AMENDED IN ASSEMBLY MARCH 28, 2014

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

ASSEMBLY BILL No. 2601

Introduced by Assembly Member ~~Morrell~~ *Conway*

February 21, 2014

An act to amend Section ~~100506~~ *100503* of the Government Code, relating to ~~the California Health Benefit Exchange~~ *health care coverage.*

LEGISLATIVE COUNSEL'S DIGEST

AB 2601, as amended, ~~Morrell~~ *Conway*. California Health Benefit Exchange: ~~appeals.~~ *charge on qualified health plans.*

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 assess a charge on qualified health plans and supplemental coverage offered by carriers that is reasonable and necessary to support the development, operations, and prudent cash management of the Exchange.

This bill would prohibit the board from assessing a charge on qualified health plans or supplemental coverage, on or after January 1, 2016, or increasing that charge thereafter, unless the charge is enacted as a statute.

~~Existing law created the California Health Benefit Exchange (Exchange) as an independent public entity in the state government, not affiliated with an agency or department. The Exchange is governed by an executive board consisting of 5 members. Existing law requires the board to establish an appeal process for prospective and current~~

~~enrollees of the Exchange that complies with all requirements of the federal Patient Protection and Affordable Care Act concerning the role of a state Exchange in facilitating federal appeals of Exchange-related determinations.~~

~~This bill would make technical, nonsubstantive changes to these provisions.~~

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

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

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

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

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

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

(c) 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. The board shall consistently and uniformly apply these requirements, standards, and criteria to all carriers. In the course of selectively contracting for health care coverage offered to qualified individuals and qualified small employers through the Exchange, the board

shall seek to contract with carriers so as to provide health care coverage choices that offer the optimal combination of choice, value, quality, and service.

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

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

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

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

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

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

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

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

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

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

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

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

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

(m) Employ necessary staff.

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

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

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

(ii) Other relevant labor pools.

(B) The salaries established by the board under subparagraph (A) shall not exceed the highest comparable salary for a position

of that type, as determined by the surveys conducted pursuant to subparagraph (A).

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

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

(n) Assess a charge on the qualified health plans offered by carriers that is reasonable and necessary to support the development, operations, and prudent cash management of the Exchange. This charge shall not affect the requirement under Section 1301 of the federal act that carriers charge the same premium rate for each qualified health plan whether offered inside or outside the Exchange. *The board shall not assess a charge on qualified health plans pursuant to this subdivision, or on supplemental coverage pursuant to paragraph (10) of subdivision (a) of Section 100504, on or after January 1, 2016, or increase that charge thereafter, unless the charge or increase is enacted as a statute.*

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

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

(q) (1) Annually prepare a written report on the implementation and performance of the Exchange functions during the preceding fiscal year, including, at a minimum, the manner in which funds were expended and the progress toward, and the achievement of, the requirements of this title. The report shall also include data provided by health care service plans and health insurers offering bridge plan products regarding the extent of health care provider and health facility overlap in their Medi-Cal networks as compared to the health care provider and health facility networks contracting with the plan or insurer in their bridge plan contracts. This report

shall be transmitted to the Legislature and the Governor and shall be made available to the public on the Internet Web site of the Exchange. A report made to the Legislature pursuant to this subdivision shall be submitted pursuant to Section 9795.

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

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

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

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

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

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

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

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

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

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

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

(4) In addition to the report described in paragraph (1), the board shall be responsive to requests for additional information from the Legislature, including providing testimony and commenting on

proposed state legislation or policy issues. The Legislature finds and declares that activities including, but not limited to, responding to legislative or executive inquiries, tracking and commenting on legislation and regulatory activities, and preparing reports on the implementation of this title and the performance of the Exchange, are necessary state requirements and are distinct from the promotion of legislative or regulatory modifications referred to in subdivision (d) of Section 100520.

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

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

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

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

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

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

(4) The State Medi-Cal Director.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(m) Employ necessary staff.

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

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

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

(ii) Other relevant labor pools.

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

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

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

(n) Assess a charge on the qualified health plans offered by carriers that is reasonable and necessary to support the development, operations, and prudent cash management of the Exchange. This charge shall not affect the requirement under Section 1301 of the federal act that carriers charge the same premium rate for each qualified health plan whether offered inside or outside the Exchange. *The board shall not assess a charge on qualified health plans pursuant to this subdivision, or on supplemental coverage pursuant to paragraph (10) of subdivision (a) of Section 100504, on or after January 1, 2016, or increase that charge thereafter, unless the charge or increase is enacted as a statute.*

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

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

(q) (1) Annually prepare a written report on the implementation and performance of the Exchange functions during the preceding fiscal year, including, at a minimum, the manner in which funds were expended and the progress toward, and the achievement of, the requirements of this title. This report shall be transmitted to

the Legislature and the Governor and shall be made available to the public on the Internet Web site of the Exchange. A report made to the Legislature pursuant to this subdivision shall be submitted pursuant to Section 9795.

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

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

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

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

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

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

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

(4) The State Medi-Cal Director.

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

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

(v) Report, or contract with an independent entity to report, to the Legislature by December 1, 2018, on whether to adopt the option in Section 1312(c)(3) of the federal act to merge the individual and small employer markets. In its report, the board shall provide information, based on at least two years of data from

the Exchange, on the potential impact on rates paid by individuals and by small employers in a merged individual and small employer market, as compared to the rates paid by individuals and small employers if a separate individual and small employer market is maintained. A report made pursuant to this subdivision shall be submitted pursuant to Section 9795.

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

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

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

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

~~SECTION 1. Section 100506 of the Government Code is amended to read:~~

~~100506. (a) The board shall establish an appeals process for prospective and current enrollees of the Exchange that complies with all requirements of the federal act concerning the role of a state Exchange in facilitating federal appeals of Exchange-related determinations. The scope of those appeals shall not be construed to be broader than the requirements of the federal act in any event. Once the federal regulations concerning appeals have been issued in final form by the United States Secretary of Health and Human Services, the board may establish additional requirements related to appeals, provided that the board determines, prior to adoption, that any additional requirement results in no cost to the General Fund and no increase in the charge imposed under subdivision (n) of Section 100503.~~

~~(b) The board shall not be required to provide an appeal if the subject of the appeal is within the jurisdiction of the Department of Managed Health Care pursuant to the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code) and its implementing regulations, or within the jurisdiction of the Department of Insurance pursuant to the Insurance Code and its implementing regulations.~~

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