California State Auditor

July 2013

Report 2013-602

New High Risk Entity

Covered California Appears Ready to Operate California's First Statewide Health Insurance Exchange, but Critical Work and Some Concerns Remain

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California State Auditor

Elaine M. Howle State Auditor
Doug Cordiner Chief Deputy

July 18, 2013 2013-602

The Governor of California
President pro Tempore of the Senate
Speaker of the Assembly
State Capitol
Sacramento, California 95814

Dear Governor and Legislative Leaders:

As authorized by California Government Code, Section 8546.5, the California State Auditor (state auditor) presents this audit report designating Covered California's establishment of a health insurance exchange as a high-risk issue in California. To implement provisions of the federal Patient Protection and Affordable Care Act (Affordable Care Act), state law required Covered California to create and operate for the first time in California a health insurance exchange, which is a competitive insurance marketplace in which individuals and small businesses will be able to purchase qualified health plans (QHPs) starting on October 1, 2013.

This report concludes that although Covered California has made great strides in implementing key federal and state requirements pertaining to the exchange's establishment and operations, critical work and some concerns remain. Specifically, Covered California's financial sustainability is wholly dependent on enrollment in QHPs offered through the exchange. Recognizing this, Covered California has worked diligently and collaboratively with various stakeholders, including the California Department of Health Care Services and the Management Risk Medical Insurance Board to streamline eligibility and enrollment as well as to promote and support enrollment. Even so, future enrollment is unpredictable and is based on market factors outside of Covered California's control. Consequently, enrollment in the exchange and the financial sustainability of Covered California will need to be monitored. Additionally, to ensure that its QHPs comply with Affordable Care Act requirements, Covered California needs to develop monitoring, recertification, and decertification procedures for QHPs offered through the exchange.

Respectfully submitted,

[redacted]

ELAINE M. HOWLE, CPA
State Auditor

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Contents

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Summary

Results in Brief

Under the federal Patient Protection and Affordable Care Act (Affordable Care Act), the public entity known as Covered California is responsible for creating and operating a health insurance exchange (exchange) for the first time in California. The exchange is a competitive insurance marketplace in which individuals and small businesses will be able to purchase health insurance. According to the Affordable Care Act, the exchange must be ready by October 1, 2013, for consumers to enroll in qualified health plans (QHPs). Faced with this looming deadline, Covered California has made great strides in implementing key federal and state requirements pertaining to the exchange's establishment and operation. However, until Californians actually start enrolling in Covered California's QHPs, the future solvency of the exchange remains uncertain. Because of this potential financial challenge, we are adding Covered California's operations to our list of high-risk issues that the State faces.

Covered California's governance and oversight appear adequate. State law created an independent board to oversee Covered California, and the board has adopted several conflict-of-interest and financial disclosure policies in accordance with federal requirements. To ensure that it appropriately spends $910 million in federally awarded funds, Covered California has developed financial internal controls that an in-depth independent audit will need to analyze further, a task that Covered California is pursuing. In compliance with state law, Covered California has adopted a procurement policy that emphasizes competition, and staff appear to follow this policy when initiating contracts. In addition to establishing its own procurement policy, Covered California has unique authority to keep details of its individual contracts confidential. Despite this authority, it has publicly released many of its contracts, including their associated dollar amounts. Covered California recently developed a draft contract transparency policy that essentially directs staff to follow the Public Records Act—except for QHP contracts and bids—when determining whether to release contracts publicly. However, the policy has not yet been formally adopted by the board.

Covered California is responsible for developing processes for certifying QHPs to ensure that these plans meet, and continue to meet, federal and state requirements. Covered California established a multistep QHP certification process and selected 13 issuers that will offer QHPs through the exchange starting in fall 2013. As it moves forward, Covered California must implement QHP monitoring, recertification, and decertification processes to comply with federal law.

Audit Highlights . . .

Our review of Covered California's implementation of portions of the federal Patient Protection and Affordable Care Act (Affordable Care Act) highlighted the following:

- *Until Californians actually start enrolling in Covered California's qualified health plans, the future solvency of its health insurance exchange remains uncertain and thus, we are adding Covered California's operations to our list of high-risk issues that the State faces.*
- *Although Covered California's governance and oversight appear adequate, an in-depth independent audit is needed to further analyze its financial controls.*
- *Covered California's plans for service centers in Contra Costa, Fresno, and Sacramento counties seem to meet consumers' needs for assistance; however, it is facing hiring challenges that could delay implementation of these centers.*
- *Although Covered California's outreach plans appear to be more than adequate, the effect of this outreach will not be known until enrollment begins in October 2013.*
- *Financial sustainability will be an area of risk that will need to be monitored because future enrollment is unpredictable and is based on market factors outside of Covered California's control.*

The State's success in implementing the Affordable Care Act will largely depend on the effectiveness of the enrollment processes that Covered California puts in place. To this end, Covered California has worked diligently with the California Department of Health Care Services (Health Care Services), the Managed Risk Medical Insurance Board (insurance board), and other stakeholders to streamline eligibility and enrollment as well as to promote and support enrollment. Specifically, Covered California has collaborated with Health Care Services and the insurance board to develop the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS), which aims to streamline how individuals and businesses in California will obtain health coverage. Currently, CalHEERS is in the development and testing phase but, as noted above, it must be operational no later than October 1, 2013. In addition to obtaining project management services from the California Health and Human Services Agency's Office of Systems Integration, Covered California is using an independent consultant to review the work of its systems developer. If the CalHEERS project experiences delays or other difficulties, Covered California has created contingency plans. In addition, Covered California's plans to operate service centers in Contra Costa, Fresno, and Sacramento counties seem to meet consumers' needs for assistance; however, it is facing hiring challenges that could delay implementation of these centers.

A successful outreach, marketing, and education effort is also critical to Covered California's success. Recognizing this, Covered California has allocated a significant amount of its federal funds for these activities. In fiscal year 2012–13, Covered California's budget for marketing and outreach was $89 million, representing about 24 percent of its total budget, and the entity estimates that it will spend $106 million, or 28 percent, of its overall budget in fiscal year 2013–14 for these same efforts. In concert with Health Care Services and the insurance board, Covered California established a comprehensive marketing plan that outlines the goals, objectives, and strategies of the statewide marketing, outreach, and education program. Although the effects of Covered California's outreach activities will not be realized until after enrollment begins in October 2013 and continues in subsequent enrollment periods, its outreach plans appear to be more than adequate.

After January 2015, when the federal government will award no additional Affordable Care Act grants, Covered California anticipates that revenues from the participation fees assessed on QHPs offered through the exchange will pay for its operations. Recognizing that its financial condition is dependent on enrollment in the QHPs offered through the exchange, Covered California appears to have engaged in a deliberate and thoughtful financial planning effort to anticipate the contingencies it may face.

Despite these efforts, future enrollment is unpredictable and is based on market factors outside of Covered California's control. Hence, financial sustainability will be an area of risk that will need to be monitored.

Recommendations

To provide as much public transparency as possible, Covered California's board should formally adopt a policy to retain confidentiality only for contracts, contract amendments, and payment rates that are necessary to protect Covered California's interests in future contract negotiations.

To comply with federal requirements, Covered California should develop a plan and procedures for monitoring, recertification, and decertification of qualified health plans.

To ensure financial sustainability, Covered California should conduct regular reviews of enrollment, costs, and revenue and make prompt adjustments to its financial sustainability plan as necessary.

Agency Comments

Covered California concurred with the findings of our report and agreed to implement our recommendations.

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Introduction

Background

Nearly 49 million Americans were without health insurance in 2011, according to U.S. Census Bureau data. With 7.4 million uninsured residents, California was the state with the largest number of people who lacked medical coverage. Over the past decade, premiums have risen five times faster than inflation, and the percentage of employers offering health insurance coverage has declined from 71 percent to 60 percent.[1] As a result, the number of uninsured Californians has risen steadily over the past 10 years.

To expand health insurance coverage and to make health care more accessible and affordable, the U.S. Congress enacted the federal Patient Protection and Affordable Care Act (Affordable Care Act) in March 2010. The Affordable Care Act and its implementing regulations authorize states to take the lead in applying many of the legislation's reforms. In particular, each state has the opportunity to create and operate its own health insurance exchange (exchange), a competitive marketplace in which individuals and small businesses will be able to purchase health insurance. California was the first state to enact legislation creating a state-operated exchange. The California Health Benefit Exchange, recently renamed Covered California, is in the process of establishing such a marketplace, which must be operational by October 2013 to comply with federal requirements.

Significant Provisions of the Federal Patient Protection and Affordable Care Act That Have Already Taken Effect

- **No-Cost Preventive Care:** Prohibits health insurance issuers (issuers) from charging deductibles or co-payments for preventive care measures, such as immunizations, cancer screenings, and diabetes screenings.
- **No Denial of Coverage for Children With Preexisting Condition:** Prohibits issuers from denying coverage to children under age of 19 because of medical conditions or preexisting conditions.
- **Extended Coverage for Young Adults:** Requires that most issuers and employers providing dependent children coverage make that coverage available to adult children up to age 26.
- **Ban on Health Policy Rescissions:** Prohibits issuers from canceling health coverage retroactively except in cases of fraud or intentional misrepresentation.
- **No Lifetime Limits on Benefits:** Prohibits issuers from imposing lifetime dollar limits on benefits.

Source: The federal Patient Protection and Affordable Care Act

The Affordable Care Act

The Affordable Care Act aims to expand access to health insurance, control health care costs, and improve the quality and efficiency of the health care delivery system. The Affordable Care Act includes numerous provisions that take effect over several years. Beginning in 2010 many key reforms of the Affordable Care Act have already taken effect. The reforms summarized in the text box seek to protect consumers, increase access to health care, improve quality, and lower costs. For example, the Affordable Care Act prohibits health insurance issuers from denying coverage to children under

[1] We obtained data and an analysis related to California from the *California Health Care Almanac: California Employer Health Benefits Survey: Fewer Covered, More Cost,* California HealthCare Foundation, April 2013.

the age of 19 years due to preexisting conditions—that is, health problems that developed before the children applied to join the plans. Starting in 2014 this protection from denial based on preexisting conditions will extend to Americans of all ages.

Many of the Affordable Care Act's other significant reforms will occur in 2014 and beyond. The Affordable Care Act requires most Americans to maintain a minimum level of health insurance coverage beginning in 2014. To this end, starting in fall 2013, individuals and small businesses will have access to an exchange in which they can compare and shop for health plans. Households with incomes between 100 percent and 400 percent of the federal poverty level may be eligible for federal tax credits that cover a portion of the cost of coverage. Under the Affordable Care Act, states may expand their Medicaid program to cover more low-income Americans.[2]

California's Implementation of the Affordable Care Act

The Affordable Care Act gives states the option to create their own exchange or to allow the federal government to operate an exchange for them. In 2010 the Legislature enacted the California Patient Protection and Affordable Care Act and created the California Health Benefit Exchange, which is intended to be an organized, transparent marketplace for individuals and small business owners to purchase affordable quality health care coverage and to claim available federal tax credits and other subsidies. In 2012 California's exchange was renamed *Covered California*.

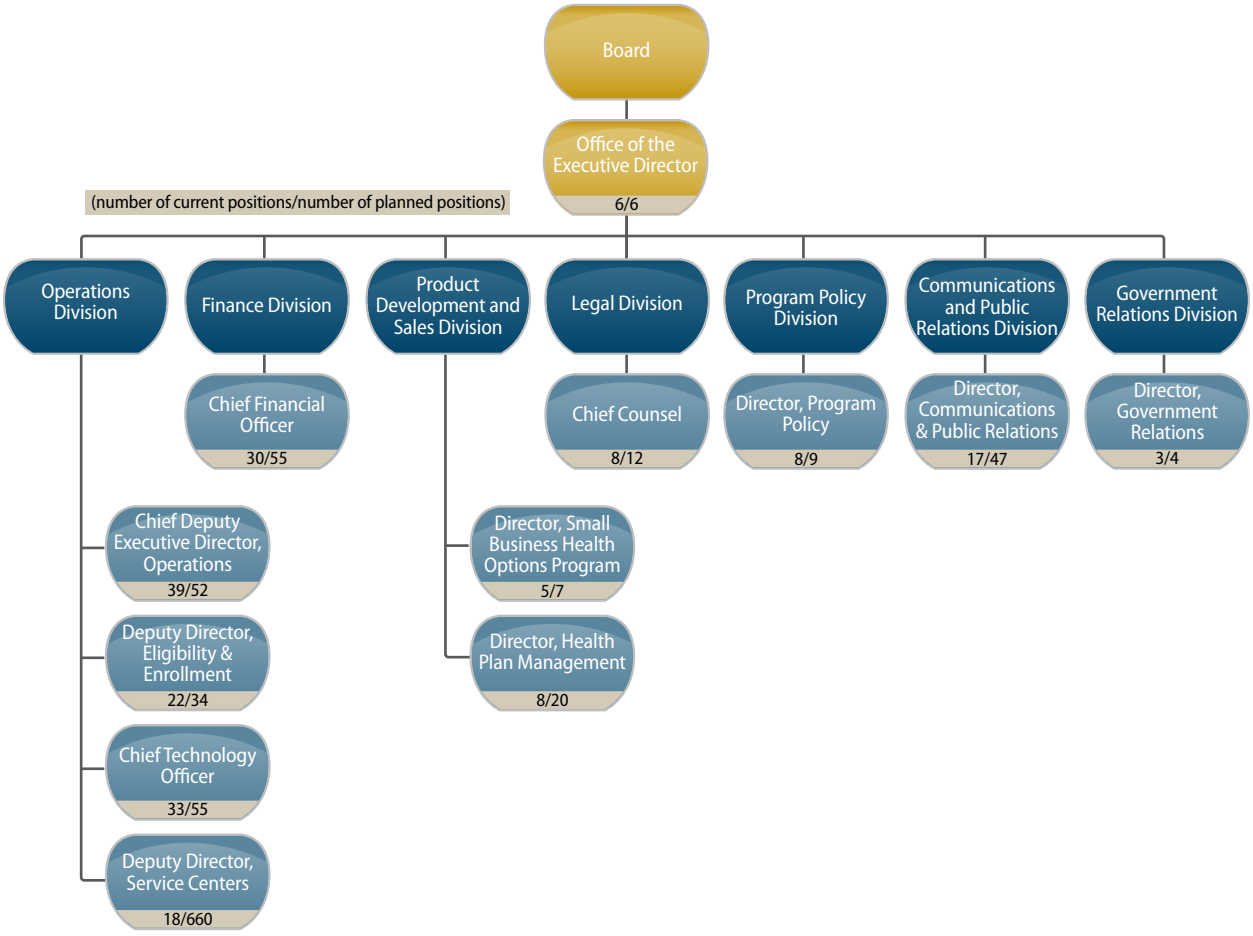
The Role of Covered California

Covered California is an independent public entity with a five-member governing board of directors. The board's membership consists of the secretary of the California Department of Health and Human Services or the secretary's designee and four other California residents—two appointed by the governor, one by the speaker of the Assembly, and one by the Senate Committee on Rules. State law requires the board to meet the minimum requirements of the Affordable Care Act as well as other specified criteria. Covered California's mission is to increase the number of insured Californians, improve health care quality, lower costs, and reduce health disparities through an innovative, competitive

[2] The federal government announced on July 2, 2013, that employers with at least 50 full time workers will have until January 1, 2015, to comply with certain Affordable Care Act mandates. However, because the exchange is to be used by individuals and small businesses, this delay does not have a significant impact on Covered California.

marketplace that empowers consumers to choose the health plans that give them the best value. Figure 1 displays Covered California's organizational structure and staff as of June 2013 as well as its planned staffing levels.

Figure 1
Covered California's Organization and Staffing



Source: Organization chart obtained from Covered California's federal grant application with updates provided by Covered California's executive staff.
Note: Current positions are as of June 2013, and planned positions are to be filled by 2014.

State law prohibits the use of California's General Fund to establish or operate Covered California. Since September 2010 the federal government has awarded Covered California more than $910 million in grants for research, planning, information technology development, and implementation of the exchange. Beginning in 2015 Covered California must be self-sustaining—state law requires Covered California to support its operations from a reasonable charge assessed on qualified health plans and other supplemental products, including dental and vision plans.

The Expansion of Medi-Cal to Cover More Adults

The Affordable Care Act also gives states the option to significantly expand their Medicaid programs—publicly financed health coverage programs for low-income Americans. The federal government will initially pay all additional costs of the expansion and will later reduce its contributions to 90 percent. California has decided to implement the optional expansion of Medi-Cal—the State's Medicaid program—to cover an estimated 1.4 million adults with incomes at or below 133 percent of the federal poverty level who are currently ineligible but who will be "newly eligible" to receive health coverage under the Medicaid expansion. In addition, individuals who are currently already eligible for Medi-Cal but are not yet covered may be encouraged to enroll in the program because of a number of factors, including the requirement that most individuals obtain coverage, enrollment and eligibility simplifications, and enhanced marketing and outreach activities to encourage individuals to obtain health coverage. However, unlike the newly eligible population, the State will continue to be responsible for 50 percent of the costs for services for these individuals who would have been eligible under current Medi-Cal eligibility standards.

According to the Legislative Analyst's Office (LAO), in the short term, fiscal savings to the State would far outweigh the nonfederal costs associated with providing health care to the expansion population. After several years, when the enhanced federal matching rate has decreased from 100 percent to 90 percent, the LAO estimates that overall savings to the State would likely continue to outweigh costs. Specifically, under the expansion, more than a million individuals could obtain Medi-Cal coverage, thereby reducing the overall amount of uncompensated care provided in California. In addition, increased Medi-Cal funding would offset county costs for indigent health care.

Analysis Results

Covered California's Governance and Oversight Appear Adequate

Covered California, the public entity implementing the State's health insurance exchange (exchange) under the federal Patient Protection and Affordable Care Act (Affordable Care Act), has complied with the key federal and state requirements related to governance and oversight that we reviewed. With the addition of receiving annual audits of its use of federal funds—a task it is pursuing—Covered California will improve its oversight and the controls it has in place to ensure that it spends funds appropriately. Overseen by an independent five-member board of directors, Covered California has established policies and procedures to address state and federal requirements concerning conflict-of-interest disclosures, including disclosures of financial interests. In August 2011, to comply with state requirements, the board hired an executive director who is responsible for managing the day-to-day operations of Covered California. Finally, although Covered California generally uses a competitive procurement process, its contracts can lack some transparency because of a broad statutory exemption allowing the entity to not disclose certain elements of its contracts to the public. Covered California recently drafted a policy to use this exemption in limited circumstances only; however the policy has not yet been adopted by the board

As of June 2013 Covered California has been awarded more than $910 million in federal grants for funding through 2014. Table 1 on the following page indicates, a key task remaining for Covered California is to provide for annual independent audits to ensure that its internal controls are adequate and that it spends federal funds appropriately.

Covered California Has Thus Far Satisfied the Requirements of Federal Oversight Agencies

Covered California currently complies with federal financial oversight requirements, and it is exploring options for having independent audits performed of its use of federal funds. Since September 2010 the federal government has awarded Covered California more than $910 million in grants for research, planning, information technology development, and the implementation of its exchange. Table 2 on page 11 shows, as of May 2013, Covered California has spent nearly $132 million of its federal grants. This federal funding came with many stipulations as to how and when Covered California could use the funding provided. For example, Covered California must receive authorization from the federal government if it wants to use the funds awarded for a different purpose than what the grant agreement approves. In

accordance with federal law, Covered California submits an annual report to the federal government detailing its expenditures. In addition, the federal grant's terms and conditions require Covered California to submit quarterly progress reports in which it provides expenditure data and contractual information to the federal government as one means of ensuring that it is using funds for authorized purposes.

Table 1
Covered California's Compliance With Key Federal and State Governance and Oversight Requirements

FEDERAL REQUIREMENTS FOR COVERED CALIFORNIA	PROGRESS TOWARD COMPLETION	STEPS THAT COVERED CALIFORNIA HAS TAKEN
Must make publicly available a set of governance standards that include guidelines for ethics, conflicts of interest, accountability and transparency, and disclosures of financial interest.	✓	In August 2012 Covered California's board of directors approved and made public bylaws that include all of the required elements.
Must implement procedures for disclosure of financial interests by members of its board or governance structure.	✓	Established procedures for disclosure categories for employees who receive gifts or income from health insurance issuers, among other sources.
Must keep an accurate accounting of expenditures and annually submit a report detailing these accountings to the federal government.	✓	Partnered with the California Department of Social Services for accounting services and sends financial and progress reports quarterly and annually to the U.S. Department of Health and Human Services.
Must use grant funds in accordance with federal requirements.	↑	Prepared and submitted the reports described above, and plans to obtain independent audits of its federal expenditures starting with fiscal year 2012–13.
STATE REQUIREMENTS FOR COVERED CALIFORNIA		
Must be governed by a board as specified in state law and the board must hire an executive director to manage operations.	✓	In April 2011 the board, whose composition appears to comply with state law, convened its first meeting. In August 2011 the board hired an executive director.
Must apply for available planning and establishment grants.	✓	Applied for and received four federal grants totaling more than $910 million.
Must establish and use a competitive contracting process.	✓	The board adopted a contracting process that emphasizes competition, and Covered California generally uses competitive bidding for all high-dollar contracts.

Sources: 45 Code of Federal Regulations, Section 155.110; 42 United States Code, sections 18031 and 18033; California Government Code, sections 100500 and 100505; and California State Auditor's analysis of Covered California's policies.

✓ = Completed
↑ = Progressing as expected
✗ = Yet to begin

Existing federal oversight notwithstanding, Covered California is still required to maintain its own processes, or *internal controls*, for ensuring that it spends federal funds appropriately. The federal Office of Management and Budgets has not yet published specific guidance on Affordable Care Act funding, but as a general principle applicable to all federal funds, state agencies must establish an adequate system of internal controls. Currently, Covered California depends on the California Department of

Social Services (Social Services) to provide accounting and other administrative services until Covered California establishes its own finance division. Social Services also assists Covered California in completing federal financial reporting activities. According to Covered California's chief financial officer, Covered California is working with Social Services to transition administrative functions to Covered California. To this point, Covered California has established some written policies and procedures for its financial functions, including contract management processes and procurement protocols. The chief financial officer stated that as Covered California continues to grow and transition operations from Social Services, it will continue to develop additional administrative, accounting, and budgeting policies and procedures.

Table 2
Covered California's Spending as of May 2013

FEDERAL GRANTS	FUNDS AWARDED TO COVERED CALIFORNIA	FUNDS SPENT BY COVERED CALIFORNIA	AVAILABLE BALANCE
Planning for health insurance exchange	$1,000,000	$530,000	$0*
Phase 1 implementation	39,421,383	39,421,383	0
Phase 1.2 implementation	196,479,629	79,966,093	116,513,536
Phase 2 implementation	673,705,358	12,040,298	661,665,060
Totals	**$910,606,370**	**$131,957,774**	**$778,178,596**

Sources: Federal Notice of Awards, Covered California's quarterly financial report submitted to the U.S. Department of Health and Human Services, and Covered California's June 2013 report to its board.

* Planning grant dollars are no longer available.

For its current stage of organizational development, Covered California's internal controls appear adequate; however, it needs a formal audit process designed to assess its financial and program compliance with federal requirements. State law does not require the board to begin receiving annual audits until January 2016. However, the terms of Covered California's federal grants stipulate that grantees are subject to federally required annual audits for state agencies spending more than $500,000 in federal grant dollars. Covered California's chief financial officer has sought approval from both the California Department of Finance and the California State Controller's Office to contract with an independent accounting firm to conduct an audit covering fiscal year 2012–13. As of June 2013 a decision regarding this audit had not been finalized. Ensuring that these audits are conducted will help Covered California identify potential weaknesses and will also help it prepare for the time when it must be financially viable on its own.

Covered California Appears to Follow Its Procurement Policy

Covered California has broad statutory authority to establish its own procurement and contracting policy. The board adopted a procurement and contracting policy that emphasizes competition, and we found that staff have followed this policy when initiating contracts. The Public Contract Code generally governs how state entities enter into contracts to acquire goods and services; however, state law exempts Covered California from these requirements. According to its general counsel, this exemption is necessary for Covered California to meet critical deadlines for planning, establishing, and operating the insurance exchange. State law requires the Covered California board to establish and use its own competitive process to select participating health insurance issuers (issuers) and any other contractors.

In December 2011 the board adopted a procurement policy that was later updated in February 2013, which gives Covered California flexibility to use standard state procurement methods, such as leveraged purchase agreements, or to use its own contracting methods. The policy allows staff to award contracts without competitive bidding but only with written justification and only when timeliness or unique expertise is required. In August 2012 Covered California established draft procurement and contracting procedures, which gives staff direction on how to carry out the board-approved policy. As shown in Table 3, less than half of its contracts, and only about 1 percent of the total dollar amount awarded to date, were awarded without competitive bids. The remaining contracts were bid competitively, involved interagency agreements that do not require competition, or were based on existing contracts the California Department of General Services had negotiated.

Table 3
Covered California Contracts Awarded as of May 2013

TYPE OF CONTRACT CLASSIFIED BY METHODOLOGY USED IN THE AWARD PROCESS	NUMBER OF CONTRACTS AWARDED	AVERAGE DOLLAR AMOUNT FOR EACH CONTRACT	TOTAL DOLLAR AMOUNTS FOR ALL CONTRACTS
Contract not competitively bid	40	$175,220	$7,008,799
Competitively bid contract	23	19,445,288	447,241,621
Interagency agreement	19	2,251,921*	40,534,578*
Master services agreement†	8	5,392	43,138
California multiple award schedule†	5	225,211	1,126,056
Totals	**95**	**$22,103,032**	**$495,954,192**

Source: California State Auditor's analysis of information provided by Covered California's contract manager.

* We excluded contract amounts from Covered California's interagency agreement with the California Health and Human Services Agency's Office of Systems Integration (OSI) because the contract amounts would duplicate a competitively awarded contract already appearing in the table that OSI pays on behalf of Covered California.

† These are existing contracts negotiated by the California Department of General Services and available to all government entities.

We reviewed 10 contracts, five that were competitively bid and five that were not, totaling nearly $513 million, to determine if Covered California followed its contracting policies and procedures. We found that for all 10 contracts, the entity followed its established policies and procedures. Furthermore, Covered California's bylaws state that the board will periodically review awarded contracts over $5,000 and will ensure that all such contracts are necessary and consistent with state regulations pertaining to the Affordable Care Act. In February 2013 the board adopted a policy regarding a quarterly board review of all contracts awarded during the preceding quarter. The board conducted its quarterly review during the June 2013 board meeting; however, based on the board meeting document, it is difficult to determine what the review specifically entailed. Even so, the fact that the board has the opportunity to examine all contracts awarded is an important additional control over Covered California's contracting practice.

Covered California Has a Uniquely Broad Exemption to Keep Its Contracts Confidential

In addition to establishing its own procurement policy, Covered California has unique statutory authority to keep details of all of its contracts confidential. Despite this authority, Covered California has publicly released many of its contracts, including their associated dollar amounts. Recently, Covered California developed a written policy, which the board has yet to adopt, limiting its use of its authority to withhold contract details only to certain contracts and bids. According to state law, Covered California must release a contract for public inspection one year after the contract is signed; however, it may keep the rates of payment in a contract and the contract amounts confidential indefinitely. In addition, state law specifies that the deliberative processes—discussions and communications Covered California has related to the contracting process—are exempt from disclosure.

Despite unique authority to keep its contracts confidential, Covered California has publicly released many of its contracts.

Despite this authority, Covered California has publicly released many of its contracts, including the associated dollar amounts of the contracts. The varied contracts that Covered California has selected to disclose include contracts for legal and consulting services and for information technology development services. In May 2013 Covered California drafted a policy concerning contract disclosure that would have Covered California essentially mirroring the requirements found in the Public Records Act and only using the statutory exemption for qualified health plan (QHP) contracts and bids. According to its general counsel, the policy has not been formally adopted by the board. However, the general counsel explained that Covered California has, for the last few months, been releasing all contracts, including their rates,

in response to public records requests, with appropriate redactions based on exemptions available to all public entities under the Public Records Act. The general counsel stated that Covered California may make use of its statutory exemption so it will not be at a negotiating disadvantage in future contracting efforts.

In 2013 Senate Bill 332 was introduced to change Covered California's statutory exemption from contract disclosure. Specifically, this legislation would require that all Covered California's contracts with participating issuers be open to inspection by the Joint Legislative Audit Committee, and that the rates of payment sections of these contracts be open to public inspection three years from the date the contract is available for public inspection.

Whether or not this legislation is enacted, Covered California will continue to face difficult decisions regarding the disclosure of its contracts. For this reason, and to provide as much public transparency as possible, Covered California's board should formally adopt a policy to retain confidentiality only for contracts, contract amendments, and payment rates that are necessary for limiting negotiating disadvantages with future contracts.

Covered California Has a Comprehensive QHP Certification Process, but Its Recertification and Decertification Processes Have Yet to Be Developed

A key function of Covered California is to establish processes for certification, recertification, and decertification of QHPs to ensure that these plans meet, and continue to meet, federal and state requirements. As Table 4 indicates, Covered California has established a comprehensive, multistep certification process for QHPs that will be sold through the exchange. This process ensures that the QHPs selected for sale through the exchange will, among other requirements, provide essential health benefits, as defined in the text box, and will be available for enrollment in October 2013. Facing numerous time-sensitive deadlines, Covered California rightly prioritized the QHPs' certification process over other considerations. As Covered California moves forward, it needs to develop formal plans and procedures to monitor and recertify QHPs, and it also needs to develop the criteria upon which it will decertify noncompliant QHPs or it will risk not complying with federal requirements.

Essential Health Benefits Required by the Federal Patient Protection and Affordable Care Act

Qualified health plans offered in each state's health insurance exchange must provide the following:

- Ambulatory and emergency services
- Hospitalization and laboratory services
- Maternity, newborn, and pediatric care
- Mental health and substance use services
- Prescription drug coverage
- Rehabilitative and habilitative services
- Preventive and wellness services and chronic disease management

Source: The federal Patient Protection and Affordable Care Act, sections 1301 and 1302.

Table 4
Covered California's Compliance With Key Federal and State Requirements for Qualified Health Plans

FEDERAL REQUIREMENTS FOR COVERED CALIFORNIA	PROGRESS TOWARD COMPLETION	STEPS THAT COVERED CALIFORNIA HAS TAKEN
Must establish and complete a process for the certification of qualified health plans (QHPs).	✓	Established a QHP certification process and in June 2013 selected 13 issuers that will offer QHPs through the health insurance exchange.
Must monitor the QHP issuers for demonstration of ongoing compliance with certification requirements.	↑	Included language in the QHP contract template allowing for ongoing monitoring and requiring submission of specified performance data, but it has not yet established policies and procedures or developed a monitoring plan.
Must establish a process for recertification and decertification of QHPs.	✗	Has not yet established procedures and criteria for how it will recertify or decertify a QHP.
STATE REQUIREMENTS FOR COVERED CALIFORNIA		
In each region of the State, provide a choice of QHPs at each of five federally specified coverage levels.	✓	Ensured that each region of the State has a choice of QHPs at each of the five federally specified coverage levels.

Sources: 45 Code of Federal Regulations, Part 155; California Government Code, Section 100502 et seq.; and the California State Auditor's analysis of Covered California's plans.

✓ = Completed

↑ = Progressing as expected

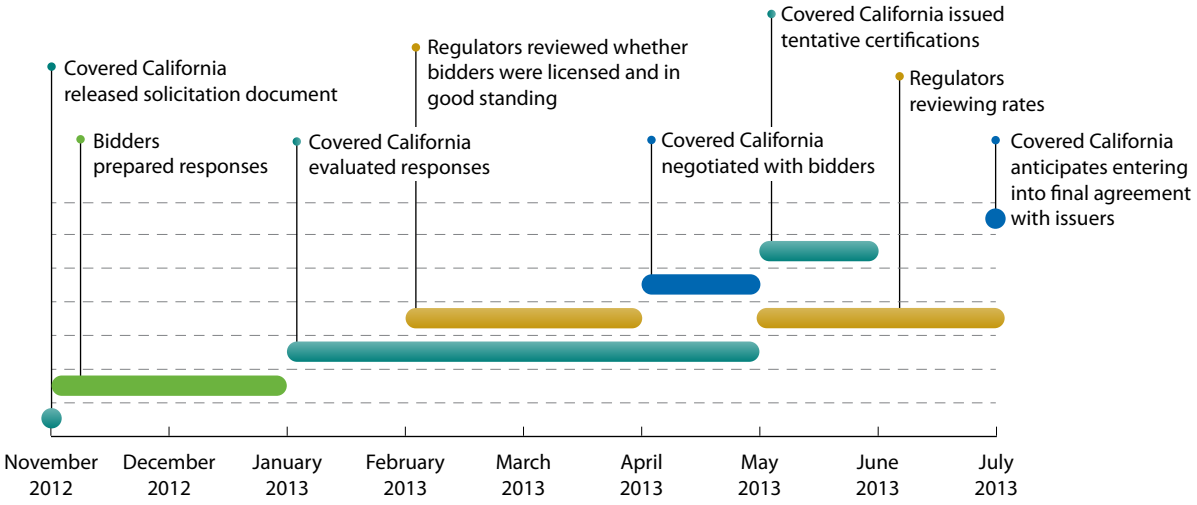
✗ = Yet to begin

Consistent with state law, in August 2012 the board determined that, rather than accepting all issuers that meet minimum Affordable Care Act requirements, Covered California will function as an *active purchaser*, a role that allows it to contract selectively with specific issuers. Covered California may also exclude other issuers as long as the criteria for selection are consistent with its seeking to provide health insurance coverage choices that offer the optimal combination of choice, value, quality, and service. According to an August 2012 board briefing document, the active purchaser role allows Covered California to influence the competitiveness of the marketplace as well as the cost of coverage. To fulfill this role, Covered California has established a multistep certification process that consists of an initial solicitation, evaluation of issuer responses, negotiations with issuers, reviews by state regulators, tentative certifications, and final agreements. Figure 2 on the following page details the timing of these activities, some of which have had to occur concurrently. In January 2013 more than 33 issuers expressed interest in offering QHPs through the Covered California exchange. In May 2013, after several months of extensive evaluation, negotiation, and reviews, Covered California tentatively selected 13 issuers that will offer QHPs through the exchange starting in fall 2013.

One of the requirements in the QHP solicitation was that all potential issuers be licensed and "in good standing" to offer health insurance coverage in California. In collaboration with the California Department of Managed Health Care (Managed Health Care) and the California Department of Insurance (Insurance),

Covered California compiled a list of requirements that potential issuers must meet to qualify for the *good standing* criterion. These requirements include financial solvency and adequate reserves, sufficient administrative and organizational capacity, and benefit design standards that meet federal and state mandates. The QHP solicitation requires potential issuers to attest that they meet these and other regulatory compliance requirements, and the document explains that Managed Health Care and Insurance have primary responsibility for regulatory review of issuers' claims of good standing and for providing Covered California recommendations based on this review.

Figure 2
Timeline Showing Covered California's Certification Process for Qualified Health Plans



Source: Covered California's solicitation for qualified health plans.

Covered California's evaluation of solicitation responses consisted of two parts. A team of Covered California staff and consultants performed the initial evaluation. These reviewers evaluated the responses against the criteria the board had approved. Following the initial evaluation, the executive team evaluated responses that met the board-approved requirements. According to the interim health plan management director (plan management director), a key factor that the executive team considered was ensuring that the exchange would offer an appropriate number and type of plans in each of the State's 19 regions. Specifically, state law requires Covered California to offer individuals and small businesses in each region a choice of QHPs in each federally specified coverage level or *metal tier*, which the text box describes. The purpose of the tiers is to allow consumers to compare QHPs that offer similar levels of coverage which, along with Covered California's standardization of benefits and cost sharing (for deductibles, co-payments, and so forth), should help consumers make informed decisions.

To help ensure compliance with state requirements and to encourage competition throughout the State, Covered California encouraged issuers to submit QHP bids in all the rating regions in which they are licensed, and it gave preference to issuers that developed QHP bids that met quality and service criteria while offering coverage options that provide reasonable access to the population of geographically underserved areas of the State as well as to the more densely populated areas. The plan management director told us that Covered California's goal was to have two or three issuers offering between four and six QHPs per rating region.

The Coverage Levels or *Metal Tiers* Specified in the Federal Patient Protection and Affordable Care Act

Percentage of medical costs covered by health insurance issuer:

Bronze	60%
Silver	70%
Gold	80%
Platinum	90%

In addition, California adopted a fifth coverage level for plans that provide catastrophic coverage only.

Sources: 42 United States Code, Section 18022, and the California Government Code, Section 100503.

According to the plan management director, in April 2013, Covered California entered into negotiations with QHP issuers over premium rates and coverage terms and conditions. The premium rates within the same metal tier may vary only by region, age of participant, and family size. In May 2013 Covered California completed its price negotiation with the selected issuers. However, before the premium rates are finalized, Managed Health Care and Insurance have to conduct a review of the negotiated rates to ensure that the rate development and justification are consistent with federal requirements. As of June 2013 Covered California tentatively selected 13 issuers that will offer QHPs through the exchange starting in fall 2013 and is awaiting the result of the regulatory agencies' review before it signs final agreements with each of the 13 issuers.[3] As indicated in the Appendix, each region of the State has a choice of QHPs at each of the five federally specified coverage levels. We also summarize the QHP rates offered throughout the State in the Appendix. For example, a 40-year-old individual living in Sacramento County will pay an average monthly premium of $379 for a silver plan. According to the plan management director, once the final agreement is signed, the certification process is complete. Barring anything unforeseen, this process appears to have allowed Covered California to certify QHPs before the first enrollment period beginning in October 2013, in accordance with federal law.

In addition to establishing and completing a certification process for QHPs, Covered California must develop and implement monitoring, recertification, and decertification processes in order to be in compliance with federal regulations. However, Covered California has yet to formally establish policies and procedures

[3] On July 15, 2013, Managed Health Care announced that it found that the QHP rates offered through Covered California's exchange were justifiable. However, Insurance had not completed its review as of publication of this report.

or develop a plan to monitor issuers for ongoing compliance with certification requirements. To its credit, Covered California built into the QHP contract the authority to perform ongoing monitoring of issuers, and it also requires issuers to submit specified performance data. According to the plan management director, Covered California will monitor compliance both proactively, through required performance reports on issuers, and reactively, through responses to consumer complaints and regulator inquiries. However, Covered California has not established formal procedures for ongoing monitoring. The plan management director anticipates implementing these procedures in August 2013.

Covered California has not established formal procedures or a plan for ongoing monitoring of its qualified health plans.

The plan management director also anticipates that recertification will be less intensive than the initial certification process and added that requirements for recertification and decertification will be based on certification requirements, with some modifications. Moreover, she stated that while Covered California recognizes the importance of recertification and decertification procedures, creating and completing the original certification process ahead of the enrollment period took precedence for the board. We agree that Covered California's effort to certify QHPs was a massive undertaking that was rightly among the top priorities of this new entity. However, as Covered California moves forward, it must adopt procedures for monitoring, recertification, and decertification of QHPs so that it can ensure that individuals and businesses purchasing health coverage through the exchange receive insurance that meets the requirements of the Affordable Care Act.

Covered California Has Worked Diligently and Collaboratively to Streamline the Eligibility and Enrollment Processes

As in the case of its certification procedures, Covered California's processes for evaluating and enrolling insurance applicants are developing rapidly. Although Covered California still has substantial work to do, its current efforts and plans appear to be adequate. The State's success in implementing the Affordable Care Act depends largely on the effectiveness of the enrollment processes that Covered California establishes. The exchange that Covered California will operate must be able to determine applicants' eligibility for QHPs, for certain federal subsidies, and for the Medi-Cal program; and it must allow individuals to submit their application online, in person, by mail, or by phone.

To comply, Covered California, in collaboration with the California Department of Health Care Services (Health Care Services) and the Managed Risk Medical Insurance Board (insurance board), has engaged a systems developer to design and implement the California Healthcare Eligibility, Enrollment, and Retention

System (CalHEERS), an information technology (IT) system that will provide online tools for individuals and businesses to obtain health coverage through the exchange. Covered California has entered into an agreement with the Office of Systems Integration (OSI) at the California Health and Human Services Agency (California Health and Human Services) to provide project management of CalHEERS and the systems developer. Additionally, Covered California has a contract with an independent consultant that will oversee the CalHEERS project, and Covered California has developed a contingency plan to manage risk and recovery from unintended developments. To address the needs of consumers who request assistance, Covered California is planning to operate service centers, and it is developing a single streamlined application, available online and as a paper document, to collect information necessary for eligibility determinations. Table 5 summarizes Covered California's efforts to fulfill federal requirements for establishing processes that determine applicants' eligibility for enrollment in one of the exchange's QHPs.

Table 5
Covered California's Progress in Implementing Key Federal Requirements for the Exchange's Eligibility and Enrollment Processes

FEDERAL REQUIREMENTS FOR COVERED CALIFORNIA	PROGRESS TOWARD COMPLETION	STEPS THAT COVERED CALIFORNIA HAS TAKEN
Must provide consumers with a single streamlined application that will allow Covered California to determine the eligibility for health care coverage and federal subsidies.	↑	Adopted the federal application model as a starting point and is working with key stakeholders to revise the application to meet the State's unique needs.
Must maintain a Web site that includes certain information and functionality aimed at streamlining eligibility determinations and consumers' enrollment in qualified health plans.	↑	Contracted with a systems developer to design and develop the California Healthcare Eligibility, Enrollment, and Retention System that it expects to launch by October 1, 2013, when enrollment starts.
Must operate a toll-free call center that addresses the needs of consumers requesting assistance.	↑	Signed leases for two of the three service center locations and has begun hiring staff for the two state-operated centers.

Sources: 45 Code of Federal Regulations, sections 155.405 and 155.205 as well as the California State Auditor's analysis of Covered California's policies.
✓ = Completed
↑ = Progressing as expected
✗ = Yet to begin

Covered California Has Engaged a Systems Developer to Design and Implement CalHEERS

In June 2012, after a competitive bidding process, Covered California entered into a contract with a systems developer to provide design, development, and implementation services for CalHEERS. This IT system will serve as a centralized tool for determining consumers' eligibility and for enrolling eligible

Californians in Medi-Cal or for federally authorized tax credits and subsidies. Further, CalHEERS will help individuals and small business employers to compare the different QHPs' benefits, cost sharing, and quality and then to enroll in QHPs in their regions. To determine Medi-Cal eligibility, CalHEERs must be able to communicate with existing eligibility data systems that Health Care Services and other agencies operate. On behalf of Covered California, OSI has agreed to provide project management services for the development, implementation, and maintenance of CalHEERS and the CalHEERS contracts.

Covered California Has Ensured That Its CalHEERS Project Has Active Oversight

To ensure the success of the CalHEERS project, Covered California and OSI receive advice and oversight from a federal and a state agency, and an independent systems expert. The federal Centers for Medicare and Medicaid Services closely monitor CalHEERS' progress and require Covered California to monitor CalHEERS as well and to regularly submit reports detailing key milestones and tasks. Based on an agreement with California Health and Human Services, the California Department of Technology (technology department) will assist in the review of project documentation that the CalHEERS system developer creates and will provide advice and counsel to OSI and Health and Human Services regarding OSI's management of the CalHEERS project. The technology department generally has oversight authority over the State's information technology projects; however, according to the technology department's senior counsel, Covered California is exempt from the technology department's oversight authority. As such, the technology department's role is limited to providing advice and consultation regarding CalHEERS.

Covered California hired a systems expert to provide independent verification and validation consulting services and to issue monthly reports that discuss findings, observations, and updates.

Covered California also hired a systems expert to provide independent verification and validation (IV&V) consulting services. The IV&V service provider produces a structured, exception-based monthly assessment report that illustrates the strengths and weaknesses of the project. The report also includes the IV&V service provider's recommendations for correcting the weaknesses that the monthly reports identify. We reviewed the latest IV&V report, which the consultant issued in May 2013 and which covered April 1, 2013, through May 1, 2013. The report discusses findings and observations, and it includes updates on the status of each open finding and observation.

According to the report, the term *finding* points to the project's deficiencies with respect to CalHEERS performing activities in accordance with industry standards or with best practices that

are appropriate for this phase of the project. The report applies the term *observations* to potential process improvements that the consultant believes will benefit the project or to areas in which the project complies only partially with industry standards that are appropriate for this phase of the project. Therefore, in the consultant's report, findings have more importance and they call for greater attention than observations do. Further, the report prioritizes both findings and observations according to one of the following risk levels for CalHEERS: *low*, indicating that the IV&V service provider expects no apparent impacts to key milestones, deliverables, or operational processes; *medium*, indicating potential impacts to key milestones, deliverables, or operational processes; or *high*, indicating possibly significant impacts to key milestones, deliverables, or operational processes.

The May 2013 IV&V report indicated that during the life of the project, the consultant has written three findings and 21 observations, and Covered California has corrected one of those findings and eight of the 21 observations. The remaining two open findings carry medium risk and relate to project management. Specifically, one finding notes that the schedule is not an effective project management tool because of discrepancies between the schedule and key release dates. The second finding is that current project management processes and tools do not extend to key data systems that must communicate with CalHEERS, such as the Medi-Cal eligibility determination system. Of the 13 observations that remain open, the consultant considers one low risk, 10 medium risk, and two observations high risk. One high risk observation concerns the lack of detail surrounding the definition of the design for CalHEERS interface with financial institutions, and the other high risk observation concerns the backlog of open change requests. According to the consultant, if left unresolved, the medium risk findings and high risk observations could lead to schedule delays. Covered California staff and its CalHEERS developer are currently implementing the corrective actions identified in the IV&V report.

If Covered California staff and its system developer cannot resolve the concerns of its independent verification and validation consultant, schedule delays could result.

Covered California Has Developed a Robust Contingency Plan for CalHEERS

In planning how to minimize risks and what to do in the event of a system failure, Covered California has developed a robust CalHEERS contingency plan that it indicated it shared with its federal partners in January 2013. The plan identifies overall risk, mitigation strategies, and contingency actions in the event CalHEERS or any of the data systems that must interact with CalHEERS cannot be delivered in time to meet the mandatory federal dates. Specifically, the overall risk was broken down into nine discrete risks, including the following three: If CalHEERS is

not ready on January 1, 2014, the State may not be in compliance with the federal and state requirements; if the electronic access to certain federal data systems is not available, then real-time verification of federal information may not occur; and if the data transfer between statewide welfare systems and CalHEERS is not available, certain Medi-Cal eligibility determinations may need to be performed manually.

For each of the nine discrete risks, Covered California identified specific mitigation steps to reduce the probability that the risk will occur. Some common mitigation strategies include using industry standard processes for project management, conducting joint planning with project sponsors and partners, and completing activities such as system development, testing, and training on schedule. In addition, for each discrete risk, Covered California has developed a contingency plan in the event the mitigation strategies fail. Some of the contingency approaches include reducing or deferring scope where reasonable or feasible, ensuring that the highest priority is on implementing individual eligibility and enrollment functionality, and deferring more complex automation and implementing manual work-around procedures. By having a robust contingency plan in place, Covered California is better positioned to manage risk and recover from unintended developments.

By having a robust contingency plan in place, Covered California is better positioned to manage risk and recover from unintended developments.

Although Covered California's Call Center Plan Apparently Will Meet Consumers' Needs, the Program's Hiring Effort Is Off to a Slow Start

A project management plan for the service centers (service centers plan) indicates that as of May 2013 Covered California is on schedule to complete the key tasks related to call centers that will serve consumers; however, Covered California is facing some challenges that could slow implementation of the centers. The CalHEERS contract also includes the design, development, implementation, and support of the software and equipment necessary to operate the service centers, including call centers. To address the needs of individuals with disabilities and limited English proficiency, it will have personnel ready to assist consumers in several languages, including English, Spanish, Cantonese, Mandarin, and Vietnamese. In addition, Covered California plans to supplement its bilingual staff with on-demand language services covering additional languages. According to the chief technology officer, the call centers will support telecommunications devices for the deaf and hearing impaired.

Covered California has selected three locations for the service centers: Contra Costa, Fresno, and Sacramento counties. Covered California plans to manage and operate the service centers in

Fresno and Sacramento counties, and after a competitive selection, it chose to partner with Contra Costa County's department of social services to manage a third service center. According to the chief technology officer, the two state-operated service centers were to be located in Sacramento County and in Central or Southern California; the choice of Fresno County was based on availability of cost-effective space and ready access to an adequate labor pool. Covered California estimates that operating the three service centers will require about 800 staff, including more than 600 state employees for the Sacramento and Fresno service centers and about 200 county employees for the Contra Costa service center. Although Contra Costa is responsible for hiring its own staff, Covered California will train them. Covered California plans to hire and train the employees in waves to be ready to open the centers for enrollment in fall 2013.

Although the CalHEERS contract includes the design and development of the IT infrastructure of the service centers, Covered California is generally managing the service centers as a separate project. Therefore, Covered California has developed a service centers plan that displays the key tasks and milestones needing completion to successfully launch the centers on schedule.

Covered California has made progress on these tasks and milestones; however, it faces challenges that could delay implementation of the centers. For example, according to the service centers plan, although Covered California plans to open the center in Fresno in November 2013, it has yet to sign a lease agreement for the site. The chief technology officer explained that, although Covered California is still in negotiation for the Fresno service center site, it has a cooperation agreement with the current tenant that will allow Covered California to install data and telecommunications equipment while it finalizes its lease agreement. This recent development will apparently help Covered California stay on schedule with opening the Fresno service center.

Although Covered California plans to open a service center in Fresno in November 2013, it has yet to sign a lease agreement for the site.

In addition, Covered California is facing possible delays in its hiring efforts. The service centers plan indicates that during its first and second hiring waves, Covered California should have hired 50 employees by March 2013 and another 304 employees by May 2013. However, in May 2013 the chief technology officer indicated that Covered California has actually hired very few staff for the centers. In fact, according to the chief technology officer, Covered California has made just 44 hiring offers, and it is waiting for authorization from the Legislature to perform background checks on its service center staff before extending further offers.

In June 2013 Senate Bill 509 (SB 509) became law and gives Covered California the authority to require fingerprinting and background checks as a condition of employment for its contractors and employees, including service center staff whose duties will include access to certain personal, confidential information. Following the passage of SB 509, the chief technology officer stated that the hiring process for the centers will ramp up in the next several months and if the process continues as planned, Covered California will have sufficient staff to manage enrollment. While Covered California has expressed confidence that it will open the centers in time to support enrollment, there is a risk that Covered California may face significant challenges in adequately staffing its call centers in time to meet demand.

While Covered California has expressed confidence that it will open the service centers in time to support enrollment, there is a risk that it may face significant challenges in adequately staffing its call centers in time to meet demand.

Covered California Has Collaborated With Other California Agencies to Create a Single Application That Collects Necessary Enrollment Information

Covered California has an inclusive process for developing a single streamlined application to collect information necessary to determine consumers' eligibility for enrollment in a QHP, for advance payments of premium tax credit, for cost-sharing reductions, and for Medi-Cal. Thus far, the efforts of Covered California and Health Care Services, which oversees Medi-Cal, to create a single application for consumers appear sufficient to reach Covered California's goal to be ready by October 2013. The development process also includes participation from the insurance board and from stakeholders from state agencies, county governments, health care service plans, and consumer advocates. Collectively, these participating members are referred to as the *eligibility expansion stakeholder workgroup* (eligibility workgroup). In consultation with the eligibility workgroup, Covered California and Health Care Services chose to use the federal application as the model for its state-developed application. This ensures that the application will capture all necessary questions to determine eligibility. In addition, Covered California and Health Care Services collaborated with the eligibility workgroup to ensure that its state-developed application will meet the needs of the State's diverse population and thereby minimize barriers to enrollment.

The California-based single streamlined application will be available in two versions: an online version within CalHEERS and a paper version. Based on the data elements the stakeholders identified, Covered California has developed the initial version of the online application form and is currently testing it for usability and accuracy. The online application is scheduled to be ready by October 2013. The paper version of the application is currently under development and will include the same data elements as the online version.

Covered California's Planned Outreach Efforts Are Extensive and Appear to Satisfy Federal and State Requirements

Although the effect of Covered California's outreach activities will not be realized until after enrollment in October 2013 and in subsequent enrollment periods, its outreach plans appear more than adequate. The primary objective of Covered California's outreach efforts is to promote and support enrollment. Covered California primarily plans to accomplish this objective in two ways: (1) by conducting education, outreach, and marketing activities to ensure that Californians are aware of the newly available coverage programs, and (2) by establishing an assister program to reach diverse populations and help them enroll in the exchange. Covered California has allocated a substantial portion of its federal funds for these activities. For example, in fiscal year 2012–13, Covered California's marketing and outreach budget was roughly $89 million, representing about 24 percent of its total budget, and it estimates that it will spend $106 million, or 28 percent, of its overall budget on these efforts in fiscal year 2013–14.

In fiscal year 2012–13, Covered California's marketing and outreach budget was roughly $89 million, and it estimates that it will spend $106 million—28 percent of its overall budget—on these efforts in fiscal year 2013–14.

Covered California is progressing as expected with the federal and state outreach requirements that we reviewed, as described in Table 6 on the following page. Specifically, in concert with Health Care Services and the insurance board, Covered California established a comprehensive outreach and marketing plan that outlines the goals, objectives, and strategies of the statewide marketing, outreach, and education and assister programs. According to the marketing plan, the overall goal is to maximize the enrollment of uninsured Californians by providing a one-stop marketplace for affordable, quality health care options and health insurance information; by educating Californians to understand the benefits of health insurance coverage; by encouraging insured Californians to retain their coverage; and by continuing to ensure the availability of affordable coverage for all eligible Californians. To support its goal, Covered California and its partners have identified several marketing and communication objectives that are measurable and time-specific.

A key component of the marketing plan is identifying the target audiences of Covered California's marketing and outreach efforts. According to the marketing plan, those audiences encompass more than 5.3 million California residents, of which 2.6 million may qualify for federal subsidies available through Covered California. The marketing plan further stratifies the target audience into groups based on a number of demographic factors, including age, gender, income level, and race or ethnicity. According to the marketing plan, members of target groups have different needs and motivations, and therefore they will need different messages and delivery systems to prompt them to seek health insurance coverage.

Table 6
Covered California's Compliance With Key Federal and State Outreach Requirements

FEDERAL REQUIREMENTS FOR COVERED CALIFORNIA	PROGRESS TOWARD COMPLETION	STEPS THAT COVERED CALIFORNIA HAS TAKEN
Must conduct outreach and education activities to educate consumers and encourage participation.	↑	Established an outreach and education program to ensure that consumers know about the affordable health care options under the federal Patient Protection and Affordable Care Act.
Must establish a navigator program to aid in public awareness and enrollment in health plans.	↑	Developed an assister program that is composed of in-person assisters and other navigators whose responsibilities include conducting public outreach activities.
STATE REQUIREMENTS FOR COVERED CALIFORNIA		
Must publicize the availability of health care coverage and federal subsidies.	↑	Established a statewide marketing, outreach, and education campaign consisting of seven phases that began in September 2012 and continues through December 2015.
Must provide outreach and assistance to consumers facing barriers to enrollment.	↑	Required the assister program to be culturally and linguistically appropriate for addressing the needs of consumers facing barriers to enrollment.

Sources: 45 Code of Federal Regulations, sections 155.205-155.210; California Government Code, Section 100503; and the California State Auditor's analysis of Covered California's outreach plans.

✓ = Completed
↑ = Progressing as expected
✗ = Yet to begin

To reach all the targeted populations, Covered California is planning for a local and statewide outreach and marketing effort that focuses on partnerships with community-based organizations as well as a paid media campaign. Covered California's outreach campaign consists of seven phases, which began September 2012 and continues through December 2015. Covered California has recently completed Phase I, which, according to the marketing plan, was largely a build-up phase to ensure that all aspects of the campaign—including research, media planning, creative development, partnerships, and social media—are ready for Phase II, when consumer outreach and education begins.

Covered California is currently in Phase II, which began in January 2013 and will continue through July 2013. During this phase, Covered California developed a media plan and established partnerships with community-based organizations to educate consumers about the new coverage options. An important aspect of Covered California's Phase II activities is the Outreach and Education Grant Program (outreach and education program) during which grant recipients will promote public awareness among consumers and small businesses. According to the May 2013 grant funding announcement, by July 1, 2013, Covered California plans to award more than $36.3 million among 48 selected grant recipients, including community-based organizations, clinics, and government agencies. The outreach and education program aims to target communities and populations at the local level and establishes trusted messengers in communities to help address barriers that prevent consumers and small businesses from purchasing coverage.

Covered California chose the grant recipients from nearly 200 applicants and indicated that it selected the grantees based on their abilities to target audiences. Covered California estimates that between July 2013 and December 2014 the grantees will reach nearly nine million individual consumers and 220,000 small businesses throughout the State through outreach and education activities.

To ensure accountability and the proper use of outreach and education program grants, Covered California has established a monitoring and evaluation plan. According to the grant application, grantees must comply with monitoring and evaluation requirements that Covered California has established, which include completing required reports, cooperating with monthly site visits by grant monitors, and maintaining records of program expenditures and activities. The application further states that grantees that do not comply with the scope of work or by meeting preestablished deliverables will receive additional training and will be asked to correct deficiencies within 30 days or risk grant termination. We believe that these monitoring policies, if followed, should ensure that recipients spend grant dollars properly.

Another way that Covered California plans to promote public awareness and enrollment is through the *assister program*, which will conduct outreach and education as well as provide one-on-one, in-person assistance to help California's diverse population learn about the health insurance options. Assistance will be provided in a culturally and linguistically appropriate manner to address the needs of consumers facing barriers to enrollment. The assister program consists of entities and individuals who provide guidance to consumers and who fall into one of the program's two parts: *in-person assistance* and *navigators*. The roles and responsibilities of these two groups are similar, although there are differences in funding, compensation, and timelines, as Table 7 describes.

Table 7
Differences Between In-Person Assistance and Navigators

	IN-PERSON ASSISTANCE	NAVIGATORS
Funding source	Federal grants initially and then Covered California's operating funds.	Covered California's operating funds
Compensation method*	Flat fee of $58 per successful application and $25 per successful annual renewal.	Grants awarded by Covered California
Implementation time frame	Begins before the initial October 2013 enrollment period.	Starts after initial enrollment begins

Source: Covered California's Web seminar for its assister program given on February 7, 2013.

* Certain assisters—such as insurance agents, hospitals, clinics, and county health departments—will not receive compensation. These types of entities may receive compensation from other sources, or they may have a business interest in enrolling consumers and in having them covered by insurance.

Covered California anticipates that the assister program will have more than 3,600 assister entities and more than 21,000 individual assisters. To ensure that the assister program is successful and that it maintains geographic, cultural, and linguistic access to target markets, Covered California has developed recruitment strategies that began in January 2013. In addition, Covered California indicates that it intends to begin training and certifying in-person assisters and navigators in August and November 2013, respectively.

In addition to its outreach and education program and its assister program, Covered California has created a strong plan for a paid media campaign that is designed to reach both broad and targeted audiences in urban and rural markets across the State. Covered California's paid media campaign, including print, radio, social media, and television, is expected to reinforce all aspects of the outreach and education program, improving performance in those areas. The first paid media efforts are expected to launch in summer 2013. According to the outreach and marketing plan, Covered California will use evaluation tools to assess the success of the outreach components and adjust messaging, tactics, and paid media as necessary.

Covered California must closely monitor its outreach effort because enrollment effects revenue generation and the overall success of the exchange.

Covered California appears to have engaged in a logical and deliberate process when developing its marketing plan. To ensure the effectiveness and efficiency of its outreach, marketing, and education campaign, we believe that it is important for Covered California to closely monitor its entire outreach effort because enrollment has a direct effect on revenue generation and the overall success of the exchange.

Although Covered California Has a Thoughtful Funding Plan, Whether Funding Will Be Sufficient to Support Covered California's Operations Remains to Be Seen

Beginning in January 2015 the Affordable Care Act prohibits awarding federal grants for the continued operations of the exchange, and state law prohibits Covered California from using the State's General Fund. Therefore, Covered California must have a sufficient funding source to support ongoing operations. Covered California anticipates that revenues from the participation fees assessed on QHPs that issuers offer through the individual and Small Employer Health Options Program (SHOP) exchange will pay for its operations. Recognizing that its financial condition depends on enrollment in the QHPs offered through the exchange, Covered California has developed a financial sustainability plan (financial plan) analyzing whether its operations can be sustained under a range of potential enrollment scenarios. Moreover, Covered California has included in its financial plan appropriate measures to ensure ongoing fiscal solvency, such as an annual minimum reserve target and an operating budget that is

flexible enough to accommodate differing enrollment levels. Within the limits of the information it currently has, Covered California appears to have engaged in a deliberate, thoughtful financial planning effort to anticipate the several contingencies it may face.

To obtain federal approval to operate a state-based exchange and secure additional federal implementation funding, Covered California had to demonstrate that it can be financially sustainable beginning in 2015. While a variety of potential financing options could support Covered California's operations, state law requires it to charge fees that are reasonable and necessary on QHPs to support the development, operations, and prudent cash management of the exchange. Therefore, Covered California has decided to charge issuers a participation fee on the QHPs they offer through its exchange.

As Table 8 indicates, in November 2012 Covered California developed and submitted a financial plan to the federal government that presented multiyear enrollment scenarios, revenue, and operating expense projections and that proposed premium assessment rates in both the individual and SHOP markets that generally would provide the revenue required to operate the exchange. Moreover, the financial plan showed that Covered California will adjust its expenses and fees to support its operations under a range of enrollment conditions.

Table 8
Covered California's Compliance With Key Federal and State Requirements for Funding Its Operations

FEDERAL REQUIREMENTS FOR COVERED CALIFORNIA	PROGRESS TOWARD COMPLETION	STEPS THAT COVERED CALIFORNIA HAS TAKEN
Must have sufficient funding to support its ongoing operations beginning January 1, 2015.	↑	Created a financial sustainability plan (financial plan), which it submitted to the federal government as a part of its grant application and it intends to conduct annual reviews of enrollment, costs, and revenues and to refine the plan as necessary.
STATE REQUIREMENTS FOR COVERED CALIFORNIA		
Assess a fee on the qualified health plans (QHPs) offered by health insurance issuers through the exchange that is reasonable and necessary to support the operations of the exchange.	↑	Established an initial fee of $13.95 assessed on a per-member, per-month basis for individual QHPs sold through the exchange and created a similar fee structure for QHPs offered to small employers. However, the sufficiency of these fees to support Covered California's operations remains to be seen.
Maintain enrollment and expenditures to ensure that expenditures do not exceed the amount of revenue, and institute appropriate measures to ensure fiscal solvency.	↑	Developed a financial plan to cover operating costs and to establish a prudent reserve under a range of enrollment scenarios.

Sources: 42 United States Code, Section 18031; 45 Code of Federal Regulations, Section 155.160; California Government Code, Section 100503; and California State Auditor's analysis of Covered California's 2012 Financial Sustainability Plan, Qualified Health Plans Model Contract and June 2013 status report and budget presentation.

✓ = Completed
↑ = Progressing as expected
✗ = Yet to begin

For the portion of the exchange available to individual purchasers (individual exchange), Covered California planned for three financial scenarios based on the California Simulation of Insurance Markets (CalSIM), an enrollment projection model created by the University of California, Los Angeles and the University of California, Berkeley. The CalSIM estimates included two potential levels of enrollment: base and enhanced. In planning for uncertainty and challenges, Covered California analyzed a third level of enrollment, which sets the enrollment at 20 percent below the base enrollment level. Covered California developed separate costs and revenue projections for each of these enrollment scenarios.

Adopting the enhanced enrollment level as its goal, Covered California developed costs and revenue estimates related to its targeted enrollment numbers for the individual exchange. Specifically, in May 2013, it established an initial participation fee of $13.95 to be assessed monthly for each member in QHPs sold through the individual exchange beginning in January 2014. With respect to the SHOP, Covered California anticipated a similar funding model that includes a monthly participation fee of $18.60 per member in QHPs sold through the SHOP.

Covered California's financial plan indicates that the enhanced scenario would generate revenue of more than $64 million from January 2014 through June 2014. With federal grants covering the majority of its $384 million estimated operating costs for fiscal year 2013–14, Covered California expects a year-end reserve of nearly $57 million. In the following fiscal year, even with a mid-year reduction in participation fees from $13.95 for the individual exchange and $18.60 for the SHOP to $10.46 and $9.30, respectively, Covered California estimates that it would end the year with nearly $184.5 million in reserve—enough to cover more than seven months of its operating costs. Following the enhanced enrollment trend, Covered California further estimates that in the following years, its assessment revenue would continue to increase as enrollment increases. Therefore, Covered California anticipates that it will adjust the participation fee downward or upward according to enrollment and the goal of maintaining a three- to six-month reserve of annual operating expenses.

The financial plan shows that under all enrollment scenarios, the assessment revenue generated would not be sufficient to cover Covered California's operating costs in fiscal year 2015–16 and it would have an average net loss of approximately $73 million—requiring it to access its reserve.

Under all enrollment scenarios, Covered California expects its financial condition in fiscal year 2015–16 to be more challenging than in earlier years because it will no longer have federal grants to support its operations. The financial plan shows that under all enrollment scenarios, the assessment revenue generated would not be sufficient to cover Covered California's operating costs in fiscal year 2015–16. Specifically, under all three enrollment scenarios,

Covered California would have an average net loss of approximately $73 million. To remain solvent, Covered California would need to access the reserve fund it accumulated for this purpose.

Consequently, the size of the reserve at the beginning of fiscal year 2015–16 is a critical factor for determining whether Covered California can withstand the financial pressures it anticipates in that first year in which enrollment fees must fully cover its operational costs. If enrollment was 20 percent below the base enrollment level, the financial plan estimates that Covered California would need to increase its participation fee for the individual exchange to $16.04 for the first half of fiscal year 2015–16, and then further increase the fee to $20.86 for the last half of that fiscal year to remain solvent and have a reserve representing three months of operating costs. Whether these increases in participation fees would further exacerbate the problem of low enrollment is not known at this time. According to the financial plan, should enrollment continue to be low, Covered California would take additional measures necessary to reduce the overall costs of its operations to better match its financial position.

The size of Covered California's financial reserve at the beginning of fiscal year 2015–16 is a critical factor in determining whether it can withstand the financial pressures anticipated in this particular year.

As previously noted, future participation fees will need to be adjusted to reflect the actual enrollment Covered California achieves and the annual review of its operational needs. Covered California indicates that it will begin to track enrollment starting in October 2013. As part of its established annual budget review and approval process, in January 2014 Covered California will evaluate its financial condition, including enrollment level, revenue collected, and operating expenses; and if necessary, it will reconsider the participation fee it charges issuers. If enrollment levels in either the individual exchange or SHOP are lower than the budgeted level, Covered California will need to increase future participation fees in order to ensure that it has enough revenue to cover operations. At the same time, Covered California expects that a reduced enrollment would result in a corresponding reduction in variable operating costs, such as assister payments and service center staffing.

Given the limits of its current information, Covered California appears to have engaged in a thoughtful planning process to ensure that it will remain solvent in the future. Obviously, these financial plans depend greatly on patterns of enrollment in the exchange's QHPs by individuals and small employers, and those enrollments can only be projected at this time. Consequently, financial sustainability will continue to be an area of risk that will need to be closely monitored.

Recommendations

To provide as much public transparency as possible, Covered California's board should formally adopt a policy to retain confidentiality only for contracts, contract amendments, and payment rates that are necessary to protect Covered California's interests in future contract negotiations.

To comply with federal requirements, Covered California should develop a plan and procedures for monitoring, recertification, and decertification of qualified health plans.

To ensure the success of its outreach effort, Covered California should track the effect on enrollment figures of its planned outreach and marketing activities and of its assister program.

To ensure financial sustainability, Covered California should conduct regular reviews of enrollment, costs, and revenue and make prompt adjustments to its financial sustainability plan as necessary.

We prepared this report under the authority vested in the California State Auditor by Section 8546.5 of the California Government Code.

ELAINE M. HOWLE, CPA
State Auditor

Date: July 18, 2013

Staff: Benjamin M. Belnap, CIA, Audit Principal
Tram T. Truong
Chuck Kocher, CIA, CFE
Sara Noceto

Legal Counsel: Scott A. Baxter, JD

For questions regarding the contents of this report, please contact Margarita Fernández, Chief of Public Affairs, at 916.445.0255.

Appendix

MONTHLY PREMIUMS FOR QUALIFIED HEALTH PLANS OFFERED THROUGH COVERED CALIFORNIA

In June 2013 Covered California tentatively selected 13 health insurance issuers (issuers) to offer qualified health plans (QHPs) beginning in fall 2013 for health insurance coverage starting in January 2014. According to Covered California, the selected issuers represent a mix of small to large for-profit and nonprofit companies that have regional and statewide provider networks to ensure access to doctors and hospitals in all areas of the State. As indicated in Table A, the QHPs offer different levels of health insurance coverage categorized as *bronze, silver, gold*, and *platinum tiers*.

Table A
Qualified Health Plans Offered by Coverage Level and Region for a 40-Year-Old Individual Enrollee

CALIFORNIA REGION AND THE COUNTIES IT INCLUDES	HEALTH INSURANCE ISSUER	QUALIFIED HEALTH PLAN (QHP) TYPE	QHP MONTHLY PREMIUM PER ENROLLEE FOR EACH COVERAGE TIER			
			BRONZE	SILVER	GOLD	PLATINUM
Region 1: Alpine, Del Norte, Siskiyou, Modoc, Lassen, Shasta, Trinity, Humboldt, Tehama, Plumas, Nevada, Sierra, Mendocino, Lake, Butte, Glenn, Sutter, Yuba, Colusa, Amador, Calaveras, Tuolumne	Anthem	Preferred provider organization (PPO)	$234	$309	$376	$436
	Blue Shield	Exclusive provider organization (EPO)	266	318	379	434
	Kaiser Permanente	Health maintenance organization (HMO)	261	347	426	458
	Region 1 Average Premium		**254**	**325**	**394**	**443**
Region 2: Napa, Sonoma, Solano, Marin	Anthem	PPO	259	343	416	482
	Blue Shield	EPO	282	338	402	461
	Health Net	PPO	348	396	450	507
	Kaiser Permanente	HMO	275	365	448	482
	Western Health Advantage	HMO	257	369	434	471
	Region 2 Average Premium		**284**	**362**	**430**	**481**
Region 3: Sacramento, Placer, El Dorado, Yolo	Anthem	HMO	—	476	601	687
	Anthem	PPO	250	332	403	467
	Blue Shield	PPO	278	333	396	454
	Kaiser Permanente	HMO	261	347	426	458
	Western Health Advantage	HMO	282	406	477	518
	Region 3 Average Premium		**268**	**379**	**461**	**517**
Region 4: San Francisco	Anthem	EPO	281	373	453	525
	Blue Shield	PPO	312	375	445	510
	Chinese Community Health Plan	HMO	246	325	431	478
	Health Net	PPO	344	392	445	501
	Kaiser Permanente	HMO	289	383	470	506
	Region 4 Average Premium		**295**	**370**	**449**	**504**

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CALIFORNIA REGION AND THE COUNTIES IT INCLUDES	HEALTH INSURANCE ISSUER	QUALIFIED HEALTH PLAN (QHP) TYPE	QHP MONTHLY PREMIUM PER ENROLLEE FOR EACH COVERAGE TIER			
			BRONZE	SILVER	GOLD	PLATINUM
Region 5: Contra Costa	Anthem	PPO	$276	$366	$444	$515
	Blue Shield	PPO	273	328	390	447
	Contra Costa Health Services	HMO	301	352	398	448
	Health Net	PPO	317	362	411	463
	Kaiser Permanente	HMO	261	347	426	458
	Region 5 Average Premium		**286**	**351**	**414**	**466**
Region 6: Alameda	Alameda Alliance for Health	HMO	329	384	458	550
	Anthem	PPO	270	357	433	503
	Blue Shield	EPO	265	317	378	433
	Kaiser Permanente	HMO	275	365	448	482
	Region 6 Average Premium		**285**	**356**	**429**	**492**
Region 7: Santa Clara	Anthem	HMO	—	340	430	491
	Anthem	PPO	254	336	409	474
	Blue Shield	PPO	305	366	435	498
	Health Net	PPO	312	356	404	456
	Kaiser Permanente	HMO	289	383	470	506
	Valley Health Plan	HMO	266	351	403	460
	Region 7 Average Premium		**285**	**355**	**425**	**481**
Region 8: San Mateo	Anthem	PPO	298	395	479	556
	Blue Shield	PPO	327	391	465	533
	Chinese Community Health Plan	HMO	266	351	465	516
	Health Net	PPO	346	394	447	504
	Kaiser Permanente	HMO	289	383	470	506
	Region 8 Average Premium		**305**	**383**	**465**	**523**
Region 9: Santa Cruz, Monterey, San Benito	Anthem	PPO	288	382	464	538
	Blue Shield	EPO	279	335	398	456
	Health Net	PPO	345	393	446	503
	Region 9 Average Premium		**304**	**370**	**436**	**499**
Region 10: San Joaquin, Stanislaus, Merced, Mariposa, Tulare	Anthem	PPO	223	295	358	416
	Blue Shield	PPO	269	322	383	439
	Health Net	PPO	348	397	451	508
	Kaiser Permanente	HMO	247	328	403	434
	Region 10 Average Premium		**272**	**336**	**399**	**449**
Region 11: Fresno, Kings, Madera	Anthem	HMO	—	333	421	481
	Anthem	PPO	218	288	350	406
	Blue Shield	PPO	237	284	337	386
	Kaiser Permanente	HMO	247	328	403	434
	Region 11 Average Premium		**234**	**308**	**378**	**427**

CALIFORNIA REGION AND THE COUNTIES IT INCLUDES	HEALTH INSURANCE ISSUER	QUALIFIED HEALTH PLAN (QHP) TYPE	QHP MONTHLY PREMIUM PER ENROLLEE FOR EACH COVERAGE TIER			
			BRONZE	SILVER	GOLD	PLATINUM
Region 12: San Luis Obispo, Ventura, Santa Barbara	Anthem	PPO	$246	$326	$395	$458
	Blue Shield	PPO	262	314	374	429
	Kaiser Permanente	HMO	250	332	408	439
	Ventura County Health Plan	HMO	253	336	376	430
	Region 12 Average Premium		**253**	**327**	**388**	**439**
Region 13: Mono, Inyo, Imperial	Anthem	PPO	305	404	490	569
	Blue Shield	PPO	330	396	471	539
	Kaiser Permanente	HMO	238	316	388	417
	Region 13 Average Premium		**291**	**372**	**450**	**508**
Region 14: Kern	Anthem	PPO	212	281	341	395
	Blue Shield	PPO	231	277	329	377
	Health Net	PPO	248	283	321	362
	Kaiser Permanente	HMO	238	316	388	417
	Region 14 Average Premium		**232**	**289**	**345**	**388**
Region 15: Los Angeles (North)	Anthem	EPO	207	274	333	386
	Anthem	HMO	—	254	322	368
	Blue Shield	PPO	210	252	300	344
	Health Net	HMO	—	222	253	285
	Health Net	PPO	248	—	—	—
	Kaiser Permanente	HMO	221	294	361	388
	L.A. Care	HMO	188	253	287	317
	Molina Healthcare	PPO	204	259	285	342
	Region 15 Average Premium		**213**	**258**	**306**	**347**
Region 16: Los Angeles (South)	Anthem	EPO	225	299	363	420
	Anthem	HMO	—	259	327	374
	Blue Shield	PPO	240	287	342	392
	Health Net	HMO	—	242	276	311
	Health Net	PPO	301	—	—	—
	Kaiser Permanente	HMO	245	325	399	429
	L.A. Care	HMO	196	265	301	332
	Molina Healthcare	PPO	204	259	285	342
	Region 16 Average Premium		**235**	**277**	**328**	**371**
Region 17: San Bernardino, Riverside	Anthem	HMO	—	265	335	382
	Anthem	PPO	219	290	352	408
	Blue Shield	PPO	220	264	314	360
	Health Net	HMO	—	246	281	317
	Health Net	PPO	270	—	—	—
	Kaiser Permanente	HMO	226	300	368	396
	Molina Healthcare	PPO	204	259	285	342
	Region 17 Average Premium		**228**	**271**	**323**	**368**

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CALIFORNIA REGION AND THE COUNTIES IT INCLUDES	HEALTH INSURANCE ISSUER	QUALIFIED HEALTH PLAN (QHP) TYPE	QHP MONTHLY PREMIUM PER ENROLLEE FOR EACH COVERAGE TIER			
			BRONZE	SILVER	GOLD	PLATINUM
Region 18: Orange	Anthem	EPO	$217	$288	$350	$406
	Anthem	HMO	—	286	361	413
	Blue Shield	PPO	242	290	345	395
	Health Net	HMO	—	252	288	324
	Health Net	PPO	287	—	—	—
	Kaiser Permanente	HMO	250	332	407	438
	Region 18 Average Premium		**249**	**290**	**350**	**395**
Region 19: San Diego	Anthem	EPO	233	308	374	434
	Anthem	HMO	—	336	424	485
	Blue Shield	PPO	267	320	381	436
	Health Net	HMO	—	269	307	346
	Health Net	PPO	276	—	—	—
	Kaiser Permanente	HMO	238	316	388	417
	Molina Healthcare	PPO	249	316	348	417
	SHARP Health Plan	HMO (coinsurance)	238	328	372	402
	SHARP Health Plan	HMO (co-pay)	—	317	364	389
	Region 19 Average Premium		**250**	**314**	**370**	**416**

Source: Covered California's Qualified Health Plan Booklet June 2013.

COVERED CALIFORNIA

July 8, 2013

Elaine M. Howle
California State Auditor
555 Capitol Mall, Suite 300
Sacramento, CA 95814

Subject: Covered California Response to State Audit Report 2013-602

Dear Ms. Howle:

Please find enclosed the response of Covered California to State Audit Report 2013-602.

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 progress to ensure effective implementation of the Affordable Care Act because of the hard work of our staff, board, state partners and many stakeholders. State Audit Report 2013-602 demonstrates several key accomplishments, and underscores our progress towards meeting our mission to increase the number of insured Californians, improve health care quality, lower costs, and reduce health disparities through an innovative, competitive market place that empowers consumers to choose the health plan and providers that give them the best value.

I wish to extend my thanks to the audit team and appreciate their hard work in preparing the report. We look forward to working with you and your staff as we report on our progress in the coming months and years, and specifically progress addressing the recommendations contained in this report.

[redacted]

Peter V. Lee
Executive Director

cc: Board of Directors, Covered California

Attachment

Covered California's Response to the State Auditor's Report and its Recommendations
July 8, 2013

Overall Response

Covered California agrees with the findings of the State Auditor's report stating there are "great strides in implementing key federal and state requirements pertaining to the exchange's establishment and operation." We appreciate the Audit findings regarding the sound governance, fiscal management procedures and controls, health plan contracting, information technology build, and marketing plan. All of these core elements will be vital to our launch and ongoing success. Having built a strong foundation, we agree there is continued work to assure effective implementation of California's health benefit exchange.

Recommendation No. 1

To provide as much public transparency as possible, Covered California's board should formally adopt a policy to retain confidentiality only for contracts, contract amendments, and payment rates that are necessary to protect Covered California's interests in future contract negotiations.

Response

Covered California agrees with this recommendation and will propose that the California Health Benefit Exchange Board adopt a formal contract confidentiality policy consistent with its current practice. As the report reflects, Covered California has acted on and stated our policy of not exercising the potential Public Record Act exemptions found in our originating legislation. In May 2013, Covered California clearly articulated its operating procedure at a public board meeting and communicated in formal correspondence to the federal Center for Consumer Information and Insurance Oversight that Covered California not only mirrors the requirements found in the Public Records Act, but has exhibited a remarkable practice of transparency in our operations and contracting processes.

Recommendation No. 2

To comply with federal requirements, Covered California should develop procedures for monitoring, recertification, and decertification of qualified health plans based on the information in the model contract.

Response

Covered California agrees with this recommendation and has established the legal and policy foundation for monitoring compliance with a wide variety of performance standards established in the QHP model contract. These standards and other criteria that were part the initial solicitation process, will form the basis for the set of recertification and decertification criteria to be developed later in 2013, and early 2014.

The recertification and decertification criteria will be applied in mid-2014 for the 2015 plan year. However, ongoing monitoring of contract compliance by QHPs with existing contract terms will begin immediately upon execution of the final contracts with the Covered California plans starting July 2013.

The QHP contract lays the legal foundation for recertification and decertification criteria but does not limit Covered California from adopting additional recertification requirements. Timing of efforts to build and execute the plan management function is critical and as the State Auditor's report notes, Covered California rightly prioritized the QHP selection and certification process which will be completed in July 2013.

Recommendation No. 3

To ensure the success of its outreach effort, Covered California should track the effect on enrollment figures of its planned outreach and marketing activities and of its assister program.

Response

Covered California is in agreement with the recommendation that the tracking of the effectiveness of outreach efforts on an ongoing basis will be central to our success. Covered California is planning a compelling, creative and cost-effective integrated marketing and outreach approach to reach Californians with important information about new health insurance choices. To ensure the success of its education, outreach and enrollment efforts, we will use various data components generated throughout the customer relationship to track key metrics such as organizational awareness, media campaign drivers, response rates, website visits, lead generation, and ultimately enrollment. Covered California's goal is use the insight into who is enrolling, and how various media drivers and channels resonate throughout California's diverse population segments to allocate and adjust our outreach efforts to have the best possible enrollment for the investment. Ultimately, this data will steer our approach to maximize the efficacy of the investment in outreach to maximize enrollment of the Californians in affordable health insurance.

Recommendation No. 4

To ensure financial sustainability, Covered California should conduct regular reviews of enrollment, costs, and revenue to make prompt adjustments to its financial sustainability plan as necessary.

Response

Covered California is in agreement with this recommendation and will be conducting at least quarterly reviews of enrollment, costs, and revenue to provide the board with the ability to consider adjustments. The financial plan presented to the board in November 2012 demonstrates Covered California's operations can be self-supporting under a wide range of enrollment conditions. While the financial condition of Covered California is dependent on the level of participation in products, operations are

sustainable in the long run under a wide range of potential enrollment scenarios, and that Covered California will have the ability to adapt its scale of operation to meet demand for coverage through its offerings.

Recently, at the June 2013 board meeting, an updated multi-year forecast was provided for both the individual exchange and the Small Employer Health Options Program (SHOP). These illustrations built in the Per Member Per Month (PMPM) participation fees for 2014 and estimates of the PMPMs for future years. Further, this illustration demonstrates Covered California recognizes revenue is highly dependent upon enrollment levels and has built the capacity to adjust revenue (by altering the PMPM participation fee) and expenses (by closely tracking fixed versus incremental expenses) to assure self-sufficiency in the face of uncertainty regarding enrollment levels.

cc: Members of the Legislature
Office of the Lieutenant Governor
Little Hoover Commission
Department of Finance
Attorney General
State Controller
State Treasurer
Legislative Analyst
Senate Office of Research
California Research Bureau
Capitol Press