

AMENDED IN SENATE APRIL 16, 2013

SENATE BILL

No. 28

Introduced by Senators Hernandez and Steinberg

December 3, 2012

An act to amend Section ~~12698.30~~ of the Insurance Code, and to amend Sections 14005.31, 14005.32, 14132, and 15926 of, to amend and repeal Sections 14008.85, 14011.16, and 14011.17 of, to amend, repeal, and add Sections 14005.18, 14005.28, 14005.30, 14005.37, and 14012 of, to add Sections 14005.60, 14005.62, 14005.63, 14005.64, 14132.02, and 15926.2 to, the Welfare and Institutions 100503 of the Government Code, to amend Section 12739.53 of, and to add Section 12712.5 to, the Insurance Code, and to amend Section 14011.6 of the Welfare and Institutions Code, relating to health.

LEGISLATIVE COUNSEL'S DIGEST

SB 28, as amended, Hernandez. ~~Medi-Cal eligibility. California Health Benefit Exchange.~~

(1) Existing law establishes the California Major Risk Medical Insurance Program (MRMIP), which is administered by the Managed Risk Medical Insurance Board (MRMIB), to provide major risk medical coverage to persons who, among other things, have been rejected for coverage by at least one private health plan. Existing law requires MRMIB to enter into an agreement with the federal Department of Health and Human Services to administer a temporary high risk pool to provide health coverage, until January 1, 2014, to specified individuals who have preexisting conditions, consistent with the federal Patient Protection and Affordable Care Act (PPACA).

Under 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 also requires the board to undertake activities necessary to market and publicize the availability of health care coverage and federal subsidizes through the Exchange and to undertake outreach and enrollment activities.

This bill would require MRMIB to provide the Exchange, or its designee, with specified information of subscribers and applicants of MRMIP and the temporary high risk pool in order to assist the Exchange in conducting outreach to those subscribers and applicants.

The bill would require the board governing the Exchange to provide a specified notice informing those subscribers and applicants that they may be eligible for reduced-cost coverage through the Exchange or no-cost coverage through Medi-Cal.

Existing

(2) *Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid Program provisions.*

Existing law requires, to the extent that federal financial participation is available, that the department implement an option provided for under the federal Social Security Act for a program for accelerated enrollment of children into the Medi-Cal program. Existing law requires the department to designate the single point of entry, as defined, as the qualified entity for determining eligibility under these provisions.

~~This bill would, commencing January 1, 2014, implement various provisions of the federal Patient Protection and Affordable Care Act (Affordable Care Act), as amended, by, among other things, modifying provisions relating to determining eligibility for certain groups. The bill would, in this regard, extend Medi-Cal eligibility to specified adults and would require that income eligibility be determined based on modified adjusted gross income (MAGI), as prescribed. The bill would prohibit the use of an asset or resources test for individuals whose financial eligibility for Medi-Cal is determined based on the application of MAGI. The bill would also add, commencing January 1, 2014,~~

~~benefits, services, and coverage included in the essential health benefits package, as adopted by the state and approved by the United States Secretary of Health and Human Services, to the schedule of Medi-Cal benefits. October 1, 2013, require the department to designate the Exchange and its agents, and specified county departments as qualified entities for determining eligibility under the above-mentioned provisions. The bill would also require the qualified entity to grant accelerated enrollment if a complete eligibility determination cannot be made based upon the receipt of an application for a child at the time of the initial application.~~

~~Because the bill would require counties are required to make additional Medi-Cal eligibility determinations and this bill would expand Medi-Cal eligibility, determinations, 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, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to these statutory provisions.

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

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.

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

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

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

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

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

34 (A) Fairly and affirmatively offer, market, and sell all products
35 made available to individuals in the Exchange to individuals
36 purchasing coverage outside the Exchange.

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

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

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

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

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

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

21 (k) (1) Undertake activities necessary to market and publicize
22 the availability of health care coverage and federal subsidies
23 through the Exchange. The board shall also undertake outreach
24 and enrollment activities that seek to assist enrollees and potential
25 enrollees with enrolling and reenrolling in the Exchange in the
26 least burdensome manner, including populations that may
27 experience barriers to enrollment, such as the disabled and those
28 with limited English language proficiency.

29 (2) *Use the information received pursuant to Section 12712.5*
30 *of, and paragraph (10) of subdivision (b) of Section 12739.53 of,*
31 *the Insurance Code to provide an individual a notice that he or*
32 *she may be eligible for reduced-cost coverage through the*
33 *Exchange or no-cost coverage through Medi-Cal. The notice shall*
34 *include information on obtaining coverage pursuant to those*
35 *programs.*

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

38 (m) Employ necessary staff.

39 (1) The board shall hire a chief fiscal officer, a chief operations
40 officer, a director for the SHOP Exchange, a director of Health

1 Plan Contracting, a chief technology and information officer, a
2 general counsel, and other key executive positions, as determined
3 by the board, who shall be exempt from civil service.

4 (2) (A) The board shall set the salaries for the exempt positions
5 described in paragraph (1) and subdivision (i) of Section 100500
6 in amounts that are reasonably necessary to attract and retain
7 individuals of superior qualifications. The salaries shall be
8 published by the board in the board's annual budget. The board's
9 annual budget shall be posted on the Internet Web site of the
10 Exchange. To determine the compensation for these positions, the
11 board shall cause to be conducted, through the use of independent
12 outside advisors, salary surveys of both of the following:

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

15 (ii) Other relevant labor pools.

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

20 (C) The Department of Human Resources shall review the
21 methodology used in the surveys conducted pursuant to
22 subparagraph (A).

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

28 (n) Assess a charge on the qualified health plans offered by
29 carriers that is reasonable and necessary to support the
30 development, operations, and prudent cash management of the
31 Exchange. This charge shall not affect the requirement under
32 Section 1301 of the federal act that carriers charge the same
33 premium rate for each qualified health plan whether offered inside
34 or outside the Exchange.

35 (o) Authorize expenditures, as necessary, from the California
36 Health Trust Fund to pay program expenses to administer the
37 Exchange.

38 (p) Keep an accurate accounting of all activities, receipts, and
39 expenditures, and annually submit to the United States Secretary
40 of Health and Human Services a report concerning that accounting.

1 Commencing January 1, 2016, the board shall conduct an annual
2 audit.

3 (q) (1) Annually prepare a written report on the implementation
4 and performance of the Exchange functions during the preceding
5 fiscal year, including, at a minimum, the manner in which funds
6 were expended and the progress toward, and the achievement of,
7 the requirements of this title. This report shall be transmitted to
8 the Legislature and the Governor and shall be made available to
9 the public on the Internet Web site of the Exchange. A report made
10 to the Legislature pursuant to this subdivision shall be submitted
11 pursuant to Section 9795.

12 (2) In addition to the report described in paragraph (1), the board
13 shall be responsive to requests for additional information from the
14 Legislature, including providing testimony and commenting on
15 proposed state legislation or policy issues. The Legislature finds
16 and declares that activities including, but not limited to, responding
17 to legislative or executive inquiries, tracking and commenting on
18 legislation and regulatory activities, and preparing reports on the
19 implementation of this title and the performance of the Exchange,
20 are necessary state requirements and are distinct from the
21 promotion of legislative or regulatory modifications referred to in
22 subdivision (d) of Section 100520.

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

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

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

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

34 (2) Individuals and entities with experience in facilitating
35 enrollment in health plans.

36 (3) Representatives of small businesses and self-employed
37 individuals.

38 (4) The State Medi-Cal Director.

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

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

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

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

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

24 (y) Ensure that the Exchange provides oral interpretation
25 services in any language for individuals seeking coverage through
26 the Exchange and makes available a toll-free telephone number
27 for the hearing and speech impaired. The board shall ensure that
28 written information made available by the Exchange is presented
29 in a plainly worded, easily understandable format and made
30 available in prevalent languages.

31 *SEC. 2. Section 12712.5 is added to the Insurance Code, to*
32 *read:*

33 *12712.5. In order to assist the California Health Benefit*
34 *Exchange, established under Title 22 (commencing with Section*
35 *100500) of the Government Code, in conducting outreach to*
36 *program subscribers and applicants, the board shall provide the*
37 *Exchange, or its designee, with the names, addresses, email*
38 *addresses, telephone numbers, other contact information, and*
39 *written and spoken languages of program subscribers and*
40 *applicants.*

1 *SEC. 3. Section 12739.53 of the Insurance Code is amended*
2 *to read:*

3 12739.53. (a) The board shall, consistent with Section 1101
4 of the federal Patient Protection and Affordable Care Act (P.L.
5 111-148) and state and federal law and contingent on the agreement
6 of the federal Department of Health and Human Services and
7 receipt of sufficient federal funding, enter into an agreement with
8 the federal Department of Health and Human Services to administer
9 the federal temporary high risk pool in California.

10 (b) If the federal Department of Health and Human Services
11 and the state enter into an agreement to administer the federal
12 temporary high risk pool, the board shall do all of the following:

13 (1) Administer the program pursuant to that agreement.

14 (2) Begin providing coverage in the program on the date
15 established pursuant to the agreement with the federal Department
16 of Health and Human Services.

17 (3) Establish the scope and content of high risk medical
18 coverage.

19 (4) Determine reasonable minimum standards for participating
20 health plans, third-party administrators, and other contractors.

21 (5) Determine the time, manner, method, and procedures for
22 withdrawing program approval from a plan, third-party
23 administrator, or other contractor, or limiting enrollment of
24 subscribers in a plan.

25 (6) Research and assess the needs of persons without adequate
26 health coverage and promote means of ensuring the availability
27 of adequate health care services.

28 (7) Administer the program to ensure the following:

29 (A) That the program subsidy amount does not exceed amounts
30 transferred to the fund pursuant to this part.

31 (B) That the aggregate amount spent for high risk medical
32 coverage and program administration does not exceed the federal
33 funds available to the state for this purpose and that no state funds
34 are spent for the purposes of this part.

35 (8) Maintain enrollment and expenditures to ensure that
36 expenditures do not exceed amounts available in the fund and that
37 no state funds are spent for purposes of this part. If sufficient funds
38 are not available to cover the estimated cost of program
39 expenditures, the board shall institute appropriate measures to limit
40 enrollment.

1 (9) In adopting benefit and eligibility standards, be guided by
2 the needs and welfare of persons unable to secure adequate health
3 coverage for themselves and their dependents and by prevailing
4 practices among private health plans.

5 (10) (A) As required by the federal Department of Health and
6 Human Services, implement procedures to provide for the transition
7 of subscribers into qualified health plans offered through ~~an~~
8 ~~exchange or exchanges to be the California Health Benefit~~
9 ~~Exchange established pursuant to the federal Patient Protection~~
10 ~~and Affordable Care Act (P.L. 111-148) Title 22 (commencing~~
11 ~~with Section 100500) of the Government Code.~~

12 (B) In order to assist the Exchange in conducting outreach to
13 program subscribers and applicants, provide the Exchange, or its
14 designee, with the names, addresses, email addresses, telephone
15 numbers, other contact information, and written and spoken
16 languages of program subscribers and applicants.

17 (11) Post on the board's Internet Web site the monthly progress
18 reports submitted to the federal Department of Health and Human
19 Services. In addition, the board shall provide notice of any
20 anticipated waiting lists or disenrollments due to insufficient
21 funding to the public, by making that notice available as part of
22 its board meetings, and concurrently to the Legislature.

23 (12) Develop and implement a plan for marketing and outreach.

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

31 *SEC. 4. Section 14011.6 of the Welfare and Institutions Code*
32 *is amended to read:*

33 14011.6. (a) To the extent federal financial participation is
34 available, the department shall exercise the option provided in
35 Section 1920a of the federal Social Security Act (42 U.S.C. Sec.
36 1396r-1a) to implement a program for accelerated enrollment of
37 children.

38 (b) The department shall designate the single point of entry, as
39 defined in subdivision (c), as the qualified entity for determining
40 eligibility under this section.

1 (c) For purposes of this section, “single point of entry” means
2 the centralized processing entity that accepts and screens
3 applications for benefits under the Medi-Cal ~~Program~~ *program*
4 for the purpose of forwarding them to the appropriate counties.

5 (d) *Commencing October 1, 2013, the department shall*
6 *designate the California Health Benefit Exchange, established*
7 *under Title 22 (commencing with Section 100500) of the*
8 *Government Code, and its agents and county human services*
9 *departments as qualified entities for determining eligibility for*
10 *accelerated enrollment under this section.*

11 ~~(d)~~

12 (e) The department shall implement this section only if, and to
13 the extent that, federal financial participation is available.

14 ~~(e)~~

15 (f) The department shall seek federal approval of any state plan
16 amendments necessary to implement this section. When federal
17 approval of the state plan amendment or amendments is received,
18 the department shall commence implementation of this section on
19 the first day of the second month following the month in which
20 federal approval of the state plan amendment or amendments is
21 received, or on July 1, 2002, whichever is later.

22 ~~(f)~~

23 (g) Notwithstanding Chapter 3.5 (commencing with Section
24 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
25 the department shall, without taking any regulatory action,
26 implement this section by means of all-county letters. Thereafter,
27 the department shall adopt regulations in accordance with the
28 requirements of Chapter 3.5 (commencing with Section 11340) of
29 Part 1 of Division 3 of Title 2 of the Government Code.

30 ~~(g)~~

31 (h) Upon the receipt of an application for a child who has
32 coverage pursuant to the accelerated enrollment program, a county
33 shall determine whether the child is eligible for Medi-Cal benefits.
34 If the county determines that the child does not meet the eligibility
35 requirements for participation in the Medi-Cal program, the county
36 shall report this finding to the Medical Eligibility Data System so
37 that accelerated enrollment coverage benefits are discontinued.
38 The information to be reported shall consist of the minimum data
39 elements necessary to discontinue that coverage for the child. This
40 subdivision shall become operative on July 1, 2002, or the date

1 that the program for accelerated enrollment coverage for children
2 takes effect, whichever is later.

3 (i) *If a complete eligibility determination cannot be made based*
4 *upon the receipt of an application for a child at the time of the*
5 *initial application, the qualified entity shall grant accelerated*
6 *enrollment pursuant to this section.*

7 *SEC. 5. If the Commission on State Mandates determines that*
8 *this act contains costs mandated by the state, reimbursement to*
9 *local agencies and school districts for those costs shall be made*
10 *pursuant to Part 7 (commencing with Section 17500) of Division*
11 *4 of Title 2 of the Government Code.*

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**All matter omitted in this version of the bill
appears in the bill as introduced in the
Senate, December 3, 2012. (JR11)**