AMENDED IN ASSEMBLY JUNE 30, 2014

AMENDED IN SENATE MAY 6, 2014

AMENDED IN SENATE APRIL 21, 2014

SENATE BILL No. 974

Introduced by Senator Anderson
~~**(Coauthor: Senator Torres)**~~
(Coauthors: Senators Gaines and Torres)

February 11, 2014

An act to amend Section 100503 of the Government Code, relating to health care coverage, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

SB 974, as amended, Anderson. California Health Benefit Exchange.

Existing federal law, the federal Patient Protection and Affordable Care Act (PPACA), enacts various health care coverage market reforms that take effect January 1, 2014. Among other things, PPACA requires each health insurance issuer that offers health insurance coverage in the individual or group market in a state to accept every employer and individual in the state that applies for that coverage and to renew that coverage at the option of the plan sponsor or the individual. PPACA also requires each state to, by January 1, 2014, establish an American Health Benefit Exchange that facilitates the purchase of qualified health plans by qualified individuals and qualified small employers, as specified.

Existing law establishes the California Health Benefit Exchange *(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, among other things, to determine the criteria and process for eligibility, enrollment, and disenrollment of enrollees and potential enrollees in the Exchange and coordinate that process with state and local government entities administering other specified health care coverage programs, as specified.

This bill would additionally require the ~~board~~ *board, without unreasonable delay,* to allow an applicant to indicate in ~~his or her~~ *an* application for ~~a qualified health plan~~ *health care coverage* whether or not ~~he or she~~ *the applicant* would like assistance with completing the application from an Exchange certified insurance agent or certified enrollment counselor. *The bill would prohibit the Exchange from disclosing any personal information, as defined, that was obtained from the application for health care coverage to a certified insurance agent or certified enrollment counselor until the Exchange has complied with the provision described above.* The bill would also prohibit the Exchange from disclosing personal ~~information, as defined,~~ *information that was obtained from the application for health care coverage* to a certified insurance agent or certified enrollment counselor if the applicant indicates that ~~he or she~~ *the applicant* does not want assistance from an Exchange certified insurance agent or certified enrollment counselor. *The bill would provide that these provisions do not preclude the Exchange from sharing the information of current enrollees or applicants with the same certified enrollment counselor or certified insurance agent of record that provided the applicant assistance with an existing application, or their successor or authorized staff, as specified.*

This bill would declare that it is to take effect immediately as an urgency statute.

Vote: 2/3. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

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:

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

(a) (1) Determine the criteria and process for eligibility, enrollment, and disenrollment of enrollees and potential enrollees in the Exchange and coordinate that process with the state and local government entities administering other health care coverage programs, including the State Department of Health Care Services, the Managed Risk Medical Insurance Board, and California counties, in order to ensure consistent eligibility and enrollment processes and seamless transitions between coverage.

(2) (A) ~~Allow~~ *Without unreasonable delay, allow* an applicant to indicate in ~~his or her~~ *an* application for ~~a qualified health plan~~ *health care coverage* whether or not ~~he or she~~ *the applicant* would like assistance with completing the application from an Exchange certified insurance agent or certified enrollment counselor.

(B) Until the Exchange has complied with subparagraph (A), the Exchange shall not disclose any personal information, as defined in Section 1798.3 of the Civil Code, that was obtained from the application for health care coverage to a certified insurance agent or certified enrollment counselor.

~~(B)~~

(C) The Exchange shall not disclose personal information, as defined in Section 1798.3 of the Civil Code, *that was obtained from the application for health care coverage* to a certified insurance agent or certified enrollment counselor if the applicant indicates that ~~he or she~~ *the applicant* does not want assistance from an Exchange certified insurance agent or certified enrollment counselor.

(D) Nothing in this section shall preclude the Exchange from sharing the information of current enrollees or applicants with the same certified enrollment counselor or certified insurance agent of record that provided the applicant assistance with an existing application, or their successor or authorized staff, as otherwise permitted by federal and state laws and regulations.

(b) Develop processes to coordinate with the county entities that administer eligibility for the Medi-Cal program and the entity that determines eligibility for the Healthy Families Program, including, but not limited to, processes for case transfer, referral,

1 and enrollment in the Exchange of individuals applying for
2 assistance to those entities, if allowed or required by federal law.
3 (c) Determine the minimum requirements a carrier must meet
4 to be considered for participation in the Exchange, and the
5 standards and criteria for selecting qualified health plans to be
6 offered through the Exchange that are in the best interests of
7 qualified individuals and qualified small employers. The board
8 shall consistently and uniformly apply these requirements,
9 standards, and criteria to all carriers. In the course of selectively
10 contracting for health care coverage offered to qualified individuals
11 and qualified small employers through the Exchange, the board
12 shall seek to contract with carriers so as to provide health care
13 coverage choices that offer the optimal combination of choice,
14 value, quality, and service.
15 (d) Provide, in each region of the state, a choice of qualified
16 health plans at each of the five levels of coverage contained in
17 subsections (d) and (e) of Section 1302 of the federal act.
18 (e) Require, as a condition of participation in the Exchange,
19 carriers to fairly and affirmatively offer, market, and sell in the
20 Exchange at least one product within each of the five levels of
21 coverage contained in subsections (d) and (e) of Section 1302 of
22 the federal act. The board may require carriers to offer additional
23 products within each of those five levels of coverage. This
24 subdivision shall not apply to a carrier that solely offers
25 supplemental coverage in the Exchange under paragraph (10) of
26 subdivision (a) of Section 100504.
27 (f) (1) Except as otherwise provided in this section and Section
28 100504.5, require, as a condition of participation in the Exchange,
29 carriers that sell any products outside the Exchange to do both of
30 the following:
31 (A) Fairly and affirmatively offer, market, and sell all products
32 made available to individuals in the Exchange to individuals
33 purchasing coverage outside the Exchange.
34 (B) Fairly and affirmatively offer, market, and sell all products
35 made available to small employers in the Exchange to small
36 employers purchasing coverage outside the Exchange.
37 (2) For purposes of this subdivision, "product" does not include
38 contracts entered into pursuant to Part 6.2 (commencing with
39 Section 12693) of Division 2 of the Insurance Code between the
40 Managed Risk Medical Insurance Board and carriers for enrolled

1 Healthy Families beneficiaries or contracts entered into pursuant
2 to Chapter 7 (commencing with Section 14000) of, or Chapter 8
3 (commencing with Section 14200) of, Part 3 of Division 9 of the
4 Welfare and Institutions Code between the State Department of
5 Health Care Services and carriers for enrolled Medi-Cal
6 beneficiaries. "Product" also does not include a bridge plan product
7 offered pursuant to Section 100504.5.
8 (3) Except as required by Section 1301(a)(1)(C)(ii) of the federal
9 act, a carrier offering a bridge plan product in the Exchange may
10 limit the products it offers in the Exchange solely to a bridge plan
11 product contract.
12 (g) Determine when an enrollee's coverage commences and the
13 extent and scope of coverage.
14 (h) Provide for the processing of applications and the enrollment
15 and disenrollment of enrollees.
16 (i) Determine and approve cost-sharing provisions for qualified
17 health plans.
18 (j) Establish uniform billing and payment policies for qualified
19 health plans offered in the Exchange to ensure consistent
20 enrollment and disenrollment activities for individuals enrolled in
21 the Exchange.
22 (k) Undertake activities necessary to market and publicize the
23 availability of health care coverage and federal subsidies through
24 the Exchange. The board shall also undertake outreach and
25 enrollment activities that seek to assist enrollees and potential
26 enrollees with enrolling and reenrolling in the Exchange in the
27 least burdensome manner, including populations that may
28 experience barriers to enrollment, such as the disabled and those
29 with limited English language proficiency.
30 (*l*) Select and set performance standards and compensation for
31 navigators selected under subdivision (*l*) of Section 100502.
32 (m) Employ necessary staff.
33 (1) The board shall hire a chief fiscal officer, a chief operations
34 officer, a director for the SHOP Exchange, a director of Health
35 Plan Contracting, a chief technology and information officer, a
36 general counsel, and other key executive positions, as determined
37 by the board, who shall be exempt from civil service.
38 (2) (A) The board shall set the salaries for the exempt positions
39 described in paragraph (1) and subdivision (i) of Section 100500
40 in amounts that are reasonably necessary to attract and retain

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

1 the requirements of this title. The report shall also include data
2 provided by health care service plans and health insurers offering
3 bridge plan products regarding the extent of health care provider
4 and health facility overlap in their Medi-Cal networks as compared
5 to the health care provider and health facility networks contracting
6 with the plan or insurer in their bridge plan contracts. This report
7 shall be transmitted to the Legislature and the Governor and shall
8 be made available to the public on the Internet Web site of the
9 Exchange. A report made to the Legislature pursuant to this
10 subdivision shall be submitted pursuant to Section 9795.
11 (2) The Exchange shall prepare, or contract for the preparation
12 of, an evaluation of the bridge plan program using the first three
13 years of experience with the program. The evaluation shall be
14 provided to the health policy and fiscal committees of the
15 Legislature in the fourth year following federal approval of the
16 bridge plan option. The evaluation shall include, but not be limited
17 to, all of the following:
18 (A) The number of individuals eligible to participate in the
19 bridge plan program each year by category of eligibility.
20 (B) The number of eligible individuals who elect a bridge plan
21 option each year by category of eligibility.
22 (C) The average length of time, by region and statewide, that
23 individuals remain in the bridge plan option each year by category
24 of eligibility.
25 (D) The regions of the state with a bridge plan option, and the
26 carriers in each region that offer a bridge plan, by year.
27 (E) The premium difference each year, by region, between the
28 bridge plan and the first and second lowest cost plan for individuals
29 in the Exchange who are not eligible for the bridge plan.
30 (F) The effect of the bridge plan on the premium subsidy amount
31 for bridge plan eligible individuals each year by each region.
32 (G) Based on a survey of individuals enrolled in the bridge plan:
33 (i) Whether individuals enrolling in the bridge plan product are
34 able to keep their existing health care providers.
35 (ii) Whether individuals would want to retain their bridge plan
36 product, buy a different Exchange product, or decline to purchase
37 health insurance if there was no bridge plan product available. The
38 Exchange may include questions designed to elicit the information
39 in this subparagraph as part of an existing survey of individuals
40 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) (1) Determine the criteria and process for eligibility,
35 enrollment, and disenrollment of enrollees and potential enrollees
36 in the Exchange and coordinate that process with the state and
37 local 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

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

(2) (A) ~~Allow~~ *Without unreasonable delay, allow* an applicant to indicate in ~~his or her~~ *an* application for ~~a qualified health plan~~ *health care coverage* whether or not ~~he or she~~ *the applicant* would like assistance with completing that application from an Exchange certified insurance agent or certified enrollment counselor.

(B) Until the Exchange has complied with subparagraph (A), the Exchange shall not disclose any personal information, as defined in Section 1798.3 of the Civil Code, that was obtained from the application for health care coverage to a certified insurance agent or certified enrollment counselor.

~~(B)~~

(C) The Exchange shall not disclose personal information, as defined in Section 1798.3 of the Civil Code, *that was obtained from the application for health care coverage* to a certified insurance agent or certified enrollment counselor if the applicant indicates that ~~he or she~~ *the applicant* does not want assistance from an Exchange certified insurance agent or certified enrollment counselor.

(D) Nothing in this section shall preclude the Exchange from sharing the information of current enrollees or applicants with the same certified enrollment counselor or certified insurance agent of record that provided the applicant assistance with an existing application, or their successor or authorized staff, as otherwise permitted by federal and state laws and regulations.

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

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

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) Require, as a condition of participation in the Exchange,
18 carriers that sell any products outside the Exchange to do both of
19 the following:
20 (A) Fairly and affirmatively offer, market, and sell all products
21 made available to individuals in the Exchange to individuals
22 purchasing coverage outside the Exchange.
23 (B) Fairly and affirmatively offer, market, and sell all products
24 made available to small employers in the Exchange to small
25 employers purchasing coverage outside the Exchange.
26 (2) For purposes of this subdivision, "product" does not include
27 contracts entered into pursuant to Part 6.2 (commencing with
28 Section 12693) of Division 2 of the Insurance Code between the
29 Managed Risk Medical Insurance Board and carriers for enrolled
30 Healthy Families beneficiaries or contracts entered into pursuant
31 to Chapter 7 (commencing with Section 14000) of, or Chapter 8
32 (commencing with Section 14200) of, Part 3 of Division 9 of the
33 Welfare and Institutions Code between the State Department of
34 Health Care Services and carriers for enrolled Medi-Cal
35 beneficiaries.
36 (g) Determine when an enrollee's coverage commences and the
37 extent and scope of coverage.
38 (h) Provide for the processing of applications and the enrollment
39 and disenrollment of enrollees.

1 (i) Determine and approve cost-sharing provisions for qualified
2 health plans.
3 (j) Establish uniform billing and payment policies for qualified
4 health plans offered in the Exchange to ensure consistent
5 enrollment and disenrollment activities for individuals enrolled in
6 the Exchange.
7 (k) Undertake activities necessary to market and publicize the
8 availability of health care coverage and federal subsidies through
9 the Exchange. The board shall also undertake outreach and
10 enrollment activities that seek to assist enrollees and potential
11 enrollees with enrolling and reenrolling in the Exchange in the
12 least burdensome manner, including populations that may
13 experience barriers to enrollment, such as the disabled and those
14 with limited English language proficiency.
15 (*l*) Select and set performance standards and compensation for
16 navigators selected under subdivision (*l*) of Section 100502.
17 (m) Employ necessary staff.
18 (1) The board shall hire a chief fiscal officer, a chief operations
19 officer, a director for the SHOP Exchange, a director of Health
20 Plan Contracting, a chief technology and information officer, a
21 general counsel, and other key executive positions, as determined
22 by the board, who shall be exempt from civil service.
23 (2) (A) The board shall set the salaries for the exempt positions
24 described in paragraph (1) and subdivision (i) of Section 100500
25 in amounts that are reasonably necessary to attract and retain
26 individuals of superior qualifications. The salaries shall be
27 published by the board in the board's annual budget. The board's
28 annual budget shall be posted on the Internet Web site of the
29 Exchange. To determine the compensation for these positions, the
30 board shall cause to be conducted, through the use of independent
31 outside advisors, salary surveys of both of the following:
32 (i) Other state and federal health insurance exchanges that are
33 most comparable to the Exchange.
34 (ii) Other relevant labor pools.
35 (B) The salaries established by the board under subparagraph
36 (A) shall not exceed the highest comparable salary for a position
37 of that type, as determined by the surveys conducted pursuant to
38 subparagraph (A).

1 (C) The Department of Human Resources shall review the
2 methodology used in the surveys conducted pursuant to
3 subparagraph (A).
4 (3) The positions described in paragraph (1) and subdivision (i)
5 of Section 100500 shall not be subject to otherwise applicable
6 provisions of the Government Code or the Public Contract Code
7 and, for those purposes, the Exchange shall not be considered a
8 state agency or public entity.
9 (n) Assess a charge on the qualified health plans offered by
10 carriers that is reasonable and necessary to support the
11 development, operations, and prudent cash management of the
12 Exchange. This charge shall not affect the requirement under
13 Section 1301 of the federal act that carriers charge the same
14 premium rate for each qualified health plan whether offered inside
15 or outside the Exchange.
16 (o) Authorize expenditures, as necessary, from the California
17 Health Trust Fund to pay program expenses to administer the
18 Exchange.
19 (p) Keep an accurate accounting of all activities, receipts, and
20 expenditures, and annually submit to the United States Secretary
21 of Health and Human Services a report concerning that accounting.
22 Commencing January 1, 2016, the board shall conduct an annual
23 audit.
24 (q) (1) Annually prepare a written report on the implementation
25 and performance of the Exchange functions during the preceding
26 fiscal year, including, at a minimum, the manner in which funds
27 were expended and the progress toward, and the achievement of,
28 the requirements of this title. This report shall be transmitted to
29 the Legislature and the Governor and shall be made available to
30 the public on the Internet Web site of the Exchange. A report made
31 to the Legislature pursuant to this subdivision shall be submitted
32 pursuant to Section 9795.
33 (2) In addition to the report described in paragraph (1), the board
34 shall be responsive to requests for additional information from the
35 Legislature, including providing testimony and commenting on
36 proposed state legislation or policy issues. The Legislature finds
37 and declares that activities including, but not limited to, responding
38 to legislative or executive inquiries, tracking and commenting on
39 legislation and regulatory activities, and preparing reports on the
40 implementation of this title and the performance of the Exchange,

1 are necessary state requirements and are distinct from the
2 promotion of legislative or regulatory modifications referred to in
3 subdivision (d) of Section 100520.
4 (r) Maintain enrollment and expenditures to ensure that
5 expenditures do not exceed the amount of revenue in the fund, and
6 if sufficient revenue is not available to pay estimated expenditures,
7 institute appropriate measures to ensure fiscal solvency.
8 (s) Exercise all powers reasonably necessary to carry out and
9 comply with the duties, responsibilities, and requirements of this
10 act and the federal act.
11 (t) Consult with stakeholders relevant to carrying out the
12 activities under this title, including, but not limited to, all of the
13 following:
14 (1) Health care consumers who are enrolled in health plans.
15 (2) Individuals and entities with experience in facilitating
16 enrollment in health plans.
17 (3) Representatives of small businesses and self-employed
18 individuals.
19 (4) The State Medi-Cal Director.
20 (5) Advocates for enrolling hard-to-reach populations.
21 (u) Facilitate the purchase of qualified health plans in the
22 Exchange by qualified individuals and qualified small employers
23 no later than January 1, 2014.
24 (v) Report, or contract with an independent entity to report, to
25 the Legislature by December 1, 2018, on whether to adopt the
26 option in Section 1312(c)(3) of the federal act to merge the
27 individual and small employer markets. In its report, the board
28 shall provide information, based on at least two years of data from
29 the Exchange, on the potential impact on rates paid by individuals
30 and by small employers in a merged individual and small employer
31 market, as compared to the rates paid by individuals and small
32 employers if a separate individual and small employer market is
33 maintained. A report made pursuant to this subdivision shall be
34 submitted pursuant to Section 9795.
35 (w) With respect to the SHOP Program, collect premiums and
36 administer all other necessary and related tasks, including, but not
37 limited to, enrollment and plan payment, in order to make the
38 offering of employee plan choice as simple as possible for qualified
39 small employers.

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

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

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

SEC. 3. Sections 1 and 2 of this bill shall become operative on October 1, 2014.

SEC. 4. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

Protecting ~~Californian's~~ *Californians'* privacy rights is of the utmost importance, and in order to protect the privacy rights of individuals applying for health care coverage through the California Health Benefit Exchange at the earliest possible time, it is necessary that this act take effect immediately.

O