Payment to Agency Report — A Public Document

PAYMENT TO AGENCY REPORT
California Form 801
For Official Use Only

Date Stamp

1. Agency Name

Covered California

Division, Department, or Region (if applicable)

Executive

Street Address

1601 Exposition Blvd., Sacramento, CA 95815

Area Code/Phone Number: (916)228-8608

Email: allison.pease@covered.ca.gov

Agency Contact (name and title): Allison Pease, Attorney

☐ **Amendment** (explain in comment section)

Date of Original Filing: _____ (month, day, year)

2. Donor Name and Address

☐ Individual _____ (Last Name) _____ (First Name)

☑ Other University of Pennsylvania (Name)

440 Franklin Building, 3451 Walnut Street (Address) Philadelphia (City) PA (State) 19104 (Zip Code)

Academic institution.

If "Other" is marked, describe the entity's business activity (if business) or its nature and interests.

→ If applicable, identify the name of each source and the amount(s) received by the donor for this payment:

_____ (Name) $_____ (Amount) _____ (Name) $_____ (Amount)

3. Payment Information (Complete Sections 3.1 (a or b), 3.2, 3.3)

3.1 (a) Travel Payment

Philadelphia, PA (Location of Travel) 9/13/17 - 9/15/17 (Dates (month, day, year))

United Airlines (Transportation Provider) ☐ Rail ☑ Air ☐ Bus ☐ Auto ☐ Other (Check Applicable Boxes) The Study at University City (Name of Lodging Facility)

$484.88 Lodging Expenses | $146.28 Meal Expenses | $1,074.20 Transportation Expenses | $_____ Other Expenses | $1,705.36 Total Expenses

3.1 (b) Payment(s) not related to travel: _____ (Dates (month, day, year)) $_____ (Total Expenses)

3.2. Payment Description. Provide a specific description of the payment and its agency purpose and use.

Reimburse travel to speak on panels w/ state officials & private sector leaders at Penn Law School's 5th Annual Health Ins. Exchange Conference. Topics: states' actions to preserve markets & future of exchanges, directly related to CC's functions to operate health ins. exchange & improve health.

3.3. Identify the officials who used the payment in Section 3.1 (See instructions)

Last Name	First Name	Position/Title	Department/Division
Lee	Peter	Executive Director	Executive

4. Verification

I authorized the acceptance of the reported payment(s) as in compliance with FPPC regulations.

Signature | Karen Johnson (Print Name) | Chief Deputy Director (Title) | 4/18/18 (month, day, year)

Comment: Received reimbursement on 2/2/18.

(Use this space or an attachment for any additional information)

Clear Page

Payment to Agency Report — A Public Document

PAYMENT TO AGENCY REPORT
California Form 801
For Official Use Only

Date Stamp

1. Agency Name

Covered California

Division, Department, or Region (if applicable)

Executive

Street Address

1601 Exposition Blvd., Sacramento, CA 95815

Area Code/Phone Number: (916)228-8608

Email: allison.pease@covered.ca.gov

Agency Contact (name and title): Allison Pease, Attorney

☐ **Amendment** (explain in comment section).

Date of Original Filing: _____ (month, day, year)

2. Donor Name and Address

☐ Individual _____ (Last Name) _____ (First Name)

☑ Other National Academy for State Health Policy (Name)

10 Free Street, 2nd Floor (Address) Portland (City) ME (State) 04101 (Zip Code)

Nonprofit org. of state health policymakers dedicated to helping states achieve excellence in health policy and practice.

If "Other" is marked, describe the entity's business activity (if business) or its nature and interests.

→ If applicable, identify the name of each source and the amount(s) received by the donor for this payment:

_____ (Name) $_____ (Amount) _____ (Name) $_____ (Amount)

3. Payment Information (Complete Sections 3.1 (a or b), 3.2, 3.3)

3.1 (a) Travel Payment

Portland, ME (Location of Travel) 10/23/17 - 10/24/17 (Dates (month, day, year))

Southwest Airlines, Uber, Lyft (Transportation Provider)

☐ Rail ☑ Air ☐ Bus ☐ Auto ☑ Other (Check Applicable Boxes)

Portland Marriott Downtown (Name of Lodging Facility)

$190.25 Lodging Expenses | $_____ Meal Expenses | $338.15 Transportation Expenses | $_____ Other Expenses | $528.40 Total Expenses

3.1 (b) Payment(s) not related to travel: _____ (Dates (month, day, year)) $_____ (Total Expenses)

3.2. Payment Description. Provide a specific description of the payment and its agency purpose and use.

Reimburse travel to speak at plenary session of 30th Annual State Health Policy Conf. Topics: state s' flexible administration of health care w/ expected decreased federal funding, directly related to CC's functions to operate health ins. exchange & improve health by assuring access to care.

3.3. Identify the officials who used the payment in Section 3.1 (See instructions)

Last Name	First Name	Position/Title	Department/Division
Lee	Peter	Executive Director	Executive

4. Verification

I authorized the acceptance of the reported payment(s) as in compliance with FPPC regulations.

Signature | Karen Johnson (Print Name) | Chief Deputy Director (Title) | 4/18/18 (month, day, year)

Comment: Received reimbursement on 1/818.

(Use this space or an attachment for any additional information)

Clear Page

Payment to Agency Report

A Public Document

PAYMENT TO AGENCY REPORT
California Form 801
For Official Use Only

Date Stamp

1. Agency Name

Covered California

Division, Department, or Region (if applicable)

Executive

Street Address

1601 Exposition Blvd., Sacramento, CA 95815

Area Code/Phone Number: (916)228-8608

Email: allison.pease@covered.ca.gov

Agency Contact (name and title): Allison Pease, Attorney

☐ **Amendment** (explain in comment section)

Date of Original Filing: _____ (month, day, year)

2. Donor Name and Address

☐ Individual _____ Last Name _____ First Name

☑ Other National Association of Health Underwriters (Name)

1212 New York Ave NW, Suite 1100 (Address) Washington (City) D.C. (State) 20005 (Zip Code)

Nonprofit org. representing health ins. agents & brokers, offering educational opportunities & promoting affordable ins.

If "Other" is marked, describe the entity's business activity (if business) or its nature and interests.

→ If applicable, identify the name of each source and the amount(s) received by the donor for this payment:

_____ Name $_____ Amount _____ Name $_____ Amount

3. Payment Information (Complete Sections 3.1 (a or b), 3.2, 3.3)

3.1 (a) Travel Payment

Washington, D.C. (Location of Travel) 2/26/18 - 2/28/18 (Dates (month, day, year))

United Airlines (Transportation Provider)

☐ Rail ☑ Air ☐ Bus ☐ Auto ☐ Other (Check Applicable Boxes)

_____ Name of Lodging Facility

$_____ Lodging Expenses $_____ Meal Expenses $1,624.40 Transportation Expenses $_____ Other Expenses $1,624.40 Total Expenses

3.1 (b) Payment(s) not related to travel:

_____ Dates (month, day, year) $_____ Total Expenses

3.2. Payment Description. Provide a specific description of the payment and its agency purpose and use.

Reimburse travel to speak at 2018 Capitol Conf. Topics: successes of CC, utilization of agents/brokers in CA exchange, CC's vision for future of markets, which is directly related to CC's functions to operate health ins. exchange & improve health by assuring access to care.

3.3. Identify the officials who used the payment in Section 3.1 (See instructions)

Last Name	First Name	Position/Title	Department/Division
Lee	Peter	Executive Director	Executive

4. Verification

I authorized the acceptance of the reported payment(s) as in compliance with FPPC regulations.

Signature _____ Karen Johnson (Print Name) Chief Deputy Director (Title) 4/18/18 (month, day, year)

Comment:

(Use this space or an attachment for any additional information)

Clear Page

Payment to Agency Report — A Public Document

PAYMENT TO AGENCY REPORT
California Form 801
For Official Use Only

Date Stamp

1. Agency Name

Covered California

Division, Department, or Region (if applicable)

Executive

Street Address

1601 Exposition Blvd., Sacramento, CA 95815

Area Code/Phone Number: (916)228-8608

Email: allison.pease@covered.ca.gov

Agency Contact (name and title): Allison Pease, Attorney

☐ **Amendment** (explain in comment section)

Date of Original Filing: _____ (month, day, year)

2. Donor Name and Address

☐ Individual _____ Last Name _____ First Name

☑ Other National Coalition on Health Care — Name

1111 14th Street, NW, Suite 900 — Address
Washington — City
D.C. — State
20005 — Zip Code

Non-profit org. dedicated to bringing together stakeholders to achieve affordable, high-value health care system.

If "Other" is marked, describe the entity's business activity (if business) or its nature and interests.

→ If applicable, identify the name of each source and the amount(s) received by the donor for this payment:

_____ Name $_____ Amount _____ Name $_____ Amount

3. Payment Information (Complete Sections 3.1 (a or b), 3.2, 3.3)

3.1 (a) Travel Payment

Los Angeles, CA — Location of Travel
3/28/18 — Dates (month, day, year)

Southwest Airlines, Uber — Transportation Provider

☐ Rail ☑ Air ☐ Bus ☐ Auto ☑ Other — Check Applicable Boxes

_____ Name of Lodging Facility

$_____ Lodging Expenses
$_____ Meal Expenses
$504.81 Transportation Expenses
$_____ Other Expenses
$504.81 Total Expenses

3.1 (b) Payment(s) not related to travel:

_____ Dates (month, day, year)
$ _____ Total Expenses

3.2. Payment Description. Provide a specific description of the payment and its agency purpose and use.

Reimburse travel to speak at Southern CA Health Care Summit. Topics: strategies for improving affordability of high quality care & coverage, which is directly related to CC's functions to operate health ins. exchange & improve health by assuring access to affordable, high quality care.

3.3. Identify the officials who used the payment in Section 3.1 (See instructions)

Last Name	First Name	Position/Title	Department/Division
Lee	Peter	Executive Director	Executive

4. Verification

I authorized the acceptance of the reported payment(s) as in compliance with FPPC regulations.

Signature _____ Print Name: Karen Johnson — Title: Chief Deputy Director — 4/18/18 (month, day, year)

Comment:
(Use this space or an attachment for any additional information)

Clear Page