February 2011

Health Benefit Exchange: California vs. Federal Provisions

A Comparison of California Legislation AB 1602/SB 900 with the U.S. Patient Protection and Affordable Care Act (amended)

California HealthCare Foundation

CALIFORNIA	FEDERAL
Organizational Locus/Governance/Staffing	
Organizational Locus/Board Composition	
The exchange is to be an independent state agency. [GC §100500(a) per SB 900 §2] ↗	An exchange is to be a governmental agency or nonprofit entity that is established by a state. [§1311(d)(1)]
A five-person board to be appointed. Members must meet expertise requirements, reflect the cultural, ethnic and geographical diversity of the state, and have no conflicts of interest. [GC §100500(a)-(g) per SB 900 §2] +	No provision.
Staffing	
Executive director [GC §100500(i) per SB 900 §2] and other executive positions to be hired by board. Only these positions are exempt from civil service. Law specifies criteria and procedures for determining their salaries, which are to be publicly disclosed. [GC §100503(m) per AB 1602 §7] +	No provision.
Public Disclosure Requirements, Exemptions	
Open-meeting rules generally apply, but closed sessions allowed to discuss litigation, personnel, contracting, and rates. [GC §100500(j) per SB 900 §2] See also GC §100508(a),(b) per AB 1602 §12 +	No provision.
Funding of Exchange Operations	
Start-Up	
Board is to apply for federal exchange planning and establishment grants. Until board and executive director are functional, CHHS can apply for those grants. [GC §100500(k) per SB 900 §2] ↗	HHS Sec'y is to make grants to states for activities related to establishing an exchange. [§1311(a)]
California Health Facilities Authority Fund may provide the exchange a working capital loan of up to $5 million, only if federal funds are insufficient or untimely. To be repaid with interest. [GC §15438(s) per AB 1602 §3] +	Grant can be renewed through 2014 as long as HHS Sec'y determines state is making progress toward exchange and insurance market reform implementation.
The exchange may receive and accept gifts, grants, or donations. [GC §100504(a)(4),(5) per AB 1602 §8] +	

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Glossary of Terms, page 9

CALIFORNIA	FEDERAL
Ongoing Operation	
The exchange is to assess a charge on the qualified health plans (QHPs) offered by carriers that is "reasonable and necessary to support the development, operations, and prudent cash management of the exchange." [GC §100503(n) per AB 1602 §7] ↘↗	States are to ensure that their exchange is self-sustaining beginning on January 1, 2015, including allowing the exchange to charge assessments or user fees to participating health insurance issuers, or to otherwise generate funding, to support its operations. [§1311(d)(5)]
If end-of-fiscal-year balance in California Health Trust Fund equals or exceeds the exchange operating budget for the next fiscal year, the board is to reduce the QHP assessment so any surplus does not exceed that level. [GC §100520(f) per AB 1602 §13] ✚	
Protection of the General Fund	
No state General Fund money may be used for the exchange, and no liability incurred by the exchange or its officers or employees can be paid from the General Fund. The exchange may not begin operations without sufficient non-General Fund resources. An annual assessment of the impact of the exchange on other publicly funded health programs administered by the state is required. [GC §100521 per AB 1602 §14] ✚	No provision.
Mechanics: California Health Trust Fund	
Exchange administrative expenditures are to be paid from the California Health Trust Fund [GC §100503(o) per AB 1602 §7], which is established and continuously appropriated. [GC §100520 per AB 1602 §13] ✚	No provision, though consistent with federal charge to ensure exchange is self-sustaining.
Funds intended for administrative and operational expenses of the exchange may not be used for staff retreats, promotional giveaways, excessive executive compensation, or promotion of federal or state legislative or regulatory modifications. [GC §100520(d) per AB 1602 §13] ☑	§1311(d)(5)(B)
Plan Certification/Contracting	
Goal	
The exchange is to facilitate the purchase of QHPs by qualified individuals and qualified small employers no later than January 1, 2014. [GC §100503(u) per AB 1602 §7]	Each state is to establish an exchange to serve the individual and small employer markets not later than January 1, 2014. [§1311(b)(1)]
Federally Mandated Provisions	
The exchange is to implement procedures for the certification, recertification, and decertification of health plans as QHPs consistent with federal guidelines under PPACA §1311, including the following requirements. [GC §100502(a) per AB 1602 §6]	General incorporation by cross-reference of PPACA §1311 and subsequent guidance issued by HHS Sec'y.

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Federally Mandated Provisions *(cont.)*	
Submit justification for any premium increase prior to its implementation. ☑	§1311(e)(2)
Make accurate and timely disclosure in plain language of certain data and information. ☑	§1311(e)(3)(A),(B)
Permit individuals to learn their cost-sharing obligations under the plan. ☑	§1311(e)(3)(C)
Carriers that contract with the exchange must have a license or certificate of authority from, and must be in good standing with, their respective regulatory agencies. [GC §100507(b) per AB 1602 §11] ☑	§1301(a)(1)(C)(i)
Additional State-Defined Powers of the Exchange	
The exchange is to determine the minimum requirements a carrier must meet to be considered for participation, and the standards and criteria for selecting QHPs that are in the best interests of qualified individuals and qualified small employers. ↝	An exchange may certify a health plan as a QHP [eligible to be offered through the exchange] if—
	The health plan meets the requirements for certification, yet to be determined by HHS Sec'y, under subsection (c)(1); and
The exchange is to consistently and uniformly apply these requirements, standards, and criteria to all carriers. ✚	The exchange determines that it is in the interests of qualified individuals and qualified employers in the state. [§1311(e)(1)]
In selectively contracting, 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." [GC §100503(c) per AB 1602 §7] ✚	
The exchange is to establish and use a competitive process to select participating carriers and any other contractors (but the process is exempt from usual state contracting procedures). [GC §100505 per AB 1602 §9] ✚	
Product Offerings	
Inside the Exchange	
The exchange is to determine and approve cost-sharing provisions for QHPs [GC §100503(i) per AB 1602 §7] ↝	Maximum out-of-pocket costs limited to same as allowed for health savings accounts (HSAs). [§1302(c)(1)] Deductibles in small group market limited to $2,000/$4,000 self/family, indexed. [§1302(c)(2)]
In each California region, the exchange is to provide a choice of QHPs at each of the five federally specified coverage levels (four "precious metals" plus catastrophic). [GC §100503(d) per AB 1602 §7] ↝	Defines four permissible "actuarial value" levels for cost-sharing [§1302(d)], plus a catastrophic plan limited to certain populations. [§1302(e)]
Participating carriers are to "fairly and affirmatively" offer at least one product in each of the five levels. [GC §100503(e), HSC §1366.6(b), Ins. Code §10112.3(b), per AB 1602 §§7,15,16] ✚	To offer QHP in exchange, carrier must offer at least one QHP at the silver level and at least one at the gold level in each such exchange. [§1301(a)(1)(C)(ii)]

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Inside the Exchange *(cont.)*	
Exchange may require participating carriers to offer additional products in each of the five levels. [GC §100503(e), HSC §1366.6(b), Ins. Code §10112.3(b), per AB 1602 §§7,15,16] ✚	No provision.
The board may standardize products to be offered through the exchange. [GC §100504(c) per AB 1602 §8] ✚	No provision.
No specific provision on dental plans, but compliance with federal requirement should be authorized by general requirement to implement procedures for certification of QHPs consistent with federal guidelines. [GC §100502(a) as added by AB 1602 §6]	Standalone dental plans must be offered through the exchange if they comply with IRC §9832(c)(2)(A) and §1302(I)(J). [§1311(d)(2)(B)(ii)]
Benefits in Excess of the Federal Essential Health Benefits	
The provisions that prohibit the exchange from creating a liability for the General Fund effectively preclude it from recognizing state benefit mandates that exceed the federal essential health benefits. [GC §100521(a) per AB 1602 §14]	A "State may require that a [QHP] offered in such state offer benefits in addition to the [federally defined] essential health benefits" but, if the state does so, the "State shall make payments [to the individual or the individual's QHP] to defray the cost of any additional benefits." [§1311(d)(3)(B)] Exchanges may make QHPs available "notwithstanding any provision of law that may require benefits other than the essential health benefits." [§1311(d)(3)(A)]
In the Outside Market	
Effective January 1, 2014, carriers may only sell products that conform to the five federally specified coverage levels (four "precious metals" plus catastrophic). [HSC §1366.6(d), Ins. Code §10112.3(d), per AB 1602 §§15,16] ☑	PHSA §2707(a) [added by §1201(4)] applies the "essential health benefits" requirements and cost-sharing limitations of §1302 to the individual and small group markets generally.
Carriers that do not participate in the exchange may not sell products in the catastrophic coverage level. [HSC §1366.6(d), Ins. Code §10112.3(d), per AB 1602 §§15,16] ✚	"Nothing in this title shall be construed to preempt any State law that does not prevent the application of the provisions of this title." [§1321(d)]
If the exchange designates standardized products inside the exchange, carriers that do not participate in the exchange must nevertheless offer at least one exchange-designated standardized product in each of the four "precious metal" levels (but not the catastrophic level). [HSC §1366.6(e), Ins. Code §10112.3(e), per AB 1602 §§7,15,16] ✚	§1321(d)

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"Clearinghouse" for Outside Market	
Provision	
DMHC director and insurance commissioner are to examine the federal Internet portal to determine whether it provides sufficient information to achieve fair and affirmative marketing of all individual and small employer products, particularly outside the exchange. [HSC §1346.2, Ins. Code §10112.4, per SB 900 §§3,4] ✚ If it does not, DMHC and CDI are to jointly develop and maintain an electronic clearinghouse to achieve that purpose. ✚	HHS Sec'y is to establish "a mechanism, including an Internet Web site," through which a state resident or small business may identify affordable coverage options [§1103(a)]. The HHS Sec'y is to maintain and update that portal and assist states in developing and maintaining their own. [§1311(c)(5)]
Premium Collection and Plan Payment	
In the Individual Market	
The exchange may collect premiums and assist in the administration of subsidies with respect to individual coverage made available in the exchange. [GC §100504(a)(1) per AB 1602 §8] ✚	Individuals have the option to pay their share of the premium directly to the QHP. [§1312(b)] Cost-sharing reductions payments and advance payments of premium tax credits will be made directly to the QHP issuer by the U.S. Treasury. [§1412(a)(3)]
The "SHOP Exchange" and the Small Employer Market	
"SHOP Exchange"	
The exchange is to establish a Small Business Health Options Program (SHOP), separate from exchange activities related to the individual market, consistent with PPACA §1312(a)(2). [GC §100502(m) per AB 1602 §6] ↗ California did not adopt the federal option to have the SHOP exchange run by a completely separate entity. ↗ The exchange is to collect premiums and administer all other necessary tasks, including enrollment and plan payment, for the SHOP exchange "in order to make the offering of employee plan choice as simple as possible for qualified small employers." [GC §100503(w) per AB 1602 §7] ✚	Exchanges are to provide for the establishment of a "Small Business Health Options Program" or SHOP exchange. [§1311(b)(1)(B)] States may choose whether to provide [individual] exchange and SHOP exchange services through separate entities or a single entity. [§1311(b)(2)] No provision.
Definition of Small Employer Market	
Open Issue: *Action is required to define businesses with one employee as small employers under California law, effective January 1, 2014. Also, federal guidelines may impose the 1-100 employee definition unless the state affirmatively acts to maintain the cut-off at 50 for 2014-2015.*	"Small employer" is defined as an employer with 1 to 100 employees. [§1304(b)(2)] But, for plan years beginning before January 1, 2016, states may keep the upper limit at 50 employees. [§1304(b)(3)]
Merging the Individual and Small Employer Markets	
By December 1, 2018, the exchange is to report to the legislature whether legislation should merge the individual and small employer markets. [GC §100503(v) per AB 1602 §7] ↗	A state may require the individual and small group insurance markets to be merged. [§1312(c)(3)]

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Eligibility / Enrollment	
General	
The exchange is to determine the criteria and process for eligibility, enrollment, and disenrollment and coordinate that process with the state and local government entities administering other health care coverage programs, including [DHCS, MRMIB], and California counties, "in order to ensure consistent eligibility and enrollment processes and seamless transitions between coverage." [GC §100503(a) per AB 1602 §7] ↝	The HHS Sec'y is to establish a system under which residents of each state may apply for enrollment in, receive a determination of eligibility for participation in, and continue participation in, applicable state health subsidy programs (defined to include premium tax credits for exchange coverage). [§1413]
Enrollment Functions	
The exchange is to provide for the processing of applications and the enrollment and disenrollment of enrollees. [GC §100503(h) per AB 1602 §7] ↝	The exchange's role in processing applications is referenced in §§1411 and 1412. It does not specify that the exchange "enrolls" anyone in a QHP, but does say the exchange can enroll people in Medi-Cal/Healthy Families, and the phrase "enroll (in a QHP) through the Exchange" is used. See, e.g., §1411(e)(2)(A)(i).
The exchange is to require participating carriers 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 QHP offered by the carrier. [GC §100503(x) per AB 1602 §7] ✚	No federal provision expressly requires notification about enrollment in a QHP. But the QHP issuer must notify the HHS Sec'y and the exchange when it reduces the premium charge to the insured due to advance payment of a premium tax credit. [§1412(c)(2)(B)(ii)]
The exchange is to establish uniform billing and payment policies for [QHPs] offered in the exchange to ensure consistent enrollment and disenrollment activities for individuals enrolled in the exchange. [GC §100503(j) per AB 1602 §7] ✚	The issuer is to notify HHS Sec'y if an advance-credit recipient fails to pay their share of the premium, and must allow a 3-month grace period for nonpayment of premiums. [§1412(c)(2)(B)(iv)]
For Medi-Cal / Healthy Families	
The exchange is to inform individuals about eligibility requirements for Medi-Cal, Healthy Families, and other applicable state or local public programs; it must screen applications for such eligibility and, if the individuals are eligible, enroll them. [GC §100502(f) per AB 1602 §6] ☑	§1311(d)(4)(F)
The exchange is to "develop processes to coordinate with the county entities that administer eligibility for the Medi-Cal program" and with MRMIB for the Healthy Families Program. [GC §100503(b) per AB 1602 §7] ✚	No provision on coordination with counties.
For Exchange and Tax Credit Eligibility	
The exchange is to perform all federally required or delegated duties related to determining eligibility for premium tax credits, reduced cost sharing, or individual responsibility exemptions. [GC §100502(k) per AB 1602 §6]	The exchange's role in processing of such applications is referenced in §§1411 and 1412.

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For Exchange and Tax Credit Eligibility *(cont.)*	
The exchange is to grant certificates of exemption from individual mandate. It must transfer identifying data to U.S. Treasury Sec'y on (1) individuals granted exemptions, (2) employees found eligible for premium tax credits, (3) workers receiving premium tax credits who change employers, and (4) individuals who cease QHP coverage during a plan year. It must also notify the employer when an employee receiving a premium tax credit ceases QHP coverage. [GC §100502(h),(i) and (j) per AB 1602 §6] ☑	§1311(d)(4)(H),(I) and (J). However, since §1411(e)(2)(B) says HHS Sec'y is to issue the certificate of exemption referred to in §1311(d)(4)(H), further federal guidance on the exchange's role will be required.
Appeals	
The exchange is to establish an appeals process for enrollees that complies with, but is no broader than, all federal requirements concerning the exchange's role in facilitating federal appeals of exchange-related determinations. [GC §100506(a) per AB 1602 §10] ↝	The HHS Sec'y is to establish procedures for appeals and redeterminations. [§1411(f)(1)]
Confidentiality and Sharing of Individual Information	
The exchange may share information with relevant state departments, consistent with federal confidentiality provisions, only as necessary for the administration of the exchange. [GC §100504(a)(8) and (b) per AB 1602 §8] ↝	Incorporates by reference "Confidentiality of Applicant Information" rules in §1411(g). Provisions covering disclosure of tax return information appear at IRC §6103(l)(21), per §1414(a)(1).
Continuity of Coverage When Income Changes	
The exchange may collaborate with DHCS and MRMIB, "to the extent possible, to allow an individual the option to remain enrolled with his or her carrier and provider network" as their eligibility switches from tax credits to public coverage or vice-versa. [GC §100504(a)(7) per AB 1602 §8] +	No provision.
Outreach/Marketing/Consumer Information	
Outreach/Marketing	
The exchange is to establish a "navigator" program. [GC §100502(l) per AB 1602 §6] ☑	§1311(d)(4)(K). Incorporates the "duties of navigators" from §1311(i)(3).
The exchange is to select and set performance standards and compensation for navigators. [GC §100503(l) per AB 1602 §7] ↝	No specific provision, but clearly within the purview of exchanges under §1311(i)(1) and (6).
Open Issue: *Unclear where "start-up" funds for navigators might come from before the exchange becomes operational.*	Grants to navigators to be made from the operational funds of the exchange and not federal funds received by the state to establish the exchange. §1311(i)(6)

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Provider Directories	
The exchange may require participating carriers to make available to the exchange and regularly update an electronic directory of contracting health care providers. The exchange may collect and provide data about which providers are currently accepting new patients. [GC §100504(a)(9) per AB 1602 §8] ✚	To be certified, QHPs must "ensure a sufficient choice of providers… and provide information to enrollees and prospective enrollees on the availability of in-network and out-of-network providers." [§1311(c)(1)(B)]
Other Consumer Information	
The exchange is to operate a toll-free hotline and Web site with standardized comparative information on QHPs; present plan options in standardized format, including uniform outline of coverage per PHSA §2715; assign quality ratings per federal guidelines; and make available electronic calculator to determine actual cost of coverage after premium tax-credits and cost-sharing reductions. [GC §100502(b),(c),(d),(e),(f) per AB 1602 §6] ☑	§1311(d)(4)(B),(D),(E),(G)
The exchange is to provide oral interpretation services in any language for individuals seeking coverage through the exchange and make available a toll-free telephone number for the hearing and speech impaired. [GC §100503(y) per AB 1602 §7] ✚	No provision on oral interpretation services.
Navigators are to provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the exchange. [GC §100502(l) per AB 1602 §6] ✚	The standardized summary of benefits and coverage is to be presented in a culturally and linguistically appropriate manner and utilize terminology understandable by the average plan enrollee. [PHSA §2715(b)(2), added by §1001(5)]
Other	
General Powers of the Exchange	
The exchange is authorized to "exercise all powers reasonably necessary to carry out and comply with the duties, responsibilities, and requirements of this act and the federal act." [GC §100503(s) per AB 1602 §7]	General cross-reference to all "duties, responsibilities, and requirements" of exchange under federal act.
Additional powers, typical of those usually granted to boards and commissions, appear at GC §100504(a)(2),(3) per AB 1602 §8. Rules and regulations may be adopted on an emergency basis until January 1, 2016. [GC §100504(a)(6) per AB 1602 §8] ✚	No provision.
The exchange may make available supplemental coverage for enrollees to the extent permitted by the federal act, provided no General Fund money is used for that. [GC §100504(a)(10) per AB 1602 §8] ↝	
Fiscal Accountability	
The exchange is responsible for accurate accounting and annual report to HHS Sec'y. [GC §100503(p) per AB 1602 §7] ☑	§1313(a)(1)
An annual audit will be done beginning January 1, 2016. [GC §100503(p) per AB 1602 §7] ✚	An exchange is to be subject to annual audits by the HHS Sec'y. [§1313(a)(3)]

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Fiscal Accountability *(cont.)*	
For additional provisions on fiscal accountability see GC §100503(q)(1) and (r) per AB 1602 §7. ✚	No provisions.
Reporting to Legislature	
The exchange is to respond to requests from legislature for information, testimony, comments on proposed legislation, and policy issues. Interprets §1311(d)(5)(B). [GC §100503(q)(2) per AB 1602 §7] ✚	§1311(d)(5)(B)
Consultation with Stakeholders	
The exchange is to consult with specified stakeholders relevant to carrying out the exchange activities. [GC §100503(t) per AB 1602 §7] ☑	§1311(d)(6) [Note that federal law specifies "educated" health care consumers.]

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About This Table

This table was prepared by Ed Neuschler and Rick Curtis of the Institute for Health Policy Solutions. Many provisions of the federal health care reform law are phrased in general terms, and their implications and requirements for the California exchange will not be fully understood until subsequent federal regulations or administrative guidance applicable to all exchanges are released. As a result, provisions of the California implementing laws that incorporate or reference federal law often either simply restate the applicable federal provision or are broadly framed to allow the exchange to comply with future federal rules and guidance, which are expected to be more specific.

Glossary of Terms

"Carrier" in California parlance = "Issuer" in federal parlance

CDI = California Department of Insurance

CHHS = California Health and Human Services Agency

DHCS = (California) Department of Health Care Services

DMHC = (California) Department of Managed Health Care

GC = (California) Government Code

HSC = (California) Health and Safety Code

IRC = Internal Revenue Code

MRMIB = Managed Risk Medical Insurance Board (responsible for the Healthy Families Program and the state high-risk pool, among other programs)

PHSA = (federal) Public Health Service Act

PPACA = Patient Protection and Affordable Care Act (federal health reform legislation)

QHP = Qualified Health Plan (i.e., offered through exchange)