

AMENDED IN SENATE MAY 27, 2014
AMENDED IN SENATE APRIL 29, 2014
AMENDED IN SENATE MARCH 28, 2014

SENATE BILL

No. 1052

Introduced by Senator Torres

February 18, 2014

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

LEGISLATIVE COUNSEL'S DIGEST

SB 1052, as amended, Torres. Health care coverage.

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

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

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

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

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

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

~~This bill would require the board of the Exchange to ensure that its Internet Web site provides a direct link to the formularies for each qualified health plan offered through the Exchange that are posted by *carriers plans and insurers* pursuant to the bill's provisions. The bill would also require the board, *on or before January 1, 2016*, to create a search tool on its Internet Web site that allows potential enrollees to~~

search for qualified health plans by a particular drug and by a particular therapeutic condition.

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

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

Vote: majority. Appropriation: no. Fiscal committee: yes.

State-mandated local program: yes.

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

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

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

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

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

21 ~~(c) Determine the minimum requirements a carrier must meet~~
22 ~~to be considered for participation in the Exchange, and the~~
23 ~~standards and criteria for selecting qualified health plans to be~~
24 ~~offered through the Exchange that are in the best interests of~~
25 ~~qualified individuals and qualified small employers. The board~~
26 ~~shall consistently and uniformly apply these requirements,~~
27 ~~standards, and criteria to all carriers. In the course of selectively~~
28 ~~contracting for health care coverage offered to qualified individuals~~

1 and qualified small employers through the Exchange, the board
2 shall seek to contract with carriers so as to provide health care
3 coverage choices that offer the optimal combination of choice,
4 value, quality, and service.

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

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

17 (f) (1) Except as otherwise provided in this section and Section
18 100504.5, require, as a condition of participation in the Exchange,
19 carriers that sell any products outside the Exchange to do both of
20 the following:

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

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

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

38 (3) Except as required by Section 1301(a)(1)(C)(ii) of the federal
39 act, a carrier offering a bridge plan product in the Exchange may

- 1 limit the products it offers in the Exchange solely to a bridge plan
2 product contract.
- 3 ~~(g) Determine when an enrollee's coverage commences and the
4 extent and scope of coverage.~~
- 5 ~~(h) Provide for the processing of applications and the enrollment
6 and disenrollment of enrollees.~~
- 7 ~~(i) Determine and approve cost-sharing provisions for qualified
8 health plans.~~
- 9 ~~(j) Establish uniform billing and payment policies for qualified
10 health plans offered in the Exchange to ensure consistent
11 enrollment and disenrollment activities for individuals enrolled in
12 the Exchange.~~
- 13 ~~(k) Undertake activities necessary to market and publicize the
14 availability of health care coverage and federal subsidies through
15 the Exchange. The board shall also undertake outreach and
16 enrollment activities that seek to assist enrollees and potential
17 enrollees with enrolling and reenrolling in the Exchange in the
18 least burdensome manner, including populations that may
19 experience barriers to enrollment, such as the disabled and those
20 with limited English language proficiency.~~
- 21 ~~(l) Select and set performance standards and compensation for
22 navigators selected under subdivision (l) of Section 100502.~~
- 23 ~~(m) Employ necessary staff.~~
- 24 ~~(1) The board shall hire a chief fiscal officer, a chief operations
25 officer, a director for the SHOP Exchange, a director of Health
26 Plan Contracting, a chief technology and information officer, a
27 general counsel, and other key executive positions, as determined
28 by the board, who shall be exempt from civil service.~~
- 29 ~~(2) (A) The board shall set the salaries for the exempt positions
30 described in paragraph (1) and subdivision (i) of Section 100500
31 in amounts that are reasonably necessary to attract and retain
32 individuals of superior qualifications. The salaries shall be
33 published by the board in the board's annual budget. The board's
34 annual budget shall be posted on the Internet Web site of the
35 Exchange. To determine the compensation for these positions, the
36 board shall cause to be conducted, through the use of independent
37 outside advisors, salary surveys of both of the following:~~
- 38 ~~(i) Other state and federal health insurance exchanges that are
39 most comparable to the Exchange.~~
- 40 ~~(ii) Other relevant labor pools.~~

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

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

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

13 ~~(n) Assess a charge on the qualified health plans offered by~~
14 ~~carriers that is reasonable and necessary to support the~~
15 ~~development, operations, and prudent cash management of the~~
16 ~~Exchange. This charge shall not affect the requirement under~~
17 ~~Section 1301 of the federal act that carriers charge the same~~
18 ~~premium rate for each qualified health plan whether offered inside~~
19 ~~or outside the Exchange.~~

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

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

28 ~~(q) (1) (A) Annually prepare a written report on the~~
29 ~~implementation and performance of the Exchange functions during~~
30 ~~the preceding fiscal year, including, at a minimum, all of the~~
31 ~~following:~~

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

34 ~~(ii) Data provided by health care service plans and health~~
35 ~~insurers offering bridge plan products regarding the extent of health~~
36 ~~care provider and health facility overlap in their Medi-Cal networks~~
37 ~~as compared to the health care provider and health facility networks~~
38 ~~contracting with the plan or insurer in their bridge plan contracts.~~

39 ~~(iii) The total number of uninsured Californians as a percentage~~
40 ~~of the state population.~~

1 ~~(iv) An evaluation of the effectiveness of the activities~~
2 ~~undertaken pursuant to subdivision (k). This evaluation shall be~~
3 ~~conducted by an independent entity selected by the board.~~

4 ~~(B) The report required by this paragraph shall be transmitted~~
5 ~~to the Legislature and the Governor and shall be made available~~
6 ~~to the public on the Internet Web site of the Exchange. A report~~
7 ~~made to the Legislature pursuant to this paragraph shall be~~
8 ~~submitted pursuant to Section 9795.~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

30 ~~(4) The State Medi-Cal Director.~~

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

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

35 ~~(v) Report, or contract with an independent entity to report, to~~
36 ~~the Legislature by December 1, 2018, on whether to adopt the~~
37 ~~option in Section 1312(c)(3) of the federal act to merge the~~
38 ~~individual and small employer markets. In its report, the board~~
39 ~~shall provide information, based on at least two years of data from~~
40 ~~the Exchange, on the potential impact on rates paid by individuals~~

1 and by small employers in a merged individual and small employer
2 market, as compared to the rates paid by individuals and small
3 employers if a separate individual and small employer market is
4 maintained. A report made pursuant to this subdivision shall be
5 submitted pursuant to Section 9795.

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

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

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

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

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

31 ~~100503. In addition to meeting the minimum requirements of~~
32 ~~Section 1311 of the federal act, the board shall do all of the~~
33 ~~following:~~

34 ~~(a) Determine the criteria and process for eligibility, enrollment,~~
35 ~~and disenrollment of enrollees and potential enrollees in the~~
36 ~~Exchange and coordinate that process with the state and local~~
37 ~~government entities administering other health care coverage~~
38 ~~programs, including the State Department of Health Care Services,~~
39 ~~the Managed Risk Medical Insurance Board, and California~~

1 counties, in order to ensure consistent eligibility and enrollment
2 processes and seamless transitions between coverage.

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

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

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

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

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

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

- 1 ~~(B) Fairly and affirmatively offer, market, and sell all products~~
2 ~~made available to small employers in the Exchange to small~~
3 ~~employers purchasing coverage outside the Exchange.~~
4 ~~(2) For purposes of this subdivision, “product” does not include~~
5 ~~contracts entered into pursuant to Part 6.2 (commencing with~~
6 ~~Section 12693) of Division 2 of the Insurance Code between the~~
7 ~~Managed Risk Medical Insurance Board and carriers for enrolled~~
8 ~~Healthy Families beneficiaries or contracts entered into pursuant~~
9 ~~to Chapter 7 (commencing with Section 14000) of, or Chapter 8~~
10 ~~(commencing with Section 14200) of, Part 3 of Division 9 of the~~
11 ~~Welfare and Institutions Code between the State Department of~~
12 ~~Health Care Services and carriers for enrolled Medi-Cal~~
13 ~~beneficiaries.~~
14 ~~(g) Determine when an enrollee’s coverage commences and the~~
15 ~~extent and scope of coverage.~~
16 ~~(h) Provide for the processing of applications and the enrollment~~
17 ~~and disenrollment of enrollees.~~
18 ~~(i) Determine and approve cost-sharing provisions for qualified~~
19 ~~health plans.~~
20 ~~(j) Establish uniform billing and payment policies for qualified~~
21 ~~health plans offered in the Exchange to ensure consistent~~
22 ~~enrollment and disenrollment activities for individuals enrolled in~~
23 ~~the Exchange.~~
24 ~~(k) Undertake activities necessary to market and publicize the~~
25 ~~availability of health care coverage and federal subsidies through~~
26 ~~the Exchange. The board shall also undertake outreach and~~
27 ~~enrollment activities that seek to assist enrollees and potential~~
28 ~~enrollees with enrolling and reenrolling in the Exchange in the~~
29 ~~least burdensome manner, including populations that may~~
30 ~~experience barriers to enrollment, such as the disabled and those~~
31 ~~with limited English language proficiency.~~
32 ~~(l) Select and set performance standards and compensation for~~
33 ~~navigators selected under subdivision (l) of Section 100502.~~
34 ~~(m) Employ necessary staff.~~
35 ~~(1) The board shall hire a chief fiscal officer, a chief operations~~
36 ~~officer, a director for the SHOP Exchange, a director of Health~~
37 ~~Plan Contracting, a chief technology and information officer, a~~
38 ~~general counsel, and other key executive positions, as determined~~
39 ~~by the board, who shall be exempt from civil service.~~

1 ~~(2) (A) The board shall set the salaries for the exempt positions~~
2 ~~described in paragraph (1) and subdivision (i) of Section 100500~~
3 ~~in amounts that are reasonably necessary to attract and retain~~
4 ~~individuals of superior qualifications. The salaries shall be~~
5 ~~published by the board in the board's annual budget. The board's~~
6 ~~annual budget shall be posted on the Internet Web site of the~~
7 ~~Exchange. To determine the compensation for these positions, the~~
8 ~~board shall cause to be conducted, through the use of independent~~
9 ~~outside advisors, salary surveys of both of the following:~~
10 ~~(i) Other state and federal health insurance exchanges that are~~
11 ~~most comparable to the Exchange.~~
12 ~~(ii) Other relevant labor pools.~~
13 ~~(B) The salaries established by the board under subparagraph~~
14 ~~(A) shall not exceed the highest comparable salary for a position~~
15 ~~of that type, as determined by the surveys conducted pursuant to~~
16 ~~subparagraph (A).~~
17 ~~(C) The Department of Human Resources shall review the~~
18 ~~methodology used in the surveys conducted pursuant to~~
19 ~~subparagraph (A).~~
20 ~~(3) The positions described in paragraph (1) and subdivision (i)~~
21 ~~of Section 100500 shall not be subject to otherwise applicable~~
22 ~~provisions of the Government Code or the Public Contract Code~~
23 ~~and, for those purposes, the Exchange shall not be considered a~~
24 ~~state agency or public entity.~~
25 ~~(n) Assess a charge on the qualified health plans offered by~~
26 ~~carriers that is reasonable and necessary to support the~~
27 ~~development, operations, and prudent cash management of the~~
28 ~~Exchange. This charge shall not affect the requirement under~~
29 ~~Section 1301 of the federal act that carriers charge the same~~
30 ~~premium rate for each qualified health plan whether offered inside~~
31 ~~or outside the Exchange.~~
32 ~~(o) Authorize expenditures, as necessary, from the California~~
33 ~~Health Trust Fund to pay program expenses to administer the~~
34 ~~Exchange.~~
35 ~~(p) Keep an accurate accounting of all activities, receipts, and~~
36 ~~expenditures, and annually submit to the United States Secretary~~
37 ~~of Health and Human Services a report concerning that accounting.~~
38 ~~Commencing January 1, 2016, the board shall conduct an annual~~
39 ~~audit.~~

1 ~~(q) (1) (A) Annually prepare a written report on the~~
2 ~~implementation and performance of the Exchange functions during~~
3 ~~the preceding fiscal year, including, at a minimum, all of the~~
4 ~~following:~~

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

7 ~~(ii) The total number of uninsured Californians as a percentage~~
8 ~~of the state population.~~

9 ~~(iii) An evaluation of the effectiveness of the activities~~
10 ~~undertaken pursuant to subdivision (k). This evaluation shall be~~
11 ~~conducted by an independent entity selected by the board.~~

12 ~~(B) The report required by this paragraph shall be transmitted~~
13 ~~to the Legislature and the Governor and shall be made available~~
14 ~~to the public on the Internet Web site of the Exchange. A report~~
15 ~~made to the Legislature pursuant to this paragraph shall be~~
16 ~~submitted pursuant to Section 9795.~~

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

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

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

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

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

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

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

3 ~~(4) The State Medi-Cal Director.~~

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

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

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

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

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

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

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

38 ~~SEC. 3.~~

39 *SECTION 1.* Section 100503.1 is added to the Government
40 Code, to read:

1 100503.1. (a) The board shall ensure that the Internet Web
2 site maintained under subdivision (c) of Section 100502 provides
3 a direct link to the formulary, or formularies, for each qualified
4 health plan offered through the Exchange that is posted by the
5 carrier pursuant to Section 1367.205 of the Health and Safety Code
6 or Section 10123.192 of the Insurance Code.

7 (b) ~~The~~ *On or before January 1, 2016, the* board shall create a
8 search tool on the Internet Web site maintained under subdivision
9 (c) of Section 100502 that allows potential enrollees to search for
10 qualified health plans by a particular drug and by a particular
11 therapeutic condition.

12 ~~SEC. 4.~~

13 *SEC. 2.* Section 1363.01 of the Health and Safety Code is
14 amended to read:

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

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

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

36 ~~SEC. 5.~~

37 *SEC. 3.* Section 1367.205 is added to the Health and Safety
38 Code, to read:

39 1367.205. (a) In addition to the list required to be provided
40 under Section 1367.20, a health care service plan that provides

1 prescription drug benefits and maintains one or more drug
2 formularies shall do all of the following:

3 (1) Post the formulary or formularies for each product offered
4 by the plan on the plan's Internet Web site in a manner that is
5 accessible and searchable by potential enrollees, enrollees, and
6 providers.

7 (2) Update the formularies posted pursuant to paragraph (1)
8 with any change to those formularies within 24 hours after making
9 the change.

10 (3) Use a standard template to display the formulary or
11 formularies for each product offered by the plan. This template
12 shall do both of the following:

13 (A) Use the United States Pharmacopeia classification system.

14 (B) Organize drugs by therapeutic class, listing drugs
15 alphabetically.

16 (4) Include all of the following on any published formulary for
17 any product offered by the plan, including, but not limited to, the
18 formulary or formularies posted pursuant to paragraph (1) and the
19 list provided pursuant to Section 1367.20:

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

22 (B) The range of cost sharing for a potential enrollee of each
23 specific drug included on the formulary, as follows:

24 (i) Under \$100 – \$.

25 (ii) \$100-\$250 – \$\$.

26 (iii) \$251-\$500 – \$\$\$.

27 (iv) Over \$500 – \$\$\$\$.

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

30 (D) The notification described in subdivision (c) of Section
31 1363.01.

32 (b) The department may develop a standard formulary template
33 provided that the department consults with the Department of
34 Insurance on the template design. If the department develops this
35 template, a health care service plan shall use the template to comply
36 with paragraph (3) of subdivision (a).

37 (c) For purposes of this section, "formulary" means the complete
38 list of drugs preferred for use and eligible for coverage under a
39 health care service plan product and includes the drugs covered

1 under both the pharmacy benefit of the product and the medical
2 benefit of the product.

3 ~~SEC. 6.~~

4 *SEC. 4.* Section 1368.016 of the Health and Safety Code is
5 amended to read:

6 1368.016. (a) A health care service plan that provides coverage
7 for professional mental health services, including a specialized
8 health care service plan that provides coverage for professional
9 mental health services, shall, pursuant to subdivision (f) of Section
10 1368.015, include on its Internet Web site, or provide a link to,
11 the following information:

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

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

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

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

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

28 (6) A detailed description of how an enrollee may request
29 continuity of care pursuant to subdivisions (a) and (b) of Section
30 1373.95.

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

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

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

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

1 (e) Nothing in this article shall preclude a health care service
2 plan from including additional information on its Internet Web
3 site for applicants, enrollees or subscribers, or providers, including,
4 but not limited to, the cost of procedures or services by health care
5 providers in a plan’s network.

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

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

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

25 ~~SEC. 7.~~

26 *SEC. 5.* Section 10123.192 is added to the Insurance Code, to
27 read:

28 10123.192. (a) A health insurer that provides prescription drug
29 benefits and maintains one or more drug formularies shall do all
30 of the following:

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

35 (2) Update the formularies posted pursuant to paragraph (1)
36 with any change to those formularies within 24 hours after making
37 the change.

38 (3) Use a standard template to display the formulary or
39 formularies for each product offered by the insurer. This template
40 shall do both of the following:

1 (A) Use the United States Pharmacopeia classification system.

2 (B) Organize drugs by therapeutic class, listing drugs
3 alphabetically.

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

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

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

11 (i) Under \$100 – \$.

12 (ii) \$100-\$250 – \$\$.

13 (iii) \$251-\$500 – \$\$\$.

14 (iv) Over \$500 – \$\$\$\$.

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

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

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

26 (c) For purposes of this section, “formulary” means the complete
27 list of drugs preferred for use and eligible for coverage under a
28 health insurance product and includes the drugs covered under
29 both the pharmacy benefit of the product and the medical benefit
30 of the product.

31 ~~SEC. 8.~~

32 *SEC. 6.* Section 10123.199 of the Insurance Code is amended
33 to read:

34 10123.199. (a) A health insurer that provides coverage for
35 professional mental health services shall establish an Internet Web
36 site. Each Internet Web site shall include, or provide a link to, the
37 following information:

38 (1) A telephone number that the insured or provider can call,
39 during normal business hours, for assistance obtaining mental
40 health benefits coverage information, including the extent to which

1 benefits have been exhausted, in-network provider access
2 information, and claims processing information.

3 (2) A link to prescription drug formularies posted pursuant to
4 Section 10123.192, or instructions on how to obtain formulary
5 information.

6 (3) A detailed summary description of the process by which the
7 insurer reviews and approves, modifies, or denies requests for
8 health care services as described in Section 10123.135.

9 (4) Lists of providers or instructions on how to obtain a provider
10 list as required by Section 10133.1.

11 (5) A detailed summary of the health insurer's grievance process.

12 (6) A detailed description of how the insured may request
13 continuity of care as described in Section 10133.55.

14 (7) Information concerning the right, and applicable procedure,
15 of the insured to request an independent medical review pursuant
16 to Section 10169.

17 (b) Except as otherwise specified, the material described in
18 subdivision (a) shall be updated at least quarterly.

19 (c) The information described in subdivision (a) may be made
20 available through a secured Internet Web site that is only accessible
21 to the insured.

22 (d) The material described in subdivision (a) shall also be made
23 available to insureds in hard copy upon request.

24 (e) Nothing in this article shall preclude an insurer from
25 including additional information on its Internet Web site for
26 applicants or insureds, including, but not limited to, the cost of
27 procedures or services by health care providers in an insurer's
28 network.

29 (f) The department shall include on the department's Internet
30 Web site, a link to the Internet Web site of each health insurer
31 described in subdivision (a).

32 (g) This section shall not apply to Medicare supplement
33 insurance, Employee Assistance Programs, short-term limited
34 duration health insurance, Champus-supplement insurance, or
35 TRI-CARE supplement insurance, or to hospital indemnity,
36 accident-only, and specified disease insurance. This section shall
37 also not apply to specialized health insurance policies, except
38 behavioral health-only policies.

39 (h) This section shall not apply to a health insurer that contracts
40 with a specialized health care service plan, insurer, or other entity

1 to cover professional mental health services for its insureds,
2 provided that the health insurer provides a link on its Internet Web
3 site to an Internet Web site operated by the specialized health care
4 service plan, insurer, or other entity with which it contracts, and
5 that plan, insurer, or other entity complies with this section or
6 Section 1368.016 of the Health and Safety Code.

7 ~~SEC. 9.~~

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

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