewed by plans on or after January 1, 2014, shall be subject*  
17 *to the following requirements:*

18 *(a) The premium for in force or new business for a federally*  
19 *eligible defined individual shall not exceed the premium for the*  
20 *second lowest cost silver plan of the individual market in the rating*  
21 *area in which the individual resides which is offered through the*  
22 *California Health Benefit Exchange established under Title 22*  
23 *(commencing with Section 100500) of the Government Code, as*  
24 *described in Section 36B(b)(3)(B) of Title 26 of the United States*  
25 *Code.*

26 *(b) For a contract that a plan has discontinued offering, the*  
27 *premium applied to the first rating period of the new contract that*  
28 *the federally eligible defined individual elects to purchase shall*  
29 *be no greater than the premium applied in the prior rating period*  
30 *to the discontinued contract.*

31 *SEC. 5. Section 10901.3 of the Insurance Code is repealed.*

32 ~~10901.3. (a) (1) After the federally eligible defined individual~~  
33 ~~submits a completed application form for a health benefit plan,~~  
34 ~~the carrier shall, within 30 days, notify the individual of the~~  
35 ~~individual's actual premium charges for that health benefit plan~~  
36 ~~design. In no case shall the premium charged for any health benefit~~  
37 ~~plan identified in subdivision (d) of Section 10785 exceed the~~  
38 ~~following amounts:~~

39 ~~(A) For health benefit plans that offer services through a~~  
40 ~~preferred provider arrangement, the average premium paid by a~~

1 subscriber of the Major Risk Medical Insurance Program who is  
 2 of the same age and resides in the same geographic area as the  
 3 federally eligible defined individual. However, for federally  
 4 qualified individuals who are between the ages of 60 and 64,  
 5 inclusive, the premium shall not exceed the average premium paid  
 6 by a subscriber of the Major Risk Medical Insurance Program who  
 7 is 59 years of age and resides in the same geographic area as the  
 8 federally eligible defined individual.

9 (B) For health benefit plans identified in subdivision (d) of  
 10 Section 10785 that do not offer services through a preferred  
 11 provider arrangement, 170 percent of the standard premium charged  
 12 to an individual who is of the same age and resides in the same  
 13 geographic area as the federally eligible defined individual.  
 14 However, for federally qualified individuals who are between the  
 15 ages of 60 and 64, inclusive, the premium shall not exceed 170  
 16 percent of the standard premium charged to an individual who is  
 17 59 years of age and resides in the same geographic area as the  
 18 federally eligible defined individual. The individual shall have 30  
 19 days in which to exercise the right to buy coverage at the quoted  
 20 premium rates.

21 (2) A carrier may adjust the premium based on family size, not  
 22 to exceed the following amounts:

23 (A) For health benefit plans that offer services through a  
 24 preferred provider arrangement, the average of the Major Risk  
 25 Medical Insurance Program rate for families of the same size that  
 26 reside in the same geographic area as the federally eligible defined  
 27 individual.

28 (B) For health benefit plans identified in subdivision (d) of  
 29 Section 10785 that do not offer services through a preferred  
 30 provider arrangement, 170 percent of the standard premium charged  
 31 to a family that is of the same size and resides in the same  
 32 geographic area as the federally eligible defined individual.

33 (b) When a federally eligible defined individual submits a  
 34 premium payment, based on the quoted premium charges, and that  
 35 payment is delivered or postmarked, whichever occurs earlier,  
 36 within the first 15 days of the month, coverage shall begin no later  
 37 than the first day of the following month. When that payment is  
 38 neither delivered or postmarked until after the 15th day of a month,  
 39 coverage shall become effective no later than the first day of the  
 40 second month following delivery or postmark of the payment.

1 ~~(e) During the first 30 days after the effective date of the health~~  
2 ~~benefit plan, the individual shall have the option of changing~~  
3 ~~coverage to a different health benefit plan design offered by the~~  
4 ~~same carrier. If the individual notified the plan of the change within~~  
5 ~~the first 15 days of a month, coverage under the new health benefit~~  
6 ~~plan shall become effective no later than the first day of the~~  
7 ~~following month. If an enrolled individual notified the carrier of~~  
8 ~~the change after the 15th day of a month, coverage under the health~~  
9 ~~benefit plan shall become effective no later than the first day of~~  
10 ~~the second month following notification.~~

11 *SEC. 6. Section 10901.3 is added to the Insurance Code, to*  
12 *read:*

13 *10901.3. (a) After the federally eligible defined individual*  
14 *submits a completed application form for a health benefit plan,*  
15 *the carrier shall, within 30 days, notify the individual of the*  
16 *individual's actual premium charges for that health benefit plan*  
17 *design. In no case shall the premium charged for any health benefit*  
18 *plan identified in subdivision (d) of Section 10785 exceed the*  
19 *premium for the second lowest cost silver plan of the individual*  
20 *market in the rating area in which the individual resides which is*  
21 *offered through the California Health Benefit Exchange established*  
22 *under Title 22 (commencing with Section 100500) of the*  
23 *Government Code, as described in Section 36B(b)(3)(B) of Title*  
24 *26 of the United States Code.*

25 *(b) When a federally eligible defined individual submits a*  
26 *premium payment, based on the quoted premium charges, and that*  
27 *payment is delivered or postmarked, whichever occurs earlier,*  
28 *within the first 15 days of the month, coverage shall begin no later*  
29 *than the first day of the following month. When that payment is*  
30 *neither delivered or postmarked until after the 15th day of a month,*  
31 *coverage shall become effective no later than the first day of the*  
32 *second month following delivery or postmark of the payment.*

33 *(c) During the first 30 days after the effective date of the health*  
34 *benefit plan, the individual shall have the option of changing*  
35 *coverage to a different health benefit plan design offered by the*  
36 *same carrier. If the individual notified the plan of the change within*  
37 *the first 15 days of a month, coverage under the new health benefit*  
38 *plan shall become effective no later than the first day of the*  
39 *following month. If an enrolled individual notified the carrier of*  
40 *the change after the 15th day of a month, coverage under the health*

1 *benefit plan shall become effective no later than the first day of*  
2 *the second month following notification.*

3 *SEC. 7. Section 10901.9 of the Insurance Code is repealed.*

4 ~~10901.9. Commencing January 1, 2001, premiums for health~~  
5 ~~benefit plans offered, delivered, amended, or renewed by carriers~~  
6 ~~shall be subject to the following requirements:~~

7 ~~(a) The premium for new business for a federally eligible defined~~  
8 ~~individual shall not exceed the following amounts:~~

9 ~~(1) For health benefit plans identified in subdivision (d) of~~  
10 ~~Section 10785 that offer services through a preferred provider~~  
11 ~~arrangement, the average premium paid by a subscriber of the~~  
12 ~~Major Risk Medical Insurance Program who is of the same age~~  
13 ~~and resides in the same geographic area as the federally eligible~~  
14 ~~defined individual. However, for federally qualified individuals~~  
15 ~~who are between the ages of 60 to 64, inclusive, the premium shall~~  
16 ~~not exceed the average premium paid by a subscriber of the Major~~  
17 ~~Risk Medical Insurance Program who is 59 years of age and resides~~  
18 ~~in the same geographic area as the federally eligible defined~~  
19 ~~individual.~~

20 ~~(2) For health benefit plans identified in subdivision (d) of~~  
21 ~~Section 10785 that do not offer services through a preferred~~  
22 ~~provider arrangement, 170 percent of the standard premium charged~~  
23 ~~to an individual who is of the same age and resides in the same~~  
24 ~~geographic area as the federally eligible defined individual.~~  
25 ~~However, for federally qualified individuals who are between the~~  
26 ~~ages of 60 to 64, inclusive, the premium shall not exceed 170~~  
27 ~~percent of the standard premium charged to an individual who is~~  
28 ~~59 years of age and resides in the same geographic area as the~~  
29 ~~federally eligible defined individual.~~

30 ~~(b) The premium for in force business for a federally eligible~~  
31 ~~defined individual shall not exceed the following amounts:~~

32 ~~(1) For health benefit plans identified in subdivision (d) of~~  
33 ~~Section 10785 that offer services through a preferred provider~~  
34 ~~arrangement, the average premium paid by a subscriber of the~~  
35 ~~Major Risk Medical Insurance Program who is of the same age~~  
36 ~~and resides in the same geographic area as the federally eligible~~  
37 ~~defined individual. However, for federally qualified individuals~~  
38 ~~who are between the ages of 60 and 64, inclusive, the premium~~  
39 ~~shall not exceed the average premium paid by a subscriber of the~~  
40 ~~Major Risk Medical Insurance Program who is 59 years of age~~

1 and resides in the same geographic area as the federally eligible  
2 defined individual.

3 (2) For health benefit plans identified in subdivision (d) of  
4 Section 10785 that do not offer services through a preferred  
5 provider arrangement, 170 percent of the standard premium charged  
6 to an individual who is of the same age and resides in the same  
7 geographic area as the federally eligible defined individual.  
8 However, for federally qualified individuals who are between the  
9 ages of 60 and 64, inclusive, the premium shall not exceed 170  
10 percent of the standard premium charged to an individual who is  
11 59 years of age and resides in the same geographic area as the  
12 federally eligible defined individual. The premium effective on  
13 January 1, 2001, shall apply to in force business at the earlier of  
14 either the time of renewal or July 1, 2001.

15 (e) The premium applied to a federally eligible defined  
16 individual may not increase by more than the following amounts:

17 (1) For health benefit plans identified in subdivision (d) of  
18 Section 10785 that offer services through a preferred provider  
19 arrangement, the average increase in the premiums charged to a  
20 subscriber of the Major Risk Medical Insurance Program who is  
21 of the same age and resides in the same geographic area as the  
22 federally eligible defined individual.

23 (2) For health benefit plans identified in subdivision (d) of  
24 Section 10785 that do not offer services through a preferred  
25 provider arrangement, the increase in premiums charged to a  
26 nonfederally qualified individual who is of the same age and resides  
27 in the same geographic area as the federally defined eligible  
28 individual. The premium for an eligible individual may not be  
29 modified more frequently than every 12 months.

30 (2) For a contract that a carrier has discontinued offering, the  
31 premium applied to the first rating period of the new contract that  
32 the federally eligible defined individual elects to purchase shall  
33 be no greater than the premium applied in the prior rating period  
34 to the discontinued contract.

35 *SEC. 8. Section 10901.9 is added to the Insurance Code, to*  
36 *read:*

37 *10901.9. Commencing on January 1, 2014, premiums for health*  
38 *benefit plans offered, delivered, amended, or renewed by carriers*  
39 *shall be subject to the following requirements:*

1 (a) *The premium for in force or new business for a federally*  
 2 *eligible defined individual shall not exceed the premium for the*  
 3 *second lowest cost silver plan of the individual market in the rating*  
 4 *area in which the individual resides which is offered through the*  
 5 *California Health Benefit Exchange established under Title 22*  
 6 *(commencing with Section 100500) of the Government Code, as*  
 7 *described in Section 36B(b)(3)(B) of Title 26 of the United States*  
 8 *Code.*

9 (b) *For a contract that a carrier has discontinued offering, the*  
 10 *premium applied to the first rating period of the new contract that*  
 11 *the federally eligible defined individual elects to purchase shall*  
 12 *be no greater than the premium applied in the prior rating period*  
 13 *to the discontinued contract.*

14 *SEC. 9. No reimbursement is required by this act pursuant to*  
 15 *Section 6 of Article XIII B of the California Constitution because*  
 16 *the only costs that may be incurred by a local agency or school*  
 17 *district will be incurred because this act creates a new crime or*  
 18 *infraction, eliminates a crime or infraction, or changes the penalty*  
 19 *for a crime or infraction, within the meaning of Section 17556 of*  
 20 *the Government Code, or changes the definition of a crime within*  
 21 *the meaning of Section 6 of Article XIII B of the California*  
 22 *Constitution.*

23 ~~SECTION 1. Section 100503 of the Government Code is~~  
 24 ~~amended to read:~~

25 ~~100503. In addition to meeting the minimum requirements of~~  
 26 ~~Section 1311 of the federal act, the board shall do all of the~~  
 27 ~~following:~~

28 ~~(a) Determine the criteria and process for eligibility, enrollment,~~  
 29 ~~and disenrollment of enrollees and potential enrollees in the~~  
 30 ~~Exchange and coordinate that process with the state and local~~  
 31 ~~government entities administering other health care coverage~~  
 32 ~~programs, including the State Department of Health Care Services,~~  
 33 ~~the Managed Risk Medical Insurance Board, and California~~  
 34 ~~counties, in order to ensure consistent eligibility and enrollment~~  
 35 ~~processes and seamless transitions between coverage.~~

36 ~~(b) Develop processes to coordinate with the county entities~~  
 37 ~~that administer eligibility for the Medi-Cal program and the entity~~  
 38 ~~that determines eligibility for the Healthy Families Program,~~  
 39 ~~including, but not limited to, processes for case transfer, referral,~~

1 and enrollment in the Exchange of individuals applying for  
2 assistance to those entities, if allowed or required by federal law.

3 (e) Determine the minimum requirements a carrier must meet  
4 to be considered for participation in the Exchange, and the  
5 standards and criteria for selecting qualified health plans to be  
6 offered through the Exchange that are in the best interests of  
7 qualified individuals and qualified small employers. The board  
8 shall consistently and uniformly apply these requirements,  
9 standards, and criteria to all carriers. In the course of selectively  
10 contracting for health care coverage offered to qualified individuals  
11 and qualified small employers through the Exchange, the board  
12 shall seek to contract with carriers so as to provide health care  
13 coverage choices that offer the optimal combination of choice,  
14 value, quality, and service.

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

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

27 (f) (1) Require, as a condition of participation in the Exchange,  
28 carriers that sell products outside the Exchange to do both of the  
29 following:

30 (A) Fairly and affirmatively offer, market, and sell all products  
31 made available to individuals in the Exchange to individuals  
32 purchasing coverage outside the Exchange.

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

36 (2) For purposes of this subdivision, “product” does not include  
37 contracts entered into pursuant to Part 6.2 (commencing with  
38 Section 12693) of Division 2 of the Insurance Code between the  
39 Managed Risk Medical Insurance Board and carriers for enrolled  
40 Healthy Families beneficiaries or contracts entered into pursuant

1 to Chapter 7 (commencing with Section 14000) of, or Chapter 8  
2 (commencing with Section 14200) of, Part 3 of Division 9 of the  
3 Welfare and Institutions Code between the State Department of  
4 Health Care Services and carriers for enrolled Medi-Cal  
5 beneficiaries.

6 (g) ~~Determine when an enrollee's coverage commences and the~~  
7 ~~extent and scope of coverage.~~

8 (h) ~~Provide for the processing of applications and the enrollment~~  
9 ~~and disenrollment of enrollees.~~

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

12 (j) ~~Establish uniform billing and payment policies for qualified~~  
13 ~~health plans offered in the Exchange to ensure consistent~~  
14 ~~enrollment and disenrollment activities for individuals enrolled in~~  
15 ~~the Exchange.~~

16 (k) ~~Undertake activities necessary to market and publicize the~~  
17 ~~availability of health care coverage and federal subsidies through~~  
18 ~~the Exchange. The board shall also undertake outreach and~~  
19 ~~enrollment activities that seek to assist enrollees and potential~~  
20 ~~enrollees with enrolling and reenrolling in the Exchange in the~~  
21 ~~least burdensome manner, including populations that may~~  
22 ~~experience barriers to enrollment, such as the disabled and those~~  
23 ~~with limited English language proficiency.~~

24 (l) ~~Select and set performance standards and compensation for~~  
25 ~~navigators selected under subdivision (l) of Section 100502.~~

26 (m) ~~Employ necessary staff.~~

27 (1) ~~The board shall hire a chief fiscal officer, a chief operations~~  
28 ~~officer, a director for the SHOP Exchange, a director of Health~~  
29 ~~Plan Contracting, a chief technology and information officer, a~~  
30 ~~general counsel, and other key executive positions, as determined~~  
31 ~~by the board, who shall be exempt from civil service.~~

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

- 1 (i) ~~Other state and federal health insurance exchanges that are~~  
2 ~~most comparable to the Exchange.~~
- 3 (ii) ~~Other relevant labor pools.~~
- 4 (B) ~~The salaries established by the board under subparagraph~~  
5 ~~(A) shall not exceed the highest comparable salary for a position~~  
6 ~~of that type, as determined by the surveys conducted pursuant to~~  
7 ~~subparagraph (A).~~
- 8 (C) ~~The Department of Human Resources shall review the~~  
9 ~~methodology used in the surveys conducted pursuant to~~  
10 ~~subparagraph (A).~~
- 11 (3) ~~The positions described in paragraph (1) and subdivision (i)~~  
12 ~~of Section 100500 shall not be subject to otherwise applicable~~  
13 ~~provisions of the Government Code or the Public Contract Code~~  
14 ~~and, for those purposes, the Exchange shall not be considered a~~  
15 ~~state agency or public entity.~~
- 16 (n) ~~Assess a charge on the qualified health plans offered by~~  
17 ~~carriers that is reasonable and necessary to support the~~  
18 ~~development, operations, and prudent cash management of the~~  
19 ~~Exchange. This charge shall not affect the requirement under~~  
20 ~~Section 1301 of the federal act that carriers charge the same~~  
21 ~~premium rate for each qualified health plan whether offered inside~~  
22 ~~or outside the Exchange.~~
- 23 (o) ~~Authorize expenditures, as necessary, from the California~~  
24 ~~Health Trust Fund to pay program expenses to administer the~~  
25 ~~Exchange.~~
- 26 (p) ~~Keep an accurate accounting of all activities, receipts, and~~  
27 ~~expenditures, and annually submit to the United States Secretary~~  
28 ~~of Health and Human Services a report concerning that accounting.~~  
29 ~~Commencing January 1, 2016, the board shall conduct an annual~~  
30 ~~audit.~~
- 31 (q) (1) ~~Annually prepare a written report on the implementation~~  
32 ~~and performance of the Exchange functions during the preceding~~  
33 ~~fiscal year, including, at a minimum, the manner in which funds~~  
34 ~~were expended and the progress toward, and the achievement of,~~  
35 ~~the requirements of this title. This report shall be transmitted to~~  
36 ~~the Legislature and the Governor and shall be made available to~~  
37 ~~the public on the Internet Web site of the Exchange. A report made~~  
38 ~~to the Legislature pursuant to this subdivision shall be submitted~~  
39 ~~pursuant to Section 9795.~~

1     ~~(2) In addition to the report described in paragraph (1), the board~~  
2 ~~shall be responsive to requests for additional information from the~~  
3 ~~Legislature, including providing testimony and commenting on~~  
4 ~~proposed state legislation or policy issues. The Legislature finds~~  
5 ~~and declares that activities including, but not limited to, responding~~  
6 ~~to legislative or executive inquiries, tracking and commenting on~~  
7 ~~legislation and regulatory activities, and preparing reports on the~~  
8 ~~implementation of this title and the performance of the Exchange,~~  
9 ~~are necessary state requirements and are distinct from the~~  
10 ~~promotion of legislative or regulatory modifications referred to in~~  
11 ~~subdivision (d) of Section 100520.~~

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

16     ~~(s) Exercise all powers reasonably necessary to carry out and~~  
17 ~~comply with the duties, responsibilities, and requirements of this~~  
18 ~~act and the federal act.~~

19     ~~(t) Consult with stakeholders relevant to carrying out the~~  
20 ~~activities under this title, including, but not limited to, all of the~~  
21 ~~following:~~

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

23         ~~(2) Individuals and entities with experience in facilitating~~  
24 ~~enrollment in health plans.~~

25         ~~(3) Representatives of small businesses and self-employed~~  
26 ~~individuals.~~

27         ~~(4) The State Medi-Cal Director.~~

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

29     ~~(u) Facilitate the purchase of qualified health plans in the~~  
30 ~~Exchange by qualified individuals and qualified small employers~~  
31 ~~no later than January 1, 2014.~~

32     ~~(v) Report, or contract with an independent entity to report, to~~  
33 ~~the Legislature by December 1, 2018, on whether to adopt the~~  
34 ~~option in paragraph (3) of subdivision (e) of Section 1312 of the~~  
35 ~~federal act to merge the individual and small employer markets.~~  
36 ~~In its report, the board shall provide information, based on at least~~  
37 ~~two years of data from the Exchange, on the potential impact on~~  
38 ~~rates paid by individuals and by small employers in a merged~~  
39 ~~individual and small employer market, as compared to the rates~~  
40 ~~paid by individuals and small employers if a separate individual~~

1 and small employer market is maintained. A report made pursuant  
2 to this subdivision shall be submitted pursuant to Section 9795.

3 ~~(w) With respect to the SHOP Program, collect premiums and~~  
4 ~~administer all other necessary and related tasks, including, but not~~  
5 ~~limited to, enrollment and plan payment, in order to make the~~  
6 ~~offering of employee plan choice as simple as possible for qualified~~  
7 ~~small employers.~~

8 ~~(x) Require carriers participating in the Exchange to immediately~~  
9 ~~notify the Exchange, under the terms and conditions established~~  
10 ~~by the board, when an individual is or will be enrolled in or~~  
11 ~~disenrolled from a qualified health plan offered by the carrier.~~

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

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