California Health Benefit Exchange Authorizing Statute

AB 1602 Intent Sections

SEC. 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.

Government Code Title 22, Sections 100500-100521

100500. (a) There is in state government the California Health Benefit Exchange, an independent public entity not affiliated with an agency or department, which shall be known as the Exchange. The Exchange shall be governed by an executive board consisting of five members who are residents of California. Of the members of the board, two shall be appointed by the Governor, one shall be appointed by the Senate Committee on Rules, and one shall be appointed by the Speaker of the Assembly. The Secretary of California Health and Human Services or his or her designee shall serve as a voting, ex officio member of the board.

(b) Members of the board, other than an ex officio member, shall be appointed for a term of four years, except that the initial appointment by the Senate Committee on Rules shall be for a term of five years, and the initial appointment by the Speaker of the Assembly shall be for a term of two years. Appointments by the Governor made after January 2, 2011, shall be subject to confirmation by the Senate. A member of the board may continue to serve until the appointment and qualification of his or her successor. Vacancies shall be filled by appointment for the unexpired term. The board shall elect a chairperson on an annual basis.

(c) (1) Each person appointed to the board shall have demonstrated and acknowledged expertise in at least two of the following areas:

(A) Individual health care coverage.

(B) Small employer health care coverage.

(C) Health benefits plan administration.

(D) Health care finance.

(E) Administering a public or private health care delivery system.

(F) Purchasing health plan coverage.

(2) Appointing authorities shall consider the expertise of the other members of the board and attempt to make appointments so that the board's composition reflects a diversity of expertise.

(d) Each member of the board shall have the responsibility and duty to meet the requirements of this title, the federal act, and all applicable state and federal laws and regulations, to serve the public interest of the individuals and small businesses seeking health care coverage through the Exchange, and to ensure the operational well-being and fiscal solvency of the Exchange.

(e) In making appointments to the board, the appointing authorities shall take into consideration the cultural, ethnic, and geographical diversity of the state so that the board's composition reflects the communities of California.

(f) (1) A member of the board or of the staff of the Exchange shall not be employed by, a consultant to, a member of the board of directors of, affiliated with, or otherwise a representative of, a carrier or other insurer, an agent or broker, a health care provider, or a health care facility or health clinic while serving on the board or on the staff of the Exchange. A member of the board or of the staff of the Exchange shall not be a member, a board member, or an employee of a trade association of carriers, health facilities, health clinics, or health care providers while serving on the board or on the staff of the Exchange. A member of the board or of the staff of the Exchange shall not be a health care provider unless he or she receives no compensation for rendering services as a health care provider and does not have an ownership interest in a professional health care practice.

(2) A board member shall not receive compensation for his or her service on the board but may receive a per diem and reimbursement for travel and other necessary expenses, as provided in Section 103 of the Business and Professions Code, while engaged in the performance of official duties of the board.

(3) For purposes of this subdivision, "health care provider" means a person licensed or certified pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, or licensed pursuant to the Osteopathic Act or the Chiropractic Act.

(g) No member of the board shall make, participate in making, or in any way attempt to use his or her official position to influence the making of any decision that he or she knows or has reason to know will have a reasonably foreseeable material financial effect, distinguishable from its effect on the public generally, on him or her or a member of his or her immediate family, or on either of the following:

(1) Any source of income, other than gifts and other than loans by a commercial lending institution in the regular course of business on terms available to the public without regard to official status aggregating two hundred fifty dollars ($250) or more in

value provided to, received by, or promised to the member within 12 months prior to the time when the decision is made.

(2) Any business entity in which the member is a director, officer, partner, trustee, employee, or holds any position of management.

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

(i) The board shall hire an executive director to organize, administer, and manage the operations of the Exchange. The executive director shall be exempt from civil service and shall serve at the pleasure of the board.

(j) The board shall be subject to the Bagley-Keene Open Meeting Act (Article 9 (commencing with Section 11120) of Chapter 1 of Part 1 of Division 3 of Title 2), except that the board may hold closed sessions when considering matters related to litigation, personnel, contracting, and rates.

(k) (1) The board shall apply for planning and establishment grants made available to the Exchange pursuant to Section 1311 of the federal act. If an executive director has not been hired under subdivision (i) when the United States Secretary of Health and Human Services makes the planning and establishment grants available, the California Health and Human Services Agency shall, upon request of the board, submit the initial application for planning and establishment grants to the United States Secretary of Health and Human Services.

(2) If a majority of the board has not been appointed when the United States Secretary of Health and Human Services makes the planning and establishment grants available, the California Health and Human Services Agency shall submit the initial application for planning and establishment grants to the United States Secretary of Health and Human Services. Any subsequent applications shall be made as described in paragraph (1) once a majority of the members have been appointed to the board.

(3) The board shall be responsible for using the funds awarded by the United States Secretary of Health and Human Services for the planning and establishment of the Exchange, consistent with subdivision (b) of Section 1311 of the federal act.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

Health and Safety Code Sections

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).

1346.2. The director shall, in coordination with the Insurance Commissioner, review the Internet portal developed by the United States Secretary of Health and Human Services under subdivision (a) of Section 1103 of the federal Patient Protection and Affordable Care Act (Public Law 111-148) and paragraph (5) of subdivision (c) of Section 1311 of that act, and any enhancements to that portal expected to be implemented by the secretary on or before January 1, 2015. The review shall examine whether the Internet portal provides sufficient information regarding all health benefit products offered by health care service plans and health insurers in the individual and small employer markets in California to facilitate fair and affirmative marketing of all individual and small employer products, particularly outside the California Health Benefit Exchange created under Title 22 (commencing with Section 100500) of the Government Code. If the director and the Insurance Commissioner jointly determine that the Internet portal does not adequately achieve those purposes, they shall jointly develop and maintain an electronic clearinghouse to achieve those purposes. In performing this function, the director and the Insurance Commissioner shall routinely monitor individual and small employer benefit filings with, and complaints submitted by individuals and small employers to, their respective departments, and shall use any other available means to maintain the clearinghouse.

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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).

10112.4. The commissioner shall, in coordination with the Director of the Department of Managed Health Care, review the Internet portal developed by the United States Secretary of Health and Human Services under subdivision (a) of Section 1103 of the federal Patient Protection and Affordable Care Act (Public Law 111-148) and paragraph (5) of subdivision (c) of Section 1311 of that act, and any enhancements to that portal expected to be implemented by the secretary on or before January 1, 2015. The review shall examine whether the Internet portal provides sufficient information regarding all health benefit products offered by health care service plans and health insurers in the individual and small employer markets in California to facilitate fair and affirmative marketing of all individual and small employer products, particularly outside the Health Benefit Exchange created under Title 22 (commencing with Section 100500) of the Government Code. If the commissioner and the Director of the Department of Managed Health Care jointly determine that the Internet portal does not adequately achieve those purposes, they shall jointly develop and maintain an electronic clearinghouse to achieve those purposes. In performing this function, the commissioner and the Director of the Department of Managed Health Care shall routinely monitor individual and small employer benefit filings with, and complaints submitted by individuals and small employers to, their respective departments, and shall use any other available means to maintain the clearinghouse.