SJOBERG EVASHENK CONSULTING, INC.
CALIFORNIA HEALTH BENEFIT EXCHANGE
INDEPENDENT EXTERNAL PROGRAMMATIC AUDIT
PLAN YEAR 2015

SUMMARY OF RESULTS

BACKGROUND

In 2010, California was the first state to adopt legislation to establish a state-based health insurance exchange under the Patient Protection and Affordable Care Act (ACA). The California Legislature established the California Health Benefit Exchange, known as Covered California, 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.

To achieve the intent of the State's legislation, Covered California adopted a mission to increase the number of insured Californians, improve health care quality, lower costs, and reduce health disparities through an innovative, competitive marketplace that empowers consumers to choose the health plan and providers that give them the best value. Covered California developed annual goals and Division objectives that were mapped to its strategic pillars to help ensure its activities and resources are aligned with its mission.

Plan Year 2015 was Covered California's second year of ACA implementation. During this plan year, Covered California accomplished several significant milestones towards achieving its mission, as follows:

- As of June 2015, Covered California enrolled more than 1.3 million members.
- California significantly reduced the number of uninsured Californians. Specifically, California's uninsured rate for all ages fell from 12 percent in 2014 to 8.6 percent in 2015.
- According to the Center for Disease Control and Prevention survey, California was one of six states noted as having a statistically significant lower percentage of uninsured individuals ages 18-64 in the first six months of 2015 than in 2014.

- The National Health Council recognized Covered California as a patient-focused insurance marketplace with strong policies in place to meet the needs of people with chronic diseases and disabilities.

- Covered California received the highest overall ratings of all 50 states for performance related to the five key principles of a patient-focused marketplace: non-discrimination, state oversight, uniformity, transparency, and continuity of care.

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, 2015. Following the Center for Consumer Information and Insurance Oversight's interpretive guidance, the scope of this annual external programmatic audit was established to include an assessment of its compliance with key requirements established by 45 CFR Part 155, such as the general functions of the Exchange, Individual Market eligibility determinations and enrollment processes, certification of Qualified Health Plan issuers (carriers), and small business market program administration. Specifically, the audit focused on the following six areas:

- Exchange information systems, including access to information, data integrity and reliability, and system controls;

- Individual market eligibility and enrollment, including eligibility determinations, insurance affordability programs and related reporting requirements, and enrollment terminations;

- Accounts receivable, including both individual and small business markets;

- Accounts payable practices, including payments to small business market partners and to the third-party administrator;

- Service Centers, including the access and security of data and the accuracy and reliability of data reported to customers and recorded in information systems at Service Centers; and

- Exchange oversight of consumer assistance activities and non-exchange entities.

COVERED CALIFORNIA'S COMMENTS ON THE AUDIT

Covered California evaluated the recommendations provided by SEC, and assessed the recommendations for the overall cost-benefits of implementation, potential for alternative mitigating controls, and risk tolerance. The results of the evaluation and

assessment are presented in the column titled "Covered California's Responses and Intended Corrective Actions Plan" of the table following the "Audit Findings, Recommendations, and Corrective Actions" section.

Covered California has been forthcoming and diligent while being closely monitored, heavily audited, and held to strict federal and state regulations and requirements. Furthermore, Covered California is making tremendous strides to streamline assistance to consumers it serves while progressing towards compliance with all applicable regulations and requirements.

Covered California has implemented ongoing monitoring and oversight of operations and program activities, including the development of the enterprise-wide risk management process in response to the State Leadership and Accountability Act, and the creation of the Program Integrity Division to improve system and operational efficiencies and help ensure program compliance with federal and state regulations. The successful implementation of these processes will not only continue to direct Covered California's compliance efforts, but will also help Covered California realize its vision of ensuring all Californians have access to affordable, high quality care.

In conclusion, Covered California is proud of its achievements in the areas of program efficiency and effectiveness. Covered California is ready and willing to take appropriate corrective actions to remedy areas needing further improvement.

AUDIT FINDINGS, RECOMMENDATIONS, AND CORRECTIVE ACTIONS

In 2015, only its second year as a fully-operational exchange, Covered California business processes continued to evolve and management continued to identify opportunities for improvement. This audit identified six areas where continued improvements are needed. The first three findings of this report addressed the accuracy and reliability of Covered California's information systems and the potential impact of identified inaccuracies, which could compromise Covered California's compliance with eligibility and enrollment regulations related to the Individual Market and fiscal operations related to both individual and small business marketplaces. This audit also addressed opportunities to enhance overall customer service, oversight of non-exchange entities and third-party service providers, and improved compliance with established privacy policies among Covered California's operating divisions. The findings, recommendations, and Covered California's Responses and Intended Corrective Actions Plan are presented below. 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
Finding 1: Covered California Cannot Sufficiently Rely on the Integrity of Data Recorded in and Generated by Key Information Systems		
1.1	Establish a process to reconcile the California Healthcare Eligibility and Enrollment Retention System (CalHEERS), to ensure the integrity and accuracy of data maintained in CalHEERS. Further refine the reconciliation process to include all key data fields.	*Covered California continues to implement and improve the existing reconciliation process, which typically involves key data fields such as benefit effective dates, or partitioning of financial value such as advanced premium tax credit/cost-sharing reductions (APTC/CSR). Data Inconsistencies are resolved in a timely manner. This is an ongoing process.*
1.2	Work with program partners to ensure information and data is accurately reported and transferred. Implement fixes in CalHEERS to ensure notifications are generated timely.	*An ongoing work plan has been implemented to evaluate CalHEERS generated reports for eligibility and enrollment consistency. A separate ongoing work plan was developed to address root cause of issues to help ensure notifications are generated timely.*
1.3	Negotiate a contract amendment with the Small-business Health Options Program provider, Pinnacle, to require monthly data reconciliations, self-audits that address premium billing, and audit access to fiscal processes and records.	*A contract amendment with Pinnacle was executed as of February 8, 2017, requiring monthly reconciliations, self-audits, and audit access to Pinnacle's records.*
1.4	Ensure all program staff understand the impact of changes to enrollment information and the effect changes have on data integrity.	*Refresher training was provided to all program staff in August and September of 2016, highlighting the impact of changes in enrollment and the downstream effects that consumers may encounter, along with impacts to transactions and data.*
Finding 2: Controls Over Accounts Receivable and Accounts Payable Should Be Enhanced		
2.1	Evaluate options to resolve inefficient accounts receivable and accounts payable processes related to accuracy, timeliness, and reliability of Pinnacle reports; reducing the number and detail of	*Covered California's Financial Management Division (FMD) and Covered California Small Business (CCSB) began the process of evaluating the option of relying more on Pinnacle's core system in order to reduce inaccurate reports, resulting in summary*

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	existing reports; evaluating the extent to which Fi$Cal will be able to accommodate business needs; and implementing a new fiscal system that has sufficient premium billing functionality.	*level processing requirements which are currently under review by Pinnacle. FMD is currently using Structured Query Language (SQL) to review and validate payment reports. It is estimated this will be completed by fiscal year 2017/18.*
2.2	Implement enhanced internal controls and review processes to fully reconcile all monies held in suspense.	*Internal controls and review processes were enhanced by adding a lockbox manager tool, which allows FMD and Pinnacle to reconcile cash receipts on a daily basis. FMD is in the process of reconciling cash in order to fully reconcile items in suspense. It is estimated this will be completed by late fiscal year 2016/17.*
2.3	Assess whether Covered California should continue its practice of invoicing carriers or require carriers to self-bill.	*Covered California has considered alternate billing processes, but has ultimately determined that Covered California is the system of record. Ongoing reconciliation was implemented to help ensure accurate Per Member/Per Month (PMPM) invoicing.. In January 2016, Covered California and carriers reached an agreement that the 2016 PMPM would be paid as billed, eliminating the practice of carriers adjusting the bill.*
Finding 3: Covered California's Processes Are Not Sufficient To Ensure Accurate and Allowable Enrollments and Terminations		
3.1	Continue with planned implementation of new processes and system updates to identify outstanding verifications and establish a process to ensure a final eligibility determination is made within the reasonable opportunity period (ROP).	*Covered California has prioritized system enhancements to implement automatic processing of cases that exceed the 95-day ROP and discontinue outstanding verifications for Social Security Number, income, American Indians/American Natives, and Minimum Essential Coverage. The estimated completion date is December 31, 2017.*
3.2	Develop or refine existing policies, procedures, and training resources for extending the ROP when a good faith effort is made	*A Service Center Representative (SCR) refresher course for SEPs was launched on March 18, 2016; updated policies and procedures were implemented in June 2016*

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	by an enrollee, manual verifications, enrollment terminations, enrollment during a special enrollment period (SEP), and documentation retained to support Exchange decisions.	*to strengthen policies on inconsistencies, manual verifications, terminations, and SEPs; and training materials and task guides have been updated to reflect current regulations. All completed by December 30, 2016.*
3.3	Establish a process to identify carrier-initiated terminations not in compliance with federal requirements and work with carriers to ensure carriers are knowledgeable of termination requirements.	*Guidance for carriers regarding carrier-initiated terminations and grace periods were developed. Ongoing communication of policies and procedures provided in weekly calls with carriers. Monitoring of carrier-initiated terminations and working with CalHEERS to develop reports that identify carrier-initiated terminations that do not comply with federal requirements are estimated to be completed by June 30, 2017.*
3.4	Expand, as resources permit, the Termination Reason categories in CalHEERS to capture all reasons why coverage might be terminated.	*Expanding the list of Termination Reason categories will be added to the list of proposed changes for CalHEERS to be evaluated for approval through standard protocol. If approved, it is estimated to be completed by December 2017.*
Finding 4: Enhancements Can Be Made to Better Improve the Customer Experience		
4.1	Improve documentation standards and related training for communications with consumers.	*The Service Center worked on updating a clearly defined documentation standard for all business units. Standards were integrated into staff training and monitored by the Quality Assurance (QA) Unit, team leads, and supervisor teams. This was implemented September 2016 and processes are ongoing.*
4.2	Refine notices for eligibility determination notices triggered by a representative or county, not a change reported by a consumer.	*Language has been updated in notices to clearly and correctly communicate determination of eligibility and was completed September 26, 2016.*
4.3	Develop enhanced quality assurance (QA) policies and	*Service Center has updated QA policies and procedures to provide a larger scope of*

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	procedures that address issues raised in this finding, including follow-up and correcting incorrect information in CalHEERS, requiring SCR management consistently and uniformly document all QA activities conducted with SCRs, and communication between Service Center staff and management, as well as other divisions.	*QA evaluations and reporting for business units. Issues identified are addressed by management and coaching is provided to SCRs to correct the issue. Service Center engages in a series of meetings to clarify process changes and provide feedback on materials and training provided to staff to help ensure consistency and distribute information. Partial implementation occurred August and September 2016, with an estimated completion date of June 30, 2017.*
Finding 5: Covered California Program Managers Should Increase Oversight of Non-Exchange Entities, Contractors, and Carriers		
5.1	Negotiate with Pinnacle to implement a new, financially-focused Service Level Agreement (SLA) that clearly defines the expectations of FMD and required deliverables and assign liquidated damages when services levels are not met.	*Covered California amended its contract with Pinnacle to include a defined SLA that clearly notes the expectations and liquidated damage percentages for service levels concerned with financial reporting expectations. The contract amendment was executed as of February 8, 2017.*
5.2	Implement a formal oversight process that focuses on the financial aspects of Pinnacle's performance.	*The Covered California Small Business contract manager has developed written processes and procedures for the formal oversight that focuses on ensuring the accuracy of the financial aspects of Pinnacle's performance. A comprehensive invoice and staffing validation oversight process was implemented January 1, 2016. An internal reconciliation with budgets and the Financial Management Division was implemented. The contract amendment addressing these areas was executed on February 8, 2017.*
5.3	Continue efforts to implement carrier contract oversight and monitoring, including processes for evaluating carrier compliance with contract provisions.	*In February 2016, Covered California began assessing the 2015 performance credits and penalties. Plan Management Division also implemented a new process for monthly review of the QHP Issuer Customer Services Metrics in June 2016. Performance*

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		deficiencies will be addressed in quarterly meetings and discussion of performance that is below target will occur.
5.4	Negotiate with outsourced Service Centers to incorporate additional specificity on minimum performance standards into its contracts.	*In September 2016, Covered California incorporated additional specificity on minimum performance standards into the 2016 Surge Vendor Contract proposal. Awarded contracts will be required to have the same team lead and quality standards that mirror State Service Centers.*
Finding 6: Controls over Privacy and Security of Personally Identifiable Information Should Be Enhanced.		
6.1	Continue existing efforts to develop and implement regulation guides, policy manuals, training programs and risk assessments, and implement a process to proactively monitor programs, business units, and non-exchange entities.	*On April 1, 2016, Covered California published its new Privacy Standards Guide which is based upon privacy-related regulations, as well as other requirements, and permits the Privacy Office to proactively monitor programs, business units, and non-exchange entities. On April 4, 2016, the Privacy Office likewise implemented its new online privacy training program to help ensure employee compliance with Exchange privacy standards specified within the Privacy Standards Guide.*
6.2	Increase management enforcement of the existing authentication procedures and the no cell-phone policy on Service Center Floors.	*The cell phone policy is documented in the Employee Expectations memo which is reviewed and signed by each Service Center staff member. Memos are provided upon appointment and reviewed annually. During leadership meetings, managers continue to reinforce the importance of the cell phone policy. The authentication policy is documented in the knowledgebase articles for staff reference material. Refresher training was provided to staff in February 2016. Additionally, the QA team continues to provide feedback on authentication during the evaluation process.*

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6.3	Incorporate procedures for ongoing evaluation of contractor access to CalHEERS to ensure entities no longer authorized to access personally identifiable information are deactivated from the CalHEERS system in a timely manner.	*As of April 1, 2016, procedures are documented and processes are in place for the timely deactivation from CalHEERS for the following: Certified application Counselor, Medi-Cal Managed Care Plan, Navigator Grant, and Plan-based Enroller, and Pinnacle employees.*