



Establishing the California Health Benefits Exchange AB 1602 (J. Pérez) and SB 900 (Alquist)

Summary

AB 1602 establishes the duties and operations of the California Health Benefits Exchange where eligible individuals and small businesses can claim their federal premium, cost sharing subsidies and tax credits. SB 900 establishes the Exchange and the governing board for the Exchange.

Purpose of the Exchange

AB 1602 establishes the California Health Benefit Exchange, a more organized and competitive insurance marketplace where individuals and small businesses can:

- Choose amongst qualifying health plans operating under common rules related to pricing and coverage standards;
- Better understand coverage choices and plan performance by requiring information to be presented in a consumer friendly format with standardized explanations of benefits, costs, and customer satisfaction.
- Claim their premium and cost sharing subsidies. The Exchange will be the sole place where eligible individuals and small businesses can receive their federal tax credits or subsidies.

Exchange Governing Board

SB 900 establishes the California Health Benefit Exchange as an independent state entity governed by a five member board. The board will consist of two of gubernatorial appointees, one appointee of the Senate Rules Committee, one appointee of the Speaker of the Assembly and an ex-officio member, the Secretary of Health and Human Services. The five members must be residents of California and have demonstrated expertise in at least two of the following areas:

- Individual health care coverage
- Small employer health care coverage
- Health benefits plan administration
- Health care finance
- Administering a public or private health care delivery system
- Purchasing health plan coverage

Members are subject to strict conflict of interest guidelines. No individual who is a representative of, or employed by, in any capacity, an insurance carrier, agent

or broker, health care provider, health care facility or clinic, can serve as an Exchange board or staff member. All are also subject to the existing one year ban on any contact with the Exchange board and its staff upon leaving their capacity as a board or staff member.

The Exchange is subject to the Bagley-Keene Open Meeting Act (so all meetings will be open to the public with a statutorily required notice), with some limited ability to enter into closed session on contracting/rate setting matters, similar to the authority provided to the Managed Risk Medical Insurance Board. However, AB 1602 specifies that the contracts and their provisions, other than the actual rates, are open to the public one year after their effective date for inspection.

Board members will receive no salary.

Exchange Operations

AB 1602 codifies into state law the federal requirements pertaining to state exchanges, including:

- Establishing and maintaining an Internet web site where people can obtain standardized, easily comparable information about health plans available through the Exchange, as well as any and all cost sharing required.
- Certifying health plans as eligible for participation in the exchange as “qualifying health plans”.
- Informing individuals of the eligibility requirements for Medi-Cal, Healthy Families and other applicable state or local programs and screening and enrolling them if they are eligible.
- Calculating eligibility for premium tax credits, cost sharing subsidies and exemption from the individual mandate.
- Establishing the navigator program to assist potential enrollees in choosing coverage through the Exchange.

In addition to the general requirements of the federal law, AB 1602 provides for the following:

- Keeps the individual and small group insurance markets separate (the federal law allows for the two markets to be merged, at state option), and establishes the Small Business Health Options Program (SHOP) where small businesses can enroll their employees in qualified health plans and claim their federal tax credits.
- Requires the Exchange to establish its eligibility and enrollment processes consistent with federal law, and to coordinate those processes with existing health care coverage programs, such as Medi-Cal and Healthy Families to ensure consistency and seamless transitions between coverage. (For example, parents of Healthy Families kids will likely be eligible for coverage in the Exchange, while their children maintain their

- coverage in Healthy Families so the Exchange will need to coordinate coverage and enrollment between the parents and the kids.)
- Authorizes the Exchange to selectively contract with carriers that provide the optimal combination of choice, value, quality and service to the individuals and small businesses participating in the Exchange. This is what all large employers and purchasers currently do – negotiate for plans offering the best value, service and quality to its members.
 - Authorizes the Exchange to make health plans being offered in the Exchange more understandable and comparable in terms of cost sharing and benefit structure to the public by permitting standardization of the plans being offered.
 - Protects the Exchange from adverse selection concerns by:
 - Requiring carriers that wish to participate in the Exchange to sell all five levels of coverage both inside the Exchange and outside of the Exchange.
 - Prohibiting carriers that do not participate in the Exchange from selling catastrophic only policies
 - Requires carriers not participating in the Exchange to sell at least one standardized plan in each of the four precious metal coverage levels if the Exchange chooses to standardize plans being offered in the Exchange. Nothing in this provision limits the ability of the plan to sell any and all other products it wishes to sell that meet the minimum federal requirements or imposes any obligation on health plans that do not participate in the individual or small group markets to offer in those respective markets.
 - Authorizes the board to require health insurers to keep updated electronic directories of the health care providers with whom they contract and whether they are accepting new patients. This will allow individuals enrolling in the Exchange to determine which health plans include their provider in their network.

General Fund Protections

- Prior to commencing operations, the Board must make a determination that sufficient financial resources exist or will exist in the fund, and provide this to the Department of Finance and the Joint Legislative Budget Committee.
- In addition to the stringent federal reporting and auditing requirements in the federal law, the Exchange is subject to an independent annual audit.
- Must approve its budget in public, include the salaries of the executive staff in the budget, and post all of this on its website.
- The Exchange is required to report to the Legislature and the Governor annually on its expenses, performance, operations and progress in

meeting the federal requirements. This report must also be posted on the Exchange website and made available to the public.

- Requires the Exchange Board to 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. Prohibits state General Fund (GF) money from being used for any purpose under this bill without a subsequent appropriation.
- Prohibits any liability incurred by the Exchange or any of its officers or employees from being satisfied using moneys from the GF.
- The independent, non-partisan Legislative Analyst has determined that there is no General Fund liability in establishing the Exchange.