## Senate Bill No. 3

CHAPTER 5

An act to amend, repeal, and add Sections 100501 and 100503 of, and to add and repeal Sections 100504.5 and 100504.6 of, the Government Code, to amend, repeal, and add Section 1366.6 of, and to add and repeal Section 1399.864 of, the Health and Safety Code, to amend, repeal, and add Section 10112.3 of, and to add and repeal Section 10961 of, the Insurance Code, and to add and repeal Section 14005.70 of the Welfare and Institutions Code, relating to health care coverage.

[Approved by Governor July 11, 2013. Filed with Secretary of State July 11, 2013.]

LEGISLATIVE COUNSEL'S DIGEST

SB 3, Hernandez. Health care coverage: bridge plan.

Existing law, the federal Patient Protection and Affordable Care Act, requires each state to, by January 1, 2014, establish an American Health Benefit Exchange that makes available qualified health plans to qualified individuals and small employers.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income persons receive health care benefits. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. Existing law also provides for the regulation of health insurers by the Department of Insurance.

Under existing law, carriers that sell any products outside the California Health Benefit Exchange (Exchange) are required to fairly and affirmatively offer, market, and sell all products made available to individuals or small employers in the Exchange to individuals or small employers, respectively, purchasing coverage outside the Exchange.

Existing law also requires carriers that participate in the Exchange to fairly and affirmatively offer, market, and sell in the Exchange at least one product within 5 levels of specified coverage.

This bill would exempt a bridge plan product, as defined, from that latter requirement.

This bill would, among other things, also require the Exchange to enter into contracts with and certify as a qualified health plan bridge plan products that meet specified requirements, including being a Medi-Cal managed care plan. The bill would also require the Exchange to make available bridge plan products to eligible individuals. The bill would authorize the Exchange, after consulting with stakeholders, to adopt regulations to implement those

provisions, and until January 1, 2016, exempt the adoption, amendment, or repeal of those regulations from the Administrative Procedure Act.

The bill would require the Exchange to annually prepare a specified written report on the implementation and performance of the Exchange functions during the preceding fiscal year, and to prepare, or contract for the preparation of, an evaluation of the bridge plan program using the first 3 years of experience with the program, as specified.

The bill would authorize a health care service plan or insurance carrier offering a bridge plan product in the Exchange to limit the products it offers in the Exchange to the bridge plan product, except as required by federal law. The bill would define "bridge plan product" as an individual health benefit plan offered by a licensed health care service plan or health insurer that contracts with the Exchange, as specified.

The bill would also require the State Department of Health Care Services to impose specified requirements in its contracts with a health care service plan or health insurer to provide Medi-Cal managed care coverage but would authorize the department to contract with the Exchange to delegate the implementation of those provisions.

The bill would require the Exchange to seek federal approval to allow specified individuals the option to enroll in a different bridge plan product if the individual's primary care provider is included in the contracted network of the different bridge plan product and either the bridge plan product for which the individual is eligible is not offered in that individual's service area or is not offered as a bridge plan product by the Exchange.

The bill would provide that its provisions would become inoperative on the October 1 that is 5 years after the date that federal approval of the bridge plan option occurs.

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

SECTION 1. (a) It is the intent of the Legislature that the Exchange provide a more affordable coverage option for low-income individuals, improve continuity of care for individuals moving from Medi-Cal to the Exchange, and reduce the need for individuals previously enrolled in the Medi-Cal program to change health plans due to changes in their household income.

(b) In addition to other plan choices, it is the intent of the Legislature that the Exchange offer quality, affordable health plan choices that, to the extent possible, will be the lowest cost silver plan offered in the individual's geographic region through Medi-Cal managed care plans that bridge Medicaid coverage and private commercial health insurance for eligible lower income individuals.

(c) It is the intent of the Legislature that the Exchange encourage Medi-Cal managed care plans to seek to contract to offer bridge plan products.

SEC. 2. Section 100501 of the Government Code is amended to read:

100501. For purposes of this title, the following definitions shall apply:

(a) "Board" means the board described in subdivision (a) of Section 100500.

(b) "Bridge plan product" means an individual health benefit plan as defined in subdivision (f) of Section 1399.845 of the Health and Safety Code that is offered by a health care service plan licensed under 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) or as defined in subdivision (a) of Section 10198.6 of the Insurance Code that is offered by a health insurer licensed under the Insurance Code that contracts with the Exchange pursuant to this title.

(c) "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.

(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 established by Section 100520.

(g) "Health plan" and "qualified health plan" have the same meanings as those terms are defined in Section 1301 of the federal act.

(h) "Healthy Families coverage" means coverage under the Healthy Families Program pursuant to Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code.

(i) "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.

(j) "Modified adjusted gross income" shall have the same meaning as the term is used in Section 1401(d)(2)(B) (26 U.S.C. Sec. 36B) of the federal act.

(k) "Members of the modified adjusted gross income household" shall mean any individual who would be included in the calculation for modified adjusted gross income pursuant to Section 1401(a) (26 U.S.C. Sec. 36B(d)) of the federal act and as otherwise determined by the Exchange as permitted by the federal act and this title.

(*l*) "SHOP Program" means the Small Business Health Options Program established by subdivision (m) of Section 100502.

(m) "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.

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

SEC. 3. Section 100501 is added to the Government Code, to read:

100501. For purposes of this title, the following definitions shall apply:

(a) "Board" means the board described in subdivision (a) of Section 100500.

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

(d) "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.

(e) "Fund" means the California Health Trust Fund established by Section 100520.

(f) "Health plan" and "qualified health plan" have the same meanings as those terms are defined in Section 1301 of the federal act.

(g) "SHOP Program" means the Small Business Health Options Program established by subdivision (m) of Section 100502.

(h) "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.

(i) This section shall become operative only if Section 2 of the act that added this section becomes inoperative pursuant to subdivision (n) of that Section 2.

SEC. 4. Section 100503 of the Government Code 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) 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.

(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 and qualified small employers through the Exchange, 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 subsections (d) and (e) of Section 1302 of the federal act.

(e) Require, as a condition of participation in the Exchange, carriers to fairly and affirmatively offer, market, and sell in the Exchange at least one product within each of the five levels of coverage contained in subsections (d) and (e) of Section 1302 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 Exchange under paragraph (10) of subdivision (a) of Section 100504.

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

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

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

(2) For purposes of this subdivision, “product” does not include contracts entered into pursuant to Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code between the Managed Risk Medical Insurance Board and carriers for enrolled Healthy Families beneficiaries or contracts entered into pursuant to Chapter 7 (commencing with Section 14000) of, 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.

(3) Except as required by Section 1301(a)(1)(C)(ii) of the federal act, a carrier offering a bridge plan product in the Exchange may limit the products it offers in the Exchange solely to a bridge plan product contract.

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

(k) Undertake activities necessary to market and publicize the availability of health care coverage and federal subsidies through the Exchange. The board shall also undertake outreach and enrollment activities that seek to assist enrollees and potential enrollees with enrolling and reenrolling in the Exchange 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 (*l*) of Section 100502.

(m) Employ necessary staff.

(1) The board shall hire a chief fiscal officer, a chief operations officer, a director for the SHOP Exchange, a director of Health Plan Contracting, a chief technology and information officer, a general counsel, and other key executive positions, as determined by the board, who shall be exempt from civil service.

(2) (A) The board shall set the salaries for the exempt positions described in paragraph (1) and subdivision (i) of Section 100500 in amounts that are reasonably necessary to attract and retain individuals of superior qualifications. The salaries shall be published by the board in the board's annual budget. The board's annual budget shall be posted on the Internet Web site of the Exchange. To determine the compensation for these positions, the board shall cause to be conducted, through the use of independent outside advisors, salary surveys of both of the following:

(i) Other state and federal health insurance exchanges that are most comparable to the Exchange.

(ii) Other relevant labor pools.

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

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

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

(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 Exchange. This charge shall not affect the

requirement under Section 1301 of the federal act that carriers charge the same premium rate for each qualified health plan whether offered inside or outside the Exchange.

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

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

(q) (1) Annually prepare a written report on the implementation and performance of the Exchange 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 Exchange. A report made to the Legislature pursuant to this subdivision shall be submitted pursuant to Section 9795.

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

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

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

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

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

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

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

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

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

(ii) Whether individuals would want to retain their bridge plan product, buy a different Exchange product, or decline to purchase health insurance if there was no bridge plan product available. The Exchange may include

questions designed to elicit the information in this subparagraph as part of an existing survey of individuals receiving coverage in the Exchange.

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

(4) 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 Exchange, are necessary state requirements and are distinct from the promotion of legislative or regulatory modifications referred to in subdivision (d) of Section 100520.

(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 act and the federal act.

(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) Representatives of small businesses and self-employed individuals.

(4) The State Medi-Cal Director.

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

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

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

(w) With respect to the SHOP Program, collect premiums and administer all other necessary and related tasks, including, but not limited to, enrollment and plan payment, in order to make the offering of employee plan choice as simple as possible for qualified 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 inoperative on the October 1 that is five years after the date that federal approval of the bridge plan option occurs, and, as of the second January 1 thereafter, is repealed, unless a later enacted statute that is enacted before that date deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 5. Section 100503 is added to the Government Code, 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) 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.

(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 and qualified small employers through the Exchange, 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 subsections (d) and (e) of Section 1302 of the federal act.

(e) Require, as a condition of participation in the Exchange, carriers to fairly and affirmatively offer, market, and sell in the Exchange at least one

product within each of the five levels of coverage contained in subsections (d) and (e) of Section 1302 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 Exchange under paragraph (10) of subdivision (a) of Section 100504.

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

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

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

(2) For purposes of this subdivision, "product" does not include contracts entered into pursuant to Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code between the Managed Risk Medical Insurance Board and carriers for enrolled Healthy Families beneficiaries or contracts entered into pursuant to Chapter 7 (commencing with Section 14000) of, 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.

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

(k) Undertake activities necessary to market and publicize the availability of health care coverage and federal subsidies through the Exchange. The board shall also undertake outreach and enrollment activities that seek to assist enrollees and potential enrollees with enrolling and reenrolling in the Exchange 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 (*l*) of Section 100502.

(m) Employ necessary staff.

(1) The board shall hire a chief fiscal officer, a chief operations officer, a director for the SHOP Exchange, a director of Health Plan Contracting, a chief technology and information officer, a general counsel, and other key executive positions, as determined by the board, who shall be exempt from civil service.

(2) (A) The board shall set the salaries for the exempt positions described in paragraph (1) and subdivision (i) of Section 100500 in amounts that are reasonably necessary to attract and retain individuals of superior qualifications. The salaries shall be published by the board in the board's annual budget. The board's annual budget shall be posted on the Internet Web site of the Exchange. To determine the compensation for these positions, the board shall cause to be conducted, through the use of independent outside advisors, salary surveys of both of the following:

(i) Other state and federal health insurance exchanges that are most comparable to the Exchange.

(ii) Other relevant labor pools.

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

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

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

(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 Exchange. This charge shall not affect the requirement under Section 1301 of the federal act that carriers charge the same premium rate for each qualified health plan whether offered inside or outside the Exchange.

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

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

(q) (1) Annually prepare a written report on the implementation and performance of the Exchange 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. 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 Exchange. 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

Exchange, are necessary state requirements and are distinct from the promotion of legislative or regulatory modifications referred to in subdivision (d) of Section 100520.

(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 act and the federal act.

(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) Representatives of small businesses and self-employed individuals.

(4) The State Medi-Cal Director.

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

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

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

(w) With respect to the SHOP Program, collect premiums and administer all other necessary and related tasks, including, but not limited to, enrollment and plan payment, in order to make the offering of employee plan choice as simple as possible for qualified 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. 6. Section 100504.5 is added to the Government Code, to read:

100504.5. (a) To the extent approved by the appropriate federal agency, for the purpose of implementing the option in paragraph (7) of subdivision (a) of Section 100504, the Exchange shall make available bridge plan products to individuals specified in Section 14005.70 of the Welfare and Institutions Code. In implementing this requirement, the Exchange, using the selective contracting authority described in subdivision (c) of Section 100503, shall contract with, and certify as a qualified health plan, a bridge plan product that is, at a minimum, certified by the Exchange as a qualified bridge plan product. For purposes of this section, in order to be a qualified bridge plan product, the plan shall do all of the following:

(1) Be a health care service plan or health insurer that contracts with the State Department of Health Care Services to provide Medi-Cal managed care plan services pursuant to Section 14005.70 of the Welfare and Institutions Code.

(2) Meet minimum requirements to contract with the Exchange as a qualified health plan pursuant to Section 1301 of the federal Patient Protection and Affordable Care Act (Public Law 111-148) and Sections 100502, 100503, and 100507 of this code.

(3) Enroll in the bridge plan product only individuals who meet the requirements of Section 14005.70 of the Welfare and Institutions Code.

(4) Comply with the medical loss ratio requirements of Section 1399.864 of the Health and Safety Code or Section 10961 of the Insurance Code.

(5) Demonstrate the bridge plan product has, at minimum, a substantially similar provider network as the Medi-Cal managed care plan offered by the health care service plan or health insurer.

(b) The Exchange shall provide information on all of the available Exchange-qualified health plans in the area, including, but not limited to, bridge plan product options for selection by individuals eligible to enroll in a bridge plan product.

(c) Nothing in this section shall be implemented in a manner that conflicts with a requirement of the federal act.

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

SEC. 7. Section 100504.6 is added to the Government Code, to read:

100504.6. (a) The Exchange shall have the authority to adopt regulations to implement the provisions of Section 100504.5. Prior to the adoption of regulations, the board and its staff shall meet the requirement of subdivision (t) of Section 100503 in implementing the bridge plan option. Until January 1, 2016, the adoption, amendment, or repeal of a regulation authorized by this section shall be exempted from the Administrative Procedure Act

(Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2).

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

SEC. 8. Section 1366.6 of the Health and Safety Code is amended to read:

1366.6. (a) For purposes of this section, the following definitions shall apply:

(1) "Exchange" means the California Health Benefit Exchange established in Title 22 (commencing with Section 100500) of the Government Code.

(2) "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.

(3) "Qualified health plan" has the same meaning as that term is defined in Section 1301 of the federal act.

(4) "Small employer" has the same meaning as that term is defined in Section 1357.

(b) (1) Health care service plans participating in the Exchange shall fairly and affirmatively offer, market, and sell in the Exchange at least one product within each of the five levels of coverage contained in subsections (d) and (e) of Section 1302 of the federal act.

(2) The board established under Section 100500 of the Government Code may require plans to sell additional products within each of those levels of coverage.

(3) This subdivision shall not apply to a plan that solely offers supplemental coverage in the Exchange under paragraph (10) of subdivision (a) of Section 100504 of the Government Code.

(4) This subdivision shall not apply to a bridge plan product that meets the requirements of Section 100504.5 of the Government Code to the extent approved by the appropriate federal agency.

(c) (1) Health care service plans participating in the Exchange that sell any products outside the Exchange shall do both of the following:

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

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

(2) For purposes of this subdivision, "product" does not include contracts entered into pursuant to Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code between the Managed Risk Medical Insurance Board and health care service plans for enrolled Healthy Families beneficiaries or to contracts entered into pursuant to Chapter 7 (commencing

with Section 14000) of, 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 health care service plans for enrolled Medi-Cal beneficiaries, or for contracts with bridge plan products that meet the requirements of Section 100504.5 of the Government Code.

(d) Commencing January 1, 2014, 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 subsections (d) and (e) of Section 1302 of the federal act, except that a health care service plan that does not participate in the Exchange 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, 2014, a health care service plan that does not participate in the Exchange 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 Exchange 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 Exchange exercises its authority under subdivision (c) of Section 100504 of the Government Code. Nothing in this subdivision shall require a plan that does not participate in the Exchange 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 Exchange 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) For purposes of this section, a bridge plan product shall mean an individual health benefit plan, as defined in subdivision (f) of Section 1399.845, that is offered by a health care service plan licensed under this chapter that contracts with the Exchange pursuant to Title 22 (commencing with Section 100500) of the Government Code.

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

SEC. 9. Section 1366.6 is added to the Health and Safety Code, to read:

1366.6. (a) For purposes of this section, the following definitions shall apply:

(1) "Exchange" means the California Health Benefit Exchange established in Title 22 (commencing with Section 100500) of the Government Code.

(2) "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.

(3) "Qualified health plan" has the same meaning as that term is defined in Section 1301 of the federal act.

(4) "Small employer" has the same meaning as that term is defined in Section 1357.

(b) Health care service plans participating in the Exchange shall fairly and affirmatively offer, market, and sell in the Exchange at least one product within each of the five levels of coverage contained in subsections (d) and (e) of Section 1302 of the federal act. The board established under Section 100500 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 Exchange under paragraph (10) of subdivision (a) of Section 100504 of the Government Code.

(c) (1) Health care service plans participating in the Exchange that sell any products outside the Exchange shall do both of the following:

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

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

(2) For purposes of this subdivision, "product" does not include contracts entered into pursuant to Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code between the Managed Risk Medical Insurance Board and health care service plans for enrolled Healthy Families beneficiaries or to contracts entered into pursuant to Chapter 7 (commencing with Section 14000) of, 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 health care service plans for enrolled Medi-Cal beneficiaries.

(d) Commencing January 1, 2014, 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 subsections (d) and (e) of Section 1302 of the federal act, except that a health care service plan that does not participate in the Exchange 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, 2014, a health care service plan that does not participate in the Exchange 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 Exchange 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 Exchange exercises its authority under subdivision (c) of Section 100504 of the Government Code. Nothing in this subdivision shall require a plan that does not participate in the Exchange 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 Exchange 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) This section shall become operative only if Section 8 of the act that added this section becomes inoperative pursuant to subdivision (g) of that Section 8.

SEC. 10. Section 1399.864 is added to the Health and Safety Code, to read:

1399.864. (a) For purposes of this article, a bridge plan product shall mean an individual health benefit plan, as defined in subdivision (f) of Section 1399.845, that is offered by a health care service plan licensed under this chapter that contracts with the Exchange pursuant to Title 22 (commencing with Section 100500) of the Government Code.

(b) Until December 31, 2014, a health care service plan that contracts with the California Health Benefit Exchange to offer a qualified bridge plan product pursuant to Section 100504 of the Government Code shall do all of the following:

(1) As of the effective date of this section, if the health care service plan has not been approved by the director to offer individual health benefit plans pursuant to this chapter, the plan shall file a material modification pursuant to Section 1352 to expand its license to include individual health benefit plans.

(2) As of the effective date of this section, if the health care service plan has been approved by the director to offer individual health benefit plans pursuant to this chapter, the plan shall, pursuant to Section 1352, file an amendment to expand its license to include a bridge plan product as an individual health benefit plan.

(c) During the time the health care service plan's material modification or amendment is pending approval by the director, the health care service plan shall be deemed to comply with subdivision (b) of Section 100507 of the Government Code.

(d) A health care service plan shall maintain a medical loss ratio of 85 percent for the bridge plan product. A health care service plan shall utilize, to the extent possible, the same methodology for calculating the medical loss ratio for the bridge plan product that is used for calculating the health care service plan medical loss ratio pursuant to Section 1367.003 and shall report its medical loss ratio for the bridge plan product to the department as provided in Section 1367.003.

(e) Notwithstanding subdivision (a) of Section 1399.849, a health care service plan selling a bridge plan product shall not be required to fairly and affirmatively offer, market, and sell the health care service plan's bridge plan product except to individuals eligible for the bridge plan product pursuant to the State Department of Health Care Services and the Medi-Cal managed care plan's contract entered into pursuant to Section 14005.70 of the Welfare and Institutions Code, provided the health care service plan

meets the requirements of subdivision (b) of Section 14005.70 of the Welfare and Institutions Code.

(f) Notwithstanding subdivision (c) of Section 1399.849, a health care service plan selling a bridge plan product shall provide an initial open enrollment period of six months, and an annual enrollment period and a special enrollment period consistent with the annual enrollment and special enrollment periods of the Exchange.

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

SEC. 11. Section 10112.3 of the Insurance Code is amended to read:

10112.3. (a) For purposes of this section, the following definitions shall apply:

(1) "Exchange" means the California Health Benefit Exchange established in Title 22 (commencing with Section 100500) of the Government Code.

(2) "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.

(3) "Qualified health plan" has the same meaning as that term is defined in Section 1301 of the federal act.

(4) "Small employer" has the same meaning as that term is defined in Section 10700.

(b) Health insurers participating in the Exchange shall fairly and affirmatively offer, market, and sell in the Exchange at least one product within each of the five levels of coverage contained in subsections (d) and (e) of Section 1302 of the federal act. The board established under Section 100500 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 Exchange under paragraph (10) of subdivision (a) of Section 100504 of the Government Code. This subdivision shall not apply to a bridge plan product of a Medi-Cal managed care plan that contracts with the State Department of Health Care Services pursuant to Section 14005.70 of the Welfare and Institutions Code and that meets the requirements of Section 100504.5 of the Government Code, to the extent approved by the appropriate federal agency.

(c) (1) Health insurers participating in the Exchange that sell any products outside the Exchange shall do both of the following:

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

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

(2) For purposes of this subdivision, "product" does not include contracts entered into pursuant to Part 6.2 (commencing with Section 12693) of Division 2 between the Managed Risk Medical Insurance Board and health insurers for enrolled Healthy Families beneficiaries or to contracts entered into pursuant to Chapter 7 (commencing with Section 14000) of, 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 health insurers for enrolled Medi-Cal beneficiaries or for contracts with bridge plan products that meet the requirements of Section 100504.5 of the Government Code.

(d) Commencing January 1, 2014, a health insurer, with respect to policies that cover hospital, medical, or surgical benefits, may only sell the five levels of coverage contained in subsections (d) and (e) of Section 1302 of the federal act, except that a health insurer that does not participate in the Exchange may, 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, 2014, a health insurer that does not participate in the Exchange shall, with respect to policies that cover hospital, medical, or surgical expenses, offer at least one standardized product that has been designated by the Exchange 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 Exchange exercises its authority under subdivision (c) of Section 100504 of the Government Code. Nothing in this subdivision shall require an insurer that does not participate in the Exchange 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 Exchange 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) For purposes of this section, a bridge plan product shall mean an individual health benefit plan, as defined in subdivision (a) of Section 10198.6 that is offered by a health insurer that contracts with the Exchange pursuant to Section 100504.5 of the Government Code.

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

SEC. 12. Section 10112.3 is added to the Insurance Code, to read:

10112.3. (a) For purposes of this section, the following definitions shall apply:

(1) "Exchange" means the California Health Benefit Exchange established in Title 22 (commencing with Section 100500) of the Government Code.

(2) "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.

(3) "Qualified health plan" has the same meaning as that term is defined in Section 1301 of the federal act.

(4) "Small employer" has the same meaning as that term is defined in Section 10700.

(b) Health insurers participating in the Exchange shall fairly and affirmatively offer, market, and sell in the Exchange at least one product within each of the five levels of coverage contained in subsections (d) and (e) of Section 1302 of the federal act. The board established under Section 100500 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 Exchange under paragraph (10) of subdivision (a) of Section 100504 of the Government Code.

(c) (1) Health insurers participating in the Exchange that sell any products outside the Exchange shall do both of the following:

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

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

(2) For purposes of this subdivision, "product" does not include contracts entered into pursuant to Part 6.2 (commencing with Section 12693) of Division 2 between the Managed Risk Medical Insurance Board and health insurers for enrolled Healthy Families beneficiaries or to contracts entered into pursuant to Chapter 7 (commencing with Section 14000) of, 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 health insurers for enrolled Medi-Cal beneficiaries.

(d) Commencing January 1, 2014, a health insurer, with respect to policies that cover hospital, medical, or surgical benefits, may only sell the five levels of coverage contained in subsections (d) and (e) of Section 1302 of the federal act, except that a health insurer that does not participate in the Exchange may, 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, 2014, a health insurer that does not participate in the Exchange shall, with respect to policies that cover hospital, medical, or surgical expenses, offer at least one standardized product that has been designated by the Exchange 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 Exchange exercises its authority under subdivision (c) of Section 100504 of the Government Code. Nothing in this subdivision shall

require an insurer that does not participate in the Exchange 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 Exchange 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) This section shall become operative only if Section 11 of the act that added this section becomes inoperative pursuant to subdivision (g) of that Section 11.

SEC. 13. Section 10961 is added to the Insurance Code, to read:

10961. (a) For purposes of this article, a bridge plan product shall mean an individual health benefit plan that is offered by a health insurer licensed under this chapter that contracts with the Exchange pursuant to Title 22 (commencing with Section 100500) of the Government Code.

(b) On and after the effective date of this section, if a health insurance policy has not been filed with the commissioner, a health insurer that contracts with the California Health Benefit Exchange to offer a qualified bridge plan product pursuant to Section 100504.5 of the Government Code shall file the policy form with the commissioner pursuant to Section 10290.

(c) (1) Notwithstanding subdivision (a) of Section 10965.3, a health insurer selling a bridge plan product shall not be required to fairly and affirmatively offer, market, and sell the health insurer's bridge plan product except to individuals eligible for the bridge plan product pursuant to the State Department of Health Care Services and the Medi-Cal managed care plan's contract entered into pursuant to Section 14005.70 of the Welfare and Institutions Code, provided the health care service plan meets the requirements of subdivision (b) of Section 14005.70 of the Welfare and Institutions Code.

(2) Notwithstanding subdivision (c) of Section 10965.3, a health insurer selling a bridge plan product shall provide an initial open enrollment period of six months, and an annual enrollment period and a special enrollment period consistent with the annual enrollment and special enrollment periods of the Exchange.

(d) A health insurer that contracts with the California Health Benefit Exchange to offer a qualified bridge plan product pursuant to Section 100504 of the Government Code shall maintain a medical loss ratio of 85 percent for the bridge plan product. A health insurer shall utilize, to the extent possible, the same methodology for calculating the medical loss ratio for the bridge plan product that is used for calculating the health insurer's medical loss ratio pursuant to Section 10112.25 and shall report its medical loss ratio for the bridge plan product to the department as provided in Section 10112.25.

(e) This section shall become inoperative on the October 1 that is five years after the date that federal approval of the bridge plan option occurs, and, as of the second January 1 thereafter, is repealed, unless a later enacted

statute that is enacted before that date deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 14. Section 14005.70 is added to the Welfare and Institutions Code, to read:

14005.70. (a) The State Department of Health Care Services shall ensure that its contracts with a health care service plan or health insurer to provide Medi-Cal managed care coverage meet all of the following requirements:

(1) A health care service plan or health insurer shall provide coverage in its bridge plan product to its Medi-Cal managed care enrollees and other individuals that meet the requirements in paragraph (2) if the Medi-Cal managed care plan offers a bridge plan product pursuant to Section 100504.5 of the Government Code.

(2) Only the following individuals shall be eligible to enroll in the Medi-Cal managed care plan's bridge plan product if the Medi-Cal managed care plan offers a bridge plan product:

(A) An individual who is determined to be eligible for the Exchange and whose Medi-Cal coverage or Healthy Families coverage was terminated. In implementing this subparagraph, the Exchange shall adopt processes to ensure that individuals have no gap in coverage to the greatest extent possible. The Exchange shall request approval from the federal government to limit enrollment under this subparagraph to individuals with a family income at or below 250 percent of the federal poverty level.

(B) Other members of the modified adjusted gross income household, as defined in Section 100501 of the Government Code, in which there are Medi-Cal or Healthy Families enrollees.

(C) A parent or caretaker relative of a child on Medi-Cal. The Exchange may delay the operative date of this subparagraph until it has the operational capability to implement this subparagraph, but no later than January 1, 2015.

(3) Provide all of the following:

(A) Except as provided in subparagraph (C) of paragraph (2), an individual who is eligible to enroll in a bridge plan product under subparagraph (A) of paragraph (2) shall only be eligible to enroll in a bridge plan product offered by the health care service plan or health insurer through which the individual was enrolled prior to eligibility for a bridge plan product as either a Medi-Cal beneficiary or as a Healthy Families enrollee.

(B) An individual who is eligible to enroll in a bridge plan product under subparagraph (B) of paragraph (2) shall only be eligible to enroll in a bridge plan product offered by the health care service plan or health insurer through which the member of the household was enrolled as a Medi-Cal beneficiary or as a Healthy Families enrollee.

(C) The Exchange shall seek federal approval to allow individuals described in subparagraphs (A) and (B) the option to enroll in a different bridge plan product if the individual's primary care provider is included in the contracted network of the different bridge plan product and either of the following applies to the bridge plan product for which the individual is eligible:

(i) The product is not offered in that individual's service area.

(ii) The product is not offered as a bridge plan product by the Exchange.

(4) The Medi-Cal managed care plan shall only offer a bridge plan product if the bridge plan product premium contribution amount in the silver category for the eligible individual is equal to, or less than, the premium contribution amount for the lowest cost plan in the silver category that would have been available to that individual without the bridge plan product.

(b) The State Department of Health Care Services may enter into a contract with the California Health Benefit Exchange to delegate the implementation of any part of this section to the Exchange.

(c) Notwithstanding subdivision (a) of Section 1399.849 of the Health and Safety Code and subdivision (a) of Section 10965.3 of the Insurance Code, the State Department of Health Care Services may allow a Medi-Cal managed care plan, pursuant to its contract under this section, to limit enrollment into bridge plan products to eligible individuals identified in paragraph (2) of subdivision (a) of this section based on limitations in contracted network capacity for bridge plan products as provided in Section 1399.857 of the Health and Safety Code or Section 10753.12 of the Insurance Code.

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

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