BerryDunn

Covered California

Senate Bill 260 Performance Audit (SB 260)

Final Report

Submitted by:

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Submitted On: August 29, 2024

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Executive Summary

The California Health Benefit Exchange (Covered California) engaged BerryDunn to conduct a performance audit to assess Covered California's compliance with Senate Bill (SB) 260 (Chapter 845, Statutes of 2019), which was designed to facilitate the transition of eligible individuals from Medi-Cal to Covered California. The auto-plan selection program was launched in July 2022 and system functionality was activated on May 11, 2023 to formally implement the program for consumers transitioning from Medi-Cal beginning June 2023 with a July 1st effective date.

In order to assess Covered California's performance as administrator of the SB260 program, BerryDunn addressed four audit objectives which are based on identified risk areas and the Exchange's primary program responsibilities:

1. Whether Covered California correctly determined applicants' eligibility under the SB260 program, and correctly calculated the Advanced Premium Tax Credits (APTC) amount in a timely manner in accordance with Covered California's adopted policies.
2. Whether Covered California enrolled applicants into the appropriate plan in a timely manner according to SB260 and effectuated coverage before the termination of their Medicaid coverage.
3. Whether Covered California sent all applicable notices to individuals that were automatically enrolled in a Covered California plan through the SB260 program in a timely manner.
4. Households under the SB260 program must proactively opt-in to effectuate their coverage whether by paying a binder premium payment or opting-in on the Covered California customer service portal. We examined how "opted-in" and "opted-out" household information is tracked, stored, and communicated and risks related to plan effectuation.

We identified findings related to objectives 1, 3, and 4. There were no findings related to objective 2. The table below summarizes our findings and recommendations:

Table 1: Findings and Recommendations

Finding 001 – Objective 3	Individuals in the zero-dollar premium category that were transitioned from Medi-Cal to Covered California under the SB260 program did not receive the proper cancellation (NOD74) notice. CalHEERS stated that a random half of the population had notices suppressed as part of a research project.
	BerryDunn recommends that Covered California send cancellation notices to all individuals that passively or actively opt-out of coverage in the zero-dollar premium population. BerryDunn also recommends that if Covered California changes the notification processes, they do so consistently for all individuals. We also recommend that Covered California track internal projects so that they can notify all organizations and applicable third parties promptly when these projects impact consumers and other program functions.
Finding 002 – Objective 3	Individuals transitioning from Medi-Cal to Covered California were not provided a transition notice. When the last application transaction of the day was for a prior benefit month, all notices were suppressed, including the NOD01T notice of transition. This issue was identified as part of the 2023 Programmatic Audit.

	BerryDunn recommends that Covered California implement the system enhancement and continually monitor the process to ensure individuals receive the required notifications.
Finding 003 – Objective 1	The CalHEERS system contains the required functionality to conduct APTC rebalancing calculations, and the APTC is displayed on the enrollment screen. However, obtaining the data elements necessary to reconstruct the APTC calculation is time intensive due to the system design. Additionally, cases in carryforward status with an existing enrollment are not directly tied to the relevant eligibility determination.
	BerryDunn recommends that Covered California work with CalHEERS to assess whether the system can be configured to display the data used in APTC calculations, and tie the enrollment to a specific eligibility determination for cases in carryforward status. This change would enhance transparency and enable reviewers to accurately assess determinations without manual intervention.
Finding 004 – Objective 1	BerryDunn examined a sample of 125 eligibility determinations conducted under the provisions of SB260 from October 1, 2023, through December 31, 2023. Among these determinations, we identified one instance where the benchmark premium for the household was inaccurately calculated. This led to an incorrect APTC calculation for the coverage months affected by the inaccurate benchmark premium.
	BerryDunn recommends that Covered California coordinate with CalHEERS to further research the cause of the incorrect benchmark premium and to assess the population of eligibility determinations to identify the impact of the error on the population of Covered California applicants.
Finding 005 – Objective 4	The effectuation rate calculated to assess performance of the SB260 program may be imprecise due to groups within the population being included in the data used to calculate the effectuation rate, despite those groups not being intended for transfer to Covered California under the SB260 program.
	We recommend that Covered California collaborate with CalHEERS and Medi-Cal to explore whether County Medi-Cal offices can gather data from applicants regarding other health coverage. Additionally, we recommend that Covered California include terminated cases in the effectuated population count.
Finding 006 – Objective 4	39% of cases where the consumer has a net premium responsibility were in pending status while only 2% of cases were in pending status when the consumer had a $0 premium responsibility. Covered California indicated that a portion of the 39% of cases may still be within their special enrollment period, but that it is probable that the case status is outdated due to a lack of timely carrier records reconciliation for a large percentage of the consumers with a premium responsibility.
	BerryDunn recommends that the Covered California Data Integrity Unit (CCDU) continue progress on implementation of a formal process to be completed by June 30, 2024 whereby carriers will upload their data reconciliation process guides annually, and CCDU will conduct reviews of carrier processes to ensure that they meet the expectations outlined in the process guides and work with carriers to resolve deficiencies.

Program Overview

California Senate Bill 260, enacted in 2019, authorizes Covered California to automatically enroll consumers in a qualified health plan when they lose Medi-Cal coverage and gain eligibility for advanced premium tax credits (APTC). After an implementation delay due to the COVID-19 pandemic and resulting public health emergency (PHE), Covered California began its auto-enrollment program for consumers transitioning from Medi-Cal beginning June 2023 with a July 1st effective date. The SB260 program aims to ensure that individuals losing Medi-Cal coverage encounter no gaps in their health insurance if they effectuate their coverage within one month of their disenrollment from Medi-Cal.

Covered California will automatically select the lowest cost silver plan available to the consumer in order to maximize premium tax credit and cost sharing support. However, under SB260, people transitioning from Medi-Cal to Covered California must take action to effectuate their coverage to ensure that they are willing to accept the tax liability for APTC. Consumers are categorized into two types; those with monthly premiums and those without a premium. Consumers that have a monthly net premium must pay their first month's premium in order to effectuate coverage, and the process of paying the binder payment is referred to as passively opting in. Consumers who are eligible for a plan without a monthly net premium must effectuate their coverage by agreeing to certain terms and conditions via the Covered California online portal or by calling the Covered California Contact center, which is referred to as actively opting in. Covered California estimated that in 2022 about half of auto-enrolled individuals would not have a net premium for the lowest cost silver plan due to the extension of the American Rescue Plan premium subsidies through 2025 under the Inflation Reduction Act. Coverage under the Covered California SB260 program begins on the day following a consumer's Medi-Cal termination, on the condition that the consumer effectuates their coverage within the first month. Consumers who do not effectuate their coverage within the first month will have their automatically selected plan canceled; however, they will have the remainder of their 60-day special enrollment period to select a plan on their own. If the consumer does not enroll in a health plan during the 60-day special enrollment period, then the consumer will be unable to enroll in a plan based on their loss of Medi-Cal coverage and subsequent transfer to Covered California under SB260. The consumer would then need to re-apply for a special enrollment period with another Qualifying Life Event, or wait until the next Open Enrollment period.

Covered California has created customized tools, materials, and support processes for consumers who are transitioned under SB260. Covered California sends customized notices to consumers, explaining their plan enrollment and financial assistance amounts. These notices outline options to keep, switch, or cancel coverage, as well as how to seek help. The notices also contain educational material that addresses frequently asked questions related to Covered California coverage, plan benefits, cost sharing, key insurance terms, and health insurer options. Covered California maintains a dedicated webpage for consumers that directs them to their account information. Once logged in, consumers encounter a dashboard displaying their pre-selected plan, coverage effectuation options, and shortcuts to search for a preferred provider. They can also shop for a different plan and update their account information, Additionally, Covered California offers dedicated customer service phone support for consumers requiring additional assistance as they navigate their transition to Covered California.

Audit Objectives and Methodology

Covered California engaged BerryDunn to conduct a performance audit to assess whether the Exchange effectively transitioned eligible enrollees from Medi-Cal to Covered California. We conducted this performance audit in accordance with the Performance Auditing Standards contained in Chapters 8 and 9 of *Government Auditing Standards (GAS)* version 2018. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. This report does not provide an audit opinion on overall compliance with the SB260 program.

In order to obtain sufficient, appropriate audit evidence to address our audit objectives, we conducted the following audit procedures in three phases:

Planning

1. We requested the population of consumers transferred to Covered California that were subsequently determined eligible and automatically enrolled in the lowest cost silver plan or another plan, as specified by SB260.
2. We requested and reviewed documentation related to policy and procedures and system design to assess compliance and effectiveness of the SB260 program.
3. We interviewed staff to understand the administration processes for the SB260 program and review additional emerging risks related to compliance with, and administration of, the SB260 program.
4. We selected a sample of 125 SB260 program eligibility determinations. We used a risk-based stratified random sampling method to select cases that transitioned to Covered California under SB260 provisions from October 2023 through December 2023. This approach allowed us to specifically select a larger population of $0 premium opt-in customers. This particular group is deemed higher-risk by Covered California due to system issues that affected this consumer category earlier in the year, compounded by the complex functionality associated with transitioning $0 premium opt-in customers to the SB260 program.

   Included below are two tables that document BerryDunn's sampling approach for the performance audit.

Table 2: $0 Premium Opt-In Population

Case Status	Case Count	Case Percentage	Sample Size
Cancelled	24,622	76.46%	20
Enrolled	6,026	18.69%	55
Pending	597	1.85%	10
Terminated	955	2.96%	15
Blank	10	0.03%	0
Grand Total	**32,210**	**100.00%**	**100**

Table 3: Paid Premium Opt-In Population

Case Status	Case Count	Percentage	Sample Size
Cancelled	27,210	42.81%	5
Enrolled	9,792	15.40%	5
Pending	24,825	39.12%	10
Terminated	1,705	2.68%	5
Grand Total	**63,532**	**100.00%**	**25**

5. We requested detailed data from Covered California for the selected sample. Our request included the data fields requested for Affordable Care Act (ACA) testing, as well as additional data needed to test the timeliness and accuracy of automatic plan enrollment, and issuance of notices under the SB260 program. We also requested the dates that sampled individuals were terminated from Medi-Cal.

Testing

1. We reperformed the eligibility determination for each sampled case and tested that each determination met the basic eligibility criteria for subsidies under the Affordable Care Act (ACA) and Covered California policy.
2. We tested that each sampled case received the correct amount of APTC in conformance with the ACA and Covered California policy.
3. We verified whether consumers were auto-enrolled into the lowest cost silver plan or another plan, as specified.
4. We verified whether individuals received the applicable notices related to their auto enrollment, and within the timeframe required by the ACA and Covered California policy.
5. We verified whether consumers transitioning from Medi-Cal to Covered California under the SB260 program had a coverage effective date that prevents a lapse in coverage.
6. We reviewed the opt-in or opt-out actions taken by consumers and interviewed staff to understand how this information is processed, stored, and communicated by Covered California.

Reporting

1. We examined data and testing outcomes from the testing phase to analyze trends related to SB260 enrollment and effectuation.
2. This report documents the outcome of the tests we performed, and associated observations, findings, and recommendations.

Audit Findings

Finding #001 – Objective 3

Criteria:

Through inquires with PERD and CalHEERS it was determined that Covered California intended to send cancellation notices as part of an initiative to improve consumer interactions to individuals who had actively or passively opted-out of the zero-dollar premium plan.

Condition and Context:

Individuals that were transitioned from Medi-Cal to Covered California under the SB260 program did not receive the proper cancellation notice. The SB260 program includes individuals that are transitioning from Medi-Cal to Covered California in two categories: zero-dollar premium and greater than zero-dollar premium. Due to tax implications, individuals that have a zero-dollar premium must accept the terms and conditions (opt-in/opt-out) of the plan. If the individual does not opt-in or opt-out by the last day of the first month of coverage (passively opting-out), then the plan will be cancelled and Covered California will send a cancellation notice (NOD74). Additionally, if the individual chooses to cancel their plan (actively opting-out) they will receive an NOD74 notice from Covered California. Individuals with a greater than zero-dollar premium that have not paid their premium will be sent a notice of cancellation from the carrier.

BerryDunn identified 10 out of 125 sampled cases that did not receive an NOD74 notice to alert them that their plan had been cancelled. All 10 cases had zero-dollar premiums and either passively or actively opted-out of Covered California coverage after being transitioned from Medi-Cal. After BerryDunn identified those cases that did not receive a cancellation notice, CalHEERS reported that the NOD74 cancellation letters for the months of November, December, and January were intentionally suppressed for a random half of the population as part of a notice research project to optimize communication strategies. BerryDunn was not informed about this notice suppression, despite conducting several work sessions with CalHEERS and PERD to discuss the SB260 program. These sessions included inquiries about any initiatives or changes to the program that could affect testing.

Cause:

The notices were intentionally suppressed as part of a research project to optimize communication strategies.

Effect:

Individuals with zero-dollar premiums were not notified that their Covered California plan was cancelled.

Recommendation:

BerryDunn recommends that Covered California send cancellation notices to all individuals that passively or actively opt-out of coverage in the zero-dollar premium population. BerryDunn also recommends that if Covered California changes the notification processes, they do so consistently for all individuals.

Additionally, we recommend that Covered California perform a thorough assessment of impacts that any internal project may have on their consumers prior to its commencement, consider notifying the consumers who may be affected, and track such internal projects so that they can also notify other parties when applicable.

Exchange Response:

Covered California disagrees with the audit finding concerning the suppression of the cancellation notices (NOD74). We wish to emphasize that the sending of these notices is not a regulatory requirement but an initiative by Covered California to improve consumer interactions. As such the NOD74 should have not be in the scope of the audit. The temporary suppression of these notices for a subset of individuals during the months of November, December, and January was a strategic component of a broader research effort aimed at refining our communication approach. This measure was taken to evaluate the potential effects of such communications on consumers, especially to prevent any confusion during their Special Enrollment Period and to ensure that our outreach facilitates informed healthcare coverage decisions.

Moreover, it's important to acknowledge that Covered California and CalHEERS may not have communicated the intentional suppression of the notices in discussions during the audit process. However, it was a planned action by Covered California, supported by case notes on the selected cases to document the purposeful suppression of notices.

Additionally, the inclusion of the Department of Health Care Services (DHCS) guidance to counties in the audit report as a measure for evaluating Covered California's implementation of the SB260 program may not be entirely correct. The guidance issued by DHCS for county-level Medi-Cal processing serves a different purpose and should not be directly applied to assess Covered California's policies or its strategic approaches to communication.

Covered California is dedicated to improving the consumer experience through transparent, effective, and considerate communication. Our decision to suppress the sending of cancellation notices was made with our consumers' best interests in mind.

Finding #002 – Objective 3

Criteria:

Covered California has been authorized and directed to carry out the functions of 2019 California Senate Bill 260, including the determination of eligibility for a Qualified Health Plan and eligibility for Premium Tax Credits.

State of California Government Code – Title 22. California Health Benefit Exchange states:

> *(d) The Exchange shall provide an individual who is enrolled in a plan pursuant to this section with a notice that includes the following information:*
>
> *(1) The plan in which the individual is enrolled.*
>
> *(2) The individual's right to select another available plan and any relevant deadlines for that selection.*
>
> *(3) How to receive assistance to select a plan.*
>
> *(4) The individual's right not to enroll in the plan.*

(5) Information for an individual appealing their previous coverage through an insurance affordability program.

(6) A statement that services received during the first month of enrollment will only be covered by the plan if the premium is paid by the due date.

Condition and Context:

Some individuals that were transitioned from Medi-Cal to Covered California under the SB260 program did not receive the proper notice alerting them of the transition. When the last application transaction of the day was for a prior benefit month, all notices were suppressed, including the NOD01T notice of transition. This issue was discovered during BerryDunn's Programmatic Audit and was identified as part of the cause for Finding 2023-002. Covered California stated that a system enhancement will be implemented to fix this issue in 2024.

BerryDunn identified 3 out of 125 sampled cases that did not receive an NOD01T notice. These individuals were transitioned into a Covered California plan but did not receive the required notification alerting them of their new plan and any steps needed to keep the plan.

Cause:

Covered California stated that the system is working as intended, however due to a design gap when there are multiple transactions on one day, applicants were not provided with a transition notice.

Effect:

Individuals were not provided notification that they were transitioned from Medi-Cal to Covered California and were not alerted of their rights for opting in or opting out of the plan.

Recommendation:

BerryDunn recommends that Covered California implement the system enhancement and continually monitor the process to ensure individuals receive the required notifications.

Exchange Response:

Covered California agrees with the finding.

Covered California acknowledges the finding regarding the specific scenario where an eligibility notice (NOD01T) did not generate for individuals initially transitioning from Medi-Cal to Covered California, particularly when an individual's transition for a future month coincides on the same day with another transaction from the county for a prior month's eligibility. Covered California had previously identified this issue through our ongoing monitoring processes of the SB260 implementation. Covered California, in collaboration with CalHEERS, has proactively addressed the identified gap by implementing a system enhancement on June 17, 2024.

Covered California will use existing monitoring processes to ensure the implemented system enhancement functions as intended and will continue oversight to ensure compliance with notification requirements.

Corrective action completed June 17 2024.

Finding #003 – Objective 1

Criteria:

45 CFR § 155.1210 (b)(4) stipulates:

> *The State Exchange and its contractors, subcontractors, and agents must ensure that the records specified in paragraph (a) of this section include, at a minimum, the following:*
>
> *(4) Data and records relating to the State Exchange's eligibility verifications and determinations, enrollment transactions, appeals, and plan variation certifications.*

45 CFR § 155.330 (g)(1)(i) stipulates:

> *Recalculation of advance payments of the premium tax credit (APTC) and cost-sharing reductions.*
>
> *(1) When an eligibility redetermination in accordance with this section results in a change in the amount of advance payments of the premium tax credit for the benefit year, the Exchange must:*
>
> (i) *Recalculate the amount of advance payments of the premium tax credit in such a manner as to account for any advance payments already made on behalf of the tax filer for the benefit year for which information is available to the Exchange, such that the recalculated advance payment amount is projected to result in total advance payments for the benefit year that correspond to the tax filer's total projected premium tax credit for the benefit year, calculated in accordance with 26 CFR 1.36B-3 (or, if less than zero, be set at zero).*

Condition and Context:

In scenarios where an applicant and/or a member of their tax household had a prior enrollment in a Qualified Health Plan, and received APTC during the tax-year, the current APTC calculation must account for APTC already paid on behalf of the applicant(s), so that the total APTC paid on behalf of the applicant(s) in the tax-year corresponds to the total projected premium tax credit that the applicant would be eligible for in the tax-year. This calculation is referred to as rebalancing.

The CalHEERS system contains the required functionality to conduct APTC rebalancing calculations. The result of the eligibility determination's APTC calculation is displayed in the CalHEERS enrollment worksheet for system users. The enrollment worksheet includes necessary fields, such as Gross Plan Premium, Eligible Max APTC, Applied (Used) APTC, and Second Lowest Cost Silver Plan Premium. These fields, along with household income and household member composition, are necessary to perform the APTC recalculation.

The process of reconstructing an APTC rebalancing calculation is time-intensive because it requires review and incorporation of data from previous eligibility determinations and enrollments that occurred in the plan year. During our eligibility determination audit activities, we discovered that CalHEERS queries the system's APTC recalculation log directly, rather than using the portal to obtain the underlying elements of an APTC recalculation. Although this data is available in the portal, it is dispersed across multiple screens and determinations, necessitating manual review and sometimes extensive research to gather all the required data elements in order to determine that a rebalancing calculation was correct.

Additionally, it was identified that two of the 125 cases tested were in carryforward status. Cases in carryforward status maintain their current plan enrollment and APTC award, even if subsequent eligibility determinations alter their QHP eligibility or APTC amount. The system does not directly link the enrollment to the corresponding eligibility determination. As a result, for the two identified cases, the data elements from the eligibility determination that resulted in the enrollment could not be found in the portal to recalculate the APTC.

Furthermore, assessing the recalculation of APTC requires obtaining household member information from the relevant eligibility determination. This data includes the date of birth, household income, and individual eligibility for tax credits. Efficiently obtaining this information can be challenging because the CalHEERS system determines eligibility each time an application is submitted, including revisions. Each submission results in a distinct eligibility determination for the applicant, and the system does not limit the number of submissions per day. In one of the 125 sampled cases, there were 41 eligibility determinations processed in a single day, with an additional 21 determinations two days later.

Cause:

When an applicant or a member of their tax household has previously enrolled in a Qualified Health Plan through Covered California, a recalculation is performed to determine the remaining APTC available for the tax year. The CalHEERS system has multiple menu areas related to eligibility and enrollment, making it time-consuming to review and identify the relevant eligibility determination data and obtain the necessary information to reconstruct the APTC calculation. Reperforming the APTC calculation is complicated by the design of the CalHEERS system, which determines eligibility each time an application is submitted, which is required per federal regulation. However, each submission results in a distinct eligibility determination for the applicant, and the system does not limit the number of submissions processed for an applicant in a single day. The volume of determination complicates the fact that the QHP enrollment does not specify the eligibility determination that led to the plan enrollment.

Effect:

Quality assurance, review, and audit activities cannot efficiently access the data needed to verify the accuracy of APTC calculations, reducing the efficiency of these oversight processes. CalHEERS system administrators manually query and extract the necessary data and provide it through a manual APTC calculator. This system limitation increases the time required for oversight activities for both Covered California and CalHEERS staff.

The number of eligibility determinations creates difficulty for a reviewer in identifying the source data used in the determination that was effective for the applicant’s enrollment.

Recommendation:

As a co-sponsor, Covered California is not responsible for maintaining the core functionality of the CalHEERS system. Therefore, Covered California’s ability to require or influence system changes may be limited. However, BerryDunn recommends that Covered California work with CalHEERS to assess whether the system can be configured to display the data used in APTC calculations, and tie the enrollment to a specific eligibility determination for cases in carryforward status. This change would enhance transparency and enable reviewers to accurately assess determinations without manual intervention.

Exchange Response:

Covered California disagrees with the finding.

The newly added policy from the California State Administration Manual focuses on the capability to audit and reconstruct events rather than specifying how or where this information should be displayed.

If a system maintains all the relevant information needed for an audit trail in the backend, and this information can be provided to auditors upon request, it would generally be considered compliant with the requirements of SAM Section 5335.2. The key criteria are the system's ability to log, preserve, and provide detailed records of transactions and related events necessary for auditing and investigations, regardless of whether this information is displayed on the front-end portal.

In addition, since Covered California is an independent public entity governed by an executive board and not affiliated with an agency or department, the referenced SAM does not apply to Covered California. CalHEERS does log and preserve and can provide details records of transactions related events as necessary for auditing and investigation.

Covered California would like to thank BerryDunn for the recommendation.

Finding #004 – Objective 1

Criteria:

Covered California has been authorized and directed to carry out the functions of 2019 California Senate Bill 260, including the determination of eligibility for a Qualified Health Plan and eligibility for Premium Tax Credits.

California Government Code – Title 22. California Health Benefit Exchange states:

> *(a) Upon receipt of an individual's electronic account pursuant to subdivision (h) of Section 15926 of the Welfare and Institutions Code from the insurance affordability program coverage, as specified in subparagraphs (A) and (B) of paragraph (3) of subdivision (a) of Section 15926 of the Welfare and Institutions Code, the Exchange shall use the available information to enroll the individual or individuals in the lowest cost silver plan available….*

The Code of Federal Regulations (CFR) further defines the Exchange's responsibility for the determination of eligibility for Premium Tax Credits, and specifically the usage of the benchmark plan in the Premium Tax Credit calculation.

26 CFR 1.36B-3(f)(1) regarding Computing the premium assistance credit amount states:

> ***In general.*** *Except as otherwise provided in this paragraph (f), the applicable benchmark plan for each coverage month is the second-lowest-cost silver plan (as described in section 1302(d)(1)(B) of the Affordable Care Act (42 U.S.C. 18022(d)(1)(B))) offered to the taxpayer's coverage family through the Exchange for the rating area where the taxpayer resides for…..*

Condition and Context:

BerryDunn examined a sample of 125 eligibility determinations conducted under the provisions of SB260 from October 1, 2023, through December 31, 2023. Among these determinations, we identified one instance where the benchmark premium for the household was inaccurately calculated. This led to an incorrect APTC calculation for the coverage months affected by the inaccurate benchmark premium.

The affected household included an applicant who had previously enrolled in a Covered California Qualified Health Plan (QHP) and received Advance Premium Tax Credits (APTC). Following the transfer of an additional household member to the QHP under the SB260 provisions on November 2, 2023, the household's APTC was recalculated. Given that the household had already received APTC earlier in the tax year, the APTC recalculation needed to consider the APTC previously paid on behalf of the applicant(s). This ensures that the total APTC paid aligns with the total projected premium tax credit eligibility for the applicant(s) in the tax year.

However, the APTC calculation performed by the CalHEERS system was incorrect due to an inaccurate benchmark premium for the coverage months spanning from May through October 2023. As a result of this erroneous APTC calculation earlier in the coverage year, the APTC calculated on November 2, 2023, was also incorrect.

Cause:

CalHEERS identified that a system error or deficiency resulted in an incorrect benchmark premium for this case.

Effect:

The impacted household was awarded an incorrect amount of APTC for coverage year 2023. CalHEERS is researching the total impact of this system defect on all CoveredCA consumers.

Recommendation:

BerryDunn recommends that Covered California coordinate with CalHEERS to further research the cause of the incorrect benchmark premium and to assess the population of eligibility determinations to identify the impact of the error on the population of Covered California applicants.

Exchange Response:

Covered California agrees with the finding.

Covered California will continue to collaborate with CalHEERS to conduct further research on the cause of the incorrect benchmark premium and to ensure the issue has been addressed.

In November 2023, the issue was identified with the benchmark premium that impacted around 0.17% of our consumers. By December 2023, the system issue had been corrected, and data adjustments were made for the impacted population.

Finding #005 – Objective 4

Criteria:

Covered California has been authorized and directed to carry out the functions of 2019 California Senate Bill 260, including the determination of eligibility for a Qualified Health Plan and eligibility for Premium Tax Credits.

California Government Code – Title 22. California Health Benefit Exchange states:

> *(a) Upon receipt of an individual's electronic account pursuant to subdivision (h) of Section 15926 of the Welfare and Institutions Code from the insurance affordability program coverage, as specified in subparagraphs (A) and (B) of paragraph (3) of subdivision (a) of Section 15926 of the Welfare and Institutions Code, the Exchange shall use the available information to enroll the individual or individuals in the lowest cost silver plan available….*

Further, the California Government Code requires that the Exchange prepare an annual report that includes reporting on performance of the Exchange.

California Government Code – Title 22. California Health Benefit Exchange states:

> *100503(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.*

Condition and Context:

As part of BerryDunn's performance audit of Covered California's management of the SB260 provisions, we considered the data that the Exchange uses to assess the performance of the automatic plan selection and enrollment provisions of SB260. The Exchange uses the effectuation rates of applicants transferred to Covered California under the provisions of SB260 to assess the performance of the program, identify potential challenges, and opportunities.

Our procedures included interviews of Exchange management and reviews of documentation. Further, we used information obtained through our testing of 125 eligibility determinations conducted under the provisions of SB260. During an interview with the Policy Eligibility and Research Division (PERD), we inquired about data that shows low effectuation rates for the SB260 transferred individuals. PERD stated that the Division calculates effectuation rates with the data that exists in the system.

Covered California's administration of the SB260 program depends on the transfer of cases and associated data from Medi-Cal. Covered California must work with the data as it is received and has limited control over its quality or completeness. Despite this challenge, Covered California is utilizing all the information currently available to calculate the program's effectuation rates. However, the program could achieve more precise effectuation rate metrics if County Medi-Cal agencies were able to provide more information about which consumers are in need of marketplace coverage.

In calculating the effectuation rate, there are population subgroups that contribute to the total population categorized as not effectuating coverage that lead to imprecise effectuation rate data. Among these, BerryDunn identified two groups that are not intended to be transitioned under the SB260 program, including:

1) Consumers who passively opt out due to existing coverage

2) Consumers who actively opt out due to existing coverage

Cause:

For the two population subgroups identified above, we used data collected over the course of our performance audit to determine the causes of the inaccurate effectuation rate data.

1) Passive Opt-Outs – Existing Coverage

For consumers who are nonresponsive to Medi-Cal requests for information and are transferred to Covered California under SB260, where they passively opt out of QHP coverage, it remains unknown how many do so because they already have existing coverage. Information about employer sponsored coverage or other health coverage is not required for a Medicaid determination, and it is unlikely that county Medi-Cal offices collect this information. Consequently, this data is not available for consumers transferred to Covered California. Although this group is included in the population classified as not seeking coverage, in optimal conditions, cases with existing coverage are identified and made ineligible for transfer to Covered California under SB260.

2) Active Opt-Outs – Existing Coverage

The SB260 provisions were created to transition consumers who are losing their Medi-Cal coverage into a Covered California QHP. Consumers who actively opt out of a Covered California plan due to existing health coverage were not intended to be part of the SB260 program. Covered California conducts surveys among those who actively opt out, yet the low volume of respondents makes it difficult for PERD to draw meaningful conclusions from the data. Although PERD believes the population of consumers actively opting out due to existing coverage is minimal, including this group in the SB260 program distorts the effectuation data.

Effect:

The absence of precise effectuation rate data can hinder Covered California's ability to evaluate the effectiveness of its management of the SB260 program. This limitation may also impede the identification of improvement opportunities and collaboration with Medi-Cal. Presently, the inclusion of the two population subgroups identified above may cause Covered California to underestimate the SB260 program’s effectuation rate.

Recommendation:

We recommend that Covered California collaborate with CalHEERS and Medi-Cal to explore whether County Medi-Cal offices can gather data from applicants regarding consumers access to other health coverage.

Exchange Response:

Covered California disagrees with the audit finding that the effectuation rate is imprecise due to the inclusion of consumers who have sources of coverage elsewhere. Covered California

monitors effectuation rates among all consumers transferred from Medi-Cal to the exchange, who are determined eligible based on the data available within CalHEERS. Counties processing Medi-Cal renewals or other changes in circumstance request information from consumers about enrollment in other coverage. However, as this information is not required for a Medicaid or CHIP determination if it's not provided, it is assumed to be null. The effectuation rates are calculated based on the information available. Covered California would appreciate more information about which consumers are in need of marketplace coverage but disagrees that this gap in information renders our effectuation rate imprecise.

Covered California also disagrees with the assessment that we are not counting consumers in a "Terminated" status as effectuated. As long as consumers have one month of effective exchange coverage, they are counted among the effectuation rates. We do not believe that the effectuation rates analytics should have been included in the scope of the audit.

Finding #006 – Objective 4

Criteria:

Covered California has been authorized and directed to carry out the functions of 2019 California Senate Bill 260, including the determination of eligibility for a Qualified Health Plan and eligibility for Premium Tax Credits.

California Government Code – Title 22. California Health Benefit Exchange states:

> *(a) Upon receipt of an individual's electronic account pursuant to subdivision (h) of Section 15926 of the Welfare and Institutions Code from the insurance affordability program coverage, as specified in subparagraphs (A) and (B) of paragraph (3) of subdivision (a) of Section 15926 of the Welfare and Institutions Code, the Exchange shall use the available information to enroll the individual or individuals in the lowest cost silver plan available….*

Further, the California Government Code requires that the Exchange prepare an annual report that includes reporting on performance of the Exchange.

State of California Government Code – Title 22. California Health Benefit Exchange states:

> *100503(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.*

Condition and Context:

As part of BerryDunn's performance audit of Covered California's management of the SB260 provisions we analyzed the population of consumers transferred to Covered California under the provisions of SB260.

The SB260 population can be classified into four enrollment statuses:

1) Enrolled
2) Pending

3) Cancelled
4) Terminated
    - Enrolled represents applicants that have opted-in or paid their binder payment and have fully effectuated coverage in a QHP.
    - Pending represents applicants that are either within their SB260 special enrollment period and have not yet effectuated coverage, or are cases where applicants have exceeded their special enrollment period but the effectuation or cancellation data interchange file has not been processed between the carrier and Covered California.
    - Cancelled represents applicants who have actively opted out or passively opted out either via a CalHEERS batch process, through non-payment, or who have changed their plans.
    - Terminated represents applicants that had effectuated coverage, but the coverage was terminated due to becoming ineligible, eligible for another health program, or nonpayment of premiums.

The enrollment statuses can be used to track program performance by calculating effectuation rates, and identifying cases that may not have processed as required by the SB260 provisions.

Our analysis of the population of SB260 cases revealed the following statistics regarding the population of cases transferred to Covered California under SB260:

Pending:

Our analysis of the population of SB260 cases revealed that pending consumer cases accounted for 39% of the cases where the applicant(s) have a responsibility pay a premium. The Policy Eligibility and Research Division (PERD) feedback indicated that the substantial number of pending consumers could stem from delays by carriers in providing information during the reconciliation process. Further, PERD indicated that a portion of the 39% of cases may still be within their special enrollment period, but that it is probable that the case status is outdated for a large percentage of the consumers with a premium responsibility. In comparison, only 2% of the cases with a $0 premium responsibility were in pending status.

Cause:

Covered California has not taken steps to verify the reconciliation processes used by carriers to reconcile their records to those of Covered California are reliable, consistent, and meet Covered California's expectations.

Effect:

Applicant status could be inaccurate, causing delays in identifying cases that may not have processed as required by the SB260 provisions.

Recommendation:

BerryDunn recommends that the Covered California Data Integrity Unit (CCDU) continue progress on implementation of a formal process to be completed by June 30, 2024 whereby carriers will upload their data reconciliation process guides annually, and CCDU will conduct

reviews of carrier processes to ensure that they meet the expectations outlined in the process guides and work with carriers to resolve deficiencies.

Exchange Response:

Covered California agrees with the finding. A Process Guide has been created with the required information to ensure we obtain the necessary documentation from carriers. This documentation will be shared with the carriers annually.