SJOBERG & EVASHENK CONSULTING, INC.
CALIFORNIA HEALTH BENEFIT EXCHANGE
INDEPENDENT EXTERNAL PROGRAMMATIC AUDIT
PLAN YEAR 2014

SUMMARY OF RESULTS

BACKGROUND

Under the federal Patient Protection and Affordable Care Act (ACA) signed into law in March 2010, states were required to decide whether to create a state-based health insurance exchange or participate in the federal multi-state health insurance exchange. California elected to establish a state-based health insurance exchange. In 2010, state law [Government Code 100500 *et seq.*; Chapter 655, Statutes of 2010 (Perez) and Chapter 659, Statutes of 2010 (Alquist)] was enacted to implement the provisions of the Affordable Care Act and to "reduce the number of uninsured Californians by creating an organized, transparent marketplace for Californians to purchase affordable, quality health care coverage, to claim available tax credits and cost-sharing subsidies, and to meet the personal responsibility requirements imposed under the federal act." This legislation established the California Health Benefit Exchange, now known as Covered California.

Covered California is an independent public entity within California State Government. It is governed by a five-member Board appointed by the Governor and Legislature. Four of the members are appointed for four-year terms, two by the Governor, one by the Senate Rules Committee and one by the Speaker of the Assembly. The California Secretary of Health and Human Services is a voting ex-officio member of the Board. The Board elected the California Secretary of Health and Human Services Agency as Chair, signaling its intention to actively coordinate and collaborate with existing state agencies involved in providing health coverage to Californians.

As the first state in the nation to enact legislation to implement the ACA, Covered California's established mission is to increase the number of insured Californians, improve health care quality, lower health care costs, and reduce health disparities through an innovative and competitive marketplace from which consumers can choose the health plan providers that give them the best value. To achieve its mission, Covered California adopted the following goals and objectives:

- Reduce the number of uninsured Californians by creating an organized, transparent, marketplace for Californians to purchase affordable, quality health care coverage to claim available Federal

tax credits and cost-sharing subsidies, and to meet the personal responsibility requirements imposed under the ACA.

- Strengthen the health care delivery system.
- Create a competitive marketplace, including competitive processes to select participating carriers and other contractors.
- Establish patient-centered benefit designs that require health care service plans and health insurers in the individual and small employers markets to compete on the basis of price, quality, and service (and not on risk selection).
- Meet Federal and state law requirements, guidance, and regulations.

Implementing Title 45, Code of Federal Regulations (CFR), §155.1200(c), the Center of Consumer Information and Insurance Oversight (CCIIO) of the Centers for Medicare and Medicaid Services (CMS) requires State-based Marketplaces to have annual financial and programmatic audits conducted by independent external auditors, in accordance with the generally accepted government auditing standards promulgated by the Comptroller General of the United States. Such external independent audits are to be submitted to CCIIO via the web-based State-based Marketplace Annual Reporting Tool.

SCOPE AND OBJECTIVES

Covered California contracted with Sjoberg Evashenk Consulting, Inc. (SEC) to conduct an independent external programmatic audit for Plan Year ended December 31, 2014. Following CCIIO's interpretive guidance, the scope of this first annual external programmatic audit was established to include an assessment of its compliance with key requirements established by 45 CFR Part 155, Subpart C – General Functions of an Exchange; Subpart D – Exchange Functions in the Individual Market: Eligibility Determinations for Exchange Participation and Insurance Affordability Programs; Subpart E – Exchange Functions in the Individual Market: Enrollment in Qualified Health Plans; Subpart H – Exchange Functions: Small Business Health Options Program (SHOP); Subpart K – Exchange Functions: Certification of Qualified Health Plans; and privacy and security standards. The audit objectives were to:

- Determine compliance with requirements under relevant Subparts of 45 CFR Part 155.
- Evaluate whether processes and procedures are designed to prevent improper eligibility determinations and enrollment transactions.

- Identify errors that result in incorrect eligibility determinations.

Consistent with its vision to improve the health of all Californians by ensuring their access to affordable, high quality care, Covered California continues to make significant progress to ensure effective implementation of the ACA. Prior to, and during, the 2014 audit period, Covered California established a broad network of consumer assistance activities, performed both by Covered California personnel and community-based organizations. During the inaugural 2014 benefit year, Covered California enrolled 1.4 million individuals in a Covered California Plan, of which 1.14 million individuals, or 81 percent, paid their first month premium and effectuated their enrollment.

In addition to enrolling a substantial number of Californians in health plans, Covered California had established many sound business processes and internal controls, as evidenced by its many formalized and adopted, as well as drafted or in-progress, policies and procedures that contain many strong control points and features. This audit also found that Covered California had established ongoing monitoring and oversight functions such as biennial Financial Integrity and State Manager's Accountability Act (FISMA) reviews and risk assessments, as well as an Internal Audit function as early as 2013. Bolstering these efforts, Covered California was—during audit fieldwork—in the process of establishing a Program Integrity Division (PID) with the purpose of improving system and operational efficiencies and ensuring program compliance with Federal and state regulations and mandates.

As the initial independent external programmatic audit conducted pursuant to 45 CFR 155.1200 (Subpart M), this audit focused primarily on the Exchange's compliance with the requirements set forth in 45 CFR 155. This audit found that the Exchange demonstrated compliance with a majority of these regulations, but also revealed that continued efforts to implement required program components and increased internal and system controls remain ongoing and necessary.

COVERED CALIFORNIA'S COMMENTS ON THE AUDIT

In the audit report, the auditors presented 26 findings and 26 recommendations to which Covered California has prepared specific responses and corrective actions, as noted below. To put the audit findings in proper perspective, Covered California would like to highlight that California was the first state in the nation to enact legislation to implement the ACA by creating a State-based Marketplace to allow individuals, families, and small businesses access to shop and purchase affordable health care coverage. Plan Year 2014 was the first year of ACA implementation.

Covered California was also mindful of, and made reasonable and good faith efforts to comply with, the relevant subparts of 45 CFR Part 155. However, we should note that during the first year of program implementation, we placed our primary focus on building the necessary systems to facilitate the smooth and efficient enrollment of as many eligible Californians as possible into Covered California. As we have been successful in

facilitating enrollment, Covered California is putting even more focus on compliance. Specifically, we established a comprehensive Program Integrity Unit that became operational July 1, 2015. The purpose of PID is to implement an ongoing Oversight and Monitoring Program, as prescribed by CCIIO, to ensure program integrity, efficiency, effectiveness, and compliance.

AUDIT FINDINGS, RECOMMENDATIONS AND CORRECTIVE ACTIONS

The auditors identified 26 findings with recommendations for improvement. Six [6] findings related to Subpart C – Consumer Assistance & General Functions of the Exchange; 16 findings to Subparts D and E – Exchange Functions in the Individual Market; One [1] finding to Subpart H – Exchange Functions: SHOP; and three [3] findings to Subpart K – Certification of Qualified Health Plans (QHP). The findings, recommendations, and Covered California's responses and corrective actions are presented below, in the order of the relevant Subparts of 45 CFR Part 155. Please note, all corrective action plans have been updated as of March 1, 2017.

Auditors' Recommendation	Covered California's Responses and Intended Corrective Action Plans
Subpart C – Consumer Assistance & General Functions of the Exchange	
Finding 1: Exchange does not ensure authorized representatives fulfill responsibilities or comply with confidentiality conflict of interest laws.	
Ensure all authorized representatives have formal agreements to comply with state and federal laws concerning conflicts of interest and confidentiality of information.	*The authorized representative language was revised and informally submitted to the CMS for approval in October 2016. Formal submission for CMS review will occur in summer 2017.*
Finding 2: Required Certified Application Counselor (CAC) program was not in place.	
Implement the Certified Application Counselor (CAC) program as soon as feasible.	*As of September 2015, the CAC program was implemented.*
Finding 3: Insufficient oversight and monitoring of Certified Enrollment Entities (CEE) and individual performing consumer assistance activities.	
Establish an oversight and monitoring contract management process for Certified Enrollment Entities	*CEE and CEC oversight and monitoring process was implemented in 2016.*

Auditors' Recommendation	Covered California's Responses and Intended Corrective Action Plans
(CEE) and Certified Enrollment Counselor's (CEC).	
Finding 4: Exchange could not demonstrate that all CEEs acting as IPAs had required written plans to remain free of conflicts of interest.	
Ensure that the non-Navigator/"In-Person Assistor" program ends on June 30, 2015 as intended.	*The "In-Person Assistor" Program ended on June 30, 2015.*
Finding 5: Exchange website did not display all required information.	
Display all information required by Code of Federal Regulations (CFR) 155.205(b), and consider making required information more easily locatable.	*Information was tested and updated on the following webpage in October 2016: http://hbex.coveredca.com/insurance-companies/*
Finding 6: Increased monitoring of Exchange programs and non-Exchange entities is necessary to ensure adherence to establish privacy and security protocols.	
Implement a formal privacy and security monitoring process.	*Covered California implemented several formal privacy and security monitoring policies, processes and procedures, and continually develops strategies to ensure adherence of privacy and security protocols.*
Subparts D & E – Exchange Functions in the Individual Market	
Finding 7: Eligibility data maintained within CalHEERS contained inconsistencies and did not always agree with QHP issuer records.	
Identify the causes for inconsistencies of similar eligibility data within CalHEERS and establish processes to resolve exceptions.	*CalHEERS implemented a transaction management tool to ensure inconsistencies are identified. Reconciliation of the inconsistencies within CalHEERS eligibility data occurred in February 2017.*
Finding 8: Exchange did not always follow required eligibility verification processes.	
Fix CalHEERS functionality and perform required verifications of eligibility.	*Covered California has implemented changes in CalHEERS to ensure eligibility verification processes are followed. Covered California will continue to follow a monthly, manual process for resolving*

Auditors' Recommendation	Covered California's Responses and Intended Corrective Action Plans
	outstanding verifications until final system changes occur in October 2017.
Finding 9: Individuals not meeting required eligibility criteria received APTC and/or CSR.	
Ensure required verifications occur in CalHEERS prior to making an eligibility determination and ensure a final eligibility determination is made within 90 days for conditionally eligible individuals.	*Covered California has implemented changes in CalHEERS to ensure eligibility verification processes are followed, including automatic disenrollment for consumers that exceed the 95-day reasonable opportunity period. Covered California will continue to follow a monthly, manual process for resolving outstanding verifications until final system changes occur in October 2017.*
Finding 10: Exchange did not always provide timely written notice of eligibility determinations.	
Configure CalHEERS to automatically generate an eligibility determination notice.	*This functionality was fully implemented in the first Open Enrollment of 2014.*
Finding 11: Advanced Premium Tax Credit was not always correctly calculated and reported.	
Implement CalHEERS system updates to ensure accurate reporting of APTC to Health and Human Services (HHS) and the individual.	*CalHEERS functionality to ensure accurate reporting of APTC was fully implemented in September 2016.*
Finding 12: Process to notify employers when an employee is eligible for APTC is not in place.	
Implement a process to notify employers when an employee is determined or redetermined eligible for APTC or Cost Sharing Reduction (CSR).	*Covered California updated employer notices policies and procedures, with the most recent in February 2017.*
Finding 13: Required enrollee attestation related to APTC reconciliation requirement is missing.	
Incorporate the attestation requirement from 45 CFR 155.315(f)(4) into CalHEERS.	*The attestation requirement from 45 CFR 155.315(f)(4) was fully implemented into CalHEERS in May 2016.*

Auditors' Recommendation	Covered California's Responses and Intended Corrective Action Plans
Finding 14: Required attestations for APTC may not be obtained from the primary tax filer.	
Revise the application for health insurance with financial assistance to ensure that it obtains the required attestations from the tax filer when the person completing the application is not the tax filer.	*Awaiting approval from CMS. Formal submission for CMS review will occur in summer 2017.*
Finding 15: Data sources not periodically examined to identify changes in eligibility as part of redetermination efforts.	
Establish a process to semiannually examine available data sources to identify enrollee deaths and, for enrollees receiving APTC or CSR, changes to Medicare, Medicaid, and Children's Health Insurance Program (CHIP) eligibility.	*Covered California is scheduled to implement business requirements to perform automatic semi-annual redeterminations for Medicare, Medicaid, CHIP, tax filing status, and death in September 2017. In the interim, Covered California will continue to use a manual process.*
Finding 16: Procedures have not been established regarding eligibility determinations performed on applications submitted directly to counties.	
Use the written procedures established in February 2015 to ensure that QHP, APTC, and CSR eligibility determinations are performed for all applications submitted directly to a county agency.	*Covered California has made available our complete collection of task guides, job aides, and training materials to all 58 counties overseen by Department of Health Care Services (DHCS). These resources include all information related to performing eligibility determinations for enrollment in a QHP through Covered California, with or without APTC/CSR.*
Finding 17: Required agreement for eligibility determinations and enrollments is not in place.	
Enter into a formal, written agreement with DHCS that clearly delineates the responsibilities of each party to minimize the burden on individuals, ensure prompt eligibility determinations and enrollments, and provide	*Since its inception, Covered California has worked closely with DHCS to ensure a consumer's application is granted an accurate eligibility determination in a timely manner and directed to the appropriate agency. Covered California and DHCS are joint sponsors of CalHEERS which requires close collaboration and ongoing partnership between our agencies. Covered California believes that existing agreements between our agencies meet the*

Auditors' Recommendation	Covered California's Responses and Intended Corrective Action Plans
compliance with 45 CFR 155.345(c), (d), (e), and (g).	*requirement set forth by CCIIO, and we will seek confirmation from CCIIO of this understanding.*
Finding 18: Applicants are required to provide information beyond the minimum necessary.	
Revise the application for enrollment without financial assistance to make marital status an optional field.	*CalHEERS is re-evaluating the contents and prioritizing of fields for an applicant not requesting financial assistance. The changes will be fully implemented after the 2017 Open Enrollment Period.*
Finding 19: Eligibility change reporting requirements are not always clearly communicated to enrollees.	
Replace wording on its website that clearly identifies enrollees must report changes within 30 days. Revise webpage language to inform enrollees of the various and required channels through which they may report changes.	*Covered California's webpage was updated to clearly state that changes must be reported within 30 days, and revised the webpage to inform enrollees of all various and required channels to report changes, including online, telephone, and in person. These updates were fully implemented in April 2016.*
Finding 20: Special enrollment allowances did not meet the definition of qualifying triggering events.	
Ensure established policies during the Special Enrollment Period (SEP) are followed.	*Refresher training was conducted in February 2016, on SEP policies and procedures.*
Finding 21: Exchange could not demonstrate that it conducted monthly reconciliations of enrollment information between its internal systems, QHP issuers, and HHS.	
Establish a formal process to reconcile enrollment information with QHP issuers and HHS monthly.	*Covered California created a specialized unit to handle oversight and analysis of eligibility and enrollments concerns. The Data Integrity Unit is responsible for managing the Reconciliation, Enrollment and Membership (REM) as the established monthly reconciliation process with the Carriers participating on the California Exchange. All valid enrollments are subsequently evaluated for accuracy and completeness in accordance with all regulatory and policy guidance governing the eligibility and enrollment of consumers.*

Auditors' Recommendation	Covered California's Responses and Intended Corrective Action Plans
Finding 22: Additional corrective action is needed to fully address prior audit finding and ensure paper application data is accurately recorded in CalHEERS.	
Implement the Quality Assurance (QA)/Quality Control (QC) program initially developed in 2014 to ensure the accuracy of data from paper applications in CalHEERS.	*The service center QA team implemented paper application QA/QC program on June 30, 2016.*
Subpart H – Exchange Functions: SHOP	
Finding 23: SHOP applications could not be filed through the website.	
Ensure that all SHOP functionality is in place and continues to be operational to accept web-based applications.	*An online portal process is being developed in three phases, and is estimated to be fully implemented by March 2017.*
Subpart K – Certification of Qualified Health Plans	
Finding 24: Exchange does not collect or report all required QHP data to HHS or State Insurance Agency.	
Identify the QHP contract provisions which must be continually monitored and delegate the contract monitoring oversight responsibilities to specific staff.	*Covered California established dedicated staff to monitor QHP compliance with contract provisions, performance standards, and reporting requirements in June 2016.*
Finding 25: Exchange does not monitor certified QHP issuers for ongoing compliance with certification requirements.	
Monitor QHP issuers for compliance with certification requirements.	*Covered California hired contract management staff to comply with provisions of 45 CFR Section 155.1010(a) by November 2015. In 2016, we completed the following:* • *Identified all required data, and assigned specific staff members to monitor certification requirements for compliance.* • *Developed and maintained documentation listing all compliance and certification requirements, including status updates.*

Auditors' Recommendation	Covered California's Responses and Intended Corrective Action Plans
Finding 26: No distinct decertification process existed.	
Implement a clear, structured QHP decertification process in line with CFR provisions.	*Covered California developed a QHP decertification process in May 2015.*