

AMENDED IN ASSEMBLY MARCH 28, 2014

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

**ASSEMBLY BILL**

**No. 2301**

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**Introduced by Assembly Member Mansoor**

February 21, 2014

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An act to amend Section ~~1367~~ of the ~~Health and Safety~~ *100503* of the Government Code, relating to health care ~~service plans~~ coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 2301, as amended, Mansoor. ~~Health care service plans. California Health Benefit Exchange: reports.~~

*Existing law establishes the California Health Benefit 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. Existing law requires the board of the Exchange to annually prepare a written report on the implementation and performance of the Exchange functions during the preceding fiscal year, as specified, and requires that this report be submitted to the Legislature and the Governor and be made available to the public on the Internet Web site of the Exchange. Existing law requires the board to require carriers participating in the Exchange to immediately notify the Exchange when an individual is or will be disenrolled from a qualified health plan offered by the carrier.*

*This bill would also require the board to prepare a written report on a quarterly basis that identifies the number of covered lives under qualified health plans purchased through the individual market of the Exchange by specified categories. The bill would also require this report to identify the number of individuals who have been disenrolled from*

*those plans due to nonpayment of the premiums, as specified. The bill would require this report to be submitted to the Legislature and the Governor and to be made available to the public on the Internet Web site of the Exchange.*

~~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. Existing law requires health care service plans to meet certain requirements, including, but not limited to, having the organizational and administrative capacity to provide services to subscribers and enrollees and providing basic health care services, as defined, to those subscribers and enrollees, and having facilities licensed, as specified.~~

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

Vote: majority. Appropriation: no. 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, as  
 2     amended by Section 4 of Chapter 5 of the 1st Extraordinary Session  
 3     of the Statutes of 2013, is amended to read:

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

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

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

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

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

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

25 (f) (1) Except as otherwise provided in this section and Section  
26 100504.5, require, as a condition of participation in the Exchange,  
27 carriers that sell any products outside the Exchange to do both of  
28 the following:

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

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

35 (2) For purposes of this subdivision, “product” does not include  
36 contracts entered into pursuant to Part 6.2 (commencing with  
37 Section 12693) of Division 2 of the Insurance Code between the  
38 Managed Risk Medical Insurance Board and carriers for enrolled  
39 Healthy Families beneficiaries or contracts entered into pursuant  
40 to Chapter 7 (commencing with Section 14000) of, or Chapter 8

1 (commencing with Section 14200) of, Part 3 of Division 9 of the  
2 Welfare and Institutions Code between the State Department of  
3 Health Care Services and carriers for enrolled Medi-Cal  
4 beneficiaries. “Product” also does not include a bridge plan product  
5 offered pursuant to Section 100504.5.

6 (3) Except as required by Section 1301(a)(1)(C)(ii) of the federal  
7 act, a carrier offering a bridge plan product in the Exchange may  
8 limit the products it offers in the Exchange solely to a bridge plan  
9 product contract.

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

12 (h) Provide for the processing of applications and the enrollment  
13 and disenrollment of enrollees.

14 (i) Determine and approve cost-sharing provisions for qualified  
15 health plans.

16 (j) Establish uniform billing and payment policies for qualified  
17 health plans offered in the Exchange to ensure consistent  
18 enrollment and disenrollment activities for individuals enrolled in  
19 the Exchange.

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

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

30 (m) Employ necessary staff.

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

36 (2) (A) The board shall set the salaries for the exempt positions  
37 described in paragraph (1) and subdivision (i) of Section 100500  
38 in amounts that are reasonably necessary to attract and retain  
39 individuals of superior qualifications. The salaries shall be  
40 published by the board in the board’s annual budget. The board’s

1 annual budget shall be posted on the Internet Web site of the  
2 Exchange. To determine the compensation for these positions, the  
3 board shall cause to be conducted, through the use of independent  
4 outside advisors, salary surveys of both of the following:

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

7 (ii) Other relevant labor pools.

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

12 (C) The Department of Human Resources shall review the  
13 methodology used in the surveys conducted pursuant to  
14 subparagraph (A).

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

20 (n) Assess a charge on the qualified health plans offered by  
21 carriers that is reasonable and necessary to support the  
22 development, operations, and prudent cash management of the  
23 Exchange. This charge shall not affect the requirement under  
24 Section 1301 of the federal act that carriers charge the same  
25 premium rate for each qualified health plan whether offered inside  
26 or outside the Exchange.

27 (o) Authorize expenditures, as necessary, from the California  
28 Health Trust Fund to pay program expenses to administer the  
29 Exchange.

30 (p) Keep an accurate accounting of all activities, receipts, and  
31 expenditures, and annually submit to the United States Secretary  
32 of Health and Human Services a report concerning that accounting.  
33 Commencing January 1, 2016, the board shall conduct an annual  
34 audit.

35 (q) (1) ~~Annually~~ *Notwithstanding Section 10231.5, annually*  
36 prepare a written report on the implementation and performance  
37 of the Exchange functions during the preceding fiscal year,  
38 including, at a minimum, the manner in which funds were expended  
39 and the progress toward, and the achievement of, the requirements  
40 of this title. The report shall also include data provided by health

1 care service plans and health insurers offering bridge plan products  
2 regarding the extent of health care provider and health facility  
3 overlap in their Medi-Cal networks as compared to the health care  
4 provider and health facility networks contracting with the plan or  
5 insurer in their bridge plan contracts. ~~This report shall be~~  
6 ~~transmitted to the Legislature and the Governor and shall be made~~  
7 ~~available to the public on the Internet Web site of the Exchange.~~  
8 A report made to the Legislature pursuant to this subdivision shall  
9 be submitted pursuant to Section 9795.

10 (2) The Exchange shall prepare, or contract for the preparation  
11 of, an evaluation of the bridge plan program using the first three  
12 years of experience with the program. The evaluation shall be  
13 provided to the health policy and fiscal committees of the  
14 Legislature in the fourth year following federal approval of the  
15 bridge plan option. The evaluation shall include, but not be limited  
16 to, all of the following:

17 (A) The number of individuals eligible to participate in the  
18 bridge plan program each year by category of eligibility.

19 (B) The number of eligible individuals who elect a bridge plan  
20 option each year by category of eligibility.

21 (C) The average length of time, by region and statewide, that  
22 individuals remain in the bridge plan option each year by category  
23 of eligibility.

24 (D) The regions of the state with a bridge plan option, and the  
25 carriers in each region that offer a bridge plan, by year.

26 (E) The premium difference each year, by region, between the  
27 bridge plan and the first and second lowest cost plan for individuals  
28 in the Exchange who are not eligible for the bridge plan.

29 (F) The effect of the bridge plan on the premium subsidy amount  
30 for bridge plan eligible individuals each year by each region.

31 (G) Based on a survey of individuals enrolled in the bridge plan:

32 (i) Whether individuals enrolling in the bridge plan product are  
33 able to keep their existing health care providers.

34 (ii) Whether individuals would want to retain their bridge plan  
35 product, buy a different Exchange product, or decline to purchase  
36 health insurance if there was no bridge plan product available. The  
37 Exchange may include questions designed to elicit the information  
38 in this subparagraph as part of an existing survey of individuals  
39 receiving coverage in the Exchange.

1 (3) In addition to the evaluation required by paragraph (2), the  
2 Exchange shall post the items in subparagraphs (A) to (F),  
3 inclusive, on its Internet Web site each year.

4 (4) (A) *In addition to the report described in paragraph (1),*  
5 *and notwithstanding Section 10231.5, the board shall quarterly*  
6 *prepare a written report that identifies the number of covered lives*  
7 *under qualified health plans purchased through the individual*  
8 *market of the Exchange by the following categories:*

9 (i) *Total number overall.*

10 (ii) *Age.*

11 (iii) *Ethnicity.*

12 (iv) *Gender.*

13 (v) *Income level.*

14 (vi) *The geographic regions listed in Section 1357.512 of the*  
15 *Health and Safety Code and Section 10965.9 of the Insurance*  
16 *Code.*

17 (B) *The report required by this paragraph shall also identify*  
18 *the number of individuals, by the categories listed in subparagraph*  
19 *(A), who, since the end of the last quarter, or since January 1,*  
20 *2014, in the case of the first report, have been disenrolled from a*  
21 *qualified health plan purchased through the individual market of*  
22 *the Exchange due to nonpayment of the premiums.*

23 (C) *The report required by this paragraph shall be completed*  
24 *within 30 days of the end of a quarter.*

25 (5) *The reports required by this subdivision shall be transmitted*  
26 *to the Legislature and the Governor and shall be made available*  
27 *to the public on the Internet Web site of the Exchange. The reports*  
28 *made to the Legislature pursuant to this subdivision shall be*  
29 *submitted pursuant to Section 9795.*

30 ~~(4)~~

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

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

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

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

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

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

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

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

18 (4) The State Medi-Cal Director.

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

20 (u) Facilitate the purchase of qualified health plans in the  
21 Exchange by qualified individuals and qualified small employers  
22 no later than January 1, 2014.

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

34 (w) With respect to the SHOP Program, collect premiums and  
35 administer all other necessary and related tasks, including, but not  
36 limited to, enrollment and plan payment, in order to make the  
37 offering of employee plan choice as simple as possible for qualified  
38 small employers.

39 (x) Require carriers participating in the Exchange to immediately  
40 notify the Exchange, under the terms and conditions established

1 by the board when an individual is or will be enrolled in or  
2 disenrolled from any qualified health plan offered by the carrier.

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

10 (z) This section shall become inoperative on the October 1 that  
11 is five years after the date that federal approval of the bridge plan  
12 option occurs, and, as of the second January 1 thereafter, is  
13 repealed, unless a later enacted statute that is enacted before that  
14 date deletes or extends the dates on which it becomes inoperative  
15 and is repealed.

16 *SEC. 2. Section 100503 of the Government Code, as added by*  
17 *Section 5 of Chapter 5 of the 1st Extraordinary Session of the*  
18 *Statutes of 2013, is amended to read:*

19 100503. In addition to meeting the minimum requirements of  
20 Section 1311 of the federal act, the board shall do all of the  
21 following:

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

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

36 (c) Determine the minimum requirements a carrier must meet  
37 to be considered for participation in the Exchange, and the  
38 standards and criteria for selecting qualified health plans to be  
39 offered through the Exchange that are in the best interests of  
40 qualified individuals and qualified small employers. The board

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

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

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

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

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

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

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

39 (g) Determine when an enrollee’s coverage commences and the  
40 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~~ *Notwithstanding Section 10231.5, annually*  
25 *prepare a written report on the implementation and performance*  
26 *of the Exchange functions during the preceding fiscal year,*  
27 *including, at a minimum, the manner in which funds were expended*  
28 *and the progress toward, and the achievement of, the requirements*  
29 *of this title. This report shall be transmitted to the Legislature and*  
30 *the Governor and shall be made available to the public on the*  
31 *Internet Web site of the Exchange. A report made to the Legislature*  
32 *pursuant to this subdivision shall be submitted pursuant to Section*  
33 *9795.*

34 (2) (A) *In addition to the report described in paragraph (1),*  
35 *and notwithstanding Section 10231.5, the board shall quarterly*  
36 *prepare a written report that identifies the number of covered lives*  
37 *under qualified health plans purchased through the individual*  
38 *market of the Exchange by the following categories:*

39 (i) *Total number overall.*

40 (ii) *Age.*

- 1 (iii) *Ethnicity.*
- 2 (iv) *Gender.*
- 3 (v) *Income level.*
- 4 (vi) *The geographic regions listed in Section 1357.512 of the*
- 5 *Health and Safety Code and Section 10965.9 of the Insurance*
- 6 *Code.*

7 (B) *The report required by this paragraph shall also identify*  
8 *the number of individuals, by the categories listed in subparagraph*  
9 *(A), who, since the end of the last quarter, or since January 1,*  
10 *2014, in the case of the first report, have been disenrolled from a*  
11 *qualified health plan purchased through the individual market of*  
12 *the Exchange was canceled due to nonpayment of the premiums.*

13 (C) *The report required by this paragraph shall be completed*  
14 *within 30 days of the end of each quarter.*

15 (3) *The reports required by this subdivision shall be transmitted*  
16 *to the Legislature and the Governor and shall be made available*  
17 *to the public on the Internet Web site of the Exchange. The reports*  
18 *made to the Legislature pursuant to this subdivision shall be*  
19 *submitted pursuant to Section 9795.*

20 (2)

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

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

36 (s) *Exercise all powers reasonably necessary to carry out and*  
37 *comply with the duties, responsibilities, and requirements of this*  
38 *act 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 December 1, 2018, on whether to adopt the  
16 option in Section 1312(c)(3) of the federal act to merge the  
17 individual and small employer markets. In its report, the board  
18 shall provide information, based on at least two years of data from  
19 the Exchange, on the potential impact on rates paid by individuals  
20 and by small employers in a merged individual and small employer  
21 market, as compared to the rates paid by individuals and small  
22 employers if a separate individual and small employer market is  
23 maintained. A report made pursuant to this subdivision shall be  
24 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.

1 (z) This section shall become operative only if Section 4 of the  
2 act that added this section becomes inoperative pursuant to  
3 subdivision (z) of that Section 4.

4 SECTION 1. Section 1367 of the Health and Safety Code is  
5 amended to read:

6 1367. A health care service plan and, if applicable, a specialized  
7 health care service plan shall meet all of the following  
8 requirements:

9 (a) Facilities located in this state including, but not limited to,  
10 clinics, hospitals, and skilled nursing facilities to be utilized by  
11 the plan shall be licensed by the State Department of Public Health,  
12 where licensure is required by law. Facilities not located in this  
13 state shall conform to all licensing and other requirements of the  
14 jurisdiction in which they are located.

15 (b) Personnel employed by or under contract to the plan shall  
16 be licensed or certified by their respective board or agency, where  
17 licensure or certification is required by law.

18 (c) Equipment required to be licensed or registered by law shall  
19 be so licensed or registered, and the operating personnel for that  
20 equipment shall be licensed or certified as required by law.

21 (d) The plan shall furnish services in a manner providing  
22 continuity of care and ready referral of patients to other providers  
23 at times as may be appropriate consistent with good professional  
24 practice.

25 (e) (1) All services shall be readily available at reasonable times  
26 to each enrollee consistent with good professional practice. To the  
27 extent feasible, the plan shall make all services readily accessible  
28 to all enrollees consistent with Section 1367.03.

29 (2) To the extent that telehealth services are appropriately  
30 provided through telehealth, as defined in subdivision (a) of Section  
31 2290.5 of the Business and Professions Code, these services shall  
32 be considered in determining compliance with Section 1300.67.2  
33 of Title 28 of the California Code of Regulations.

34 (3) The plan shall make all services accessible and appropriate  
35 consistent with Section 1367.04.

36 (f) The plan shall employ and utilize allied health manpower  
37 for the furnishing of services to the extent permitted by law and  
38 consistent with good medical practice.

39 (g) The plan shall have the organizational and administrative  
40 capacity to provide services to subscribers and enrollees. The plan

1 shall be able to demonstrate to the department that medical  
2 decisions are rendered by qualified medical providers, unhindered  
3 by fiscal and administrative management.

4 (h) (1) ~~Contracts with subscribers and enrollees, including~~  
5 ~~group contracts, and contracts with providers, and other persons~~  
6 ~~furnishing services, equipment, or facilities to or in connection~~  
7 ~~with the plan, shall be fair, reasonable, and consistent with the~~  
8 ~~objectives of this chapter. All contracts with providers shall contain~~  
9 ~~provisions requiring a fast, fair, and cost-effective dispute~~  
10 ~~resolution mechanism under which providers may submit disputes~~  
11 ~~to the plan, and requiring the plan to inform its providers upon~~  
12 ~~contracting with the plan, or upon change to these provisions, of~~  
13 ~~the procedures for processing and resolving disputes, including~~  
14 ~~the location and telephone number where information regarding~~  
15 ~~disputes may be submitted.~~

16 (2) ~~A health care service plan shall ensure that a dispute~~  
17 ~~resolution mechanism is accessible to noncontracting providers~~  
18 ~~for the purpose of resolving billing and claims disputes.~~

19 (3) ~~On and after January 1, 2002, a health care service plan shall~~  
20 ~~annually submit a report to the department regarding its dispute~~  
21 ~~resolution mechanism. The report shall include information on the~~  
22 ~~number of providers who utilized the dispute resolution mechanism~~  
23 ~~and a summary of the disposition of those disputes.~~

24 (i) ~~A health care service plan contract shall provide to~~  
25 ~~subscribers and enrollees all of the basic health care services~~  
26 ~~included in subdivision (b) of Section 1345, except that the director~~  
27 ~~may, for good cause, by rule or order exempt a plan contract or~~  
28 ~~any class of plan contracts from that requirement. The director~~  
29 ~~shall by rule define the scope of each basic health care service that~~  
30 ~~health care service plans are required to provide as a minimum for~~  
31 ~~licensure under this chapter. This chapter does not prohibit a health~~  
32 ~~care service plan from charging subscribers or enrollees a~~  
33 ~~copayment or a deductible for a basic health care service consistent~~  
34 ~~with Section 1367.006 or 1367.007, provided that the copayments,~~  
35 ~~deductibles, or other cost sharing are reported to the director and~~  
36 ~~set forth to the subscriber or enrollee pursuant to the disclosure~~  
37 ~~provisions of Section 1363. This chapter does not prohibit a health~~  
38 ~~care service plan from setting forth, by contract, limitations on~~  
39 ~~maximum coverage of basic health care services, provided that~~  
40 ~~the limitations are reported to, and held unobjectionable by, the~~

1 director and set forth to the subscriber or enrollee pursuant to the  
2 disclosure provisions of Section 1363.

3 (j) ~~A health care service plan shall not require registration under  
4 the federal Controlled Substances Act (21 U.S.C. Sec. 801 et seq.)  
5 as a condition for participation by an optometrist certified to use  
6 therapeutic pharmaceutical agents pursuant to Section 3041.3 of  
7 the Business and Professions Code.~~

8 ~~This section shall not be construed to permit the director to  
9 establish the rates charged subscribers and enrollees for contractual  
10 health care services.~~

11 ~~The director's enforcement of Article 3.1 (commencing with  
12 Section 1357) does not establish the rates charged to subscribers  
13 and enrollees for contractual health care services.~~

14 ~~The obligation of the plan to comply with this chapter shall not  
15 be waived when the plan delegates any services that it is required  
16 to perform to its medical groups, independent practice associations,  
17 or other contracting entities.~~