AMENDED IN SENATE APRIL 28, 2015

AMENDED IN SENATE APRIL 6, 2015

SENATE BILL No. 4

Introduced by Senator Lara
(Principal coauthor: Assembly Member Bonta)
(Coauthors: Senators *Hall,* Hancock, *Hernandez, Hill,* Hueso, Mitchell, Monning, ~~and Pan~~ *Pan, and Wolk*)
(~~Coauthor:~~ *Coauthors:* Assembly ~~Member Levine~~ *Members Alejo, Levine, Lopez, and Thurmond*)

December 1, 2014

An act to add and repeal Section 100522 of, and to add and repeal Title 22.5 (commencing with Section 100530) of, the Government Code, to add and repeal Section 1366.7 of the Health and Safety Code, to add and repeal Section 10112.31 of the Insurance Code, and to add Sections 14102.1 and 14102.2 to the Welfare and Institutions Code, relating to health care coverage, and making an appropriation therefor.

LEGISLATIVE COUNSEL'S DIGEST

SB 4, as amended, Lara. Health care coverage: immigration status.

Existing law, the federal Patient Protection and Affordable Care Act (PPACA), requires each state to establish an American Health Benefit Exchange that facilitates the purchase of qualified health plans by qualified individuals and qualified small employers, and meets certain other requirements. PPACA specifies that an individual who is not a citizen or national of the United States or an alien lawfully present in the United States shall not be treated as a qualified individual and may not be covered under a qualified health plan offered through an exchange. Existing law creates the California Health Benefit Exchange for the purpose of facilitating the enrollment of qualified individual and

qualified small employers in qualified health plans as required under PPACA.

Existing law governs health care service plans and insurers. A willful violation of the provisions governing health care service plans is a crime.

This bill would require the Secretary of California Health and Human Services to apply to the United States Department of Health and Human Services for a waiver to allow individuals who are not eligible to obtain health coverage because of their immigration status to obtain coverage from the California Health Benefit Exchange. The bill would require the California Health Benefit Exchange to offer qualified health benefit plans, as specified, to these individuals. The bill would require that individuals eligible to purchase California qualified health plans pay the cost of coverage without federal assistance. These requirements would become operative when federal approval of the waiver is granted. If federal approval is not granted on or before January 1, 2017, the bill would create the California Health Exchange Program ~~for all~~ *For All* Californians within state government.

The bill would require that the California Health Exchange Program ~~for~~ *For* All Californians (Program) be governed by the executive board that governs the California Health Benefit Exchange. The bill would specify the duties of the board relative to the ~~Program~~ *program* and would require the board to, by a specified date, facilitate the enrollment into qualified health plans of individuals who are not eligible for full-scope Medi-Cal coverage and would have been eligible to purchase coverage through the Exchange but for their immigration status. ~~The bill would require the board to provide premium subsidies and cost-sharing reductions to eligible individuals that are the same as the premium assistance and cost-sharing reductions the individuals would have received through the Exchange.~~ The bill would create the California Health Trust Fund For All Californians as a continuously appropriated fund, thereby making an appropriation, would require the board to assess a charge on qualified health plans, and would make the implementation of the ~~Program's~~ *program's* provisions contingent on a determination by the board that sufficient financial resources exist or will exist in the fund. The bill would enact other related provisions.

The bill would require health care ~~services~~ *service* plans and health insurers to fairly and affirmatively offer, market, and sell in the ~~Program~~ *program* at least one product within each of the 5 levels of coverage, as specified. Because a violation of the requirements imposed on health

care service plans would be a crime, the bill would impose a state-mandated local program.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid Program provisions. The federal Medicaid Program provisions prohibit payment to a state for medical assistance furnished to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law.

This bill would extend eligibility for full-scope Medi-Cal benefits to individuals who are otherwise eligible for those benefits but for their immigration status. The bill would require these individuals to enroll into Medi-Cal managed care health plans, and to pay copayments and premium contributions, to the extent required of otherwise eligible Medi-Cal recipients who are similarly situated. The bill would require that benefits for those services be provided with state-only funds only if federal financial participation is not available. Because counties are required to make Medi-Cal eligibility determinations and this bill would expand Medi-Cal eligibility, the bill would impose a state-mandated local program.

The bill would require the State Department of Health Care Services to develop a transition plan for individuals who are enrolled in restricted-scope Medi-Cal as of a specified date, and who are otherwise eligible for full-scope Medi-Cal coverage but for their immigration status, to transition directly to full-scope Medi-Cal coverage. The bill would require the department to notify these individuals, as specified.

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 with regard to certain mandates no reimbursement is required by this act for a specified reason.

With regard to any other mandates, this bill would provide that, if the Commission on State Mandates determines that the bill contains costs so mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.

Vote: majority. Appropriation: yes. Fiscal committee: yes. State-mandated local program: yes.

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

SECTION 1. (a) (1) The Legislature finds and declares that longstanding California law provides full-scope Medi-Cal to United States citizens, lawful permanent residents, and individuals permanently residing in the United States under color of law, including those granted deferred action.

(2) It is the intent of the Legislature in enacting this act to extend full-scope Medi-Cal eligibility to California residents who are currently ineligible for Medi-Cal due to their immigration status, as long as they meet the other requirements of the Medi-Cal program.

(b) It is the intent of the Legislature that all Californians, regardless of immigration status, have access to health coverage and care.

(c) It is the intent of the Legislature that all Californians who are otherwise eligible for Medi-Cal, a qualified health plan offered through the California Health ~~Benefits~~ *Benefit* Exchange, or affordable employer-based health coverage, enroll in that coverage and obtain the care that they need.

(d) It is further the intent of the Legislature to ensure that all Californians be included in eligibility for coverage without regard to immigration status.

SEC. 2. Section 100522 is added to the Government Code, to read:

100522. (a) The Secretary of California Health and Human Services shall apply to the United States Department of Health and Human Services for a waiver authorized under Section 1332 of the federal act as defined in subdivision (e) of Section 100501 in order to allow persons otherwise not able to obtain coverage by reason of immigration status through the Exchange to obtain coverage from the Exchange by waiving the requirement that the Exchange offer only qualified health plans.

(b) The Exchange shall offer qualified health benefit plans which shall be subject to the requirements of this title, including all of those requirements applicable to qualified health plans. In addition, California qualified health plans shall be subject to the requirements of Section 1366.6 of the Health and Safety Code and Section 10112.3 of the Insurance Code in the same manner as qualified health plans.

(c) Persons eligible to purchase California qualified health plans shall pay the cost of coverage without federal advanced premium tax credit, federal cost-sharing reduction, or any other federal assistance.

(d) Subdivisions (b) and (c) of this section shall become operative upon federal approval of the waiver pursuant to subdivision (a). If subdivisions (b) and (c) of this section do not become operative on or before January 1, 2017, Title 22.5 (commencing with Section 100530) shall become operative, and as of that date, this section is repealed, unless a later enacted statute, that is enacted before January 1, 2017, deletes or extends that date.

(e) For purposes of this section, a "California qualified health plan" means a product offered to those not otherwise eligible to purchase coverage from the Exchange by reason of immigration and that comply with each of the requirements of state law and the Exchange for a qualified health plan.

SEC. 3. Title 22.5 (commencing with Section 100530) is added to the Government Code, to read:

TITLE 22.5. CALIFORNIA HEALTH EXCHANGE PROGRAM FOR ALL CALIFORNIANS

100530. (a) There is in state government the California Health Exchange Program For All Californians, an independent public entity not affiliated with an agency or department.

(b) The program shall be governed by the executive board established pursuant to Section 100500. The board shall be subject to Section 100500.

(c) It is the intent of the Legislature in enacting the program to provide coverage for Californians who would be eligible ~~for coverage and premium subsidies under~~ *to enroll in* the California Health Benefit Exchange established under Title 22 (commencing with Section 100500) but for their immigration status.

(d) This title shall become operative only if federal approval of the waiver described in subdivision (a) of Section 100522 is not granted on or before January 1, 2017. If this title does not become operative by January 1, 2017, as of that date, this title is repealed, unless a later enacted statute, that is enacted before January 1, 2017, deletes or extends that date.

100531. For purposes of this title, the following definitions shall apply:

(a) "Board" means the executive board described in subdivision (b) of Section 100530.

(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) "Eligible individual" means an individual who would have been eligible to purchase coverage through the Exchange but for his or her immigration status and who is not eligible for full-scope Medi-Cal coverage under state law.

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

(e) "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.

(f) "Fund" means the California Health Trust Fund For All Californians established by Section 100540.

(g) "Health plan" and "qualified health plan" ~~have the same meanings as those terms are defined in Section 1301 of the federal act.~~ *shall be identical to "health plan" and "qualified health plan" as defined in Title 22 (commencing with Section 100500).*

(h) "Medi-Cal coverage" means coverage under the Medi-Cal program pursuant to Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code.

(i) "Product" means one of the following:

(1) A health care service plan contract subject to Article 11.8 (commencing with Section 1399.845) of Chapter 2.2 of Division 2 of the Health and Safety Code.

(2) An individual policy of health insurance as defined in Section 106 of the Insurance Code, subject to Chapter 9.9 (commencing with Section 10965) of Part 2 of Division 2 of the Insurance Code.

(j) "Program" means the California Health Exchange Program For All Californians.

(k) "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.

100532. The board shall, at a minimum, do all of the following:

(a) Enroll individuals into coverage who would be eligible to enroll in the Exchange but for immigration status.

(b) Implement procedures for the certification, recertification, and decertification, 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 before implementation of the increase consistent with Article 6.2 (commencing with Section 1385.01) of Chapter 2.2 of Division 2 of the Health and Safety Code and Article 4.5 (commencing with Section 10181) of Chapter 1 of Part 2 of Division 2 of the Insurance Code.

(2) (A) Make available to the public and submit to the board 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 state law.

(B) The information required under subparagraph (A) shall be provided in plain language.

(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.

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

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

(e) Assign a rating to each qualified health plan offered through the program in accordance with the criteria developed by the board.

(f) Utilize a standardized format for presenting health benefits plan options in the program.

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

(h) Establish and make available by electronic means a calculator to determine the actual cost of coverage.

(i) Establish a navigator program. Any entity chosen by the board as a navigator under this subdivision shall do all of the following:

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

(2) Distribute fair and impartial information concerning enrollment in qualified health ~~plans, and the availability of premium subsidies and cost-sharing reductions through the program~~ *plans*.

(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 (42 U.S.C. Sec. 300gg-93), 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 program.

100533. In addition to meeting the requirements of Section 100532, 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

program and coordinate that process with the state and local government entities administering other health care coverage programs, including the Exchange, the State Department of Health Care Services, 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.

(c) Determine the minimum requirements a carrier must meet to be considered for participation in the program, and the standards and criteria for selecting qualified health plans to be offered through the program that are in the best interests of qualified individuals. 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 through the program, 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 Section 1302(d) and (e) of the federal act.

(e) Require, as a condition of participation in the program, carriers to fairly and affirmatively offer, market, and sell in the program at least one product within each of the five levels of coverage contained in Section 1302(d) and (e) 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 program under paragraph (10) of subdivision (a) of Section 100534.

(f) (1) Except as otherwise provided in this section, require, as a condition of participation in the program, carriers that sell any products outside the program to fairly and affirmatively offer, market, and sell all products made available to individuals in the program to individuals purchasing coverage outside the program.

(2) For purposes of this subdivision, "product" does not include contracts entered into pursuant to Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code between the State Department of Health Care Services and carriers

for enrolled Medi-Cal beneficiaries. ~~"Product" also does not include a bridge plan product offered pursuant to Section 100504.5.~~

(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 program to ensure consistent enrollment and disenrollment activities for individuals enrolled in the program.

(k) Undertake activities necessary to market and publicize the availability of health care coverage ~~and subsidies~~ through the program. The board shall also undertake outreach and enrollment activities that seek to assist enrollees and potential enrollees with enrolling and reenrolling in the program 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 (j) of Section 100532.

(m) Employ necessary staff. The board shall employ staff consistent with the applicable requirements imposed under subdivision (m) of Section 100503.

(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 program.

(o) Authorize expenditures, as necessary, from the fund to pay program expenses to administer the program.

(p) Keep an accurate accounting of all activities, receipts, and expenditures. Commencing January 1, 2017, the board shall conduct an annual audit.

(q) (1) Notwithstanding Section 10231.5, annually prepare a written report on the implementation and performance of the program functions during the preceding fiscal year, including, at a minimum, the manner in which funds were expended and the progress toward, and the achievement of, the requirements of this title. ~~The report shall also include data provided by health care service plans and health insurers offering bridge plan products~~

~~regarding the extent of health care provider and health facility overlap in their Medi-Cal networks as compared to the health care provider and health facility networks contracting with the plan or insurer in their bridge plan contracts.~~ This report shall be transmitted to the Legislature and the Governor and shall be made available to the public on the Internet Web site of the program. 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 program, are necessary state requirements and are distinct from the promotion of legislative or regulatory modifications referred to in subdivision (c) of Section 100540.

(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 title.

(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) The executive director of the Exchange.

(4) The State Medi-Cal Director.

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

(u) Facilitate the purchase of qualified health plans in the program by qualified individuals no later than January 1, 2016.

(v) Require carriers participating in the program to immediately notify the program, 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.

(w) Ensure that the program provides oral interpretation services in any language for individuals seeking coverage through the program 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 program is presented in a plainly worded, easily understandable format and made available in prevalent languages.

100534. (a) The board may do the following:

(1) Collect premiums.

(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, or 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, 2018, 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 Exchange and the State Department of Health Care Services, 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 for enrollment in a qualified health plan under this title and becomes eligible for the Exchange or the Medi-Cal program, or loses eligibility for the Medi-Cal program and becomes eligible for a qualified health plan through the program.

(8) Share information with relevant state departments, consistent with the applicable laws governing confidentiality, necessary for the administration of the program.

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

(10) Make available supplemental coverage for enrollees of the program to the extent permitted by available funding. Any supplemental coverage offered in the program shall be subject to the charge imposed under subdivision (n) of Section 100533.

~~(11) Make available premium subsidies and cost-sharing reductions to the extent funding is available.~~

(b) (1) An applicant for health care coverage shall be required to provide only the information strictly necessary to authenticate identity, determine eligibility, and determine the amount of the credit or reduction.

(2) Any person who receives information provided by an applicant pursuant to paragraph (1), whether directly or by another person at the request of the applicant, or otherwise obtains information about the applicant through the program process shall do both of the following:

(A) Use the information only for the purposes of, and to the extent necessary in, ensuring the efficient operation of the program, including verifying the eligibility of an individual to enroll through the program.

(B) Not disclose the information to any other person except as provided in this section.

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

100535. 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 1 (commencing with Section 10100) of Part 2 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.

100536. (a) The board shall establish an appeals process for prospective and current enrollees of the program.

(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.

100537. (a) Notwithstanding any other law, the program 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 program shall have a license or certificate of authority from, and shall be in good standing with, their respective regulatory agencies.

100538. (a) Records of the program that reveal the deliberative processes, discussions, communications, or any other portion of the negotiations with entities contracting or seeking to contract with the program, entities with which the program is considering a contract, or entities with which the program is considering or enters into any other arrangement under which the program provides, receives, or arranges services or reimbursement shall be exempt from disclosure under the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1).

(b) The following records of the program shall be exempt from disclosure under the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1) as follows:

(1) (A) Except for the portion of a contract that contains the rates of payments, contracts with participating carriers entered into pursuant to this title on or after the date the act that added this subparagraph becomes effective, shall be open to inspection one year after the effective dates of the contracts.

(B) If contracts with participating carriers entered into pursuant to this title are amended, the amendments shall be open to inspection one year after the effective date of the amendments.

(c) Three years after a contract or amendment is open to inspection pursuant to subdivision (b), the portion of the contract or amendment containing the rates of payment shall be open to inspection.

(d) Notwithstanding any other law, entire contracts with participating carriers or amendments to contracts with participating carriers shall be open to inspection by the Joint Legislative Audit Committee. The committee shall maintain the confidentiality of the contracts and amendments until the contracts or amendments to a contract are open to inspection pursuant to subdivisions (b) and (c).

100539. (a) No individual or entity shall hold himself, herself, or itself out as representing, constituting, or otherwise providing services on behalf of the program unless that individual or entity has a valid agreement with the program to engage in those activities.

(b) Any individual or entity who aids or abets another individual or entity in violation of this section shall also be in violation of this section.

100540. (a) The California Health Trust Fund For All Californians 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) The board of the program shall establish and maintain a prudent reserve in the fund.

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

(d) 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.

(e) Effective January 1, 2018, 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 program for the next fiscal year, the board shall reduce the charges imposed under subdivision (n) of Section 100533 during the following fiscal year in an amount that will reduce any surplus funds of the program to an amount that is equal to the agency's operating budget for the next fiscal year.

100541. (a) The board shall ensure that the establishment, operation, and administrative functions of the program do not exceed the combination of state funds, private donations, and other non-General Fund moneys available for this purpose.

(b) The implementation of the provisions of this title, other than this section, Section 100530, and paragraphs (4) and (5) of subdivision (a) of Section 100534, 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 program.~~

~~(2) A comparison of the projected resources available to support the program 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)~~

(c) 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 program without the use of General Fund moneys.

~~(e)~~

(d) The board shall assess the impact of the program'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 program'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 program policies or operations. The assessment shall be completed on at least an annual basis and submitted to the Secretary of California Health and Human Services and the Director of Finance.

SEC. 4. Section 1366.7 is added to the Health and Safety Code, to read:

1366.7. (a) For purposes of this section, the following definitions shall apply:

(1) "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.

(2) "Health plan" has the same meaning as that term is defined in subdivision (g) of Section 100530 of the Government Code.

(3) "Program" means the California Health Exchange Program For All Californians established in Title 22.5 (commencing with Section 100530) of the Government Code.

(b) Health care service plans participating in the program shall fairly and affirmatively offer, market, and sell in the program at least one product within each of the five levels of coverage contained in Section 1302(d) and (e) of the federal act. The executive board established under Section 100530 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 program under paragraph (10) of subdivision (a) of Section 100534 of the Government Code.

(c) (1) Health care service plans participating in the program that sell any products outside the program shall fairly and affirmatively offer, market, and sell all products made available to individuals in the program to individuals purchasing coverage outside the program.

(2) For purposes of this subdivision, "product" does not include contracts entered into pursuant to 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, 2015, 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 Section 1302(d) and (e) of the federal act, except that a health care service plan that does not participate in the program shall, with respect to plan contracts that cover hospital, medical, or surgical benefits, only sell the four levels of coverage contained in Section 1302(d) of the federal act.

(e) Commencing January 1, 2015, a health care service plan that does not participate in the program 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 program in each of the four levels of coverage contained in Section 1302(d) of the federal act. This subdivision shall only apply if the executive board of the program exercises its authority under subdivision (c) of Section 100534 of the Government Code. Nothing in this subdivision shall require a plan that does not participate in the program 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 program 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).

(f) A health care service plan participating in the program shall charge the same rate for the same product whether that product is offered through the program or in the outside market notwithstanding any charge imposed by the program pursuant to subdivision (n) of Section 100533 of the Government Code.

(g) This section shall become operative only if Title 22.5 (commencing with Section 100530) of the Government Code becomes operative on or before January 1, 2017. If this section does not become operative by January 1, 2017, as of that date, this

section is repealed, unless a later enacted statute, that is enacted before January 1, 2017, deletes or extends that date.

SEC. 5. Section 10112.31 is added to the Insurance Code, to read:

10112.31. (a) For purposes of this section, the following definitions shall apply:

(1) "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.

(2) "Health plan" has the same meaning as that term is defined in subdivision (g) of Section 100530 of the Government Code.

(3) "Program" means the California Health Exchange Program For All Californians established in Title 22.5 (commencing with Section 100530) of the Government Code.

(b) Health insurers participating in the program shall fairly and affirmatively offer, market, and sell in the program at least one product within each of the five levels of coverage contained in Section 1302(d) and (e) of the federal act. The executive board established under Section 100530 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 program under paragraph (10) of subdivision (a) of Section 100534 of the Government Code.

(c) (1) Health insurers participating in the program that sell any products outside the program shall fairly and affirmatively offer, market, and sell all products made available to individuals in the program to individuals purchasing coverage outside the program.

(2) For purposes of this subdivision, "product" does not include contracts entered into pursuant to 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, 2015, an insurer shall, with respect to policies that cover hospital, medical, or surgical benefits, only sell the five levels of coverage contained in Section 1302(d) and (e) of the federal act, except that an insurer that does not participate in the program shall, with respect to policies that cover hospital,

medical, or surgical benefits, only sell the four levels of coverage contained in Section 1302(d) of the federal act.

(e) Commencing January 1, 2015, an insurer that does not participate in the program shall, with respect to policies that cover hospital, medical, or surgical benefits, offer at least one standardized product that has been designated by the program in each of the four levels of coverage contained in Section 1302(d) of the federal act. This subdivision shall only apply if the board of the program exercises its authority under subdivision (c) of Section 100534 of the Government Code. Nothing in this subdivision shall require an insurer that does not participate in the program 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 program 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).

(f) An insurer participating in the program shall charge the same rate for the same product whether that product is offered through the program or in the outside market notwithstanding any charge imposed by the program pursuant to subdivision (n) of Section 100533 of the Government Code.

(g) This section shall become operative only if Title 22.5 (commencing with Section 100530) of the Government Code becomes operative on or before January 1, 2017. If this section does not become operative by January 1, 2017, as of that date, this section is repealed, unless a later enacted statute, that is enacted before January 1, 2017, deletes or extends that date.

SEC. 6. Section 14102.1 is added to the Welfare and Institutions Code, to read:

14102.1. (a) Notwithstanding any other law, individuals who meet all of the eligibility requirements for full-scope Medi-Cal benefits under this chapter, but for their immigration status, shall be eligible for full-scope Medi-Cal benefits.

(b) This section shall not apply to individuals eligible for coverage pursuant to Section 14102.

(c) Individuals who are eligible under subdivision (a) shall be required to enroll into Medi-Cal managed care health plans to the

extent required of otherwise eligible Medi-Cal recipients who are similarly situated.

(d) Individuals who are eligible under subdivision (a) shall pay copayments and premium contributions to the extent required of otherwise eligible Medi-Cal recipients who are similarly situated.

(e) Benefits for services under this section shall be provided with state-only funds only if federal financial participation is not available for those services. The department shall maximize federal financial participation in implementing this section to the extent allowable.

(f) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department, without taking any further regulatory action, shall implement, interpret, or make specific this section by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions until the time regulations are adopted. The department shall adopt regulations by July 1, 2018, in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. Commencing July 1, 2016, and notwithstanding Section 10231.5 of the Government Code, the department shall provide a status report to the Legislature on a semiannual basis, in compliance with Section 9795 of the Government Code, until regulations have been adopted *pursuant to Section 14102.2*.

SEC. 7. Section 14102.2 is added to the Welfare and Institutions Code, to read:

14102.2. (a) (1) Except as provided in subdivision (c), individuals who are enrolled in restricted scope Medi-Cal as of December 31, 2015, who are eligible under Section 14102.1 shall be transitioned directly to full-scope coverage under the Medi-Cal program in accordance with the requirements of this section. The department shall develop a transition plan for those currently enrolled in restricted scope Medi-Cal.

(2) For purposes of this section, an "emergency care provider" is defined as a hospital in the county of his or her residence where the individual received emergency care, if any.

(b) Except as provided in subdivision (c), with respect to managed care health plan enrollment, a restricted-scope enrollee who applies and is determined eligible before October 1, 2015, shall be notified by the department at least 60 days before January

1, 2016, in accordance with the department's transition plan of all of the following:

(1) Which Medi-Cal managed care health plan or plans contain his or her existing emergency care provider, if the department has this information and the emergency care provider is contracted with a Medi-Cal managed care health plan.

(2) That the restricted scope enrollee, subject to his or her ability to change as described in paragraph (3), will be assigned to a health plan that includes his or her emergency care provider and enrolled effective January 1, 2014. If the enrollee wants to keep his or her emergency care provider, no additional action shall be required if the emergency care provider is contracted with a Medi-Cal managed care health plan.

(3) That the restricted scope enrollee may choose any available Medi-Cal managed care health plan and primary care provider in his or her county of residence before January 1, 2016, if more than one such plan is available in the county where he or she resides, and he or she will receive all provider and health plan information required to be sent to new enrollees and instructions on how to choose or change his or her health plan and primary care provider.

(4) That in counties with more than one Medi-Cal managed care health plan, if the restricted scope enrollee does not affirmatively choose a plan within 30 days of receipt of the notice, he or she shall be enrolled into the Medi-Cal managed care health plan that contains his or her emergency care provider as part of the Medi-Cal managed care contracted network, if the department has this information about the emergency care provider, and the emergency care provider is contracted with a Medi-Cal managed care health plan. If the emergency care provider is contracted with more than one Medi-Cal managed care health plan, then the restricted scope enrollee shall be assigned to one of the health plans containing his or her emergency care provider in accordance with an assignment process established to ensure the linkage.

(5) That the enrollee subject to this section shall receive all provider and health plan information required to be sent to new enrollees. If the restricted scope enrollee is not assigned to two *Medi-Cal managed care health plans* pursuant to paragraph (2), and does not affirmatively select one of the available Medi-Cal managed care health plans within 30 days of receipt of the notice,

he or she shall automatically be assigned a plan through the department-prescribed auto-assignment process.

(6) That the restricted scope enrollee does not need to take any action to be transitioned to full-scope Medi-Cal or to retain his or her emergency care provider, if the emergency care provider is available pursuant to paragraph (2).

(7) That the restricted scope enrollee may choose not to transition to the full-scope Medi-Cal program, and what this choice will mean for his or her health care coverage and access to health care services.

(c) Individuals who qualify under subdivision (a) and who apply and are determined eligible for restricted scope after the date identified by the department, that is not later than October 1, 2015, shall be considered late enrollees. Late enrollees shall be notified in accordance with subdivision (b), except according to a different timeframe, but will transition to full-scope Medi-Cal coverage on January 1, 2016. Late enrollees after the date identified in this subdivision shall be transitioned pursuant to the department's restricted scope transition plan process.

(d) Emergency care providers that receive reimbursement for restricted scope coverage shall work with the department and its designees during the 2015 and 2016 calendar years to facilitate enrollment and data sharing for the purposes of delivering Medi-Cal services in the 2016 calendar year.

SEC. 8. The Legislature finds and declares that ~~Section 3 of this act, which adds~~ Section 100538 ~~to~~ *of* the Government Code, *as added by Section 3 of this act,* imposes a limitation on the public's right of access to the meetings of public bodies or the writings of public officials and agencies within the meaning of Section 3 of Article I of the California Constitution. Pursuant to that constitutional provision, the Legislature makes the following findings to demonstrate the interest protected by this limitation and the need for protecting that interest:

In order to ensure that the California Health Exchange Program For All Californians is not constrained in exercising its fiduciary powers and obligations to negotiate on behalf of the public, the limitations on the public's right of access imposed by Section 3 of this act are necessary.

SEC. 9. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution for certain

costs that may be incurred by a local agency or school district because, in that regard, this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

However, if the Commission on State Mandates determines that this act contains other costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code.

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