Assembly Bill No. 1602

CHAPTER 655

An act to amend Sections 15438 and 15439 of, and to add Sections 100501, 100502, 100503, 100504, 100505, 100506, 100507, 100508, 100520, and 100521 to, the Government Code, to add Section 1366.6 to the Health and Safety Code, and to add Section 10112.3 to the Insurance Code, relating to health care coverage, and making an appropriation therefor.

[Approved by Governor September 30, 2010. Filed with Secretary of State September 30, 2010.]

LEGISLATIVE COUNSEL'S DIGEST

AB 1602, John A. Pérez. California Health Benefit Exchange.

Existing law provides various programs to provide health care coverage to persons with limited financial resources, including the Medi-Cal program and the Healthy Families Program. Existing law provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of its provisions a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance.

Existing law, the federal Patient Protection and Affordable Care Act (PPACA), requires each state to, by January 1, 2014, establish an American Health Benefit Exchange that facilitates the purchase of qualified health plans by qualified individuals and qualified small employers, as specified, and meets certain other requirements.

This bill would enact the California Patient Protection and Affordable Care Act, and would, contingent on the enactment of SB 900, which would create the California Health Benefit Exchange (the Exchange), specify the powers and duties of the board governing the Exchange relative to determining eligibility for enrollment in the Exchange and arranging for coverage under qualified health plans, and would require the board to facilitate the purchase of qualified health plans through the Exchange by qualified individuals and qualified small employers by January 1, 2014. The bill would create the California Health Trust Fund as a continuously appropriated fund and would make the implementation of these provisions contingent on a determination by the board that sufficient financial resources exist or will exist in the fund, as specified. The bill would enact other related provisions.

The bill would impose various requirements on participating plans and insurers and, commencing January 1, 2014, on nonparticipating plans and insurers, as specified. 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.

Under existing law, the California Health Facilities Financing Authority Act, the California Health Facilities Authority is empowered to make loans under certain conditions from the continuously appropriated California Health Facilities Financing Authority Fund to nonprofit corporations or associations for financing or refinancing the acquisition, construction, or remodeling of health facilities.

This bill would authorize the authority to provide a working capital loan of up to $5 million to assist in the establishment and operation of the California Health Benefit Exchange. The bill would require that loans awarded under the bill be made from the California Health Facilities Authority Fund and would require repayment of the loan by a specified date. Because the bill would expand the purposes for which a continuously appropriated fund may be used, it would make an appropriation.

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.

Appropriation: yes.

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

SECTION 1. This act shall be known and may be cited as the California Patient Protection and Affordable Care Act.

SEC. 2. It is the intent of the Legislature to enact the necessary statutory changes to California law in order to establish an American Health Benefit Exchange in California and its administrative authority in a manner that is consistent with the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), hereafter the federal act. In doing so, it is the intent of the Legislature to do all of the following:

(a) Reduce the number of uninsured Californians by creating an organized, transparent marketplace for Californians to purchase affordable, quality health care coverage, to claim available federal tax credits and cost-sharing subsidies, and to meet the personal responsibility requirements imposed under the federal act.

(b) Strengthen the health care delivery system.

(c) Guarantee the availability and renewability of health care coverage through the private health insurance market to qualified individuals and qualified small employers.

(d) Require that health care service plans and health insurers issuing coverage in the individual and small employer markets compete on the basis of price, quality, and service, and not on risk selection.

(e) Meet the requirements of the federal act and all applicable federal guidance and regulations.

SEC. 3. Section 15438 of the Government Code is amended to read:

15438. The authority may do any of the following:

(a) Adopt bylaws for the regulation of its affairs and the conduct of its business.

(b) Adopt an official seal.

(c) Sue and be sued in its own name.

(d) Receive and accept from any agency of the United States, any agency of the state, or any municipality, county, or other political subdivision thereof, or from any individual, association, or corporation gifts, grants, or donations of moneys for achieving any of the purposes of this chapter.

(e) Engage the services of private consultants to render professional and technical assistance and advice in carrying out the purposes of this part.

(f) Determine the location and character of any project to be financed under this part, and to acquire, construct, enlarge, remodel, renovate, alter, improve, furnish, equip, fund, finance, own, maintain, manage, repair, operate, lease as lessee or lessor, and regulate the same, to enter into contracts for any or all of those purposes, to enter into contracts for the management and operation of a project or other health facilities owned by the authority, and to designate a participating health institution as its agent to determine the location and character of a project undertaken by that participating health institution under this chapter and as the agent of the authority, to acquire, construct, enlarge, remodel, renovate, alter, improve, furnish, equip, own, maintain, manage, repair, operate, lease as lessee or lessor, and regulate the same, and as the agent of the authority, to enter into contracts for any or all of those purposes, including contracts for the management and operation of that project or other health facilities owned by the authority.

(g) Acquire, directly or by and through a participating health institution as its agent, by purchase solely from funds provided under the authority of this part, or by gift or devise, and to sell, by installment sale or otherwise, any lands, structures, real or personal property, rights, rights-of-way, franchises, easements, and other interests in lands, including lands lying under water and riparian rights, that are located within the state that the authority determines necessary or convenient for the acquisition, construction, or financing of a health facility or the acquisition, construction, financing, or operation of a project, upon the terms and at the prices considered by the authority to be reasonable and that can be agreed upon between the authority and the owner thereof, and to take title thereto in the name of the authority or in the name of a participating health institution as its agent.

(h) Receive and accept from any source loans, contributions, or grants for, or in aid of, the construction, financing, or refinancing of a project or any portion of a project in money, property, labor, or other things of value.

(i) Make secured or unsecured loans to, or purchase secured or unsecured loans of, any participating health institution in connection with the financing of a project or working capital in accordance with an agreement between the authority and the participating health institution. However, no loan to finance a project shall exceed the total cost of the project, as determined by

the participating health institution and approved by the authority. Funds for secured loans may be provided from the California Health Facilities Financing Fund pursuant to subdivision (b) of Section 15439 to small or rural health facilities pursuant to authority guidelines.

(j) Make secured or unsecured loans to, or purchase secured or unsecured loans of, any participating health institution in accordance with an agreement between the authority and the participating health institution to refinance indebtedness incurred by that participating health institution in connection with projects undertaken or for health facilities acquired or for working capital. Funds for secured loans may be provided from the California Health Facilities Financing Fund pursuant to subdivision (b) of Section 15439 to small or rural health facilities pursuant to authority guidelines.

(k) Mortgage all or any portion of interest of the authority in a project or other health facilities and the property on which that project or other health facilities are located, whether owned or thereafter acquired, including the granting of a security interest in any property, tangible or intangible, and to assign or pledge all or any portion of the interests of the authority in mortgages, deeds of trust, indentures of mortgage or trust, or similar instruments, notes, and security interests in property, tangible or intangible, of participating health institutions to which the authority has made loans, and the revenues therefrom, including payments or income from any thereof owned or held by the authority, for the benefit of the holders of bonds issued to finance the project or health facilities or issued to refund or refinance outstanding indebtedness of participating health institutions as permitted by this part.

(*l*) Lease to a participating health institution the project being financed or other health facilities conveyed to the authority in connection with that financing, upon the terms and conditions the authority determines proper, charge and collect rents therefor, terminate the lease upon the failure of the lessee to comply with any of the obligations of the lease, and include in that lease, if desired, provisions granting the lessee options to renew the term of the lease for the period or periods and at the rent, as determined by the authority, purchase any or all of the health facilities or that upon payment of all of the indebtedness incurred by the authority for the financing of that project or health facilities or for refunding outstanding indebtedness of a participating health institution, then the authority may convey any or all of the project or the other health facilities to the lessee or lessees thereof with or without consideration.

(m) Charge and equitably apportion among participating health institutions, the administrative costs and expenses incurred by the authority in the exercise of the powers and duties conferred by this part.

(n) Obtain, or aid in obtaining, from any department or agency of the United States or of the state, any private company, or any insurance or guarantee as to, of, or for the payment or repayment of, interest or principal, or both, or any part thereof, on any loan, lease, or obligation, or any instrument evidencing or securing the loan, lease, or obligation, made or entered into pursuant to this part; and notwithstanding any other provisions

of this part, to enter into any agreement, contract, or any other instrument whatsoever with respect to that insurance or guarantee, to accept payment in the manner and form as provided therein in the event of default by a participating health institution, and to assign that insurance or guarantee as security for the authority's bonds.

(o) Enter into any and all agreements or contracts, including agreements for liquidity and credit enhancement, interest rate swaps or hedges, execute any and all instruments, and do and perform any and all acts or things necessary, convenient, or desirable for the purposes of the authority or to carry out any power expressly granted by this part.

(p) Invest any moneys held in reserve or sinking funds or any moneys not required for immediate use or disbursement, at the discretion of the authority, in any obligations authorized by the resolution authorizing the issuance of the bonds secured thereof or authorized by law for the investment of trust funds in the custody of the Treasurer.

(q) Award grants to any eligible clinic pursuant to Section 15438.6.

(r) Award grants to any eligible health facility pursuant to Section 15438.7.

(s) (1) Notwithstanding any other provision of law, provide a working capital loan of up to five million dollars ($5,000,000) to assist in the establishment and operation of the California Health Benefit Exchange (Exchange) established under Section 100500. The authority may require any information it deems necessary and prudent prior to providing a loan to the Exchange and may require any term, condition, security, or repayment provision it deems necessary in the event the authority chooses to provide a loan. Under no circumstances shall the authority be required to provide a loan to the Exchange.

(2) Prior to the authority providing a loan to the Exchange, a majority of the board of the Exchange shall be appointed and shall demonstrate, to the satisfaction of the authority, that the federal planning and establishment grants made available to the Exchange by the United States Secretary of Health and Human Services are insufficient or will not be released in a timely manner to allow the Exchange to meet the necessary requirements of the federal Patient Protection and Affordable Care Act (Public Law 111-148).

(3) The Exchange shall repay a loan made under this subdivision no later than June 30, 2016, and shall pay interest at the rate paid on moneys in the Pooled Money Investment Account.

SEC. 4. Section 15439 of the Government Code is amended to read:

15439. (a) The California Health Facilities Authority Fund is continued in existence in the State Treasury as the California Health Facilities Financing Authority Fund. All money in the fund is hereby continuously appropriated to the authority for carrying out the purposes of this division. The authority may pledge any or all of the moneys in the fund as security for payment of the principal of, and interest on, any particular issuance of bonds issued pursuant to this part, or any particular secured or unsecured loan made pursuant to subdivision (i), (j), or (s) of Section 15438, or for a

grant awarded pursuant to subdivision (b) of Section 15438.7, and, for that purpose or as necessary or convenient to the accomplishment of any other purpose of the authority, may divide the fund into separate accounts. All moneys accruing to the authority pursuant to this part from whatever source shall be deposited in the fund.

(b) Subject to the priorities that may be created by the pledge of particular moneys in the fund to secure any issuance of bonds of the authority, and subject further to the cost of loans provided by the authority pursuant to subdivisions (i), (j), or (s) of Section 15438 and to the cost of grants provided by the authority pursuant to Section 15438.7, and subject further to any reasonable costs which may be incurred by the authority in administering the program authorized by this division, all moneys in the fund derived from any source shall be held in trust for the security and payment of bonds of the authority and shall not be used or pledged for any other purpose so long as the bonds are outstanding and unpaid. However, nothing in this section shall limit the power of the authority to make loans with the proceeds of bonds in accordance with the terms of the resolution authorizing the same.

(c) Pursuant to any agreements with the holders of particular bonds pledging any particular assets, revenues, or moneys, the authority may create separate accounts in the fund to manage assets, revenues, or moneys in the manner set forth in the agreements.

(d) The authority may, from time to time, direct the State Treasurer to invest moneys in the fund that are not required for its current needs, including proceeds from the sale of any bonds, in the eligible securities specified in Section 16430 as the agency shall designate. The authority may direct the State Treasurer to deposit moneys in interest-bearing accounts in state or national banks or other financial institutions having principal offices in this state. The authority may alternatively require the transfer of moneys in the fund to the Surplus Money Investment Fund for investment pursuant to Article 4 (commencing with Section 16470) of Chapter 3 of Part 2 of Division 4. All interest or other increment resulting from an investment or deposit shall be deposited in the fund, notwithstanding Section 16305.7. Moneys in the fund shall not be subject to transfer to any other fund pursuant to any provision of Part 2 (commencing with Section 16300) of Division 4, excepting the Surplus Money Investment Fund.

(e) All moneys accruing to the authority from whatever source shall be deposited in the fund.

SEC. 5. Section 100501 is added to the Government Code, to read:

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

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

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

(c) "Exchange" means the California Health Benefit Exchange established by Section 100500.

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

(e) "Fund" means the California Health Trust Fund established by Section 100520.

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

(g) "SHOP Program" means the Small Business Health Options Program established by subdivision (m) of Section 100502.

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

SEC. 6. Section 100502 is added to the Government Code, to read:

100502. The board shall, at a minimum, do all of the following to implement Section 1311 of the federal act:

(a) Implement procedures for the certification, recertification, and decertification, consistent with guidelines established by the United States Secretary of Health and Human Services, of health plans as qualified health plans. The board shall require health plans seeking certification as qualified health plans to do all of the following:

(1) Submit a justification for any premium increase prior to implementation of the increase. The plans shall prominently post that information on their Internet Web sites. The board shall take this information, and the information and the recommendations provided to the board by the Department of Insurance or the Department of Managed Health Care under paragraph (1) of subdivision (b) of Section 2794 of the federal Public Health Service Act, into consideration when determining whether to make the health plan available through the Exchange. The board shall take into account any excess of premium growth outside the Exchange as compared to the rate of that growth inside the Exchange, including information reported by the Department of Insurance and the Department of Managed Health Care.

(2) (A) Make available to the public and submit to the board, the United States Secretary of Health and Human Services, and the Insurance Commissioner or the Department of Managed Health Care, as applicable, accurate and timely disclosure of the following information:

(i) Claims payment policies and practices.

(ii) Periodic financial disclosures.

(iii) Data on enrollment.

(iv) Data on disenrollment.

(v) Data on the number of claims that are denied.

(vi) Data on rating practices.

(vii) Information on cost sharing and payments with respect to any out-of-network coverage.

(viii) Information on enrollee and participant rights under Title I of the federal act.

(ix) Other information as determined appropriate by the United States Secretary of Health and Human Services.

(B) The information required under subparagraph (A) shall be provided in plain language, as defined in subparagraph (B) of paragraph (3) of subdivision (e) of Section 1311 of the federal act.

(3) Permit individuals to learn, in a timely manner upon the request of the individual, the amount of cost sharing, including, but not limited to, deductibles, copayments, and coinsurance, under the individual's plan or coverage that the individual would be responsible for paying with respect to the furnishing of a specific item or service by a participating provider. At a minimum, this information shall be made available to the individual through an Internet Web site and through other means for individuals without access to the Internet.

(b) Provide for the operation of a toll-free telephone hotline to respond to requests for assistance.

(c) Maintain an Internet Web site through which enrollees and prospective enrollees of qualified health plans may obtain standardized comparative information on those plans.

(d) Assign a rating to each qualified health plan offered through the Exchange in accordance with the criteria developed by the United States Secretary of Health and Human Services.

(e) Utilize a standardized format for presenting health benefits plan options in the Exchange, including the use of the uniform outline of coverage established under Section 2715 of the federal Public Health Service Act.

(f) Inform individuals of eligibility requirements for the Medi-Cal program, the Healthy Families Program, or any applicable state or local public program and, if, through screening of the application by the Exchange, the Exchange determines that an individual is eligible for any such program, enroll that individual in the program.

(g) Establish and make available by electronic means a calculator to determine the actual cost of coverage after the application of any premium tax credit under Section 36B of the Internal Revenue Code of 1986 and any cost-sharing reduction under Section 1402 of the federal act.

(h) Grant a certification attesting that, for purposes of the individual responsibility penalty under Section 5000A of the Internal Revenue Code of 1986, an individual is exempt from the individual requirement or from the penalty imposed by that section because of either of the following:

(1) There is no affordable qualified health plan available through the Exchange or the individual's employer covering the individual.

(2) The individual meets the requirements for any other exemption from the individual responsibility requirement or penalty.

(i) Transfer to the Secretary of the Treasury all of the following:

(1) A list of the individuals who are issued a certification under subdivision (h), including the name and taxpayer identification number of each individual.

(2) The name and taxpayer identification number of each individual who was an employee of an employer but who was determined to be eligible for the premium tax credit under Section 36B of the Internal Revenue Code of 1986 because of either of the following:

(A) The employer did not provide minimum essential coverage.

(B) The employer provided the minimum essential coverage but it was determined under subparagraph (C) of paragraph (2) of subsection (c) of Section 36B of the Internal Revenue Code of 1986 to either be unaffordable to the employee or not provide the required minimum actuarial value.

(3) The name and taxpayer identification number of each individual who notifies the Exchange under paragraph (4) of subsection (b) of Section 1411 of the federal act that they have changed employers and of each individual who ceases coverage under a qualified health plan during a plan year and the effective date of that cessation.

(j) Provide to each employer the name of each employee of the employer described in paragraph (2) of subdivision (i) who ceases coverage under a qualified health plan during a plan year and the effective date of that cessation.

(k) Perform duties required of, or delegated to, the Exchange by the United States Secretary of Health and Human Services or the Secretary of the Treasury related to determining eligibility for premium tax credits, reduced cost sharing, or individual responsibility exemptions.

(*l*) Establish the navigator program in accordance with subdivision (i) of Section 1311 of the federal act. Any entity chosen by the Exchange as a navigator shall do all of the following:

(1) Conduct public education activities to raise awareness of the availability of qualified health plans.

(2) Distribute fair and impartial information concerning enrollment in qualified health plans, and the availability of premium tax credits under Section 36B of the Internal Revenue Code of 1986 and cost-sharing reductions under Section 1402 of the federal act.

(3) Facilitate enrollment in qualified health plans.

(4) Provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under Section 2793 of the federal Public Health Service Act, or any other appropriate state agency or agencies, for any enrollee with a grievance, complaint, or question regarding his or her health plan, coverage, or a determination under that plan or coverage.

(5) Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange.

(m) Establish the Small Business Health Options Program, separate from the activities of the board related to the individual market, to assist qualified small employers in facilitating the enrollment of their employees in qualified health plans offered through the Exchange in the small employer market in a manner consistent with paragraph (2) of subdivision (a) of Section 1312 of the federal act.

SEC. 7. Section 100503 is added to the Government Code, 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 subdivisions (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 subdivisions (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 Personnel Administration 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.

(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 paragraph (3) of subdivision (c) of Section 1312 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.

SEC. 8. Section 100504 is added to the Government Code, to read:

100504. (a) The board may do the following:

(1) With respect to individual coverage made available in the Exchange, collect premiums and assist in the administration of subsidies.

(2) Enter into contracts.

(3) Sue and be sued.

(4) Receive and accept gifts, grants, or donations of moneys from any agency of the United States, any agency of the state, any municipality, county, or other political subdivision of the state.

(5) Receive and accept gifts, grants, or donations from individuals, associations, private foundations, or corporations, in compliance with the conflict of interest provisions to be adopted by the board at a public meeting.

(6) Adopt rules and regulations, as necessary. Until January 1, 2016, any necessary rules and regulations may be adopted as emergency regulations in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2). The adoption of these regulations shall be deemed to be an emergency and

necessary for the immediate preservation of the public peace, health and safety, or general welfare.

(7) Collaborate with the State Department of Health Care Services and the Managed Risk Medical Insurance Board, to the extent possible, to allow an individual the option to remain enrolled with his or her carrier and provider network in the event the individual experiences a loss of eligibility of premium tax credits and becomes eligible for the Medi-Cal program or the Healthy Families Program, or loses eligibility for the Medi-Cal program or the Healthy Families Program and becomes eligible for premium tax credits through the Exchange.

(8) Share information with relevant state departments, consistent with the confidentiality provisions in Section 1411 of the federal act, necessary for the administration of the Exchange.

(9) Require carriers participating in the Exchange to make available to the Exchange and regularly update an electronic directory of contracting health care providers so that individuals seeking coverage through the Exchange can search by health care provider name to determine which health plans in the Exchange include that health care provider in their network. The board may also require a carrier to provide regularly updated information to the Exchange as to whether a health care provider is accepting new patients for a particular health plan. The Exchange may provide an integrated and uniform consumer directory of health care providers indicating which carriers the providers contract with and whether the providers are currently accepting new patients. The Exchange may also establish methods by which health care providers may transmit relevant information directly to the Exchange, rather than through a carrier.

(10) Make available supplemental coverage for enrollees of the Exchange to the extent permitted by the federal act, provided that no General Fund money is used to pay the cost of that coverage. Any supplemental coverage offered in the Exchange shall be subject to the charge imposed under subdivision (n) of Section 100503.

(b) The Exchange shall only collect information from individuals or designees of individuals necessary to administer the Exchange and consistent with the federal act.

(c) The board shall have the authority to standardize products to be offered through the Exchange.

SEC. 9. Section 100505 is added to the Government Code, to read:

100505. The board shall establish and use a competitive process to select participating carriers and any other contractors under this title. Any contract entered into pursuant to this title shall be exempt from Chapter 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, and shall be exempt from the review or approval of any division of the Department of General Services.

SEC. 10. Section 100506 is added to the Government Code, 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. In no event shall the scope of those appeals be construed to be broader than the requirements of the federal act. 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.

SEC. 11. Section 100507 is added to the Government Code, to read:

100507. (a) Notwithstanding any other provision of law, the Exchange shall not be subject to licensure or regulation by the Department of Insurance or the Department of Managed Health Care.

(b) Carriers that contract with the Exchange shall have a license or certificate of authority from, and shall be in good standing with, their respective regulatory agencies.

SEC. 12. Section 100508 is added to the Government Code, to read:

100508. (a) Records of the Exchange that reveal any of the following shall be exempt from disclosure under the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1:

(1) The deliberative processes, discussions, communications, or any other portion of the negotiations with entities contracting or seeking to contract with the Exchange, entities with which the Exchange is considering a contract, or entities with which the Exchange is considering or enters into any other arrangement under which the Exchange provides, receives, or arranges services or reimbursement.

(2) The impressions, opinions, recommendations, meeting minutes, research, work product, theories, or strategy of the board or its staff, or records that provide instructions, advice, or training to employees.

(b) (1) Except for the portion of a contract that contains the rates of payment, contracts entered into pursuant to this title shall be open to inspection one year after their effective dates.

(2) If a contract entered into pursuant to this title is amended, the amendment shall be open to inspection one year after the effective date of the amendment.

SEC. 13. Section 100520 is added to the Government Code, to read:

100520. (a) The California Health Trust Fund is hereby created in the State Treasury for the purpose of this title. Notwithstanding Section 13340, all moneys in the fund shall be continuously appropriated without regard to fiscal year for the purposes of this title. Any moneys in the fund that are

unexpended or unencumbered at the end of a fiscal year may be carried forward to the next succeeding fiscal year.

(b) Notwithstanding any other provision of law, moneys deposited in the fund shall not be loaned to, or borrowed by, any other special fund or the General Fund, or a county general fund or any other county fund.

(c) The board of the California Health Benefit Exchange shall establish and maintain a prudent reserve in the fund.

(d) The board or staff of the Exchange shall not utilize any funds intended for the administrative and operational expenses of the Exchange for staff retreats, promotional giveaways, excessive executive compensation, or promotion of federal or state legislative or regulatory modifications.

(e) Notwithstanding Section 16305.7, all interest earned on the moneys that have been deposited into the fund shall be retained in the fund and used for purposes consistent with the fund.

(f) Effective January 1, 2016, if at the end of any fiscal year, the fund has unencumbered funds in an amount that equals or is more than the board approved operating budget of the Exchange for the next fiscal year, the board shall reduce the charges imposed under subdivision (n) of Section 100503 during the following fiscal year in an amount that will reduce any surplus funds of the Exchange to an amount that is equal to the agency's operating budget for the next fiscal year.

SEC. 14. Section 100521 is added to the Government Code, to read:

100521. (a) The board shall ensure that the establishment, operation, and administrative functions of the Exchange do not exceed the combination of federal funds, private donations, and other non-General Fund moneys available for this purpose. No state General Fund money shall be used for any purpose under this title without a subsequent appropriation. No liability incurred by the Exchange or any of its officers or employees may be satisfied using moneys from the General Fund.

(b) The implementation of the provisions of this title, other than this section, Section 100500, and paragraphs (4) and (5) of subdivision (a) of Section 100504, shall be contingent on a determination by the board that sufficient financial resources exist or will exist in the fund. The determination shall be based on at least the following:

(1) Financial projections identifying that sufficient resources exist or will exist in the fund to implement the Exchange.

(2) A comparison of the projected resources available to support the Exchange and the projected costs of activities required by this title

(3) The financial projections demonstrate the sufficiency of resources for at least the first two years of operation under this title

(c) The board shall provide notice to the Joint Legislative Budget Committee and the Director of Finance that sufficient financial resources exist in the fund to implement this title.

(d) If the board determines that the level of resources in the fund cannot support the actions and responsibilities described in subdivision (a), it shall provide the Department of Finance and the Joint Legislative Budget Committee a detailed report on the changes to the functions, contracts, or

staffing necessary to address the fiscal deficiency along with any contingency plan should it be impossible to operate the Exchange without the use of General Fund moneys.

(e) The board shall assess the impact of the Exchange's operations and policies on other publicly funded health programs administered by the state and the impact of publicly funded health programs administered by the state on the Exchange's operations and policies. This assessment shall include, at a minimum, an analysis of potential cost shifts or cost increases in other programs that may be due to Exchange policies or operations. The assessment shall be completed on at least an annual basis and submitted to the Secretary of Health and Human Services and the Director of Finance.

SEC. 15. Section 1366.6 is added to the Health and Safety Code, to read:

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

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

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

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

(4) "Small employer" has the same meaning as that term is defined in Section 1357.

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

(c) (1) Health care service plans participating in the Exchange that sell any products outside the Exchange shall 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 health care service plans for enrolled Healthy Families beneficiaries or to 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 health care service plans for enrolled Medi-Cal beneficiaries.

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

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

SEC. 16. Section 10112.3 is added to the Insurance Code, to read:

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

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

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

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

(4) "Small employer" has the same meaning as that term is defined in Section 10700.

(b) Health insurers participating in the Exchange shall fairly and affirmatively offer, market, and sell in the Exchange at least one product within each of the five levels of coverage contained in subdivisions (d) and (e) of Section 1302 of the federal act. The board established under Section 100500 of the Government Code may require insurers to sell additional products within each of those levels of coverage. This subdivision shall not apply to an insurer that solely offers supplemental coverage in the Exchange under paragraph (10) of subdivision (a) of Section 100504 of the Government Code.

(c) (1) Health insurers participating in the Exchange that sell any products outside the Exchange shall 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 between the Managed Risk Medical Insurance Board and health insurers for enrolled Healthy Families beneficiaries or to 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 health insurers for enrolled Medi-Cal beneficiaries.

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

(e) Commencing January 1, 2014, a health insurer that does not participate in the Exchange shall, with respect to policies that cover hospital, medical, or surgical expenses, offer at least one standardized product that has been designated by the Exchange in each of the four levels of coverage contained in subdivision (d) of Section 1302 of the federal act. This subdivision shall only apply if the board of the Exchange exercises its authority under subdivision (c) of Section 100504 of the Government Code. Nothing in this subdivision shall require an insurer that does not participate in the Exchange to offer standardized products in the small employer market if the insurer only sells products in the individual market. Nothing in this subdivision shall require an insurer that does not participate in the Exchange to offer standardized products in the individual market if the insurer only sells products in the small employer market. This subdivision shall not be construed to prohibit the insurer from offering other products provided that it complies with subdivision (d).

SEC. 17. The Legislature finds and declares that Section 12 of this act, which adds Section 100508 to the Government Code, imposes a limitation on the public's right of access to the meetings of public bodies or the writings of public officials and agencies within the meaning of Section 3 of Article I of the California Constitution. Pursuant to that constitutional provision, the Legislature makes the following findings to demonstrate the interest protected by this limitation and the need for protecting that interest:

In order to ensure that the California Health Benefit Exchange is not constrained in exercising its fiduciary powers and obligations to negotiate

on behalf of the public as it implements federal health care reform pursuant to the federal Patient Protection and Affordable Care Act (Public Law 111-148), the limitations on the public's right of access imposed by Section 12 of this act are necessary.

SEC. 18. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

SEC. 15. This act shall become operative only if Senate Bill 900 of the 2009–10 Regular Session is also enacted and becomes operative.

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