Blue Ribbon Task Force on Adult Health Care Coverage Expansion

Final Planning Phase Recommendations and Report

May 20, 2008

TABLE of CONTENTS

ATTACHMENTS

I. Background

On June 26, 2006 the San Mateo County Board of Supervisors created the Blue Ribbon Task Force on Adult Health Care Coverage Expansion (BRTF) to "explore options for providing comprehensive health care access and/or insurance to uninsured adults in San Mateo County living at or below 400% Federal Poverty Level, and to bring recommendations to the Board of Supervisors by July 2007." Between September 2006 and July 2007, the 37-member Task Force, chaired by Supervisor Jerry Hill and Supervisor Adrienne Tissier, met 7 times. Collectively, members debated key considerations of coverage expansion, confronted the trade-offs of various health care models, analyzed local aspects of achieving shared financial responsibility, evaluated the financial consequences of coverage versus insurance, and reviewed current access and provider capacity factors. On July 24, 2007 the Board of Supervisors unanimously adopted the BRTF's preliminary recommendations as a high-level framework for adult coverage expansion and asked the BRTF to bring forth final recommendations.

Between July 2007 and March 2008, the BRTF reconvened three times, and added two new members (an ACORN representative and a second representative from the Central Labor Council). The BRTF Final Planning Phase Recommendations are based on significant input and analysis conducted through three workgroups: ***The Population Definition Workgroup*** was chaired by Glen H. Brooks, Jr., Director, San Mateo County Human Services Agency (now retired). ***The Health Care Model Development Workgroup*** was chaired by Luisa Buada, CEO, Ravenswood Family Health Center. ***The Financing Mechanism Workgroup*** was chaired by Ron Robinson, CFO, Health Plan of San Mateo. Participation in the workgroups exceeded 75 members of the Task Force and community. In addition, the BRTF engaged experts from around the Country to provide consultation on delivery system design, provider capacity, cost estimates, revenue generation options and other key areas of inquiry. Expert consultation reports included (reports follow as attachments):

1. *Report to the Task Force: Demographic Highlights of the San Mateo County Uninsured Adult Population*; December 2006: Population Definition Workgroup (report)
2. *Beneficiary Cost-Sharing for San Mateo County Adult Health Care Coverage Expansion*; May 2007: Angie Chen, Goldman School of Public Policy, UC Berkeley (report)
3. *Analysis of Legal Requirements Related to Funding Alternatives for Adult Health Care Coverage Expansion*; June 2007: Michael P. Murphy, Assistant County Counsel; John C. Beiers, Chief Deputy County Counsel; and John D. Nibbelin, Deputy County Counsel (memo)
4. *San Mateo Uninsured Healthcare Claims Analysis [Actuarial Analysis];* June 2007: Milliman Consultants and Actuaries (memo)

5. *Feasibility of Insurance Product Options for the Low-Income Uninsured Adult in San Mateo County*; October 2007: The Pacific Health Consulting Group (report)
6. *County Health Care [Financing} Options*; October 2007: Altschuler Berzon, LLP. (memo)
7. *A Key Step to Ensuring Access: An Adequate Provider Network*; December 2007: Dr. Mary Giammona Medical Director Health Plan of San Mateo (presentation)
8. *Opinion Research Regarding Adult Health Care Coverage Expansion*; December 2007: EMC Research , Inc. (presentation and report)
9. *Modeling Employer Participation in Adult Health Care Coverage Expansion in San Mateo County,* December 2007: Ken Jacobs and Lucas Ronconi, Center for Labor Research and Education University of California Berkeley (report)
10. *Assessment of Strategic Priorities for San Mateo Health Services,* February 2008: Health Management Associates (report)

The BRTF also adopted several preliminary frameworks which contributed to the development of the final recommendations. These included the Complex-Chronic and Healthy Individual Coverage Model and Health Care Model Principles.

During the course of the BRTF's work, momentum grew and then recently waned around prospects for statewide health reform and coverage expansion. Research conducted with employers, as well as discussions at BRTF meetings emphasized the importance of clarifying the role that local innovation and action would play, within proposals debated at both the state and federal levels. The San Mateo County's experience in achieving universal coverage for children has been used as a guide in approaching coverage expansion for adults. The final planning phase recommendations include consideration of a changed State landscape (anticipated reform was not achieved in early 2008 and is therefore not likely in the immediate time frame), which, among other factors, requires continued local investment to sustain universal health coverage for children.

In conjunction with the work of the BRTF, the County undertook a review of its own delivery system capacity within the context of the broader healthcare delivery context in the community (Health Management Associates Phase II Analysis). This resulted in the creation of a Health System Redesign Initiative that aims to address several areas raised in the BRTF preliminary recommendations.

Many of these preliminary recommendations adopted by the Board of Supervisors are reiterated here as final recommendations. The additional information and analysis completed between September and March, the shifting State context for health reform, and the County's initiation of the Redesign Initiative are incorporated in these final planning phase recommendations related to implementation sequencing and responsibility.

II. Task Force Membership

Organization	Representative
Board of Supervisors –President Adrienne Tissier, Chair	
Board of Supervisors – Supervisor Jerry Hill, Chair	
ACORN	Elizabeth Anderson
Burlingame City Council	Ann Keighran
Central Labor Council	Shelley Kessler
Central Labor Council	Nadia Bledsoe
Community Member	Gordon Russell
County Manager's Office	John Maltbie
Health Department	Srija Srinivasan
Health Department	Louise Rodgers
Health Plan of San Mateo	Ron Robinson
Health Plan of San Mateo	Maya Altman
Human Services Agency	Beverly Beasley-Johnson
Kaiser Permanente	Linda Jensen
Legal Aid Society of San Mateo County	M. Stacey Hawver
Medical Society	Gregory Lukaszewics
Medical Society	John Hoff
Mills-Peninsula Health Services	Bob Merwin
Palo Alto Medical Foundation	Cecilia Montalvo
Peninsula Healthcare District	Susan Smith
Peninsula Interfaith Action	Barbara Keefer
Peninsula Interfaith Action	Tom Quinn/Alvin Spencer
Ravenswood Family Health Center	Luisa Buada
Redwood City Chamber of Commerce	Keith Bautista/David Amann
Redwood City Council Member/Mayor	Barbara Pierce
Samaritan House	Kitty Lopez
SAMCEDA	Dan Cruey
San Mateo Chamber of Commerce	Linda Asbury
San Mateo Council Member/Mayor	Carole Groom
San Mateo Medical Center	Sang-Ick Chang
San Mateo Medical Center (physician)	Susan Ehrlich
Sequoia Healthcare District	Stephani Scott
Sequoia Hospital	Glenna Vaskelis
Seton Medical Center	Bernadette Smith
Silicon Valley Community Foundation	Frank Lalle
Stanford University Medical Center	Gerald Shefren

III. Final Planning Phase Recommendations

1. Coverage Expansion: There are 36,000-44,000 uninsured adults age 19-64 living in San Mateo County with household incomes at or below 400% Federal Poverty Level.

a. The Blue Ribbon Task Force recommends health care coverage expansion that strives to reach the full population of uninsured adults below 400% FPL.
b. The Blue Ribbon Task Force recommends that we establish a new Adult Coverage Program (San Mateo ACE Program) that provides access to health care within San Mateo County.
c. The Blue Ribbon Task Force recommends phased enrollment in accordance with available resources and adequate access.

In September, 2007, San Mateo County was one of ten counties awarded a Health Coverage Initiative (HCI) grant from the State of California's Hospital Financing Waiver. The County was awarded $7.5 million annually for three years to provide services to uninsured adults with complex-chronic diseases. The County was also awarded unlimited administrative funds to develop and maintain the program. This program was named the San Mateo Access and Care for Everyone (ACE) Program.

The ACE Program funding is dependent on federally mandated enrollee eligibility criteria. However, enrolled adults represent a newly covered adult population. The ACE Program is the first phase of coverage expansion. Between September 2007 and March 2008 the program enrolled 2,100 adults. Based on current service utilization patterns (and resulting expenses) the program will likely enroll more than the initial 2,100 estimate.

2. Unified Administration for Coverage Program: Health care services for uninsured adults would be provided as a coverage program through the Health Plan of San Mateo (HPSM) serving as a single third party administrator.

a. The Blue Ribbon Task Force recommends that the Adult Coverage Program would be operated as a coverage program and not an insurance product in order to maintain maximum State and Federal revenues and preserve maximum flexibility for local revenues.
b. The Blue Ribbon Task Force recommends that the County would continue its commitment to finance coverage for indigent adults and that all current County-sponsored programs serving uninsured adults would be consolidated into the San Mateo ACE Program.
c. The Blue Ribbon Task Force recommends that HPSM consider access capacity for San Mateo ACE Program participants in conjunction with other publicly insured individuals such as Medi-Cal and Medicare and where needed, expand the network for all participants/members.

The Health Plan of San Mateo has established all processes and protocols required to serve as the Third Party Administrator (TPA) for the San Mateo ACE Program. HPSM TPA services began on February 1. The TPA structure allows for:

- **Uniform Information and Protection for Participants**: All program participants have received an HPSM participant ID card and Participant Handbook. These materials inform participants of allowable services, member service information such as health education, Primary Care Provider (PCP) selection, eligibility period, and independent review of services and associated uniform grievance process. Participants also have access to HPSM's call center.
- **Independent Financial Reporting and Quality Monitoring**: This system will allow for independent financial reporting, payments and verification of allowable services and is also linked to program evaluation. It will also allow for quality monitoring and inform the development of quality improvement initiatives.
- **Utilization and care management.** Authorization and tracking processes have been developed to ensure efficient and appropriate use of health care resources.

Integration of County-sponsored programs serving uninsured adults should be consolidated into HPSM in the following order and according to the following deadlines:

- **By June 2008**, present to the respective Governing Boards specific proposals for integration of the WELL Program and WELL Fee-Waiver Programs within the HPSM administrative structure.
- **By January 2009,** enroll WELL Program and WELL Fee-Waiver participants in HPSM administered coverage programs.

3. Coordinated Care Management: Benefits would be coordinated within a system where prevention and primary care are emphasized, complex-chronic care management is integral, and where delivery system providers' roles reflect their capacity and expertise to meet clients' range of medical needs.

a. The Blue Ribbon Task Force recommends that complex-chronic care management is a cornerstone of the Adult Coverage Model and payment mechanisms and enabling services and continuity of care must be aligned in order to be successful.
b. The Blue Ribbon Task Force recommends that care management outcomes target improved health for clients with the most medically complex conditions and improved cost-controls by increasing the use of primary and preventive care and decreasing the use of emergency and inpatient care.
c. The Blue Ribbon Task Force recommends that the public delivery system must be strengthened in order to meet the care management standards necessary to expand coverage including, but not limited to: appointment wait times, specialty care contracts resulting in access, and primary care availability.
d. The Blue Ribbon Task Force recommends improved management of chronic disease across systems to ensure efficiency and effectiveness in care coordination and targeting of medical resources.

In early 2008, HPSM instituted performance-based incentives (Pay for Performance) through the Medi-Cal contract. Over two years they will be phasing in process-based incentives as well as outcome-based measures which will be related to indicators of appropriate primary and preventive care as well as care management. Examples of some incentivized procedures include payment for: developing patient asthma action plans, Body Mass Index (BMI) measurements, certain diabetic tests, early prenatal visits and the use of streamlined technology such as electronic claim and encounter forms. HPSM provides quarterly reporting to assist providers in maximizing this strategy for improved care management.

SMMC is preparing to launch the new radically redesigned clinic focus on chronic disease management. The clinic will be distributed across the Adult Primary Care Clinic, allowing for a deeper and broader reach across the entire patient population. The clinic will embody all of the principles of a fully operational chronic disease management clinic, as well as provide critical access for SMMC patients who are known to utilize care inappropriately or ineffectively resulting in high expenditures and poor health outcomes. Key components of the clinic include: group visits, open and advanced access, 24/7 access to a triage nurse,

home visits, active medication management, focus on patient and family empowerment, consistent use of evidence-based practice guidelines and a variety of other features.

4. Delivery System: Coverage expansion requires maximum capacity of the safety-net and private provider delivery systems.

e. The Blue Ribbon Task Force recommends that the Adult Coverage Program provider network be a part of a Community Health Network for the Underserved, organized to meet the needs of the Medi-Cal, adult coverage and other public coverage programs.
f. The Blue Ribbon Task Force recommends that the public safety net system plays a key role within San Mateo County's delivery system and that this system must be strengthened for long-term viability.
g. The Blue Ribbon Task Force recommends that all members of the health care system participate to their optimal configuration (HPSM as Third Party Administrator, SMMC as public safety net, Private Providers) and that all publicly insured and covered individuals be considered in this configuration.

In February, 2008, the San Mateo County Health System Redesign Initiative (Redesign) was created to address both the financial sustainability and system and policy opportunities for the healthcare delivery system for uninsured and underserved populations. The Initiative aims to accomplish the following charge:

Within two years, design and implement a new, sustainable and creative approach to healthcare delivery that incorporates key recommendations of the HMA Phase 2 Final Report and the recommendations of the Blue Ribbon Task Force on Adult Health Care Coverage Expansion.

Redesign team members reviewed the findings of the Blue Ribbon Task Force's (BRTF) deliberations and analysis aimed at identifying local delivery system capacity to meet the needs of the uninsured and underserved. The Health Management Associates (HMA) *Assessment of Strategic Priorities for San Mateo Health Services,* which was accepted by the Board of Supervisors on February 5, 2008, complemented the work of the BRTF and provided detailed findings and recommendations regarding the County's Healthcare Role within the Broader Community, Medical Services Delivered by the San Mateo Medical Center, and the Health Plan of San Mateo. The redesign team will keep the BRTF members updated on progress through a report back in October 2008, and March 2009.

One of seven top priorities for Redesign is the creation of a Community Health Network for the Underserved (CHNU), which will be a public-private healthcare delivery system for the medically underserved (Medi-Cal and uninsured) that includes defined roles for each major private sector hospital, major ambulatory care providers and a redefined role for SMMC.

In addition, the Health Plan of San Mateo approached various health care partners to increase the provider network for the medically underserved and developed agreements with two key entities:

- Kaiser has agreed to accept up to 360 pregnancies per year for prenatal care and delivery at Kaiser Redwood City. This location is within an area of San Mateo County with significantly constrained access for HPSM members. The children in these families and the newly delivered babies will also be able to receive services at the facility. Final contract negotiations are still underway and we are targeting an implementation date of May 1, 2008.

- Palo Alto Medical Foundation (PAMF) has agreed to take up to 1500 HPSM members in all lines of business (the previous number of members assigned to PAMF was 500). This represents a significant increase in HPSM patient access to PAMF.

The San Mateo Medical Center and Ravenswood Family Health Center, as a partnership, were awarded the Kaiser Permanente Specialty Care Initiative Grant (for $150,000) in order to to *foster and strengthen community-based solutions* to increase access and reduce demand for specialty care for the San Mateo County uninsured/underinsured population; and to demonstrate that specialty care access can be achieved through a shared community vision and through collaborations of private/public health care providers. Following the one-year planning phase the partnership will be eligible for an implementation grant of $300,000.

5. Revenue Generation and Financing: Financing of the proposed Adult Coverage Program would be the shared responsibility of individuals, employers, and the community at large.

h. The Blue Ribbon Task Force recommends that enrollees pay between $0 - $100/month, depending on income, as an individual contribution to coverage.
i. The Blue Ribbon Task Force recommends that the long-term financial sustainability of the safety-net is crucial to the implementation of coverage expansion and that this be considered early on in the implementation.
j. The Blue Ribbon Task Force recommends that political and public interest feasibility of the Joint Powers Authority (JPA) revenue generation mechanism (based on the legally viable option detailed in Attachment F) be considered over a year-long exploration and that this be led by the Community Financing Committee; including, but not limited to Peninsula Interfaith Action, ACORN, Central Labor Council, business and employer representation, the Health Department and others.

The Blue Ribbon Task Force conducted significant research on large-scale financing options (detailed in Attachment F) as well as the financial sustainability of the public safety-net

The Community Financing Committee has agreed to assess the feasibility of the JPA revenue generation mechanism and to bring findings from this organizing effort back to the Blue Ribbon Task Force in one-year.

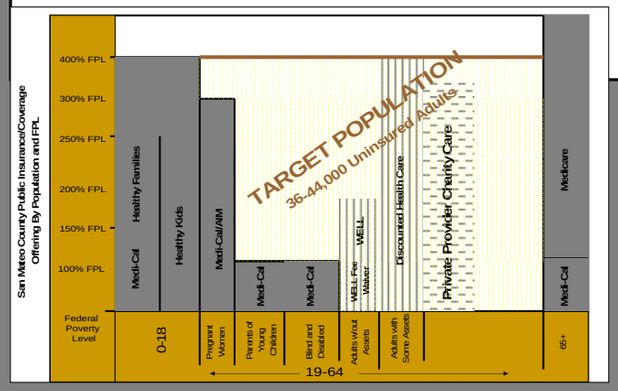
The February 5, 2008 BOS's acceptance of the HMA Phase 2 analysis confirmed the County's decision to continue its role in the delivery of healthcare services. Integral to the County's ability to maintain this role are changes to the configuration of services operated by the County, and a revised role for SMMC within the CHNU. If approved by the relevant governing boards, the County would direct its contribution to the Adult Coverage program through the unified administration provided by HPSM.

In January, 2008 The California Endowment (TCE) awarded the County, on behalf of the Blue Ribbon Task Force, a two year evaluation grant. The grant's objectives are to evaluate the system roles, integration and effectiveness of the San Mateo ACE Program as the Blue Ribbon Task Force pilot, and to make recommendations on the opportunities for further expansion.

IV. Framework for Implementation

Framework for Implementation to Allow Coverage Expansion to 36-44,000 Adults

requiring a sustained long-term effort



Strong Delivery System Allows for:

- Increased and Appropriate Access
- Financial Viability
- Leverage Competitive Advantage of All Partners for Community Goals
- Seamless Coordination
- Ease of Use for Clients
- Capacity for Incremental Expansion (to more adults)
- Maximized Coverage in Existing Programs

Unified and Coordinated System is Visible

Moving towards Coverage Expansion for Adults

Appropriate Use of Health System Roles

Community Exploration/Organizing of Public/Political Support for Long-Term Revenue Generation

Community Financing Committee

→ **Revenue Generation Mechanism Identified**

Implementation of BRTF Recommendations:

"Unified Administration for Coverage"

"Delivery System"

Health Care Redesign Team: County Manager's Office. San Mateo Medical Center, Health Department, Health Plan of San Mateo

Implementation of BRTF Recommendations:

"Coordinated Care Management"

"Delivery System"

Health Care Redesign Team: County Manager's Office. San Mateo Medical Center, Health Department, Health Plan of San Mateo

Implementation of BRTF Recommendations:

"Coverage Expansion to 36-44,000 Adults"

"Revenue Generation and Financing"

All Health System Members; Health Care Redesign Team

PHASE I: YEAR 1 (2008)

Absent State-wide Reform, the entire local delivery system must be coordinated for sustainability

"getting the house in order"

→

PHASE II: YEAR 2-3 (2009-10)

San Mateo County's Strong Safety-Net and Community Health Network for the Under Served

"the house is in order"

→

PHASE III: YEAR 2-3 and beyond (2009-10)

Safety-net and Delivery System Can Handle increased Volume with Appropriate Care and Access

"full expansion viable"

Attachment A: Report to the Task Force: Demographic Highlights of the San Mateo County Uninsured Adult Population

Report to the Task Force: Demographic Highlights of the San Mateo County Uninsured Adult Population

December 2006

Blue Ribbon Task Force on Adult Health Care Coverage Expansion:
Population Definition Workgroup*

* The Population Definition Workgroup met several times between September and December 2006. Representatives from the following organizations participated in the Workgroup: San Mateo County Human Services Agency, San Mateo County Health Department, Legal Aid Society of San Mateo County, Peninsula Interfaith Action, Mills-Peninsula Health Services, San Mateo Central Labor Council, San Mateo Medical Center. Glen H. Brooks, Jr., Director, San Mateo County Human Services Agency served as the Workgroup Chair.

Table of Contents

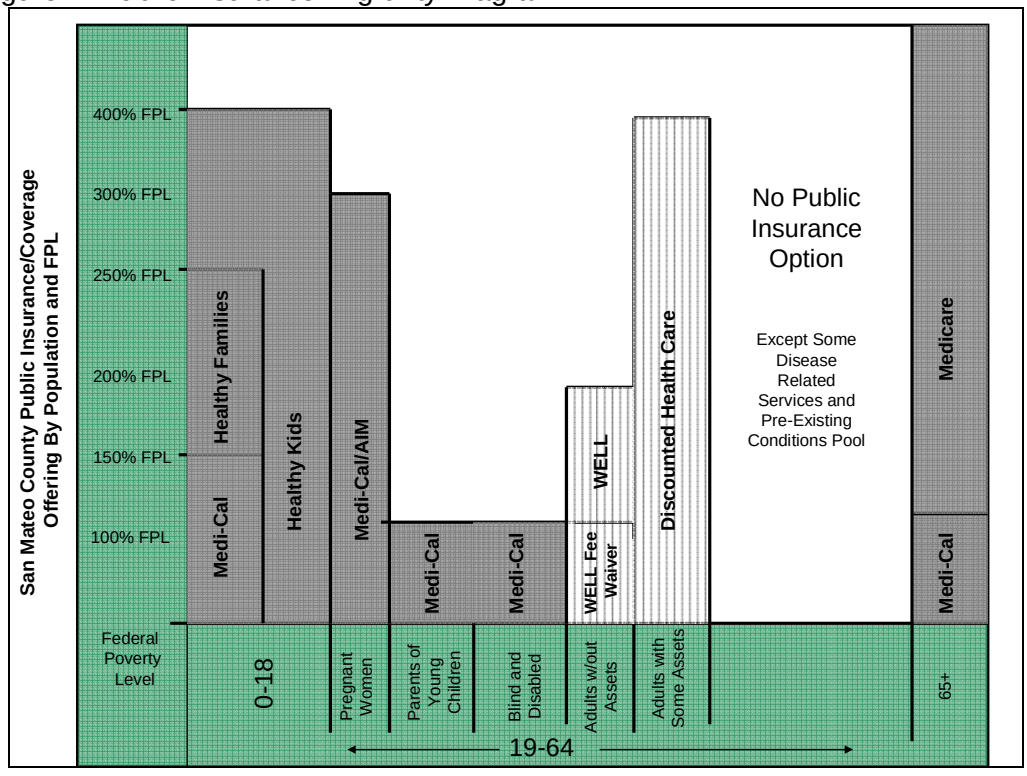
Board of Supervisors Charge
The Board of Supervisors charge to the Blue Ribbon Task Force on Adult Health Care Coverage Expansion called for exploring coverage expansion for adults at or below 400% FPL.

I. Availability of Public Insurance Coverage for San Mateo County Residents

In order to provide information on the uninsured adult population in San Mateo County, the Population Workgroup found it helpful to detail the existence of public insurance offerings as well as the availability of private insurance.

In the United States, California and similarly at the local level, most individuals and their dependants receive health insurance through an employer.[1] Some public insurance programs exist to cover individuals without private insurance, who would otherwise be uninsured. Public insurance is predominantly available to vulnerable populations such as children, older adults, low-income pregnant women and the low-income blind and disabled. The following chart depicts public insurance program availability for all San Mateo County residents according to age and income eligibility parameters. With the exception of a few specific programs (e.g., Medi-Cal for pregnant women and parents of young children and Medi-Cal for those who are Blind and Disabled), the vast majority of adults below the 400% FPL have no public insurance option.

Figure 1: Public Insurance Eligibility Diagram[2]



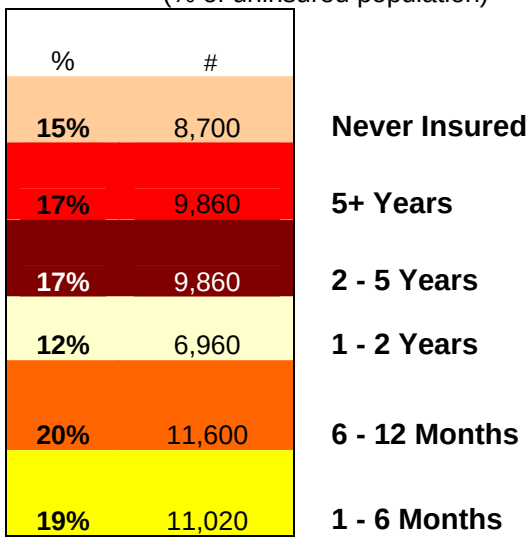
II. San Mateo County Uninsured Adults Age 19-64

A. Population Size

After review of an array of data sources, the workgroup primarily adopted two sources of data that provide rich description of San Mateo County residents: the California Health Interview Survey (CHIS, 2003) and the San Mateo County Healthy Communities Collaborative Health and Quality of Life Survey (HQL, 2001 and 2003). Using these two sources it was determined that the proportion of ***uninsured adults ages 19-64 is in the range of 12% to 13.5% of the total adult population.*** Given the current San Mateo County adult population, it is estimated that ***there are between 52,000-60,000 uninsured adults in the county.***[3]

An additional number of individuals report being without insurance at "some point during the past year", raising the number of uninsured adults in a 12 month period to 18.7% of the total adult population. This translates to a number of uninsured at *any* point during the year to 82,000 San Mateo County adults.

Figure 2: Length of Time of Uninsurance[4]
(% of uninsured population)



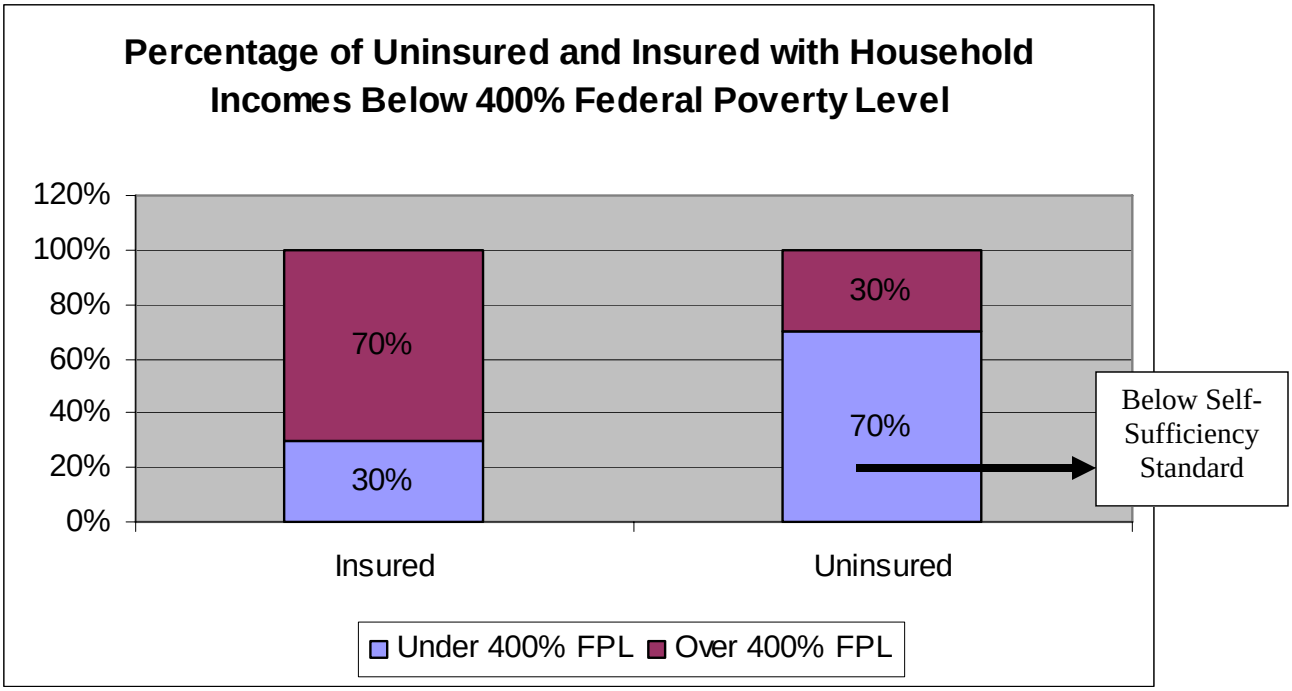
In both surveys, individuals were asked about their health insurance status; this may not include insurance that covers such benefits as vision, dental or mental health services. Individuals lacking coverage in each of these areas are frequently considered underinsured. In San Mateo County, an additional 18% of adults lack dental insurance. It should be noted that individuals with limited scope or high-deductible plans are considered insured.

In the following analyses, "uninsured adults" refers to the 12-13.5% of the population without any health insurance.

B. Household Income and Uninsured Adults below Self-Sufficiency Standard:

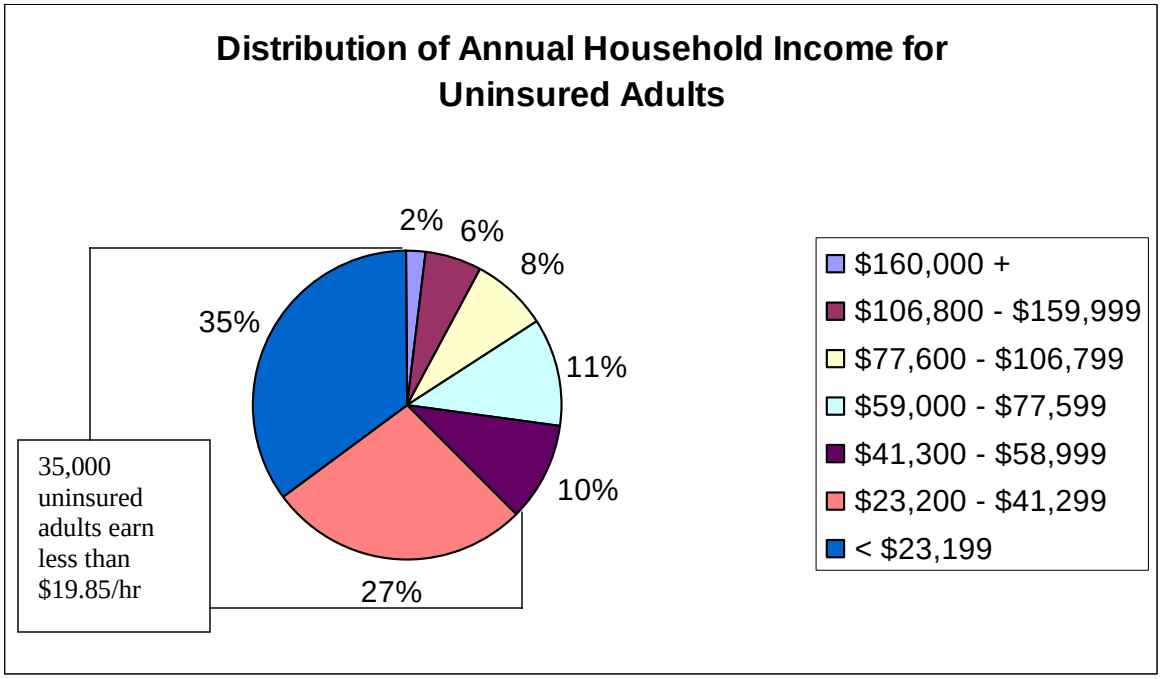
The San Mateo County self-sufficiency standard for a family of three is an annual household income of $66,442; this is nearly the equivalent to 400% Federal Poverty Level.[5] It is estimated that ***70% of uninsured adults have a household income at or below 400% FPL.*** Therefore, the total ***uninsured adult population below 400% FPL is between 36,000-44,000.*** When compared with insured residents, uninsured residents are much more likely to have household incomes below 400% FPL**.** As detailed in the figure below, only 30% of insured adults have an annual household income below the self-sufficiency standard as compared with 70% of uninsured adults.

Figure 3: Uninsured Below 400% FPL



The San Mateo County median household income is $74,546 (approximately $36.54 per hour).[6] By contrast, nearly two-thirds of uninsured adults earn less than $41,299 per year (approximately $19.85 per hour).

Figure 4: Household Income[7]



C. Employment Status

Given that most health insurance coverage is employer based, the Population Workgroup considered an analysis of the employment status, employer demographics, and availability of employer based insurance as central to the overall uninsured population definition.

- Nearly half (45.7%) of uninsured adults, almost 26,000 people, report working full-time (greater than 21 hours/week). Sixty-three percent report being "employed" either full/part-time or sporadically.[8] This translates to 35,000 uninsured adults who are working in some capacity.

- Eighty-four percent of *working* uninsured adults report that they are: "not eligible for benefits offered by an employer or their employer didn't offer health benefits."[9]

- In San Mateo County, 40% of *working* uninsured adults report working in a company with fewer than 10 employees. This is consistent with state-wide trends, where 43% of working uninsured adults work for a small company. Based on the number of uninsured adults reporting that they are employed, there are approximately 15,000 uninsured adults working for a small company.

Figure 5: San Mateo County Small Businesses and Uninsured Adults[10]

Business Size	% of Businesses	% of Jobs	% of Working Uninsured	% of Total Uninsured
0-9 Employees	76% (16,921 businesses)	12.9%	40%	27%

D. Demographic Characteristics: Age, Gender, Race/Ethnicity, Citizenship, Region of Residence

(i) Age, Gender, Family Status

Forty-nine percent of uninsured adults are male and 51% are female.[11] This is the same distribution as the overall San Mateo County population.

Highlighting an Uninsured Adult

A mother of three Healthy Kids members has high blood pressure and depression. She recently lost her job and with it her health insurance. She now avoids care for fear of medical bills.

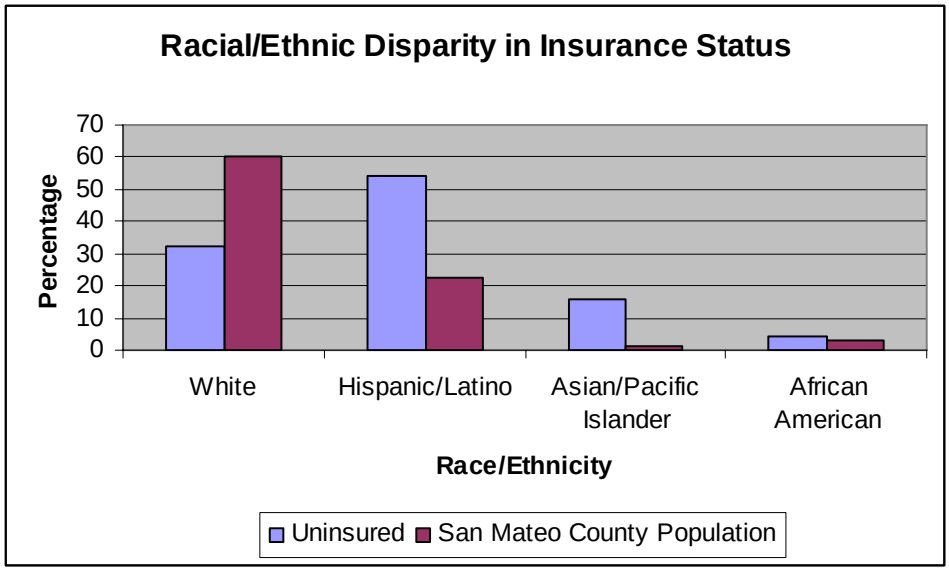
Just over half of uninsured adults are age 19-39 (52%), approximately 29,000 uninsured adults. The remaining 48% are between the ages 40-64. In comparison 44% of insured adults are age 19-39.[12]

Fifty-One percent of uninsured adults (29,000) have children in their household.[13]

(ii) Race/Ethnicity

As compared with the general racial/ethnic composition of San Mateo County, there are disproportionately more Hispanic/Latino and Asian adults who are uninsured. 54% of uninsured adults are Hispanic/Latino, as compared with a 23% countywide prevalence. This is approximately 30,000 uninsured Hispanic/Latino adults.

Figure 6: Race/Ethnicity[14]



(iii) Citizenship Status:

Uninsured adults are more likely to be non-citizens than insured adults; 55% of uninsured adults, or almost 31,000, report that they are not United States Citizens.

Of the foreign born uninsured adult population, which includes all non-citizens, 72% report having lived in the United States for more than 10 years.[15]

(iv) Region of Residence

Uninsured adults disproportionately in the southern region of the county; 37% of uninsured adults (21,000) as compared with 24% of insured adults reside in this part of San Mateo County. However, a greater number (22,000) of uninsured adults live in the northern region with 39% of all uninsured adults residing in the northern region of the county. [16]

Highlighting an Uninsured Adult

A 64 year old diabetic San Mateo County Resident earns 221% FPL, and owns her own home. She has been avoiding care for fear of high medical bills and lack of insurance.

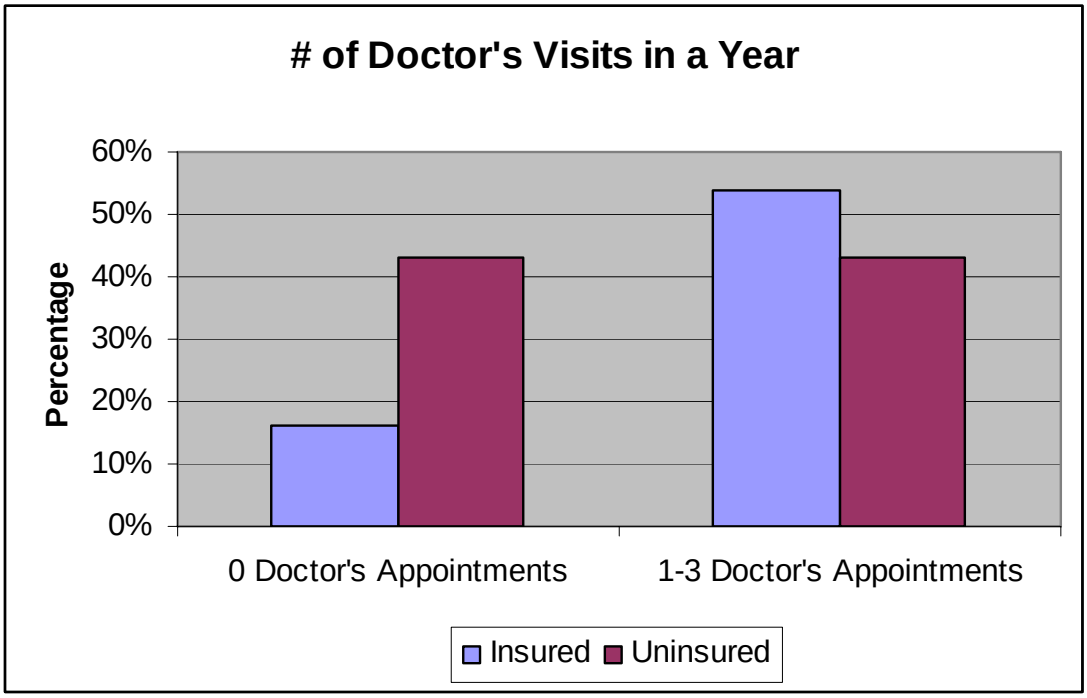
III. Utilization of Health Care Service and Health Status

Uninsured adults report lower rates of cardiovascular disease, hypertension and high blood pressure and high cholesterol than the insured population. Yet they also report significantly fewer doctors' visits and health care access which may indicate that the prevalence of various health conditions is under-diagnosed.

Uninsured adults also report higher rates of chronic drinking, smoking, and two or more years of depression than insured adults.

- Forty-six percent of uninsured adults report having no usual source of medical care, as compared with 4.2% of the insured adult population.

Figure 7: Doctor's Visits



- Similarly, adults without insurance access care with less frequency than adults with insurance; 43% did not have a doctor's appointment in a 12 month period and an additional 43% accessed between 1-3 doctor's visits during the last year. This is compared with 16% and 54% of insured adults respectively.[17]

[1] National Employer Health Benefits Survey and California Employer Health Benefits Survey, California HealthCare Foundation.

[2] Figure 1 does not include those adults enrolled in Share of Cost Medi-Cal. It also does not include some Blind and Disabled who also have a share of cost. The WELL Fee Waiver, WELL and Discounted Health Care Programs are not insurance programs. Eligibility requirements, include an asset level requirement, can be found at http://intranet.co.sanmateo.ca.us/smmc/clinical/health.html.

[3] The number of uninsured was calculated using the San Mateo County adult population of 438,819 as reported in the 2005 American Community Survey, and the upper and lower percentages of uninsured adults as reported in the San Mateo County Healthy Communities Collaborative Health and Quality of Life Survey (12%) and UCLA Center for Health Policy Research, California Health Interview Survey, 2003 (13.5%). For information reported from the San Mateo County Healthy Communities Collaborative Health and Quality of Life Survey, 2001 and 2004 data was combined to increase the sample size and reliability of the data.

[4] The number of uninured indicated in the chart is calculated using the mid-point of the population projection.

[5] The San Mateo County Human Services Agency publishes the San Mateo County self-sufficiency standard annually. $66,442 is a monthly income of $5,536 at an hourly wage of $31.94.
[6] 2005 inflation adjusted dollars; 2005 American Community Survey.
[7] San Mateo County Healthy Communities Collaborative Health and Quality of Life Survey.
[8] UCLA Center for Health Policy Research, California Health Interview Survey, 2003.
[9] UCLA Center for Health Policy Research, California Health Interview Survey, 2003.
[10] State of California Employment Development Department.
[11] San Mateo County Healthy Communities Collaborative Health and Quality of Life Survey.
[12] UCLA Center for Health Policy Research, California Health Interview Survey, 2003.
[13] San Mateo County Healthy Communities Collaborative Health and Quality of Life Survey.
[14] San Mateo County Healthy Communities Collaborative Health and Quality of Life Survey. 2005 American Community Survey.
[15] UCLA Center for Health Policy Research, California Health Interview Survey, 2003. The foreign born category includes all non-citizens, but also includes legal-permanent residents.
[16] San Mateo County Healthy Communities Collaborative Health and Quality of Life Survey.
[17] UCLA Center for Health Policy Research, California Health Interview Survey, 2003.

Attachment B: Beneficiary Cost-Sharing for San Mateo County Adult Health Care

ADVANCED POLICY ANALYSIS

REPORT TO THE TASK FORCE: BENEFICIARY COST SHARING FOR SAN MATEO COUNTY ADULT HEALTH CARE COVERAGE EXPANSION

BLUE RIBBON TASK FORCE ON ADULT HEALTH CARE COVERAGE EXPANSION:
FINANCING DEVELOPMENT WORKGROUP

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TABLE OF CONTENTS

A. Pricing Public Coverage

This report employs findings from academic research, other public coverage expansions and a survey of low-income, uninsured adults to inform the design of an appropriate fee structure for adult health care coverage expansion in San Mateo County. Existing research about beneficiary cost sharing for public coverage indicates that low-income adults are very price sensitive.[1] Imposing cost sharing requirements will likely reduce participation, which would reduce the costs to the County of providing subsidized care. The Task Force should weigh the need to achieve sustainable program financing against the goal to reduce uninsurance among low-income adults in San Mateo County. Designing the monthly fee structure is a critical step that will influence participation rates, individual health status, county revenues and program sustainability.

The most serious consequence of setting fees too high would be reduced take up of health care coverage. Low-income adults have little flexibility in their budgets, and both their ability and willingness to pay for coverage decreases as monthly fees increase. Higher fees may also discourage continuous coverage because adults with limited resources must constantly balance competing financial needs. If fewer adults choose to participate or to stay enrolled in coverage, high fees could impact both the size and composition of the program's risk pool. High fees may prevent healthier adults from participating in coverage, and the participant pool would consist of primarily high-cost, high-risk individuals.[2] Finally, setting fees too high could undermine the Task Force's goal of reducing uninsurance and improving access to health care.

Although setting fees very low or waiving them completely would lead to higher participation, setting them too low could limit the long-term viability of the County's adult coverage expansion. Research has shown that cost sharing promotes shared responsibility and efficient utilization of health services.[3]

B. Bay Area Coverage Expansions

This report looks at the relationship between beneficiary cost sharing requirements and participation for planned adult coverage expansions in Santa Clara and San Francisco, an ongoing program in Contra Costa, a completed pilot program in Alameda and the ongoing children coverage expansion in San Mateo. Please see Appendix A: Bay Area Health Care Coverage Expansions for a summary of program information and fees.

San Francisco Health Access Program

On July 1, 2007, the City and County of San Francisco will implement the San Francisco Health Access Program (SFHAP). SFHAP provides sliding scale fee subsidies for all uninsured San Francisco residents with household incomes at or below 500% FPL; adults with incomes above 500% FPL can participate in the program with no public subsidy. There are no other requirements for eligibility. SFHAP replaces San Francisco's existing sliding scale subsidy program, and the Department of Public Health hopes to transition all of the estimated 57,000 uninsured adults who currently use public or nonprofit health services to SFHAP coverage;[4] this would represent 70% of the 82,000 uninsured adults in San Francisco. The financing mechanism for SFHAP includes an employer spending requirement (ESR), which will begin on January 1, 2008.

[1] Gilmer and Kronick, 2005.
[2] Hirota et al., 2006.
[3] Manning et al., 1987.
[4] Tangerine Brigham, 28 February 2007.

Santa Clara Valley Care Adult Coverage Initiative

Santa Clara County will launch its Valley Care pilot program on September 1, 2007. Valley Care provides publicly subsidized health care coverage for documented employees of small businesses[5] located in Santa Clara County. Working adults must have household incomes at or below 350% FPL to participate. The Santa Clara Valley Health and Hospital System will administer the three-year pilot program. Participants may be required to pay a monthly fee, which would be capped at $50 per month.[6] Due to limited pilot funding, Valley Care will limit enrollment to 12,500 adults per year, which represents 15% of the 82,000 eligible, uninsured adults in the county. The financing mechanism for Valley Care also includes an employer share, which will be paid by small business owners who choose to participate in the program.

Contra Costa Basic Health Care

The Contra Costa County Basic Health Care program was established in 1983. Basic Health Care offers publicly subsidized health care coverage to all uninsured adult residents of Contra Costa County with household incomes at or below 300% FPL. The County developed the sliding fee scale for Basic Health Care in 1983, and it has not been altered in the past 24 years.[7] Participants in Basic Health Care access health services at county clinics and the county hospital. Contra Costa does very little outreach for the program, and only 5,100 adults are enrolled in Basic Health Care; this represents 9% of the 55,000[8] eligible, uninsured adults in Contra Costa County. Adults enrolled in Basic Health Care are predominantly very low-income; 88% of enrollees have household incomes at or below 150% FPL.[9]

Alameda Alliance Family Care

From July 1, 2000–June 30, 2005, Alameda County's nonprofit health plan, Alameda Alliance for Health, administered Alliance Family Care, a public health care coverage program for families. Family Care provided subsidized health coverage for parents with household incomes at or below 300% FPL; only adults with children enrolled in Alliance health plans were eligible for coverage. Public subsidies for Family Care were based on age, rather than income, and fees ranged from $20–120 per month. The program was not financially sustainable after the five years of pilot funding, and members were disenrolled in 2005. In August 2002, 5,250 adults were enrolled in Family Care, which represents 40% of the 13,000 eligible, uninsured parents.[10] 86% of adults enrolled in Family Care were very low-income, with household incomes at or below 200% FPL, and 52% were of Hispanic ethnicity.[11] Funding for Family Care came from a number of sources, including the Alameda Alliance for Health, the County's tobacco master settlement funds and private foundation grants.

[5] The Valley Care initiative defines a small business as a company with 50 or fewer employees.
[6] Sarah Muller, 13 February 2007. As of April 2007, Santa Clara County is still in the process of designing the monthly fee structure for Valley Care.
[7] Wanda Session, 7 March 2007.
[8] Data from CHIS 2005.
[9] Long, 2002.
[10] Hirota et al., 2006.
[11] Taylor, Kullgren and McLaughlin, 2003.

C. Program Fee Structures

All of the local health care coverage expansions described above utilize sliding scale fee structures, with fees varying by household income or age. Fees for most public health coverage programs increase progressively as a share of household income because the marginal utility of each additional dollar diminishes as income increases.[12]

County	Monthly Fees by % Federal Poverty Level[13]								
	0–100	101–150	151–200	201–250	251–300	301–350	351–400	401–450	451–500
Adults									
San Francisco	$0 (0%)	$20 (1.57%)		$50 (2.35%)		$100 (3.36%)		$150 (3.92%)	
Santa Clara	t.b.d.					$50 (1.81%)	--	--	--
Contra Costa	$0 (0%)	$25 (1.68%)	$50 (2.61%)	$75 (3.21%)		--	--	--	--
Alameda	fees determined by age ($20–$120 per month)					--	--	--	--
Children									
San Mateo	$4 (0.75%)	$6 (0.40%)		$12 (0.56%)		$20 (0.67%)		--	--

Table 1: Monthly fee structures for Bay Area health care coverage expansions. Santa Clara has not yet finalized its beneficiary cost-sharing requirements. The share of household income represented by monthly fees is calculated by using the midpoint of the income range for each fee. San Francisco Department of Public Health, Santa Clara Valley Health and Hospital System, Contra Costa Health Services Department and Health Plan of San Mateo.

II. San Mateo County Survey

In addition to information from existing research and other public coverage expansions, this report presents findings from an original survey of low-income, uninsured adults in San Mateo County. These findings provide evidence of the target population's willingness to pay for and participate in public health care coverage. The decision to participate depends not only on an individual's willingness, but also on his ability to pay for coverage. While ability to pay varies according to objective measures, such as household income, family status and cost of living, willingness to pay depends on both objective measures and subjective preferences.

County staff and community partners cooperated in collecting 399 usable survey responses from uninsured San Mateo County residents with household incomes at or below 400% FPL. Survey sites included county clinics, nonprofit clinics, schools, churches and other community organizations. The majority of adults who have contact with public or nonprofit services are very low-income, and most survey respondents had household incomes at or below 200% FPL.

[12] Donaldson, 1999.

[13] Adults with household incomes from 101–200% FPL pay 1.57% of their income for SFHAP, while those with household incomes from 301–400% FPL pay 3.36% of their income. Table 1, below, summarizes the fee structures for the five county-based public health care coverage expansions discussed above. Although fees increase progressively as a share of income for SFHAP and Basic Health Care, the share of income consumed by health care fees never exceeds 4% of income.

Please see Appendix B: Survey Analysis for a complete discussion of the survey design, methodology, sample and results.

A. Survey Findings

Low-income San Mateo County residents are very price sensitive in their demand for public health care coverage. At a price of $10 per month, 96% of eligible adults would participate in coverage. The level of expected participation does not decrease steadily, but drops off dramatically; 71% of eligible adults would participate at a price of $25 per month, but only 33% would pay $50 per month. This negative trend between fees and participation reflects the expected economic relationship. Figure 1, below, illustrates the predicted relationship between monthly fees and participation.

Willingness to pay for and participate in coverage increases as ability to pay increases. The study found that a 100% increase in Federal Poverty Level predicted a 24% increase in participation. This increase is equivalent in magnitude to the 24% decrease in participation when fees increase from $10 to $25 per month. Therefore, a 100% increase in FPL increases willingness to pay by approximately $15. Additionally, the equivalence suggests that a flat fee structure, with fees increasing by $15 for every 100% increase in FPL, would achieve consistent enrollment across income categories. For example, setting fees at $25 per month for individuals with household incomes from 100–200% FPL, and $40 per month for individuals with household incomes from 200–300% FPL, would achieve 71% enrollment in both income categories.

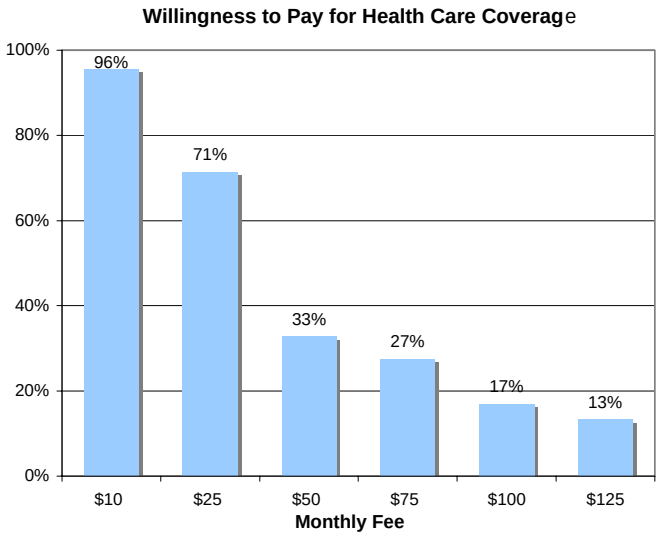

Figure 1: Proportion of eligible adults who would pay for coverage by monthly fee.

III. Beneficiary Cost Sharing Recommendations

The Financing Development Workgroup plans to implement a sliding scale fee structure, with fees varying by household income. Beneficiary cost sharing contributions will likely fall somewhere within the range of $20–150 per member per month. The following sections of the report consider design options for implementing the sliding scale fee structure and criteria for evaluating fees.

A. Beneficiary Fee Structure

Fees for most publicly subsidized programs are stepped according to household income, which means that all participants with incomes in a certain range (e.g. 101–200% FPL) pay the same monthly fee. Stepped fees reduce administrative workload because staff do not have to calculate a different fee for each participant, and the steps simplify participant revenue projections. In addition, fees can be calculated either as a percentage of program costs (e.g. participants contribute 10% of program costs) or as a dollar contribution.

B. Evaluating Cost Sharing Options

The Task Force's primary goal is to reduce uninsurance and increase access to health care for low-income adults in San Mateo County. In order to achieve this goal, the coverage program must be affordable for low-income individuals and generate an adequate level of revenues from participant fees. In determining beneficiary cost sharing requirements, the Task Force should consider the differential impacts of fees in terms of its three criteria of maximizing participation, minimizing the financial burden for individuals and maintaining program sustainability.

Maximize Participation

The fundamental purpose of expanding health care coverage to low-income adults is to increase the number of San Mateo County residents who have access to health care. Adults with health coverage are more likely to use preventive services, and research has demonstrated the positive effects of health coverage on health status. However, low-income adults are very constrained in both their ability and willingness to pay for coverage.

Enrollment in other public coverage programs has been higher among very low-income adults. Findings from the San Mateo County survey indicate that setting a low fee base between $10 and $25 per month,[14] and increasing fees by $15 for every 100% increase in FPL, would achieve high enrollment across income categories. The $15 increase results in a flat fee structure, with monthly fees consuming the same percentage share of income for all income categories.

Participation in public health coverage also depends on the relative costs of alternative health care options. In San Mateo County, these options include both retail and nonprofit health clinics. Although these clinics provide a limited range of services, adults who consider themselves healthy and do not regularly access health services would save money by paying for occasional health care instead of enrolling in public coverage. Low-income, uninsured San Mateo County residents can access affordable health services at the nonprofit Ravenswood Family Health Center (RFHC) in East Palo Alto and the nonprofit Samaritan House Clinics in Redwood City or San Mateo.[15] Uninsured patients at RFHC pay an annual maximum of $250 for health services, and 92% of all patients have household incomes at or below 200% FPL.[16] Services provided by Samaritan House and through its network of volunteer specialists are completely free of charge. Many of the patients at these clinics are "those who can't afford WELL, but make too much

[14] The fee base represents the cost sharing requirement for adults with household incomes between 100 and 200% FPL because adults with household incomes up to 100% FPL will most likely be exempt from cost-sharing requirements.

[15] In addition to Ravenswood and Samaritan House, low-income, uninsured adults can access care at Arbor Free Clinic in Menlo Park. Arbor, which is operated by Stanford Medical students, provides acute care on Sundays from 11am to 2pm.

[16] Luisa Buada, 23 February 2007.

money for the fee waiver."[17] The Samaritan House clinics currently provide 12,000 patient visits per year, while RFHC provides 26,000 patient visits for 7,700 unique patients per year.

Minimize Financial Burden for Individuals

Despite their stated willingness to pay for public health care coverage, low-income adults may not have the ability to pay for coverage. The extremely high cost of living in San Mateo County makes it difficult for low-income, uninsured adults to maintain stable housing and meet other basic needs. Thus, fees for public coverage must be very low to minimize the additional financial burden they create for these adults. Advocates for the uninsured suggest that fees ranging from 1–2% of monthly income are affordable and encourage "strong participation."[18]

Many existing public coverage programs utilize progressive fee structures under the assumption that higher-income adults have higher ability to pay. Progressive fees are based on the economic concept of marginal utility, which assumes that the utility of each additional dollar diminishes as income increases. However, adults in San Mateo County with household incomes between 200 and 400% FPL still earn less than the County's self-sufficiency standard, so they may not have the ability to pay progressively higher fees for public services.[19]

Maintain Sustainability

Waiving all beneficiary cost sharing requirements would maximize participation and minimize the financial burden for individuals, but the Task Force should balance those objectives with the need for sustainability. Although revenues from beneficiary fees will not generate a major share of program financing, fees are necessary to ensure ongoing political and public support for the coverage expansion. Shared responsibility for program financing promotes efficient usage of health services and decreases unnecessary care. Even advocates for low-income adults agree that an affordable level of cost sharing would encourage low-income adults to value health coverage.[20] Responsibility also extends to the risk pool, and lower fees would increase enrollment and diversify the composition of the program's participant pool. Conversely, higher fees would reduce enrollment and discourage healthy adults from participating in coverage. Thus, higher fees could actually increase per member costs and decrease program sustainability.

C. Recommendations

Setting fees too high or too low could limit the success of the County's planned adult health care coverage expansion. Given its primary goal of reducing uninsurance and improving access to health care, the Task Force should lean toward setting fees low.

Sliding Fee Structure: A sliding fee structure could start low and increase with household income levels up to a determined maximum amount. An increase in $15 per month for every 100% FPL would generate equal rates of enrollment across income levels. If set not to represent more than 1.6% of monthly income (0-$50); there would likely be upwards of 70% enrollment.

[17] Sharon Petersen, 9 March 2007.
[18] Chavira and Wulsin, 2004.
[19] "Effects of Tying Eligibility for Health Insurance Subsidies to the Federal Poverty Level," 2007.
[20] Tom Quinn, 21 February 2007.

Lowest Cost-Sharing Amount: The lowest income adults (0-100%FPL) are the most constrained in their ability to pay. Therefore, consideration of $0 beneficiary cost-sharing at this level should be considered.

Highest Cost-Sharing Amount: Because survey completion of the higher income adults was significantly limited. The fee scales and experiences of other counties should be considered. This places the highest amount of cost sharing for those between 300-400% FPL at $75-$100 per month.

Additional Considerations: In moving forward additional fee structure elements might be considered such as; premium assistance for those who cannot pay; cost-sharing associated with age and health status; household max for multiple family members enrolled in public coverage.

Appendix A: Bay Area Health Care Coverage Expansions

Adult Coverage Expansions

County and Program	Additional Requirements	Eligible Adults	Enrolled Adults	Enrollment Trends	Monthly Fees by % Federal Poverty Level								
					0–100	101–150	151–200	201–250	251–300	301–350	351–400	401–450	451–500
San Francisco *Health Access Program*		82,000		▪ Plan to enroll all adults who use city and nonprofit clinics	$0	$20	$20	$50	$50	$100	$100	$150	$150
Santa Clara *Valley Care*	▪ Small business employee ▪ Citizen or legal resident	82,000		▪ Limited funding	t.b.d.	t.b.d.	t.b.d.	t.b.d.	t.b.d.	$50	--	--	--
Contra Costa *Basic Health Care*		55,000	5,100 (9%)	▪ 88% at or below 150% FPL	$0	$0	$25	$50	$75	--	--	--	--
Alameda *Alliance Family Care*	▪ Parent with child in Alliance plan	13,000	5,250 (40%)	▪ Limited funding ▪ 88% at or below 200% FPL ▪ 52% Hispanic	fees determined by age ($20–$120 per month)					--	--	--	--

Children's Coverage Expansion

County and Program	Additional Requirements	Eligible Children	Enrolled Children	Enrollment Trends	Monthly Fees by % Federal Poverty Level								
					0–100	101–150	151–200	201–250	251–300	301–350	351–400	401–450	451–500
San Mateo *Healthy Kids*		7,150	6,364 (89%)	▪ 86% at or below 250% FPL ▪ 88% undocumented	$4	$4	$6	$12	$12	$20	$20	--	--

Appendix B: Survey Analysis

D. Design

Monthly fees (or premiums) comprise a significant portion of health care spending by individuals. As with most economic goods, demand for health care falls when prices rise, and low-income adults exhibit especially price sensitive behavior. Therefore, the County should consider both the target population's ability and willingness to pay for coverage when designing a fee structure for public health care coverage. Ability to pay depends on relatively objective measures, such as household income, family status and cost of living, while willingness to pay varies according to both objective measures and subjective preferences. This study focused on estimating willingness to pay among low-income uninsured adults in San Mateo County.

A number of studies have used contingent valuation surveys to determine a target population's willingness to pay for health care. Contingent valuation seeks to predict future health care decisions based on respondents' stated preferences. However, critics contend that contingent valuation does not accurately predict behavior because most surveys ask respondents to evaluate one good (e.g. health care) in isolation.[21] This study established budgetary context by asking respondents about household income and family size before turning to willingness to pay. Additionally, the survey made use of face-to-face interviews, often by familiar persons, which improved accuracy and reduced non-responses.[22] To stress the importance of the study, interviewers read a standard introduction, which emphasized the County's role in the process.

Comprehension can be a major barrier to the success of any survey study. If respondents do not understand the questions they are asked, their answers fail to provide any insight into their expected behavior.[23] Given sufficient time and resources, a survey questionnaire should be written, tested and modified to ensure clarity and consistency. With limited time to conduct research, this study relied on questions taken from two existing large-scale surveys – the United States Census and the California Health Interview Survey (CHIS).[24] The Census and the CHIS collect data from large random samples at regular intervals, and these data have been evaluated and analyzed in numerous academic studies.

E. Methods

This study made use of a contingent valuation survey to estimate the proportion of adults that would pay for and participate in San Mateo County's planned adult health care coverage expansion. Please see Appendix C: Survey Questionnaire for the complete survey.

Study Population

To infer the preferences of a population from survey data, the sample of respondents must represent the overall population. Between February 26 and March 19, 2007, 582 unique

[21] "Why Surveying 'Willingness to Pay' Is Difficult," 2001.
[22] Olsen and Smith, 2001.
[23] W. Michael Hanemann, 30 January 2007.
[24] All survey questions were translated into Spanish.

individuals participated in the survey of San Mateo County adults. The survey was designed to predict participation among adults who are eligible for the health care coverage expansion. Restricting the sample to uninsured San Mateo County residents with household incomes at or below 400% FPL resulted in a sample size of 399 eligible adults. Figure 2, below, compares survey respondents with the population of low-income uninsured adults in San Mateo County.

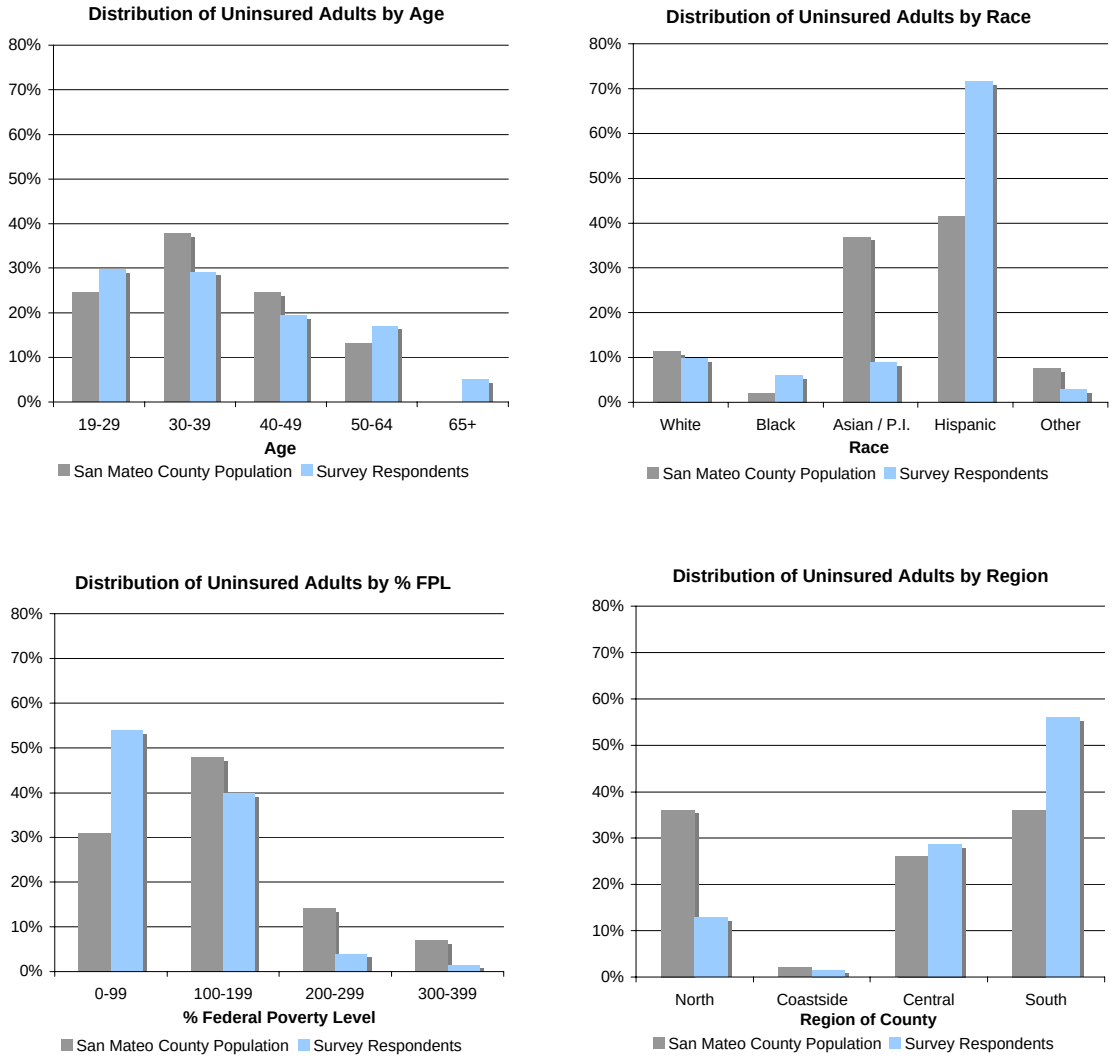

Figure 2: Distribution of study population and sample of uninsured adults by age, race, FPL and region. Population percentages are based on a total of 53,000 uninsured adults in San Mateo County, approximately 35,500 of whom had household incomes at or below 400% FPL. Age, race and FPL data from CHIS are not statistically significant. CHIS 2005, California Department of Finance, 2004 Community Assessment and survey.

The sample generally reflects the characteristics of the target population. Members of some subpopulations, including young adults, Hispanic adults and very low-income

adults, comprise higher proportions of both the overall population[25] and the sample of low-income uninsured adults. The study also over sampled residents of southern San Mateo County.

Data

The study relied on the cooperation of community partners to collect survey responses from low-income adults throughout San Mateo County. These partners included county clinics, nonprofit clinics, schools, churches and other community organizations. Table 2, below, describes the location and service provision of each organization.

Organization	Location	Type	Description
ACORN	Daly City	Community Organization	ACORN represents low- and moderate-income families working toward social justice and stronger communities.
Arbor Free Clinic	Menlo Park	Nonprofit Clinic	Arbor Free Clinic provides free acute care for low-income adults and children on Sundays from 11am–2pm.
Catholic Worker House	Redwood City	Religious Organization	Catholic Worker House provides fresh produce and other free groceries for low-income families and individuals.
Child Care Coordinating Council	San Mateo	Community Organization	The Child Care Coordinating Council helps families find and pay for child care and preschool.
Children's Health Initiative	n/a	Telephone Hotline	Children's Health Initiative staff conduct outreach and answer member questions over a telephone hotline.
Coastside Clinic	Half Moon Bay	County Clinic	Coastside Clinic provides primary and specialty care.
College Park School	San Mateo	Elementary School	College Park is a public elementary school.
Fair Oaks Clinic	Redwood City	County Clinic	Fair Oaks Clinic provides primary and specialty care.
Mental Health Services	San Mateo	County Program	Mental Health Services provides outreach and case management.
Parkside School	San Mateo	Elementary School	Parkside is a public elementary school.
Ravenswood Family Health Center	East Palo Alto	Nonprofit Clinic	Ravenswood Family Health Center provides primary and preventive care for low-income children and adults.
Redwood City Family Centers	Redwood City	Community Organization	Redwood City Family Centers provide family support services at under-performing schools.
Samaritan House Clinics	Redwood City & San Mateo	Nonprofit Clinic	The Samaritan House Clinics provide free primary care and limited specialty care for low-income adults.
San Mateo Medical Center	San Mateo	County Clinic	The Primary Care Clinic at San Mateo Medical Center (SMMC) provides primary care for adults.
Sequoia Teen Wellness Center	Redwood City	County Teen Clinic	Sequoia Teen Wellness Center provides health services for teenagers.
Shelter Network	Daly City, Menlo Park, Redwood City, San Mateo	Community Organization	Shelter Network provides housing and services for homeless families and individuals.

[25] Brooks, Jr. et al., 2006. The Population Definition Workgroup's final report to the Task Force found that 52% of uninsured adults in San Mateo County are between the ages of 19 and 39, 54% are Hispanic and 62% earn less than $19.85/hour.

St. Peter Church	Pacifica	Religious Organization	St. Peter Church is a Roman Catholic Church.
St. Vincent de Paul Society	San Mateo	Religious Organization	St. Vincent de Paul provides emergency assistance and other services for low-income families and individuals.

Table 2: Survey partners and locations. Survey responses were collected at clinics, schools, churches and other community organizations throughout San Mateo County.

Survey sample selection could influence the study's predictive power. On-site sampling at county and community organizations impacts the interpretation of survey results, because adults who already receive services at these locations have more affinity and knowledge of public services. Additionally, adults who engage in public or nonprofit services are more likely to be very low-income, because higher-income adults may be ineligible or resent the stigma of subsidized services. Therefore, predictions about the proportion of adults who would participate in public coverage may be overstated. However, with limited time and resources to predict willingness to pay, the convenience of on-site sampling best meets the Task Force's objective. Additionally, sampling at these sites likely improved the response rate and accuracy of the study, because most interviewers had existing relationships with respondents.

The primary objective of the study was to predict the proportion of eligible adults who would pay for and participate in public coverage based on monthly fees and income. The outcome of interest was measured as a "yes" or "no" response to the question: "*Would you be willing to pay $x per month for health care coverage that provides basic coverage for doctor visits, hospitalizations and prescription medications?"* A "yes" response to this willingness to pay question was interpreted as a positive likelihood of participating in the County's planned public coverage expansion.

Key independent variables included six different fee levels (ranging from $10–125 per member per month) and income. The original survey question asked respondents about their monthly pre-tax household income, which subsequent calculations converted into annual income and Federal Poverty Level. Missing income data for a small number of respondents was replaced with the average FPL for the sample, which did not significantly impact the conclusions. Although the study collected 582 survey responses, the statistical analysis was limited to 399 uninsured adults. A test of the interaction between insurance and monthly fee demonstrated that uninsured adults exhibited a significantly stronger decrease in participation when monthly fees increased. Respondents with incomes above 400% FPL and those who did not live in San Mateo County were also restricted from the sample.

The study also included a number of demographic variables for each individual, including city of residence, age, gender, race/ethnicity, primary language, household size, work status and health status. City of residence was recategorized into regions of the County because uninsured adults are concentrated in certain cities. The survey classified age into five categories, which simplified data entry while preserving the capacity to analyze the effect of age on participation. The race/ethnicity survey questions confused respondents, so race was recategorized to include non-Hispanic White and non-Hispanic Black. To investigate the effect of family status, the study generated a new binary variable "single

adult" for adults with household size equal to one. A "poverty" variable was also generated for adults with household incomes below 100% FPL.

Specification

The base specification estimated a linear regression model for the probability that an adult would participate in public health care coverage. The most parsimonious models predicted participation as a function of monthly fee and FPL. Additional linear regression models, which added demographic controls for health status, region of residence, race, primary language, age and family status, exhibited the same trends in outcomes. The study did not estimate separate regression models for adults in different income categories because further stratifying the sample size of 399 adults would have significantly reduced the predictive power and the precision of the econometric analysis. In addition to linear regressions, the study estimated probit regression models to report the marginal effects of different monthly fees and changes in FPL. A probit regression model predicts the probability of success for a binary dependent variable at the mean value of all independent variables; therefore, the probit calculated the probability that an average adult would participate in coverage. In addition to the parsimonious and full models, an expanded regression added an interaction term to quantify the relationship between income and "poverty." The significance of the interaction demonstrated that increases in FPL had a stronger effect on participation for adults with household incomes below the poverty level.

F. Results

In every regression model, the probability of participating in public health care coverage decreased as monthly fees increased. This result is consistent with economic theory. At a price of $10 per month, 96% of eligible adults would participate in coverage. The level of expected participation did not decrease steadily, but dropped off dramatically; 71% of eligible adults would participate at a price of $25 per month, but only 33% would participate at $50 per month. Table 3, below, shows the results for the full probit regression model with willingness to pay for coverage as the dependent variable. The full specification, including controls for health status, region of residence, race, primary language, age and family status, explained 37% of the variation in expected probability of participation.

	Dependent variable: Willingness to Pay for Health Care Coverage
Monthly fee	
$10 (reference)	**0.955*** ** (0.046)
$25	**-0.242*** (0.140)
$50	**-0.628*** ** (0.102)
$75	**-0.681*** ** (0.086)
$100	**-0.786*** ** (0.057)
$125	**-0.821*** ** (0.046)
% Federal Poverty Level	**0.241*** (0.032)

	Dependent variable: Willingness to Pay for Health Care Coverage

Standard errors in parentheses

* significant at 10%; ** significant at 5%; *** significant at 1%

Table 3: Willingness to pay for health care coverage by monthly fee and household income. The probit regression included controls for health status, region of residence, race, primary language, age and family status. The participation rate for the reference category ($10 monthly fee) was estimated from a parsimonious linear regression controlling for fees and family income. Coefficients for other monthly fees represent decreases from the base of 96%. The sample size for these estimates is 399 low-income uninsured adults.

The study found that a 100% increase in Federal Poverty Level increased the likelihood of participation by 24% for an adult with household income below the poverty level. The magnitude of this increase is equivalent to the decrease (24%) in willingness to pay when the monthly fee increases from $10 to $25. The predictive power of the regression with regard to FPL is limited by the very small number of respondents with household incomes over 200% FPL – of the total sample of 399 low-income uninsured adults, only 22 had household incomes above 200% FPL.

Individual demographic characteristics were not strongly correlated with the probability of paying for and participating in coverage. Self-described health status had no impact on an adult's likelihood of participating in coverage. Race, primary language and family status also failed to significantly influence the probability of participation. Adults between the ages of 19 and 64 demonstrated similar preferences, while those over age 65, who were eligible for Medicare, were 38% less likely to participate.

G. Discussion

Low-income adults are very price sensitive in their demand for public health care coverage. The relationship between higher fees and lower participation was consistently estimated in every linear and probit regression model. The study found that 96% of the target population would pay $10 per month for coverage, while only 33% would pay $50 per month. The consistency of this negative trend between fees and participation reflects the expected economic relationship.

Willingness to pay for and participate in coverage increases as ability to pay increases. The study found that a 100% increase in Federal Poverty Level predicted a 24% increase in participation. This increase is equivalent in magnitude to the 24% decrease in participation when fees increase from $10 to $25 per month. Therefore, a 100% increase in FPL increases willingness to pay by $15. The equivalence suggests that a flat fee structure, with fees increasing by $15 for every 100% increase in FPL, would achieve consistent enrollment across income categories. For example, setting fees at $25 per month for individuals with household incomes between 100 and 200% FPL, and $40 per month for individuals with household incomes between 200 and 300% FPL, would achieve 71% enrollment in both income categories.

A key limitation to the study's predictive power is the selection of a convenience sample, because those adults who were already engaged in public or nonprofit services may be more likely to participate in the County's planned coverage expansion. However, only 30% of eligible adults are currently enrolled in San Mateo County's WELL program,

which costs less than $21 per member per month. The low enrollment in WELL may indicate that only a small proportion of the target population is willing to participate in public coverage.

The study has other potential limitations. First, it assumes that respondents understood all of the survey questions, which required some knowledge of basic health care coverage. This assumption is unlikely to hold for all adults in the sample because some of them have never been enrolled in health coverage. Next, like most surveys, the study relies on self-stated measures of family size, household income and other variables. Although a number of respondents did not provide answers for all of the questions, statistical analysis did not find any significant trends in the missing data.

In order to predict participation rates, the study's findings must be generalized to the target population. Very low-income adults comprised 94% of the sample and approximately 79% of the target population.[26] Therefore, although the study sample included a very high proportion of adults with household incomes at or below 200% FPL, the sample reflects the high proportion of very low-income adults within the target population. The survey data reflected the disproportionate rates of uninsurance among young adults, Hispanic adults and very low-income adults that exist in the population.[27] The demonstrated positive relationship between household income and participation would likely hold for the target population, but the magnitude of the relationship could decline if respondents in the study's convenience sample assigned greater value to health care and participation in public services.

[26] Data from CHIS 2005.
[27] Graves and Long, 2006.

Appendix C: Survey Questionnaire

The following are the English and Spanish versions[28] of the questionnaire used to survey low-income adults in San Mateo County. The monthly fee in Question 10 randomly varied among six prices ($10, $25, $50, $75, $100 and $125).

H. English

San Mateo County Blue Ribbon Task Force on Adult Health Care Coverage Expansion

1) Do you currently have health insurance?

Yes	No

2) What city do you live in?

Atherton	Belmont	Brisbane	Burlingame	Colma	Daly City	East Palo Alto	Foster City	HMB	Hillsborough

Menlo Park	Millbrae	Pacifica	Portola Valley	Redwood City	San Bruno	San Carlos	San Mateo	South SF	Woodside

3) What is your age?

19–29	30–39	40–49	50-64	65+

4) Are you female or male?

Female	Male

5) Are you Latino or Hispanic?

Yes	No

i. **Which of the following would you use to describe yourself?**

White	Black or African American	Asian	American Indian or Alaska Native	Other Pacific Islander	Native Hawaiian	Other

6) How many people live in your household? *(including yourself and your spouse, children and/or parents)*

#

7) Do you work?

Yes	No

8) What is your monthly household income before taxes?

$

9) Would you say your health in general is excellent, very good, good, fair or poor?

Excellent	Very Good	Good	Fair	Poor

10) Would you be willing to pay $10 each month for health care coverage that provides basic coverage for doctor visits, hospitalizations and prescription medications?

Yes	No

This survey was completed in Mandarin ☐ Survey Site: _____

[28] One Mandarin speaker participated in the survey.

I. Spanish

San Mateo County Blue Ribbon Task Force on Adult Health Care Coverage Expansion

1) **¿Tiene seguro de salud?**

Si	No

2) **¿En que ciudad vive?**

Atherton	Belmont	Brisbane	Burlingame	Colma	Daly City	East Palo Alto	Foster City	HMB	Hillsborough

Menlo Park	Millbrae	Pacifica	Portola Valley	Redwood City	San Bruno	San Carlos	San Mateo	South SF	Woodside

3) **¿Cuantos años tiene?**

19–29	30–39	40–49	50–64	65+

4) **¿Cuál es su género?**

Femenino	Masculino

5) **¿Es usted Hispano o Latino?**

Si	No

i. **¿Cómo describe a si mismo?**

Blanco	Negro o Afro Americano	Asiatico	Nativo Americano	Otro de las islas del Pacifico	Nativo de Hawai	Otro

6) **¿Cuantas personas viven en su hogar?** ***(incluyendo a usted, su esposo(a), niños y/o padres)***

#

7) **¿Tiene trabajo?**

Si	No

8) **¿Cuantos ingresos tiene su hogar cada mes antes de pagar impuestos?**

$

9) **¿En general, usted diría que su salud es excelente, muy buena, buena, razonable o pobre?**

Excelente	Muy buena	Buena	Razonable	Pobre

10) **¿Pagaría $10 por mes por un seguro de salud que incluye cobertura básica por visitas al médico, hospitalizacion y medicamentos recetados?**

Si	No

Sitio: _____

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Eugene Bardach, PhD
Emeritus Professor of Public Policy, Goldman School of Public Policy, University of California, Berkeley, multiple interviews

Tangerine Brigham, MPP
Director of Health Access Program, San Francisco Department of Public Health, February 28, 2007

Luisa Buada, RN, MPH
Chief Executive Officer, Ravenswood Family Health Center, February 23, 2007

Liana Eskola
Community Organizer, Peninsula Interfaith Action, February 21, 2007

W. Michael Hanemann, PhD
Chancellor's Professor, Department of Agricultural & Resource Economics, University of California, Berkeley, January 30, 2007

Patricia Jaramillo
Health Coordinator, Redwood City School District, March 27, 2007

Rucker Johnson, PhD
Assistant Professor of Public Policy, Goldman School of Public Policy, University of California, Berkeley, multiple interviews

Ellen Kaiser, RN, MHA
Director of Planning and Evaluation, San Francisco Health Plan, February 6, 2007

Dawn Mai
One-e-App Program Specialist, San Mateo County Health Department, multiple interviews

David Mandelkern, MBA
President and Chief Executive Officer, QuickHealth, multiple interviews

Jane Mauldon, PhD
Associate Professor of Public Policy, Goldman School of Public Policy, University of California, Berkeley, January 30, 2007

SaraT Mayer, MPP
Management Analyst, Health Policy, Planning & Promotion, San Mateo County Health Department, multiple interviews

Cindy Moon, MPP, MPH
CareAdvantage Project Manager, Health Plan of San Mateo, multiple interviews

Sarah Muller
Associate Policy Director, Working Partnerships USA, multiple interviews

Sharon Petersen
Director of Program Operations, Samaritan House, multiple interview

Sosefina Pita
Children's Health Initiative Supervisor, San Mateo County Health Department, multiple interviews

Tom Quinn
Board Treasurer, Peninsula Interfaith Action, February 21, 2007

Steven Raphael, PhD
Professor of Public Policy, Goldman School of Public Policy, University of California, Berkeley, January 24, 2007

Tanja Rieck
Assistant Director of Programs and Services, Shelter Network of San Mateo County, February 21, 2007

Wanda Session
Health Services Finance Administrator, Contra Costa Health Services Department, March 7, 2007

David Sharples
Community Organizer, Association of Community Organizations for Reform Now, March 12, 2007

Carolyn Thon
Member Services and Outreach Director, Health Plan of San Mateo, March 6, 2007

Kathy van Kirk
Community Health Advocate Supervisor, San Mateo Medical Center, March 6, 2007

Attachment C: Coverage Expansion; Analysis of Legal Requirements Related to Funding Alternatives for Adult Health Care Coverage Expansion

COUNTY OF SAN MATEO

INTERDEPARTMENTAL CORRESPONDENCE

To: Honorable Members of the San Mateo County Blue Ribbon Task Force on Adult Health Care Coverage Expansion

From: Michael P. Murphy, Assistant County Counsel; John C. Beiers, Chief Deputy County Counsel; and John D. Nibbelin, Deputy County Counsel

Subject: Analysis of Legal Requirements Related to Funding Alternatives for Adult Health Care Coverage Expansion

Date: June 4, 2007

I. Introduction and Summary Conclusions

The County of San Mateo (the "County") has a number of options that it may choose to pursue in order to fund any coverage expansion that this Task Force may choose to recommend to the Board of Supervisors. We have included a brief discussion of possible funding sources below, as well as an analysis of legal requirements or constraints that may be imposed by each. We have also provided an analysis explaining the legal impediments to imposing a payroll tax or mitigation fee on employers within the County in order to fund healthcare expansion, as well as a discussion of the approach used by the City and County of San Francisco to require medium and large employers to expend a certain amount per hour on employee health care benefits.

II. Potential Revenue Sources

As noted, there are a number of options that the Task Force and County can consider in assembling funding for any health care coverage expansion, and they are discussed below. Among these sources are a number of potential new taxes, fees and charges, and funds that the County may require of employers in the unincorporated area pursuant to the County's police powers. As discussed below, many of these funding sources are subject to voter approval and others may be subject to potential legal challenges.

a. Sales Tax:

General: Section 7285 of the Revenue and Taxation Code authorizes counties to impose transactions and use taxes for general purposes at the rate of .25%, or multiples thereof, up to a maximum allowable combined rate of 2%.

How Used: Revenues raised under section 7285 may be used for general purposes.

How Allocated/Paid: Sales taxes are allocated/paid as a set percentage of the sales transaction subject to the tax. The tax is collected by the merchant who remits funds to the State Board of Equalization which, in turn, distributes to the county its share of the sales tax.

Who Pays: Individual consumers pay the sales tax.

Existing Rate: The sales tax rate in San Mateo County is currently set at 8.25 percent. 6.25 percent is allocated to the State, 1 percent is allocated to local jurisdictions (including the County in the unincorporated area), and 1 percent is allocated to two County-wide entities (0.5 percent to San Mateo County Transit District and 0.5 percent to the San Mateo County Transportation Authority).

Amount of Revenue Received: The State Board of Equalization reports that taxable sales in San Mateo County were $11.4 billion during the 2003 calendar year.

Voting Requirement: In order to increase the sales tax, the County would need a two-thirds vote of its Board of Supervisors and a two-thirds vote of the County electorate.

Amount of New Revenue: Based on 2003 data, the State Board of Equalization estimates that each 0.25% increase in the sales tax rate would generate $28.4 million annually.

b. Business License Tax:

General: Under section 7284 of the California Revenue & Taxation Code, counties may "license, for revenue and regulation . . . every kind of lawful business transacted in the unincorporated area of the county . . . ."

How Used: A business license tax may be used for either general revenue purposes or for specific purposes (revenues used for general purposes are subject to a majority vote requirement under Proposition 218, whereas revenues for specific purposes require a two-thirds votes).

How Allocated/Paid: A business license tax may be a flat annual amount imposed on private business operators or a percentage of gross revenues.

Who Pays: The business license tax is imposed on the business operator.

Existing Rate: The County of San Mateo does not presently impose a business license tax.

Amount of Revenue Received: The County of San Mateo presently receives no revenue from business license taxes.

Voting Requirement: If revenues are to be used for general purposes, the tax must be approved by a simple majority vote of those living within the jurisdiction subject to the taxation. If revenues are to be used for a specific purpose, the tax is considered a "special tax," and is subject to a two-third vote.

Amount of New Revenue: The amount of new revenue would depend on the activities taxed and the levels at which the taxes were imposed.

Note: The County's taxing authority under section 7284 is limited to business activities *conducted in the unincorporated area*. Thus, for example, under current law, the County cannot impose a business license tax on activities within incorporated city limits.

c. Transient Occupancy Tax:

General: The County has the authority, under section 7280 of the Revenue & Taxation Code, to levy a tax on the privilege of occupying rooms in hotels, inns, beds and breakfasts, etc., when the occupancy is for thirty or fewer days. The County has adopted a transient occupancy tax ("TOT") ordinance pursuant to section 7280 that applies to lodging in the unincorporated area.

How Used: Revenues are presently used for general purposes.

How Allocated/Paid: Operators of facilities that provide transient lodging collect the TOT from lodgers on the County's behalf. Thereafter, they periodically remit TOT revenues to the County.

Who Pays: The TOT is imposed on the lodger as a tax on the privilege of occupying a transient room. As noted, the facility operator collects it on the County's behalf.

Existing Rate: Pursuant to the San Mateo County Ordinance Code, the TOT is presently set at ten percent of the rent charged by the operator for the room. Section 7280 of the Revenue and Taxation Code does not state a maximum rate for a TOT.

Amount of Revenue Received: According to the Tax Collector's Office, during the 2005-2006 fiscal year, the County collected $771,551.29 in TOT revenue. Through

January 18, 2007, the County has collected approximately $595,000 in TOT for the 2006-2007 fiscal year.

Voting Requirement: Pursuant to Proposition 218, any increase in the rate of the TOT would be subject to a vote. If revenues are to be used for general purposes, the tax must be approved by a simple majority vote of those living within the jurisdiction subject to the taxation (i.e., the unincorporated area). If revenues are to be used for a specific purpose, the tax is considered a "special tax," and is subject to a two-third vote.

Amount of New Revenue: The amount of new revenue would depend on the amount by which the TOT rate is increased.

d. Parcel Tax:

General: A parcel tax is an annual charge per parcel of real property that is collected on the property tax bill.

How Used: Revenues collected pursuant to a parcel tax may be used for either general or special purposes.

How Allocated/Paid: A parcel tax may be based on factors such as the size of the parcel, but it cannot be based on assessed value. Under current law, the County has no authority to impose parcel taxes within incorporated cities.

Who Pays: Individual owners of parcels within the unincorporated area.

Existing Rate: The County does not currently collect a parcel tax within the unincorporated area.

Amount of Revenue Received: The County does not currently receive parcel tax revenue.

Voting Requirement: If revenues are to be used for general purposes, the tax must be approved by a simple majority vote of those living within the jurisdiction subject to the taxation (i.e., the unincorporated area). If revenues are to be used for a specific purpose, the tax is considered a "special tax," and is subject to a two-third vote.

Amount of New Revenue: The amount of revenue raised through a parcel tax would depend on the number of parcels affected and the charge imposed on each. The County Assessor's office states that there are presently 24,740 parcels in the unincorporated area.

e. Impact/Mitigation Fees

General: Impact/mitigation fees are imposed by governmental agencies to mitigate the impacts caused by the operations or development by the parties on whom the fees are imposed.

How Used: These fees are used specifically to offset or mitigate the particular impacts identified.

How Allocated/Paid: There must be a reasonable relationship between the harm sought to be mitigated and the impact/mitigation fees charged.

Who Pays: Individuals who create the harm to be mitigated.

Existing Rate: The County does not currently collect a mitigation fee.

Amount of Revenue Received: The County does not currently receive mitigation fee revenue.

Voting Requirement: None.

Amount of New Revenue: The amount of revenue raised through a mitigation fee would depend on the harm identified and the amount reasonably determined to be a necessary fee to mitigate the harm.

Additional Considerations: While the County has the authority to impose impact/mitigation fees, under existing law, it may do so only with respect to the unincorporated area. Less than ten percent of the population and of all employers in the County are located in the unincorporated area. Moreover, under California and Federal constitutional and statutory law principles, there must be a reasonable relationship between the harm sought to be mitigated and the fee imposed. Thus, for example, in order to impose an impact fee on employers who do not provide health insurance benefits, the burden would be on the County to establish that these employers, by their operations, are creating an identifiable public harm that they should remedy through payment of a mitigation fee and any such showing could be subject to challenge by the affected parties.

f. Use of County Police Power to Require Health Care Expenditures in Connection With Employee Minimum Wages (City and County of San Francisco's Approach)

The City and County of San Francisco has adopted the *San Francisco Health Security Ordinance*, which generally requires, among other things, that medium sized employers (defined as those with between 20 and 99 employees) and large employers (those with 100 or more employees) make "health care expenditures" of a certain amount for each hour worked by each employee. For example, under the Ordinance, through June 30, 2007, a medium sized employer would be required to make $1.06 in "health care expenditures" for each hour worked by each of its employers. "Health care expenditures" are "any amount[s] paid by a covered employer to its covered employees or to a third party on behalf of its covered employees for the purpose of providing health care services

for covered employees or reimbursing the cost of such services for its covered employees . . . ."

San Francisco has adopted this approach pursuant to its general police power, which allows it, among other things, to adopt a minimum wage within its jurisdiction. Soon after adoption, the Golden Gate Restaurant Association filed suit against the City in United States District Court, alleging that the Ordinance is preempted by the Employee Retirement Income Security Act ("ERISA"), which generally supercedes state and local laws that relate to the administration of employee benefit plans. The lawsuit remains pending.

Like San Francisco, pursuant to its general police power, the County has the authority to set minimum wages within the unincorporated area of the County and it could therefore adopt an ordinance similar to that in place in San Francisco . It would, however, require a change in state law to vest the County with the authority to set minimum wages within the incorporated areas. Further, assuming the County took such an approach, it would have to deal with the same ERISA preemption issues currently being litigated by the City and County of San Francisco.

III. Analysis Regarding Payroll Taxes

Some members of the Task Force and of the public have inquired about whether the County has the authority to impose a tax on employers equal to a percentage of each employer's payroll, the proceeds of which would be used to fund healthcare expansion. Having researched the matter, our view is that counties do not have the authority to impose payroll taxes.

Section 24 of Article XIII of the California Constitution vests the Legislature with the power to "authorize local government to impose" local taxes. The California Supreme Court has stated that a "grant of power [by the Legislature] is an essential prerequisite to all local taxation, because local governments have no inherent power to tax." *Santa Clara County Local Trans. Auth. v. Guardino* (1995) 11 Cal. 4th 220, 248. Thus, in order for a general law city or a county to impose a particular local tax, there must be a specific grant of authority from the Legislature allowing for it.

Nowhere in the California Revenue and Taxation Code (or in any other provision of law) has the Legislature authorized counties to impose payroll taxes, either within or outside of the unincorporated area. It follows that counties lack the authority to impose such taxes.

While some charter cities have imposed such taxes, they are differently positioned than counties because their authority to tax for local/municipal purposes does not originate in a grant of authority from the Legislature but, rather, it is based on the California Constitution itself. Specifically, a chartered city may impose a local tax under the *municipal affairs* clause of the California Constitution [Cal. Const., Art. XI, sec. 5 ("It shall be competent in any city charter to provide that the city governed thereunder may

make and enforce all ordinances and regulations in respect to municipal affairs, subject only to restrictions and limitations provided in their several charters and in respect to other matters they shall be subject to general laws. City charters adopted pursuant to this Constitution shall supersede any existing charter, and with respect to municipal affairs shall supersede all laws inconsistent therewith.")].

The California Supreme Court has upheld the authority of a chartered city, such as San Francisco, to impose a payroll expense tax, even in the absence of specific authorization from the Legislature. *A.B.C. Distributing Co., Inc. v. City and County of S.F.* (1975) 15 Cal. 3d 566, 576 ("We conclude that the payroll expense tax is a valid tax measure authorized by the 'home rule' provisions of the state Constitution (art. XI, secs. 5, 7) which impliedly empower local governmental agencies to levy taxes for general revenue purposes.").

No such "municipal/county affairs" power is vested in counties, including charter counties, such as San Mateo County. *See Dibb v. County of San Diego* (1994) 8 Cal. 4th 1200, 1207 ("The principal difference between 'city home rule' and 'county home rule' lay in the fact that since 1896, cities, by express provision in their charters could acquire control of 'municipal affairs' independent of general laws pertaining thereto. The scope of home rule available to cities thus was coextensive with the purview of the broad and general expression, 'municipal affairs.' No such general grant of authority to incorporate provisions relating to 'county affairs' was included in [the prior version of present section 4 of Article 11] with respect to county charters.").

Rather, counties (and general law cities), lacking the home rule powers of chartered cities, must rely on the general law of the state for taxing authority. A payroll expense tax is not among the taxes specifically authorized under California law and it follows that no such tax can be imposed by the County. Moreover, from a jurisdictional perspective, there's presently no authority for the proposition that a county can impose a payroll expense tax on businesses lying outside of the unincorporated area.

Please do not hesitate to contact this office if you would like to further discuss the matters raised in this memorandum.

cc: John Maltbie, County Manager

JDN:jdn

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Attachment D: San Mateo Uninsured Healthcare Claims Analysis
[Actuarial Analysis]

A MILLIMAN GLOBAL FIRM
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June 7, 2007

Ron Robinson
Chief Financial Officer
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Re: San Mateo Uninsured Healthcare Claim Analysis – *Updated Pricing Results*

Dear Ron:

As requested, we have updated the monthly claim cost estimates for Health Plan of San Mateo's (HPSM) proposed program for uninsured, low-income, San Mateo residents. These results are an update to the analysis originally presented in our April 20, 2007 analysis. Please review our initial letter for a more thorough discussion of the analysis process and underlying assumptions. We understand you will review these results and consider the feasibility of offering such healthcare plans with the projected costs presented in this letter. We would be happy to discuss the results and next steps once you complete your review of this analysis.

This letter and the attached exhibits have been prepared for the internal use of Health Plan of San Mateo and are subject to the terms of the Consulting Services Agreement signed November 14, 2005. They are only to be relied upon by Health Plan of San Mateo. No portion may be provided to, or relied upon by, any other party without Milliman, Inc.'s prior written consent. We do understand the results will be discussed at the Blue Ribbon Task Force on Adult Health Care Coverage Expansion meeting, which is open to the public. Wider distribution will require Milliman, Inc. to complete a more thorough internal conflict check.

Results

Based on feedback and recommendations received from HPSM, we have made the following changes to our original actuarial models:

- Eliminated the high deductible plan option.
- Increased the prescription drug discount assumptions to reflect the 340B Rx pricing. For 35% of the population, we have assumed an additional 40% discount off typical commercial discounts. Based on research and an internal consultant inquiry, we understand 340B is equivalent to slightly over 50% discount off AWP, which in turn

is equivalent to an approximate 40% improved discount than typical commercial discounts. Therefore, we assumed an "additional" discount off our previous pricing for 35% of the population.

- Eliminated Access for Infants and Mothers (AIM). We understand AIM covers pregnant women from 201% to 300% FPL. Therefore, we have eliminated maternity coverage from the 0% to 200% plan and assumed 50% maternity costs for the 201% to 400% plan.
- Included a reduction in cost for estimated out-of-area costs. To estimate this, we eliminated 10% of emergency care and 5% of non-maternity hospital costs. We did not make any adjustments to physician costs, with the exception of the associated physician costs for emergency and hospital visits.

As requested, we also increased the degree of healthcare management (DoHM) by 20%. Recall, the underlying database in our initial draft analysis included a mix of management efficiencies, which we estimated to be approximately 30% from a loosely managed system to a well managed system. We would classify a loosely managed system as having 0% DoHM, having little to no management processes, and a well managed system as having 100% DoHM, reflecting best practice efficiencies. Table 1 summarizes the total (inpatient bed days for the initial draft versus this updated analysis), assuming the 20% improvement in DoHM.

Table 1
Summary of Before and After Inpatient Bed Days per 1,000
Includes Medical, Surgical, Mental Health and Substance Abuse Before Reduction for OOA

Plan	Moderate Management (April 20, 2007)	Improved Management (June 7, 2007)
0% to 200% FPL	240	204
201% to 400% FPL	256	228

Attachment 1 is similar in format to what was presented in the April 20, 2007 letter, but has been updated with the new assumptions. As you can see, summarized in Table 2, the total per member per month (PMPM) claim costs has decreased 14.1% for the 0% to 200% FPL plan, and 14.5% for the 201% to 400% FPL plan.

Table 2 Summary of Before and After Net PMPM Claim Costs			
Plan	**Moderate Management (April 20, 2007)**	**Improved Management (June 7, 2007)**	**Percentage Change**
0% to 200% FPL	$293.57	$252.18	-14.1%
201% to 400% FPL	$291.59	$249.42	-14.5%

Based on conversations with you, we assumed the efficiency would benefit the sickest portion of the population, using specific point of contact processes to improve the health of the members. This less healthy cohort, termed the "Complex Chronic," has been defined as the most costly 15% after making several adjustments to estimate the exclusion of accidents.

Attachment 2 summarizes the PMPM claim costs assuming the improvement in management impacts the Complex Chronic members only. Remember, we segregated the two populations based on a 15/85 split of the costs. Assuming these two cohorts are representative of the given health status differences, if the mix were to change by 1%, or 16/84, the projected claim cost would increase from $271.24 to $282.49, or 4.1%, for the 0% to 200% plan. The 201% to 400% plan would have a similar increase from $291.77 to $304.00, or 4.2%.

Annual Maximum Impact

During our last conference call, we discussed the impact of implementing an annual benefit maximum for the 201% to 400% plan. You also asked us the impact of several annual maximum scenarios. Using the Milliman *Health Cost Guidelines* (HCGs) and the underlying Claim Probability Distributions (CPDs), we developed a tool to test the impact of limiting plan costs beyond several maximum scenarios. Our CPD was consistent with a non-maternity healthcare benefit, including prescription drugs for an adult population. Our results are shown in Table 3.

Table 3 Impact of Annual Benefit Maximums 201% to 400% FPL Plan			
Annual Allowed Benefit	**Gross Monthly Cost Estimate**	**Gross Annual Cost Estimate**	**Savings**
$500,000	$291.70	$3,500	0.0%
$300,000	$291.02	$3,492	0.2%
$200,000	$290.17	$3,482	0.5%
$100,000	$284.31	$3,412	2.5%
$50,000	$269.17	$3,230	7.7%
$10,000	$205.69	$2,468	29.5%
$5,000	$154.18	$1,850	47.1%
$1,000	$57.05	$685	80.4%

As you can see, an annual maximum would need to be fairly low in order to achieve meaningful savings. This is due to a several reasons. The primary one is that since we assumed Medicare reimbursement levels, large costs are greatly reduced because of the low payment rates. In addition, the costs we calibrated the CPD with exclude out-of-area emergencies, which also reduces the potential for catastrophic claims. Note though that the percentage of impacted members is very small. In our analysis, the percentage of members with annual gross claims in excess of $10,000 is approximately 5%, and the percentage greater than $25,000 is 2%.

Please note that the above CPD analysis was based on adjusted commercial population distribution data, which may look different than that incurred by an uninsured population. We would be happy to discuss refining our analysis in order to reflect a more consistent population if you request.

Caveats and Closing

In performing our analysis, we relied on data and other information provided to us by HPSM. We have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete.

The attached models are based on Milliman research and on our experience in working with many types of payers and health plans. Actual experience will vary from our models for many reasons, including differences in population health status, in reimbursement levels, in the delivery of health care services, as well as other non-random and random factors. It is important that actual experience be monitored and that adjustments are made, as appropriate.

As we previously mentioned, we can assist with further refinements, such as premium rate format (e.g., age-banded) or development of out-of-pocket cost profile vignettes, which may assist in comparing the relative plan costs to other stakeholders. In the meantime, if you have any questions regarding our analysis, please give me a call.

Sincerely,

Craig B. Keizur, FSA, MAAA
Consulting Actuary

/amd
Attachment

cc: ST Mayer
Stan Roberts, Milliman
Jason Hart, Milliman

Attachment 1 - *Updated 6/7/2007*
Health Plan of San Mateo
Claim Cost and Illustrative Premium Rates for Uninsured Population

Updated 6/7/2007

Center Date	July 01, 2007
Assumed Reimbursement Assumption:	(Estimated) 100% Medicare Allowable

Plan Description	Complex Chronic / Healthy Individual	
FPL Eligibility	0%-200%	200% - 400%
Deductible (Individual)	$0	$0
First Dollar Basic Coverage	n/a	n/a
OOP Max (Individual)	$5,000	$5,000
Office Copay (PCP/Spec), Non-Preventive	$0/$0	$10/$25
Hospital Copay (per admit)	$0	$200
Emergency Copay	$25	$50
Rx Copay	$3/$10	$10/$25
Projected Gross Claim Costs (PMPM)		
Hospital Inpatient (non-maternity)	$46.21	$52.00
Hospital Outpatient (non-maternity)	44.10	45.83
Physician (non-maternity)	103.40	103.23
Maternity (Hospital and Physician)	0.00	11.74
Prescription Drug	42.71	44.67
Dental	24.86	24.86
Other	9.96	9.44
Subtotal	$271.24	$291.77
Reduction for Out-of-Area	($5.21)	($5.49)
Value of Benefit Cost Sharing	($13.85)	($36.86)
Net PMPM Claim Cost	$252.18	$249.42
Gross Cost for Non-Maternity	$271.24	$280.03
Assumed Retention (Administration and Profit Margin)	15.0%	15.0%
Per Member Per Month Plan Premium Rate		
[Net Claims / (1 - Admin)], Rounded	$297	$293
Illustrative Adult, Age 25	$206	$198
Illustrative Adult, Age 45	$371	$325

Attachment 2 - *Updated 6/7/2007*
Health Plan of San Mateo
Complex Chronic and Healthy Individual Cost Projection

Center Date: July 01, 2007
Assumed Reimbursement Assumption: (Estimated) 100% Medicare Allowable

FPL	0%-200%			200% - 400%		
Plan Cohort	Complex Chronic	Healthy Individual	Total	Complex Chronic	Healthy Individual	Total
Assumed Distribution [1]	15%	85%	100%	15%	85%	100%
Projected Gross Claim Costs (PMPM)						
Hospital	$473.96	$22.61	$90.31	$554.72	$17.20	$97.83
Physician	491.88	34.84	103.40	492.07	34.61	103.23
Maternity [2]	0.00	0.00	0.00	14.23	11.30	11.74
Rx	213.57	12.56	42.71	223.38	13.13	44.67
Dental [2]	24.86	24.86	24.86	24.86	24.86	24.86
Other [3]	23.19	7.62	9.96	21.81	7.26	9.44
Subtotal	$1,227.47	$102.49	$271.24	$1,331.07	$108.36	$291.77
Additional Management Savings	-15.0%	20.7%	-6.1%	-7.9%	0.0%	-5.5%
Distribution of Costs						
Hospital	39%	22%	33%	42%	16%	34%
Physician	40%	34%	38%	37%	32%	35%
Maternity [2]	0%	0%	0%	1%	10%	4%
Rx	17%	12%	16%	17%	12%	15%
Dental [2]	2%	24%	9%	2%	23%	9%
Other [3]	2%	7%	4%	2%	7%	3%
Subtotal	100%	100%	100%	100%	100%	100%
Illustrative PMPM Cost if 16/84 Split			$282.49			$304.00
Increase in Gross PMPM Claim Cost			4.1%			4.2%

(1) Allocation between Complex Chronic and Healthy Individual based on actuarially adjusted claim probability distributions (CPD) from Milliman HCG.
(2) Assumed maternity and dental incidence and costs are spread evenly among cohorts.
(3) Assume "other" services magnitude for CC to be 1/2 of hospital and physician split.

Attachment E: Feasibility of Insurance Product Options for the Low-Income Uninsured Adult in San Mateo County

FEASIBILITY OF INSURANCE PRODUCT OPTIONS FOR THE LOW INCOME ADULT UNINSURED IN SAN MATEO COUNTY

Prepared for the
HEALTH PLAN OF SAN MATEO

By the PACIFIC HEALTH CONSULTING GROUP
October 31, 2007

1

INTRODUCTION

- San Mateo Health Commission formed the Health Plan of San Mateo in 1987. HPSM is a state licensed, managed care health plan, and serves 59,000 individuals through five programs
- There is a countywide effort to expand health insurance coverage led by the BOS and Blue Ribbon Task Force
- During the course of Task Force meetings, HPSM committed its interest and willingness to explore insurance product options for the adult uninsured in San Mateo County, products that could be offered by the Health Plan to help reduce the number of uninsured adults living in the County. This report discusses the first phase of that exploration.

2

SCOPE and PURPOSE OF THE FEASIBILITY STUDY

This feasibility study explores possible employer group and individual health insurance products, identifies their respective advantages and disadvantages, models financial outcomes, and recommends the selection of best options.

3

STUDY FINDINGS

- The number of uninsured adults in San Mateo County is a moving target. A number of sources could be used to develop estimates.
- UCLA California Health Interview Survey (CHIS) is one of the most widely used sources in the State. While the data has limitations because it is a survey and is subject to statistically limitations, the depth of the breakdowns makes it a valuable tool for planning purposes.
- The number of uninsured that have sufficient income to be able to purchase insurance or contribute to an employer offered health plan is relatively low. (At the 300% plus FPL level the number was 19,000 in 2005)
- The number that are employed 20 hours or more a week is even lower (3,000 in 2005).

4

STUDY FINDINGS

- HPSM can offer a group product like HealthWorx (51+ employees). This would require an amendment to its existing license from the California Department of Managed Health Care (DMHC)
- Two additional products can be considered: an individual and a small employer group. These would also require licensure by DMHC.
- Individual products required medical underwriting to be financially feasible. Employer group products cannot be denied based on medical risk.
- Any employer group option is a potentially high-risk venture.
- Administrative costs need to be minimized. Yet, new competencies have to be developed, unless expensive outsourcing is chosen.
- Marketing challenge: finding employers and employees to bear ongoing financial obligations and employers capable of performing recordkeeping

5

FEASIBILITY RECOMMENDATIONS

- A HealthWorx-like product should be available to offer large employer groups.
- An individual health insurance product should not be pursued because it would require medical underwriting and the potential rejection of applicants.
- A small employer group health insurance product should be developed and implemented in a limited, phased approach.
- The development of employer group health insurance products for both small and larger employers will provide flexibility in responding to employer and employee needs.

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Attachment F: County Health Care [Financing] Options

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M E M O R A N D U M

TO: San Mateo County Blue Ribbon Task Force

FROM: Scott Kronland
Stacey Leyton

DATE: October 29, 2007

RE: County Health Care Options

INTRODUCTION

This memorandum addresses the legal issues raised by several options for funding the expansion of health care access in San Mateo County. These options include:

(1) Raising the sales tax;
(2) Imposing a payroll tax or other employer tax;
(3) Charging employers a health care mitigation fee;
(4) Raising business licensing fees to pay for health care; and
(5) Using the police power to require employers either to maintain a certain minimum level of health spending or to make payments to the County for health care.

After discussing the County's legal authority under California law to raise money through each of these options, we then address whether placing obligations on employers would be preempted by the federal Employee Retirement Income Security Act ("ERISA").

For purposes of this memorandum, we have assumed the County's goal is to provide health care services to county residents with family incomes of less than 400% of the federal poverty level, and that the County ideally would like employers that do not currently spend adequate amounts on health care for their-low wage employees to bear part of the burden of funding this program expansion.

We are available for further research and analysis, or to answer questions about and to discuss the conclusions we reach in this memorandum. In addition, we have delivered a longer memorandum with greater detail and further supporting citations to County Counsel.

DISCUSSION

I. Legal Issues Involving Authority Under State Law to Raise Money.

A. Sales Tax

The County unquestionably has authority to raise money through a sales tax (or other non-employment-based tax that is authorized by state law). That funding option, however, would not be focused on employers. A tax increase also would need to be approved by a two-thirds vote of the electorate.

B. Employer Tax

It is less clear whether the County presently has the legal authority under state law to impose a payroll tax or other tax directly upon employers in incorporated areas of the County. In our view, Health and Safety Code Section 1445 conveys this authority. That statute authorizes counties to "provide for the care and maintenance of the indigent sick or dependent poor of the county," to "provide medical and dental care and health services and supplies to persons in need thereof who are unable to provide the same for themselves," and "for these purposes [to] levy the necessary taxes." While we have not located any court decisions that address the nature of this taxation authority, the best reading of the statutory language is that Section 1445 grants the County the authority to impose a tax upon employers in unincorporated *and* incorporated areas so long as the proceeds of the tax are designated to provide health care to those unable to pay for it themselves.

If the Commission wishes to consider the option of a payroll tax or similar tax upon employers based on the authority conferred by Section 1445, we would recommend that further legal research be conducted in this area. Another option would be to seek explicit authorization from the California Legislature to impose a payroll tax to fund health care, for example by amending Section 1445 to make it more specific.

Any tax upon employers would need to be approved by a two-thirds vote of the electorate.

C. Health Care Mitigation Fee

Authority to Impose the Fee

Because the police power of counties extends only to unincorporated areas, the County could charge employers in incorporated areas a health care mitigation fee only if the Legislature has explicitly or implicitly delegated authority to do so to the County.

We are not aware of any explicit delegation of authority to the County to adopt a health care mitigation fee. Thus, the County's power to impose such a fee would depend on the argument that its authority and duty to provide health care services to indigent persons under Welfare and Institutions Code Section 17000 and Health and Safety Code Section 1445 necessarily *imply* the authority to charge employers a fee for their employees who are likely to need such services. When the County acts pursuant to the mandate of Section 17000, it does so "as an agent of the state,"[1] and under this authority counties have operated hospitals, clinics, and other health programs in both incorporated and unincorporated areas.

Courts have held that Section 17000 grants county agencies the authority to adopt regulations that are "reasonably necessary" to accomplish the statute's purpose, and that it requires counties to provide necessary medical services to those unable to pay for such services themselves, including those members of the working poor who have a limited ability to pay.[2] San Mateo County would thus have the discretion to define eligibility for county health care services to encompass a large number of employed individuals not otherwise provided health coverage by their employers.

However, the theory that the statutes that authorize and require the County to provide medical services to indigent county residents impliedly grant the County the authority to impose a health care mitigation fee is novel and legally untested, and we are not aware of any decisions in which courts have upheld a fee under similar circumstances. In general, when localities have sought authority to act in an areas outside their territorial jurisdiction, courts have demanded a very strong showing of necessity. Thus, it would be legally safer to obtain explicit authority from the California Legislature for the County to impose a mitigation fee upon employers that do not spend a specified amount on health care for their employees than to rely on this untested theory.

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[1] *Mooney v. Pickett* (1971) 4 Cal.3d 669, 679.

[2] *Mooney,* 4 Cal.3d at 679; *Hunt v. Superior Court* (2002) 21 Cal.4th 984, 1013; *Alford v. County of San Diego* (2007) 151 Cal.App.4th 16, 29.

Classification as a fee or special tax

If the Legislature were to grant the County explicit authority to impose a health care fee, or a court were to rule that the County *does* have the implied authority to impose such a fee, there would still be a question whether such an exaction, though labeled a "fee," is really a "tax" that requires voter approval. In some circumstances courts have held that charges labeled "fees" were actually taxes and therefore invalid without voter approval. The line between a fee and a tax is not always clear, but the following are some characteristics of a charge properly classified as a fee:

- The proceeds of the fee are used for a specific regulatory program or service, not for general revenue purposes;
- The fee amount does not exceed the reasonable cost of providing this service or regulatory activity; and
- The fee amount charged to particular fee-payers has a reasonable or fair relationship to the burden the fee-payer is imposing that is addressed by the regulatory activity, or to the benefits that the fee-payer will receive from the service or regulatory activity.[3]

The County could establish a strong link between a health care mitigation fee and the *benefits* enjoyed by an employer fee-payer, so long as the program is structured in a way that the employees whose employers pay the fee actually do enjoy significant benefits as a result, and those benefits bear a reasonable relationship to the fee amount. For example, the County could grant such employees a discount on enrolling in the county health care system or in the fees charged for utilizing those services. It would not be necessary to show that employers *perceived* the county program as conveying a benefit to them or that the amount paid by a particular employer is precisely proportionate to the benefit its employees receive. However, in order to establish the reasonableness of this relationship, the program should be structured so that employers who pay the fee receive some benefit for all or most of their employees, including those employees who are not residents of San Mateo County. For example, San Francisco is establishing medical reimbursement accounts on behalf of non-county residents whose employers make payments to the county; San Mateo County could do something similar and/or could make reciprocal arrangements with other counties for discounts on health care services for residents of those counties whose employers make payments to San Mateo County.

The County could also argue that employers who do not provide health coverage for their employees put the *burden* of doing so on the government and that the amount of the fee is reasonably related to what it will cost the County to provide health care services

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[3] *See* Gov. Code §50076; *Sinclair Paint Co. v. State Bd. of Equalization* (1997) 15 Cal.4th 866, 878, 881; *Pennell v. City of San Jose* (1986) 42 Cal.3d 365, 375 n.11.

for those uninsured employees. This argument would be supported by documentation of the costs to the County of providing health care to the working uninsured.

Neither the benefit nor the burden argument has been tested in court.

D. License Fee

The legal issues raised by adoption of a health care mitigation fee could not be avoided by imposing a fee to fund health care services as part of a licensing scheme.

To impose a license tax – that is, a charge that pays for the costs of a particular regulatory program – a county would need specific authorization by state law and would need to obtain approval by a two-thirds vote of the electorate.

To impose a license fee – that is, a charge that pays for the costs of a particular regulatory program – in incorporated areas, a county would also need specific statutory authority.[4] If a state statute grants the County authority to charge a specific business license fee in incorporated areas, the question whether the County can increase that fee to pay for the expansion of county health care services will depend upon (1) whether that specific statutory authorization is broad enough to encompass a charge for the costs of health care services, and (2) whether the fee amount charged is no greater than what is reasonably necessary to cover the costs of the regulatory program, which includes the costs that the operation of the business at issue imposes upon the County.[5] That is, the amount of any fee or fee increase imposed upon a particular business would need to be reasonably related to the cost that the County incurs for providing health care services to employees of that business. This means that, for example, a license fee imposed upon restaurants could be used only to pay for health care services for restaurant employees and could not be more than the amount necessary to pay for those services.

As with the mitigation fee, the Legislature could solve the problem of whether the County has authority to impose or increase a license fee by adopting legislation that grants express authority to counties to charge or increase business license fees for this purpose. However, even with such statutory authorization, the County would still need to prove that the fee is reasonably related to the costs of the regulatory program to avoid classification as a tax.

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[4] Rev. & Tax. Code §7284(a).

[5] *See* Gov. Code §54985(a); *Plumas County v. Wheeler* (1906) 149 Cal. 758, 764*; United Business Comm'n v. City of San Diego* (1979) 91 Cal.App.3d 156, 165-66.

E. Exercise of Police Power

Minimum wage laws are generally exercises of the police power to protect the public welfare. Similarly, a minimum health care spending requirement could be imposed as an exercise of the police power. San Francisco has chosen this option, and requires businesses located in the City and County to spend at least a minimum amount on employee health care, either directly or by paying money to San Francisco for that purpose. But San Francisco has authority as both a city and a county, while San Mateo County's police power is limited to unincorporated areas of the County. To extend a similar requirement to incorporated areas, San Mateo County could create a joint powers arrangement with each city that would be included.

The Joint Exercise of Powers Act permits parties that have police power in different geographic areas – for example, counties with police power in unincorporated areas and cities with such power in incorporated areas – to combine those powers.[6] Courts have upheld joint powers arrangements in which municipalities have contracted to exercise police and eminent domain powers.[7] As a result, so long as cities are willing to cooperate, the joint powers option would appear to eliminate any problems concerning the County's authority to operate within incorporated areas.

The joint powers agreement could either designate San Mateo County as the entity that would administer the expanded health care services and enforce the spending mandate, or could establish a separate entity with this authority (which could contract with San Mateo County for such administration and/or enforcement).[8]

Additionally, counties and cities and cities have statutory authority to contract for (1) the county to enforce within the city the city's health-related ordinances and (2) the city to enforce in unincorporated territory adjacent to the city the county's health-related rules, and courts have interpreted this authority broadly.[9] Possibly, then, the County could enter into contracts with cities to establish a health care program funded by employers. However, because these provisions simply grant authority for a city or county to contract for the enforcement of already applicable rules, the employer spending mandate would be effective in both incorporated and unincorporated areas only if each city adopted an ordinance that set forth the specific requirements to be enforced; this could create

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[6] Gov. Code §6502.

[7] *See City of Oakland v. Williams* (1940) 15 Cal.2d 542, 549; *Burbank-Glendale-Pasadena Airport Authority v. Hensler* (2000) 83 Cal.App.4th 556, 562-63.

[8] Gov. Code §§6503.5, 6306.

[9] Health & Safety Code §§101400, 101415; *City of Pasadena v. County of Los Angeles*, 235 Cal.App.2d 153 (1965).

practical difficulties whenever such requirements needed to be modified. Therefore, a joint powers arrangement would be the preferable way to proceed.

The use of the police power would likely avoid the need for the two-thirds approval by voters that is necessary to raise taxes. Rather than imposing a fee and granting employers credit against the fee amount for their private health care spending, the County could impose a minimum expenditure requirement upon employers, permitting employers to fulfill that mandate by paying the County if they so choose.

II. ERISA Preemption Issues.

Most employer-funded health care, including group health insurance, is provided through an ERISA plan. In general, local legislation that requires or effectively mandates the modification or adoption of ERISA plans is preempted, but legislation that simply gives incentives that may affect an employer's choices about ERISA plans is not preempted.[10] If San Mateo County requires employers to maintain a minimum level of health care expenditures, or imposes a fee or tax but grants employers a credit against the fee or tax for private health care spending, the employers may challenge the law as preempted by ERISA.

Two such recent employer challenges have resulted in the laws at issue being held invalid; however, in both of those cases, the laws required employers to spend a specified amount on health care for their employees or to pay the difference between the mandated amount and the amount actually spent to the government (in one case) or community health clinics (in the other). The courts concluded that no rational employer would choose to pay money to the government or a charity if it did not receive any benefits for doing so, and so the laws effectively required employers to modify their existing ERISA health care plans to increase their spending level to the mandated amount.[11]

While there are serious flaws in the reasoning of these decisions, the safest course would be to avoid their reach. In order to avoid ERISA preemption, the San Mateo County scheme should be designed so that:

- Employers have an option for compliance that does not involve setting up their own ERISA plan or increasing their spending on an existing ERISA plan (for example, an option of paying money to the County);

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[10] *See New York State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.* (1995) 514 U.S. 645, 658-60; *California Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., Inc.* (1997) 519 U.S. 316, 334; *WSB Elec., Inc. v. Curry* (9th Cir. 1996) 88 F.3d 788, 796.

[11] *Retail Indus. Leaders Ass'n v. Fielder* (4th Cir. 2007) 475 F.3d 180, 185, 193; *Retail Indus. Leaders Ass'n v. Suffolk County* (E.D.N.Y. 2007) 497 F.Supp.2d 403, 407, 417.

- Employers receive a sufficient benefit from that non-ERISA option that it is a realistic one (for example, discounts for their employees to enroll in the County health program and/or other benefits for non-County residents); and
- The non-ERISA option differs from health insurance in critical respects.

In San Francisco, for example, the city and county will grant resident employees whose employers pay a fee to the government health program a 75% discount on the quarterly enrollment fee (which operates on a sliding scale based upon income of the enrollee) and nonresident employees whose employers make such payments a medical reimbursement account. The maximum amount an employer would be required to spend per employee is less than the average cost to provide private health insurance, and less than the value of the health care services the city and county will provide.

In our view, a system like San Francisco's is not preempted by ERISA. On November 2, a federal district court judge will hold a hearing on this issue and is expected to rule shortly thereafter.[12] Regardless of how the trial court rules, the case is likely to be appealed to the U.S. Court of Appeals for the Ninth Circuit, and resolution of that appeal would likely take a minimum of a year. Thus, while there is a very strong argument that a spending mandate with a government payment option like San Francisco's is safe from ERISA preemption, that legal issue will not be finally resolved by courts in this jurisdiction in the immediate future.

In the San Francisco case, the restaurant association has also argued that an employer that elects to comply with the law by making payments to the government will be required to establish an ERISA plan simply in order to calculate the amount of and make those payments. Because the ERISA statute says that an employer's purchase of health insurance for its employees establishes an ERISA plan, the association is implicitly arguing that making a payment to the government is like purchasing health insurance. While we believe that this argument lacks merit, in anticipation of a similar argument, the County should structure its program in a manner that makes it clear that the county program is not health insurance and differs from insurance in critical respects.

[12] Our law firm represents several labor organizations that have intervened as defendants in the San Francisco litigation to join the City and County in defending the challenged ordinance.

Attachment G: A Key Step to Ensuring Access: An Adequate Provider Network

A Key Step to Ensuring Access: An Adequate Provider Network

The Status of HSPM

Mary D. Giammona, MD, MPH
HPSM Medical Director
Blue Ribbon Panel Presentation
December 13, 2007

Agenda

- Background—HPSM
- Overview of Provider Network
- Snapshots of Specific Provider Types
- Steps Being Taken Now
- Next Steps and Needs
- Q and A

Background—HPSM

- HPSM has over **60,000 members**
- We have **5 Lines of Business**
  - Largest is Medi-Cal
- With Healthy Families and Healthy Kids (both cover children under 19), and Medi-Cal, the **largest group covered is children** (about 55%)
- With CareAdvantage, our Medicare Advantage program (covers seniors and persons with disabilities), our **most vulnerable/sickest members are dual eligibles**

Overview of Provider Network

- A number of our providers' practices, both primary care and specialty **providers, are "full"**
  - Taking "established patients only"
- There is a **mismatch of** sorts in some areas
  - Most availability of pediatric providers found in North County
    - Most pediatric patients are in South County
- Ongoing **need to increase our network** wherever possible

Overview of HPSM Provider Network

Environmental Scan of San Mateo County physicians

- Reviewed HPSM physician roster by LOB and EPO status
- Conducted "secret shopper" surveys of HPSM PCPs, including
  - Family Practice (FP), Internal Medicine (IM), Pediatrics (Peds)
- Identified external physicians
- Reviewed specialty capacity in all areas (highlights presented here)

Snapshots of Specific Provider Types

Percentage of Adult Members by Region

Region of County	Age of Member 21-65	Age of Member 66-100+
North	**43%**	**55%**
Central	27%	27%
South	29%	17%

PCP—Adults

•Are the majority of MDs HPSM MDs?

- •North **YES**
- •Central NO
- •South NO

Geomap of HPSM Adult Providers

Acrobat Document

Snapshots of Specific Provider Types

Percentage of Pediatric Members by Region

Region of County	Age of Member 0-18
North	32%
Central	21%
South	**46%**

PCP—Peds

•Are the majority of MDs HPSM MDs?

- •North **YES**
- •Central NO
- •South NO

Geomap of HPSM Peds Providers

Acrobat Document

Snapshots of Specific Provider Types

Women of Childbearing Age by Region

Region of County	Where Greatest Number Reside
North	++.5%
Central	++%
South	+++%

OB-Gyn MDs

•Are the majority of MDs HPSM MDs?

- •North **YES**
- •Central NO
- •South NO

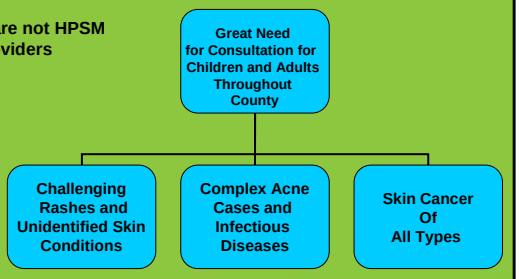
Geomap of HPSM OB-Gyn Providers

Acrobat Document

Snapshots of Specific Provider Types

Dermatologists

Majority are not HPSM providers



Geomap for HPSM Dermatologists

Acrobat Document

Snapshots of Specific Provider Types

Neurologists

Majority are not HPSM providers

- Increased Need as Population Ages
  - Alzheimer's
  - Strokes
- Agnews Members Moving Into Community
  - Almost 100% Have History Of Seizures
  - Even if Do Accept HPSM, MDs Don't Accept Medi-Cal
  - MD Home Visits??

Geomap of HPSM Neurologists

Acrobat Document

Snapshots of Specific Provider Types

Orthopedists

Majority are not HPSM providers

- Most Needed by Kids And Elderly
  - Broken Bones—Falls, Casts, Revisions
  - Deformities—Congenital Or Due to Aging

Gastroenterologists

•The majority are not HPSM providers

- Increasing Need as Members Age
  - Cancer Screening Becomes More Critical

ONGOING UNMET NEED ACROSS COUNTY

Geomap of HPSM Orthopedists

Acrobat Document

Geomap of HPSM GI MDs

Acrobat Document

Steps Being Taken

- Collaboration with Palo Alto Medical Foundation (PAMF)
  - Was on "established patient only" status
  - **Agreed to accept** additional patients
  - Expands capacity for **pediatric and adult primary care and specialty patients** at PAMF's multiple South County sites

Steps Being Taken

- Contracting with Kaiser Redwood City
  - Providing **Ob-Gyn and Peds** Services
  - Will expand available **South County delivery** services
  - Will provide **full-scope pediatric services** for the new baby and any siblings
  - Increases capacity in these two areas of need for **South County provider network**
- May expand to **Adult specialty services** in North County (SSF facility)

Steps Being Taken

- Collaboration with San Mateo Medical Center (SMMC)
  - **Pediatric Clinic Expansion** Efforts
  - **Increased appointment slots**—evenings and weekends—Main Campus, DC, SSF
  - Examining possible Saturday appts at Fair Oaks
- Nurse Advice Line Pilot
  - For **Primary Care Patients of SMMC**
  - Encourage patient confidence and **use of home care** where appropriate
  - **Reduce avoidable emergency room visits**

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Next Steps and Needs

- **NEEDED:** Care providers in community for Agnews members
  - **PCPs and specialists**
  - SMMC is helping, but need public-private partnership to provide adequate care
- **GOAL**: Expansion to additional uninsured adults
- **NEEDED:**
  - More **PCP capacity**
  - More **specialist capacity**—chronic diseases
  - **Openness** when HPSM "knocks on your door"
  - More **understanding and respect** for all patients and HPSM members
    - They notice and appreciate this
    - They tell us about it regularly

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Thank You!

- Questions?

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Attachment H: Opinion Research Regarding Adult Health Care Coverage Expansion

San Mateo County
Blue Ribbon Task Force
on
Adult Health Care Coverage Expansion

Stakeholders Interview Summary

During October and November 2007, Apex Strategies conducted twenty (20) stakeholder interviews with twenty-one (21) individuals regarding the proposed San Mateo County Adult Health Care Expansion.

Participants

The stakeholders were representatives of the following organizations (grouped together by constituencies):

Community, Business and Labor Leaders

- Larry Buckmaster, Redwood City-San Mateo Chamber of Commerce
- Dan Cruey, SAMCEDA
- Mark Lockenmeyer, President Harbor Industrial Association
- Shelley Kessler, Central Labor Council
- Rayna Lehman, Director of Community Services at CLC
- Linda Asbury, President and CEO San Mateo Chamber of Commerce
- Jack Olson, Executive Director San Mateo County Farm Bureau
- Don Mendel, Nurseryman's Exchange General Counsel
- Charise McHugh, Half Moon Bay Chamber of Commerce Executive Director
- Georgette Sarles, Georgette's of Westlake, Westlake Merchants Association, Daly City Colma Chamber of Commerce President
- Anne Le Claire, President and CEO, Convention and Visitors Bureau
- Laura Baughman, San Bruno Chamber of Commerce Executive Director

Business Owners

- Richard Hutchens, Grace Body Shop
- Peter Hartzell, Hartzell Construction
- Barry Jolette, San Mateo Credit Union
- Matt Matteson, Matteson Co.
- Steve Karp, Karp Companies
- Memo Morantes, President of Finance and Insurance Services Company
- Eric Lamb, President DPR Construction
- Tony Fazio, Winning Directions
- Allan Jaffe, Printer

Interview Agenda

A copy of the interview questions is attached to this Summary in Attachment A. The agenda for the interviews is summarized as follows:

- **Knowledge.** Stakeholders were queried about their knowledge of the Blue Ribbon Task Force and the health care expansion proposal.

- **Need.** Stakeholders were asked whether they believed that health care expansion was needed and their reasons for that opinion.

- **Shared Financial Responsibility.** Stakeholders were asked their opinions about having a portion of the cost of health care expansion borne by employers within the County.

- **Funding Options.** Stakeholders were asked for their funding preference. They were given the opportunity to suggest their own funding solutions and to weigh in on various alternatives identified by the Blue Ribbon Task Force.

- **Coverage and Expansion Options.** Questions were posed on whether stakeholders had any questions or concerns about the type of coverage that would be available to low income workers. Stakeholders also were asked whether they had any thoughts or concerns generally about the coverage expansion effort.

- **Support.** Stakeholders were asked whether their business or organization would support the effort to expand health coverage and their reasons for that position.

- **Open Input.** Finally, stakeholders were asked whether there were any other points that they would like to add to what had already been covered.

Summary of Stakeholder Input

Knowledge:

- **Are you aware of the effort?**
  - Most of the stakeholders were aware of the work being done by the Task Force. Some were on the Task Force and others had members of their organizations who were on the Task Force and reporting back about the effort.
  - Two stakeholders had no prior knowledge and several others stated that they were only "vaguely" aware of the effort.

- **Is it necessary? Why or why not?**
  - Almost universally the stakeholders believed that it is important to discuss and address the issue.
  - One stakeholder feels that the effort is "unconstitutional" and that health care coverage should be left up to the individual.
  - Many of the stakeholders, while agreeing that this is an important issue that needs discussion, felt strongly that health care coverage needs to be addressed on a state or national level.
  - A business owner was concerned about the financial implications and was concerned about potentially forcing some businesses which do provide health care coverage to support other businesses that do not.

Regarding Shared Responsibility:

- **Do you have a preferred method of contribution?**
  - Many of the stakeholders did not have a preferred method of contribution.
  - There were several who were concerned about the impact of shared responsibility on businesses and stakeholders who were involved with Chambers of Commerce and other business organizations had policies against "mandatory" employer-funded programs.
  - One stakeholder wanted to ensure that any system took into account what businesses were already doing – "no double payments, need to credit what business is already contributing."
  - Another stakeholder did not see the nexus between having employers pay for the uninsured in society.
  - A business owner, with employees throughout California and in other states was concerned about the impact of a local health care coverage solution creating different coverages in different offices.
- **Do you think participation by employers should be required or voluntary?**
  - About half of the stakeholders thought that participation should be voluntary. The general concern about mandatory contributions was the potential impact on businesses and that it might drive businesses out of the County.
  - Those supporting mandatory participation believed that only a mandatory system would work. "Voluntary is naïve" said one of the stakeholders.
  - One stakeholder felt that mandatory would only work if the issue was addressed at the State level; if dealt with only at the San Mateo County level, then it should be voluntary.

Regarding Requiring Employers to Provide Coverage or Pay Into County Fund:

- **Do you think it is fair/right to set a minimum health coverage standard for all businesses?**
  - Stakeholders were evenly split on whether setting a minimum health coverage standard for all businesses was fair.
  - Several stakeholders supporting a minimum standard suggested that employers who don't pay for their employees' health care should be required to "pay into a pot."
  - One stakeholder personally believes in a safety net programs, but worries that it might lead to employment hiring discrimination issues.
  - Several stakeholders were supportive only if it was "fair" and "affordable."
- **Should some businesses be exempt? Why? What type/size?**
  - Almost all of the stakeholders believed that small businesses should be exempt. They generally were concerned that small businesses would have trouble contributing at the levels proposed and still staying profitable. They were also worried about the administrative burden on the small employer.
  - Several stakeholders did suggest that no businesses should be exempt.
  - Stakeholders differed on the definition of a "small" business. Some pegged the level at 4 – 5 employees, others at the 20 employee level. One stakeholder stated that looking at number of employees was not the right approach, suggesting instead that profitability was a better standard. Another stakeholder suggested that businesses in which there is a high risk of injury should not be exempt in any case.
  - Another stakeholder suggested that all businesses that already cover their employees should be exempt.
  - Some stakeholders were concerned about the ultimate burden of society if people are not covered. The stakeholders mentioned an additional burden on County public health which is a burden to all (for example day laborers who end up at public hospitals when they get hurt on the job).

Funding Options

- **A health care minimum spending requirement? Is 7.5% of each employee's wages reasonable?**
  - Stakeholders were evenly split on the minimum spending requirement concept.
  - Some of the stakeholders opposing the minimum spending requirement felt that it was too employer focused, that the health care coverage issue should be addressed other than through the employer.
  - Those supporting the minimum spending requirement felt that it was a fair way to address the health care coverage of employees.

- Some of those who were generally supportive of the minimum spending requirement thought that the 7.5% level was too high or that a straight percentage would not necessarily be appropriate (i.e., "healthcare costs are not tied to wages").

- **A health care minimum wage, or fee per hour worked for any uninsured employee?**
  - Several stakeholders thought that the employer flat fee was "the best of the worst." Several others thought it was good if the fee was "small" or "affordable."
  - Other stakeholders objected that the minimum wage or flat fee was too employer focused and potentially too heavy a burden for businesses that already can't afford to cover their employees.

- **An annual business health fee, in addition to the business license fee?**
  - Stakeholders were split on the idea of an annual health fee. Some did not care for it and others thought it was too "employer focused." Others thought it was the best funding idea or, at the least, the "best of the worst ideas."
  - Those supportive of the fee were concerned about how it could be implemented on a county basis without the cooperation of the cities in the County. One stakeholder suggested a joint powers authority to address this problem.

- **A countywide ½ cent sales tax?**
  - Many stakeholders liked the sales tax idea but, almost universally, were concerned that it would never get passed. "This is non-starter, needs 2/3; will put tax too high;" "Hard to do but fairest option;" and "two-thirds vote is high hurdle to reach and this would not pass it."
  - Three stakeholders objected that a sales tax is too regressive. One said anything <u>but</u> a sales tax would be acceptable for funding, another suggested that a sales tax hits the poor the most, and a third objected that it is not only regressive but "lets employers off the hook."
  - Supporters of the sales tax option felt that it would spread the cost of health care coverage more broadly across the County population and be the most fair.

- **Do you have other ideas or suggestions?**
  - There were a number of suggestions, but no single idea predominated.
  - Voluntary up-tick on individual co-pays to support the Samaritan (retired doctor as provider non-profit model).
  - Do not use TOT that should be used for marketing.
  - Some stakeholders felt people are "maxed-out" on parcel taxes.
  - Cities have to buy in. What are they willing to support?
  - Governor's Plan—state may come though…Need to make sure no double contributions will be paid.
  - Need to make sure we have a system that can be backed away from if state or federal system is put in place. Would be willing to join a system administered by the County if there were cost savings to be had by strength in numbers in negotiating for rates.

- Needs to be statewide to spread burden. Get some from employers and some from all statewide consumers.
- Need to look at funding out of companies' profit margins.
- Should be able to sign up for insurance the day you need it at the hospital.
- Tax needs to be widespread—Does not want property tax or income tax to be considered.
- County had a fixed fee type plan at one point for their employees; could it be expanded to cover other businesses?
- General Obligation Bond to set an endowment that could fund coverage.
- Needs to be spread out to make it more fair no one group should pay.
- Tobacco tax.
- Maybe a "sin tax on cigarettes and the like."

Do you have any thoughts or concerns about the type of coverage that would be available to low income workers?

- Some of the stakeholders felt that only catastrophic coverage should be made available while others believed that preventative care coverage was needed.
  - Workers should have access to regular and preventive care so they don't use the expensive emergency room as their healthcare provider.
  - Need to have catastrophic like coverage…Basic coverage. No dental or vision coverage as insurance but perhaps dental, preventative and vision covered by a voucher system where each person got a visit a year for a check up in dental, vision or preventative.
  - Catastrophic only, then employees can "pick up difference through a supplemental policy".
  - More than basic coverage should be offered…more universal care, need healthy workers to be productive.
  - Catastrophic is necessary. Preventative would be worth doing but it can't be free…maybe a check up once a year could be free but there needs to be a co-pay for someone with a cold who wants to go to the doctor. Co-pay needs to be reasonable though.

Do you have any other thoughts or concerns generally about the coverage expansion effort?

- There should be a survey done of all employers on the effects that would happen if this were to go into place as mandatory to insure there are no unintended consequences such as would employers make different hiring decisions, office location decisions, expansion decisions, hiring practices, etc.

- Do we have a clear picture of exactly who needs this coverage and what they need and want and would use?
- This is the last link in the chain for taking away people's will to work. Free medical will bring more illegal immigrants.
- How do we get a good deal that can be spread to all businesses that would choose to join? Wants to make sure a plan would be cost effective for dependent coverage as well. Need to effectively deal with chronic illness and education of health issues.
- Part timers are used by employers to avoid having to cover for insurance by some businesses. Concern about any program's potential to "crowd out" i.e. encourage employers to dump their covered folks into a program. Need to look at affordable programs for non-profits countywide—This is a big issue in non-profit world.
- Some people make choices, which is why they don't have money for insurance, i.e. new versus used car etc.
- Don't put limits on the business like 6 or 10 because then the businesses won't grow and take that step. No growth or limiting growth is not good.
- Not economical at county level. No economies of scale. State is better but will need a big push and pressure to deliver.
- Should provide for uniform and universal health care to maximums achievable.
- Need to make sure there is no double dipping if federal or state government enacts something. Need to develop a way to get credits.
- Philosophically good to spread it out over population—not just employers—if employer only we would be opposed. We would not see this as fair.
- Don't like another layer of bureaucracy and not sure County can handle the administration well, overhead could end up being costly.
- Undocumented workers need to be covered and need to pay.
- What about those who fall through the cracks, concerned about seniors who are "house poor."
- Cost containment must be part of the discussion. Need to have insurance companies agree to make less money on administration—Insurance companies need to give up something.
- Needs to be Bay Area or statewide to really be successful and level the playing field to get full business support for this…won't work if it makes local San Mateo businesses less competitive in the region.

Do you think this is generally something your business/organization would support? Why/why not? What are your concerns? Anything you would like to add that we didn't cover?

- Most stakeholders thought they could be brought in to support some sort of plan if the economics could be worked out satisfactorily. Specific comments and concerns follow:

- No, does not support mandates. Challenge is, this is an admirable effort to look locally for solutions. This is a State and federal issue that is where it should be solved. San Francisco as a model doesn't translate to San Mateo.
- Yes. Labor is dealing with this issue at local, state and federal arena. Won't give up until it is solved.
- Healthcare is a big issue at bargaining table. Health crisis is everywhere. Some people go in and out of coverage need to deal with that. Occupational health and safety issues also something that needs to be covered prefers system that doesn't look at why but covers anything regardless of reason. It would be a shame if people didn't continue this effort and keep going. State issues could impact San Mateo need to monitor. "Labor is committed to making healthcare for all real."
- No. Clearly thinks this effort is laudable supports notion of coverage but County is not the right level to tackle this issue.
- Can't raise his rates to cover this increase if it were to happen due to fees his business can charge are standardized. This will remove the middle class. "This is the dumbest move I have seen yet."
- Philosophically likes the idea of County taking lead on this issue. How the economics shake out will make a big difference in how he feels about the proposal. If the economics can work out to have a small business that is paying can join the system and have the rates go down then there can be a way to build support and maybe capture some of the delta to help support the County. If it comes forward as a win-win and brings down the costs of healthcare as a benefit then he would be an enthusiastic supporter.
- We should look at mandatory catastrophic healthcare as a part of auto insurance—tied to drivers license.
- This issue is not a "business problem" but a "community problem". This is quality of life issue.
- Anything that impacts bottom lines won't be popular right now, need to think more long term, need to work for long term goal, Sacramento unlikely to come up with something.
- Not in a position to support this type of effort.
- Supports this as concept but thinks it is a state issue—issue for low income people—will end up a taxpayer issue. Will this issue be abandoned by the County if there are state and federal solutions? Need to ensure there is no double dipping and business being asked to pay at both levels.
- Organization would have to go through the Government Affairs committee but thinks they would likely support something at the end of the day.
- Supportive of this effort as a business owner and a community leader. Will be an advocate for something to happen on this issue.
- Yes, he could support the requirement to pay a fee into a fund.

- Yes his business could support it. At some point this issue has to get addressed or there will be major societal problems like a disease epidemic that could have been avoided if people went in for health care.
- Yes, would support effort.

Conclusions and Recommendations:

Conclusion: The stakeholders are divided on their support for the County taking on this issue. While almost everyone supports the "conversation" many are concerned about unintended consequences to businesses (especially small businesses) and the potential for new fees to drive business from the County. **Recommendation:**

1. Need to benchmark what (if anything) has happened to businesses in other areas where these fees are in place i.e. San Francisco.
2. Need to be clear if small businesses (defined by most as 4-5 employees) or low profit businesses (the restaurant industry was cited by many) will be treated differently.

Clarifying these issues could help with acceptance.

Conclusion: Most of the stakeholders prefer that the health care issue be addressed at the State or Federal level and question the ability of the County to really do something meaningful at the County level. Also, several stakeholders expressed concern about "double dipping/double paying" if something were to be enacted at the State or Federal level. **Recommendation:** Need to clarify how any local spending requirement would relate to any requirements put in place at another level of government.

Conclusion: The stakeholders embraced no preferred mechanism of payment. Several felt the half-cent sales tax would not be workable and "vowed to work against" this payment mechanism. Other stakeholders like the idea of spreading the contributions over more than just those who are working or employing people. **Recommendation**: Determine whether the sales tax is in fact "on the table" and if it is not then stop discussing it. Continue to look at other mechanisms (such as bonds or cigarette taxes) and define the specifics of collection, as there were a lot of questions about how a countywide fee could be collected through a city business licensing procedure.

Conclusion: Most stakeholders do like the idea of preventive health care being part of the coverage offered through a program expansion and almost universally the stakeholders articulated that they wanted to get people to stop using the emergency rooms for basic coverage. **Recommendation:** Benchmark how much taxpayer money could be saved by reducing the emergency room visits. Educating the employers and taxpayers of these savings could help acceptance of the program.

Conclusion: Several employer stakeholders lamented the cost of providing healthcare to employees and wished they could offer more and better coverage for a reasonable cost. **Recommendation:** Look at expanding the pool of who could be covered under the program to include small businesses and work the economics of the pool as a benefit of being in business in San Mateo County.

Prepared by: Eileen Goodwin, Apex Strategies
Distribution: Blue Ribbon Task Force Support Team

Attachment A: Form of Stakeholder Questions

San Mateo County – Health Care Blue Ribbon Task Force
Stakeholder interviews
Who:
How:
When:

1. The County has created a Blue Ribbon Task Force to look at health care reform for the County that would guarantee health coverage for all low income county residents. Are you aware of this effort? What is your general impression of this effort?
    a. Is it necessary? Why or why not?

2. The Task Force has adopted a principle of shared financial responsibility and is trying to find a way for employers to contribute.
    a. Do you have a preferred method of contribution?
    b. Do you think participation by employers should be required or voluntary?

3. What do you think about requiring employers to either provide health insurance or pay into a County fund that would then provide coverage for the low income uninsured?
    a. Do you think it is fair/right to set a minimum health coverage standard for all businesses?
    b. Should some businesses be exempt? Why? What type/size?

4. What do you think about some of the funding options presenting in the summary?
    a. A health care minimum spending requirement.
        i. Is 7.5% of each employee's wages reasonable?
    b. A health care minimum wage, or fee per hour worked for any uninsured employee
    c. An annual business health fee, in addition to the business license fee
    d. A countywide ½ cent sales tax
    e. Do you have other ideas or suggestions?

5. Do you have any thoughts or concerns about the type of coverage that would be available to low income workers?

6. Do you have any other thoughts or concerns generally about the coverage expansion effort?

7. Do you think this is generally something your business/organization would support? Why/why not? What are your concerns? Anything you would like to add that we didn't cover?

Attachment I: Modeling Employer Participation in Adult Health Care Coverage Expansion in San Mateo County

Modeling Employer Participation in Adult Health Care Coverage Expansion in San Mateo County

Ken Jacobs and Lucas Ronconi
UC Berkeley Center for Labor Research and Education

December 2007

For the San Mateo County Blue Ribbon Task Force

I. Introduction

The San Mateo County Blue Ribbon Task Force recommended coverage for uninsured adults below 400 percent of the federal poverty level (FPL) living in San Mateo, estimated at 36,000-44,000 individuals. The Task Force further recommended that the program be funded through shared responsibility between the public, individuals and employers. Public funds would come from a mix of new state revenues and redirection of existing revenues. Individuals would pay a share of cost on a sliding scale based on income. This report addresses options for employer participation and assesses the potential revenue that may be generated.

The health access expansion is taking place at a time of declining job-based coverage in the state and the nation. The share of individuals with employer sponsored coverage in California fell by five percent points between 2000 and 2006.[1] A policy of shared responsibility between the public, the participants and employers serves the dual function of raising revenue for the program and avoiding the creation of an incentive for employers with lower wage workforces to drop coverage once the new program becomes available.

Kronland and Leyton 2007 provided the Blue Ribbon Commission a detailed legal analysis of options for employer participation. We focus on models consistent with three of the policy optioned outlined in their report:

- payroll tax with a credit for health spending;
- mitigation fee and credit for health spending; and
- employer health spending requirement.

Each of these options would require action by other political bodies along with the San Mateo Board of Supervisors. A payroll tax would require a two-thirds vote of the electorate.[2] A fee would likely require authorization through state law. Such a fee would need to have a reasonable relationship to the "burden" the fee addresses or the "benefit" to the firms paying the fee.

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[1] Current Population Survey, March Supplement 2000-2006.

[2] There is some question about the Counties ability to levy a payroll tax on employers in incorporated areas of the County. Health and Safety Code Section 1445 conveys taxing authority to Counties to meet the obligations of Section 17000 of the Health and Safety Code. If the Task Force wishes to consider the option of a payroll tax or similar tax upon employers based on the authority conferred by Section 1445, the legal analysts recommend further research be conducted in this area.

An employer health spending requirement would set a minimum standard for employers on health care spending, in the same way that local governments may set a higher minimum wage. Employers are required to spend a minimum amount on health services for their employees, broadly defined. Since this uses the County's police powers, the County would have jurisdiction only over unincorporated areas. The requirement could be extended to incorporated areas through a Joint Powers Authority with each city that chose to be included.

Table 1: Summary of Policy Frameworks

Option	**Comment**
Payroll tax	Two-thirds vote of the electorate for dedicated tax. Authority to implement in unincorporated areas not definitive.
Mitigation fee	Authorization by state legislature; fee must have a reasonable relationship to "burden" or "benefit."
Minimum Health Spending Requirement	Joint Powers Authority approved by participating cities.

Employee Retirement Insurance Security Act (ERISA) preempts state and local laws that require the modification or adoption of employee benefit plans.[3] To avoid ERISA preemption Kronland and Leyton recommend that employers have an option for compliance that does not involve setting up their own ERISA plan or increasing their spending on an existing plan and that employers receive a sufficient benefit from that non-ERISA option such that it is a realistic one.

II. Population

The San Mateo County Blue Ribbon Task Force defined the target population as adults below 400 percent of the federal poverty level (FPL) living in San Mateo, estimated at 36,000-44,000 individuals.

Any program for employer participation will have to take into account the disjunction between where people live and work. The Blue Ribbon recommendation is to provide coverage to people who live in San Mateo County. In order to determine potential revenue and participation in the program, we must first estimate what share of the uninsured workers who live in San Mateo County also work in the County, and conversely, how many of the uninsured workers employed in San Mateo County live outside of the County.

Using the 2000 Census, we estimate that 71 percent of private sector employees who live in San Mateo County also work in the County, while 59 percent of private sector employees who work in the County are also residents (Table 2). Commuters to San Francisco and San Mateo County

[3] The San Francisco Health Care Security Ordinance has been challenged in U.S. district court by the Golden Gate Restaurant Association on federal preemption grounds. (say something more)

account for nearly one-third of those who live in the County and work outside, while commuters from those two counties account for one-quarter of those who live outside San Mateo and commute in.

Table 2: Distribution of Private Sector Employees with incomes below 400% FPL living or working in San Mateo by place of residence and work.

	Live in San Mateo, where do they work?	Work in San Mateo, where do they live?
San Mateo	60.9%	57.8%
San Francisco	18.4%	14.8%
Santa Clara	13.0%	10.2%
Alameda	3.6%	8.3%
Other	3.9%	8.9%
Total	100%	100%

Source: Census (2000), IPUMS 5% Sample, Weighted Estimates

According to the Quarterly Census of Employment and Wages, there were 306,000 private sector employees between 19 and 64 in San Mateo County in 2006. Using the California Health Interview Survey, we estimate that 40,000 of those workers do not have health insurance, 35,000 of whom are in families with incomes under 400% FPL. Using data from the table above, we estimate that 20,400 of those workers live in San Mateo County (Table 3). This is the population we use for our estimates.

Table 3: Uninsured San Mateo Employees by Business Size and Percent of FPL

Firm Size	Private Sector Employees	Uninsured	Uninsured below 400% FPL	Live and work in San Mateo
1 to 19	70,000	14,000	13,000	7,400
20 to 99	94,000	14,000	12,000	7,000
100+	142,000	12,000	10,000	6,000
Total	306,000	40,000	35,000	20,400

Source: EDD (2006), QCEW (2006), CHIS (2005), Census (2000).

III Modeling Assumptions

Each of the models presented below is premised on the assumption that employers are required to meet the minimum standard or contribute on all employees who:

- Earn less than $3,333 per month ($40,000 a year).
- Work eight or more hours a week.
- Are not eligible for Medi-Cal, Tri Care/Champus or Medicare.
- Are not receiving health care services through another employer.

Any employer requirement will need to be directed as closely as possible at the target group, in this case, workers under 400% of FPL. In order to protect worker's privacy and avoid the potential for discrimination (or perception of discrimination) in hiring, we recommend that any criteria for covered workers be based on earnings in that firm, not family income. Since the Federal Poverty Level is based on family income, the earnings level should be set to correspond as closely as possible with a family income of 400% of FPL.

Table 4 shows the distribution of uninsured private sector employees by salary and FPL. This information is useful to set the value at which wages would be capped on payment into the program. Employers would be required to contribute only for those uninsured workers earning below this maximum. Since employers' contribution depend on wages, while access to the Health Program depends on FPL, setting a cap on wages generates 'exclusion' and 'inclusion' errors: First, if the wage cap is set very high, then it is more likely that a large number of uninsured workers above 400% FPL would have contributions made on their behalf to the program ('inclusion error'). Second, if the wage rate is set very low, a large number of workers below 400% FPL are likely to be excluded ('exclusion error').

We find that if covered workers are defined as workers earning less than $40,000 a year, 2.8 percent of the workers under 400 percent of FPL would be excluded (1.1 percent below 250 percent FPL and 1.7 percent between 250 percent and 400 percent FPL), while 10 percent of the covered workers would be in families with incomes below 400 percent FPL, (Table 4). If the cap is lowered to $35,000 a year, an additional 3.2 percent of eligible workers are excluded, while the inclusion error drops by only 1 percent point to 9 percent of workers who are not eligible. For this reason, we use $40,000 as the cut off.

Table 4 – Distribution of Uninsured Private Sector Employees in California by Wage and Federal Poverty level (FPL)

Individual Annual Wage	Family Income below 250% FPL	Family Income between 250 and 400% FPL	Family income above 400% FPL	Total
above $40,000	**1.1%**	**1.7%**	7.7%	10.5%
$35,000 to $40,000	1.0%	2.2%	**1.0%**	4.1%
$30,000 to $35,000	2.3%	2.1%	**0.7%**	5.1%
$25,000 to $30,000	3.8%	2.9%	**1.9%**	8.6%
$20,000 to $25,000	8.4%	1.9%	**1.2%**	11.5%
less than $20,000	46.5%	8.5%	**5.2%**	60.1%
Total	63.0%	19.2%	17.7%	100.0%

Source: 2006 Current Population Survey

IV. Models for Employer Participation

In this section we provide revenue projections for three program options. Each of these options could be used equally with a payroll tax and credit for health spending, a mitigation fee, or a health care spending requirement.

Option 1: The San Francisco Model

- Large Employers of 100+ workers are required to spend 75% of the average County spending for single coverage prorated by hour ($1.76) per employee on health services;[4]
- Medium Employers of 20-99 workers are required to spend 50% of the average County spending for single coverage prorated by hour ($1.17) an hour on health services;
- Firms under 20 workers are exempt.

This option follows the requirements of the San Francisco Health Care Security Ordinance. Taking into account the exemption of small businesses with fewer than 20 employees, firms employing 13,000 of the 24,000 uninsured who live and work in San Mateo County would be covered under the policy. With full participation by employers and individuals, this option would generate $35 million a year for the program from employers (Table 5).

Table 5: Projected Revenue Option 1: San Francisco Model

Firm Size	Uninsured Below 400% FPL	Avg. Work Hours	Hourly Contribution	Annual Revenue
1 to 19	7,400	36.7	NA	0
20-99	7,000	37.3	$1.17	$15,600,000
100+	6,000	35.8	$1.76	$19,500,000
Total	20,400			$35,100,000

Source: EDD (2006), QCEW (2006), and CHIS (2005). Numbers may not add due to rounding.

Option 2: $1.25 per hour, no employer size exemption

- All firms required to spend 55% of the average county spending for single coverage prorated by hour ($1.25) per employee on health services.

This option mirrors the current hourly health spending requirement in the Quality Standards Program at the San Francisco International Airport, San Mateo County's largest employer. Option 2 applies to all firms, so would increase the number of employees potentially covered to the full 20,400, and the total revenue from employers to $47.8 million (Table 6).

Table 6: Projected Revenue for Option 2: $1.25 per hour all employers

Firm Size	Uninsured Below 400% FPL	Avg. Work Hours	Hourly Contribution	Annual Revenue
1 to 19	7,400	36.7	$1.25	$17,300,000
20-99	7,000	37.3	$1.25	$16,700,000
100+	6,000	35.8	$1.25	$13,800,000
Total	20,400			$47,800,000

Source: EDD (2006), QCEW (2006), and CHIS (2005). Numbers may not add due to rounding.

[4] According to the 2007 California Employer Benefits Survey, the average California firm providing health benefits currently covers 80 percent of the cost of individual premiums.

Option 3: 7.5% of payroll

- All firms required to spend a minimum of 7.5% of payroll per individual on health services

Using a percentage of payroll follows the methodology in the proposed state health care legislation. In this model, required health spending would be indexed to wages. Wages generally grow at a slower pace than health premiums. Total revenue from employers with full participation would be $26.8 million.

Table 7: Projected Revenue Option 3: 7.5% per hour, all employers

Firm Size	Uninsured Below 400% FPL	Avg. Monthly Salary	Annual Revenue
1 to 19	7,400	$1,450	$9,600,000
20-99	7,000	$1,502	$9,500,000
100+	6,000	$1,410	$7,700,000
Total	20,400		$26,800,000

Source: EDD (2006), QCEW (2006), and CHIS (2005). Numbers may not add due to rounding.

V. Other Revenue Sources

Additional sources of revenue would include individual payments and potential collaborative agreements with surrounding Counties.

Collaborations with Other Counties

San Francisco's current policy is to provide Health Reimbursement Accounts for workers who do not live in the County and are not eligible for the local program. San Mateo could seek a reciprocity agreement with San Francisco so that funds collected from employers would be transferred to the county of residence and workers would be eligible to enroll in the health program of their county of residence at the discounted rate. As shown in Table 2, 18% of working San Mateo residents in families under 400 percent FPL work in San Francisco. With full participation by San Francisco employers, this would result in $9.6 million in additional annual revenue for the County program.

Individual Contributions

For this analysis we assume that individuals whose employers pay into the program receive a 75% discount on the individual fee. We assume individual fees on the following schedule:

Table 8: Individual Contribution Rate

Family Income as a Percent of the Federal Poverty Level	Quarterly Contribution	
	Full	Discounted
0-100%	$ 0	0
101-200%	$ 60	$ 15
201-300%	$150	$37.5
301-400%	$300	$ 75

Table 9 shows expected employee contributions to the fund from uninsured private sector employees who are below 400 percent FPL, live in San Mateo and work in either San Mateo or San Francisco.

Table 9: Employee Contributions

FPL	Contribution with 75% discount ($/quarter)	Number of discount eligible uninsured workers	Annual Revenues
0-100	0	7,000	0
101-200	$15	11,000	$ 700,000
201-300	$37.5	5,000	$ 700,000
301-400	$75	3,000	$ 800,000
Total		26,000	$2,200,000

Note: Assumes full employer participation. Numbers may not add up due to rounding.

Table 10 provides an estimate of contributions to the fund from uninsured people who are below 400 percent FPL, live in San Mateo, and do not work for an employer that would contribute to the program, and are therefore not eligible for the discounted rate.

Table 10 Individual Contributions

FPL	Contribution ($/quarter)	No. people	Annual Revenues
0-100	$ 0	4,000	0
101-200	$ 60	5,000	$1,300,000
201-300	$150	2,000	$1,400,000
301-400	$300	2,000	$1,800,000
Total		13,000	$4,500,000

Note: Assumes full participation. Numbers may not add up due to rounding.

If businesses with fewer than 20 employees are excluded from the employer requirement as in option 1, then the number of workers eligible for the discount falls and those who pay in full rises. The total collected from individuals would rise to $9.2 million, compared to $6.7 million for options 2 and 3 (Table 8).

Summary Revenue Projections

The models we analyzed have the potential to bring in between $43 and $64 million a year into the Adult Health Care Expansion Program (Table 12). Given the commute patterns of County residents and workers, joint agreements with adjacent Counties would increase program viability.

Table 12: Comparison of Total Annual Revenues by option (in millions)

	Model 1: San Francisco	Model 2: $1.25 an hour	Model 3: 7.5% payroll
Employer	35.1	47.8	26.8
Individual	9.2	6.7	6.7
Other Counties	9.6	9.6	9.6
Total	53.9	64.1	43.1

Source: EDD (2006), QCEW (2006), and CHIS (2005).

VI. Final Considerations

Program Participation

The projections are based on full enrollment. To the degree that employers and individuals chose not to participate in the program both the revenues and expenses would be lower than projected.

Crowd-out of Employer Coverage

The estimates presented do not take into account crowd-out—employers and employees dropping private coverage and shifting to the County Health Program. We find that of the 95,000 private sector employees who live and work in San Mateo County and have incomes under 400% FPL an estimated 55,000 have health coverage on the job.

An employer spending requirement would significantly reduce the incentive for employers to drop coverage, while providing a low-cost health care option for firms that do not currently provide coverage to their workers. It would also serve to stabilize job-based health coverage in the County at a time when the share of workers with job-based health insurance has fallen 5.2 percentage points in the State since 2007.[5] We are not able to assess how the different options would effect crowd-out. In general, the more the health spending requirement matches current spending, the less likely employers are to drop coverage. In California, the average employer

[5] Current Population Survey, March Supplement

spends close to 8% of payroll on health care and 11.2% on those workers who have job-based coverage.[6]

Changes in Employment Practices

The estimates also assume that San Mateo employers will not measurably alter employment practices in response to the spending requirement. We anticipate an impact on business costs equivalent to a similarly sized increase in the minimum wage. Research on state and local minimum wage increases has found no measurable impact on employment from similarly sized increases. Employer offer is lowest in non-mobile industries, such as retail, construction and hospitality.[7] San Mateo's neighbor to the north, San Francisco, already has a similar requirement, which further reduces the risk of business relocation.

Health Cost Increases

The long term viability of any program will depend on how well revenues keep up with program costs. Option 3 would effectively index the employer requirement to wage inflation. Health inflation has significantly exceeded wage inflation over the last decade.[8] The San Francisco legislation indexes the employer share to the average spending by the ten largest California Counties on single coverage, and so more closely tracks health care costs.

[6] Graham-Squire, Dave, Ken Jacobs and Arindrajit Dube, California Healthcare: Firm Spending and Worker Coverage, UC Berkeley Center for Labor Research and Education, Policy Brief, March 2007, http://laborcenter.berkeley.edu/healthcare/firm_spending07.pdf.
[7] California Health Interview Survey 2005
[8] Robert Wood Johnson Foundation's State Coverage Initiatives, September, 2006

Attachment J: Assessment of Strategic Priorities for San Mateo Health Services

HMA

HEALTH MANAGEMENT ASSOCIATES

Assessment of Strategic Priorities for San Mateo Health Services

Executive Summary

JANUARY 2, 2008

Research and Consulting in the Fields of Health and Human Services Policy, Health Economics and Finance, Program Evaluation, Data Analysis, and Health System Restructuring

AUSTIN, TEXAS • CHICAGO, ILLINOIS • COLUMBUS, OHIO • INDIANAPOLIS, INDIANA • LANSING, MICHIGAN
SACRAMENTO, CALIFORNIA • SOUTHERN CALIFORNIA • TALLAHASSEE, FLORIDA • WASHINGTON, D.C.

Executive Summary

Over the course of the past four months, HMA has reached the following conclusions about the health care priorities for San Mateo County. These conclusions, generated after extensive interviews, clinical observation, data analysis and comparison to similar systems across the state and the nation, are grouped into "findings" and recommendations" as outlined below and are discussed at greater length within the full report.

The Broader Community: Findings

- There is clear under-service for vulnerable populations in communities within San Mateo County and the County will need to continue a role in both providing and coordinating care.
- The San Mateo County subsidy is significant and will continue to rise in the absence of significant restructuring.
- The private health care provider community is actively competing for the commercially-insured patient market and, thus, such an emphasis for the County system is a waste of effort.
- The response of private providers to Medi-Cal reimbursement indicates that the issue is not only "coverage" but must also be delivery system reform.
- The Blue Ribbon Task Force has brought the key players to the table but must now move into a focus on delivery system.
- The corporatization of providers makes the strategies for restructuring the delivery system more problematic.
- There is a lack of certain health care services, even for the insured.
- Mixed messages about the focus and mission of the County's health system are apparent.
- There is a relatively small and predictable medically underserved population.
- There are smart and committed people in leadership positions.
- The County currently has strategically-placed and comprehensive health services upon which to build an integrated (and managed) approach to care.
- Private providers are willing to come to the table to participate in creating an equitable and sustainable delivery system for the underserved.
- There exists support from the governing body and general public for the County's health leadership.

The Broader Community: Recommendations

- **The County should acknowledge that maintaining the status quo is not a viable option.** Health care costs will continue to rise. The number of those without health insurance—or those "covered" individuals who still cannot gain access to care—will continue to increase. If something drastic is not done to reconfigure the delivery of care, the County will have few options: curtail the number of people eligible to get care; limit the scope of services supported by the County; get out of the business altogether; or continue to put more money into the health system every year and limit the dollars that can be allocated for other services. Assuming the final option is unlikely and the others available can only hurt those with little or no access to care, the County should look seriously at how most effectively to restructure its resources to meet its mission.
- **The County should continue to stay in the business of delivering care, but do it more effectively and efficiently and as a part of an integrated system of care with other providers.** Examples across the country abound in which local governments pulled out of the direct delivery of care, lost their leverage for increased reimbursement, took on mounting costs for indigent patients served in other institutions and found themselves unable to meet the growing burden. More creative solutions have involved developing delivery systems with other providers in which duplication of service was minimized and high utilizing and expensive patient populations were effectively managed, and which built upon the assets and expertise of partners. This is a more difficult approach, but the only sustainable one.
- **The County should become more aggressive at restructuring its own health services and policies to achieve new levels of efficiencies.** There are operational, policy and structural changes that can and must be made to assure that the County's own operations are functioning effectively and efficiently. HMA believes the County will need to continue to remain as a key component of the health care safety net for the broader community and needs to be administratively, financially and clinically sound. These improvements need to be addressed within the delivery system, among the elements of the County's health care service areas and related to the role of the government itself.
- **The County should take the lead in fashioning a new, sustainable and creative approach to health care delivery.** All of the elements are in place—both within the County's own resources and including those of the private sector—to pull together a rational system of health care services for all residents of San Mateo County who need it. The County needs to: clearly identify the population that needs to be "assured" care, identify the scope of services that are needed for the target population, and develop/negotiate a health care network that makes use of the County's own delivery system and programs as well as brings commitment from the private sector providers. It is the County's responsibility—and in its

best interest—to look at using those resources to leverage a rational delivery system. This is a role that the County has started in its efforts with the Blue Ribbon Task Force and now needs to be continued to draw on all resources to establish a new way of delivering care.

- **As much as possible, the County should coordinate all available sources of funding and leverage them to support one multi-dimensional approach to the delivery of effective health care services for vulnerable populations within San Mateo County.** Astute financial evaluation should be part of the creation of a delivery system made up of both public and private partners. The County should define its subsidy—both current and future—and every attempt should be made to maximize the State and federal contributions to the care of these populations. Further, there should be an exploration of the redirection of funding generated by the two health care districts within the County to assure maximum coordination with the broader effort to establish an effective health care safety net for medically fragile populations and communities.

The County's Health Care Role: Findings

- The County has both committed and smart leaders in all areas who are willing to better coordinate between the different "silos" of County health care interests to "raise all boats."
- The coordination of the three areas of health service activity in the County is not institutionalized; there is not a clear expectation for joint planning around common objectives.
- Policies and practices are sometimes implemented that are not beneficial to either the individual institutions within the County or to access to health care services for those patients the County is targeting to serve.
- Data is not readily available across the County's programs and institutions that would help coordinate both an understanding of issues and a determination of best responses.
- The County often projects mixed messages about its role in and commitment to health care access causing some confusion in the larger community.

The County's Health Care Role: Recommendations

- **The County should publicly clarify its role as it relates to health services.** All County officials and institutional leadership should understand and publicly support the County priorities and mission.
- **A County-wide Strategic Plan should be generated.** This plan should identify operational, financial, clinical, utilization, health status, and organizational priorities and benchmarks. It should designate areas of responsibility and call for

regular reporting on progress or on identification of problems. It should be approved by the Board of Supervisors and be overseen by the County Manager. Health care is constantly fluctuating and the County can't afford to not be on top of those fluctuations.

- **The County Manager should require the leadership of SMMC, the health department and the HPSM to meet on a weekly basis and to meet the objectives laid out in the Strategic Health Care Plan.** The three leaders should identify priority issues, develop collaborative responses, and report back monthly to the County Manager, who should play the primary role of coordinating both the health care activity within the County's facilities and any efforts to build a more comprehensive system.
- **The County should review its financial oversight to assure that the review is not done in silos but, rather, reflects the financial commitment, revenue strategies and use of resources of the County as a whole.** Decisions in one area may result in seemingly better financial outcomes, while those same decisions may have significantly adverse repercussions in another area. This coalescing will require improved data collection and staff attention, but is critical to making policy and service allocation determinations that make sense system-wide.
- **The County should assure consistency in Board oversight of health activities.** Different County Supervisors are involved in different aspects of health care services within the County (the SMMC, the HPSM, the Blue Ribbon Task Force, etc.). There should be an attempt to coordinate those efforts as much as possible, particularly as they relate to the overall County strategic health plan.
- **The County should look at organizational changes that would allow for greater flexibility for its health care managers while retaining necessary accountability.** The County should explore procedural fixes that could allow for more timely hiring, for redrafting (and consolidating) job descriptions to gain efficiencies, etc. These changes should be accomplished within clear guidelines for demonstrating budget neutrality or savings. The ability to quickly respond to the changing needs of the health system, however, should allow for a more efficiently run operation.

SMMC Medical Services: Findings

- The primary care network of clinics is the backbone of the safety net in San Mateo County.
- The community-based clinics are well located and staffed with well qualified personnel.
- Productivity and better use of space capacity is possible within the primary care clinics.
- Chronic Disease Management planning and programs have begun but still

remains a marginal strategy.

- Specialty care at SMMC has a wide scope but its depth is shallow compared to need.
- Access to specialty care is limited and difficult, and referral methods are inefficient.
- The organization of specialty care services is rather fragmented and lacks medical leadership from SMMC.
- Current specialty contracting may not provide the highest value to SMMC and its patients.
- The Emergency Department is busy for the size of the hospital, but serves many low acuity patients and functions as a screening site for admissions from primary care and a way of accessing urgent specialty consultation.
- Inpatient acute care has a low census and a low occupancy rate, yet has patients in beds awaiting placement.
- The organization of inpatient acute care at the provider's level is determined by the contracted medical staff, and the mix of specialists who provide hospitalist services reflects group and individual interests.
- Primary care, specialty care, Emergency Department, and inpatient acute care represent relatively separate entities within SMMC and are disjointed from each other as they are from psychiatry and long-term care.

SMMC Medical Services: Recommendations

- **SMMC ambulatory services, both primary and specialty (along with psychiatry and long-term care), should be a critical part of a broader network of care for underserved patients in San Mateo County.** This network should be organized by the County, but it should include contributions of care from other private and community-based providers. The medical services of SMMC should be included as a key element and leader within the network. However, the scope of SMMC medical services and operations will have to change and improve.
- **Financial considerations dictate the continuation of inpatient acute care**; however, the size, volume and scope should be determined through the broader planning process with other providers in San Mateo County.
- **The SMMC medical services (ambulatory, ED, inpatient, psych and LTC) should be prioritized and coordinated around a chronic disease management approach** as the central focus. These efforts should be an organizational priority and funded on "hard money." The plan to create the Radical Redesign Clinic for disease management should allow for rapid deployment throughout the ambulatory system.

- **A method should be devised to identify patients with chronic medical illness**, who present within the system, or are underserved, and they should be recruited into chronic disease management programs.
- **Efforts to increase primary care and specialty care productivity and maxime capacity should be continued and increased until benchmarks are met**. Decreasing the number of part-time physicians and the variability of hours worked should be a goal of SMMC medical administration. New benchmarks, more appropriate for disease management, should be chosen or devised and adopted.
- **The demand for specialty care access necessary for the underserved population in San Mateo County should be determined**. This can serve the organization of a broader network of care within the County and should be accomplished regardless of external grant funding availability, and with other stakeholders at the table. SMMC is likely to play a major role in providing specialty care to the underserved, but should not assume this role alone.
- **Specialty care should be reorganized around chronic disease management**. This should include communication with and training of primary care providers, a refocus of specialists' time, and a new system of prioritizing referrals that is efficient and improves appropriate access.
- **Aggressive efforts should be made to attract and retain pediatric and geriatric patients in the ambulatory system** in coordination with the Health Department and the Health Plan.
- **Medical leadership for specialty care and inpatient acute care should be designated** within the SMMC organizational structure that has the responsibility for defining scope and productivity of medical practice. This leadership should set medical policy in collaboration with the medical departments and divisions.
- **The current practice of contracting with physicians should be significantly redesigned**. SMMC should consider the employment of specialists or a relationship with a large physician group to provide positions and/or coverage.
- **Remove unnecessary obstacles to receiving care at SMMC**, either at the outpatient clinics (i.e., phone access, referral systems or financial policies) or for inpatient admissions (i.e., implement direct admission policies).
- **A Chief Medical Officer (CMO) position for SMMC should be created** to provide strong and accountable medical leadership at SMMC that cuts across and coordinates all care provided within the system. The different clinical departments should meet regularly, share a common strategic plan, and understand their role and the roles of other departments.
- **Integrate medical services into efforts to better address moving patients into lower levels of care.** This would allow more efficient discharge from inpatient acute care and psychiatry. The primary care physician should be part of a team

that supports home and community-based long-term care as well.

Psychiatric and Long-Term Care (LTC) Services: Findings

- A lack of sufficient numbers and types of alternative placements are creating bottlenecks throughout the system and are the major driver of non-paid and paid administrative days.
- Other contributors to administrative days appear to be documentation gaps in inpatient psychiatric services and delays and conflicts around discharge status and discharge planning.
- There are major information gaps that prevent accurate analysis of "social admissions" and administrative days for both psych and med/surg patients.
- There is no high level administrative leader for inpatient psychiatric services.
- The current system has high quality people and a significant commitment to psychiatric and LTC services, but the various levels of care (community-based and institutional) are fragmented.
- Burlingame could be a more significant provider of care for patients with behavioral problems if there was intensive training and ongoing support of staff.
- Burlingame has significant physical plant constraints that reduce the County's ability to serve persons with more complex needs, especially for persons with physical/medical/behavioral complexities.
- San Mateo County appears to have a shortage of LTC beds relative to need.

Psychiatric and Long Term Care Services: Recommendations

- **Comprehensively Assess the Future LTC Service Needs of the County and the County's Role in Meeting These Needs.** Assess the ideal configuration of long-term care options including SNF, assisted living, housing with on-site supports, support at home and specialized models of care (for gero-psych, dementia, TBI, etc.); map out current availability (public and private); determine the scope of the County's responsibility for long-term care; and determine the most feasible model for the County long-term care continuum consistent with the County's mission.
- **Consider conducting a feasibility study regarding the future of the Burlingame facility**. A feasibility study is likely needed to determine how much more money the County should invest in this facility versus the cost to buy or build a better facility. The study should include varying models of care (dementia, gero-psych – although not so large as to present a danger of IMD designation), assisted living and so on. The County should consider whether any patch payments would be eliminated (or future need for same reduced) with access to a newer "multipurpose" facility. The need to continue SNF beds at SMMC, or alternately

to provide additional SNF beds at SMMC (1A), should also be addressed as part of a feasibility study.

- **Implement one or more initiatives to address fragmentation of care and funding silos.** Potential initiatives include:
  - *Develop a County LTC budget* (probably specific to adults, but it could include children). Long-term care not only includes Unit 1A and Burlingame and persons in need of long-term supports presenting at Psychiatric Emergency Services (PES) and/or admitted to the psych unit, but also encompasses long-term care services funded through Aging and Adult Services and Mental Health Services. Only then, can the true cost of patching placements and other measures versus retaining patients at SMMC and Burlingame LTC, be assessed.
  - *Implement a comprehensive care management/coordination program* that provides a unified, multidisciplinary team or single case manager/care coordinator for each patient who then follows the patient across divisions and programs. This program could target specific types of patients.
  - *Implement the Long-term Services and Support Project* (*LTSSP) in as comprehensive a manner as possible, inclusive of mental health services.* The LTSSP offers an integrated model of care that is especially suited to the County, since the County already assumes comprehensive responsibility for Medi-Cal and uninsured County residents and has an existing structure (the HPSM) to deliver coordinated care.
- **Establish and fill a Vice President of Behavioral Health Services position and a Vice President of Skilled Nursing Facility Services position as soon as possible.** The complexity of issues to be dealt with specific to both inpatient psychiatric services and SNF services is such that a high level administrator is required to address issues within their respective service areas and across the entire County continuum of care.
- **Implement an initiative to improve documentation of need for and provision of acute inpatient psychiatric services, using an "unbiased" resource to coordinate and implement.** DMH findings are of sufficient concern to warrant a targeted documentation improvement initiative. By necessity, such an initiative would also include a review of the inpatient psychiatric services model of care and quality of care.
- **Collect data on each "social admit" and patient not in acute status (psych, med/surg, LTC) in order to assess the most appropriate use of resources for other levels and models of care.** This information should be collected systematically in order to identify the needed placements options, the need for patch payments, the utility of a potential step-down unit at SMMC, and the need

for additional long-term care beds and specialized programs (such as dementia and gero-psych).

- **Review and revise the Memorandum of Understanding (MOU) between SMMC and Behavioral Health and Recovery Services to incorporate enhanced reporting requirements and to address what are reported to be poorly aligned financial incentives.** Revised reporting requirements should include detailed tracking of acute and admin days. The MOU should include a revised financial arrangement that better aligns incentives and terminology that is consistent with state and federal regulations and consistent throughout the MOU and across County divisions.
- **Review the current SMMC admission and discharge planning processes across service areas and divisions/programs.** The LTC Admission Criteria should be specific and reflect actual practice. SMMC, MHS and Aging & Adult Services should determine what, if any, changes could be made to speed-up documentation of the appropriate least restrictive placements.
- **Provide additional training to Burlingame staff.** Burlingame LTC staff need additional training to accommodate patients with more challenging behaviors. They also need ongoing assistance/consultation from psychologists regarding behavior planning and approaches. Depending on the needs of such residents, an increase in staffing might also be required.
- **Assess out-of-county placements.** A review of the extent to which these admissions result in an inability to admit San Mateo County residents to SMMC or Burlingame LTC or transfer residents within SMMC and Burlingame LTC, should be quantified. The County should attempt to determine how many San Mateo County residents have become the responsibility of other counties. Once this information is quantified and assessed, the County may want to pursue a MOU with surrounding counties regarding their mutual interests, responsibilities and liabilities.
- **There are enough concerns about the impact of the potential MPHS/SMMC partnership proposal that indicate that more thought should be given to it before it proceeds.** Do not pursue the currently proposed options for an arrangement with Mills Peninsula Healthcare that would threaten to convert SMMC to IMD status or take up SMMC beds until a broader delivery system plan is developed that clearly sets out service requirements for all participating providers.

The Health Plan of San Mateo: Findings

- The HPSM could expand its role within the administration of the County health services.

- The Healthcare Coverage Initiative could be an important vehicle for managing some of the system's most complex patients.
- HPSM administration and operations need to be enhanced to meet the demands, particularly in care management, of the entire delivery system.
- HPSM has demonstrated its ability to successfully diversify and to keep pace administratively with both membership and product line growth.
- Provider access and capacity, both within and outside the contracted network, is an ongoing concern.
- HPSM has not built its CareAdvantage program to the full extent that it could and should.

The Health Plan of San Mateo: Recommendations

- **HPSM should take an even stronger role within County health services, particularly in long-term care services.** HPSM leadership's vision for the health plan includes prominence in the administration of the County's expanding health coverage programs. For example, the health plan is very interested in pursuing the Long-term Services and Support Project (LTSSP) in partnership with the County.
- **HPSM should work closely with SMMC in the administration of the Coverage Initiative.** The health plan appears to be well positioned to play a primary role in the administration of the coverage initiative. HPSM's systems and processes are scalable and can accommodate the projected volume growth.
- **Growing the CareAdvantage program should be a priority.** As one of two special needs plans in San Mateo County, the potential for growth is there. HPSM has relied on passive enrollment for its membership, and has not yet developed a formal marketing plan to promote its benefit design and attract members, or to retain current members.
- **Significant attention should be paid to operational issues within HPSM, particularly in the area of data.** An important emphasis should be placed on the efficiency and accuracy of HPSM's collection and reporting of CareAdvantage members' diagnoses (i.e., risk adjustment factors). It is critical for HPSM to educate its providers on the importance of accurate coding. Reimbursement under Medicare Advantage is now based entirely on risk adjustment factors for individual members. Current analysis of data across the country indicates that the general "rule of thumb" is that $80-$120 per member per month is "left on the table" due to coding errors.
- **The development of an institutional SNP should be explored if/when the moratorium on new SNPs is lifted.** An area worthy of additional analysis for HPSM's Medicare line of business is expansion to an institutional SNP. Both the

County and HPSM are interested in long term care and an institutional SNP could improve care coordination and reimbursement.

- **HPSM should aggressively develop care management capabilities, in connection with both the SMMC efforts and as a part of the development of a broader delivery system for medically fragile people**. Health plan leadership acknowledged the opportunities that exist regarding care management for its members.
- **HPSM should coordinate with other County programs to assure consistency and streamline bureaucracy**. Among the areas of consideration for operational efficiencies county-wide include enrollment and eligibility determination functions, as well as decision support capabilities. The lines of responsibility are at times blurred between the County and HPSM. Examples include the WELL program. The plan's IT and decision support capabilities are quite sophisticated, and are continuing to advance. The health plan is scheduled to replace its claims system and install a medical management system. Opportunities to "share" these resources and staff expertise with SMMC to assist with decision support and analysis (an area of weakness as identified by SMMC financial staff) should be assessed.
- **HPSM should play a pivotal role in defining health care provider needs and gaps**. In recognition of the varying provider participation issues throughout the County, HPSM is urged to monitor the success of its recently implemented PCP incentives. In addition, network inadequacies should be addressed and a broader delivery system plan established which would include current access issues in some parts of the County (e.g., southern portion) and to certain specialties.
- **HPSM should seek accreditation**. As HPSM continues to diversify and increase membership, HPSM leadership are encouraged to consider seeking NCQA accreditation in anticipation of future state or CMS requirements for participation in Medi-Cal or Medicare Advantage. HMA acknowledges the staff and financial costs associated with the preparation required to develop and submit an application and ready the plan for URAC accreditation are high, and that the time for seeking the accreditation is more likely in the future. However, the importance of accreditation should not be completely lost to other demands and priorities.

Health Financing: Findings

- System losses are widespread among service lines.
- Base payments for Med-Cal services do not cover costs in the SMMC system.
- Medicare payment does not cover the costs of serving Medicare patients within the SMMC system.

- Absent any significant changes, the County subsidy will continue to grow and will approach or exceed $80 million by FY 2011.
- The local government subsidy in San Mateo is one of the highest in the nation.
- The FQHC designation for SMMC clinics cannot be extended to new sites without a change in their configuration.
- Despite FQHC limitations, there are ways to increase revenue generation in the SMMC clinics.
- Medi-Cal designation of the clinics as hospital-based is contingent upon maintaining the acute care unit.
- Currently, SMMC does not pursue enhanced Medicare reimbursement for services provided in the clinics.
- Under current constraints, SMMC loses money on long-term care services at both SMMC and Burlingame.
- SMMC needs to avoid converting to IMD status.
- The County does not recoup its cost for delivering psychiatric services.
- There are overwhelming financial reasons for maintaining acute care hospital status for the SMMC.
- The financial implications of providing more acute care are difficult to assess.
- The Inter-Governmental Transfer (IGT) related to the HPSM is one area for potential new federal matching dollars.
- New federal Medicaid rules could have a significant impact on public hospital systems.
- Ongoing operational demands limit SMMC's ability to adequately evaluate all revenue maximization strategies (including psych and LTC) and potential health reform impacts on the County.
- State health reform efforts could have serious consequences (and opportunities) for San Mateo County.

Health Financing: Recommendations

- **Advocacy at the federal level to extend the moratorium on implementing the public hospital rules is an important priority for the County.** Under the current waiver, Medi-Cal reimbursement is configured to assure continued losses. From a public hospital perspective, California Health Care Reform must include an increase in State support for Medi-Cal payments to public hospitals. Federal regulations (current and pending) limit financing options available to the

County. The estimated impact in terms of lost federal dollars of this rule on California public hospitals is $500 million annually.

- **Financial objectives and goals should be set and evaluated from a county-wide perspective, with each manager of a program or operating entity striving to maximize the state or federal dollars spent on health care for County residents and minimizing County subsidy**. Financial impact is currently being measured in silos (SMMC, public health, HPSM). An assessment at a higher level may result in more positive financing arrangements for the County as a whole.
- **Acute care services must be maintained at a level to prevent SMMC from reaching IMD status.** Designation as an IMD has serious financial repercussions including the loss of Medi-Cal supplemental payments, conversion of long-term care rates to freestanding instead of hospital-based (enhanced nursing home rates and seeing the hospital-based FQHC rate drop from $300 per encounter to, at best, $125).
- **State level advocacy is needed to alleviate underfunding of LTC services.** The base rate for long-term care is inadequate to cover the costs of the Burlingame facility. The current reimbursement is optimized within existing state and federal policy. Therefore, the solution is to identify additional state funding opportunities.
- **Aggressive efforts should be made to increase pediatric outpatient visits at SMMC clinics**. The costs associated with children are less than the $300 per encounter rate and would generate income to offset the subsidy of other patients and services. SMMC and the health department should explore the provision of mental health services within the SMMC ambulatory clinics in order to access the FQHC rates for those services.
- **Opportunity exists to increase Medicaid HMO payments to public entities in order to guarantee access.** Payment from the State to HMOs can be financed with local dollars (IGT). Medicaid HMO rates are based on "actuarial soundness." The County should advocate expansion of the current arrangement that generates $10 million in additional payments ($5 million net). It may be cost beneficial for the County to engage an actuary to develop the appropriate rationale for optimizing these payments.
- **Additional reimbursement and financial analysis resources are needed to evaluate all revenue maximization strategies (including psych and LTC) and the potential impact of health reform on the County.** SMMC must be proactive, and not reactive, to Medi-Cal funding opportunities and to initiatives like Health Care Reform. With recent activity at both the State and federal levels, the complexity of these programs and the opportunities that exist are increasing dramatically. Further, the impact of various components cannot be calculated in isolation as the effect is often related to other components and initiatives.