AB-174 Health care. (2019-2020)

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Assembly Bill No. 174

CHAPTER 795

An act to amend Section 5922 of the Corporations Code, and to add and repeal Section 100509 of the Government Code, relating to health care.

[Approved by Governor October 12, 2019. Filed with Secretary of State October 12, 2019.]

LEGISLATIVE COUNSEL'S DIGEST

AB 174, Wood. Health care.

Existing federal law, the Patient Protection and Affordable Care Act (PPACA), requires each state to establish an American Health Benefit Exchange to facilitate the purchase of qualified health benefit plans by qualified individuals and qualified small employers. PPACA defines a “qualified health plan” as a plan that, among other requirements, provides an essential health benefits package. Existing state law creates the California Health Benefit Exchange, also known as Covered California, to facilitate the enrollment of qualified individuals and qualified small employers in qualified health plans as required under PPACA. Existing law, until January 1, 2023, requires the Exchange, among other duties, to administer an individual market assistance program to provide health care coverage financial assistance to California residents with household incomes at or below 600% of the federal poverty level.

This bill would, until January 1, 2023, require the board of the Exchange to develop and prepare biannual public reports for the purpose of informing the California Health and Human Services Agency, the Legislature, and the public about the enrollment process for the individual market assistance program. The bill would require the reports to contain specified information, including, among other things, the number of applications received for the program during the reporting period and the disposition of those applications.

Existing law requires a nonprofit corporation, as defined, that operates or controls a health facility, or operates or controls a facility that provides similar health care, to obtain the written consent of the Attorney General prior to selling or otherwise disposing of a material amount of its assets to another nonprofit corporation or entity. Existing law provides certain exceptions to this requirement, including if the Attorney General has given the corporation a written waiver as to the proposed agreement or transaction.

This bill would correct an erroneous cross-reference relating to the Attorney General’s written waiver.

Vote: majority Appropriation: no Fiscal Committee: yes Local Program: no

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 5922 of the Corporations Code is amended to read:

5922. Prior to issuing any written decision referred to in Section 5921, or giving a written waiver under subdivision (c) of Section 5920, the Attorney General shall conduct one or more public meetings, one of which shall be in the county in which the facility is located, to hear comments from interested parties. At least 14 days before conducting the public meeting, the Attorney General shall provide written notice of the time and place of the meeting through publication in one or more newspapers of general circulation in the affected community and to the board of supervisors of the county in which the facility is located. This notice shall be provided in English and in the primary languages spoken at the facility and the threshold languages for Medi-Cal beneficiaries as determined by the State Department of Health Care Services for the county in which the facility is located. If a substantive change in the proposed agreement or transaction is submitted to the Attorney General after the initial public meeting, the Attorney General may conduct an additional public meeting to hear comments from interested parties with respect to that change.

SEC. 2. Section 100509 is added to the Government Code, to read:

100509. (a) The board shall develop and prepare biannual public reports for the purpose of informing the California Health and Human Services Agency, the Legislature, and the public about the enrollment process for the individual market assistance program pursuant to Title 25 (commencing with Section 10800). The reports shall include, but not be limited to, the following deidentified, aggregated information:

(1) The number of applications received for the individual market assistance program during the reporting period.

(2) The number of applicants included on the applications referenced in paragraph (1).

(3) Aggregate applicant demographics, including, but not limited to, gender, age, race, ethnicity, and primary language.

(4) The disposition of applications submitted during the reporting period, including the number of eligibility determinations that resulted in approval for state premium assistance.

(5) The number of program participants and average monthly state premium assistance received by participants in the following categories:

(A) Above 400 percent and at or below 600 percent, of the federal poverty level.

(B) Above 200 percent and at or below 400 percent, of the federal poverty level.

(C) At or below 138 percent of the federal poverty level.

(6) The qualified health plan issuers selected by program participants.

(7) Any other information the board determines to be relevant to the individual market assistance program design.

(b) The reports required to be submitted to the Legislature pursuant to subdivision (a) shall be submitted in compliance with Section 9795.

(c) This section shall remain in effect only until January 1, 2023, and as of that date is repealed.