

AMENDED IN ASSEMBLY JUNE 19, 2013

AMENDED IN ASSEMBLY JUNE 15, 2013

AMENDED IN ASSEMBLY MAY 28, 2013

AMENDED IN SENATE MARCH 6, 2013

CALIFORNIA LEGISLATURE—2013–14 FIRST EXTRAORDINARY SESSION

---

---

**SENATE BILL**

**No. 3**

**Introduced by Senator Hernandez**

February 5, 2013

---

---

An act to amend, repeal, and add Sections 100501 and 100503 of, and to add and repeal Sections 100504.5 and 100504.6 of, the Government Code, to amend, repeal, and add Section 1366.6 of, and to add and repeal Section 1399.864 of, the Health and Safety Code, to amend, repeal, and add Section 10112.3 of, and to add and repeal Section 10961 of, the Insurance Code, and to add and repeal Section 14005.70 of the Welfare and Institutions Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 3, as amended, Hernandez. Health care coverage: bridge plan.

Existing law, the federal Patient Protection and Affordable Care Act, 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.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income persons receive health care benefits. 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 also provides for the regulation of health insurers by the Department of Insurance.

Under existing law, carriers that sell any products outside the California Health Benefit Exchange (Exchange) are required to fairly and affirmatively offer, market, and sell all products made available to individuals or small employers in the Exchange to individuals or small employers, respectively, purchasing coverage outside the Exchange.

Existing law also requires carriers that participate in the Exchange to fairly and affirmatively offer, market, and sell in the Exchange at least one product within 5 levels of specified coverage.

This bill would exempt a bridge plan product, as defined, from that latter requirement.

This bill would, among other things, also require the Exchange to enter into contracts with and certify as a qualified health plan bridge plan products that meet specified requirements, including being a Medi-Cal managed care plan. The bill would also require the Exchange to make available bridge plan products to eligible individuals. The bill would authorize the Exchange, after consulting with stakeholders, to adopt regulations to implement those provisions, and until January 1, 2016, exempt the adoption, amendment, or repeal of those regulations from the Administrative Procedure Act.

The bill would require the Exchange to annually prepare a specified written report on the implementation and performance of the Exchange functions during the preceding fiscal year, and to prepare, or contract for the preparation of, an evaluation of the bridge plan program using the first 3 years of experience with the program, as specified.

The bill would authorize a health care service plan or insurance carrier offering a bridge plan product in the Exchange to limit the products it offers in the Exchange to the bridge plan product, except as required by federal law. The bill would define “bridge plan product” as an individual health benefit plan offered by a licensed health care service plan or health insurer that contracts with the Exchange, as specified.

The bill would also require the State Department of Health Care Services to impose specified requirements in its contracts with a health care service plan or health insurer to provide Medi-Cal managed care coverage but would authorize the department to contract with the Exchange to delegate the implementation of those provisions.

The bill would require the Exchange to seek federal approval to allow specified individuals the option to enroll in a different bridge plan product if the individual’s primary care provider is included in the

contracted network of the different bridge plan product and either the bridge plan product for which the individual is eligible is not offered in that individual’s service area or is not ~~selected~~ offered as a bridge plan product by the Exchange.

The bill would provide that its provisions would become inoperative on the October 1 that is 5 years after the date that federal approval of the bridge plan option occurs.

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

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

1 SECTION 1. (a) It is the intent of the Legislature that the  
2 Exchange provide a more affordable coverage option for  
3 low-income individuals, improve continuity of care for individuals  
4 moving from Medi-Cal to the Exchange, and reduce the need for  
5 individuals previously enrolled in the Medi-Cal program to change  
6 health plans due to changes in their household income.

7 (b) In addition to other plan choices, it is the intent of the  
8 Legislature that the Exchange offer quality, affordable health plan  
9 choices that, to the extent possible, will be the lowest cost silver  
10 plan offered in the individual’s geographic region through  
11 Medi-Cal managed care plans that bridge Medicaid coverage and  
12 private commercial health insurance for eligible lower income  
13 individuals.

14 (c) It is the intent of the Legislature that the Exchange encourage  
15 Medi-Cal managed care plans to seek to contract to offer bridge  
16 plan products.

17 SEC. 2. Section 100501 of the Government Code is amended  
18 to read:

19 100501. For purposes of this title, the following definitions  
20 shall apply:

21 (a) “Board” means the board described in subdivision (a) of  
22 Section 100500.

23 (b) “Bridge plan product” means an individual health benefit  
24 plan as defined in subdivision (f) of Section 1399.845 of the Health  
25 and Safety Code that is offered by a health care service plan  
26 licensed under the Knox-Keene Health Care Service Plan Act of  
27 1975 (Chapter 2.2 (commencing with Section 1340) of Division  
28 2 of the Health and Safety Code) or as defined in subdivision (a)

1 of Section 10198.6 of the Insurance Code that is offered by a health  
2 insurer licensed under the Insurance Code that contracts with the  
3 Exchange pursuant to this title.

4 (c) “Carrier” means either a private health insurer holding a  
5 valid outstanding certificate of authority from the Insurance  
6 Commissioner or a health care service plan, as defined under  
7 subdivision (f) of Section 1345 of the Health and Safety Code,  
8 licensed by the Department of Managed Health Care.

9 (d) “Exchange” means the California Health Benefit Exchange  
10 established by Section 100500.

11 (e) “Federal act” means the federal Patient Protection and  
12 Affordable Care Act (Public Law 111-148), as amended by the  
13 federal Health Care and Education Reconciliation Act of 2010  
14 (Public Law 111-152), and any amendments to, or regulations or  
15 guidance issued under, those acts.

16 (f) “Fund” means the California Health Trust Fund established  
17 by Section 100520.

18 (g) “Health plan” and “qualified health plan” have the same  
19 meanings as those terms are defined in Section 1301 of the federal  
20 act.

21 (h) “Healthy Families coverage” means coverage under the  
22 Healthy Families Program pursuant to Part 6.2 (commencing with  
23 Section 12693) of Division 2 of the Insurance Code.

24 (i) “Medi-Cal coverage” means coverage under the Medi-Cal  
25 program pursuant to Chapter 7 (commencing with Section 14000)  
26 of Part 3 of Division 9 of the Welfare and Institutions Code.

27 (j) “Modified adjusted gross income” shall have the same  
28 meaning as the term is used in Section 1401(d)(2)(B) (26 U.S.C.  
29 Sec. 36B) of the federal act.

30 (k) “Members of the modified adjusted gross income household”  
31 shall mean any individual who would be included in the calculation  
32 for modified adjusted gross income pursuant to Section 1401(a)  
33 (26 U.S.C. Sec. 36B(d)) of the federal act and as otherwise  
34 determined by the Exchange as permitted by the federal act and  
35 this title.

36 (l) “SHOP Program” means the Small Business Health Options  
37 Program established by subdivision (m) of Section 100502.

38 (m) “Supplemental coverage” means coverage through a  
39 specialized health care service plan contract, as defined in  
40 subdivision (o) of Section 1345 of the Health and Safety Code, or

1 a specialized health insurance policy, as defined in Section 106 of  
2 the Insurance Code.

3 (n) This section shall become inoperative on the October 1 that  
4 is five years after the date that federal approval of the bridge plan  
5 option occurs, and, as of the second January 1 thereafter, is  
6 repealed, unless a later enacted statute that is enacted before that  
7 date deletes or extends the dates on which it becomes inoperative  
8 and is repealed.

9 SEC. 3. Section 100501 is added to the Government Code, to  
10 read:

11 100501. For purposes of this title, the following definitions  
12 shall apply:

13 (a) “Board” means the board described in subdivision (a) of  
14 Section 100500.

15 (b) “Carrier” means either a private health insurer holding a  
16 valid outstanding certificate of authority from the Insurance  
17 Commissioner or a health care service plan, as defined under  
18 subdivision (f) of Section 1345 of the Health and Safety Code,  
19 licensed by the Department of Managed Health Care.

20 (c) “Exchange” means the California Health Benefit Exchange  
21 established by Section 100500.

22 (d) “Federal act” means the federal Patient Protection and  
23 Affordable Care Act (Public Law 111-148), as amended by the  
24 federal Health Care and Education Reconciliation Act of 2010  
25 (Public Law 111-152), and any amendments to, or regulations or  
26 guidance issued under, those acts.

27 (e) “Fund” means the California Health Trust Fund established  
28 by Section 100520.

29 (f) “Health plan” and “qualified health plan” have the same  
30 meanings as those terms are defined in Section 1301 of the federal  
31 act.

32 (g) “SHOP Program” means the Small Business Health Options  
33 Program established by subdivision (m) of Section 100502.

34 (h) “Supplemental coverage” means coverage through a  
35 specialized health care service plan contract, as defined in  
36 subdivision (o) of Section 1345 of the Health and Safety Code, or  
37 a specialized health insurance policy, as defined in Section 106 of  
38 the Insurance Code.

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

4 SEC. 4. Section 100503 of the Government Code is amended  
5 to read:

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

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

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

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

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

38 (e) Require, as a condition of participation in the Exchange,  
39 carriers to fairly and affirmatively offer, market, and sell in the  
40 Exchange at least one product within each of the five levels of

1 coverage contained in subsections (d) and (e) of Section 1302 of  
2 the federal act. The board may require carriers to offer additional  
3 products within each of those five levels of coverage. This  
4 subdivision shall not apply to a carrier that solely offers  
5 supplemental coverage in the Exchange under paragraph (10) of  
6 subdivision (a) of Section 100504.

7 (f) (1) Except as otherwise provided in this section and Section  
8 100504.5, require, as a condition of participation in the Exchange,  
9 carriers that sell any products outside the Exchange to do both of  
10 the following:

11 (A) Fairly and affirmatively offer, market, and sell all products  
12 made available to individuals in the Exchange to individuals  
13 purchasing coverage outside the Exchange.

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

17 (2) For purposes of this subdivision, “product” does not include  
18 contracts entered into pursuant to Part 6.2 (commencing with  
19 Section 12693) of Division 2 of the Insurance Code between the  
20 Managed Risk Medical Insurance Board and carriers for enrolled  
21 Healthy Families beneficiaries or contracts entered into pursuant  
22 to Chapter 7 (commencing with Section 14000) of, or Chapter 8  
23 (commencing with Section 14200) of, Part 3 of Division 9 of the  
24 Welfare and Institutions Code between the State Department of  
25 Health Care Services and carriers for enrolled Medi-Cal  
26 beneficiaries. “Product” also does not include a bridge plan product  
27 offered pursuant to Section 100504.5.

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

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

34 (h) Provide for the processing of applications and the enrollment  
35 and disenrollment of enrollees.

36 (i) Determine and approve cost-sharing provisions for qualified  
37 health plans.

38 (j) Establish uniform billing and payment policies for qualified  
39 health plans offered in the Exchange to ensure consistent

1 enrollment and disenrollment activities for individuals enrolled in  
2 the Exchange.

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

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

13 (m) Employ necessary staff.

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

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

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

30 (ii) Other relevant labor pools.

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

35 (C) The Department of Human Resources shall review the  
36 methodology used in the surveys conducted pursuant to  
37 subparagraph (A).

38 (3) The positions described in paragraph (1) and subdivision (i)  
39 of Section 100500 shall not be subject to otherwise applicable  
40 provisions of the Government Code or the Public Contract Code

1 and, for those purposes, the Exchange shall not be considered a  
2 state agency or public entity.

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

10 (o) Authorize expenditures, as necessary, from the California  
11 Health Trust Fund to pay program expenses to administer the  
12 Exchange.

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

18 (q) (1) Annually prepare a written report on the implementation  
19 and performance of the Exchange functions during the preceding  
20 fiscal year, including, at a minimum, the manner in which funds  
21 were expended and the progress toward, and the achievement of,  
22 the requirements of this title. The report shall also include data  
23 provided by health care service plans and health insurers offering  
24 bridge plan products regarding the extent of health care provider  
25 and health facility overlap in their Medi-Cal networks as compared  
26 to the health care provider and health facility networks contracting  
27 with the plan or insurer in their bridge plan contracts. This report  
28 shall be transmitted to the Legislature and the Governor and shall  
29 be made available to the public on the Internet Web site of the  
30 Exchange. A report made to the Legislature pursuant to this  
31 subdivision shall be submitted pursuant to Section 9795.

32 (2) The Exchange shall prepare, or contract for the preparation  
33 of, an evaluation of the bridge plan program using the first three  
34 years of experience with the program. The evaluation shall be  
35 provided to the health policy and fiscal committees of the  
36 Legislature in the fourth year following federal approval of the  
37 bridge plan option. The evaluation shall include, but not be limited  
38 to, all of the following:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8 (2) Individuals and entities with experience in facilitating  
9 enrollment in health plans.

10 (3) Representatives of small businesses and self-employed  
11 individuals.

12 (4) The State Medi-Cal Director.

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

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

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

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

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

37 (y) Ensure that the Exchange provides oral interpretation  
38 services in any language for individuals seeking coverage through  
39 the Exchange and makes available a toll-free telephone number  
40 for the hearing and speech impaired. The board shall ensure that

1 written information made available by the Exchange is presented  
2 in a plainly worded, easily understandable format and made  
3 available in prevalent languages.

4 (z) This section shall become inoperative on the October 1 that  
5 is five years after the date that federal approval of the bridge plan  
6 option occurs, and, as of the second January 1 thereafter, is  
7 repealed, unless a later enacted statute that is enacted before that  
8 date deletes or extends the dates on which it becomes inoperative  
9 and is repealed.

10 SEC. 5. Section 100503 is added to the Government Code, to  
11 read:

12 100503. In addition to meeting the minimum requirements of  
13 Section 1311 of the federal act, the board shall do all of the  
14 following:

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

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

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

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

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

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

16 (A) Fairly and affirmatively offer, market, and sell all products  
17 made available to individuals in the Exchange to individuals  
18 purchasing coverage outside the Exchange.

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

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

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

34 (h) Provide for the processing of applications and the enrollment  
35 and disenrollment of enrollees.

36 (i) Determine and approve cost-sharing provisions for qualified  
37 health plans.

38 (j) Establish uniform billing and payment policies for qualified  
39 health plans offered in the Exchange to ensure consistent

1 enrollment and disenrollment activities for individuals enrolled in  
2 the Exchange.

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

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

13 (m) Employ necessary staff.

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

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

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

30 (ii) Other relevant labor pools.

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

35 (C) The Department of Human Resources shall review the  
36 methodology used in the surveys conducted pursuant to  
37 subparagraph (A).

38 (3) The positions described in paragraph (1) and subdivision (i)  
39 of Section 100500 shall not be subject to otherwise applicable  
40 provisions of the Government Code or the Public Contract Code

1 and, for those purposes, the Exchange shall not be considered a  
2 state agency or public entity.

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

10 (o) Authorize expenditures, as necessary, from the California  
11 Health Trust Fund to pay program expenses to administer the  
12 Exchange.

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

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

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

38 (r) Maintain enrollment and expenditures to ensure that  
39 expenditures do not exceed the amount of revenue in the fund, and

1 if sufficient revenue is not available to pay estimated expenditures,  
2 institute appropriate measures to ensure fiscal solvency.

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

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

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

10 (2) Individuals and entities with experience in facilitating  
11 enrollment in health plans.

12 (3) Representatives of small businesses and self-employed  
13 individuals.

14 (4) The State Medi-Cal Director.

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

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

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

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

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

39 (y) Ensure that the Exchange provides oral interpretation  
40 services in any language for individuals seeking coverage through

1 the Exchange and makes available a toll-free telephone number  
2 for the hearing and speech impaired. The board shall ensure that  
3 written information made available by the Exchange is presented  
4 in a plainly worded, easily understandable format and made  
5 available in prevalent languages.

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

9 SEC. 6. Section 100504.5 is added to the Government Code,  
10 to read:

11 100504.5. (a) To the extent approved by the appropriate federal  
12 agency, for the purpose of implementing the option in paragraph  
13 (7) of subdivision (a) of Section 100504, the Exchange shall make  
14 available bridge plan products to individuals specified in Section  
15 14005.70 of the Welfare and Institutions Code. In implementing  
16 this requirement, the Exchange, using the selective contracting  
17 authority described in subdivision (c) of Section 100503, shall  
18 contract with, and certify as a qualified health plan, a bridge plan  
19 product that is, at a minimum, certified by the Exchange as a  
20 qualified bridge plan product. For purposes of this section, in order  
21 to be a qualified bridge plan product, the plan shall do all of the  
22 following:

23 (1) Be a health care service plan or health insurer that contracts  
24 with the State Department of Health Care Services to provide  
25 Medi-Cal managed care plan services pursuant to Section 14005.70  
26 of the Welfare and Institutions Code.

27 (2) Meet minimum requirements to contract with the Exchange  
28 as a qualified health plan pursuant to Section 1301 of the federal  
29 Patient Protection and Affordable Care Act (Public Law 111-148)  
30 and Sections 100502, 100503, and 100507 of this code.

31 (3) Enroll in the bridge plan product only individuals who meet  
32 the requirements of Section 14005.70 of the Welfare and  
33 Institutions Code.

34 (4) Comply with the medical loss ratio requirements of Section  
35 1399.864 of the Health and Safety Code or Section 10961 of the  
36 Insurance Code.

37 (5) Demonstrate the bridge plan product has, at minimum, a  
38 substantially similar provider network as the Medi-Cal managed  
39 care plan offered by the health care service plan or health insurer.

1 (b) The Exchange shall provide information on all of the  
2 available Exchange-qualified health plans in the area, including,  
3 but not limited to, bridge plan product options for selection by  
4 individuals eligible to enroll in a bridge plan product.

5 (c) Nothing in this section shall be implemented in a manner  
6 that conflicts with a requirement of the federal act.

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

13 SEC. 7. Section 100504.6 is added to the Government Code,  
14 to read:

15 100504.6. (a) The Exchange shall have the authority to adopt  
16 regulations to implement the provisions of Section 100504.5. Prior  
17 to the adoption of regulations, the board and its staff shall meet  
18 the requirement of subdivision (t) of Section 100503 in  
19 implementing the bridge plan option. Until January 1, 2016, the  
20 adoption, amendment, or repeal of a regulation authorized by this  
21 section shall be exempted from the Administrative Procedure Act  
22 (Chapter 3.5 (commencing with Section 11340) of Part 1 of  
23 Division 3 of Title 2).

24 (b) This section shall become inoperative on the October 1 that  
25 is five years after the date that federal approval of the bridge plan  
26 option occurs, and, as of the second January 1 thereafter, is  
27 repealed, unless a later enacted statute that is enacted before that  
28 date deletes or extends the dates on which it becomes inoperative  
29 and is repealed.

30 SEC. 8. Section 1366.6 of the Health and Safety Code is  
31 amended to read:

32 1366.6. (a) For purposes of this section, the following  
33 definitions shall apply:

34 (1) "Exchange" means the California Health Benefit Exchange  
35 established in Title 22 (commencing with Section 100500) of the  
36 Government Code.

37 (2) "Federal act" means the federal Patient Protection and  
38 Affordable Care Act (Public Law 111-148), as amended by the  
39 federal Health Care and Education Reconciliation Act of 2010

1 (Public Law 111-152), and any amendments to, or regulations or  
2 guidance issued under, those acts.

3 (3) “Qualified health plan” has the same meaning as that term  
4 is defined in Section 1301 of the federal act.

5 (4) “Small employer” has the same meaning as that term is  
6 defined in Section 1357.

7 (b) (1) Health care service plans participating in the Exchange  
8 shall fairly and affirmatively offer, market, and sell in the Exchange  
9 at least one product within each of the five levels of coverage  
10 contained in subsections (d) and (e) of Section 1302 of the federal  
11 act.

12 (2) The board established under Section 100500 of the  
13 Government Code may require plans to sell additional products  
14 within each of those levels of coverage.

15 (3) This subdivision shall not apply to a plan that solely offers  
16 supplemental coverage in the Exchange under paragraph (10) of  
17 subdivision (a) of Section 100504 of the Government Code.

18 (4) This subdivision shall not apply to a bridge plan product  
19 that meets the requirements of Section 100504.5 of the Government  
20 Code to the extent approved by the appropriate federal agency.

21 (c) (1) Health care service plans participating in the Exchange  
22 that sell any products outside the Exchange shall do both of the  
23 following:

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

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

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

1 bridge plan products that meet the requirements of Section  
2 100504.5 of the Government Code.

3 (d) Commencing January 1, 2014, a health care service plan  
4 shall, with respect to plan contracts that cover hospital, medical,  
5 or surgical benefits, only sell the five levels of coverage contained  
6 in subsections (d) and (e) of Section 1302 of the federal act, except  
7 that a health care service plan that does not participate in the  
8 Exchange shall, with respect to plan contracts that cover hospital,  
9 medical, or surgical benefits, only sell the four levels of coverage  
10 contained in Section 1302(d) of the federal act.

11 (e) Commencing January 1, 2014, a health care service plan  
12 that does not participate in the Exchange shall, with respect to plan  
13 contracts that cover hospital, medical, or surgical benefits, offer  
14 at least one standardized product that has been designated by the  
15 Exchange in each of the four levels of coverage contained in  
16 Section 1302(d) of the federal act. This subdivision shall only  
17 apply if the board of the Exchange exercises its authority under  
18 subdivision (c) of Section 100504 of the Government Code.  
19 Nothing in this subdivision shall require a plan that does not  
20 participate in the Exchange to offer standardized products in the  
21 small employer market if the plan only sells products in the  
22 individual market. Nothing in this subdivision shall require a plan  
23 that does not participate in the Exchange to offer standardized  
24 products in the individual market if the plan only sells products in  
25 the small employer market. This subdivision shall not be construed  
26 to prohibit the plan from offering other products provided that it  
27 complies with subdivision (d).

28 (f) For purposes of this section, a bridge plan product shall mean  
29 an individual health benefit plan, as defined in subdivision (f) of  
30 Section 1399.845, that is offered by a health care service plan  
31 licensed under this chapter that contracts with the Exchange  
32 pursuant to Title 22 (commencing with Section 100500) of the  
33 Government Code.

34 (g) This section shall become inoperative on the October 1 that  
35 is five years after the date that federal approval of the bridge plan  
36 option occurs, and, as of the second January 1 thereafter, is  
37 repealed, unless a later enacted statute that is enacted before that  
38 date deletes or extends the dates on which it becomes inoperative  
39 and is repealed.

1 SEC. 9. Section 1366.6 is added to the Health and Safety Code,  
2 to read:

3 1366.6. (a) For purposes of this section, the following  
4 definitions shall apply:

5 (1) “Exchange” means the California Health Benefit Exchange  
6 established in Title 22 (commencing with Section 100500) of the  
7 Government Code.

8 (2) “Federal act” means the federal Patient Protection and  
9 Affordable Care Act (Public Law 111-148), as amended by the  
10 federal Health Care and Education Reconciliation Act of 2010  
11 (Public Law 111-152), and any amendments to, or regulations or  
12 guidance issued under, those acts.

13 (3) “Qualified health plan” has the same meaning as that term  
14 is defined in Section 1301 of the federal act.

15 (4) “Small employer” has the same meaning as that term is  
16 defined in Section 1357.

17 (b) Health care service plans participating in the Exchange shall  
18 fairly and affirmatively offer, market, and sell in the Exchange at  
19 least one product within each of the five levels of coverage  
20 contained in subsections (d) and (e) of Section 1302 of the federal  
21 act. The board established under Section 100500 of the Government  
22 Code may require plans to sell additional products within each of  
23 those levels of coverage. This subdivision shall not apply to a plan  
24 that solely offers supplemental coverage in the Exchange under  
25 paragraph (10) of subdivision (a) of Section 100504 of the  
26 Government Code.

27 (c) (1) Health care service plans participating in the Exchange  
28 that sell any products outside the Exchange shall 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 health care service  
40 plans for enrolled Healthy Families beneficiaries or to contracts

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

6 (d) Commencing January 1, 2014, a health care service plan  
7 shall, with respect to plan contracts that cover hospital, medical,  
8 or surgical benefits, only sell the five levels of coverage contained  
9 in subsections (d) and (e) of Section 1302 of the federal act, except  
10 that a health care service plan that does not participate in the  
11 Exchange shall, with respect to plan contracts that cover hospital,  
12 medical, or surgical benefits, only sell the four levels of coverage  
13 contained in Section 1302(d) of the federal act.

14 (e) Commencing January 1, 2014, a health care service plan  
15 that does not participate in the Exchange shall, with respect to plan  
16 contracts that cover hospital, medical, or surgical benefits, offer  
17 at least one standardized product that has been designated by the  
18 Exchange in each of the four levels of coverage contained in  
19 Section 1302(d) of the federal act. This subdivision shall only  
20 apply if the board of the Exchange exercises its authority under  
21 subdivision (c) of Section 100504 of the Government Code.  
22 Nothing in this subdivision shall require a plan that does not  
23 participate in the Exchange to offer standardized products in the  
24 small employer market if the plan only sells products in the  
25 individual market. Nothing in this subdivision shall require a plan  
26 that does not participate in the Exchange to offer standardized  
27 products in the individual market if the plan only sells products in  
28 the small employer market. This subdivision shall not be construed  
29 to prohibit the plan from offering other products provided that it  
30 complies with subdivision (d).

31 (f) This section shall become operative only if Section 8 of the  
32 act that added this section becomes inoperative pursuant to  
33 subdivision (g) of that Section 8.

34 SEC. 10. Section 1399.864 is added to the Health and Safety  
35 Code, to read:

36 1399.864. (a) For purposes of this article, a bridge plan product  
37 shall mean an individual health benefit plan, as defined in  
38 subdivision (f) of Section 1399.845, that is offered by a health care  
39 service plan licensed under this chapter that contracts with the

1 Exchange pursuant to Title 22 (commencing with Section 100500)  
2 of the Government Code.

3 (b) Until December 31, 2014, a health care service plan that  
4 contracts with the California Health Benefit Exchange to offer a  
5 qualified bridge plan product pursuant to Section 100504 of the  
6 Government Code shall do all of the following:

7 (1) As of the effective date of this section, if the health care  
8 service plan has not been approved by the director to offer  
9 individual health benefit plans pursuant to this chapter, the plan  
10 shall file a material modification pursuant to Section 1352 to  
11 expand its license to include individual health benefit plans.

12 (2) As of the effective date of this section, if the health care  
13 service plan has been approved by the director to offer individual  
14 health benefit plans pursuant to this chapter, the plan shall, pursuant  
15 to Section 1352, file an amendment to expand its license to include  
16 a bridge plan product as an individual health benefit plan.

17 (c) During the time the health care service plan's material  
18 modification or amendment is pending approval by the director,  
19 the health care service plan shall be deemed to comply with  
20 subdivision (b) of Section 100507 of the Government Code.

21 (d) A health care service plan shall maintain a medical loss ratio  
22 of 85 percent for the bridge plan product. A health care service  
23 plan shall utilize, to the extent possible, the same methodology for  
24 calculating the medical loss ratio for the bridge plan product that  
25 is used for calculating the health care service plan medical loss  
26 ratio pursuant to Section 1367.003 and shall report its medical loss  
27 ratio for the bridge plan product to the department as provided in  
28 Section 1367.003.

29 (e) Notwithstanding subdivision (a) of Section 1399.849, a  
30 health care service plan selling a bridge plan product shall not be  
31 required to fairly and affirmatively offer, market, and sell the health  
32 care service plan's bridge plan product except to individuals  
33 eligible for the bridge plan product pursuant to the State  
34 Department of Health Care Services and the Medi-Cal managed  
35 care plan's contract entered into pursuant to Section 14005.70 of  
36 the Welfare and Institutions Code, provided the health care service  
37 plan meets the requirements of subdivision (b) of Section 14005.70  
38 of the Welfare and Institutions Code.

39 (f) Notwithstanding subdivision (c) of Section 1399.849, a health  
40 care service plan selling a bridge plan product shall provide an

1 initial open enrollment period of six months, and an annual  
2 enrollment period and a special enrollment period consistent with  
3 the annual enrollment and special enrollment periods of the  
4 Exchange.

5 (g) This section shall become inoperative on the October 1 that  
6 is five years after the date that federal approval of the bridge plan  
7 option occurs, and, as of the second January 1 thereafter, is  
8 repealed, unless a later enacted statute that is enacted before that  
9 date deletes or extends the dates on which it becomes inoperative  
10 and is repealed.

11 SEC. 11. Section 10112.3 of the Insurance Code is amended  
12 to read:

13 10112.3. (a) For purposes of this section, the following  
14 definitions shall apply:

15 (1) “Exchange” means the California Health Benefit Exchange  
16 established in Title 22 (commencing with Section 100500) of the  
17 Government Code.

18 (2) “Federal act” means the federal Patient Protection and  
19 Affordable Care Act (Public Law 111-148), as amended by the  
20 federal Health Care and Education Reconciliation Act of 2010  
21 (Public Law 111-152), and any amendments to, or regulations or  
22 guidance issued under, those acts.

23 (3) “Qualified health plan” has the same meaning as that term  
24 is defined in Section 1301 of the federal act.

25 (4) “Small employer” has the same meaning as that term is  
26 defined in Section 10700.

27 (b) Health insurers participating in the Exchange shall fairly  
28 and affirmatively offer, market, and sell in the Exchange at least  
29 one product within each of the five levels of coverage contained  
30 in subsections (d) and (e) of Section 1302 of the federal act. The  
31 board established under Section 100500 of the Government Code  
32 may require insurers to sell additional products within each of  
33 those levels of coverage. This subdivision shall not apply to an  
34 insurer that solely offers supplemental coverage in the Exchange  
35 under paragraph (10) of subdivision (a) of Section 100504 of the  
36 Government Code. This subdivision shall not apply to a bridge  
37 plan product of a Medi-Cal managed care plan that contracts with  
38 the State Department of Health Care Services pursuant to Section  
39 14005.70 of the Welfare and Institutions Code and that meets the

1 requirements of Section 100504.5 of the Government Code, to the  
2 extent approved by the appropriate federal agency.

3 (c) (1) Health insurers participating in the Exchange that sell  
4 any products outside the Exchange shall do both of the following:

5 (A) Fairly and affirmatively offer, market, and sell all products  
6 made available to individuals in the Exchange to individuals  
7 purchasing coverage outside the Exchange.

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

11 (2) For purposes of this subdivision, “product” does not include  
12 contracts entered into pursuant to Part 6.2 (commencing with  
13 Section 12693) of Division 2 between the Managed Risk Medical  
14 Insurance Board and health insurers for enrolled Healthy Families  
15 beneficiaries or to contracts entered into pursuant to Chapter 7  
16 (commencing with Section 14000) of, or Chapter 8 (commencing  
17 with Section 14200) of, Part 3 of Division 9 of the Welfare and  
18 Institutions Code between the State Department of Health Care  
19 Services and health insurers for enrolled Medi-Cal beneficiaries  
20 or for contracts with bridge plan products that meet the  
21 requirements of Section 100504.5 of the Government Code.

22 (d) Commencing January 1, 2014, a health insurer, with respect  
23 to policies that cover hospital, medical, or surgical benefits, may  
24 only sell the five levels of coverage contained in subsections (d)  
25 and (e) of Section 1302 of the federal act, except that a health  
26 insurer that does not participate in the Exchange may, with respect  
27 to policies that cover hospital, medical, or surgical benefits, only  
28 sell the four levels of coverage contained in Section 1302(d) of  
29 the federal act.

30 (e) Commencing January 1, 2014, a health insurer that does not  
31 participate in the Exchange shall, with respect to policies that cover  
32 hospital, medical, or surgical expenses, offer at least one  
33 standardized product that has been designated by the Exchange in  
34 each of the four levels of coverage contained in Section 1302(d)  
35 of the federal act. This subdivision shall only apply if the board  
36 of the Exchange exercises its authority under subdivision (c) of  
37 Section 100504 of the Government Code. Nothing in this  
38 subdivision shall require an insurer that does not participate in the  
39 Exchange to offer standardized products in the small employer  
40 market if the insurer only sells products in the individual market.

1 Nothing in this subdivision shall require an insurer that does not  
2 participate in the Exchange to offer standardized products in the  
3 individual market if the insurer only sells products in the small  
4 employer market. This subdivision shall not be construed to  
5 prohibit the insurer from offering other products provided that it  
6 complies with subdivision (d).

7 (f) For purposes of this section, a bridge plan product shall mean  
8 an individual health benefit plan, as defined in subdivision (a) of  
9 Section 10198.6 that is offered by a health insurer that contracts  
10 with the Exchange pursuant to Section 100504.5 of the Government  
11 Code.

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

18 SEC. 12. Section 10112.3 is added to the Insurance Code, to  
19 read:

20 10112.3. (a) For purposes of this section, the following  
21 definitions shall apply:

22 (1) “Exchange” means the California Health Benefit Exchange  
23 established in Title 22 (commencing with Section 100500) of the  
24 Government Code.

25 (2) “Federal act” means the federal Patient Protection and  
26 Affordable Care Act (Public Law 111-148), as amended by the  
27 federal Health Care and Education Reconciliation Act of 2010  
28 (Public Law 111-152), and any amendments to, or regulations or  
29 guidance issued under, those acts.

30 (3) “Qualified health plan” has the same meaning as that term  
31 is defined in Section 1301 of the federal act.

32 (4) “Small employer” has the same meaning as that term is  
33 defined in Section 10700.

34 (b) Health insurers participating in the Exchange shall fairly  
35 and affirmatively offer, market, and sell in the Exchange at least  
36 one product within each of the five levels of coverage contained  
37 in subsections (d) and (e) of Section 1302 of the federal act. The  
38 board established under Section 100500 of the Government Code  
39 may require insurers to sell additional products within each of  
40 those levels of coverage. This subdivision shall not apply to an

1 insurer that solely offers supplemental coverage in the Exchange  
2 under paragraph (10) of subdivision (a) of Section 100504 of the  
3 Government Code.

4 (c) (1) Health insurers participating in the Exchange that sell  
5 any products outside the Exchange shall do both of the following:

6 (A) Fairly and affirmatively offer, market, and sell all products  
7 made available to individuals in the Exchange to individuals  
8 purchasing coverage outside the Exchange.

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

12 (2) For purposes of this subdivision, “product” does not include  
13 contracts entered into pursuant to Part 6.2 (commencing with  
14 Section 12693) of Division 2 between the Managed Risk Medical  
15 Insurance Board and health insurers for enrolled Healthy Families  
16 beneficiaries or to contracts entered into pursuant to Chapter 7  
17 (commencing with Section 14000) of, or Chapter 8 (commencing  
18 with Section 14200) of, Part 3 of Division 9 of the Welfare and  
19 Institutions Code between the State Department of Health Care  
20 Services and health insurers for enrolled Medi-Cal beneficiaries.

21 (d) Commencing January 1, 2014, a health insurer, with respect  
22 to policies that cover hospital, medical, or surgical benefits, may  
23 only sell the five levels of coverage contained in subsections (d)  
24 and (e) of Section 1302 of the federal act, except that a health  
25 insurer that does not participate in the Exchange may, with respect  
26 to policies that cover hospital, medical, or surgical benefits, only  
27 sell the four levels of coverage contained in Section 1302(d) of  
28 the federal act.

29 (e) Commencing January 1, 2014, a health insurer that does not  
30 participate in the Exchange shall, with respect to policies that cover  
31 hospital, medical, or surgical expenses, offer at least one  
32 standardized product that has been designated by the Exchange in  
33 each of the four levels of coverage contained in Section 1302(d)  
34 of the federal act. This subdivision shall only apply if the board  
35 of the Exchange exercises its authority under subdivision (c) of  
36 Section 100504 of the Government Code. Nothing in this  
37 subdivision shall require an insurer that does not participate in the  
38 Exchange to offer standardized products in the small employer  
39 market if the insurer only sells products in the individual market.  
40 Nothing in this subdivision shall require an insurer that does not

1 participate in the Exchange to offer standardized products in the  
2 individual market if the insurer only sells products in the small  
3 employer market. This subdivision shall not be construed to  
4 prohibit the insurer from offering other products provided that it  
5 complies with subdivision (d).

6 (f) This section shall become operative only if Section 11 of the  
7 act that added this section becomes inoperative pursuant to  
8 subdivision (g) of that Section 11.

9 SEC. 13. Section 10961 is added to the Insurance Code, to  
10 read:

11 10961. (a) For purposes of this article, a bridge plan product  
12 shall mean an individual health benefit plan that is offered by a  
13 health insurer licensed under this chapter that contracts with the  
14 Exchange pursuant to Title 22 (commencing with Section 100500)  
15 of the Government Code.

16 (b) On and after the effective date of this section, if a health  
17 insurance policy has not been filed with the commissioner, a health  
18 insurer that contracts with the California Health Benefit Exchange  
19 to offer a qualified bridge plan product pursuant to Section  
20 100504.5 of the Government Code shall file the policy form with  
21 the commissioner pursuant to Section 10290.

22 (c) (1) Notwithstanding subdivision (a) of Section 10965.3, a  
23 health insurer selling a bridge plan product shall not be required  
24 to fairly and affirmatively offer, market, and sell the health  
25 insurer's bridge plan product except to individuals eligible for the  
26 bridge plan product pursuant to the State Department of Health  
27 Care Services and the Medi-Cal managed care plan's contract  
28 entered into pursuant to Section 14005.70 of the Welfare and  
29 Institutions Code, provided the health care service plan meets the  
30 requirements of subdivision (b) of Section 14005.70 of the Welfare  
31 and Institutions Code.

32 (2) Notwithstanding subdivision (c) of Section 10965.3, a health  
33 insurer selling a bridge plan product shall provide an initial open  
34 enrollment period of six months, and an annual enrollment period  
35 and a special enrollment period consistent with the annual  
36 enrollment and special enrollment periods of the Exchange.

37 (d) A health insurer that contracts with the California Health  
38 Benefit Exchange to offer a qualified bridge plan product pursuant  
39 to Section 100504 of the Government Code shall maintain a  
40 medical loss ratio of 85 percent for the bridge plan product. A

1 health insurer shall utilize, to the extent possible, the same  
2 methodology for calculating the medical loss ratio for the bridge  
3 plan product that is used for calculating the health insurer’s medical  
4 loss ratio pursuant to Section 10112.25 and shall report its medical  
5 loss ratio for the bridge plan product to the department as provided  
6 in Section 10112.25.

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

13 SEC. 14. Section 14005.70 is added to the Welfare and  
14 Institutions Code, to read:

15 14005.70. (a) The State Department of Health Care Services  
16 shall ensure that its contracts with a health care service plan or  
17 health insurer to provide Medi-Cal managed care coverage meet  
18 all of the following requirements:

19 (1) A health care service plan or health insurer shall provide  
20 coverage in its bridge plan product to its Medi-Cal managed care  
21 enrollees and other individuals that meet the requirements in  
22 paragraph (2) if the Medi-Cal managed care plan offers a bridge  
23 plan product pursuant to Section 100504.5 of the Government  
24 Code.

25 (2) Only the following individuals shall be eligible to enroll in  
26 the Medi-Cal managed care plan’s bridge plan product if the  
27 Medi-Cal managed care plan offers a bridge plan product:

28 (A) An individual who is determined to be eligible for the  
29 Exchange and ~~who can demonstrate that his or her~~ *whose* Medi-Cal  
30 coverage or Healthy Families coverage was terminated. *In*  
31 *implementing this subparagraph, the Exchange shall adopt*  
32 *processes to ensure that individuals have no gap in coverage to*  
33 *the greatest extent possible.* The Exchange shall request approval  
34 from the federal government to limit enrollment under this  
35 subparagraph to individuals with a family income at or below 250  
36 percent of the federal poverty level.

37 (B) Other members of the modified adjusted gross income  
38 household, as defined in Section 100501 of the Government Code,  
39 in which there are Medi-Cal or Healthy Families enrollees.

1 (C) A parent or caretaker relative of a child on Medi-Cal. The  
2 Exchange may delay the operative date of this subparagraph until  
3 it has the operational capability to implement this subparagraph,  
4 but no later than January 1, 2015.

5 (3) Provide all of the following:

6 (A) Except as provided in subparagraph (C) of paragraph (2),  
7 an individual who is eligible to enroll in a bridge plan product  
8 under subparagraph (A) of paragraph (2) shall only be eligible to  
9 enroll in a bridge plan product offered by the health care service  
10 plan or health insurer through which the individual was enrolled  
11 prior to eligibility for a bridge plan product as either a Medi-Cal  
12 beneficiary or as a Healthy Families enrollee.

13 (B) An individual who is eligible to enroll in a bridge plan  
14 product under subparagraph (B) of paragraph (2) shall only be  
15 eligible to enroll in a bridge plan product offered by the health  
16 care service plan or health insurer through which the member of  
17 the household was enrolled as a Medi-Cal beneficiary or as a  
18 Healthy Families enrollee.

19 (C) The Exchange shall seek federal approval to allow  
20 individuals described in subparagraphs (A) and (B) the option to  
21 enroll in a different bridge plan product if the individual's primary  
22 care provider is included in the contracted network of the different  
23 bridge plan product and either of the following applies to the bridge  
24 plan product for which the individual is eligible:

25 (i) The product is not offered in that individual's service area.

26 (ii) The product is not ~~selected~~ *offered* as a bridge plan product  
27 by the Exchange.

28 (4) The Medi-Cal managed care plan shall only offer a bridge  
29 plan product if the bridge plan product premium contribution  
30 amount in the silver category for the eligible individual is equal  
31 to, or less than, the premium contribution amount for the lowest  
32 cost plan in the silver category that would have been available to  
33 that individual without the bridge plan product.

34 (b) The State Department of Health Care Services may enter  
35 into a contract with the California Health Benefit Exchange to  
36 delegate the implementation of any part of this section to the  
37 Exchange.

38 (c) Notwithstanding subdivision (a) of Section 1399.849 of the  
39 Health and Safety Code and subdivision (a) of Section 10965.3 of  
40 the Insurance Code, the State Department of Health Care Services

1 may allow a Medi-Cal managed care plan, pursuant to its contract  
2 under this section, to limit enrollment into bridge plan products to  
3 eligible individuals identified in paragraph (2) of subdivision (a)  
4 of this section based on limitations in contracted network capacity  
5 for bridge plan products as provided in Section 1399.857 of the  
6 Health and Safety Code or Section 10753.12 of the Insurance Code.  
7 (d) This section shall become inoperative on the October 1 that  
8 is five years after the date that federal approval of the bridge plan  
9 option occurs, and, as of the second January 1 thereafter, is  
10 repealed, unless a later enacted statute that is enacted before that  
11 date deletes or extends the dates on which it becomes inoperative  
12 and is repealed.

O