COVERED CALIFORNIA POLICY AND ACTION ITEMS

August 15, 2019 Board Meeting

HEALTH PLAN CONTRACT UPDATES: DELIVERY REFORM PLANNING

QUALIFIED HEALTH PLAN CONTRACT EXTENSION

James DeBenedetti, Director of Plan Management Division

QUALIFIED HEALTH PLAN (QHP) CONTRACTS

- Covered California is currently in year three of a four-year contract period (2017-2020). The contract term was extended from three to four years last November.
- Covered California is proposing to extend the current contract period through 2021 to provide additional time to
  - Review industry best practices and identify promising areas for purchaser alignment
  - Complete a comprehensive review of existing requirements and experience to date
  - Ensure sufficient stakeholder engagement in the development of new contract requirements
  - Increase alignment with other purchasers
- This additional time would improve the development of contract requirements for the next cycle (2022-2024) and result in a draft contract being presented to the board in November 2020 for discussion and public comment, with final approval in January 2021

REASONS FOR PROPOSED EXTENSION

- Following the contract extension approval last November, California established an individual mandate for health insurance coverage and additional premium subsidy support from the State
- Numerous other State initiatives have been introduced this year as well (collaborative pharmacy purchasing efforts, potential auto-enrollment from Medi-Cal to Covered California, changes to open enrollment deadlines, etc.)
- These initiatives require significant staff resources within Covered California, its contracting health plans, and other stakeholders, to provide technical assistance and develop implementation plans for these new initiatives
  - This delayed the production of materials for stakeholder engagement efforts, which has significantly reduced the time available for stakeholders to provide feedback and recommend improvements before a draft of the 2021-23 contract is presented to the board for review

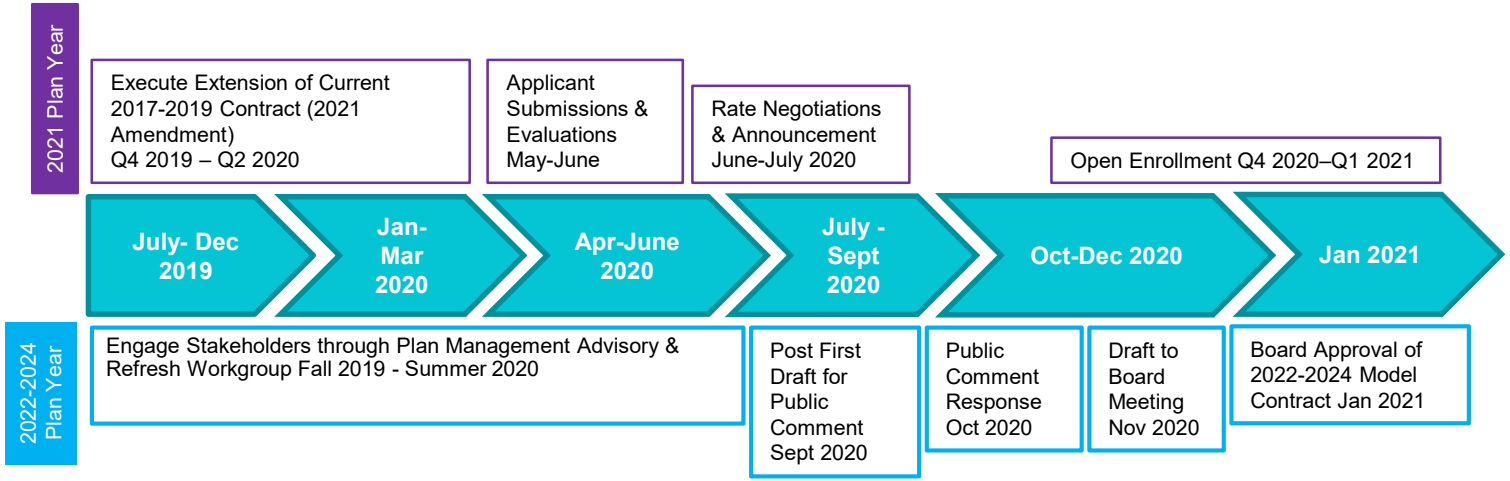
CURRENT STATUS OF CONTRACT REFRESH

- Work related to what are expected to be the most significant revisions, concerning quality improvement and delivery system reform, requires more time than could be done by November 2019:
  - The review of industry best practices and identification of promising areas for purchaser alignment was completed and published in July
  - The comprehensive review of experience to date was delayed to publication in September to add the most recent year of data (2018)
  - Stakeholder engagement has continued during this time, but fully informed discussions require their understanding of findings contained in the above publications
  - Meetings to promote alignment between large purchasers (DHCS, CalPERS, PBGH, etc.) have begun, but are still in their initial stages
- Review of potential changes to other elements of the contract have only recently begun because they are expected to be much less significant, so have been a lower priority

CONTRACT EXTENSION PROPOSAL

- Additional time is needed to ensure
  - Active, informed stakeholder engagement in the development of new QHP contract requirements
  - Alignment between Covered California and other larger purchasers on quality metrics and other contract requirements
- As was done for 2020, the 2021 plan year will be open to all licensed health and dental issuers
  - New entrants will be eligible for a one year contract term only – Plan Year 2021
  - Covered California will continue encouraging Medi-Cal Managed Care Plans to apply as new entrants
  - Covered California will continue encouraging existing issuers to expand to areas with less coverage
- The Certification process in 2021 will apply to a new contract period: 2022-2024

2022-24 CONTRACT DEVELOPMENT WILL OVERLAP WITH THE 2021 CERTIFICATION CYCLE



PRESENTATION ON EVIDENCE REVIEW; MEASUREMENT AND PURCHASER STRATEGY

Taylor Priestley, Health Equity Officer, Plan Management Division

EXPECTATIONS DEVELOPMENT APPROACH: REFRESHING COVERED CALIFORNIA'S STRATEGY

Covered California engaged outside experts to review and synthesize the available evidence base for Right Care and Delivery System Improvement Strategies, organized in the following projects:

- *Best Evidence Value-Enhancing Strategies (HMA):* Synthesize the evidence for each value-enhancing strategy and evaluate its potential effectiveness in terms of cost, quality of care, improved health, reduction in health disparities, and provider burden.
- *Measurement Review and Benchmarking (PwC):* Identify relevant benchmarks and data sources to provide valid comparison points for current expectations and performance standards for QHP issuers and Covered California's populations overall.
- *Purchaser Strategy (PwC):* Review activities and initiatives of other large health purchasers to identify key areas of focus, strategies and performance measures that Covered California should consider for potential adoption or alignment.

Find all documents related to the Attachment 7 refresh effort here:
https://hbex.coveredca.com/stakeholders/plan-management/

FRAMEWORK FOR RIGHT CARE/ACCOUNTABILITY AND DELIVERY SYSTEM IMPROVEMENT EXPECTATIONS

Covered California originally organized the complementary and mutually reinforcing strategies to support these expectations in two domains:

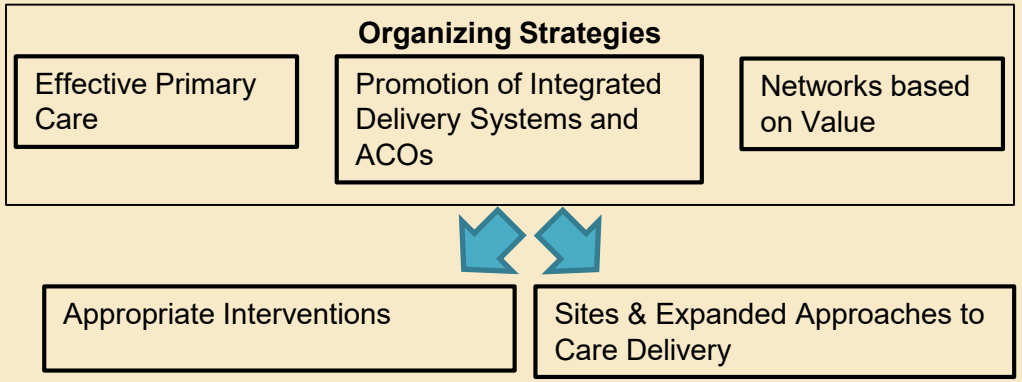
Right Care/Accountability Strategies	Delivery System Improvement Strategies
Chronic Care, General Care, and Access	Networks Based on Value
Hospital Care	Promotion of Effective Primary Care
Major/Complex Care	Promotion of Integrated Healthcare Models and Accountable Care Organizations
Mental/Behavioral Health and Substance Use Disorder Treatment	Alternate Sites of Care Delivery
Preventive Services	Consumer and Patient Engagement
Health Equity: Disparities in Healthcare	Population-Based and Community Health Promotion Beyond Enrolled Population
Pharmacy Utilization Management	

CURRENT QUALITY CARE AND DELIVERY REFORM FRAMEWORK

Assuring Quality Care Domains

- Individualized Equitable Care
- Health Promotion and Prevention
- Mental Health and Substance Use Disorder Treatment
- Acute, Chronic and other Conditions
- Complex Care

Effective Care Delivery Strategies



Key Drivers of Quality Care and Effective Delivery

Covered California recognizes that promoting change in the delivery system requires aligning with other purchasers and working with all relevant payers to reform health care delivery in a way that reduces the burden on providers.

- Benefit Design & Network Design
- Measurement & Public reporting
- Payment
- Patient-Centered Social Determinants
- Patient and Consumer Engagement
- Data Sharing and Analytics
- Administrative Simplification
- Quality Improvement
- Certification, Accreditation & Regulation
- Learning & Technical Assistance

Community Drivers: Workforce, Community-wide Social Determinants, Population & Public Health

HEALTH MANAGEMENT ASSOCIATES

Quality of Care Improvement and Delivery System Reform: Evidence Review

Nora Leibowitz

August 15, 2019

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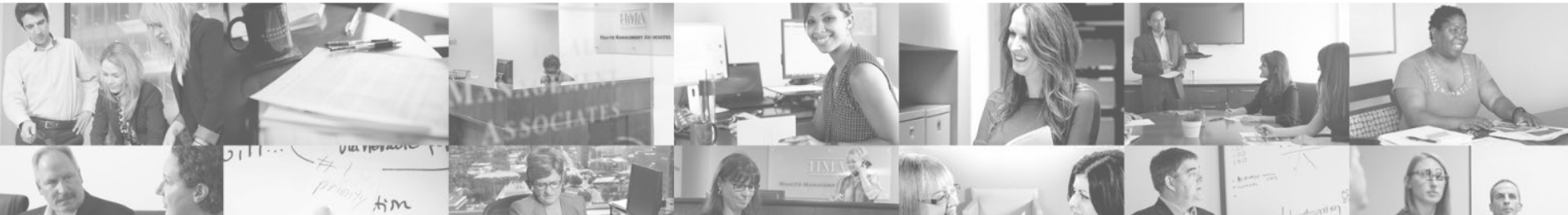

EVIDENCE REVIEW: IDENTIFICATION OF STRATEGIES ACROSS TEN DOMAINS

- **Goal: identify beneficial strategies for Covered California to consider adopting based on evidence or value of potential impact**
- **"Right Care"/Accountability (Assuring Quality Care)**
  - Identification and Management of High-Risk or High-Cost Individuals
  - Mental/Behavioral Health and Substance Use Disorder Treatment
  - Preventive Services
  - Health Equity: Disparities in Health Care
- **Delivery System Improvement (Effective Care Delivery)**
  - Networks based on value
  - Promotion of Integrated Health Care Models and Accountable Care Organizations
  - Consumer and Patient Engagement
  - Promotion of Effective Primary Care
  - Alternate Sites of Care Delivery
  - Population-based and Community Health Promotion Beyond Enrolled Population

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EVIDENCE REVIEW: PROJECT TEAM

- **22 HMA and external Subject Matter Experts i**nformed and shaped the research, provided insights on best practices, identified areas for further exploration based on initial findings
  - **HMA** SMEs developed expertise at state and federal agencies, public sector health plans, public and private health care programs, and health services research organizations
  - **Catalyst for Payment Reform** (CPR) – private sector insurance market expertise, deep knowledge of purchaser efforts to improve the health care market
  - **Mark Fendrick, MD**, Center for Value-Based Insurance Design at University of Michigan – developed the concept of value-based insurance design
  - **José Escarce, MD, PhD,** UCLA and RAND – expertise includes health economics, managed care, physician behavior, racial and ethnic disparities in medical care, technological change in medicine
  - **Catherine DesRoches, DrPH,** Harvard Medical School - expertise in emerging trends in health care delivery; executive director of OpenNotes, an organization dedicated to expanding the use of open visit notes and studying the results
- **4 Work Stream Leads** organized the research and writing
  - Bring Marketplace, health plan, health services research expertise

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SUBJECT MATTER EXPERTS AND LEAD WRITERS

Right Care/Accountability Strategies		
Aimee Lashbrook, JD, MHSA	Jeanene Smith, MD, MPH	Maddy Shea, PhD
Alejandra Vargas-Johnson (CPR)	Linda Lee, MPH	Monica Trevino, MA
Barry Jacobs, **Psy.D.**	Lori Raney, MD	Nora Leibowitz, MPP*
Jeffrey Ring, PhD	Lori Weiselberg, MPH	Rich VandenHeuvel, MSW
José Escarce, MD, PhD (UCLA)	Maclaine Lehan (CPR)	Suzanne Daub, LCSW
Delivery System Improvement Strategies – Networks		
Alana Ketchel, MPP/MPH*	Catherine DesRoches, DrPH (Harvard)	Roslyn Murray (CPR)
Andréa Caballero, MPA (CPR)	Craig Thiele, MD	Steve Soto
Art Jones, MD	Jeanene Smith, MD, MPH	Tom Friedman, MPA
Delivery System Improvement Strategies – Clinical		
Alejandra Vargas-Johnson (CPR)	Nicola Pinson, JD*	Maddy Shea, PhD
Jean Glossa, MD, MBA, FACP	Jeanene Smith, MD, MPH	Suzanne Delbanco, PhD, MPH (CPR)
Delivery System Improvement Strategies – Population Health		
Maddy Shea, PhD	Nora Leibowitz, MPP*	

* Denotes lead writer

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EVIDENCE REVIEW: METHODOLOGY

- **Literature review, evidence gathering**
  - SMEs provided input to guide literature review, including discussion of sub-strategies, search methods, key search terms, core sources of literature, known studies, and identified promising practices
  - Sources included peer-reviewed literature, case studies, other evidence for specified strategies
- **Evaluated potential impact of each strategy**
  - in terms of savings, quality of care, improved health, provider burden, administrative burden and/or potential to reduce health disparities
- **Investigated key drivers**
- **Identified areas for ongoing monitoring**

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RECOMMENDATIONS

1. Ensure issuers' network strategies deliver both cost effective and high-quality care
2. Issuers and providers should be required to identify and effectively manage care for high-risk or high-cost individuals
3. Require or encourage issuers to contract with Accountable Care Organizations (ACOs) or comparable vehicles for care integration that meet criteria for delivering higher value
4. Require issuers to invest in and promote enrollment in primary care practices that reflect best evidence in delivery and promotion of high-value care.
5. Insurers should promote the use of non-clinical providers where they have been demonstrated to improve access to care, address social determinants of health, health disparities, and support more effective engagement of patients and families
6. Covered California should actively monitor and assess its issuers' activities in channeling patients to alternate sites and models of care and in engaging patients in making choices regarding their provider, treatment, and source of care
    + Alternate sites and models of care delivery (e.g., telehealth, retail clinics, urgent care) are promising ways to deliver high value care but lack consistent evidence of the particular strategies to make them most effective
    + Actively engaging consumers in selection of patient-informed high value providers, services, and treatments has shown success in pilot and limited settings, but few, if any, proven models take these strategies to large scale

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KEY DRIVER OBSERVATIONS

- Standardize and promote data-sharing and data exchange
- Promote aligned, effective, and parsimonious measurement across all stakeholders
- Payment can be used to deliver value
- Continued monitoring of and contribution to ongoing research is needed to address current limitations in evidence
- Availability of issuer and provider robust analytic services is critical

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Presentation on Measurement and Benchmark Project

Prepared For Covered California
August 15, 2019

DRAFT 2019-08-05

Project Background

PwC researched benchmark/reference values for measures in Attachment 7 of Covered California's Qualified Health Plan (QHP) contract and made recommendations for updated measures and data sources for the upcoming QHP contract update.

The analysis was performed through a systematic survey and evaluation of available public and proprietary data and information, considering information obtained from the Purchaser Strategy analysis, interviews with industry experts, and evidence presented by Health Management Associates (HMA).

Recommendations were developed through an iterative process that was based on measure and benchmark selection criteria developed for this project, and incorporated feedback from Covered California.

Project Team

Engagement Leader
Pete Davidson, FSA, MAAA

Project Leader
Susan Maerki, MHSA, MAE

Project Manager
Roger Yang, ASA, MAAA

Project Staff
Rohan Shah
Shiow Shin Heong

Subject Experts
Eric Michael, PharmD
Greg Mansur, MPH

Measure Alignment

Measures often vary between programs and over time depending on program focus and maturity.

Diabetes Measures	QRS		IHA	Medicaid Core	Medi-Cal EAS	MSSP	CQMC
	2018	2019	MY19	Adult FY18	MY18	2019	
Eye Exams	✓	✓	✓		✓		✓
Foot Exams							✓
HbA1c Testing	✓			✓	✓		✓
Poor HbA1c (>9%)			✓	✓	✓	✓	✓
BP Control			✓		✓		
Nephropathy	✓	✓	✓		✓		✓
HbA1c <8%	✓	✓	✓		✓		

Measure Selection

Current Attachment 7 reporting requirements are extensive, and information reported by QHPs can be difficult to compare or evaluate particularly for "homegrown" measures. Updating measures to align with those used by other purchasers and regulators to minimize burden, as well addressing high impact areas, were determined to be high importance for selecting measures.

Measure Criteria	Key Sources of Measures
★ Evidence based ★ Outcomes based where possible ★ Address high impact measure areas ★ Consistent with program goals ★ Unambiguous specification ★ Feasible to collect ★ Useable and relevant ★ Aligned with other measure sets	❖ Health Insurance Exchange Quality Rating System (QRS) ❖ Healthcare Effectiveness Data and Information Set (HEDIS) ❖ Integrated Healthcare Association (IHA) ❖ National Quality Forum (NQF) ❖ Medi-Cal External Accountability Set (EAS) ❖ Agency for Healthcare Research and Quality (AHRQ) ❖ Others: MSSP, CQMC, OSHPD, CMS Hospital Compare, Cal Hospital Compare, Medicaid Core Sets, and more

Benchmark Selection

Benchmarks are used to measure performance or progress toward Covered California's goals. Potential benchmarks for each measure were evaluated on multiple dimensions. While external points of comparison are useful, the unique attributes of Covered California enrollees and California's population and healthcare delivery system more generally, point to the importance of analyzing Covered California baseline performance and assessing progress towards its goals.

Benchmark Criteria	Benchmark Hierarchy
★ Useable and relevant ★ Has a benchmark/performance target to identify minimum "floor" and best practice ★ Measurement is updated and collected over time ★ Adoption and promotion will increase value ★ Appropriate for use in Pay for Performance and Alternative Payment Models	▲ Benchmark for monetary incentives/sanctions ▲ Incentivize performance improvement ▲ Minimum performance benchmark ▲ Aspirational benchmark ▲ Non-standard measures and measures without benchmarks

Summary of Recommendations

- ★ **Establish clear principles to guide selection** and updating of measures and benchmarks
- ★ In the absence of nationally standardized and already collected measures, for key domains **Covered California should use its claims and encounter data to develop measures and benchmarks**
- ★ Covered California may need to **consider new measures or adopt less widely used measures** to further its objectives in important domains
- ★ Given the broad lack of alignment across purchasers, Covered California should **align in ways that address priority concerns** and that will foster better alignment in the future
- ★ Covered California should continue to **leverage existing data collection, measures and processes**
- ★ Covered California should work to improve analysis and response rates to existing sources and build on those surveys to **better capture patients' perspectives of their experience getting coverage and care**

Presentation on Purchaser Strategy Project

Prepared For Covered California
August 15, 2019

DRAFT 2019-08-05

Project Background

PwC conducted a review of current and future healthcare purchasing strategies to help Covered California understand, align with, and leverage the efforts of other purchasers.

- Interviews of large health care purchasers. A list of organizations interviewed and questions is on the next page.
- Analysis of information on purchasing initiatives being pursued by national or regional health plans, as well as information from PwC and other surveys.
- Analysis of information provided to Covered California by its QHP issuers.
- Summary of key findings including the level of prioritization associated with each strategy by purchaser type, highlighting current and emerging activities and, when provided, discussing measurement approaches.

Project Team

Engagement Leader
Greg Mansur, MPH

Project Manager
Jasmine Macies, MPH

Project Staff
Janet Rubin
Carolyn Steager

Subject Experts
Eric Michael, PharmD

Project Background

Interview Questions
1. Which strategies represent your greatest area of focus? 2. What specific strategies are your organization pursuing to drive value: a. In the next 2-3 years? b. In the next 5 years? 3. Which strategies do you feel require consistency among purchasers? 4. What is your measurement strategy for initiatives you are pursuing? 5. What challenges have you identified regarding your strategic initiatives?

Organizations Interviewed	
Health Plans	
Aetna	Inland Empire Health Plan
Anthem	Kaiser
BCBS North Carolina	LA Care
Blue Shield of CA	Molina
Health Net	
Large Employers	
Boeing	Disney
CalPERS	University of California
	Walmart
Government Entities	
California DHCS (Medi-Cal)	CMS/CMMI
Other	
Conduent	Integrated Healthcare Association
Magellan	National Alliance for Healthcare Purchaser Coalitions
CVS	National Business Group on Health

Key Findings

Purchasers who were interviewed agreed that all strategies are important and that there is substantial overlap across strategies, however a few were highlighted as priorities across all purchasers.

	Quality Care	Care Delivery
Areas of Focus	1. Chronic Care 2. Major/Complex Care and 3. Mental/Behavioral Health & Substance Use Disorder Treatment	1. Networks based on value 2. Integrated healthcare models/ACOs 3. Alternate sites of care delivery
Enabling Factors / Drivers	• Use measurement / data to inform impact • Channeling members to most effective providers • Payment (total cost of care) • Patient and consumer engagement	• Payments • Channeling members • Provider level coaching in less sophisticated markets (i.e., rural) • Patient and consumer engagement
Collaboration Opportunities	• Standard measures and clinical information • Address data and information challenges	• Common measure sets for provider level reporting • Work with carrier partners or other stakeholders to engage providers

Priorities by Purchaser

		Priority by Purchaser			
		Strategy	Employer	Plan	Public
Quality Care	1	Health Equity: Reducing Disparities in Healthcare	Low	Low	Medium
	2	Preventive Services	Low	Low	Low
	3	Mental/Behavioral Health and SUD Treatment	**High**	**High**	**High**
	4	Acute, Chronic and other Conditions	**High**	**High**	Medium
	5	Major/Complex Care	**High**	**High**	**High**
Care Delivery	6	Networks Based on Value	**High**	**High**	**High**
	7	Promotion of Effective Primary Care	Medium	Medium	Medium
	8	Promotion of IHM and ACO's	**High**	**High**	**High**
	9	Pharmacy Utilization Management	**High**	Medium	Medium
	10	Non-Hospital Sites/Care Delivery	**High**	**High**	Medium
	11	Hospital Care	Medium	Medium	Medium
Fndns	12	Patient and Consumer Engagement	**High**	**High**	**High**
	13	Population-based and Community Health Promotion	Low	Low	Low

COVERED CALIFORNIA REGULATIONS

PROPOSED EMERGENCY REGULATIONS FOR HARDSHIP AND RELIGIOUS CONSCIENCE EXEMPTION

Bahara Hosseini, Office of Legal Affairs

BACKGROUND

- The Legislature passed budget and trailer bills that established a California individual mandate and penalty starting in 2020, requiring California residents to enroll in and maintain minimum essential coverage, receive an exemption, or pay a penalty.
- Covered California will grant exemptions year-round for hardship and religious conscience.
  - Hardship includes financial hardship and other life circumstances that would prevent an individual from obtaining coverage.
  - Hardship exemptions can be granted throughout the year and entitle a consumer to purchase a catastrophic plan if desired.
- Covered California was granted emergency rulemaking authority by the Legislature through January 1, 2022 for hardship and religious conscience exemptions.

OVERVIEW OF PROPOSED REGULATION

- Outlining the definitions and general requirements for religious conscience and hardship exemptions through the Exchange (Section 6910)
- Establishing eligibility standards for religious conscience and hardship exemptions through the Exchange (Section 6912)
- Specifying eligibility process for religious conscience and hardship exemptions, including the notice requirements (Section 6914)
- Specifying the verification process for religious conscience and hardship exemptions (Section 6916)
- Specifying the eligibility redetermination process for religious conscience and hardship exemptions during a calendar year (Section 6918)
- Specifying right to appeal the eligibility determination and redetermination for the religious conscience and hardship exemptions (Section 6920)

NEXT STEPS

- Government Code section 100725(c) requires the Board to discuss proposed regulations at a properly noticed meeting before adopting them.
- Staff will request that the Board to formally adopt the exemption regulation package in September so it can be filed with the Office of Administrative Law.
- Any additional proposed changes to the proposed emergency regulations for hardship and religious conscience exemptions will be communicated to stakeholders for review and commenting prior to Action in September.

CHANGES TO ELIGIBILITY AND ENROLLMENT REGULATIONS FOR INDIVIDUAL MARKET

Bahara Hosseini, Office of Legal Affairs

BACKGROUND

- Covered California was granted emergency rulemaking authority by the Legislature through January 1, 2022.

- These regulations are the result of ongoing collaboration and consultation with the CDSS, DHCS, DMHC, CDI, FTB, consumer advocates, QHP issuers, and other stakeholders.

OVERVIEW OF THE MAIN PROPOSED CHANGES

- Added authority for the CECs, CACs, MMCPEs, PBEs, and CIAs to submit an application on behalf of an applicant or application filer after obtaining their consent.
- Added back the Exchange's "direct notification" requirement before eligibility for APTC could be denied due to the tax filer's failure to comply with the tax filing requirements, per federal rules.
- Revised our passive renewal hierarchy to allow for auto-enrollment from a HDHP to a non-HDHP offered by the same issuer at the same metal tier.

OVERVIEW OF THE MAIN PROPOSED CHANGES CONT.

- Added state of emergency due to fire, flood, or other natural or human-caused disaster SEP under the exceptional circumstances QLE.
- Added a new SEP QLE and coverage effective date for individuals who newly gain access to an individual coverage health reimbursement arrangement (HRA) or is newly provided a qualified small employer HRA (QSEHRA) in accordance with the new federal final rule effective 8/19/19.
- Added back the coverage effective date of 1st of the month following birth/adoption/foster care placement as an additional option for the qualified individuals and enrollees.

OVERVIEW OF THE MAIN PROPOSED CHANGES CONT.

- Revised the regulations regarding the issuers' responsibilities in cases of retroactive terminations for clarity purposes.
- Revised the appeal regulations to add the appeal right for the eligibility determination and redetermination for the State subsidies, including the amount of the State advance premium assistance subsidy.
- Revised the appeal regulations to add the appeal right for the eligibility determination and redetermination for religious conscience and hardship exemptions.

NEXT STEPS

- Government Code section 100504(a)(6) requires the Board to discuss proposed regulations at a properly noticed meeting before adopting them.
- Staff will request that the Board to formally adopt the regulation package in September so it can be filed with the Office of Administrative Law.
- Any additional proposed changes to the proposed emergency regulations for eligibility and enrollment in the individual market will be communicated to stakeholders for review and commenting prior to Action in September.

COVERED CALIFORNIA FOR SMALL BUSINESS (CCSB) ELIGIBILITY AND ENROLLMENT REGULATION REVISION

Dora Mejia, Chief Financial Officer
Terri Convey, Individual and Small Business Outreach and Sales Director

BACKGROUND

- CCSB regulations set the charge for processing a check returned to Covered California for insufficient funds to $25.
- The regulation does not include insufficient electronic payments made via automated clearing house (ACH).
- This amount represents a fraction of the cost of actually processing a insufficient funds payment.
- Current CCSB regulations do not provide payment options for entities that submit multiple insufficient fund payments.

BACKGROUND

- In the last fiscal year, the CCSB program received 197 returned payments, for an average amount of $5,712 each.
- Payments are returned for a number of reasons such as: stop payments, insufficient funds, closed accounts, etc.
- Surveyed entities charge from $0 to $100 for a returned payment.
- Due to our automated process, premiums are sometimes paid to carriers on behalf of small business before we receive notice that a payment failed to clear.
- The resulting reconciliation with health plans could impact health care enrollment should the small business not submit payment. The program also has groups that have multiple returned payments, making the group's enrollment status more precarious.

PROPOSED REGULATION CHANGES

- CCSB proposes changing the regulation to allow Covered California to charge a reasonable fee.
- Once the regulation is adopted, CCSB proposes to increase the fee from $25 to $50 to offset the actual costs of processing a returned payment. For an average returned payment of $5,712, the $50 fee represents .875% of the total.
- The regulation change would also require employers to submit a money order or cashiers check after two returned payments within a 6-month period. The requirement would be effective for 12-months.
- Notice of the returned payment charge amount will be included on the group's premium invoice.

PROPOSED REGULATION: § 6532. EMPLOYER PAYMENT OF PREMIUMS

(e) If a qualified employer makes a premium payment ~~via check~~ that is returned unpaid for any reason, the SHOP shall apply a ~~$25.00 insufficient funds fee .~~reasonable charge for the returned payment that reflects the actual cost incurred for processing returned payments. A reasonable charge for this service shall be set annually by Covered California, shall not exceed the actual cost incurred for processing and the same charge shall apply to each returned payment. This reasonable charge shall be noticed annually to all qualified employers on the premium invoice. If a qualified employer makes a second premium payment that is returned unpaid for any reason within six months of the prior returned payment, the qualified employer shall submit premium payment and the reasonable charge for returned payment in the form of a cashier's check or money order. This requirement shall continue for a period of 12 months beginning with the first of the month following the last paid-through date. If premium payment is not submitted in one of these two forms, the qualified employer group may be subject to termination of non-payment of premium as described in 6538 (c)(2).

NEXT STEPS

- Government Code section 100504(a)(6) requires the Board to discuss proposed regulations at a properly noticed meeting before adopting them.
- The Board discussed the regulation package at the May 16, 2019 and June 26, 2019 Board meetings.
- Covered California requests the Board to formally adopt the regulation as drafted so it can be filed with the Office of Administrative Law.

IDENTITY VERIFICATION REGULATIONS - AUTHORIZATION TO SUBMIT PERMANENT RULEMAKING PACKAGE TO THE OFFICE OF ADMINISTRATIVE LAW

Crystal Hirst, Office of Legal Affairs

IDENTITY VERIFICATION

- The Office of Legal Affairs requires Board approval to complete the permanent rulemaking process for the identity verification regulations.
- The identity verification regulations are currently emergency regulations. This rulemaking package seeks to make the emergency regulations permanent. The Board previously approved the emergency regulations on October 27, 2016.
- The Office of Legal Affairs commenced the permanent rulemaking process on May 3, 2019, by providing notice to all interested parties.
- The 45-day public comment period ran from May 3, 2019 to June 21, 2019. Covered California received no comments.

IDENTITY VERIFICATION

- The rulemaking package does not make any major changes to the emergency regulations that the Board previously approved.
- As discussed in the previous Board meeting, the changes address minor grammatical issues and incorporate federal regulations by reference.
- Government Code section 100500(a)(6) requires the Board to discuss proposed regulations at a properly noticed meeting before adopting them.
- The Board discussed the regulation package during the Board meeting on June 26, 2019.
- The Office of Legal Affairs now requests the Board to formally adopt the regulation package so it can be filed with the Office of Administrative Law.