Blue Ribbon Task Force on Adult Health Care Coverage Expansion

Preliminary Recommendations

July 24, 2007

TABLE OF CONTENTS

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 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." This 37-member Task Force, chaired by Supervisor Jerry Hill and Supervisor Adrienne Tissier, has met 7 times over the course of the past year. Collectively, members debated key considerations of coverage expansion, confronted the trade-offs of various health care models, shared financial responsibility, the financial constraints of coverage versus insurance, access and provider participation factors, and collectively came to preliminary recommendations emphasizing the shared responsibility and shared benefits of adult health care coverage expansion.

The Task Force conducted analysis and considered options for each component of coverage expansion in 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 order to inform their decisions, each Workgroup sought the expertise of experts from across the State, including foundation partners, academic researchers, policy analysts and colleagues from other cities and counties. For example, the Financing Mechanism Workgroup hired Milliman, Inc to conduct an actuarial analysis of the proposed health care model; and the Health Care Model Development Workgroup brought the Just Coverage Initiative to the table to assist in prioritizing a benefits package.

The Blue Ribbon Task Force on Adult Health Care Coverage Expansion Preliminary Recommendations provide a high-level framework for adult coverage expansion. In addition to these recommendations, the Task Force has identified several areas of continued analysis which will assist in adding further details to the preliminary recommendations. In order to consider the findings of this analysis, and develop final recommendations, the Task Force has agreed to reconvene for 1-2 meetings in the Fall.

II. PRELIMINARY 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 that provides access to health care within San Mateo County.
    c. The Blue Ribbon Task Force recommends that we explore an insurance product offered through the Health Plan of San Mateo (HPSM) targeting uninsured adults and employers of uninsured adults.
    d. The Blue Ribbon Task Force recommends phased enrollment in accordance with available resources.

2. ***Leveraged Financing and Consumer Protection:*** Local, State and Federal funding associated with care to uninsured adults should be maximized and coordinated as funding for services provided to clients enrolled in the Adult Coverage Program.
    a. The Blue Ribbon Task Force recommends that the Adult Coverage Program would be operated as coverage 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.
    c. The Blue Ribbon Task Force recommends that local consumer protection processes, including a robust appeals and independent review process, would be integrated into the coverage product operations.

3. ***Unified Administration:*** Health care services for uninsured adults would be provided through the Health Plan of San Mateo as a single third party administrator.
    a. Current County-sponsored programs serving uninsured adults below 400% include the WELL Program and the soon-to-be launched Coverage Initiative WELL Plus Program. The Blue Ribbon Task Force recommends that these would be consolidated into the Adult Coverage Program.
    b. Local providers play an important role in serving uninsured adults below 400% FPL through their safety net and charity care programs. The Blue Ribbon Task Force recommends that these contributions would be integrated into the Adult Coverage offering.

4. ***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 new coverage offerings would focus on reaching and enrolling individuals with complex chronic conditions or at risk of developing such conditions.
    d. The Blue Ribbon Task Force recommends that the delivery system would include participation of providers able to meet the contracting standards of the Health Plan of San Mateo.

5. ***New Revenue Generation and Shared Responsibility:*** Financing of the proposed Adult Coverage Program and the proposed HPSM insurance product offering would be the shared responsibility of individuals, employers, and the community at large.
    a. Analysis of data provided through 600 surveys of uninsured and low-income adults supports enrollees' willingness to contribute toward the cost of coverage. The Blue Ribbon Task Force recommends that enrollees pay between $0 - $100/month, depending on income, as an individual contribution to coverage.
    b. The Blue Ribbon Task Force recommends that new financing mechanisms involving employers and the community be fully explored.

6. ***Delivery System Capacity:*** Coverage expansion would require appropriate delivery system capacity.
    a. The Blue Ribbon Task Force recommends the completion of a provider capacity analysis that would detail existing and likely available capacity represented by providers willing to participate in the new Adult Coverage program and HPSM insurance product offering. This analysis should consider reimbursement mechanisms that could alleviate capacity constraints.
    b. The Blue Ribbon Task Force recommends that the County consider the optimal configuration of the public safety net system as a key contribution to the delivery system available to serve individuals through the new Adult Coverage program and HPSM insurance product offering.

III. Implementation Timeline and Next Steps for Unanswered Questions/Remaining Factors

Blue Ribbon Task Force on Adult Health Care Coverage Expansion -- June 2007
Next Steps (July -March) Timeline

Preliminary Task Force Recommendations to Board of Supervisors
Coverage Initiative Implementation Requirements to Board of Supervisors
Coverage Initiative Funding Starts
Enrollment in Complex-Chronic Care Model Starts
Final Task Force Recommendations to Board of Supervisors

Objective	Acitivity	June	July	August	September	October	November	December	January	February	March
		Model Pilot Phase (Coverage Initiative)					Current Eligibles Integration Phase				
		Final Recommendation Development Phase									
Task Force Activities	Presentation of Preliminary Recommendations to Board of Supervisors										
Completion of Task Force Recommendations	Presentation of findings at additional Task Force Meetings										
	Final Task Force Recommendations to Board of Supervisors										
	Development communications plan for community dissemination										
Employer Participation	Finalize Health Plan of San Mateo product feasibility analysis										
Determine opportunities for employer participation in coverage expansion	Explore potential for subsidization of new insurance product										
	Hire and retain independent market research firm for employer survey/focus groups										
	Explore legality of options for employer contribution and participation										
	Conduct employer focus groups/small group discussions										
	Explore impact of potential participation mechanisms on business environment										
Private Provider Participation	Consider patients/clients able to be served as well as dollars/services able to be contributed										
Define private providers' contributions to Adult Coverage Program	Explore limits on units of service and/or limits on funding provided for some types of services within the proposed scope of benefits										
Capacity Considerations	Research, including the number, type (e.g,. by specialty, by geographic location), and expertise of existing providers										
Confront capacity considerations	Conduct informative interviews/small group discussion with free-clinic providers										
	Determine sufficiency of a new provider network to meet population demands										
Additional Revenue Generation	Explore options for legislative changes, including increasing/changing the authority of a county entity with regards to mandates and taxation										
Explore mechanisms for broad revenue generation	Conduct willingness and ability to participate analysis with local employers										
	Explore feasibility and legality of implementing a sales Tax; changing and/or expansion of Health Care Districts; licensing fee increase										
Third Party Administration Implementation	Define risk-sharing and liability for 200-400% FPL population										
Prepare Policies and Procedures for Third Party Administration	Explore most viable reimbursement methods to create appropriate care management incentives										
	Quantify upfront investment needed to fully leverage technology and deliver the access/care coordination required for success										
	Transition current WELL members and future WELL members to Third Party Administrator										
	Determine tracking to maximize State reimbursement										
Coverage Initiative	Create Coverage Initiative Steering Committee										
Create Planning and Implementation Infrastructure for Coverage Initiative (WELL Plus) Pilot	Create topic area subcommittees for public systems preparation: Human Resources, Speciality Care and Contracts, Space and Capacity, Finance Claiming and Accounting										
	Enrollment of WELL Plus eligibles as aligned with Coverage Initiative population										
	Create topic area subcommittees for system integration and preparation for expansion: Project Management, Enrollment Eligibility and Outreach, Access Appointments and Scheduling, Data Collection and Evaluation, Radical Redesign Care Model, Supplemental Foundation Funding										
Program Implementation Infrastructure	Establish oversight structure and membership										
Create Adult Coverage Program Oversight and Evaluation Structure	Establish subcommittees required for implementation and define duration of charge										
	Establish marketing, outreach and enrollment mechanisms										
	Ongoing enrollment of eligible adults										

Attachment A: Task Force and Workgroup Rosters

I. Blue Ribbon Task Force on Adult Health Care Coverage Expansion Roster

Organization	Representative[1]
Board of Supervisors – Supervisor Adrienne Tissier, Chair	
Board of Supervisors – Supervisor Jerry Hill, Chair	
Burlingame City Council	Ann Keighran
Central Labor Council	Shelley Kessler
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
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

[1] The representatives listed are the official designee of the associated organization holding 1-2 seats on the Task Force. Each representative listed here participated in at least one of the Task Force Meetings. Additional organizations with Task Force seats, but not attending scheduled meetings included: City of Half Moon Bay; City of Menlo Park; City of Daly City.

II. Population Definition Workgroup Roster*

Workgroup Chair: Glen H. Brooks, Jr., Director, San Mateo County Human Services Agency

Legal Aid Society of San Mateo County
Mills-Peninsula Health Services
Peninsula Interfaith Action
San Mateo County Central Labor Council
San Mateo County Health Department
San Mateo County Human Services Agency
San Mateo Medical Center

III. Health Care Model Development Workgroup Roster*

Workgroup Chair: Luisa Buada, CEO, Ravenswood Family Health Center

Burlingame City Council
Community Members
Kaiser Permanente
Legal Aid Society of San Mateo County
Mills-Peninsula Health Services
Palo Alto Medical Foundation
Peninsula Health Care District
Peninsula Interfaith Action
Ravenswood Family Health Center
Samaritan House
San Mateo County Central Labor Council
San Mateo County Health Department
San Mateo County Medical Association
San Mateo Medical Center
Sequoia Hospital
Seton Medical Center
The California Endowment

IV. Financing Mechanism Workgroup Roster*

Workgroup Chair, Ron Robinson, CFO, Health Plan of San Mateo

ACORN
City of San Mateo
Community Members
County Managers Office
Health Plan of San Mateo
Kaiser Permanente
Legal Aid Society of San Mateo County
Mills-Peninsula Health Services
Palo Alto Medical Foundation
Peninsula Health Care District
Peninsula Interfaith Action
Redwood City Chamber of Commerce
Samaritan House
San Mateo County Central Labor Council
San Mateo County Health Department
San Mateo County Medical Association
San Mateo Medical Center
Sequoia Health Care District
Seton Medical Center
Silicon Valley Community Foundation
United Way of the Bay area
West Bay Financial Services

* The Workgroups were supported through participation by and funding from The California Endowment; The California HealthCare Foundation, Blue Shield Foundation of California.

Attachment B: Population Report

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

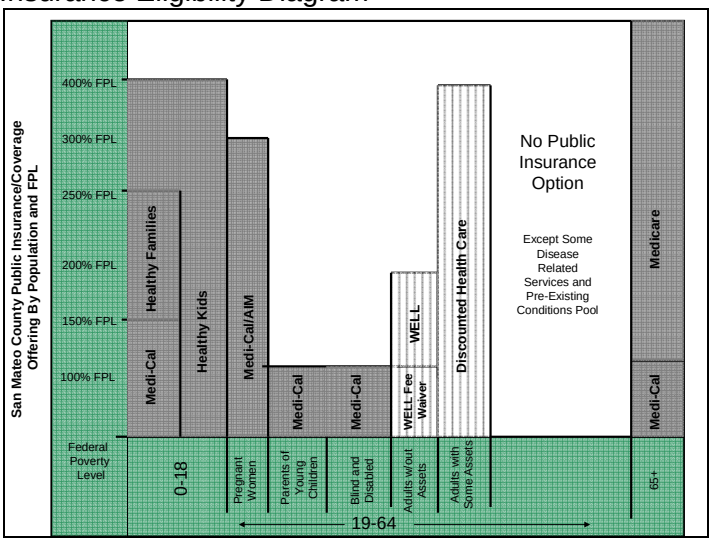
Board of Supervisors Charge
The Board of Supervisors charge to the Blue Ribbon Task Force on Adult Health Care Coverage Expansion called for exploring coverage expansion for adults at or below 400% FPL.

IV. 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.[2] 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[3]



[2] National Employer Health Benefits Survey and California Employer Health Benefits Survey, California HealthCare Foundation.
[3] 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.

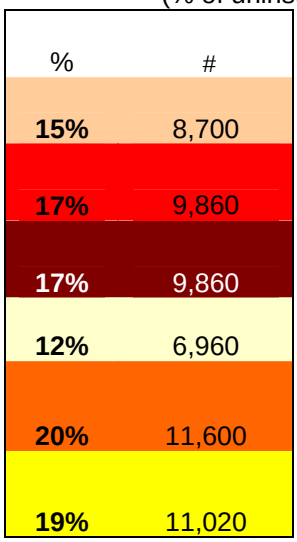
V. San Mateo County Uninsured Adults Age 19-64

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.***[4]

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[5]
(% 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.

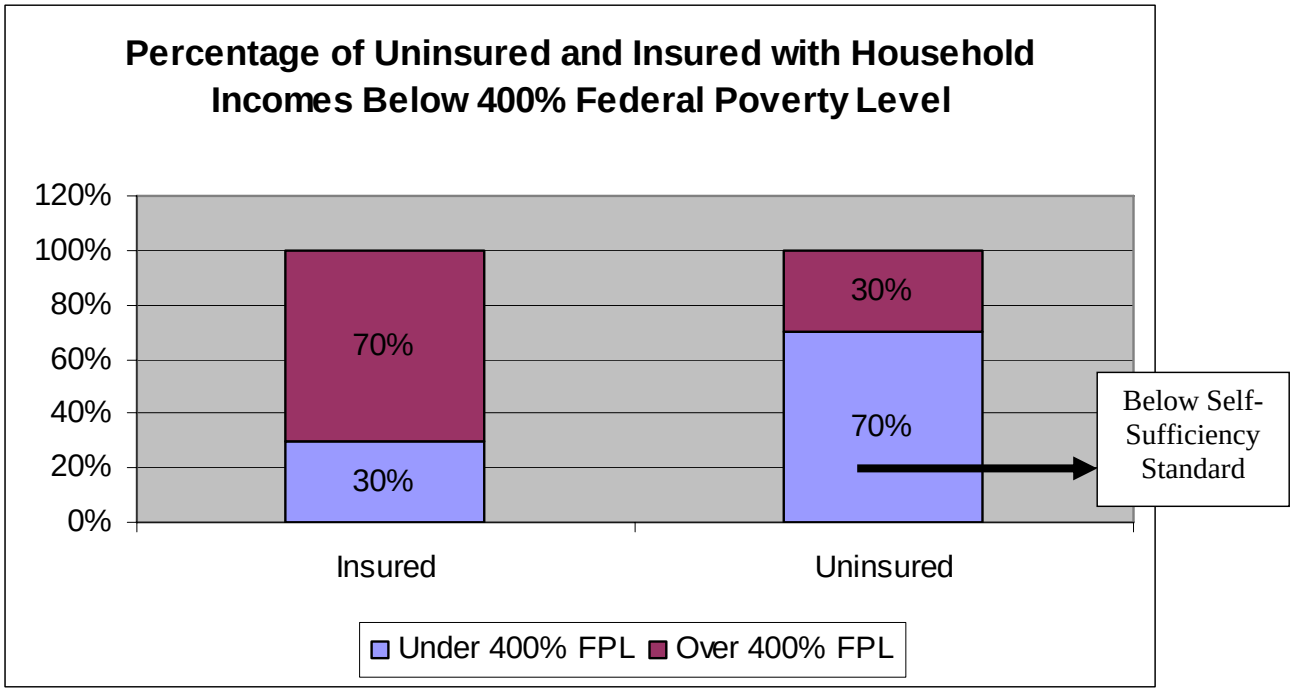
[4] The number of uninsured was calculated using the San Mateo County adult population of 438,819 as reported in the 2005 American Community Survey, and the upper and lower percentages of uninsured adults as reported in the San Mateo County Healthy Communities Collaborative Health and Quality of Life 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.

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

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.[6] 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.

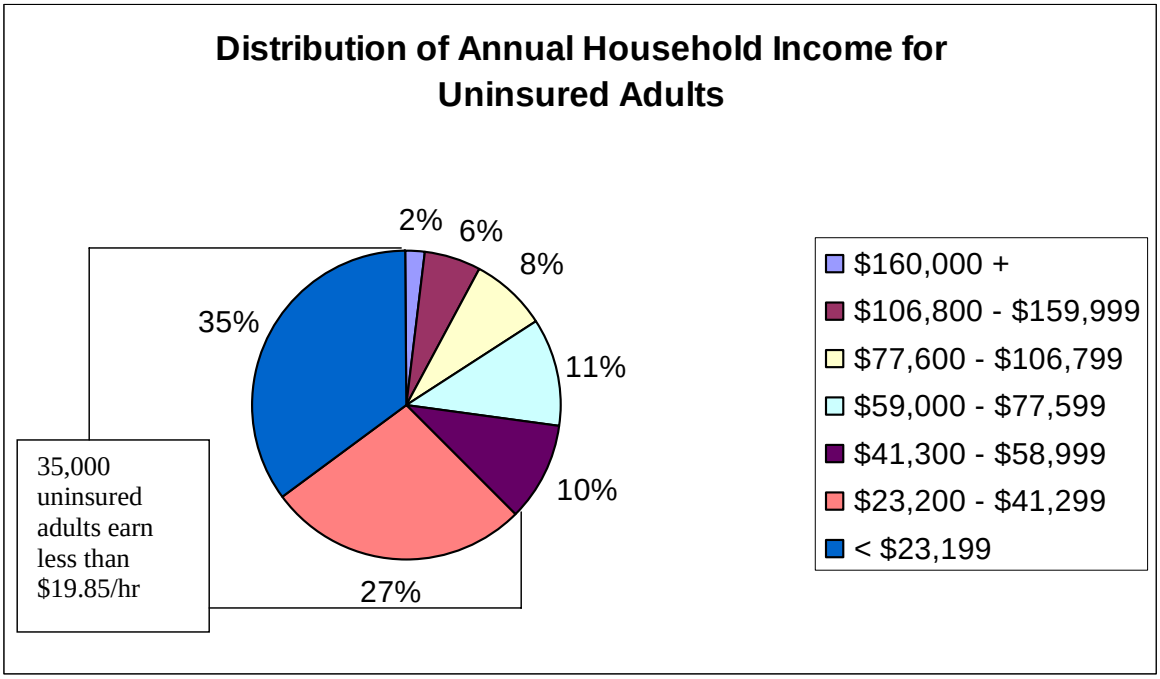
Figure 3: Uninsured Below 400% FPL



The San Mateo County median household income is $74,546 (approximately $36.54 per hour).[7] By contrast, nearly two-thirds of uninsured adults earn less than $41,299 per year (approximately $19.85 per hour).

[6] 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.
[7] 2005 inflation adjusted dollars; 2005 American Community Survey.

Figure 4: Household Income[8]



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.[9] 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."[10]

[8] San Mateo County Healthy Communities Collaborative Health and Quality of Life Survey.
[9] UCLA Center for Health Policy Research, California Health Interview Survey, 2003.
[10] UCLA Center for Health Policy Research, California Health Interview Survey, 2003.

- 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[11]

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.[12] 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.[13]

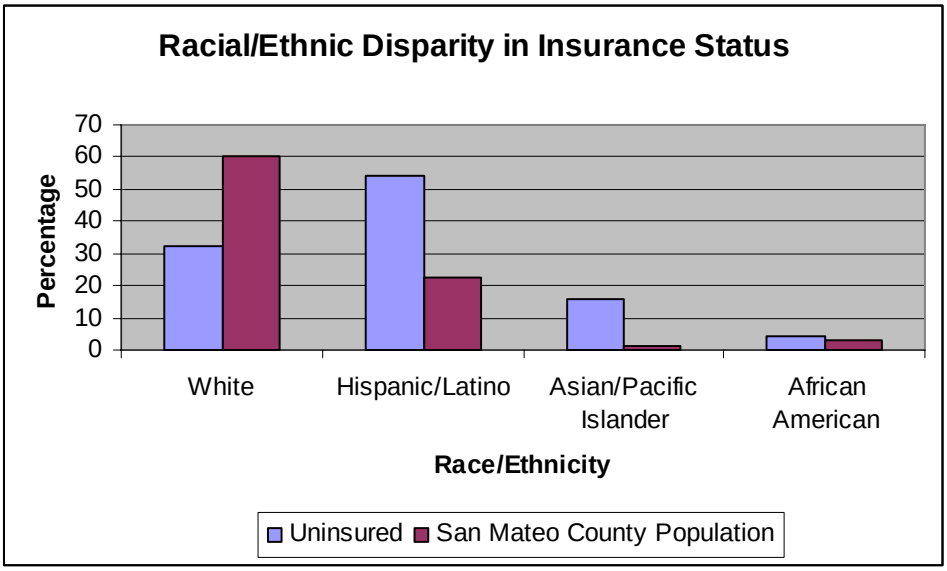
Fifty-One percent of uninsured adults (29,000) have children in their household.[14]

(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[15]

[11] State of California Employment Development Department.
[12] San Mateo County Healthy Communities Collaborative Health and Quality of Life Survey.
[13] UCLA Center for Health Policy Research, California Health Interview Survey, 2003.
[14] San Mateo County Healthy Communities Collaborative Health and Quality of Life Survey.
[15] San Mateo County Healthy Communities Collaborative Health and Quality of Life Survey. 2005 American Community Survey.



(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.[16]

(iv) Region of Residence

Uninsured adults disproportionately in the southern region of the county; 37% of uninsured adults (21,000) as compared with 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. [17]

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.

24%

VI. 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

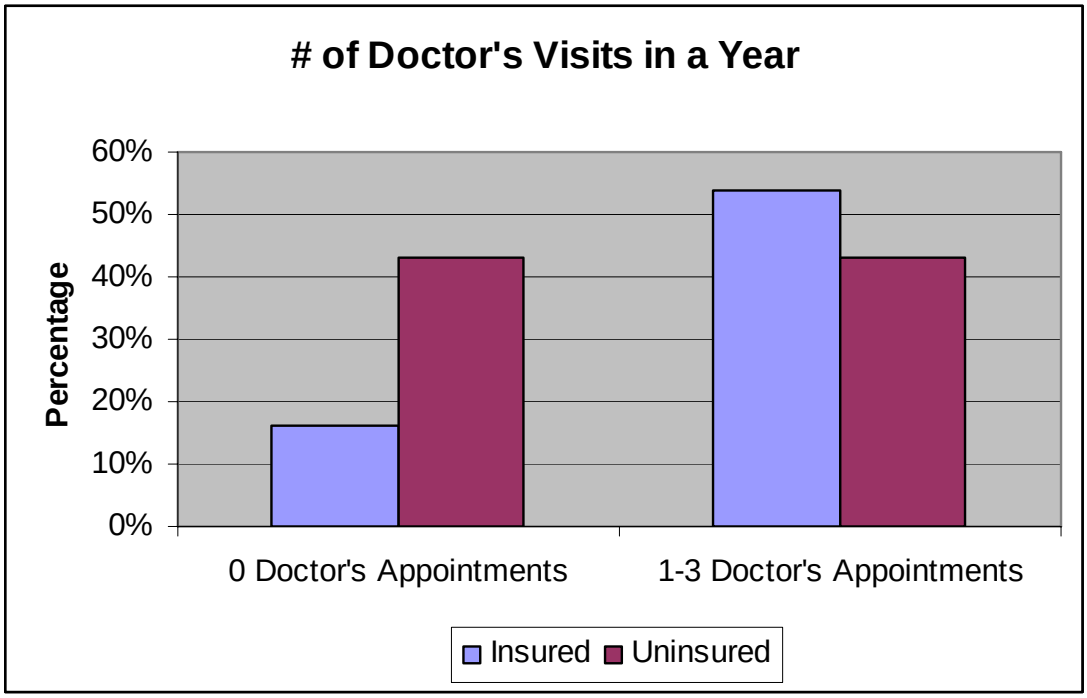
[16] UCLA Center for Health Policy Research, California Health Interview Survey, 2003. The foreign born category includes all non-citizens, but also includes legal-permanent residents.
[17] San Mateo County Healthy Communities Collaborative Health and Quality of Life Survey.

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.[18]

[18] UCLA Center for Health Policy Research, California Health Interview Survey, 2003.

Attachment C: Health Care Model Workgroup Principles

The following principles were developed by members of the Health Care Model Development Workgroup, and adopted by the Task Force, as guidelines for evaluating and selecting an appropriate coverage expansion model(s). The principles are not weighted. They may be revisited or refined by the Task Force, following adoption, as it considers financing, feasibility or other factors, including long-term community planning that extends beyond the time horizon of the Task Force.

1. Health care coverage should **promote population health.**
    - The system should be an outcome-oriented approach to health that aims to improve the health of an entire population and reduce health disparities among population groups.
    - The system should address a broad range of factors that impact health such as environment, occupational risks/exposure, social structure, economics, housing, etc.
    - The system should empower individuals and groups of individuals to be advocates for their health.

2. Health care coverage should be **affordable for the community** as a whole, affordable to individuals, and should reflect a **community-wide shared responsibility**.
    - Coverage financing and policies should reduce crowd-out – prioritize individuals with no other coverage option.
    - Coverage financing should maximally leverage existing public programs.
    - Coverage should maximize use of resources to become cost-effective.
    - Individuals should pay something where able and ability to pay should be determined by income (e.g. higher income individuals pay more than lower income individuals).
    - Individuals' cost of health services should not be a barrier to accessing care.

3. Health care coverage should **provide access to a defined basic level of service for all consumers.**
    - The coverage should enable access to health care across settings (e.g., ambulatory, inpatient, other).
    - The coverage model should emphasize preventive care, primary care, chronic disease management and catastrophic coverage.
    - The model should facilitate continuity of care through use of a medical home.
    - The model should address the need for portability of coverage and reciprocity with neighboring counties wherever possible.

4. The health care coverage **provider network should be inclusive** and should **promote access** and **care coordination** for consumers.

- A provider network should include public and private providers similar to the Medi-Cal network.
- The provider network should be managed by a capable and interested third party such as the Health Plan of San Mateo.
- The health system should employ mechanisms for care coordination.
- The health system should leverage technology to promote effective and efficient care management and client privacy.
- The health system should create incentives for providers to serve the most challenging and medically complicated patients.

5. The health care system should be **simple for consumers** to use
   - The system should be consumer-friendly.
   - There should be administrative simplicity for eligibility, enrollment and retention for consumers and providers.
   - The system should be culturally and linguistically competent.

6. The health care coverage strategy should **make effective use of local and national experience** and expertise and should feedback into the knowledge base.
   - The strategy should build on local experience and strengths.
   - The strategy should use smart practices/learnings from other efforts.
   - The strategy should set the goal of ideal coverage, while employing incremental changes to achieve that goal.
   - The strategy should consider the development of ongoing revenue streams and seeking additional funding as mechanisms for reaching the goal of ideal coverage.
   - The strategy should include benchmarks by which change is measured and ideal coverage is obtained.

Attachment D: Complex-Chronic and Health Individual Coverage Model

Concept: A single system where care is tiered by care management needs: 1) individuals with complex chronic medical diseases, approximately 15% of the target population representing approximately 80% of the cost, will be engaged in a comprehensive primary care setting which provides both medical and enabling services.[19] Front-loaded services will provide for improvements in disease management and access intended to reduce long-term (and high-cost) medical services through select service providers. 2) individuals *without* complex chronic disease, the majority of the population, are covered for basic benefits and have regular access to primary and preventive care.

- **Complex-Medical Chronic Care Component**: Individuals with multiple complex-chronic diseases require both medical and enabling services to maintain their health. In addition, they require enabling services to ensure coordination of care and use of primary and preventive care. Individuals from 0-400% FPL will be enrolled in a complex-chronic care management program based on medical diagnosis. This will focus on and prioritize medical chronic diseases. Individuals falling into this category who seek health care coverage will be mandated to participate in this program and the provider system will be selective to those providers able to develop and implement the necessary system. Incentives to implement the necessary system will be created through a payment structure administered by the third party administrator.[20]

- **Healthy Individual Care Component:** All other adults enrolled in the program not requiring complex-chronic care management and enabling services will served through prioritization of a comprehensive scope of coverage that prioritizes primary and preventive care services.

- **Administrator and Provider Network:** An interested and capable third party administrator such as the Health Plan of San Mateo will be selected. The Provider Network will be open to all private and public providers willing and able to meet the quality and care management standards identified in the model. The Administrator will consider both Medi-Cal and Medicare payment rates.

[19] In a typical market, 10% of the population presents the top tier of costs; however, based on preliminary data from the San Mateo County indigent population seeking care, this may be higher for the target population.

[20] The complex-chronic care system will expect utilization of primary care services to be significantly higher (30% demonstrated in Health Tech Model) and utilization of ICU and Referral Services to be significantly lower (40% demonstrated in Health Tech Model) than a traditional model.

Primary Scope of Benefits and Co-Pay Levels:

Benefits Included[21]	0-200% FPL				201-400%FPL			
	Complex- Medical Chronic		Healthy Individual		Complex- Medical Chronic		Healthy Individual	
Medical Benefits	Y/N	$	Y/N	$	Y/N	$	Y/N	$
Outpatient – Primary and Preventive Care	+	Very- Low	+	Very-Low	+	Low	+	Low
Outpatient Specialty Care	+	Moderate	+	Moderate	+	Moderate	+	Moderate
Prescription Drugs	+	Very-Low	+	Very-Low	+	Low	+	Low
Emergency Room	+	High	+	High	+	High	+	High
Hospitalization	+	High	+	High	+	High	+	High
Mental Health	+	Very-Low	+	Very-Low	+	Low	+	Low
Ophthalmology	+	Moderate	+	Moderate	+	Moderate	+	Moderate
Dental	+	$0 cleaning Basic 80% Other 50% Max $1,000/yr	+	$0 cleaning Basic 80% Other 50% Max $1,000/yr	+	$0 cleaning Basic 80% Other 50% Max $1,000/yr	+	$0 cleaning Basic 80% Other 50% Max $1,000/yr
Enabling Services								
Electronic Medical Record	+	--	+	--	+	--	+	--
24/7 Advise Line	+	--	+	--	+	--	+	--
Social Workers	+	--	N/A		+	--	N/A	
Health Educators (*promotoras*)	+	--	N/A		+	--	N/A	
Health Care Coaches	+	--	N/A		+	--	N/A	
Other (as researched):	+	--	N/A		+	--	N/A	

Secondary Scope of Benefits:

The following are benefits which the Health Care Model Development Workgroup considers important, but secondary to the medical benefits listed above. Cost options should be considered for these benefits as a factor in determining their inclusion/exclusion.

- Optometry Exams
- Durable Medical Equipment and Prosthesis
- Substance Abuse Treatment

Attachment E: Cost Estimates for Adult Coverage Expansion and Actuarial Report

A MILLIMAN GLOBAL FIRM
Milliman
Consultants and Actuaries

1301 Fifth Avenue, Suite 3800
Seattle, Washington 98101-2605
Telephone: (206) 504-5789
Fax: (206) 682-1295
Email: craig.keizur@milliman.com

June 7, 2007

Ron Robinson
Chief Financial Officer
Health Plan of San Mateo
701 Gateway Drive, Suite 400
So. San Francisco, CA 94080

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 F: Beneficiary Cost Sharing for San Mateo County Adult Health Care Coverage Expansion

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

MAY 2007

ANGIE CHEN
GOLDMAN SCHOOL OF PUBLIC POLICY
UNIVERSITY OF CALIFORNIA, BERKELEY

The author conducted this study as part of the program of professional education at the Goldman School of Public Policy, University of California at Berkeley. This paper is submitted in partial fulfillment of the course requirements for the Master of Public Policy degree. The judgments and conclusions are solely those of the author, and are not necessarily endorsed by the Goldman School of Public Policy, by the University of California or by any other agency.

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.[22] 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.[23] 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.[24]

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;[25] 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.

[22] Gilmer and Kronick, 2005.
[23] Hirota et al., 2006.
[24] Manning et al., 1987.
[25] 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[26] 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.[27] 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.[28] 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[29] 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.[30]

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.[31] 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.[32] 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.

[26] The Valley Care initiative defines a small business as a company with 50 or fewer employees.
[27] 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.
[28] Wanda Session, 7 March 2007.
[29] Data from CHIS 2005.
[30] Long, 2002.
[31] Hirota et al., 2006.
[32] 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.[33]

County	Monthly Fees by % Federal Poverty Level[34]								
	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.

VII. 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.

[33] Donaldson, 1999.

[34] 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.

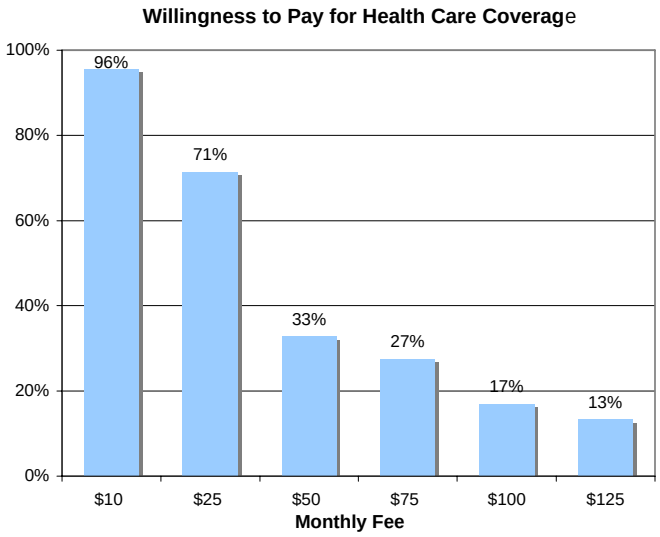


Figure 1: Proportion of eligible adults who would pay for coverage by monthly fee.

VIII. 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,[35] 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.[36] 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.[37] 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

[35] 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.

[36] 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.

[37] Luisa Buada, 23 February 2007.

money for the fee waiver."[38] 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."[39]
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.[40]

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.[41] 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.

[38] Sharon Petersen, 9 March 2007.
[39] Chavira and Wulsin, 2004.
[40] "Effects of Tying Eligibility for Health Insurance Subsidies to the Federal Poverty Level," 2007.
[41] 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.[42] 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.[43] 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.[44] 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).[45] 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

[42] "Why Surveying 'Willingness to Pay' Is Difficult," 2001.
[43] Olsen and Smith, 2001.
[44] W. Michael Hanemann, 30 January 2007.
[45] 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.

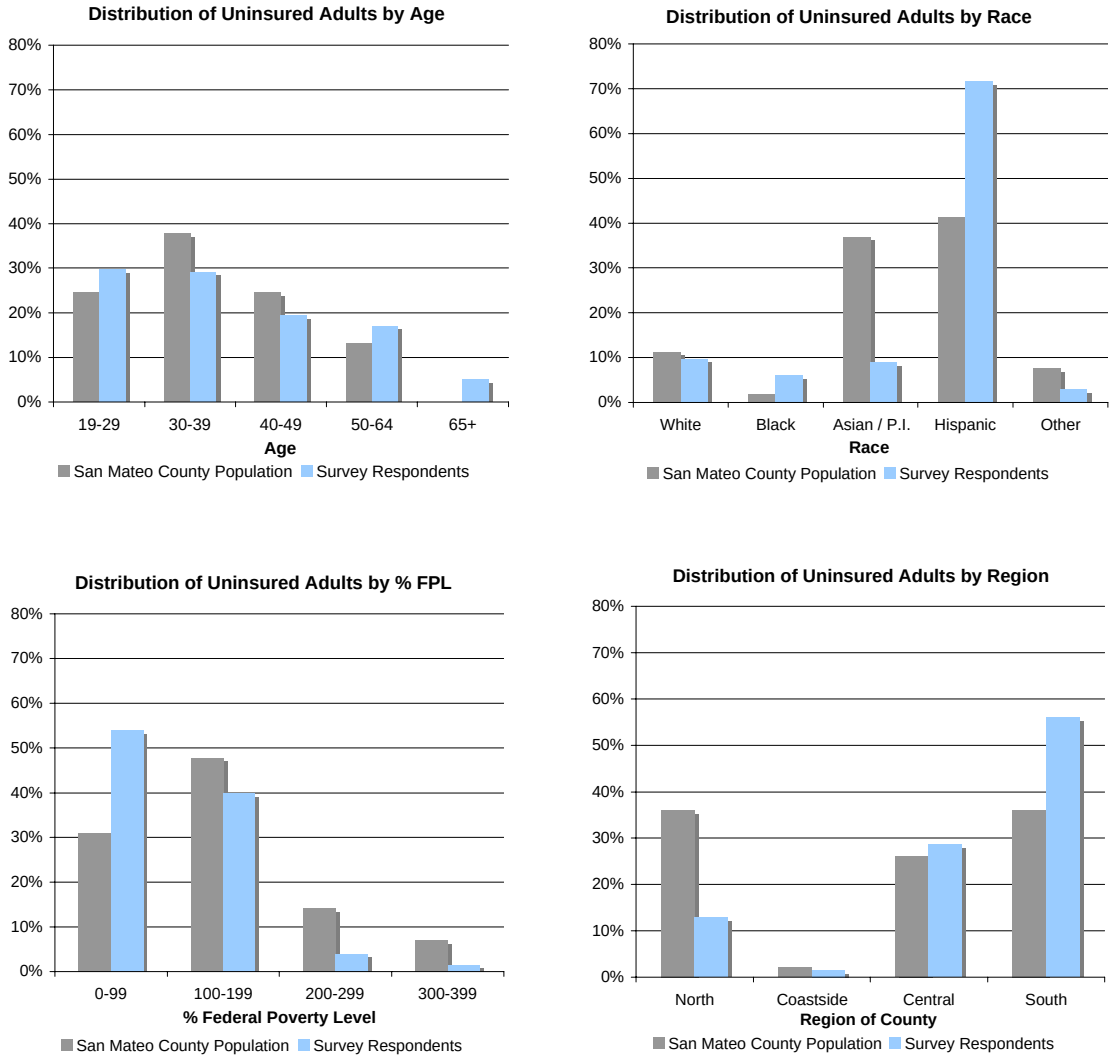


Figure 2: Distribution of study population and sample of uninsured adults by age, race, FPL and region. Population percentages are based on a total of 53,000 uninsured adults in San Mateo County, approximately 35,500 of whom had household incomes at or below 400% FPL. Age, race and FPL data from CHIS 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[46] 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.

[46] 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.[47] 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.[48] 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.

[47] Data from CHIS 2005.
[48] Graves and Long, 2006.

Appendix C: Survey Questionnaire

The following are the English and Spanish versions[49] 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: _____

[49] 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: _____

References

Academic and Research Sources

"2004 Community Assessment: Health and Quality of Life in San Mateo County." San Mateo: The Healthy Community Collaborative of San Mateo County. January 2005.

"Analyses and Options Regarding Affordability." Boston: Commonwealth Health Insurance Connector Authority. August 2006.

Bayoumi, Ahmed M. "The Measurement of Contingent Valuation for Health Economics." *Pharmacoeconomics* 22 (2004): 691-700.

Brook, Robert H., et al. "The Health Insurance Experiment: A Classic RAND Study Speaks to the Current Health Care Reform Debate." Santa Monica: RAND Corporation. 2006.

Brooks, Jr., Glen H., et al. "Report to the Task Force: Demographic Highlights of the San Mateo County Uninsured Adult Population." San Mateo: Blue Ribbon Task Force on Adult Health Care Coverage Expansion. December 2006.

Bundorf, M. Kate, and Mark V. Pauly. "Is Health Insurance Affordable for the Uninsured?" *Journal of Health Economics* 25 (2006): 650-673.

Chavira, Cynthia and Lucien Wulsin. "Premium Subsidies for Low-Wage Workforce: What Is an Appropriate Price Point?" Los Angeles: Insure the Uninsured Project. June 2004.

Chernew, Michael, David M. Cutler and Patricia Seliger Keenan. "Increasing Health Insurance Costs and the Decline in Health Insurance Coverage." *Health Services Research* 40 (2005): 1021-1039.

"Commonwealth Enrollee Contributions, Benefits and Cost-Sharing." Boston: Commonwealth Health Insurance Connector Authority. August 2006.

Cookson, Richard. "Willingness to Pay Methods in Health Care: A Sceptical View." *Health Economics* 12 (2003): 891-894.

Donaldson, Cam. "Valuing the Benefits of Publicly-Provided Health Care: Does 'Ability to Pay' Preclude the Use of 'Willingness to Pay'?" *Social Science and Medicine* 49 (1999): 551-563.

"Effects of Tying Eligibility for Health Insurance Subsidies to the Federal Poverty Level." Menlo Park: Kaiser Family Foundation. February 2007.

Gilmer, Todd and Richard Kronick. “It’s the Premiums, Stupid: Projections of the Uninsured through 2013. *Health Affairs* Web Exclusive. 5 April 2005 <http://content.healthaffairs.org/cgi/content/full/hlthaff.w5.143/DC1>.

Ginsburg, Marjorie, Susan Dorr Goold and Marion Danis. “(De)constructing ‘Basic’ Benefits: Citizens Define the Limits of Coverage.” *Health Affairs* 25 (2006): 1648–1655.

Graves, John A. and Sharon K. Long. “Why Do People Lack Health Insurance?” Washington: Urban Institute. May 2006.

“Health Coverage for Low-Income Americans: An Evidence-Based Approach to Public Policy.” Washington: Kaiser Commission on Medicaid and the Uninsured. November 2006.

Hirota, Sherry, et al. “Inclusion of Immigrant Families in U.S. Health Coverage Expansions.” *Journal of Health Care for the Poor and Underserved* 17 (2006): 81-94.

Hudman, Julie, and Molly O’Malley. “Health Insurance Premiums and Cost-Sharing: Findings from the Research on Low-Income Populations.” Washington: Kaiser Commission on Medicaid and the Uninsured. March 2003.

“Insurance Premium Cost-Sharing and Coverage Take-Up.” Menlo Park: Kaiser Family Foundation. February 2007.

Kominski, Gerald F., Dylan H. Roby and Jennifer R. Kincheloe. “Cost of Insuring California’s Uninsured.” UCLA Center for Health Policy Research. May 2005.

Ku, Leighton and Teresa A. Coughlin. “The Use of Sliding Scale Premiums in Subsidized Insurance Programs.” Washington: Urban Institute. March 1997.

Long, Peter. “County Efforts to Expand Health Coverage among the Uninsured in Six California Counties.” Oakland: Medi-Cal Policy Institute. February 2002.

Manning, Willard G., et al. “Health Insurance and the Demand for Medical Care: Evidence from a Randomized Experiment.” *The American Economic Review* 77 (1987): 251-277.

Marquis, M. Susan, et al. “Subsidies and the Demand for Individual Health Insurance in California.” *Health Services Research* 39 (2004): 1547-1570.

Newhouse, Joseph P., and the Insurance Experiment Group. *Free for All? Lessons from the RAND Health Insurance Experiment.* Cambridge: Harvard University Press. February 1996.

Olsen, Jan Abel and Richard D. Smith. “Theory versus Practice: A Review of ‘Willingness-to-Pay’ in Health and Health Care.” *Health Economics* 10 (2001): 39-52.

"Overview of Local Children's Coverage Expansions." San Mateo: Institute for Health Policy Solutions. May 2006.

Quesnel-Vallée, Amélie. "Is it Really Worse to Have Public Health Insurance Than to Have No Insurance at All? Health Insurance and Adult Health in the United States." *Journal of Health and Social Behavior* 45 (2004): 376-392.

Ryan, Jennifer. "Local Coverage Initiatives: Solution or Band-Aid for the Uninsured?" Washington: National Health Policy Forum. June 2005.

"San Francisco Health Access Program: Serving Uninsured Adults." San Francisco: Universal Healthcare Council. June 2006.

Scott, Mary Kate. "Health Care in the Express Lane: The Emergence of Retail Clinics." Oakland: California HealthCare Foundation. July 2006.

Taylor, Erin Fries, Jeffrey T. Kullgren and Catherine G. McLaughlin. "Who Enrolls in a Program for Parents of Publicly Insured Children?" *Health Affairs* Web Exclusive. 24 September 2003 <http://content.healthaffairs.org/cgi/content/full/hlthaff.w3.460v1/DC1>.

Taylor, Erin Fries, Peter Cunningham and Kelly McKenzie. "Community Approaches to Providing Care for the Uninsured." *Health Affairs* 25 (2006). 11 April 2006 <http://content.healthaffairs.org/cgi/content/full/25/3/w173>.

"The Massachusetts Health Plan: How Did They Do It?" Washington: Alliance for Health Reform. May 2006.

"Why Surveying 'Willingness to Pay' Is Difficult." Minnesota: State Health Access Data Assistance Center. March 2001.

Yeglan, Jill, David Pockell and Eleanor Murray. "To Buy or Not to Buy: A Profile of California's Non-Poor Uninsured." Oakland: California HealthCare Foundation. April 2000.

Yoon, Jean, et al. "One in Five Californians Were Uninsured in 2005 Despite Modest Gains in Coverage." UCLA Center for Health Policy Research. October 2006.

Personal Interviews

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 G: 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

L:\CLIENT\H_DEPTS\HOSPCLIN\2007\Blue Ribbon Task Force Funding Analysis rev 2.doc