

AMENDED IN SENATE APRIL 29, 2014

AMENDED IN SENATE MARCH 28, 2014

**SENATE BILL**

**No. 1052**

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**Introduced by Senator Torres**

February 18, 2014

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An act to amend Section 100503 of, and to add Section 100503.1 to, the Government Code, *to amend Sections 1363.01 and 1368.016 of, and to add Section 1367.205 to, the Health and Safety Code, and to amend Section 10123.199 of, and to add Section 10123.192 to, the Insurance Code*, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 1052, as amended, Torres. ~~California Health Benefit Exchange: annual report: qualified health plan formularies.~~ *Health care coverage.*

*Existing law, the Knox-Keene Health Care Service Plan Act (Knox-Keene Act) of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. The Knox-Keene Act requires a health care service plan that provides prescription drug benefits and maintains one or more drug formularies to provide to members of the public, upon request, a copy of the most current list of prescription drugs on the formulary, as specified.*

*This bill would require a health care service plan or health insurer that provides prescription drug benefits and maintains one or more drug formularies to post those formularies on its Internet Web site, update that posting within 24 hours after making any formulary changes, use a standard template to display formularies, and include in any*

*published formulary, among other information, the prior authorization or step edit requirements for, and the range of cost sharing for, each drug included on the formulary. The bill would authorize the Department of Managed Health Care and the Department of Insurance to develop a standard formulary template and would require plans and insurers to use that template to comply with specified provisions of the bill. The bill would make other related conforming changes. Because a willful violation of these requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program.*

Existing law establishes the California Health Benefit Exchange within state government, specifies the powers and duties of the board governing the Exchange, and requires the board to facilitate the purchase of qualified health plans through the Exchange by qualified individuals and small employers. Existing law requires the board to undertake activities necessary to market and publicize the availability of health care coverage and federal subsidies through the Exchange and to undertake outreach and enrollment activities that seek to assist with enrolling in the Exchange in the least burdensome manner. Existing law also requires the board of the Exchange to annually prepare a written report on the implementation and performance of the Exchange functions during the preceding fiscal year, as specified, and requires that this report be submitted to the Legislature and the Governor and be made available to the public on the Internet Web site of the Exchange.

This bill, would also require the report to include the total number of uninsured Californians as a percentage of the state population and an independent evaluation of the marketing and outreach and enrollment activities undertaken by the Exchange.

Existing law requires the board of the Exchange to determine the minimum requirements a carrier must meet to be considered for participation in the Exchange and the standards and criteria for selecting qualified health plans to be offered through the Exchange that are in the best interests of qualified individuals and qualified small employers.

~~This bill would prohibit the Exchange from offering a qualified health plan unless the carrier offering the plan posts the formulary for the plan on the Internet Web site of the carrier, updates that posting within 24 hours after making any changes to the formulary, uses a standard template to display the formulary for all qualified health plans offered by the carrier, and includes in any published formulary the prior authorization or step edit requirements for, and the range of coinsurance cost of, each drug included on the formulary. The bill would require~~

the board of the Exchange to ensure that its Internet Web site provides a direct link to the ~~formulary posted by a carrier before the plan is offered through the Exchange~~ *formularies for each qualified health plan offered through the Exchange that are posted by carriers pursuant to the bill's provisions*. The bill would also require the board to create a search tool on its Internet Web site that allows potential enrollees to search for qualified health plans by a particular drug and by a particular therapeutic condition.

*The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.*

*This bill would provide that no reimbursement is required by this act for a specified reason.*

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

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

1 SECTION 1. Section 100503 of the Government Code, as  
2 amended by Section 4 of Chapter 5 of the First Extraordinary  
3 Session of the Statutes of 2013, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

30 (m) Employ necessary staff.

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

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

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

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

7 (ii) Other relevant labor pools.

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

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

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

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

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

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

35 (q) (1) (A) Annually prepare a written report on the  
36 implementation and performance of the Exchange functions during  
37 the preceding fiscal year, including, at a minimum, all of the  
38 following:

39 (i) The manner in which funds were expended and the progress  
40 toward, and the achievement of, the requirements of this title.

- 1 (ii) Data provided by health care service plans and health  
2 insurers offering bridge plan products regarding the extent of health  
3 care provider and health facility overlap in their Medi-Cal networks  
4 as compared to the health care provider and health facility networks  
5 contracting with the plan or insurer in their bridge plan contracts.
- 6 (iii) The total number of uninsured Californians as a percentage  
7 of the state population.
- 8 (iv) An evaluation of the effectiveness of the activities  
9 undertaken pursuant to subdivision (k). This evaluation shall be  
10 conducted by an independent entity selected by the board.
- 11 (B) The report required by this paragraph shall be transmitted  
12 to the Legislature and the Governor and shall be made available  
13 to the public on the Internet Web site of the Exchange. A report  
14 made to the Legislature pursuant to this paragraph shall be  
15 submitted pursuant to Section 9795.
- 16 (2) The Exchange shall prepare, or contract for the preparation  
17 of, an evaluation of the bridge plan program using the first three  
18 years of experience with the program. The evaluation shall be  
19 provided to the health policy and fiscal committees of the  
20 Legislature in the fourth year following federal approval of the  
21 bridge plan option. The evaluation shall include, but not be limited  
22 to, all of the following:
- 23 (A) The number of individuals eligible to participate in the  
24 bridge plan program each year by category of eligibility.
- 25 (B) The number of eligible individuals who elect a bridge plan  
26 option each year by category of eligibility.
- 27 (C) The average length of time, by region and statewide, that  
28 individuals remain in the bridge plan option each year by category  
29 of eligibility.
- 30 (D) The regions of the state with a bridge plan option, and the  
31 carriers in each region that offer a bridge plan, by year.
- 32 (E) The premium difference each year, by region, between the  
33 bridge plan and the first and second lowest cost plan for individuals  
34 in the Exchange who are not eligible for the bridge plan.
- 35 (F) The effect of the bridge plan on the premium subsidy amount  
36 for bridge plan eligible individuals each year by each region.
- 37 (G) Based on a survey of individuals enrolled in the bridge plan:
- 38 (i) Whether individuals enrolling in the bridge plan product are  
39 able to keep their existing health care providers.

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

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

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

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

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

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

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

32 (2) Individuals and entities with experience in facilitating  
33 enrollment in health plans.

34 (3) Representatives of small businesses and self-employed  
35 individuals.

36 (4) The State Medi-Cal Director.

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

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

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

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

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

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

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

34 SEC. 2. Section 100503 of the Government Code, as added by  
35 Section 5 of Chapter 5 of the First Extraordinary Session of the  
36 Statutes of 2013, is amended to read:

37 100503. In addition to meeting the minimum requirements of  
38 Section 1311 of the federal act, the board shall do all of the  
39 following:

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

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

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

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

30 (e) Require, as a condition of participation in the Exchange,  
31 carriers to fairly and affirmatively offer, market, and sell in the  
32 Exchange at least one product within each of the five levels of  
33 coverage contained in subsections (d) and (e) of Section 1302 of  
34 the federal act. The board may require carriers to offer additional  
35 products within each of those five levels of coverage. This  
36 subdivision shall not apply to a carrier that solely offers  
37 supplemental coverage in the Exchange under paragraph (10) of  
38 subdivision (a) of Section 100504.

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

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

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

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

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

22 (h) Provide for the processing of applications and the enrollment  
23 and disenrollment of enrollees.

24 (i) Determine and approve cost-sharing provisions for qualified  
25 health plans.

26 (j) Establish uniform billing and payment policies for qualified  
27 health plans offered in the Exchange to ensure consistent  
28 enrollment and disenrollment activities for individuals enrolled in  
29 the Exchange.

30 (k) Undertake activities necessary to market and publicize the  
31 availability of health care coverage and federal subsidies through  
32 the Exchange. The board shall also undertake outreach and  
33 enrollment activities that seek to assist enrollees and potential  
34 enrollees with enrolling and reenrolling in the Exchange in the  
35 least burdensome manner, including populations that may  
36 experience barriers to enrollment, such as the disabled and those  
37 with limited English language proficiency.

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

40 (m) Employ necessary staff.

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

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

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

17 (ii) Other relevant labor pools.

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

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

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

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

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

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

6 (q) (1) (A) Annually prepare a written report on the  
7 implementation and performance of the Exchange functions during  
8 the preceding fiscal year, including, at a minimum, all of the  
9 following:

10 (i) The manner in which funds were expended and the progress  
11 toward, and the achievement of, the requirements of this title.

12 (ii) The total number of uninsured Californians as a percentage  
13 of the state population.

14 (iii) An evaluation of the effectiveness of the activities  
15 undertaken pursuant to subdivision (k). This evaluation shall be  
16 conducted by an independent entity selected by the board.

17 (B) The report required by this paragraph shall be transmitted  
18 to the Legislature and the Governor and shall be made available  
19 to the public on the Internet Web site of the Exchange. A report  
20 made to the Legislature pursuant to this paragraph shall be  
21 submitted pursuant to Section 9795.

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

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

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

- 1 (t) Consult with stakeholders relevant to carrying out the  
2 activities under this title, including, but not limited to, all of the  
3 following:
- 4 (1) Health care consumers who are enrolled in health plans.
  - 5 (2) Individuals and entities with experience in facilitating  
6 enrollment in health plans.
  - 7 (3) Representatives of small businesses and self-employed  
8 individuals.
  - 9 (4) The State Medi-Cal Director.
  - 10 (5) Advocates for enrolling hard-to-reach populations.
- 11 (u) Facilitate the purchase of qualified health plans in the  
12 Exchange by qualified individuals and qualified small employers  
13 no later than January 1, 2014.
- 14 (v) Report, or contract with an independent entity to report, to  
15 the Legislature by December 1, 2018, on whether to adopt the  
16 option in Section 1312(c)(3) of the federal act to merge the  
17 individual and small employer markets. In its report, the board  
18 shall provide information, based on at least two years of data from  
19 the Exchange, on the potential impact on rates paid by individuals  
20 and by small employers in a merged individual and small employer  
21 market, as compared to the rates paid by individuals and small  
22 employers if a separate individual and small employer market is  
23 maintained. A report made pursuant to this subdivision shall be  
24 submitted pursuant to Section 9795.
- 25 (w) With respect to the SHOP Program, collect premiums and  
26 administer all other necessary and related tasks, including, but not  
27 limited to, enrollment and plan payment, in order to make the  
28 offering of employee plan choice as simple as possible for qualified  
29 small employers.
- 30 (x) Require carriers participating in the Exchange to immediately  
31 notify the Exchange, under the terms and conditions established  
32 by the board when an individual is or will be enrolled in or  
33 disenrolled from any qualified health plan offered by the carrier.
- 34 (y) Ensure that the Exchange provides oral interpretation  
35 services in any language for individuals seeking coverage through  
36 the Exchange and makes available a toll-free telephone number  
37 for the hearing and speech impaired. The board shall ensure that  
38 written information made available by the Exchange is presented  
39 in a plainly worded, easily understandable format and made  
40 available in prevalent languages.

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

4 SEC. 3. Section 100503.1 is added to the Government Code,  
5 to read:

6 ~~100503.1. (a) A qualified health plan shall not be offered~~  
7 ~~through the Exchange unless the carrier offering the plan does all~~  
8 ~~of the following:~~

9 ~~(1) Posts the formulary for the qualified health plan on the~~  
10 ~~Internet Web site of the carrier in a manner that is accessible and~~  
11 ~~searchable by potential enrollees, enrollees, and providers.~~

12 ~~(2) Updates the formulary posted pursuant to paragraph (1) with~~  
13 ~~any change to that formulary within 24 hours after making the~~  
14 ~~change.~~

15 ~~(3) Uses a standard template to display the formulary for all~~  
16 ~~qualified health plans offered by the carrier. This template shall~~  
17 ~~do both of the following:~~

18 ~~(A) Use the United States Pharmacopeia classification system.~~

19 ~~(B) Organize drugs by therapeutic class, listing drugs~~  
20 ~~alphabetically.~~

21 ~~(4) Includes both of the following on any published formulary~~  
22 ~~for the qualified health plan, including, but not limited to, the~~  
23 ~~formulary posted pursuant to paragraph (1):~~

24 ~~(A) Any prior authorization or step edit requirements for each~~  
25 ~~specific drug included on the formulary.~~

26 ~~(B) The range of coinsurance cost to a potential enrollee of each~~  
27 ~~specific drug included on the formulary, as follows:~~

28 ~~(i) Under \$100 — \$.~~

29 ~~(ii) \$100-\$250 — \$\$.~~

30 ~~(iii) \$251-\$500 — \$\$\$.~~

31 ~~(iv) Over \$500 — \$\$\$\$.~~

32 ~~(b)~~

33 *100503.1. (a) The board shall ensure that the Internet Web*  
34 *site maintained under subdivision (c) of Section 100502 provides*  
35 *a direct link to the formulary posted pursuant to paragraph (1) of*  
36 *subdivision (a) before the plan is, or formularies, for each qualified*  
37 *health plan offered through the Exchange that is posted by the*  
38 *carrier pursuant to Section 1367.205 of the Health and Safety*  
39 *Code or Section 10123.192 of the Insurance Code.*

40 (e)

1 (b) The board shall create a search tool on the Internet Web site  
 2 maintained under subdivision (c) of Section 100502 that allows  
 3 potential enrollees to search for qualified health plans by a  
 4 particular drug and by a particular therapeutic condition.

5 ~~(d) For purposes of this section, “formulary for the qualified~~  
 6 ~~health plan” means the complete list of drugs preferred for use and~~  
 7 ~~eligible for coverage under the qualified health plan and includes~~  
 8 ~~the drugs covered under both the pharmacy benefit of the plan and~~  
 9 ~~the medical benefit of the plan.~~

10 *SEC. 4. Section 1363.01 of the Health and Safety Code is*  
 11 *amended to read:*

12 1363.01. (a) Every plan that covers prescription drug benefits  
 13 shall provide notice in the evidence of coverage and disclosure  
 14 form to enrollees regarding whether the plan uses a formulary.  
 15 The notice shall be in language that is easily understood and in a  
 16 format that is easy to understand. The notice shall include an  
 17 explanation of what a formulary is, how the plan determines which  
 18 prescription drugs are included or excluded, and how often the  
 19 plan reviews the contents of the formulary.

20 (b) Every plan that covers prescription drug benefits shall  
 21 provide to members of the public, upon request, information  
 22 regarding whether a specific drug or drugs are on the plan’s  
 23 formulary. Notice of the opportunity to secure this information  
 24 from the plan, including the plan’s telephone number for making  
 25 a request of this nature *and the Internet Web site where the*  
 26 *formulary is posted under Section 1367.205*, shall be included in  
 27 the evidence of coverage and disclosure form to enrollees.

28 (c) Every plan shall notify enrollees, and members of the public  
 29 who request formulary information, that the presence of a drug on  
 30 the plan’s formulary does not guarantee that an enrollee will be  
 31 prescribed that drug by his or her prescribing provider for a  
 32 particular medical condition.

33 ~~(d) This section shall become operative July 1, 1999.~~

34 *SEC. 5. Section 1367.205 is added to the Health and Safety*  
 35 *Code, to read:*

36 1367.205. (a) *In addition to the list required to be provided*  
 37 *under Section 1367.20, a health care service plan that provides*  
 38 *prescription drug benefits and maintains one or more drug*  
 39 *formularies shall do all of the following:*

- 1     (1) *Post the formulary or formularies for each product offered*  
2 *by the plan on the plan’s Internet Web site in a manner that is*  
3 *accessible and searchable by potential enrollees, enrollees, and*  
4 *providers.*
- 5     (2) *Update the formularies posted pursuant to paragraph (1)*  
6 *with any change to those formularies within 24 hours after making*  
7 *the change.*
- 8     (3) *Use a standard template to display the formulary or*  
9 *formularies for each product offered by the plan. This template*  
10 *shall do both of the following:*
- 11         (A) *Use the United States Pharmacopeia classification system.*  
12         (B) *Organize drugs by therapeutic class, listing drugs*  
13 *alphabetically.*
- 14     (4) *Include all of the following on any published formulary for*  
15 *any product offered by the plan, including, but not limited to, the*  
16 *formulary or formularies posted pursuant to paragraph (1) and*  
17 *the list provided pursuant to Section 1367.20:*
- 18         (A) *Any prior authorization or step edit requirements for each*  
19 *specific drug included on the formulary.*
- 20         (B) *The range of cost sharing for a potential enrollee of each*  
21 *specific drug included on the formulary, as follows:*
- 22             (i) *Under \$100 – \$.*  
23             (ii) *\$100-\$250 – \$\$.*  
24             (iii) *\$251-\$500 – \$\$\$.*  
25             (iv) *Over \$500 – \$\$\$\$.*
- 26         (C) *Identification of any drugs on the formulary that are*  
27 *preferred over other drugs on the formulary.*
- 28         (D) *The notification described in subdivision (c) of Section*  
29 *1363.01.*
- 30     (b) *The department may develop a standard formulary template*  
31 *provided that the department consults with the Department of*  
32 *Insurance on the template design. If the department develops this*  
33 *template, a health care service plan shall use the template to*  
34 *comply with paragraph (3) of subdivision (a).*
- 35     (c) *For purposes of this section, “formulary” means the*  
36 *complete list of drugs preferred for use and eligible for coverage*  
37 *under a health care service plan product and includes the drugs*  
38 *covered under both the pharmacy benefit of the product and the*  
39 *medical benefit of the product.*

1 SEC. 6. Section 1368.016 of the Health and Safety Code is  
2 amended to read:

3 1368.016. (a) ~~On or before January 1, 2012, every~~ A health  
4 care service plan that provides coverage for professional mental  
5 health services, including a specialized health care service plan  
6 that provides coverage for professional mental health services,  
7 shall, pursuant to subdivision (f) of Section 1368.015, include on  
8 its Internet Web site, or provide a link to, the following  
9 information:

10 (1) A telephone number that the enrollee or provider can call,  
11 during normal business hours, for assistance obtaining mental  
12 health benefits coverage information, including the extent to which  
13 benefits have been exhausted, in-network provider access  
14 information, and claims processing information.

15 (2) A link to prescription drug formularies *posted pursuant to*  
16 *Section 1367.205*, or instructions on how to obtain the formulary,  
17 as described in Section 1367.20.

18 (3) A detailed summary that describes the process by which the  
19 plan reviews and authorizes or approves, modifies, or denies  
20 requests for health care services as described in Sections 1363.5  
21 and 1367.01.

22 (4) Lists of providers or instructions on how to obtain the  
23 provider list, as required by Section 1367.26.

24 (5) A detailed summary of the enrollee grievance process as  
25 described in Sections 1368 and 1368.015.

26 (6) A detailed description of how an enrollee may request  
27 continuity of care pursuant to subdivisions (a) and (b) of Section  
28 1373.95.

29 (7) Information concerning the right, and applicable procedure,  
30 of an enrollee to request an independent medical review pursuant  
31 to Section 1374.30.

32 (b) Any modified material described in subdivision (a) shall be  
33 updated at least quarterly.

34 (c) The information described in subdivision (a) may be made  
35 available through a secured Internet Web site that is only accessible  
36 to enrollees.

37 (d) The material described in subdivision (a) shall also be made  
38 available to enrollees in hard copy upon request.

39 (e) Nothing in this article shall preclude a health care service  
40 plan from including additional information on its Internet Web

1 site for applicants, enrollees or subscribers, or providers, including,  
2 but not limited to, the cost of procedures or services by health care  
3 providers in a plan’s network.

4 (f) The department shall include on the department’s Internet  
5 Web site a link to the Internet Web site of each health care service  
6 plan and specialized health care service plan described in  
7 subdivision (a).

8 (g) This section shall not apply to Medicare supplement  
9 insurance, Employee Assistance Programs, short-term limited  
10 duration health insurance, Champus-supplement insurance, or  
11 TRI-CARE supplement insurance, or to hospital indemnity,  
12 accident-only, and specified disease insurance. This section shall  
13 also not apply to specialized health care service plans, except  
14 behavioral health-only plans.

15 (h) This section shall not apply to a health care service plan that  
16 contracts with a specialized health care service plan, insurer, or  
17 other entity to cover professional mental health services for its  
18 enrollees, provided that the health care service plan provides a link  
19 on its Internet Web site to an Internet Web site operated by the  
20 specialized health care service plan, insurer, or other entity with  
21 which it contracts, and that plan, insurer, or other entity complies  
22 with this section or Section 10123.199 of the Insurance Code.

23 *SEC. 7. Section 10123.192 is added to the Insurance Code, to*  
24 *read:*

25 *10123.192. (a) A health insurer that provides prescription*  
26 *drug benefits and maintains one or more drug formularies shall*  
27 *do all of the following:*

28 *(1) Post the formulary or formularies for each product offered*  
29 *by the insurer on the insurer’s Internet Web site in a manner that*  
30 *is accessible and searchable by potential insureds, insureds, and*  
31 *providers.*

32 *(2) Update the formularies posted pursuant to paragraph (1)*  
33 *with any change to those formularies within 24 hours after making*  
34 *the change.*

35 *(3) Use a standard template to display the formulary or*  
36 *formularies for each product offered by the insurer. This template*  
37 *shall do both of the following:*

38 *(A) Use the United States Pharmacopeia classification system.*

39 *(B) Organize drugs by therapeutic class, listing drugs*  
40 *alphabetically.*

1 (4) Include all of the following on any published formulary for  
2 any product offered by the insurer, including, but not limited to,  
3 the formulary or formularies posted pursuant to paragraph (1):

4 (A) Any prior authorization or step edit requirements for each  
5 specific drug included on the formulary.

6 (B) The range of cost sharing for a potential insured of each  
7 specific drug included on the formulary, as follows:

8 (i) Under \$100 – \$.

9 (ii) \$100-\$250 – \$\$.

10 (iii) \$251-\$500 – \$\$\$.

11 (iv) Over \$500 – \$\$\$\$.

12 (C) Identification of any drugs on the formulary that are  
13 preferred over other drugs on the formulary.

14 (D) A notification that the presence of a drug on the insurer's  
15 formulary does not guarantee that an insured will be prescribed  
16 that drug by his or her prescribing provider for a particular  
17 medical condition.

18 (b) The department may develop a standard formulary template  
19 provided that the department consults with the Department of  
20 Managed Health Care on the template design. If the department  
21 develops this template, a health insurer shall use the template to  
22 comply with paragraph (3) of subdivision (a).

23 (c) For purposes of this section, "formulary" means the  
24 complete list of drugs preferred for use and eligible for coverage  
25 under a health insurance product and includes the drugs covered  
26 under both the pharmacy benefit of the product and the medical  
27 benefit of the product.

28 SEC. 8. Section 10123.199 of the Insurance Code is amended  
29 to read:

30 10123.199. (a) ~~On or before January 1, 2012, every~~ A health  
31 insurer that provides coverage for professional mental health  
32 services shall establish an Internet Web site. Each Internet Web  
33 site shall include, or provide a link to, the following information:

34 (1) A telephone number that the insured or provider can call,  
35 during normal business hours, for assistance obtaining mental  
36 health benefits coverage information, including the extent to which  
37 benefits have been exhausted, in-network provider access  
38 information, and claims processing information.

- 1 (2) A link to prescription drug formularies *posted pursuant to*  
2 *Section 10123.192*, or instructions on how to obtain formulary  
3 information.
- 4 (3) A detailed summary description of the process by which the  
5 insurer reviews and approves, modifies, or denies requests for  
6 health care services as described in Section 10123.135.
- 7 (4) Lists of providers or instructions on how to obtain a provider  
8 list as required by Section 10133.1.
- 9 (5) A detailed summary of the health insurer's grievance process.
- 10 (6) A detailed description of how the insured may request  
11 continuity of care as described in Section 10133.55.
- 12 (7) Information concerning the right, and applicable procedure,  
13 of the insured to request an independent medical review pursuant  
14 ~~to subdivision (i) of Section 10169.~~
- 15 (b) Except as otherwise specified, the material described in  
16 subdivision (a) shall be updated at least quarterly.
- 17 (c) The information described in subdivision (a) may be made  
18 available through a secured Internet Web site that is only accessible  
19 to the insured.
- 20 (d) The material described in subdivision (a) shall also be made  
21 available to insureds in hard copy upon request.
- 22 (e) Nothing in this article shall preclude an insurer from  
23 including additional information on its Internet Web site for  
24 applicants or insureds, including, but not limited to, the cost of  
25 procedures or services by health care providers in an insurer's  
26 network.
- 27 (f) The department shall include on the department's Internet  
28 Web site, a link to the Internet Web site of each health insurer  
29 described in subdivision (a).
- 30 (g) This section shall not apply to Medicare supplement  
31 insurance, Employee Assistance Programs, short-term limited  
32 duration health insurance, Champus-supplement insurance, or  
33 TRI-CARE supplement insurance, or to hospital indemnity,  
34 accident-only, and specified disease insurance. This section shall  
35 also not apply to specialized health insurance policies, except  
36 behavioral health-only policies.
- 37 (h) This section shall not apply to a health insurer that contracts  
38 with a specialized health care service plan, insurer, or other entity  
39 to cover professional mental health services for its insureds,  
40 provided that the health insurer provides a link on its Internet Web

1 site to an Internet Web site operated by the specialized health care  
2 service plan, insurer, or other entity with which it contracts, and  
3 that plan, insurer, or other entity complies with this section or  
4 Section 1368.016 of the Health and Safety Code.

5 *SEC. 9. No reimbursement is required by this act pursuant to*  
6 *Section 6 of Article XIII B of the California Constitution because*  
7 *the only costs that may be incurred by a local agency or school*  
8 *district will be incurred because this act creates a new crime or*  
9 *infraction, eliminates a crime or infraction, or changes the penalty*  
10 *for a crime or infraction, within the meaning of Section 17556 of*  
11 *the Government Code, or changes the definition of a crime within*  
12 *the meaning of Section 6 of Article XIII B of the California*  
13 *Constitution.*