



COVERED CALIFORNIA POLICY AND ACTION ITEMS

November 21, 2019 Board Meeting

DISCLOSURE REQUIREMENTS FOR CERTIFIED INSURANCE AGENTS WHO SELL NON-REGULATED HEALTH PRODUCTS

Terri Convey, Outreach & Sales Division Director

SUMMARY

- ❑ In March 2019, Covered California presented to the Board a potential requirement for Certified Insurance Agents to obtain disclosure statements from consumers who enroll in non-regulated health products
- ❑ We conducted further research and determined the only non-regulated health products being sold by our Agents are Health Care Sharing Ministries (HCSMs)
- ❑ Based on feedback, surveys, and other research, we believe less than 12% of Agents sell HCSMs

STAKEHOLDER FEEDBACK

- Beginning in September 2019, Covered California shared with its insurance agents, advocates, and stakeholders the series of drafts of its Disclosure and Attestation Form, Product Comparison Table, and Policy and Procedures
- Carriers, Agents, one Health Care Sharing Ministry, and multiple stakeholder and advocate organizations provided feedback and revisions on the various draft versions
- Since the September Board discussion, two policy additions were made as a result of stakeholder feedback:
 - Require an Agent to run a consumer's eligibility for financial assistance or Medi-Cal prior to enrolling them in an HCSM; and,
 - Require an Agent who sells HCSMs to disclose the number of HCSMs sold during the past year. Data will be collected during the Agent's annual, web-based certification training.

STAFF POLICY RECOMMENDATION FOR BOARD ACTION

- Covered California recommends Board adoption of a policy requiring Agents selling Health Care Sharing Ministries (HCSMs) to:
 - Run a consumer's eligibility for financial assistance or Medi-Cal prior to selling the consumer an HCSM
 - Collect a signed Consumer Acknowledgement and Full Disclosure Form from any consumer who purchases an HCSM (sample provided)
 - Retain the Consumer Acknowledgement and Full Disclosure Form in hard copy or electronically for 3 years, to be made available to Covered California upon request
 - Attest to agreement to abide by Covered California policy regarding HCSMs during annual, web-based Agent recertification training
 - Disclose the number of HCSMs sold by the Agent in the prior plan year during annual, web-based Agent recertification training

2020 STATE PREMIUM ASSISTANCE PROGRAM DESIGN AMENDMENT: PROPOSED RECONCILIATION REPAYMENT LIMITS AS OF 11/21/2019

Katie Ravel, Director of Policy, Eligibility and Research

YEAR-END CONSUMER RECONCILIATION OF ADVANCED PREMIUM SUBSIDIES

- State premium subsidies will be reconciled at year-end through the Franchise Tax Board.
- Reconciliation adjusts consumers' final premium subsidy based on their year-end income compared to the income they projected when they applied for coverage.
- Covered California is charged with developing reconciliation repayment limits for state premium subsidy program.
- Repayment of the federal premium tax credit is capped for individuals whose year-end income is at or below 400 percent of the federal poverty level (FPL), while those above 400 percent FPL must repay the entire amount of credit they received in advance.

FEDERAL RECONCILIATION CAPS

- Repayment of the federal premium tax credit is capped for individuals whose year-end income is at or below 400 percent FPL.
- Consumers whose year-end income exceeds 400 percent FPL must repay the entire amount of credit they received in advance.

Household FPL	Single	All other filing statuses
Less than 200%	\$300	\$600
At least 200% but less than 300%	\$775	\$1550
At least 300% but less than 400%	\$1300	\$2600
More than 400%	No limit	No limit

2020 STATE SUBSIDY PROGRAM DESIGN DOCUMENT: PROPOSED RECONCILIATION POLICY

1. Proposes reconciliation repayment limits for state premium subsidy:
 - For individuals who receive advanced state premium subsidy and file taxes at or below 400% FPL, proposed repayment limits mirror the federal limits.
 - For individuals who file taxes between 400 and 600% FPL, proposed repayment limits increase at a similar rate to the federal repayment limits.
 - A repayment limit is also proposed for individuals who file between 600 and 700% FPL.*
2. Individuals who attest to income above 400% FPL and receive state subsidy dollars in advance, but file at or below 400% FPL will not have a reconciliation repayment limit.

*While this is outside of the premium subsidy eligibility range, this would mirror a federal policy that was briefly in law for individuals up to 500% FPL with the aim of softening the “cliff” for those who end the year just over the income range for subsidy eligibility.

PROPOSED STATE SUBSIDY RECONCILIATION PAYMENT LIMITS

- The amount of advanced California Premium Subsidy the household must reconcile is the difference between the amount received based on attested income and the amount eligible for based on final income at tax filing, subject to the following repayment caps.
- Note: These repayment caps do not apply to households that attested to having an income greater than 400% FPL during the benefit year but had a final income below 400% FPL.

			<i>Approximate percentage of household income*</i>	
FPL	Single filers	All other filers	Single filer	Four Person Tax Household
Less than 200	\$300	\$600	2.4%	2.3%
At least 200 but less than 300	\$775	\$1,550	2.5%	2.4%
At least 300 but less than 400	\$1,300	\$2,600	3.0%	2.9%
At least 400 but less than 500	\$2,000	\$4,000	3.6%	3.5%
At least 500 but less than 600	\$3,000	\$6,000	4.4%	4.2%
At least 600 but less than 700	\$4,200	\$8,400	5.2%	5.0%
700 or above	No cap	No cap		

* Percentage of household income shown for reference, and uses the income at the midpoint of the FPL Range (e.g. for 400% to 500% FPL, the income used is 450% FPL).

2020 STATE SUBSIDY PROGRAM DESIGN DOCUMENT: EDITS REFLECTED IN 11/21/2019 DRAFT

Covered California made several clarifying changes to the Program Design Document based on feedback from the September presentation:

1. Adds the following definitions, pursuant to Section 100815 of the Government Code:
 - Actual family size;
 - Projected family size;
 - Actual filing status;
 - Projected filing status;
 - Actual household income;
 - Projected household income.
2. Adds the formula for state subsidy reconciliation based on actual household size, income, and filing status and factoring in the consumer's maximum allowed federal premium tax credits. Also considers the state subsidy taken in advance throughout the year.

REQUESTED ACTION: CALIFORNIA STATE SUBSIDY

- The Board discussed the California State Subsidy Reconciliation Program Design during the Board meeting on September 19, 2019.
- Staff now request the Board to formally adopt the California State Subsidy Reconciliation Program Design so that it can be submitted to Department of Finance for approval.

2020 TRIBAL ADVISORY WORKGROUP

Peter V. Lee, Executive Director

TRIBAL ADVISORY WORKGROUP POLICY

- The Tribal Advisory Workgroup was established by § VI of the Tribal Consultation Policy adopted by the Board in November 2012. The purpose of the workgroup is to play a consultative role in developing Exchange policies that benefit tribal members by offering advice and recommendations to staff.
- The Tribal Consultation Policy outlines a specific workgroup structure, provision for both face-to-face and webinar/phone participation, appointed workgroup representation by region and other criteria, and specified meeting protocols.
- A September 2019 Tribal Advisory Workgroup meeting was cancelled due to a lack of a physical quorum, as required by a recent amendment to the Bagley-Keene Act. Members of the workgroup represent areas throughout California. Although Covered California has a policy to reimburse members for travel, Tribal representatives noted the hardship of travel given that Tribes are located all throughout the state.
- At the October 2019 annual Tribal Consultation, Tribal representatives expressed the desire for more flexibility in how the workgroup is structured and conducted, including greater allowance for remote participation, reassessment of Workgroup membership, and meeting protocols in order to enhance participation and facilitate better dialogue on policies impacting Tribes and American Indian/Alaska Native enrollees.

PROPOSED CHANGES TO TRIBAL ADVISORY WORKGROUP

- In recognition of the challenges expressed by Tribal representatives at the October 2019 Tribal Consultation, and with the shared goal of enhancing participation and meaningful engagement through the Tribal Advisory Workgroup, Covered California proposes to:
 - Eliminate the Tribal Advisory Workgroup from the 2012 Tribal Consultation Policy;
 - Consult with Tribal Advisory Workgroup members and other Tribal representatives to create, for approval by the Executive Director, an updated structure and process for a workgroup that will enhance participation, foster timely meetings and discussions, and allow for timely enactment and flexibility to amend as needed in the future in consultation with Tribal representatives.
- Approving this action would provide Covered California and Tribal leaders the flexibility needed to establish a more effective workgroup structure that will in turn bolster our government-to-government relationship and consultative process; help generate increasingly productive annual Tribal Consultations; and foster improved engagement on how to best serve American Indian/Alaska Native enrollees.

OVERVIEW OF COVERED CALIFORNIA EFFORTS TO IMPROVE HEALTH SYSTEM PERFORMANCE

James DeBenedetti, Director of Plan Management Division

COVERED CALIFORNIA'S FIRST FIVE YEARS: OVERVIEW OF IMPACTS AND DETAILED PERFORMANCE INFORMATION

As part of its efforts to hold itself and its issuers publicly accountable and to inform its contracting for 2022-2024, Covered California will release two reports next week:

- ***Covered California's Progress to Assure Quality, Lower Costs and Improve Health System Performance – 2014-2019*** highlights the key strategies undertaken by the state and Covered California and the early results of those efforts.
- ***Covered California Progress Report: Assuring Quality Care and Promoting Delivery System Reform – 2014-2019*** summarizes Covered California's contracted issuers' efforts to meet the contractual requirements imposed to foster better quality, healthier populations, lower costs, attention to health equity and issuers' efforts to promote changes in how health care is delivered. The report includes data on performance and issues for future consideration that will inform Covered California's work to update its contractual requirements.

COVERED CALIFORNIA'S QUALITY CARE AND DELIVERY REFORM FRAMEWORK

Assuring Quality Care

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

ORGANIZING STRATEGIES

- Effective Primary Care
- Promotion of Integrated Delivery Systems and ACOs
- Networks Based on Value

Sites and Expanded Approaches to Care Delivery

Appropriate Interventions

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 burdens on providers.

- Benefit Design
- Measurement for Improvement Choice and Accountability
- Payment
- Patient-Centered Social Needs
- Patient and Consumer Engagement
- Data Sharing and Analytics
- Administrative Simplification
- Quality Improvement and Technical Assistance
- Certification, Accreditation and Regulation

Community Drivers: Workforce, Community-Wide Social Determinants, Population and Public Health

COVERED CALIFORNIA — CORE APPROACHES TO IMPROVING HEALTH SYSTEM PERFORMANCE

- **Create an effective consumer-driven marketplace:** Covered California operates an effective consumer-driven marketplace, creating a level playing field where consumers benefit from meaningful competition and expanded enrollment.
- **Hold health plans accountable for quality and for advancing reform:** Covered California holds health plans accountable through its selection of plans to participate in the marketplace and an array of reporting and performance requirements.
- **Align efforts to foster systemic change:** By working with other purchasers, providers and consumers, Covered California has helped catalyze major gains in patient safety, maternity care and in performance measurement for both hospitals and physician practices.
- **Use data and evidence to drive continuous improvement:** Covered California continuously reviews and reflects on what is working to improve care in order to refine future requirements and inform multi-stakeholder collaborations in ways that will increase impact while reducing burdensome, unnecessary requirements.

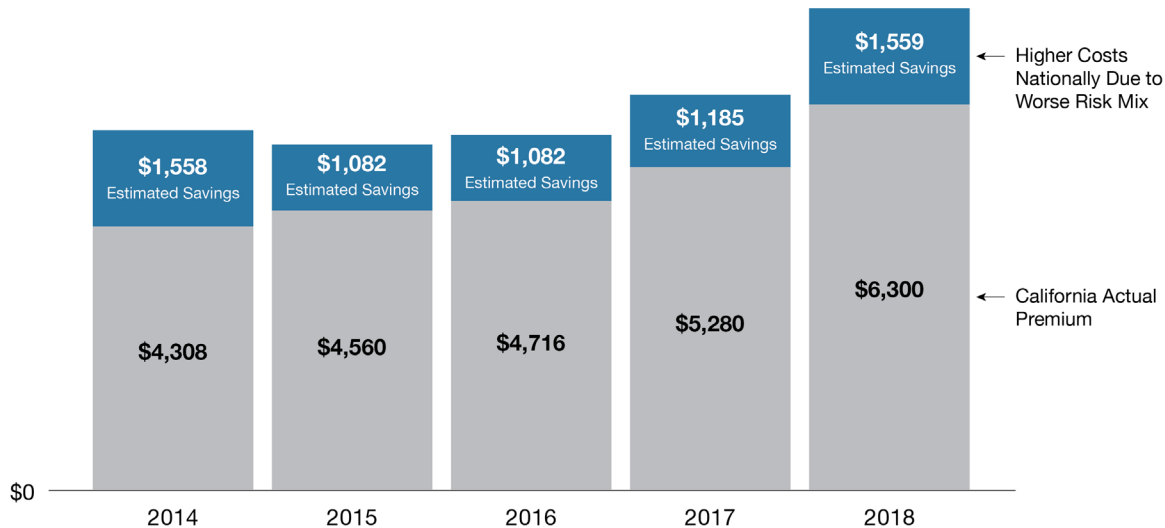
COVERED CALIFORNIA'S FIRST FIVE YEARS: KEY OBSERVATIONS

- **Lower Costs:** California has dramatically expanded coverage and Covered California has reduced costs by having a healthier risk mix: saving unsubsidized consumers over \$1,000 per year annually and saving those consumers and the U.S. Treasury an estimated \$12.5 billion between 2014 and 2018.
- **Satisfied Consumers:** The majority of Covered California enrollees are in plans that have scores on enrollee satisfaction measures with their health plan and their health care above the 50th percentile nationally.
- **Great Quality for Many with Wide Variation for Others:** Kaiser Permanente and Sharp Health Plan are among the highest performers in the nation – being above 90th percentile in many indicators – and provide care to about 35% of Covered California enrollees. Among other issuers, select physician organizations* score equally well but there is wide variation in overall performance on quality measures pointing to multiple opportunities for improvement.
- **Health Disparities Getting Needed Attention:** Covered California is at the beginning of long-term initiatives to reduce health disparities. Issuers are initiating efforts to address disparities under Covered California requirements that may impact some of their 19.5 million Californians, not just those enrolled in Covered California plans.
- **Collaboration and Alignment:** Improving Care for All Californians: Covered California's collaborative efforts with other payers and purchasers have led to positive systemic changes in care delivery. For example, hospital quality, maternity safety and opioid safety collaborative improvement efforts have led to reductions in hospital associated infections, big drops in number of low-risk C-sections and gains in prevention and treatment of opioid use.
- **Requirements to Change Delivery Are Making a Difference:** Driven by contract requirements and common vision, issuers are expanding their use of Accountable Care Organization and promoting coordinated care, with 25% of Covered California enrollees in these structures as of 2018, far exceeding the national average of 10% and the California commercial level.

*Source: IHA report on top physician organizations https://www.iha.org/sites/default/files/resources/my_2018_top_ten_honorees.pdf

CALIFORNIA'S LOWER PREMIUM COSTS FOR UNSUBSIDIZED ENROLLEES

California's Healthier Risk Mix Leading To Lower Premium for Unsubsidized Insureds



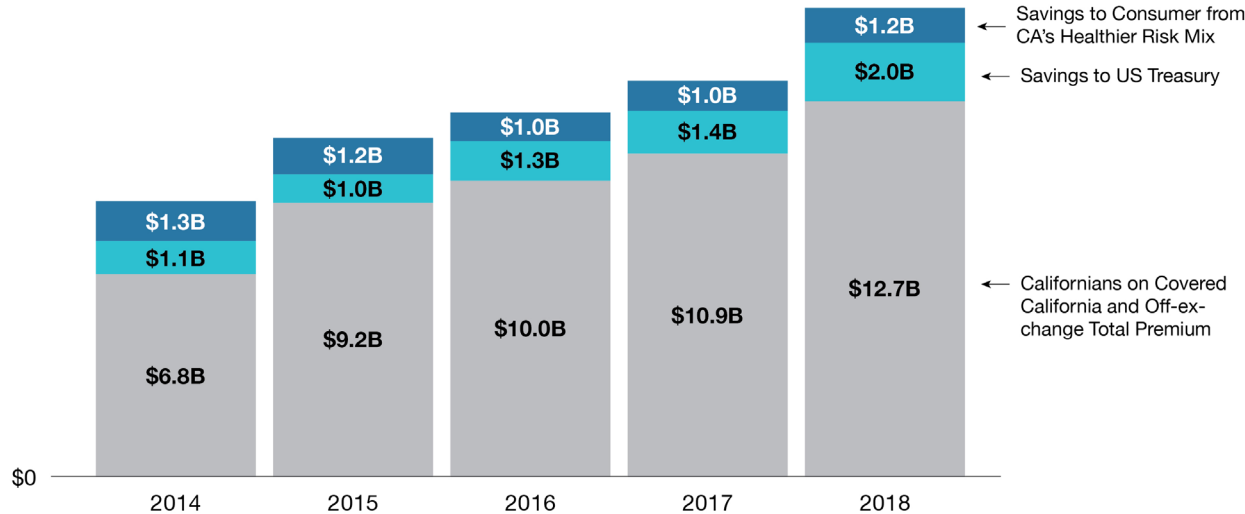
- The state of California and Covered California have implemented effective policies to reduce costs for unsubsidized enrollees.
- The lower costs to unsubsidized enrollees mean their average annual premium is \$1,080 to \$1,560 less than those enrollees would have paid if the risk mix had been similar to that seen in the rest of the nation.

Note: In the period from 2014 to 2018, the cumulative average premium increase in California was one-third lower than the increase for the rest of the US: relative to 2014, the average premium in 2018 was 76 percent higher in the rest of the US, compared to 46 percent in California. In 2018, a large average premium increase was driven by the gross premium for the Covered California Silver tier (the most commonly chosen tier) increased by an additional 12.5% due to the elimination of the Cost-Sharing Reduction (CSR) payments from Centers for Medicare and Medicaid Services (CMS).

Covered California analysis of data from CCIO (risk adjustment reports at <https://go.cms.gov/37nYijY>), CMS (effectuated enrollment snapshots, such as <https://go.cms.gov/37oK5mY>), and Covered California's own administrative data.

LOWER COSTS MEAN BIG SAVINGS TO CONSUMERS AND THE FEDERAL GOVERNMENT

California's Combined Impact on Lowering Costs in the Individual Market – 2014-2018 (in billions)

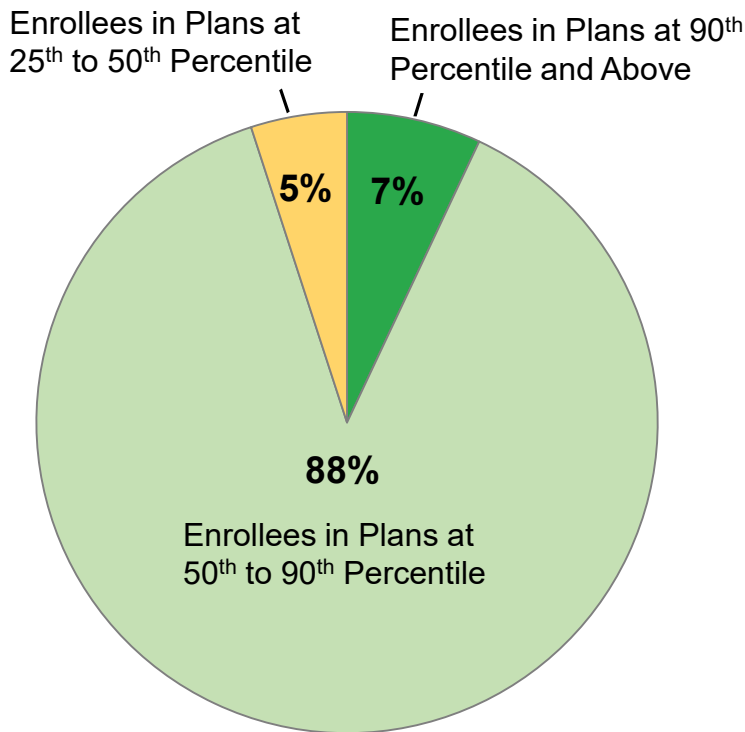


Note: Across five years, the cumulative savings to consumers was about \$5.7 billion, and to the US Treasury was \$6.8 billion, for a combined savings of \$12.5 billion.

Covered California analysis of data from CCIIO (risk adjustment reports at <https://go.cms.gov/37nYijY>), CMS (effectuated enrollment snapshots, such as <https://go.cms.gov/37oK5mY>), and Covered California's own administrative data. Savings derived holding observed enrollment constant, and estimating hypothetical premiums had risk mix in California mirrored that of the rest of the nation in each of the respective years (using the enrollment-weighted average risk score for all states for which risk adjustment data are reported, excluding California).

- Covered California design principles led to **\$12.5 Billion** in total savings to enrollees and the U.S. Treasury in the last 5 years.
- Policy actions to promote market stability, active negotiation with issuers, standard plan benefit designs, and extensive marketing and outreach have contributed to the savings.

COVERED CALIFORNIA ENROLLEES' OVERALL RATING OF HEALTH PLANS (CAHPS)



- In 2019, 95% of Covered California enrollees were in plans that are ranked above the 50th percentile nationally for enrollee experience related to their health plan (Rating of Health Plan measure).
- In 2019, 75% of Covered California enrollees are in plans that are ranked above the 50th percentile nationally for consumer satisfaction with their health care (Rating of All Health Care measure).
- There were no enrollees in plans that are ranked below the 25th percentile nationally for either CAHPS score.



Data Source: QRS reporting for all national marketplace plans. Weighted average based on enrollment in products eligible for a QRS score in the individual market.

COVERED CALIFORNIA CONSUMERS IN INTEGRATED SYSTEMS GETTING GREAT CARE; WIDE VARIATION IN OTHER HEALTH PLANS

- Covered California prioritized 13 of 40 measures used by the national marketplace Quality Rating System to determine star ratings, based on: (1) health impact overall and on disadvantaged populations, (2) extent of health plan variation, (3) performance improvement opportunity, (4) alignment with other California accountability programs, and (5) balance across domains of care, such as prevention, chronic-illness care and behavioral health (plan-specific performance on all 40 measures is included in the *Covered California Progress Report*).
- For each measure Kaiser Permanente and Sharp Health Plan performed exceptionally well, often in the 90th percentile nationally; for other health plans there is a wide variation in the care being delivered.
- Strong performance by Kaiser Permanente and Sharp Health Plan underscore potential for improvement and the importance of fostering care that is integrated and well-coordinated.
- Improving performance by studying and addressing the causes of variation across plans will be a main focus of Covered California's efforts to foster accountability and improve care.

EXAMPLE OF EXCEPTIONAL PERFORMANCE AND VARIATION: EFFECTIVE DIABETES CARE

Hemoglobin A1c (HbA1c) Control (<8.0%) (HEDIS)

The Hemoglobin A1c Control measure represents the percent of members 18-75 years of age with diabetes (type 1 or 2) who had HbA1c Control (< 8.0%).

	US Benchmark 2019	Percent of Enrollees	Number of Enrollees	Number of Plans
Plans at 90th Percentile and Above	68 +	37%	495,018	2
Plans at 50th to 90th Percentile	58 to 68	43%	582,871	5
Plans at 25th to 50th Percentile	52 to 58	17%	223,389	4
Plans Below 25th Percentile	Below 52	3%	45,348	2
Covered CA Highest Performer	72			
Covered CA Weighted Average	64			
Covered CA Lowest Performer	49			

Highlights

- Kaiser Permanente and Sharp Health Plan perform among the 90th percentile nationally.
- There is wide variation in performance among plans with most plans performing between the 90th percentile and the 25th percentile for the Comprehensive Diabetes Care: Hemoglobin A1c Control measure.
- The Covered California weighted average for plan performance for the Hemoglobin A1c Control measure falls between the 50th to 90th percentile.

Data Source: QRS reporting for all national marketplace plans. Weighted average based on enrollment in products eligible for a QRS score in the individual market.

HEALTH EQUITY AND REDUCING DISPARITIES: COVERED CALIFORNIA AND ITS PLANS LAUNCHING MAJOR EFFORTS

Covered California requires contracted plans to collect race/ethnicity for its enrollees **and** assess potential for health disparities across four targeted conditions – diabetes, hypertension, asthma, and depression – across all of lines of business, with interventions planned where gaps are identified. Notable progress and early findings include:

- As of 2018, 8 of 11 issuers, representing 93% (1,290,280 out of 1,384,030) of enrollees, were at or above the 80% requirement for enrollee race/ethnicity self-identification.
- Four issuers (Health Net, Kaiser Permanente Southern California, LA Care, and Molina) representing 36% (503,220 out of 1,384,030) of enrollment, have received the NCQA Distinction in Multicultural Health Care recognition, which requires meeting national standards for awareness and programs addressing their populations’ racial, cultural and language differences.
- **All** plans are conducting analysis across all lines of business to assess potential of health disparities. Based on early analysis of this data:
 - Gaps or disparities in care were **not** consistent across issuers (e.g., in some issuers, African Americans appeared to warrant interventions due to gaps in diabetes care and Latinos in others)
 - The differences in care were often far greater between issuers than was evident within plans based on race/ethnicity (e.g., whether a consumer was enrolled in Kaiser Permanente or Sharp Health Plan was a far greater predictor of better performance than was any racial or ethnic status within another health plan)
- All issuers have submitted interventions to address at least one identified health condition and those interventions address the issuers’ entire individual market enrollment (both Covered California and off-exchange), as well as other lines of business (some including all commercial lives, others Medi-Cal).
- Covered California will provide additional details on these data and the planned interventions in the coming months.

IMPORTANCE OF ALIGNMENT: DRAMATIC IMPROVEMENTS IN REDUCING HOSPITAL ASSOCIATED INFECTIONS, C-SECTION RATES AND OPIOID USE

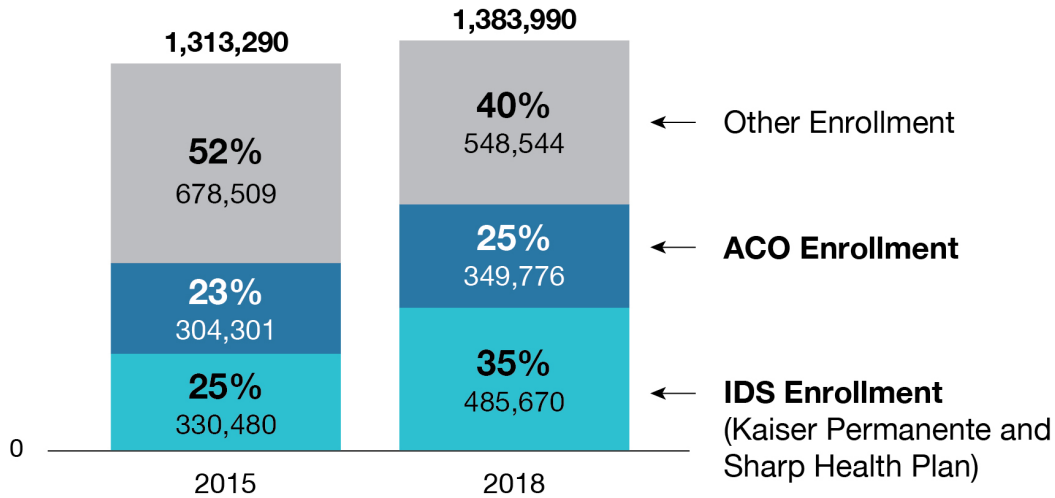
- Covered California's work with improvement collaboratives such as Smart Care California, California Maternal Quality Care Collaborative (CMQCC), and Cal Hospital Compare has led to major improvements:
 - Reduction in opioid use and increased access to treatment;
 - Decreased Hospital Associated Infections (CLABSI, SSI, MRSA, C. diff); and
 - Decreased NTSV C-section rates.
- Alignment with other stakeholders including DHCS, CalPERS, and large employers is an important component of improving quality and reducing administrative burden on providers and hospitals.

12 months 2017-18
Reduction in HAIs
3,392 Infections Saved
\$62.2M Cost Savings
251 Lives Saved

7,200
C-sections
Avoided
from 2015-
2018

COVERED CALIFORNIA CONTRACT REQUIREMENTS PROMOTING INTEGRATION: HIGH ACO ENROLLMENT

Covered California Enrollment in ACOs, Integrated Delivery Systems and Other Systems – 2015 and 2018



- California has historically high enrollment in health plans based on integrated delivery systems, with 35 percent of all enrollment in Kaiser Permanente and Sharp Health Plan.
- Covered California has pushed other plans to contract with Accountable Care Organizations, which are now serving 25 percent of all enrollment in non-IDS plans.
- Covered California ACO enrollment is more than two times the national average and far higher than the average reported for California.*

*Leavitt Partners reports that 10% of the US population and between 10-15% of Californians were in ACOs in 2018 (excluding integrated delivery systems) Source: <https://www.healthaffairs.org/doi/10.1377/hblog20180810.481968/full/>

SOME IMPLICATIONS FOR THE FUTURE

- **Individualized, Equitable Care:** Covered California's health equity work has important expansion potential in the future, including seeking collaboration with other purchasers, especially the Department of Health Care Services.
- **Reducing Performance Variation:** Consistent high performance among integrated systems, such as Kaiser Permanente and select physician organizations, demonstrates the importance of integrated and coordinated care. Covered California needs to assess what factors contribute to better performance among network plans and how performance can be improved across California, including the extent to which Accountable Care Organizations are a path to improved performance.
- **Alignment and Collaborative Efforts:** The improvement of hospital quality and safety through reducing HAI and NTSV C-section rates underscores the value of aligned activities across purchasers, plans and providers. Covered California will continue to assess other opportunities to support such efforts including reducing measurement burden; fostering better measurement and integration of behavioral health care; addressing sepsis and adverse drug events; and determining whether the volume of procedures can serve as a proxy for quality will also be assessed.

QUESTIONS & COMMENTS

COVERED CALIFORNIA REGULATIONS

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

Dora Mejia, Chief Financial Officer

AUGUST 2019 ADOPTED REGULATION

- At the August 2019 meeting, the Board adopted two changes to CCSB regulations:
 1. To allow Covered California to charge a reasonable fee for returned payment. The change was to increase the fee from \$25 to \$50 to offset the actual costs of processing a returned payment.
 2. 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.

AMENDMENT TO ADOPTED REGULATION

- Regulations pertaining to returned payment fees are found in two codes.
 - Government Code 6157 (b) “...a reasonable charge for the returned check, not to exceed the actual costs incurred by the public agency, may be imposed to recover the public agency’s processing and collection costs.”
 - Civil code 1719 (a) (1) “...any person who passes a check on insufficient funds shall be liable to the payee for the amount of the check and a service charge payable to the payee for an amount not to exceed twenty-five dollars (\$25)”

AMENDMENT TO ADOPTED REGULATION

- The Office of Administrative Law (OAL) interprets this conflict as our actual costs cannot exceed the \$25 cap set by the Civil Code.
- As we continue to receive returned payments, we need the regulation change that allows Covered California to require either a cashiers check or money order.
- Therefore, no change is necessary for the current \$25 fee.
- OAL did not require re-notice for this minor change, and approved the regulation on November 7, 2019.

PREVIOUS 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).

UPDATED 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. 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 insufficient funds fee for returned payment in the form of a cashier's check or money order. This requirement to make monthly premium payments in the form of a cashier's check or money order 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).

MEDI-CAL MANAGED CARE PLAN ENROLLMENT ASSISTANCE PERMANENT REGULATIONS FOR ADOPTION

Hayley Figeroid, Outreach and Sales Division

MEDI-CAL MANAGED CARE PLAN ENROLLMENT ASSISTANCE PROGRAM

- Covered California needs Board approval to complete the permanent rulemaking process for the Medi-Cal Managed Care Plan Enrollment Assistance (MMCP) regulations.
- The MMCP regulations are currently emergency regulations. This rulemaking package seeks to make all emergency regulations permanent. The Board previously approved the emergency regulations on September 21, 2017.
- Covered California commenced the permanent rulemaking process on September 6, 2019, by providing notice to all interested parties.
- The 45-day public comment period ran from September 6, 2019 to October 21, 2019.

MEDI-CAL MANAGED CARE PLAN ENROLLMENT ASSISTANCE PROGRAM

- The rulemaking package does not make any major changes to the emergency regulations that the Board previously approved.
- Most changes address minor grammatical issues and update citations to federal regulations.

MEDI-CAL MANAGED CARE PLAN ENROLLMENT ASSISTANCE PROGRAM

- Government Code section 100500(a)(6) needs the Board to discuss proposed regulations at a properly noticed meeting before adopting them.
- Outreach and Sales intends to return to the Board to request final approval to file the permanent regulation package with the Office of Administrative Law in January, 2020.

UPDATE TO CONFLICT-OF-INTEREST CODE

Brandon Ross, Assistant General Counsel, Office of Legal Affairs

BACKGROUND

- The Political Reform Act requires state agencies to adopt a Conflict of Interest code.
- The Conflict of Interest code identifies designated positions and requires those employees who make or participate in making governmental decisions to disclose certain financial interests to help avoid conflicts of interest.
 - The Conflict of Interest code is reviewed by the Fair Political Practices Commission (FPPC) and submitted to the Office of Administrative Law.
- The current Conflict of Interest code has not been updated since 2012.
- Agencies are required to review their code every two years and update the code when positions and divisions change or are created.

CONFLICT-OF-INTEREST CODE COMPONENTS

Two primary components:

- List of Designated Positions: The positions in the agency that are required to disclose certain financial interests and file a Statement of Economic Interests (Form 700).
 - Example: Division Directors, Chief Deputies

- Disclosure Categories: The specific types of financial interests employees and officials must disclose on their Form 700.
 - Example: Income or gifts from health care providers or carriers.

SUMMARY OF PROPOSED CHANGES

- Updated the list of designated positions to align with the addition of new positions as well as changes in duties and responsibilities of positions since 2012.

- Clarified certain disclosure categories so that code filers know which financial interests must be disclosed
 - Added pharmacy benefit management companies, third party administrators (for health claims only), and non-profit foundations formed or funded by health insurance carriers or any other health care entities.

NEXT STEPS

- After discussion at this meeting, staff will:
 - Submit to FPPC for review and comments;
 - Initiate a 45-day public comment period, which will run from November 29, 2019 to January 13, 2020; and
 - Bring comments and changes back to the Board for review and possible action at January 16, 2020 meeting.