*** NOTE: TO RETURN TO THIS PAGE, CLICK ON THE COUNTY SEAL ***

CLICK HERE FOR CHIEF EXECUTIVE OFFICER'S REPORT DATED AUGUST 17, 2012

CLICK HERE FOR CHIEF EXECUTIVE OFFICER'S REPORT DATED SEPTEMBER 14, 2012

County of Los Angeles
CHIEF EXECUTIVE OFFICE
Kenneth Hahn Hall of Administration
500 West Temple Street, Room 713, Los Angeles, California 90012
(213) 974-1101
http://ceo.lacounty.gov

WILLIAM T FUJIOKA
Chief Executive Officer

August 17, 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

REPORT ON COUNTY ADVOCACY ON FEDERAL LEGISLATION ON MEDICAL MALPRACTICE REFORM AND INTERSTATE PURCHASE OF HEALTH PLANS

This memorandum is in response to a request from the July 17, 2012 Board meeting (Agenda Item No. 44) that the Chief Executive Officer report back on any steps that have been taken by the County's Legislative Advocates to support Federal legislation to establish medical malpractice reform or to allow interstate purchase of health plans.

Medical Malpractice Reform Legislation

As previously reported in a July 19, 2012 memorandum on a motion by Supervisor Antonovich to support Federal legislation based on California's Medical Injury Compensation Reform Act (MICRA), there was no existing Board policy relating to medical malpractice. The County's Legislative Advocates, therefore, had not taken any steps to support Federal medical malpractice reform legislation. However, on August 7, 2012 the Board adopted the Supervisor's motion after clarifying that it is not intended to support H.R. 5, a Federal medical malpractice bill, which is pending in Congress, or to direct action that would serve to preempt state laws that govern medical malpractice and torts, such as MICRA. This clarification is consistent with the overall policy in the County's Federal Legislative Agenda opposing Federal preemption of State and local government authority.

Pursuant to this motion, this office drafted a 5-signature letter to the Senate and House leadership and California's Congressional delegation in support of medical malpractice legislation based on MICRA. Based on this motion, the County's Legislative Advocates also will be able to advocate in support of such legislation when Congress reconvenes after Labor Day.

Interstate Purchase of Health Plans

The County's Legislative Advocates have not taken steps to support Federal legislation to allow interstate purchase of health plans (insurance) because there is no existing Board policy to support such legislation. However, consistent with existing Board policy, they have been advocated to oppose the repeal of the Affordable Care Act of 2010, which includes a provision authorizing interstate health care choice compacts that allow insurers to sell health policies in states participating in the compact. In May 2011, Georgia became the first state to allow its residents to purchase out-of-state plans. To date, no out-of-state insurer has sought to offer health plans in Georgia, which has been attributable to the fact that out-of-state insurers still must obtain approval of their health insurance policies and rates by the State of Georgia, and must build a network of providers in Georgia.

A key issue with Federal legislation to allow the interstate purchase of health plans is whether it would preempt state laws regulating health plans, including over insurance rates and mandatory covered services. Pursuant to a Federal law enacted in 1945, each state regulates and establishes requirements for health plans operating within their borders. Unless Federal legislation authorizing the interstate purchase of health plans preempts state health insurance laws, insurers may not opt to sell health insurance across state lines because they still would have to meet the same state requirements and build the same network of providers that any in-state health plan must do. The overall policy in the County's Federal Legislative Agenda opposing Federal preemption of state and local government authority could be the basis for a pursuit of County position to oppose Federal legislation which would preempt state health insurance laws.

We will continue to keep you advised.

WTF:RA
MR:MT:ma

c: Executive Office, Board of Supervisors
County Counsel

County of Los Angeles
CHIEF EXECUTIVE OFFICE
Kenneth Hahn Hall of Administration
500 West Temple Street, Room 713, Los Angeles, California 90012
(213) 974-1101
http://ceo.lacounty.gov

WILLIAM T FUJIOKA
Chief Executive Officer

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
County Counsel
Health Services
Mental Health
Public Health
Public Social Services

091412_HMHS_MBS_HBEX