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To ensure access to high-quality, patient-centered, cost-effective health care to Los Angeles County residents through direct services at DHS facilities and through collaboration with community and university partners.

July 17, 2012

TO: Each Supervisor

FROM: Mitchell H. Katz, M.D.
Director

SUBJECT: **REPORT ON IMPACT OF U.S. SUPREME COURT RULING ON THE PATIENT PROTECTION AND AFFORDABLE CARE ACT ON THE DEPARTMENT OF HEALTH SERVICES**

This is to provide a summary report on the expected impact of the Supreme Court's ruling on the Patient Protection and Affordable Care Act (ACA) on the Department of Health Services (DHS).

As a result of the Supreme Court's ruling, approximately 80% of the 2.2 million people who are currently uninsured in Los Angeles County stand to gain access to affordable insurance coverage. If California opts to participate in the Medicaid expansion beginning in 2014, it is estimated that over half of these individuals will be eligible to receive coverage through Medi-Cal. Of the remaining County residents who are eligible for coverage as a result of the ACA, a substantial number will be able to purchase subsidized health insurance through the State's health insurance exchange.

There are three main revenue sources where the ACA is expected to have the greatest financial impact: the Healthy Way L.A. (HWLA) program, Disproportionate Share Hospital (DSH) funding, and the 1115 Waiver Safety Net Care Pool (SNCP).

HWLA Program

The HWLA program is the County's Medi-Cal Coverage Expansion Low Income Health Program (LIHP) under the 1115 Bridge to Reform Waiver. HWLA enrollees will be shifted to Medi-Cal program coverage beginning on January 1, 2014. While the State is developing a LIHP transition plan that will facilitate HWLA enrollees' ability to remain with their current primary care provider, because of subtle differences in eligibility criteria and the likely requirement that patients be enrolled into managed care through the two plan model, there may be some drop off from the program.

From January 1, 2014 through December 31, 2016, the current Federal Medical Assistance Percentage (FMAP) of 50/50 (Federal/County) will change to 100% Federal FMAP. The Federal FMAP will change to 95% in 2017, 94% in 2018, 93% in 2019, and 90% in 2020 and forward. This

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ongoing enhanced FMAP will serve as a major source of revenue for DHS providers serving patients covered under the Medicaid Expansion component of the ACA.

DSH Funds

The ACA provisions contain specific annual nationwide DSH cuts, starting with a $500 million reduction in 2014 and peaking with a cut of $5.6 billion in 2019. These reductions are included in the ACA based on the expectation that as more people enroll in Medicaid (Medi-Cal) or obtain exchange insurance, there will be less need for funding to cover the uninsured. Based on the DSH cuts specified in the ACA, the Department has estimated a decrease from the current Fiscal Year (FY) 2011-12 allocation of $415.02 million to $396.6 million in 2014, steadily decreasing in subsequent years to a low of $209.0 million in 2019. These annual DSH reductions will offset the additional Medi-Cal revenue, as reflected in the chart below.

1115 Waiver SNCP

The current Waiver assumed approval of the ACA with resulting significant decreases in the number of uninsured. For this reason, the SNCP funds were frontloaded in the initial years with steady declines in future years.

ACA Impact in FY 2014-15

The chart below details the ACA impact on the Department in FY 2014-15, the first full year of ACA implementation. After FY 2014-15; these numbers will continue to change, particularly as DSH cuts increase and as SNCP funds must be renegotiated in the next State Medicaid Waiver.

IMPACT OF ACA ($ in millions)			
	FY 2011-12	**FY 2014-15**	**Incremental Change**
HWLA/Medicaid conversion	$140.0	$280.0	$140.0
DSH	415.0	396.6	(18.4)
WAIVER SNCP	198.2	130.0	(68.2)
TOTAL	$753.2	$806.6	$ 53.4

Other Impacts

The State has indicated that they plan to revisit realignment allocations to the counties based on the expectation that the numbers of uninsured will significantly decline.

Reductions in realignment revenue would negatively impact the Department. Realignment funding for FY 2011-12 is valued at approximately $330 million.

It is unknown what revenue impacts may result from patient choice, i.e., with so many more people able to obtain either Medi-Cal or insurance exchange coverage, the overall changes in the Department's payer mix may be positive or negative.

The current Waiver expires in 2015. Current Waiver revenue streams and other Waiver provisions will have to be renegotiated at that time.

Critical parameters for the Board and DHS to watch closely and influence over the coming years include:

1) Federal formula for DSH cuts
2) Medicaid rates for managed care patients
3) Capacity to care for and ability to compete for Medicaid patients
4) State posture toward realignment negotiations

DHS will keep the Board apprised as additional information is obtained. In the meantime, if you have any questions or need additional information, please let me know.

MHK:aw

c: Chief Executive Office
County Counsel
Executive Office, Board of Supervisors

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September 14, 2012

To: Supervisor Zev Yaroslavsky, Chairman
Supervisor Gloria Molina
Supervisor Mark Ridley-Thomas
Supervisor Don Knabe
Supervisor Michael D. Antonovich

From: William T Fujioka
Chief Executive Officer

RESPONSE TO QUESTIONS REGARDING COUNTY PARTICIPATION ON THE CALIFORNIA HEALTH BENEFIT EXCHANGE (HBEX)

This report is in response to the July 17, 2012 request by Supervisor Mark Ridley-Thomas to the Chief Executive Office to provide an analysis that speaks to the role of the County in participating in the California State Health Exchange and whether there is a role for the County in administering the Exchange in a meaningful way. In addition, this report responds to the July 17, 2012 request by Supervisor Gloria Molina to the Chief Executive Office and Department of Health Services to report back on the feasibility of the County being an entity competing in an operational opportunity to submit a Request for Proposal and contract for health insurance.

Background on the California Health Benefit Exchange (HBEX):

On September 30, 2010, California became the first state to pass Exchange legislation when Governor Arnold Schwarzenegger signed two bills into law, SB 900 (Alquist & Steinberg) and AB 1602 (Perez), to create the California Health Benefit Exchange (HBEX). The legislation established HBEX as a public entity independent from the State budget and financed by fees on participating plans, described the appointments of the HBEX Board and their responsibilities, and established requirements for the selection and participation of health plans. It also required a standardized format for presenting health benefits, ensuring uniform billing and payment policies, and creating

an electronic calculator to determine the cost of coverage based on income. HBEX will also have a roll in assisting individuals who are eligible for public programs outside of the Exchange.

There are five HBEX Board Members. Two members are appointed by the Governor; one by Senate Rules Committee; and one by Speaker of the Assembly. The Secretary of the Health and Human Services, Diana Dooley, serves as an ex-officio voting member and Chair of the Board. Kimberly Belshe, Paul Fearer, Susan Kennedy and Robert Ross, M.D., are the other four members. The Board is tasked with the enormously complex task of establishing and running the Exchange. This includes determining the minimum requirements for "Qualified Health Plans" that may participate on the Exchange, establishing recommended benchmarks for what "Essential Health Benefits" must be provided by plans participating on the Exchange, coordinating with the Department of Health Care Services (DHCS) and the Managed Risk Medical Insurance Board (MRMIB) to ensure continuity of coverage for patients transitioning between public programs and HBEX, and developing eligibility and enrollment systems for individuals seeking coverage in both the Exchange and through public programs.

It is estimated that approximately 2.3 million uninsured individuals, or 37 percent of California's 6.4 million total uninsured, will be eligible to obtain subsidies to purchase health insurance on the Exchange. California has received $40.4 million in grants for research, planning, information technology development, and implementation of the Exchange and is currently in the process of applying to the federal government for additional funding.

Los Angeles County Role in the Health Exchange

There are three primary areas where the County has the most pronounced role in the development of and participation with the Exchange. Those are:

1. **Ensuring a County-Administered Eligibility and Enrollment System;**

2. **Participating on the Exchange as an Essential Community Provider (ECP);**

3. **Ensuring that essential County services are considered Essential Health Benefits for Qualified Health Plans on the Exchange.**

Each is described in more detail below.

1. Ensuring a County-Administered Eligibility and Enrollment System.

The California Health Benefit Exchange will serve as one of the main entry points for millions of Californians to obtain their health care coverage. The Exchange is required to screen individuals for eligibility for coverage subsidies offered through the Exchange as well as for public programs such as Medi-Cal and Healthy Families, and subsequently facilitate enrollment of these individuals.

The Exchange must also develop a consumer-friendly and responsive customer service center to enroll individuals in Exchange and public coverage programs which must include toll-free phone access to customer service representatives. The Exchange, in partnership with DHCS and MRMIB, is implementing the California Healthcare Eligibility, Enrollment and Retention System (CalHEERS) web based portal through which individuals can be determined eligible and enroll in a health plan – whether that be private coverage, Medi-Cal or Healthy Families. The Exchange understands that many consumers, especially in the first year, will need assistance navigating this new system.

The Exchange Board is currently deciding between two options to configure this customer-service component of eligibility and enrollment. The first option prioritizes a *state-controlled* customer service and enrollment center. The alternative option, developed by the California State Association of Counties (CSAC) and the County Welfare Directors Association (CWDA) and supported by the County, prefers a more integrated approach that utilizes the *existing county-based* eligibility operations structure and service centers.

It is the County's position that it is possible – and preferable - to seamlessly integrate the County's automated enrollment systems (LEADER, in Los Angeles County) and the Exchange Board's system, and that it would be inefficient and time-consuming to create separate eligibility determination processes at the State and County levels. As such, the County supports a system that preserves and utilizes the existing county based eligibility operations structure and service centers to determine eligibility for potential subsidy coverage. The County's existing network would then be coupled with a state level call center for other non eligibility related functions.

There are a number of reasons why the County prefers this approach. First, on-going case management will be simpler at the local level, as Counties have more experience with these clients and their families, and Counties are already making plans to provide eligibility and enrollment services in person, on-line, over the phone and by mail. In

addition, Navigators who will be supported by the Health Benefit Exchange will be able to help eligible individuals enroll in a wide variety of other programs through the County-administered eligibility system such as CalFresh and CalWORKs. It is important to note that this is the only option that allows customers to be evaluated for traditional Medi-Cal as well as other human services programs in a horizontally-integrated fashion, as required by the Affordable Care Act (ACA), with a single phone call or visit. Finally, the County's customer service centers are already staffed and have the capacity to quickly meet increased demand, making the County system the easiest and fastest way to bring a fully- functioning service center online. For these reasons and others, Governor Brown has indicated that he supports Counties retaining control over eligibility and enrollment determinations.

2. Participating on the Exchange as an Essential Community Provider (ECP).

As California prepares for health reform implementation, the role of safety net providers in serving the newly, and remaining uninsured (or "residually uninsured") will be critical to maintaining a strong health care delivery system. While many providers will compete for the newly insured population, approximately 2-3 million individuals throughout California will remain uninsured and will still need a provider network. Therefore, as coverage expansion efforts continue for both the Exchange and Medi-Cal, it is important to ensure a role of safety net providers in the Exchange.

Federal health reform requires Qualified Health Plans (QHPs) on the Exchange to include Essential Community Providers (ECPs) as part of the provider network. Although federal guidance does not specifically define an ECP (this definition is also currently under debate within the HBEX Board), it does indicate that an ECP should serve predominately low income, medically underserved patients.

In order to ensure that safety net providers are included and utilized by the Qualified Health Plans in the Exchange, the County is working with advocacy groups such as the Community Clinic Association of Los Angeles County (CCLAC) and Community Health Councils (CHC) to ensure that the definition of an ECP accurately reflects traditional safety net providers. Furthermore, we are supportive of proposed incentives for QHPs that ensure that ECPs are actually utilized within the Exchange. These decisions are important to the County as the Departments of Health, Public Health and Mental Health Services determine how, and in what way, County services will be offered as options for consumers purchasing coverage on the Exchange.

3. **Ensuring essential County services are considered Essential Health Benefits (EHB) for Qualified Health Plans on the Exchange.**

The ACA requires coverage of Essential Health Benefits (EHBs) for most plans and policies in California sold in the individual and small group markets, both inside and outside the California's Exchange. Section 1302(b) of the ACA requires that at least some services within 10 specific categories of benefits must be included in the EHBs, but the federal Department of Health and Human Services has given States the flexibility to select a benchmark plan from four options that reflect the scope of services offered by a "typical employer plan." The benefits and services included in that benchmark plan would then become the Essential Health Benefits for plans participating on the Exchange. This definition is important because the State will be required to cover the cost of any mandates that fall outside of the selected benchmark plan.

SB 951 (Hernandez) and AB 1453 (Monning), establishes the Kaiser Foundation Health Plan Group HMO as the benchmark plan for the State. The County of Los Angeles supports this bill, believing that this plan is a good starting point to define essential health benefits. That said, we continue to work with the Department of Mental Health and the Department of Public Health to advocate for a more strongly defined benefit related to mental health and substance use disorder treatment.

County staff are closely monitoring the rapidly occurring developments of the Exchange Board, and provides quarterly in-person updates to the Board Deputies. We are collaborating with the Departments of Health, Public Health, Mental Health and Public Social Services to ensure that the County's interests will be represented throughout the planning and development of the Exchange.

Los Angeles County Competing for Role in health insurance exchange.

The County and Service Employees International Union (SEIU) Local 721 have agreed to study the concept of pursuing options for a program offering a DHS health plan to County employees as selection in their Options health insurance program. A Joint Labor-Management Health Insurance Committee comprised of representatives from SEIU as well as the County, represented by the CEO, DHR and DHS and consultants from AON, will commence meeting in November 2012. The purpose of the committee is to meet, explore, and review the feasibility of utilizing the County's internal health care delivery system as an option for employees and new hires to select as part of their Options health insurance benefit program. The program could also be expanded to include the Flex and MegaFlex benefit programs. The Committee will develop and

make advisory recommendations to the Chief Executive Officer to mitigate and control the cost of health insurance for employees.

If you have questions, please contact me or your staff may contact Sheila Shima at 974-1160, regarding the health exchange, or Jim Adams at 974-2404, regarding the Joint Labor-Management Health Insurance Committee.

WTF:SS
ALV:bjs

c: Executive Office, Board of Supervisors
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