

County-Based Health Coverage for Adult Immigrants:

A Proposal for Counties in Washington State

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Executive Summary

Many low-income Washington residents are not eligible to access health care through public programs such as Medicaid, Medicare, and subsidized health insurance under the Affordable Care Act (ACA), due to their immigration status. While children generally have access to Washington Apple Health regardless of immigration status, adults do not. To address these gaps, many counties across the country have implemented health programs to increase access to health care services for adults. We have highlighted six such programs in this report. Based on our review, we provide recommendations for developing similar programs in Washington State counties.

Based on our research and an economic analysis prepared by HealthTrends, we offer these initial recommendations for program components for Washington counties to consider:

- Eligibility Criteria
 - To qualify for the program, an individual should:
 - Reside in the county in which the county-based program operates
 - Have household income at or below a threshold set at or above 400% of the Federal Poverty Level (FPL)
 - Be uninsured and ineligible for other coverage or be unable to cover the cost of a Qualified Health Plan (QHP) in the Washington Health Benefit Exchange (HBE)
 - Be 19 years of age or older
- Enrollment Process
 - Applications should be available at participating clinic sites, other community locations, and online.
 - Enrollment should be conducted by navigators and application assisters in a culturally appropriate and linguistically accessible manner.
 - Social security numbers and information about immigration status should not be collected as part of enrollment.
- Model for Providing Care and Participating Providers
 - The program should be based on a Patient Centered Medical Home model.
 - The application system (or software that is used for enrollment) should make available to all participating providers access to information on the individual's assigned medical home.
 - The program should leverage existing community resources.
- Benefits and Out-of-Pocket Costs
 - The benefits should be similar to the full scope Medicaid service package, wrapping around already-available services such as emergency Medicaid.
 - The program should include a care management/care coordination component.
 - There should be no premiums or out-of-pocket costs for individuals with incomes at 138% FPL and below. For individuals with incomes above that level, there should be only limited participation costs on a sliding fee scale.

- Program Cost – Two County Estimates¹
 - A preliminary estimate of the annual cost of operating this program in King County as it is phased in is approximately \$53 million in 2020, increasing to \$68 million in 2025 as enrollment grows from an estimated 35,430 to 39,043 individuals.
 - A preliminary estimate of the annual cost of operating this program in Yakima County is approximately \$18 million in 2020, increasing to \$21 million by 2025 as enrollment grows from an estimated 15,563 to 15,813 individuals.
 - Counties should explore all potential sources of funding to develop a plan for financing the county-based program.

¹ Program costs are estimated based on a capitated payment model. See discussion *infra* part V and Appendix C for more details.

I. Introduction

Many individuals gained health insurance coverage under the Patient Protection and Affordable Care Act (ACA). And low-income children have for some time been eligible for Washington Apple Health regardless of immigration status. But despite these expansions, many adult immigrants continue to be excluded from coverage. For example, undocumented immigrants are ineligible for Qualified Health Plans (QHPs), Medicaid, and Medicare. And immigrants with certain documented statuses are excluded from Medicaid.

These uninsured immigrants have difficulty accessing the health care they need. They may be less likely to have a regular source of routine care than members of the general population.² As a result, they put off seeking care until symptoms become unbearable, resulting in exacerbated health problems that could have been avoided or minimized if affordable care had been accessible early on. In our discussions with providers and community organizations in Washington, there was a clear consensus that although safety net services exist, there remains significant unmet need in the immigrant community.

In this report, we seek to provide the basis for creating **county-based** programs for immigrants who lack affordable coverage options, so they may access care before health issues escalate and result in avoidable emergency room visits and costly, preventable complications. Such programs are needed to fill gaps in the existing safety-net and to mitigate long-standing health inequities that immigrants experience.

*Why **county-based** programs?* We chose to research and develop recommendations for solutions to this coverage gap at the **county-level** for several reasons:

- *Local differences in care/coverage needs and health system infrastructure* – Washington’s counties vary widely in the proportion of their population that is low-income and uninsured. They also differ in the health system infrastructure that will create the foundation for service delivery in these programs, including the number and geographic distribution of local clinics and hospital systems in the area, and the role that local health departments play in furnishing safety net care. We believe that, at least initially, it should be easier to create a program tailored to the needs and services available locally if the program is county-based.³
- *Funding potential* – Washington State has worked hard to implement the Affordable Care Act and will continue to focus attention on the viability of this and other federal programs as implemented in the state. Recently, there have been legislative efforts to create state level options to fill health care access gaps, including the recently-adopted premium and cost-sharing assistance program for a very small group of immigrants.⁴ But in the current environment, it is challenging to establish state wide programs, especially given budgetary constraints. Local governments bear the cost of many health and social services for low-income residents. Therefore, they may recognize the economic

² Pg. 18-19 <http://healthpolicy.ucla.edu/publications/Documents/PDF/undocumentedreport-aug2013.pdf>.

³ Washington State may also seek to organize programs based on Accountable Community of Health regions. Our recommendations are based on our research of existing programs organized around county structures, but if interest exists, exploring programs organized around ACH structures may be useful for certain regions in the state.

⁴ Senate Bill 5683, Ch. 161, 2018 Laws, <http://apps2.leg.wa.gov/billsummary?BillNumber=5683&Year=2017&BillNumber=5683&Year=2017>.

and social value of supporting this population, thus creating the momentum to act more readily.⁵ Though funding is always an issue, this recognition can spur counties to evaluate both potential savings and funding sources to ensure program sustainability. Just as the ACA reduced uncompensated care by lowering uninsurance rates for low-income residents, counties can expect beneficial impacts from creating coverage programs for the remaining group of low-income residents.

- *Existing models* – A number of counties across the country have created programs to help fill these gaps in coverage for immigrant residents who lack affordable coverage options, although some state-based models exist as well. No Washington State county presently has such a coverage program. Washington counties can benefit from out-of-state programs’ experiences with what has worked well for them and what should be avoided. Learning from those experiences will help avoid the same pitfalls in creating a similar program here. The programs, which offer varying levels of coverage, enable the uninsured to access health care services that were previously unaffordable and inaccessible.⁶

In this report, we offer recommendations to counties that respond to the needs of immigrants and promote health equity among county residents.

II. Existing Options for Low-Income Immigrants in Washington State to Obtain Free or Reduced-Cost Coverage or Health Care

Washington State provides limited coverage for specific categories of low-income immigrants and for certain health conditions and situations. It is important to understand these programs when designing new county-based coverage options, both to avoid duplicating services and to help structure the program in a way that facilitates the coordination of its benefits with those that are available from existing sources. These programs are:

A. Washington Apple Health Programs for Persons Not Generally Qualified for Medicaid Based on Immigration Status

Many categories of Washington Apple Health are limited to immigrants who are defined as “qualified” under federal law.⁷ However, some groups are eligible under broader criteria.

⁵ The King County government, for example, recently adopted a resolution explicitly stating its support for expanding coverage and lowering barriers for low-income immigrants unable to afford coverage or access Medicaid coverage. King County Board of Health Resolution 18-01, *available at* <https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=3302343&GUID=82A13DC7-88F6-40AC-967A-18E8816952B7&Options=&Search=>.

⁶ To better inform the upper limit of income eligibility, the cost of basic needs should be considered as programs are developed. See e.g., http://selfsufficiencystandard.org/sites/default/files/selfsuff/docs/WA2017_SSS.pdf (finding that in Washington State income required for economic self-sufficiency varies considerably by geography. “[T]he amount needed to make ends meet for one adult and one preschooler varies from \$15.09 per hour (\$31,870 annually) in Adams County to \$30.69 per hour (\$64,816 annually) in King County (East), or from 196% of the federal poverty guidelines to 399% of the federal poverty guidelines for a family of two.” Page VII.)

⁷ See WAC 182-503-0535.

1. Full Scope Coverage – Pregnancy, Children/Youth Under 19, Medical Care Services (MCS) Program

Pregnancy

Apple Health provides full-scope health coverage for pregnant people, regardless of immigration status, with income at or below 198% FPL (after considering automatic 5% disregard).⁸

Children/Youth Under 19

Apple Health provides full-scope health coverage to all residents under age 19 at or below 317% FPL. Premiums are charged at some income levels.⁹

MCS Program

Low income persons with disabilities are currently eligible for state medical coverage (MCS program) when they qualify for one of two state financial assistance programs: “Aged, Blind, Disabled” (ABD) benefits (small monthly cash assistance) or Housing and Essential Needs (HEN) benefits (vouchers for certain housing-related services). They must be considered “lawfully present” in the United States.

2. Limited Scope Coverage – Alien Emergency Medical/Alien Medical Programs, Kidney Disease Program, Family Planning Only

AEM/AMP/KDP 220

The Apple Health Alien Emergency Medical Program “AEM” or Alien Medical Program “AMP” provide coverage for emergency conditions treated in hospital settings, as well as outpatient dialysis, cancer treatments, treatment of life-threatening benign tumors, and anti-rejection medications for post-transplant patients.¹⁰ Eligibility is limited to persons with income at or below 138% FPL.

The Kidney Disease Program (KDP) provides coverage for individuals with End Stage Renal Disease who are ineligible for other coverage for related services.¹¹ Eligible persons have income at or below 220% FPL and limited resources.

Family Planning Only

The Family Planning Only program provides women coverage for family planning services to help them prevent unintended pregnancies. Any woman eligible for pregnancy medical is eligible for family

⁸ See <https://www.hca.wa.gov/assets/free-or-low-cost/19-003.pdf>.

⁹ \$20-30 per child enrollee per month premiums to a maximum of \$60, may be charged to otherwise eligible families with income above 215% of the Federal Poverty Limit (FPL). See <https://www.hca.wa.gov/assets/free-or-low-cost/19-003.pdf>.

¹⁰ See <https://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/apple-health-alien-medical-programs>.

¹¹ See <https://www.hca.wa.gov/billers-providers/programs-and-services/kidney-disease-program-kdp>.

planning services for twelve months after the pregnancy ends.¹² Benefits are limited to persons with income at or below 198% FPL.

B. Washington Health Benefit Exchange – Qualified Health Plans

Qualified Health Plans (QHPs) are ACA-compliant health plans covering the essential health benefits available for purchase on the State’s Health Benefit Exchange (HBE).¹³ Certain categories of immigrants are eligible to purchase a plan,¹⁴ and there are income criteria to obtain cost-sharing reductions or premium tax credits.¹⁵

C. Federally Qualified Health Centers(FQHCs) and Community Health Centers (CHCs)

Federally Qualified Health Centers (FQHCs), also known as Community Health Centers (CHCs), provide comprehensive primary care to all regardless of immigration status or ability to pay.¹⁶ Some clinics maintain referral networks to help connect individuals to specialists outside of the clinic.

D. Safety Net Services – Public Health Services, Emergency Care, Charity Care

Public Health Services

Limited services provided through a Public Health Department are available in some counties. These may include immunizations, treatment of communicable diseases such as Tuberculosis, HIV/AIDS, or sexually transmitted diseases.

Emergency Care

Federal law (the Emergency Medical Treatment and Labor Act – EMTALA) requires that patients who come to a hospital’s emergency department must be provided emergency care until they are stabilized, regardless of the patients’ insurance status or ability to pay. While EMTALA requires hospitals to provide patients emergency care, it does not address funding for the medical bills incurred for that care.

¹² WAC 182-505-0115(5).

¹³ www.wahealthplanfinder.org

¹⁴ See https://www.wahbexchange.org/wp-content/uploads/2015/09/HBE_PT_160523_Citizenship_Immigration_Eligibility_Chart.pdf. Immigrants who are undocumented, have Deferred Action for Childhood Arrivals (DACA), and certain other categories are not eligible.

¹⁵ See pg.2, https://www.wahbexchange.org/wp-content/uploads/2017/04/HBE_SN_20170419_FPL_FAQ_Chart.pdf.

¹⁶ FQHCs are community-based health care providers that receive federal funds to provide primary care services in underserved areas and may include Community Health Centers, Migrant Health Centers, Health Care for the Homeless, and Health Centers for Residents of Public Housing. See <https://www.hrsa.gov/opa/eligibility-and-registration/health-centers/fqhc/index.html>; see also Section 1905(l)(2)(B) of the Social Security Act for definition of FQHCs.

Charity Care

Washington State law requires hospitals to waive or reduce bills for patients with limited finances. This is available through the hospital where you get care.¹⁷

III. Profiles of County Programs

We looked to existing county-based programs across the country to develop recommendations for creating similar programs for counties in Washington State. We conducted a literature review of publications and online resources on several prominent county-based programs that offer(ed)¹⁸ health coverage to uninsured immigrants. We evaluated eleven programs. Of these, we identified six programs to highlight in our report based on relevance, instructiveness, and promising approaches for counties in Washington State. We chose not to highlight programs that were structured more like financial assistance or charity care programs or relied too heavily on county public health facilities.¹⁹

The six programs we profiled include, three in California and three non-California programs. The California programs are Healthy San Francisco, My Health LA, and Contra Costa Cares. The non-California programs are Maryland's Montgomery Cares, Nevada's Access to Healthcare Network Medical Discount Program, and New York's ActionHealthNYC. To gain an in-depth understanding of each of the county-based programs and how they work in practice, we developed an interview framework and conducted interviews with individuals involved in these programs, including a mix of program staff, advocates, and providers.

Program profiles include an overview of eligibility criteria, enrollment process, model for providing care and the participating providers, covered services and costs, funding for the program and provider reimbursement, and any other noteworthy details of the program.

A. California

State law in California requires counties to “relieve and support” all low-income, lawfully present residents of the county.²⁰ The counties have discretion as to how they will fulfill their obligation and it

¹⁷ Chapter 70.170 RCW and Chapter 246-453 WAC. For more information see:

<https://www.washingtonlawhelp.org/resource/charity-care-medical-coverage-for-hospital-ba>. You can look up a hospital's charity care policy at

<https://www.doh.wa.gov/DataandStatisticalReports/HealthcareinWashington/HospitalandPatientData/HospitalPolicies>.

¹⁸ All except one of the programs we evaluated still operate. One program we profiled, ActionHealthNYC, was a pilot program, the funding for which ended in July 2017 and was not renewed.

<http://www1.nyc.gov/site/doh/health/health-topics/actionhealthnyc.page>.

¹⁹ Programs that relied on public health facilities is a model that could not be easily adapted to counties across Washington State. For example, Cook County's program was not highlighted in our report because its services are provided through Cook County Health & Hospitals System (CCHHS) — the county network of clinics and hospitals. However, in Washington State, there is great variability in Public Health Departments but even then, the county clinic systems are not so robust as to serve as medical homes. Hence, the Cook County model, and others like it, could not readily be replicated in Washington State.

²⁰ Cal. Welf. & Inst. Code § 17000.

can be satisfied through county hospital systems or state hospitals that provide mental health services.²¹ However, many counties have opted to offer a package of services or health coverage programs to ensure that *all* county residents, including undocumented residents, have access to some level of care. Of California's 58 counties, 47²² provide primary care and other non-emergency services to undocumented immigrants.²³

To help finance county health and safety net programs, California established funding "Realignment" in 1991, through a portion of vehicle licensing fees and sales tax revenues.²⁴ Post-ACA some of the health realignment funds are returned to the state.²⁵ Still, this continues to be the primary source of funding for county-based programs although there is an option to use some federal funds through California's 1115 Medicaid Demonstration Global Payment Program.²⁶

Another unique aspect of care in California is that many community health clinics and Federally Qualified Health Centers (FQHCs) are represented by a local consortium that is owned and operated as an independent entity. There are eighteen community clinic consortia in California.²⁷ The consortia are membership organizations for community clinics and related safety net providers to advocate for a strong health care safety net.²⁸ Because the clinics are organized, they can more effectively advocate through coordinated policy agendas and working collectively for robust networks of safety net services, including health services for uninsured immigrants.²⁹

1. Healthy San Francisco (HSF)

Eligibility Criteria

Healthy San Francisco (HSF) is the first city-run universal health care option in the nation.³⁰

²¹ Cal. Welf. & Inst. Code § 17000 -01.

²² Thirty-five counties provide a limited package of primary care services to all residents restricted to residents over the Medi-Cal income eligibility level, thereby excluding the lowest-income undocumented residents.

²³ Denisse Rojas and Miranda Dietz, Providing Health Care to Undocumented Residents: Program details and lessons learned from three California county health programs p.2 (UC Berkeley Ctr. For Labor Research and Education Oct. 2016), *available at* <http://laborcenter.berkeley.edu/pdf/2016/Providing-Health-Care-to-Undocumented-Residents.pdf>.

²⁴ Rojas and Dietz, p.3.

²⁵ Counties either have 60% of health realignment redirected, or, use a formula-based approach that takes into account a county's cost and revenue experience, and redirect 80% of the savings realized by the county. See <http://www.dhcs.ca.gov/provgovpart/Pages/AB%2085.aspx>.

²⁶ See <http://www.dhcs.ca.gov/provgovpart/Pages/GlobalPaymentProgram.aspx>.

²⁷ Clinic Consortia Policy and Advocacy Program Evaluation Exec. Summary, June 2008, p.3, available at https://healthpolicy.ucsf.edu/sites/healthpolicy.ucsf.edu/files/UCSF_ClinicConsortia_ExSum_9.pdf.

²⁸ Clinic Consortia Policy and Advocacy Program Evaluation Exec. Summary, June 2008, p.3, available at https://healthpolicy.ucsf.edu/sites/healthpolicy.ucsf.edu/files/UCSF_ClinicConsortia_ExSum_9.pdf.

²⁹ P.5 https://healthpolicy.ucsf.edu/sites/healthpolicy.ucsf.edu/files/UCSF_ClinicConsortia_ExSum_9.pdf.

³⁰ <http://www.dailynews.com/2014/09/07/la-countys-top-health-official-shows-compassionate-side/>. Note that HSF is also a county-based program, as San Francisco is a city and county with contiguous borders and a combined local government. See <http://sfgov.org/>.

The program offers coverage to individuals with combined family income of up to 500% of the FPL.³¹ This is the highest income threshold for eligibility among the programs we researched. However, the HSF “income” test also considers an applicant’s liquid assets in determining their income.³² For this reason, some individuals with income below 500% FPL will not be eligible for HSF.

Other eligibility criteria include San Francisco residency, and age of 18 or older, being uninsured for at least 90 days, and being ineligible for public insurance programs such as Medi-Cal or Medicare.³³ Individuals who are eligible for coverage through Covered California (California’s Health Exchange for ACA compliant health plans) are not barred from enrolling in HSF if they do not enroll in a QHP. Neither immigration nor employment status are considered in determining eligibility.³⁴

Enrollment Process

To enroll an individual must make an appointment with a Certified Application Assistor (CAA) to complete an application.³⁵ Applicants must submit certain documents to complete an application, including photo identification, proof of San Francisco residency, and proof of household income and assets.³⁶ Applications are completed through a web-based system “One-e-App” that is utilized by multiple programs, including Healthy San Francisco.³⁷ Once an applicant is approved for HSF, they receive a participant identification card³⁸ and are required to renew enrollment annually.³⁹

Model for Care Provision and Participating Providers

HSF utilizes a medical home model⁴⁰; individuals select a medical home at the time of their initial enrollment and at their annual renewal.⁴¹ Enrollees can select a medical home from a network of providers comprised of facilities operated by the San Francisco Department of Public Health, San Francisco Community Clinic Consortium clinics, Kaiser Permanente, and Sister Mary Philippa Health

³¹ <http://healthysanfrancisco.org/visitors/are-you-eligible/>. HSF increased the income cap from 400% FPL to 500% FPL in January 2016, see P.1 <http://healthysanfrancisco.org/wp-content/uploads/2015-16%20HSF%20Annual%20Report.pdf>.

³² After exempting a portion of the asset (\$2,000 for individuals, \$3,000 for a family of two, and \$150 per additional family member), the remainder is divided by 12 and added to the applicant’s gross monthly countable income to determine FPL level. P.2 fn5, <http://healthysanfrancisco.org/wp-content/uploads/2013/07/HSFTaxForm%20Guide2013.pdf>. This is the only asset test used by any of the programs we researched to limit enrollee eligibility.

³³ <http://healthysanfrancisco.org/visitors/are-you-eligible/>. “Medi-Cal” is the umbrella term for a variety of publicly financed coverage programs in California, most prominently including Medicaid. See <http://www.medi-cal.ca.gov/programs.asp>.

³⁴ Healthy San Francisco Participant Handbook p.1 (Feb. 2017), available at http://healthysanfrancisco.org/files/HSF_Participant_Handbook_ENG.pdf.

³⁵ <http://healthysanfrancisco.org/visitors/how-do-i-apply/>.

³⁶ <http://healthysanfrancisco.org/visitors/necessary-documents-to-enroll/>.

³⁷ See https://healthysanfrancisco.org/wp-content/uploads/2013/07/One_E_App_Manual.pdf.

³⁸ P.4 http://healthysanfrancisco.org/files/HSF_Participant_Handbook_ENG.pdf.

³⁹ <http://healthysanfrancisco.org/participants/time-to-renew/>.

⁴⁰ As defined by the American College of Physicians, “The Patient-Centered Medical Home (PCMH) is a care delivery model whereby patient treatment is coordinated through their primary care physician to ensure they receive the necessary care when and where they need it, in a manner they can understand.” <https://www.acponline.org/practice-resources/business/payment/models/pcmh/understanding/what-pcmh>.

⁴¹ <http://healthysanfrancisco.org/participants/your-medical-home/changing-medical-homes/>.

Center.⁴² Each medical home has a hospital in its network at which participants can seek urgent and emergency care.⁴³ The medical home is responsible for referrals to specialty care that is not available on site at the clinic.⁴⁴

The San Francisco Health Network (SFHN)⁴⁵ transitioned its pharmacy benefit manager (PBM) to Walgreens. Healthy San Francisco participants enrolled with an SFHN medical home will have their pharmacy network expanded to include thirty-two pharmacies, allowing participants to fill their prescriptions at any Walgreens within San Francisco.⁴⁶

Benefits and Out-of-Pocket Costs

HSF covers an array of services including primary and preventive care, specialty care, urgent care and emergency room care, ambulance services (for emergent transportation within San Francisco), outpatient behavioral health services⁴⁷, hospital care at the hospital affiliated with the individual's medical home, family planning services, durable medical equipment, lab tests, and pharmacy services.⁴⁸

Health care services not covered by HSF include dental, vision, hearing aids, allergy testing and injections, acupuncture, chiropractic care, cosmetic, gastric bypass surgery and services, genetic testing and counseling, infertility, organ transplants, non-emergency transportation, travel immunizations, sexual reassignment surgery, and long-term care.⁴⁹

Program participants with income above 100% FPL are charged quarterly fees that are set uniformly for the program, as well as point-of-service fees that vary by medical home and service.⁵⁰ The fees range from \$60/quarter for an individual with income 101-200% FPL to \$450/quarter for an individual with income 401-500% of FPL.⁵¹ The point-of-service fees for services furnished through San Francisco Department of Public Health facilities range from \$5 for generic medication, \$10 for a primary care visit

⁴² <http://healthysanfrancisco.org/participants/your-medical-home/where-are-medical-homes/>.

⁴³ P. 8-9, http://healthysanfrancisco.org/files/HSF_Participant_Handbook_ENG.pdf.

⁴⁴ P. 7, http://healthysanfrancisco.org/files/HSF_Participant_Handbook_ENG.pdf.

⁴⁵ SFHN is the integrated health delivery system of the San Francisco Department of Public Health. It consists of: a) several primary care and specialty care clinics throughout the San Francisco, b) Zuckerberg San Francisco Hospital and Trauma Center (ZSFG), c) Laguna Honda Hospital and Rehabilitation Center and d) behavioral health services. 60% of HSF participants selected a SFHN medical home. P.15 <http://healthysanfrancisco.org/wp-content/uploads/2015-16%20HSF%20Annual%20Report.pdf>.

⁴⁶ P.2 <http://healthysanfrancisco.org/wp-content/uploads/2015-16%20HSF%20Annual%20Report.pdf>.

⁴⁷ Some mental health services are available through HSF enrollees' medical homes. Other behavioral health services may be obtained through San Francisco Behavioral Health Services, a separate program operated by the San Francisco Department of Public Health. See <http://healthysanfrancisco.org/covered-medical-services/mental-health-services/> (re mental health services); <http://healthysanfrancisco.org/covered-medical-services/alcohol-drug-treatment/> (re alcohol and drug treatment services).

⁴⁸ <http://healthysanfrancisco.org/participants/covered-medical-services/>.

⁴⁹ <http://healthysanfrancisco.org/covered-medical-services/services-not-included/>. Some of these services may be offered by individual facilities that serve as medical homes, even though the services are not specifically covered under HSF. Sexual reassignment surgery is available through a separate program of the San Francisco Department of Health for which HSF enrollees are eligible, and low-cost dental, vision, and hearing aid services are available throughout the San Francisco Bay Area. See <https://www.sfdph.org/dph/comupg/oprograms/THS/surgery.asp> and <http://healthysanfrancisco.org/covered-medical-services/services-not-included/>.

⁵⁰ <http://healthysanfrancisco.org/participants/fees/>.

⁵¹ <http://healthysanfrancisco.org/participants/fees/>.

to \$100 for same day surgery and \$200 for an inpatient admission.⁵² Point-of-service fees for services offered through a medical home other than a Department of Public Health facility vary by clinic.⁵³

Funding and Provider Payment

In addition to the statewide funding mechanisms mentioned above, in 2006 the Health Care Security Ordinance passed by the San Francisco Board of Supervisors requires employers in San Francisco to pay towards their employees' health coverage. San Francisco employers with more than twenty employees must spend a specified amount on health benefits for their employees who work at least eight hours per week.⁵⁴ Employers may spend the money toward employees' participation in Healthy San Francisco or to provide health insurance, create health savings accounts, or pay health care claims.⁵⁵

In Fiscal Year 2015-16, there was a per member per month (PMPM) City and County of San Francisco General Fund expenditure of \$159 based on 170,455 participant months.⁵⁶ An estimated \$74 million in total Healthy San Francisco program expenditures were made including \$44 million by SFDPH and approximately \$30 million by private community providers.⁵⁷ HSF generated approximately \$17 million in revenue that helped fund the program expenditures; resulting in a \$27 million General Fund Subsidy by the City and County of San Francisco.⁵⁸

2. My Health LA (MHLA)

Eligibility Criteria

To be eligible for My Health LA (MHLA), individuals must be age 19 or older, reside in Los Angeles County, have income at 138% FPL or under, and must not have nor be eligible for health insurance.⁵⁹

Enrollment Process

Enrollment occurs at MHLA participating clinics, and applicants are asked to call in advance to schedule an appointment to complete an application with a Certified Enrollment Counselor (CEC) or Certified Application Assistor (CAA) at the clinic.⁶⁰ To complete an application, personal identification, proof of Los Angeles residency, and proof of income are required.⁶¹ If unavailable, applicants may sign an affidavit attesting to identity, residency, or income.⁶² New and renewing participants are (re)enrolled

⁵² <http://healthysanfrancisco.org/participants/fees/>.

⁵³ <http://healthysanfrancisco.org/participants/fees/>.

⁵⁴ Mitchell H. Katz and Tangerine M. Brigham, Transforming A Traditional Safety Net Into A Coordinated Care System: Lessons From Healthy San Francisco p.239, Health Affairs 30, no.2 (2011):237-245.

⁵⁵ Mitchell H. Katz and Tangerine M. Brigham, Transforming A Traditional Safety Net Into A Coordinated Care System: Lessons From Healthy San Francisco p.239, Health Affairs 30, no.2 (2011):237-245.

⁵⁶ P.3 and p.42 <http://healthysanfrancisco.org/wp-content/uploads/2015-16%20HSF%20Annual%20Report.pdf>.

⁵⁷ P. 42 <http://healthysanfrancisco.org/wp-content/uploads/2015-16%20HSF%20Annual%20Report.pdf>.

⁵⁸ P. 42 <http://healthysanfrancisco.org/wp-content/uploads/2015-16%20HSF%20Annual%20Report.pdf>.

⁵⁹ <http://dhs.lacounty.gov/wps/portal/dhs/mhla>.

⁶⁰ http://file.lacounty.gov/SDSInter/dhs/223181_MHLA-Enrollmentflyer-English_112014-v2.pdf, P.7

[http://file.lacounty.gov/SDSInter/dhs/1010204_2015-16MHLAAnnualReport\(final\).pdf](http://file.lacounty.gov/SDSInter/dhs/1010204_2015-16MHLAAnnualReport(final).pdf).

⁶¹ http://file.lacounty.gov/SDSInter/dhs/223181_MHLA-Enrollmentflyer-English_112014-v2.pdf.

⁶² Per MHLA Program Director.

into the program using the One-e-App (OEA) system.⁶³ Upon approval, enrollees are mailed an identification card and welcome packet indicating membership in the program.⁶⁴

Model for Care Provision and Participating Providers

My Health LA uses a medical home model. MHLA participants select their primary care medical home at the time of enrollment and maintain it for a year.⁶⁵ The medical home provides participants their primary care and preventative care services, including routine diagnosis and treatment of illness or injury, health advice, diagnostic services (labs and basic radiology), chronic disease management, immunizations, referral services, and health education.⁶⁶ MHLA covers prescription medications to enrollees and is transitioning from having participants fill covered prescriptions primarily through the medical homes, to contracting for pharmacy services through a commercial pharmacy network.⁶⁷

My Health LA has a total of 51 medical home clinics or “Community Partner” (CP) agencies⁶⁸ consisting of 210 clinic sites.⁶⁹ Los Angeles County Department of Health Services (DHS) facilities such as hospitals, emergency rooms and urgent care centers are included in the program’s provider network.⁷⁰

Benefits and Out-of-Pocket Costs

MHLA benefits include preventive care and health screenings, health information and advice, prescription medications, and laboratory services and tests.⁷¹ Specialty, inpatient, emergency and urgent care are available through Los Angeles County Department of Health Services (DHS) facilities.⁷² Mental health and alcohol and drug treatment services are made available to enrollees through referrals to the County Departments of Mental Health and Public Health, respectively. Limited dental services are available — if a community clinic provides dental services, then MHLA enrollees may access them without additional cost through a fee-for-service arrangement between DHS and the clinic.⁷³ Vision is not included in MHLA services and there is currently no specific case management or care coordination component offered by the program or required to be provided by enrollees’ medical homes. The MHLA program is considering adding a care coordination component to the program in the future. Monthly encounter data is collected to track the level and type of services utilization for MHLA enrollees.

Services through MHLA are provided at no cost to enrollees.

⁶³ P. 7 [http://file.lacounty.gov/SDSInter/dhs/1010204_2015-16MHLAAnnualReport\(final\).pdf](http://file.lacounty.gov/SDSInter/dhs/1010204_2015-16MHLAAnnualReport(final).pdf).

⁶⁴ P.1 http://file.lacounty.gov/SDSInter/dhs/221847_MyHealthLA-Factsheet&Enrollment-English.pdf.

⁶⁵ P.15 [http://file.lacounty.gov/SDSInter/dhs/1010204_2015-16MHLAAnnualReport\(final\).pdf](http://file.lacounty.gov/SDSInter/dhs/1010204_2015-16MHLAAnnualReport(final).pdf).

⁶⁶ P.15 [http://file.lacounty.gov/SDSInter/dhs/1010204_2015-16MHLAAnnualReport\(final\).pdf](http://file.lacounty.gov/SDSInter/dhs/1010204_2015-16MHLAAnnualReport(final).pdf).

⁶⁷ Pg. 4 <http://healthysanfrancisco.org/wp-content/uploads/2015-16%20HSF%20Annual%20Report.pdf>.

⁶⁸ P. 15 http://file.lacounty.gov/SDSInter/dhs/220332_MHLA_ProviderDirectory2016-08-22.pdf.

⁶⁹ <https://dhs.lacounty.gov/wps/portal/dhs/coverageoptions/myhealthla>.

⁷⁰ P.16 http://file.lacounty.gov/SDSInter/dhs/220332_MHLA_ProviderDirectory2016-08-22.pdf.

⁷¹ http://file.lacounty.gov/SDSInter/dhs/1020334_WhatIs_MHLA_English__FPL.pdf.

⁷² P.3 [http://file.lacounty.gov/SDSInter/dhs/1010204_2015-16MHLAAnnualReport\(final\).pdf](http://file.lacounty.gov/SDSInter/dhs/1010204_2015-16MHLAAnnualReport(final).pdf).

⁷³ P.4 [http://file.lacounty.gov/SDSInter/dhs/1010204_2015-16MHLAAnnualReport\(final\).pdf](http://file.lacounty.gov/SDSInter/dhs/1010204_2015-16MHLAAnnualReport(final).pdf).

Funding and Provider Payment

Funding for MHLA comes from Los Angeles County. Currently, the program's annual budget is \$65 million. When MHLA originally started in October of 2014, it was funded at \$61 million for the year.⁷⁴

In Fiscal Year 2015-16, payments to community partner clinics for MHLA participants totaled \$57,462,497.⁷⁵ MHLA uses a capitated payment system with payments made directly to participating clinics. In FY 2015-16, the per participant per month payment rate was \$32 for primary care services (excluding dental) which is based on 1,646,443 participant months.⁷⁶ It is important to note that capitation payments to clinics were made on behalf of all participants, but 35% of these individuals did not receive a primary care service.⁷⁷ This underscores the importance of not only investing in clinical services for individuals, but also supporting the wraparound services that foster access to care, such as a care manager offers.

Other Considerations

No ordinance establishes the structure and requirements for MHLA. Rather, in 2014 the Los Angeles County Board of Supervisors directed the Department of Health Services to allocate the funds to administer the program. Each fiscal year the Board of Supervisors allocates funding for MHLA.⁷⁸

3. Contra Costa Cares (CCC)

Eligibility Criteria

To be eligible, individuals must be 19 years of age or older, residents of Contra Costa County,⁷⁹ with income up to 138% FPL, and ineligible for full-scope Medi-Cal or Covered California.⁸⁰

Enrollment Process

Eligibility determinations are conducted at community health centers and the completed applications are sent to the Contra Costa Health Plan (CCHP) which serves as the fiscal agent and manages the

⁷⁴ P.2 http://lahealthaction.org/library/cms1_221461.pdf.

⁷⁵ P.37 [http://file.lacounty.gov/SDSInter/dhs/1010204_2015-16MHLAAnnualReport\(final\).pdf](http://file.lacounty.gov/SDSInter/dhs/1010204_2015-16MHLAAnnualReport(final).pdf). This amount includes: \$46,100,404 in payments to community partner clinics for preventive and primary care services; \$6,585,772 in pharmacy related services; and \$4,776,321 in payments to community partner clinics for dental services provided by those clinics contracted with DHS to provide dental care to MHLA enrolled and eligible patients.

⁷⁶ P.4 [http://file.lacounty.gov/SDSInter/dhs/1010204_2015-16MHLAAnnualReport\(final\).pdf](http://file.lacounty.gov/SDSInter/dhs/1010204_2015-16MHLAAnnualReport(final).pdf).

⁷⁷ P.36 [http://file.lacounty.gov/SDSInter/dhs/1010204_2015-16MHLAAnnualReport\(final\).pdf](http://file.lacounty.gov/SDSInter/dhs/1010204_2015-16MHLAAnnualReport(final).pdf).

⁷⁸ P.2 http://lahealthaction.org/library/cms1_221461.pdf.

⁷⁹ Contra Costa is a Northern California County in the Northwest Bay Area, with a population of approximate 1.05 million people. See <https://suburbanstats.org/population/california/how-many-people-live-in-contra-costa-county>.

⁸⁰ Contra Costa CARES Frequently Asked Questions, 2015, available at <https://cchealth.org/insurance/pdf/2015-Contra-Costa-CARES-faq.pdf>.

program at no additional cost.⁸¹ To complete an application, personal identification, proof of county residency, and proof of income are required. Social security numbers and ITINs are collected when available. Once an application is reviewed and approved, CCHP sends an identification card to the applicant.⁸² Enrollment for Contra Costa Cares (CCC) is capped at 4,100. Initial enrollment for Contra Costa Cares (CCC) was capped at approximately 3,000 enrollees based on available funding.⁸³

Model for Care Provision and Participating Providers

The program uses a medical home model through three participating community health center organizations,⁸⁴ with a total of seven sites across the county.⁸⁵

Benefits and Out-of-Pocket Costs

Benefits are designed around primary care and increasing access to preventive services, particularly for the uninsured immigrant population. Program participants are not charged cost sharing for services provided through the program.⁸⁶ This includes medical office visits at the assigned community clinic, health evaluations, diagnosis and treatment services, immunizations, basic laboratory services related to primary care, basic radiology (x-ray) services, health education and chronic disease management, and access to a 24-hour nurse advice line administered by CCHP.⁸⁷

Excluded services are specialty care, dental, vision, emergency care and inpatient hospitalization.⁸⁸ There is also no specific case management or care coordination component to the program, although most of the community clinics provide some level of care coordination. Pharmacy services are accessed through the community health clinics directly and their sliding scale fee or pharmacy discount programs.

⁸¹ Contra Costa Cares A New Program for Uninsured Contra Costa Residents, Sept. 2015, p.2, available at http://64.166.146.245/docs/2015/BOS/20150922_643/23262_Contra%20Costa%20CARES%20program%20description%209.16.15.pdf.

⁸² Contra Costa Cares A New Program for Uninsured Contra Costa Residents, Sept. 2015, p.2, available at http://64.166.146.245/docs/2015/BOS/20150922_643/23262_Contra%20Costa%20CARES%20program%20description%209.16.15.pdf.

⁸³ P.1 Contra Costa CARES Year 1 Report, Contra Costa FAQs available at <https://cchealth.org/insurance/pdf/2015-Contra-Costa-CARES-faq.pdf>

⁸⁴ Contra Costa CARES preliminary trends report, April 2016, p. 1. The Contra Costa CARES FAQs and brochure list additional clinics as options for medical homes, but ultimately three clinics with seven sites became program participants as confirmed by interviews with program staff.

⁸⁵ Contra Costa Cares A New Program for Uninsured Contra Costa Residents, Sept. 2015, p.1, available at http://64.166.146.245/docs/2015/BOS/20150922_643/23262_Contra%20Costa%20CARES%20program%20description%209.16.15.pdf.

⁸⁶ Contra Costa CARES Frequently Asked Questions, 2015, available at <https://cchealth.org/insurance/pdf/2015-Contra-Costa-CARES-faq.pdf>.

⁸⁷ <https://cchealth.org/insurance/pdf/2015-Contra-Costa-CARES-faq.pdf>.

⁸⁸ Contra Costa Cares A New Program for Uninsured Contra Costa Residents, Sept. 2015, p.2, available at http://64.166.146.245/docs/2015/BOS/20150922_643/23262_Contra%20Costa%20CARES%20program%20description%209.16.15.pdf.

Funding and Provider Payment

Contra Costa Cares started as a twelve-month pilot program with total of \$1 million funding from Contra Costa County, and three hospitals including Kaiser Permanente, John Muir, and Sutter.⁸⁹ The program initially capped enrollment to approximately 3000 eligible individuals, although it was estimated that approximately 19,000 uninsured individuals in the county could qualify for the program.⁹⁰ The pilot was extended to eighteen months.⁹¹ Since then, the program has evolved from its pilot status and is now in its first “post-pilot” program year, capped at 4,100 enrollees with a waiting list and a budget of \$1.5 million.

Primary care providers are paid on a capitated basis estimated at \$28 per member per month (PMPM) for a total annual cost of \$336 per participant.⁹² The PMPM is intended to cover the cost of primary care services as well as basic laboratory and radiology (x-ray) services.⁹³ The cost of the remaining services offered through the program are absorbed by the participating clinics.

Other Considerations

Similar to My Health LA, a local or county ordinance was not adopted to implement Contra Costa Cares. Rather, the Board of Supervisors voted to pass a proposal which established and funded the program, leaving the implementation of its structure to program staff.⁹⁴

B. Maryland – Montgomery Cares

Eligibility Criteria

To be eligible, individuals must be 18 years of age or older, reside in Montgomery County, Maryland, be ineligible for health insurance or public coverage options, and have a household income at or below 250% FPL.⁹⁵

⁸⁹ Contra Costa CARES preliminary trends report, April 2016, p. 1.

⁹⁰ Contra Costa Cares A New Program for Uninsured Contra Costa Residents, Sept. 2015, p.1, available at http://64.166.146.245/docs/2015/BOS/20150922_643/23262_Contra%20Costa%20CARES%20program%20description%209.16.15.pdf.

⁹¹ P.1 Contra Costa CARES Year 1 Report.

⁹² Contra Costa Cares A New Program for Uninsured Contra Costa Residents, Sept. 2015, p.2, available at http://64.166.146.245/docs/2015/BOS/20150922_643/23262_Contra%20Costa%20CARES%20program%20description%209.16.15.pdf.

⁹³ Contra Costa Cares A New Program for Uninsured Contra Costa Residents, Sept. 2015, p.2, available at http://64.166.146.245/docs/2015/BOS/20150922_643/23262_Contra%20Costa%20CARES%20program%20description%209.16.15.pdf.

⁹⁴ P.235 http://64.166.146.245/docs/2015/BOS/20150922_643/653_09-22-15_1543_AGENDApacket.pdf, P.5 http://health-access.org/images/pdfs/2016_Health_Access_Profiles_of_Progress_County_Report_5_31_16.pdf.

⁹⁵ <https://montgomerycares.org/what-is-montgomery-cares/>.

Enrollment Process

To enroll in the program, individuals must apply in-person at a Montgomery Cares participating clinic.⁹⁶ Proof of income and Montgomery County residency are required to complete the application.⁹⁷ Once eligibility is determined at the clinic, a Montgomery Cares identification card is provided as proof of enrollment in the program.⁹⁸

The clinic at which an individual completes the enrollment application becomes their medical home.⁹⁹ However, enrollees can change their medical home at any time without penalty.¹⁰⁰

Model for Care Provision and Participating Providers

Montgomery Cares utilizes a medical home model to provide primary care services to its enrollees through a network of 11 clinics. Program participants are encouraged to access services through their medical home, but they are not denied services if they seek services from another participating clinic. An analysis was conducted to determine the incidence of clinic shopping amongst participants and it revealed that only 8% of enrollees sought care from participating clinics other than their assigned medical home. One reason that patients sometimes seek care from outside their assigned medical home is to obtain a specialty service that is not available at their assigned clinic, as these services vary from clinic to clinic.

Benefits and Out-of-Pocket Costs

Montgomery Cares provides primary and preventive care services including medical checkups, sick visits to diagnose and treat illnesses, age appropriate screenings, behavioral health care, some medications through MedBank,¹⁰¹ and flu shots.¹⁰² With a referral, individuals can also access laboratory and x-ray services, limited specialty care, limited dental services, and prenatal care through Maternity Partnership, a separate county-based program that provides prenatal care to low-income uninsured pregnant individuals.¹⁰³ Some specialty care is available through the clinics themselves, although the availability of onsite specialties varies from clinic to clinic. For access to specialists unavailable directly through the clinics, enrollees are referred to specialty care referral network programs, Project Access¹⁰⁴ and Catholic Charities Health Care Network, for low-cost or pro-bono specialty care services.¹⁰⁵ Overall, 80% of specialty care referrals are filled. Some clinics operate integrated behavioral health programs, others

⁹⁶ <https://montgomerycares.org/what-is-montgomery-cares/>.

⁹⁷ <https://montgomerycares.org/what-is-montgomery-cares/>.

⁹⁸ <https://montgomerycares.org/what-is-montgomery-cares/>.

⁹⁹ <https://montgomerycares.org/how-to-get-care/>.

¹⁰⁰ <https://montgomerycares.org/how-to-get-care/>.

¹⁰¹ Montgomery Cares operates its own MedBank program, not affiliated with the statewide program that assists low-income individuals obtain brand name prescription medications, see https://medbankmd.org/For_Patients.htm.

¹⁰² <https://montgomerycares.org/health-services/>.

¹⁰³ <https://montgomerycares.org/health-services/>.

¹⁰⁴ Montgomery Cares has a team of nurses and client services specialists who receive referrals from the clinics, triage them, and then arrange for specialty care.

¹⁰⁵ In Fiscal Year 2018, essential services are established in Montgomery Cares clinic contracts that clinics are expected to provide. See p.27 <https://primarycarecoalition.org/wp-content/uploads/2017/07/4-FY17-Montgomery-Cares-Final-Report.pdf>.

contract with a behavioral health provider. The program does not cover emergency room care, hospitalization, or urgent care.¹⁰⁶

Dental services are limited, as only 3 of the 11 Montgomery Cares clinics have a dental component available on site. The other clinics refer patients to 6 available dental clinics operated by the Montgomery County Department of Health and Human Services.

Prescription drug coverage available directly through the program is limited to 40 medications in 9 medication classes. The total program wide budget for prescription medications is \$1 million, and each clinic is allocated a portion based on patient volume. The clinics each decide how to spend their pharmacy funds through the Montgomery County Community Pharmacy (e.g., some clinics may spend more on hypertension and others on diabetes). Medications are covered for individuals up to 138% FPL; individuals with income 139-250% FPL are provided prescription discount cards and connected to reduced cost programs.

Each clinic has its own sliding scale fee schedule, so out-of-pocket costs vary. However, a clinic may not charge more than \$35 per visit for enrollees with income at or below 100% FPL, and enrollees cannot be denied service for inability to pay. Typically, 85-95% of patients are able to pay their fees, and payment plans are available for those unable to pay at the time of service.

Funding and Provider Payment

The Montgomery County Primary Care Coalition (PCC) administers the program and is responsible for coordinating the services of the participating providers.¹⁰⁷ The program is funded through a combination of sources including Montgomery County, grants obtained by the PCC, in-kind services secured by the participating clinics, and private donations.¹⁰⁸ The annual budget for the program is \$12 million, which includes \$1 million that is earmarked for pharmacy benefits.

Montgomery Cares reimburses participating clinics \$73 for both primary care or specialty care in person office visits. Clinics are not reimbursed for laboratory services; each clinic is responsible for those costs.

Other Considerations

Selected measures of clinical performance among clinics participating in Montgomery Cares are published annually.¹⁰⁹

C. Nevada – Access to Health Care Network Medical Discount Program

Eligibility Criteria

Nevada's Access to Health Care Network operates several programs, one of which is the Medical Discount Program (MDP) that has its roots in Washoe County but has since expanded to serve

¹⁰⁶ <https://montgomerycares.org/how-to-get-care/>.

¹⁰⁷ <https://primarycarecoalition.org/what-we-do/montgomery-cares>.

¹⁰⁸ <https://primarycarecoalition.org/what-we-do/montgomery-cares>.

¹⁰⁹ Montgomery Cares Clinical Performance Measures Fiscal Year 2015 *available at* <https://primarycarecoalition.org/wp-content/uploads/2016/01/Clinical-Measures-Annual-Report-FY-2015.pdf>.

populations statewide. Eligibility for MDP requires Nevada residency, un- or under-insured status, and an income of 100-250% FPL.¹¹⁰ Under-insured is defined as having health coverage that does not cover all services.¹¹¹ Individuals who have only Part A or Part B Medicare are eligible to enroll in MDP as under-insured.¹¹²

Enrollment Process

Individuals interested in MDP can complete an online application and will get a call within 2 business days to complete the intake process and enroll in the program.¹¹³ Individuals can also schedule an appointment to complete an application in person at MDP offices. Upon enrollment, individuals will receive an MDP identification card and member manual.¹¹⁴ The member manual is also available online. Each member is assigned an MDP care coordinator to help manage their care.¹¹⁵

Since the passage of the ACA, membership has been steady at 5,000 annually. An estimated 75% of enrollees are undocumented immigrants. Since the program's inception there have been 45,000 individuals enrolled.

Model for Care Provision and Participating Providers

MDP uses a medical home model. Patients are assigned a primary care provider and are expected to establish care within 90 days. Primary care providers send referrals to the member's MDP care coordinator for fulfillment.¹¹⁶ Referrals are required for specialty care (gynecology, orthopedics, cardiology, etc.), radiology, physical therapy, nutrition/dietician, and hospital services.¹¹⁷ Referrals are not necessary for general dentistry, optometry, chiropractic, massage, acupuncture, or audiology, among others.¹¹⁸

MDP has a network of over 2,000 providers in the state of Nevada.¹¹⁹ MDP contracted providers include CHCs, hospitals, emergency departments, urgent care centers, specialty care provider groups, DME and medical supply companies. Availability of specific provider types varies across the state.¹²⁰

¹¹⁰ <http://www.accesstohealthcare.org/services-individuals/medical-discount-program>.

¹¹¹ <http://www.accesstohealthcare.org/services-individuals/accesshealth/accesshealth-faqs>.

¹¹² <http://www.accesstohealthcare.org/services-individuals/accesshealth/accesshealth-faqs>.

¹¹³ <http://www.accesstohealthcare.org/services-individuals/accesshealth/enroll>.

¹¹⁴ <http://www.accesstohealthcare.org/services-individuals/medical-discount-program-mdp/how-use-your-medical-discount-program-membership>.

¹¹⁵ <http://www.accesstohealthcare.org/services-individuals/medical-discount-program-mdp/how-use-your-medical-discount-program-membership>.

¹¹⁶ <http://www.accesstohealthcare.org/services-individuals/medical-discount-program-mdp/how-use-your-medical-discount-program-membership>.

¹¹⁷ P.18 <http://www.accesstohealthcare.org/sites/default/files/updated%20no%20abs%20denStatewide%20Member%20Manual%20-%20Final%20-%20English%20-%204.15.pdf>.

¹¹⁸ p.19

<http://www.accesstohealthcare.org/sites/default/files/updated%20no%20abs%20denStatewide%20Member%20Manual%20-%20Final%20-%20English%20-%204.15.pdf>.

¹¹⁹ <http://www.accesstohealthcare.org/services-individuals/medical-discount-program>.

¹²⁰ See <http://providerlist.accesstohealthcare.org/apex/providerList>.

Benefits and Out-of-Pocket Costs

Services available through MDP include primary care, specialty care, behavioral health, hospitals and clinics, dental, optometry, radiology, surgery, prescriptions, acupuncture, durable medical equipment, and nutrition/diabetes management. Program officials indicate that there are no specific service exclusions other than organ transplants, cosmetic surgery, ambulance services, infertility treatment, Lasik eye surgery and other services that are not medically necessary. They have not yet encountered a request for sexual reassignment surgery.¹²¹

MDP uses a “shared responsibility model” which discounts the cost of care but requires enrollees to pay substantial out-of-pocket costs to enroll and maintain membership in the program. The program emphasizes the idea that everyone should pay a little to get something in exchange, and for members to understand the value of the program. Based on income, individuals are placed in either Tier 1 or Tier 2 at the time of enrollment.¹²² Tier 1 includes lower income individuals and lower membership and point-of-service fees than Tier 2.¹²³ MDP recently increased its fee scale for the first time since the program’s inception. In addition to monthly membership fees, participants are responsible for point-of-service fees payable at the time of service. These fees vary depending on the service and the membership Tier of the enrollee; typically, there is a \$5 - \$10 difference in Tier 1 versus Tier 2 fees.¹²⁴

	Tier 1	Tier 2
Monthly membership fees	\$40	\$45
Primary care – new patient	\$70	\$80
Primary care – follow up	\$50	\$55
Specialty care – new patient	\$150	\$160
Specialty care – follow up	\$75	\$80

Members are informed of fees prior to the appointment and are aware that fees are due at the time of service.

Reduced cost prescriptions are available statewide through any Walmart pharmacy or Walmart’s mail order prescription program.¹²⁵ Additionally, there are a few contracted pharmacies available throughout the state.¹²⁶

¹²¹ Access to Healthcare Network Medical Discount Program Member Manual p.18 (Sept. 1, 2017).

¹²² p.4

<http://www.accesstohealthcare.org/sites/default/files/updated%20no%20abs%20denStatewide%20Member%20Manual%20-%20Final%20-%20English%20-%204.15.pdf>.

¹²³ p.6

<http://www.accesstohealthcare.org/sites/default/files/updated%20no%20abs%20denStatewide%20Member%20Manual%20-%20Final%20-%20English%20-%204.15.pdf>.

¹²⁴ <http://www.accesstohealthcare.org/current-members/access-medical-discount-plan/>.

¹²⁵ p.19 <http://www.accesstohealthcare.org/sites/default/files/updated%20no%20abs%20denStatewide%20Member%20Manual%20-%20Final%20-%20English%20-%204.15.pdf>.

¹²⁶ p. 19

<http://www.accesstohealthcare.org/sites/default/files/updated%20no%20abs%20denStatewide%20Member%20Manual%20-%20Final%20-%20English%20-%204.15.pdf>.

Funding and Provider Payment

For the first 2 years, the program was funded through a \$300,000 grant and funding from hospitals. The monthly membership fees are the only ongoing source of funding for the program.

Providers are paid directly by members at the time of service. MDP does not reimburse providers directly for any service. The fee schedule is available in the MDP member handbook or an enrollee or provider can speak to a care coordinator for fee information.¹²⁷

Other Considerations

The program has never been formally evaluated since its inception nearly a decade ago. Officials at the program consider its success based on the continued membership of individuals, the providers that remain in the network, and low rates of emergency room utilization. When the program first began, emergency room utilization among the uninsured was between 30 and 40 percent. Now it is one-half of one percent.¹²⁸

MDP enforces strict no call, no show and non-payment policies. If a member has two instances of no call and no show, they will be terminated from the program. Similarly, after any instance of non-payment of service, members will be terminated. Since the program's inception, 35 individuals have been terminated for no-call no-show and 400 have been terminated for non-payment.¹²⁹ Members terminated because of non-payment can re-enroll after paying off any balance owing to MDP contracted providers but only if the non-payment was due to circumstances out of the member's control (typically limited to urgent/emergency medical services).¹³⁰

D. New York – ActionHealthNYC

Eligibility Criteria

To be eligible for Action Health New York City (NYC), an individual must be a New York City resident, 19 years of age or older, have an income of 200% FPL or under, and be uninsured and ineligible for public health insurance coverage through the New York Marketplace or Medicaid.¹³¹

Enrollment Process

ActionHealthNYC's pilot program operated for a year and ended in June 2017. Because of the short duration of the program, there was a limited 15-week enrollment period with a total of 1,300 members enrolled. To apply for ActionHealthNYC, individuals had to have a New York City resident identification card or "IDNYC" or have proof they had applied for one.

¹²⁷ See <http://www.accesstohealthcare.org/sites/default/files/updated%20no%20abs%20denStatewide%20Member%20Manual%20-%20Final%20-%20English%20-%2004.15.pdf>.

¹²⁸ It is unclear whether this emergency room utilization rate is limited to Washoe County or refers to statewide utilization.

¹²⁹ Termination is usually related to non-payment of a pathology bill that comes out after the date of service.

¹³⁰ Members terminated due to non-compliance with program guidelines (being abusive with staff/providers, no call/no shows to appointments) are not permitted to re-enroll.

¹³¹ <http://www1.nyc.gov/assets/doh/downloads/pdf/ahnyc/actionhealthnyc-faq.pdf>.

Health insurance enrollment counselors completed applications at 7 different application sites. The intake included a screen for health coverage eligibility.¹³² The individual would then select their medical home site and an initial appointment would be scheduled where a health history and psychosocial assessment was conducted. The medical home would be provided with a list of patients that had selected the site as a medical home. The medical home would then verify the individual had an appointment scheduled, if not then medical home staff would outreach to schedule an appointment.

Model for Care Provision and Participating Providers

ActionHealthNYC adopted a primary care medical home model with an enhanced care coordination component. There were 9 participating medical home sites, including 2 New York City Health + Hospitals sites and 7 FQHCs.¹³³ There were 11 hospitals and emergency departments participating in the program as well.¹³⁴

Benefits and Out-of-Pocket Costs

Services covered by ActionHealthNYC include preventive care appointments, immunizations and screening for diabetes, blood pressure, cancer, and other health conditions, mental health and substance use services, family planning (including birth control), help navigating the health care system, vision care, specialty care, emergency room visits, and inpatient care at certain hospitals. Acupuncture, chiropractic care, non-restorative cosmetic procedures, long term care, and both emergency and non-emergent medical transportation were not covered.

Pharmacy services were not directly covered by the program. However, NYC has a city-wide prescription discount program, called BigAppleRx, available to any NYC resident with their IDNYC. Laboratory services were also not covered through the program, but medical homes provided these services to ActionHealthNYC enrollees through existing channels.

Services obtained through ActionHealth NYC required cost-sharing. Individuals at or below 150% FPL paid lower fees than individuals 151-200% FPL.¹³⁵ For example, a clinic or emergency room visit is associated with a \$15 fee for individuals below 150% FPL and a \$20 fee for individuals 151-200% FPL.¹³⁶ Similarly, a hospital stay requires payment of a \$150 fee for individuals below 150% FPL and payment of a \$300 fee for individuals 151-200% FPL.¹³⁷

Funding and Provider Payment

The pilot was privately funded as a research project through three foundations. The enrollment and registration systems as well as most costs for materials were city funded.

¹³² <http://www1.nyc.gov/site/immigrants/programs/social-economic/actionhealthnyc-applying.page>.

¹³³ P.16 <http://www1.nyc.gov/assets/doh/downloads/pdf/ahnyc/action-health-member-handbook.pdf>.

¹³⁴ P.17 <http://www1.nyc.gov/assets/doh/downloads/pdf/ahnyc/action-health-member-handbook.pdf>.

¹³⁵ Pg. 15 <http://www1.nyc.gov/assets/doh/downloads/pdf/ahnyc/action-health-member-handbook.pdf>.

¹³⁶ P. 14 <http://www1.nyc.gov/assets/doh/downloads/pdf/ahnyc/action-health-member-handbook.pdf>.

¹³⁷ P. 14 <http://www1.nyc.gov/assets/doh/downloads/pdf/ahnyc/action-health-member-handbook.pdf>.

Providers were paid on a capitated basis. The primary care per member per month (PMPM) payment was \$35.25 and specialty care PMPM was \$24. Specialty care was provided to ActionHealthNYC enrollees through the public hospital system. The fee scale adopted by ActionHealthNYC was based on the public hospital system and reflected lower fees than existing FQHC sliding scale schedules. To ensure a standardized fee scale across all providers in the program, FQHCs were compensated with a lump sum payment at the beginning of the year to “buy down” their higher fees.

Additional payment was made to participating clinics for intensive care management for individuals designated for Enhanced Care Coordination (ECC). ECC patients were higher risk patients, based on physician diagnosis and there was a specific list of ECC conditions.

Providers were paid to deliver data required to conduct the program evaluation including patient demographics, utilization of services, clinical procedures and diagnoses, and others.

Other Considerations

ActionHealthNYC was launched as a pilot project by the mayor’s office and was coordinated between the New York Department of Health and the mayor’s office. The program was not implemented through legislation. The pilot ended in June of 2017 as funding came to an end.

IV. Economic Analysis for King and Yakima Counties

We engaged an economic consulting firm, HealthTrends, to develop a rough estimate of the costs to implement county-based coverage programs for individuals without other affordable coverage options in two Washington Counties, King and Yakima.¹³⁸ First we needed to approximate the size of the potential enrollee population for the proposed program. HealthTrends estimated the number of adults aged 19 and older in each county who are ineligible for full-scope Apple Health (Medicaid and CHIP) or Medicare. The estimate excludes immigrants who are eligible for QHP coverage but who do not purchase it due to its unaffordability.¹³⁹ Based primarily on data from the Migration Policy Institute¹⁴⁰ and the Washington State Office of Financial Management, HealthTrends estimated that the potential population of eligible individuals in King and Yakima counties would be 35,430 and 15,563 respectively.

HealthTrends used information from the MEPS database, which is comprised of encounter-based health care data with fields including, among other things, diagnosis codes for the encounters, the cost of the care delivered, the clinical setting where the care was provided, and the income (within designated income ranges) of the individual who received the care. The clinical settings relevant to our analysis included primary care (office-based), specialty care (office-based), hospital outpatient, hospital inpatient, emergency room, home health, dental, and a category “other medical expenses” that includes services such as durable medical equipment. Costs are classified by the setting in which they are

¹³⁸ The full HealthTrends report is Appendix C to this report.

¹³⁹ As discussed in our “Recommendations” section, we support creating a program that would be open to individuals who are eligible for QHP enrollment and subsidies, but who find it unaffordable. However, in designing an initial model, it was easiest to develop estimates for those individuals who are not eligible for publicly funded health coverage or subsidies.

¹⁴⁰ The Migration Policy Institute is an independent, nonpartisan, nonprofit think tank in Washington, DC dedicated to analysis of the movement of people worldwide. See <https://www.migrationpolicy.org/>.

incurred, rather than the procedure or type of care for which they were billed, so it is challenging to extract specific services such as the cost of outpatient behavioral health services or routine vision care. However, for counties interested in pursuing a county-based program, we recommend further and more refined data segmentation for cost forecasting of specific services that the county may cover.

HealthTrends used publicly available information from the county-based programs profiled in the report, rather than MEPS, in estimating program pharmacy costs. This helped ensure that the cost estimates for this service were likely to be grounded in real-world experience. The average per member per month expenditure for pharmacy coverage is forecasted as \$4.47.

To project the costs of health care service utilization for potential program enrollees, HealthTrends estimated the scope of the “insurance effect” on health care use by program enrollees. The “insurance effect” is the impact on health care service utilization by uninsured individuals when they get coverage. Specifically, individuals without coverage have been found to forego some level of care while they are uninsured. Once covered, these same individuals tend to seek out care. This results in an initial overall increase in health care utilization when an uninsured population obtains coverage.¹⁴¹ Counties implementing a program of the kind we propose should thus expect increased utilization of health care services by program participants once they enroll.

Estimated Program Costs

In King County total program costs are forecasted to range from approximately \$53 million in 2020 to approximately \$68 million by 2025. In Yakima County the total program costs are forecasted to range from slightly over \$18 million in 2020 to over \$21 million by 2025. These estimates include both medical and administrative expenditures. The forecast may underestimate the cost of hospital, emergency room, and inpatient costs, particularly for King County, due to an assumption that 100% of hospital-based care would be written off as charity care for individuals up to 300% FPL. Some hospitals may have these charity care standards, but standards vary across hospitals and some services may be rendered by non-hospital employees making them ineligible for charity write-off. More details about the assumptions on which these estimates were based are found in Appendix C.

V. Proposal for Washington State Counties

There are various ways to design a county-based program. Given the findings from our research and the economic analysis, we recommend some general parameters that are reasonable, equitable, and responsive to the needs of the population. We look forward to further discussion to refine and tailor these to the specific counties developing plans to implement county-based programs.

¹⁴¹ For example, the ACA’s coverage expansion in 2014 spurred a spike in spending as expected due to pent up demand. However, the use and intensity of services decelerate over time. See <https://idi.upenn.edu/brief/effects-aca-health-care-cost-containment>.

A. Preliminary Issues

1. Why Choose King and Yakima Counties?

To be successful, any county-based coverage program must be tailored to fit within the state's broader health care environment, and to take into account the individual characteristics of the population, health needs, and local providers. With the help of our consultants, HealthTrends, we selected King and Yakima Counties as the first two areas to evaluate for county-based coverage programs. This choice was based on several factors. First, both counties would likely reap a substantial benefit from a program of this sort, as both have significant uninsured immigrant populations who will make up a large part of the enrollee population. Second, we wanted to pick two counties with significant differences that still had the health care infrastructure needed to facilitate the creation and implementation of a program like this. King County was chosen because it is a Western Washington county with a network of primary care clinics and multiple hospital systems including a major safety-net publicly operated hospital (Harborview), a robust public health department that provides some clinical services, a public transportation system, and other services that would ease low income individuals' access to participating providers. We selected Yakima County which is more rural. Even though it has fewer residents than King County, Yakima still has the population base and health care infrastructure needed to create a robust safety-net care program, with a network of community clinics and several local hospitals. Most importantly, in both counties, our interviews with policymakers and stakeholders when developing this report indicated there would be interest in exploring potential solutions to the lack of health care access for immigrants.

2. Gathering Information on Local Conditions

In preparing this report, we engaged in structured discussions with health system experts in both King and Yakima counties. We gathered information that allowed us to craft proposals tailored to local needs and conditions. In King County we conducted five interviews of knowledgeable key informants – public health officials, community providers, health center administrators, and policy advocates. We also consulted with the former director of Project Access regarding access to specialty care services, an identified gap in care for uninsured immigrants. In Yakima County, we interviewed a community health center administrator and a legal advocate. We also spoke to staff at Washington Healthcare Access Alliance, the association of free clinics.

We heard that some community clinics that provide primary care are close to capacity resulting in long waits before someone can obtain follow-up care. Some individuals do not regularly visit one health center but go to different ones, and some avoid seeking care altogether; in the experience of persons we interviewed, this is due to their inability to pay the sliding-scale charges. This results in delays in care, or fragmented care with poor follow-up.

We asked interviewees what services were least accessible to low-income immigrants. They most frequently identified dental care, diagnostic tests and labs, vision, behavioral health care, prescription

medications, diabetic supplies, specialty care, interpreter services, and travel and transportation in rural areas.^{142,143}

Another concern many expressed is the need to design the program in a manner sensitive to the fear and lack of trust that many in the immigrant community experience. They must ensure individuals feel that it is safe to access the health care and services they need. This affects how the enrollment process works, communications with those eligible, and locations where services are provided.

B. Recommendations for Program Elements

Based on our research of profiled programs, identifying promising practices that offer a viable model, and an economic analysis prepared by HealthTrends, we offer these initial recommendations for program components for Washington counties to consider:

1. Eligibility Criteria

Recommendations

To qualify for the program, an individual should:

- Reside in the county in which the county-based program operates
- Have household income at or below a threshold set at or above 400% of the Federal Poverty Level (FPL)
- Be uninsured and ineligible for other coverage or be unable to cover the cost of a Qualified Health Plan (QHP) in the Washington Health Benefit Exchange (HBE)
- Be 19 years of age or older

The county-based programs we examined generally had eligibility requirements that limited enrollment to adults, residents in the county in which the program operates, income, and uninsurance/uninsurability status. These provide a framework on which to limit participation in the program. For eligibility criteria comparison among the programs we researched, see Appendix A.

Discussion

County residency – An applicant for services through a county-based coverage program should be a resident of that county to be eligible for the program. The county is implementing and seeking funding for the program to benefit its residents. Requiring county residency is a standard feature of all the programs we researched and may be verified through a driver’s license or state identification card, utility bill with name and address listed, lease or letter from the landlord, or self-attestation (particularly useful for homeless individuals who may not have other documentation available), among others.

¹⁴² Limited access to housing was mentioned by several individuals but is not within the scope of a county-based health coverage program.

¹⁴³ Types of services in demand at the Seattle/King County clinic include immunizations, laboratory tests, physical exams including women’s health exams, and radiology services. For more information, see, <https://seattlecenter.org//nas/content/live/scfweb2016/nas/content/live/scfweb2016/media/2017-SKC-Clinic-Final-Report.pdf>.

Income - The purpose of this program is to enable low-income individuals, and particularly immigrants, to access health services. Counties should strive to offer coverage to all eligible individuals who have income up to at least 400% FPL, the current income cutoff for eligibility for premium assistance when purchasing QHPs. Healthy San Francisco is a model in this regard. At a bare minimum, or first step, as a matter of equity, a program should fully cover immigrants with income below the Medicaid income threshold of 138% FPL, including both undocumented persons and those who qualify for subsidized (but not free) QHP coverage.¹⁴⁴ Both My Health LA and Contra Costa Cares provide services at no cost to all enrollees up to 138% FPL. We highly recommend also offering coverage to those who are eligible for subsidies but may be unable to afford their premiums or the cost-sharing associated with the care they and their families require.¹⁴⁵ The costs are still a significant deterrent to getting care; studies show that imposing even minimal cost-sharing on low-income individuals can decrease their use of needed health care services.¹⁴⁶ This can be addressed through a wraparound, similar to the recently-adopted premium and cost-sharing assistance program for Compact of Free Association (COFA) migrants.¹⁴⁷

For those who are ineligible for subsidies and who cannot purchase coverage on the Exchange due to their immigration status, individual insurance on the commercial market is out of reach financially. Optimally, the program should provide affordable coverage to those with income at or below a threshold set at or above 400% FPL, an income level that qualifies for Exchange financial assistance. Healthy San Francisco provides a model for a program that reaches people up to 500% FPL. Cost of living should be considered in developing the upper income limit of a county-based program.¹⁴⁸ Offering reduced-fee care to families with income above 400% of the poverty level acknowledges and addresses the real phenomenon that, in the absence of ACA-based subsidies, insurance can be unaffordable for many families, particularly if they need costly care.

Uninsurance Status – The primary aim of this program is to offer care to the lowest income individuals who are excluded from Medicaid and Qualified Health Plans due to their immigration status. We recognize, though, that at low income levels, others may be unable to cover QHP costs, even with subsidies, and should not be excluded from the program because they have access in name only to coverage that is actually unaffordable to them.

¹⁴⁴ One possible approach would be for the county to leverage QHP coverage available to documented immigrants and assist them in paying the premiums and cost-sharing required of enrollees. Affordability, however, is a general problem and not limited to the immigrant community.

¹⁴⁵ Jennifer Tolbert and Katherine Young, *Paying for Health Coverage: The Challenge of Affording Health Insurance Among Marketplace Enrollees* (Washington, DC: Kaiser Family Foundation, April 2016), available at <http://files.kff.org/attachment/issue-brief-paying-for-health-coverage-the-challenge-of-affording-health-insurance-among-marketplace-enrollees>; Rachel Garfield and Katherine Young, *How Does Gaining Coverage Affect People's Lives? Access, Utilization, and Financial Security among Newly Insured Adults* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, June 2015), available at <http://kff.org/healthreform/issue-brief/how-does-gaining-coverage-affect-peoples-lives-access-utilization-and-financial-security-among-newly-insuredadults/>.

¹⁴⁶ Artiga, Ubri, and Zur, *The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings* (Kaiser Family Foundation, June 2017), available at <http://files.kff.org/attachment/Issue-Brief-The-Effects-of-Premiums-and-Cost-Sharing-on-Low-Income-Populations>.

¹⁴⁷ Senate Bill 5683, Ch. 161, 2018 Laws, <http://apps2.leg.wa.gov/billsummary?BillNumber=5683&Year=2017&BillNumber=5683&Year=2017>.

¹⁴⁸ See e.g., http://selfsufficiencystandard.org/sites/default/files/selfsuff/docs/WA2017_SSS.pdf (finding that in Washington State income required for economic self-sufficiency varies considerably by geography. “[T]he amount needed to make ends meet for one adult and one preschooler varies from \$15.09 per hour (\$31,870 annually) in Adams County to \$30.69 per hour (\$64,816 annually) in King County (East), or from 196% of the federal poverty guidelines to 399% of the federal poverty guidelines for a family of two.” Page VII.)

Age – This program would be for adults. Washington State already offers full-scope coverage to children through the age of 18 regardless of immigration status through the Apple Health for Kids program. Currently, when these children age out of coverage, there is no coverage, or less coverage, available. A county program would offer continue of coverage from that point on.

2. Enrollment Process

Recommendations

- Applications should be available at participating clinic sites, other community locations, and online.
- Enrollment should be conducted by navigators and application assisters in a culturally appropriate and linguistically accessible manner.
- The application system should give all participating providers access to information on the individual’s medical home.
- Social security numbers and information about immigration status should not be collected as part of enrollment.

Discussion

Application Availability:

Centralized vs. distributed enrollment sites - The programs we researched primarily used two enrollment models. One model conducted enrollment activities through a centralized process, identified a medical home for the individual, and referred them for an initial appointment to establish care.¹⁴⁹ The other model used onsite enrollment processes at participating clinic locations. Among those, some assigned enrollees to the clinic at which they applied for the program, while at least one other (My Health LA) allowed enrollees to select any medical home in the system. In our interviews it became clear that using a centralized enrollment process was more administratively burdensome¹⁵⁰, resulting in clinic sites typically having to repeat some of the data collection from the patient. We are also concerned that requiring immigrants to go to a centralized location before getting care at a different location would be a barrier. For these populations, it is important not to limit the locations in ways that might cause people not to apply.

Enrollment in off-site medical homes and enrollment IT – We generally recommend that clients be able to enroll in any medical home, and not just the one located at the applicant’s enrollment site. Some navigator organizations in Washington State (such as Public Health – Seattle & King County) carry out some enrollment at sites that are not co-located with health care facilities that are likely to serve as medical homes. These navigators may already serve communities that are

¹⁴⁹ King County’s success in ACA enrollment is worth considering and may be a platform to build on. See <http://www.kingcounty.gov/depts/health/locations/health-insurance/coverage.aspx>.

¹⁵⁰ Also, in Contra Costa Cares, the centralized enrollment services were provided to the program on a pro bono basis. This is something that we could not count on receiving in a Washington State program, particularly as the programs we modeled for King and Yakima Counties are estimated to have potential enrollment several times the scope of Contra Costa Cares’ membership.

likely to make up a significant part of those who will be eligible for the county-based care program. Allowing enrollees to use application assisters at familiar sites that have experience serving their community has an obvious benefit for enrollees and their families, even when the navigator is not co-located with a medical home facility. Moreover, community health workers trained as application assisters, may be more accessible to enrollees and their families, if enrollment occurs in enrollee neighborhoods and communities. At the same time, some clients may find out at the time that they apply for the county-based program that a medical home at another location offers services from which they would benefit that are not offered at their application site. Forcing the client to go somewhere else just to apply could create obstacles that will frustrate enrollment.

Another key consideration is **information sharing among participating providers**. If a shared application software system is utilized, the application assisters can access application data to determine whether the individual is already enrolled and where the assigned medical home is. This type of information sharing could also help better coordinate care and reduce duplication of services.

We therefore recommend that, enrollment occur at participating clinic sites, community sites where navigators and assisters work, and online.

Navigators/application assisters - Using application assisters provides assurance that those who enroll individuals in the county-program have more general training on assisting clients with enrollment, health literacy issues, and providing linguistically and culturally appropriate services. Many assisters may already have a wealth of experience with enrollment assistance they can bring to helping clients apply for the county-based program, including how to respond to application questions.¹⁵¹ Using assisters also ensures that clients are able to receive all the health program application assistance they need expeditiously at one location. Some individuals who apply for the program may not know which program they qualify for. Others who are ineligible for Apple Health or QHPs, but whose family members are, will need to furnish information to support their family members' Healthplanfinder applications, in addition to applying for a county-based program. Assistance from a skilled person will help clients with complex situations and encourage individuals to apply.

Other considerations – Program enrollee card – Most out-of-state programs we examined provide enrollees a program enrollment card listing their medical home. The card is presented at the time of service to identify program participants and facilitate clinic billing and coding processes. In considering whether a county-based program in Washington should adopt this practice, we will solicit feedback from stakeholders including immigrant advocates to determine the best approach. In our interviews with individuals involved in out-of-state programs, we received anecdotal reports that program enrollee cards can help build enrollees' identification with the program, help build program legitimacy in enrollees' eyes, remind them of their medical home, serve as affirmation of their eligibility, and possibly increase their appropriate use of program services. At the same time, there is evidence that recently heightened fears within the immigrant community have led some to avoid seeking treatment at local clinics or renewing enrollment in health coverage programs (even when it wouldn't impact the

¹⁵¹ NoHLA periodically surveys Washington navigators across the state about their experience with the eligibility systems. In each survey, a significant proportion of respondents have indicated that those they assist need help understanding Healthplanfinder application questions in order to answer accurately, particularly those related to income and immigration status.

enrollee's immigration status). In this light, some might fear that the use of a coverage card by individuals in a program that includes a significant number of undocumented enrollees as having the potential to put individuals at risk of immigration enforcement.

Moreover, immigration status and social security numbers should not be requested during the application or enrollment process to maximize immigrants' privacy and confidentiality. Any county-based program should include clear information-privacy protections.

3. Model for Providing Care and Participating Providers

Recommendations

- The program should be based on a Patient Centered Medical Home model. Enrollees are assigned to a medical home at which they are expected to receive primary and preventive care services.
- The application system (or software that is used for enrollment) should make available to all participating providers access to information on the individual's assigned medical home.
- The program should leverage existing community resources.

Discussion

All of the programs we researched used some form of "medical home" model, in which enrollees were assigned to a clinic or hospital facility at which they received most of their primary and preventive care services. The benefits of the medical home model have been well documented and include comprehensive, coordinated, patient-centered care that eliminates duplicative services, reduces inpatient hospital admissions and emergency department use, thereby lowering overall costs and spending.¹⁵² We recommend counties adopt a medical home model to reduce the incidence of fragmented care and to help facilitate, preferably via a coordinated referral system, access to services that may not be available onsite. At the same time, we acknowledge that being assigned to a medical home may actually frustrate access to care if there are too many restrictions placed on location and providers. We do emphasize the need for a primary care provider to coordinate an enrollee's care but at the same time allow enough flexibility that an individual can access care when needed if the medical home provider is unavailable or unable to meet the enrollee's needs in a timely manner. Contra Costa Cares is a model to consider in this regard as the program permits enrollees to access care at multiple sites within a single medical home clinic organization.

Although some programs used initial program funding to create new clinics and service sites, most programs leveraged existing providers and clinics, and this is an approach we recommend for both counties. Yakima County has 22 existing community clinics and King County has over 50.¹⁵³ We expect that safety-net providers would be motivated to participate in a county-based program that supports provision of care and removes cost barriers for their patients. Nonprofit hospitals must invest in the community through community benefit requirements to maintain their 501(c)(3) status, and thus keep certain tax benefits. FQHCs and other community clinics could use county-based programs as an

¹⁵² See e.g., Benefits of Implementing the Primary Care Patient-Centered Medical Home: A Review of Cost & Quality Results available at <https://www.pcpc.org/guide/benefits-implementing-primary-care-medical-home>.

¹⁵³ <http://wacmhc.org/community-health-centers?view=map>.

opportunity to provide more resources to serve existing patients and to increase numbers served.¹⁵⁴ We recommend that counties use the program to accommodate program participants in existing clinics and providers to the extent possible, rather than expend funds to create new clinic sites.

4. Benefits and Out-of-Pocket Costs

Recommendations

- The benefits should be similar to the full scope Medicaid service package, wrapping around already-available services such as emergency Medicaid and hospital charity care. Programs should have as robust a benefit package as feasible, including at a minimum primary and preventive care, common lab tests and x-rays, behavioral health and routine vision care, outpatient specialty care, including dental, durable medical equipment and outpatient therapies, emergency room and urgent care, inpatient hospitalization, interpreter services, medical transportation, and some form of (prescription) pharmacy benefit.
- The program should include a care management/care coordination component.
- There should be no out-of-pocket costs for individuals at or below 138% FPL and limited participation costs on a sliding scale for incomes above that level. Out of pocket charges should be minimized and standardized for enrollees with higher incomes.

Discussion

Benefits - County programs are intended to fill gaps in coverage that remain for some populations despite ACA implementation. In Section II, we listed some out-of-state coverage programs and the benefits they offer(ed) to low-income immigrants and other enrollees and created a benefits comparison chart available in Appendix B. There are many unmet needs for uninsured low-income Medicaid-eligible individuals that a county-based program can fill. We recommend counties implement as comprehensive a program as possible without duplicating services available through existing resources. Services that should be included in a county-based coverage program include: primary and preventive care, common lab tests and x-rays, behavioral health and routine vision care, outpatient specialty care, including dental, durable medical equipment and outpatient therapies, emergency room and urgent care, inpatient hospitalization, interpreter services, medical transportation, and some form of (prescription) pharmacy benefit.

Care Management - Some of the programs researched include a care coordination or care management component as part of the medical home. We recommend any county program include a care coordination/management component that provides information, supports, and referrals to ensure individuals obtain needed care and services.

Premiums and Out-of-pocket costs - At a minimum we recommend that counties do not impose out-of-pocket costs on individuals with income at or below 138% FPL. Their care should be no more costly than Apple Health would be for Medicaid eligible individuals with the same income levels. Many out-of-state programs with higher income eligibility criteria include cost-sharing provisions. In addition to cost-sharing for services obtained, some programs also require monthly or quarterly participation fees from enrollees. See Appendix A for a cost comparison among programs. While counties may look at the premiums and cost-sharing levels in QHP coverage, it is important also to ensure that the scope of

¹⁵⁴ Rojas and Dietz, p.17.

benefits is considered. To an enrollee, cost and scope of coverage are intertwined. If a county-based program does not provide medically necessary care to the same extent as a QHP, a person may need to pay out-of-pocket for needed services. This could effectively transfer at least part of the financial burden of subsidizing the care provided to these low-to-moderate income individuals.

This problem should be addressed across the board. But, we also suggest that county-based programs work together with their participating providers to determine what fees are truly affordable, to develop lenient policies that do not deny care to people without funds, and to try to create uniformity of cost-sharing between participating providers.

5. Program Cost – Two County Estimates

Recommendations

- A preliminary estimate of the annual cost of operating this program in King County as it is phased in is approximately \$53 million in 2020, increasing to \$68 million in 2025 as enrollment grows and costs of care increase.
- A preliminary estimate of the annual cost of operating this program in Yakima County is approximately \$18 million in 2020, increasing to \$21 million by 2025.
- Counties should explore all potential sources of funding to develop a plan for financing the county-based program.

Discussion

The ways that county-based programs finance their programs vary. Sources of funding include county governments, hospitals, foundations, individual donations, and in-kind donations of services and materials. Counties should explore all of these potential sources to develop a plan for financing the county-based program. Counties should also consider scaling the project – starting as a pilot project with a capped enrollment, similar to ActionHealthNYC and Contra Costa Cares, and scaling up as the benefits of the program are realized and additional funding is identified. Specific recommendations on financing are beyond the scope of this report.

The HealthTrends report¹⁵⁵ includes a basic estimate of the costs of care that would be provided through county-based programs in King County and Yakima County based on a capitated payment model, robust covered services and other characteristics described in this report. The HealthTrends report also estimates the administrative expenses incurred to run these programs. In King County, the estimated cost of implementing the program would be approximately \$53 million in 2020, increasing to approximately \$68 million by 2025 as enrollment grows, and factoring in medical cost inflation. The PMPM in King County would be approximately \$108 in 2020 increasing to approximately \$129 by 2025. In Yakima County, the estimated cost of implementing the program would be approximately \$18 million in 2020, increasing to \$21,483,444 by 2025 as enrollment grows, and factoring in medical cost inflation. The PMPM in Yakima County would be approximately \$89 in 2020 increasing to approximately \$101 by 2025. As noted above, actual costs may vary due to differences between the assumptions on which the financial models that yielded these figures were based, and on-the-ground conditions. Additionally, program design choices (e.g., benefits offered and eligibility criteria) may differ from the original model in ways that impact costs in a positive or negative direction.

¹⁵⁵ See Appendix C for full report.

It should also be noted that the HealthTrends financial estimates for King and Yakima County programs are likely inflated in some respects relative to the budgets of some other programs, because of differences between these estimates and how other programs' budgets are set. Specifically, some other county-based programs we examined largely exclude from their budgets services that are offered by separate complementary programs that are often open to their enrollees as well. For example, My Health LA offers referrals to their enrollees to receive specialty care at county-run facilities. Healthy San Francisco helps enrollees access drug and alcohol treatment through another publicly-administered program. Montgomery Cares offers some low-income enrollees assistance with accessing prescription drugs through a separate program. In each case, the more general care program (MHLA, HSF and MC) does not book in its budget the cost of services offered by these complementary programs. By contrast, with the exception of exclusions for charity care and various Apple Health programs, our estimates have largely presumed that Washington programs will offer (and pay for) a comprehensive package of services that includes such elements as outpatient behavioral health services, prescription drugs, and a broad range of outpatient specialty care, including services such as dental care that are generally not guaranteed by the other programs we examined. Similarly, a King or Yakima County-based program may be able to reduce the actual costs of delivering some services, if they can leverage an existing program that offers those services and that is separately funded. Also, Washington based programs may be able to enter agreements with hospitals and provider groups that agree to furnish a certain amount of care to program enrollees on a pro bono basis. Thus, our financial model may overestimate costs in some respects by a) using a relatively robust package of services to establish a baseline from which counties can decide to vary; and b) including service costs rather than assuming that they may be able offered through existing resources in ways that are not yet clearly identifiable.

6. Topics for Further Development

These preliminary recommendations offer counties a framework to consider in creating a program that provides care to uninsured individuals. Many areas remain for further research and consideration, including provider payment, enrollment/eligibility renewal mechanisms, whether to require application assisters and navigators be certified, retroactive eligibility, complaint resolution, information sharing and privacy, outreach for initial enrollment, program evaluation, language and disability access, and program funding sources. Consideration of how to handle pharmacy claims if there is no program identification card issued is necessary. In addition, further exploration is needed regarding options for affordability solutions for QHP enrollees and options for women whose employer sponsored coverage does not provide the array of family planning services they need. It will be important to obtain more precise data segmentation to reflect the options that a county considers, in order to more accurately forecast costs.

VI. Conclusion

These recommendations are intended to facilitate counties' consideration of how best to eliminate the gaps in our safety-net health care system and enable low-income immigrants to get the care they need. County-based programs are successful in delivering care to economically disadvantaged individuals who are ineligible for or who simply can't afford other state and federally-funded health coverage options. County-based coverage allows communities to:

- deliver needed care that would otherwise be out of reach to many without financial resources; and
- promote health equity, by combatting continuing disparities in access to care and health outcomes experienced by immigrants, low-income individuals, and other disempowered groups.

We hope our recommendations spur conversations among county officials, public health departments, safety-net clinics, local hospitals, patient advocates, and other critical stakeholders, about the adoption of similar programs in counties across Washington State. We look forward to engaging in discussion on the development of programs, including the areas for further research and refinement.

Appendix A: Eligibility, Enrollment, and Cost Comparison

Programs	
HSF	Healthy San Francisco
MHLA	My Health LA
CCC	Contra Costa Cares
MD-MC	Maryland - Montgomery Cares
NV-MDP	Nevada Access to Health Care Network Medical Discount Program
AH-NYC	ActionHealthNYC

Key	
Y	Yes
N	No
L	Limited
FFS	Fee-for-Service

		HSF	MHLA	CCC	MD - MC	NV - MDP	AH- NYC
Eligibility	Maximum income (% FPL)	500%	138%	138%	250%	250%	200%
	Non-income assets considered	Y	N	N	N	N	N
	Minimum age	18	19	19	18	18	19
	County residency required	Y	Y	Y	Y	Y	Y
	Waiting period after uninsured	90 days	N	N	N	N	N
	Excluded if eligible for public coverage program	N	Y	Y	Y	N	Y
Application	In-person application	Y	Y	Y	Y	Y	Y
	Online application option	N	N	N	N	Y	N
	Photo identification	Y	Y	Y	N	Y	Y
	Proof of residency	Y	Y	Y	Y	Y	Y
	Proof of income	Y	Y	Y	Y	Y	Y
	Personal attestation accepted	L	Y	Y	N	N	N
Enrollment	Program membership card issued	Y	Y	Y	Y	Y	Y
	Annual renewal required	Y	Y	Y	Y	Y	Y
	Care coordinator available	*	N	L	Y	Y	L
	Medical home assigned	Y	Y	Y	Y	Y	Y
	Number of medical home clinic sites	34	210	7	11	131	9
Cost to Members	Participant fee charged (if above 100% FPL)	Y	N	N	N	Y	N
	Minimum participant fee/quarter	\$60	N	N	N	\$120	N
	Maximum participant fee/quarter	\$450	N	N	N	\$135	N
	Point of service fees/cost-sharing	Y	N	N	Y	Y	Y
Provider Payments	PMPM payment	\$159	\$32	\$28	N/A - FFS	N/A - FFS	\$59.00
	Per visit reimbursement (primary or specialty)	N/A	N/A	N/A	\$73	\$0	N/A
	Additional payment for specific diagnoses	N	N	N	N/A - FFS	N/A - FFS	Y

Appendix B: Benefits Comparison

Programs	
HSF	Healthy San Francisco
MHLA	My Health LA
CCC	Contra Costa Cares
MD-MC	Maryland - Montgomery Cares
NV-MDP	Nevada Access to Health Care Network Medical Discount Program
AH-NYC	ActionHealthNYC

		HSF	MHLA	CCC	MD - MC	NV - MDP	AH-NYC
Primary and preventive services	Preventive well-checks	Y	Y	Y	Y	Y	Y
	Health screenings	Y	Y	Y	Y	Y	Y
	Health information and advice	Y	Y	Y	Y	Y	Y
	Immunizations	Y	Y	Y	Y	Y	Y
	Chronic disease management	Y	Y	Y	Y	Y	Y
Pharmacy services/prescriptions	Y	Y	*	L	Y	*	
Reproductive Health	Family planning	*	*	*	Y	Y	Y
	Prenatal care	Y	*	*	*	Y	Y
Care coordination/case management		*	N	N	Y	Y	Y
Diagnostics	Radiology	Y	Y	Y	L	Y	Y
	Laboratory services and tests	Y	Y	Y	Y	Y	*
Specialty Care	Acupuncture	N	N	N	N	Y	N
	Allergy testing/injections	N	N	N	N	Y	N
	Audiology (hearing aids)	*	Y	N	*	Y	Y
	Cancer treatment	Y	Y	N	*	Y	Y
	Chiropractic care	N	N	N	*	Y	N
	Genetic testing/counseling	N	N	N	N	Y	N
	Hospice	N	N	N	N	Y	Y
	Long-term care	N	N	N	N	Y	N
	Massage	N	N	N	N	Y	N
	Nutrition/dietician	L	L	N	Y	Y	N
	Orthopedic care	Y	Y	N	*	Y	Y
	Travel vaccines	N	N	N	N	Y	N
	Vision care	*	N	N	*	Y	Y
Emergency services	Y	Y	N	N	Y	Y	
Urgent care	Y	Y	N	N	Y	Y	
Hospitalization	Y	Y	N	N	Y	Y	
Dental care	*	Y	N	L	Y	Y	
Behavioral health	Mental health treatment	*	*	N	OP	Y	Y
	Substance use treatment	*	Y	N	OP	Y	Y
Rehabilitative services	Physical therapy	L	L	N	*	Y	Y
	Occupational therapy	L	L	N	*	Y	Y
	Speech/language therapy	N	N	N	*	Y	Y
	Durable medical equipment	Y	Y	N	L	Y	Y
Transportation	Emergency (ambulance)	Y	N	N	N	N	N
	Non-emergent	N	N	N	N	*	N
Surgery	Y	Y	N	Y	L	Y	
Nurse advice line		N	N	Y	N	N	N
Interpreter services		*	*	*	Y	*	*

Key					
Y: Yes, covered	N: No, excluded	*: Service provided by existing program, other than emergency Medicaid/charity care	L: Limited service	OP: Outpatient only	

Appendix C: HealthTrends Economic Forecast



Economic Forecast of Proposed County-Based Health Coverage Programs in King and Yakima County

Prepared for Northwest Health Law Advocates

October 2017

By Hunter Plumer, M.H.A.
Consultant – Health Trends



Background

Despite the expansion in health coverage for a significant number of citizens resulting from the Affordable Care Act (“ACA”), a significant proportion of the undocumented immigrant population remain ineligible for comprehensive insurance coverage. Currently, uninsured undocumented immigrants can receive care qualified under Washington State’s Alien Emergency Medical Program and Apple Health for Pregnant Women. Yet, these programs only cover qualifying emergencies and a limited number of other select health services such as cancer, dialysis, nursing care, and pregnancy-related services. A lack of effective health coverage increases the cost of medical care; thereby reducing utilization of health services. This is known as the ‘insurance effect’. Economic barriers to care can result in uninsured persons forgoing needed medical care and potentially incurring onerous financial burdens on themselves and their families.

Several local, county, and state public health officials, healthcare providers, patient advocates, and community members around the country have come together to collaborate and develop solutions to provide access for the populations who remain ineligible for health coverage under the ACA. Examples of such programs that are already operational include My Health Los Angeles, Healthy San Francisco, Montgomery Cares, California Medical Services Program, and Contra Costa CARES, among others. These programs serve as a guide toward creating pilot programs in King County and Yakima County.

Study Purpose

Develop financial model forecasting the fiscal impact of a proposed county-based health coverage programs in King and Yakima County aimed at serving persons 19 years and older not eligible under the Affordable Care Act. The defined study period is full calendar years 2019 to 2025.

Key Findings

Total combined projected costs for the King County and Yakima County programs during the study period range from \$68.1 million in CY2019 to \$89.3 in CY2025, assuming effective health coverage is provided to the intended member population (i.e. undocumented immigrants ineligible for insurance coverage).¹⁵⁶ Program cost projections encompass two components: (1) direct medical expenditures and (2) indirect administrative, operational, and information technology expenses; respectively comprising 89.1% and 10.9% of annual costs. Figure 1 below presents forecasted annual expenditures toward direct medical and administrative expenses by year. Increases in expenditures are based on anticipated membership population growth and medical care cost inflation.

This study employs a multivariate regression analysis approach to estimate direct medical expenditures and utilization by clinical setting for the intended member population.¹⁵⁷ The regression models allow for estimates to be adjusted based on certain sociodemographic characteristics of the undocumented immigrant population ages 19 years and older in King County and Yakima County currently uninsured and ineligible for health coverage. See Figure 2 below for each clinical setting’s respective share of projected direct medical expenditures, subject to the scope of benefits detailed in the report.

Figure 1. Combined King County and Yakima County Program Costs, Segmented by Direct Medical and Administrative Expenditures, CY2019-2025

¹⁵⁶ Distinct projections for King County and Yakima County are provided in subsequent sections of this study.

¹⁵⁷ Except pharmacy related services which is based on benchmarks of other county-based programs.

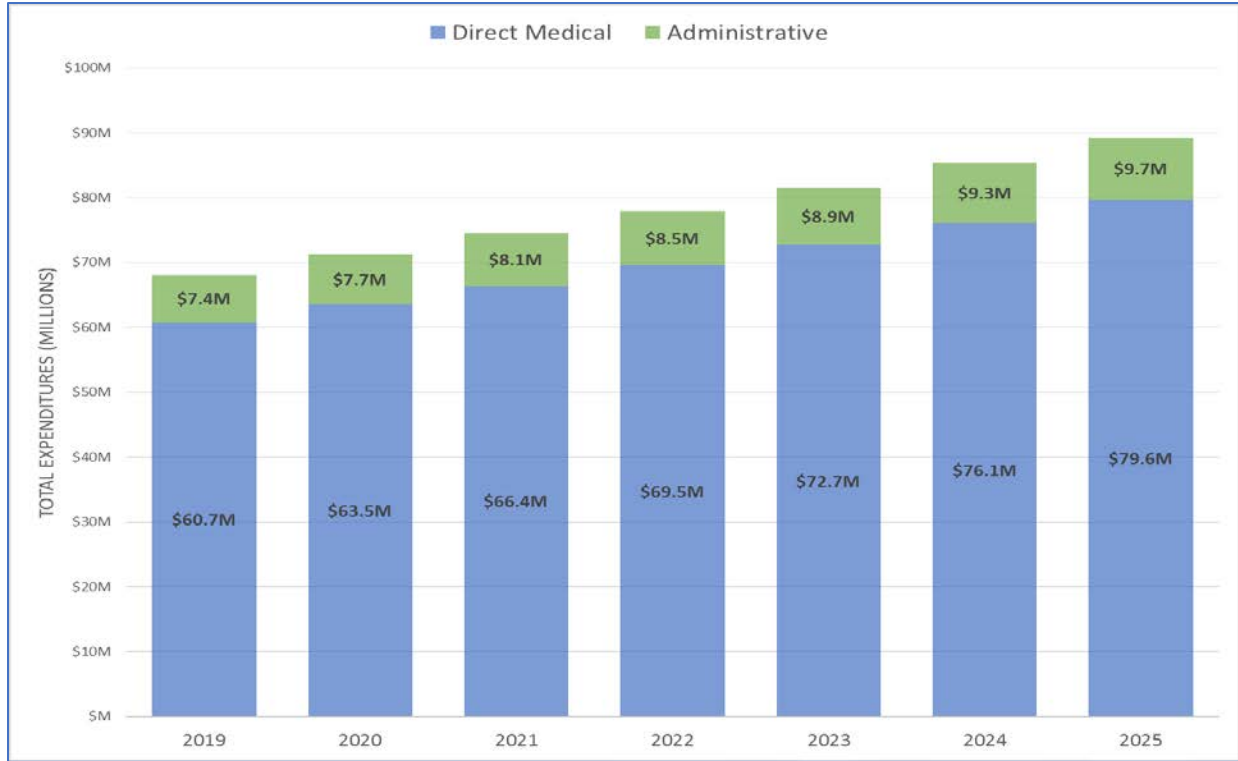
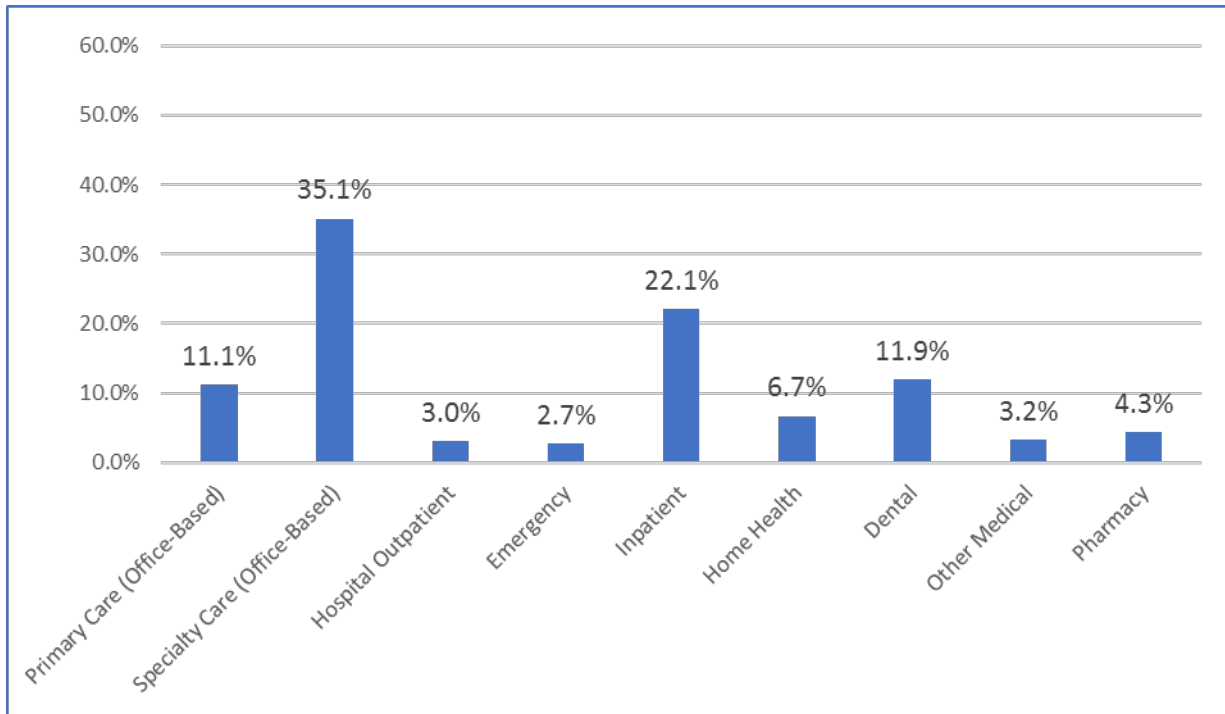



Figure 2. Estimated Proportion of Direct Medical Expenditures for King County and Yakima County Program Costs, Segmented by Clinical Setting



Data Sources

- A. Medical Expenditure Panel Survey (MEPS), CY2015

- 
- B. Migration Policy Institute (MPI) - Profile of the Undocumented Immigrant Population in King County, WA and Yakima County, WA.¹⁵⁸
 - C. Washington State Office of Financial Management (OFM) – Small Area Demographic Estimates (SADE), 2010-2016 and Forecast of the State Population by Age and Sex, 2017-2040
 - D. Kaiser Family Foundation - Distribution of Total Population by Federal Poverty Level, 2016
 - E. U.S. Bureau of Labor Statistics, Consumer Price Index for All Urban Consumers: Medical Care [CPIMEDSL], retrieved from FRED, Federal Reserve Bank of St. Louis. 2012-2016
 - F. Other county-based health coverage programs from across the nation - reports and presentations

Description of MEPS Data Source

The US Department of Health and Human Services Agency for Healthcare Research and Quality's (AHRQ) Medical Expenditure Panel Survey (2015) was used as the statistical basis for estimating medical expenditures and utilization. The Medical Expenditure Panel Survey, which began in 1996, is a set of large-scale, annual surveys of families and individuals, their medical providers (doctors, hospitals, pharmacies, etc.), and employers across the United States. MEPS collects data on the specific health services that Americans use, how frequently they use them, the cost of these services and how they are paid for, as well as data on the cost, scope, and breadth of health insurance held by and available to U.S. workers. MEPS is one of the only publicly available, statistically valid sample survey that can provide the level of utilization and expenditure detail required for the purposes of this study.

It should be noted that unlike many sample surveys that rely on a respondent's ability to recall past events, MEPS incorporates data validation steps that help assure survey validity. There is reconciliation of the MEPS household survey responses to the services the survey respondents actually consumed. The first sentence of the Medical Conditions file states: "Upon completion of the household CAPI interview and obtaining permission from the household survey respondents, a sample of medical providers are contacted by telephone to obtain information that household respondents can not accurately provide."¹⁵⁹

The MEPS Household Component (HC) provides estimates of respondents' health status, demographic and socio-economic characteristics, employment, access to care, and satisfaction with health care for the U.S. civilian noninstitutionalized population. MEPS also includes a Medical Provider Component (MPC), which covers hospitals, physicians, home health care providers, and pharmacies identified by MEPS-HC respondents. Its purpose is to supplement and/or replace information received from the MEPS-HC respondents.


Direct Medical Expenditure and Utilization Methodology

A. Collect MEPS data files for study specific analysis

¹⁵⁸ Available at the following link:

<https://www.migrationpolicy.org/programs/us-immigration-policy-program-data-hub/unauthorized-immigrant-population-profiles>

¹⁵⁹ MEPS HC-180: 2015 Medical Conditions Documentation



The analysis uses the latest publicly-available year of full MEPS data, CY2015. R, a statistical software, was used to access and model MEPS data files from its 2015 statistical survey.

Specific Data Files: MEPS releases demographic and encounter-level data into several files. The full-year population characteristics, office-based visit, hospital outpatient, emergency, inpatient, home health, other medical expenses, dental, medical conditions, and consolidated files were evaluated for the purposes of this study.

B. Analytic Framework

Clinical Settings

For MEPS-based analysis: Primary Care (office-based), Specialty Care (office-based), Hospital Outpatient, Emergency Room, Hospital Inpatient, Home Health, Dental, and Other Medical Expenses. All other health services (e.g. nursing facility) are not encompassed in the study's forecast, except for pharmacy related services, which are not MEPS-derived.¹⁶⁰

Insurance Status Classification

Medicaid and Other Public: assigned to MEPS respondents indicating they had Medicaid, SCHIP, or Other Public Insurance during the year. Does not include those also covered under Medicare.

Uninsured: a person is considered uninsured in MEPS if they did not report coverage under TRICARE, Medicare, Medicaid, SCHIP, or other public hospital/physician or private hospital/physician insurance (including Medigap plans).^{161 162}

Medicare: defined as people covered by Medicare at any point during the year.

Privately Insured: a person who had any private insurance coverage [including TRICARE/CHAMPVA] and did not have Medicare coverage at any time during the survey year.¹⁶³ Individuals with a single service plan such as dental or vision that did not also include hospital/physician benefits were not considered to be insured.

Target Outcomes


Out of pocket expenditures: payments made by the patient or family for health services.

¹⁶⁰ Pharmacy related service expenditures featured in this study are not derived from MEPS, but from data publicly available from other county-based health coverage programs' reports and presentations.

¹⁶¹ MEPS HC-181: 2015 Full Year Consolidated Data File Documentation

¹⁶² Note: a proportion medical events for persons categorized as uninsured in MEPS report sources of payments other than the self or family. These sources of payment include other 'Federal Sources (Indian Health Service, military treatment facilities, and other care provided by the federal government)', 'Other State and Local Source--includes community and neighborhood clinics, state and local health departments, and state programs other than Medicaid', Worker's Compensation, and 'Other Unclassified Sources--includes sources such as automobile, homeowner's, liability, and other miscellaneous or unknown sources'.

¹⁶³ MEPS HC-181: 2015 Full Year Consolidated Data File Documentation



Primary payer expenditures: payments made by the primary payer for health services. The primary payer corresponds to the insurance status except for uninsured whose primary payer (i.e. self and family) are accounted for in out-of-pocket expenditures.

Count of encounters: office-based visits, hospital outpatient visits, emergency room visits, hospital stays, home health encounters, and dental visits.

Sociodemographic covariate grouping

[Based on corollaries to available Migration Policy Institute data discussed further below]

Age: 19 to 24, 25 to 34, 35 to 44, 45 to 54, 55 to 64, 65+ year old

Income: Less than HS Grad, GED or HS Grad, Some College, College or more

Education: Below 50% of Federal Poverty Level (FPL), 50-99% of FPL, 100-149% of FPL, 150-199% of FPL, 200-300% of FPL, and at or above 300% of FPL

Ethnicity: Hispanic, Asian, and Other

Sex: Male and Female

C. Exclusion criteria for analysis

See Appendix 1 for a detailed description of the exclusion criteria applied to MEPS full-year consolidated and event-level files. Overall, the analysis excludes health services not anticipated to be covered by the program and covered services the uninsured population currently have access to from other state programs or health service organizations.

Examples include the following:

Alien emergency medical program (AEM): See a description in the Washington Administrative Code (“WAC”) WAC 182-507-0115 and WAC 182-507-0120

Apple Health for Pregnant Women: according to Apple Health’s eligibility overview handbook: “This program provides CN coverage to pregnant women with countable income at or below 193 percent of the FPL without regard to citizenship or immigration status.”¹⁶⁴

Hospital Charity Care


In addition to the MEPS exclusion criteria, the projected member base for both the King County and Yakima County programs are derived from the estimated number of undocumented immigrants in both counties. Therefore, all program forecasts exclude uninsured persons eligible for other Apple Health Programs and/or Qualified Health Plans but did not elect to enroll and/or purchase health coverage.¹⁶⁵

D. MEPS-based model calibration and selection

All utilization and expenditure projections in this study, except pharmacy related services and administrative expenses, are calibrated from MEPS responses based on insurance status and

¹⁶⁴ Washington Apple Health (Medicaid) Programs - Eligibility Overview. April 2017

¹⁶⁵ Citizens and documented immigrants with incomes above 400% of the FPL are also excluded.



sociodemographic covariates identified above. Andrew Jones, PhD., an economics professor from the University of York outlines a succinct description of the common challenges to modeling healthcare expenditures and utilization:

“Health care costs pose particular challenges for econometric modelling. Individual level data on medical expenditures or costs of treatment typically feature a spike at zero and a strongly skewed distribution with a heavy right-hand tail. This nonnormality stems from the fact that, due to clinical complications and comorbidities, the more severe patients may attract substantial and costly services. Relatively rare events and medical procedures might be very expensive, creating outliers in the righthand tail of the distribution. Often, a small minority of patients are responsible for a high proportion of health care costs and mean costs are well above median costs. In econometric models of costs the error term will typically exhibit a high degree of heteroskedasticity, reflecting both the process driving costs and heterogeneity across patients. **The relationship between costs and covariates may not be linear and the appropriate regression specification for such data may be nonlinear.**

When the cost data represent the population as a whole, rather than just the users of health care, the distribution will typically have a large mass point at zero (with costs truncated at zero). **The presence of a substantial proportion of zeros in the data has typically been handled by using a two-part model (2PM), which distinguishes between a binary indicator, used to model the probability of any costs, and a conditional regression model for the positive costs... The modelling of count data for doctor visits has strong affinities with the modelling of cost data, as both have non-normal heavily skewed distributions.**¹⁶⁶ (emphasis added)

The MEPS data aligns closely with the general description of healthcare data above. Many of the traditional assumptions of normality are violated and require alternative analytic techniques, such as various nonlinear specifications within the generalized linear model (GLM) framework. In particular, this study incorporates the two-part model mentioned in the excerpt above (also known as a hurdle or zero-inflated model). There were multiple micromodels calibrated to the MEPS data that are individually used to model variants of the outcome-payer-clinical setting combination (e.g. out-of-pocket primary expenditures, primary payer emergency room expenditures, count of home health visits). All models' first part were fit according to a logistic regression; however, given the multiple specifications available under the GLM framework, model selection for the second part was based on performance on the Akaike information criterion (AIC).¹⁶⁷ Based on the AIC model selection criteria, GLMs with a gamma distribution and log link consistently outperformed other models for expenditure outcomes conditional on covariates¹⁶⁸, whereas negative binomial regression outperformed Poisson regression with respect to count outcomes (i.e. utilization of visits/stays).

¹⁶⁶ Jones, A. Models For Health Care – HEDG Working Paper 10/01. Health Econometrics and Data Group. The University of York. p 1

¹⁶⁷ See Lindsey & Jones. CHOOSING AMONG GENERALIZED LINEAR MODELS APPLIED TO MEDICAL DATA. STATISTICS IN MEDICINE, VOL. 17, 59Ð68 (1998)

¹⁶⁸ All covariates were included except in the case of inpatient out-of-pocket expenditures where the two-part zero-inflated gamma regression with log link was used without an age category covariate. This was done as the model failed to converge due to the collinearity of age and insurance status (especially 65+ and Medicare).



E. Collect Insurance Status and Sociodemographic Estimates

As identified in the ‘Analytic Framework’ assumption above, the variables used to construct the MEPS-calibrated models include insurance status and the following sociodemographic covariates: age, income, sex, education, and ethnicity.

Again, the proposed county-based program aims to benefit ineligible for health insurance, which disproportionately effect undocumented immigrants who remain uninsured because of their immigration status. King County and Yakima County population estimates corresponding to insurance status and sociodemographic characteristics were compiled from the Migration Policy Institute’s Data Hub. MPI reports:

“This data tool is based on a methodology that imputes unauthorized status using U.S. Census Bureau 2010-14 American Community Survey and 2008 Survey of Income and Program Participation data. James Bachmeier at Temple University analyzed the data on legal status of immigrants that provide the basis for these estimates. Jennifer Van Hook at The Pennsylvania State University advised in developing the methodology. Learn more about the methodology here.^[169] Please note that these estimates use commonly accepted benchmarks from other research studies to determine the size of the unauthorized population and response rates to surveys. These estimates have the same sampling and coverage errors as any other survey-based estimates that rely on ACS and other Census Bureau data.” [Reference added]

For the purposes of the study, several edits were made to the base MPI estimates.

Edits to MPI age data

OFM’s 2017 Washington State age mix was used to segment MPI 16-24 age cohort estimates to 19-24 given the study’s analysis pertains only to population ages 19 years and older.¹⁷⁰ A similar revision of MPI’s 55+ age category estimate was made using Washington State’s age mix to create separate 55-64 and 65+ year old age categories.

Edits to MPI income data

As detailed in Appendix 1, several hospitals have charity care policies for patients at or below 300% of the federal poverty level (FPL). Therefore, MPI’s base population estimates of ‘at or above 200% FPL’ were further decomposed based on the Washington State income distribution featured in a Kaiser Family Foundation data report available on their website.¹⁷¹

¹⁶⁹ <https://www.migrationpolicy.org/research/daca-two-year-mark-national-and-state-profile-youth-eligible-and-applying-deferred-action>

¹⁷⁰ Forecast of the State Population by Age and Sex, 2017-2040. Washington State Office of Financial Management, Forecasting and Research Division. November 2016

¹⁷¹ Kaiser Family Foundation - Distribution of Total Population by Federal Poverty Level (2016). While the Kaiser data allowed for the 200+% FPL to be divided into 200-399% and 400+% FPL segments, additional assumptions evenly dividing the 200-399% FPL population in half to estimate 200-300% FPL were needed for subsequent modelling to accurately account for the expected charity care to be provided to patients.



Edits to construct ethnicity category

Ethnicity categories constructed based on logical combinations of MPI's base population estimates from its "Regions of Birth".

Uninsured Population

Importantly, the regression analysis will only be for the uninsured population. Therefore, the estimated population base for both counties are the counties' total population ages 19 years and older multiplied by their respective uninsured rate.

Population Projections

As described in their methodology brief, MPI population counts are from U.S. Census Bureau 2010-14 estimates. These base population counts, including the revisions discussed above, were converted as a proportion of King and Yakima County's approximate populations in 2010-2014 using OFM's 2010-2016 Postcensal Estimates.¹⁷² King and Yakima Counties' growth rates, 2.0% and 0.3% respectively, were calculated using the average annual growth from 2012 to 2016 in each county to forecast the counties' population projections into the study period. Then, the 2010-2014 proportion was applied to the counties' aggregate population projections to calculate the estimated subpopulation of undocumented immigrants ages 19 years and older.

F. Forecast Direct Medical Expenditures and Utilization with County-Specific Sociodemographic Detail

MEPS-based Model by Clinical Setting

Two simulations were conducted to estimate the expenditures and utilization target outcomes of the projected uninsured population in both counties: whether the patient population would (1) remain uninsured or (2) were provided health coverage similar to Medicaid [excluding exclusions identified above].

The simulations were based on the MEPS-calibrated two-part models for each clinical setting and adjusted to reflect the population count and sociodemographic characteristics of King County and Yakima County.

Pharmacy Related Services

In addition to the MEPS-based models, pharmacy related services were also calculated; however, the basis of these estimates are from publicly available information found in other county-based programs' reports and presentations. Upon review of the material, there was scarce expenditure information provided and several of the reports highlighted challenges from underreporting of pharmacy services by partner clinics and other providers contracted in their program. Consequently, it was decided to calculate the average per member per month (PMPM) for pharmacy related services found in the My

¹⁷² Approximate as only 20+ population counts were available for both counties because the 19-age cohort was part of the 15 to 19 age category.

Health Los Angeles ('My Health LA' or 'MHLA') and Montgomery Cares reports. Table 1 below presents pharmacy related findings, including a forecast of the average pharmacy PMPM rate (2020 projections used as a reference). The PMPM revisions are made according to the study's overall medical cost inflation method described below.

Table 1. Pharmacy Related Service PMPM Expenditures

Program	Expenditures	Participant Months	PMPM	Year	Revised PMPM (2020 Dollars)
MHLA	\$6,585,772	1,646,443	\$4.00	2015-2016 dollars	\$4.57
Montgomery Cares	\$1,233,786	309,240	\$3.99	2017 dollars	\$4.36
Average					\$4.47

My Health LA Source: FY2015-2016 Annual Report. Table G1 (p 37)

Montgomery Cares Source: Montgomery Cares Annual Report - Fiscal Year 2017. Pharmacy expenditures found on page 12. Unduplicated patient count [which were multiplied by 12 to get months] found on page 3.

Medical Cost Inflation

All projected costs are inflated according to the 2012 to 2016 weighted average growth in U.S. Bureau of Labor Statistics' (U.S. BLS) Consumer Price Index for care. See Table 2 for the annual percent change for each year from 2012 to 2016 retrieved from the Federal Reserve Bank of St. Louis (FRED) website.

Table 2. U.S. BLS Consumer Price Index for All Urban Consumers: Medical Care, Percent Change, Annual, Seasonally Adjusted

	2012	2013	2014	2015	2016	Weighted Average Annual Growth (2012-2016)
<i>Medical Care CPI Annual Percent Change</i>	3.7%	2.5%	2.4%	2.6%	3.8%	3.02%

U.S. Bureau of Labor Statistics, Consumer Price Index for All Urban Consumers: Medical Care [CPIMEDSL], retrieved from FRED, Federal Reserve Bank of St. Louis; <https://fred.stlouisfed.org/series/CPIMEDSL>

(Indirect cost methodology is described in conjunction with presentation of findings below)



Insurance Effect Analysis

An important phenomenon with particular application to the current study is the positive, strong relationship between health care utilization and insurance coverage. This is expected since, by definition, insurance lowers the cost of health care utilization to insureds.

Economists define this as the “law of the downward sloping demand curve,” i.e., other things equal, consumption increases with lower prices; with higher prices, consumption falls. The literature firmly supports this opinion. Specifically, without insurance, health care consumption is less. Further, the higher the real cost of that consumption, e.g., higher deductibles and co-pays, the lower the utilization, demonstrating a clear, inverse relationship between cost and usage.

There is significant economic literature regarding the insurance effect, i.e., without insurance, health care consumption falls. The RAND Health Insurance Experiment in 1987 was the first and only randomized study on the impact of health insurance.¹⁷³ Researchers randomly assigned participants to one of five types of health insurance: (i) free care; (ii) 25% coinsurance; (iii) 50% coinsurance; (iv) 95% coinsurance; and (v) and an HMO-style group cooperative. The study demonstrated that health care use increases as a result of insurance, and that even small cost sharing by insureds can have a negative impact on the poor, those with ill health, and children. In particular, the report found that, across all levels of coinsurance, participants with cost sharing made one to two fewer physician visits per year and had 20% fewer hospitalizations per year than participants with free health care.¹⁷⁴ Similar declines were found for dental visits, prescriptions and mental health treatment. Participants in cost sharing plans spent less on health care as a result of using fewer services rather than finding lower prices. The conclusions from this study demonstrated that *the reduced use of services resulted largely from participants foregoing care.*¹⁷⁵

While the RAND study is relatively dated, and there have been substantial changes in health care spending and utilization patterns since 1987, the RAND findings remain applicable. More recent studies and reviews have reached many of the same conclusions: that is, an insured population has a greater rate of utilization of health care services than an uninsured population, although utilization disparities are dependent on the type of health services examined.¹⁷⁶

One systematic review article in 2008 reported that health insurance was consistently found to increase health care utilization. In particular, health insurance led to increased use of outpatient services by 8%-40%.¹⁷⁷ That same review found less agreement about the effect of insurance on ED visits and hospital service use.

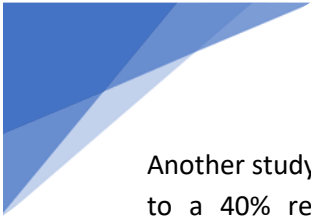
¹⁷³ RAND Corporation (2006), “The Health Insurance Experiment: A Classic RAND Study Speaks to the Current Health Care Reform Debate.”

¹⁷⁴ Ibid.

¹⁷⁵ Ibid.

¹⁷⁶ See, e.g., Kaiser Commission on Medicaid and the Uninsured (2012); Freeman J. D. et al. (2008); Centers for Disease Control and Prevention (2010); and Anderson M. et al. (2012).

¹⁷⁷ Freeman J.D. et al. (2008).



Another study, published in 2012 in the American Economic Journal, found “...not having insurance leads to a 40% reduction in emergency department visits and a 61% reduction in inpatient hospital admissions.”¹⁷⁸

In the latest report on Health Insurance Coverage and Health Care Utilization, the CDC noted that individuals between the ages of 18 and 64 with chronic conditions and without consistent health insurance coverage were more likely to forgo needed medical care than similar persons with continuous coverage.¹⁷⁹ Another study found that while chronically ill and healthy uninsured persons were half as likely to see a physician in the last 12 months as their insured counterparts, acutely ill uninsured persons were nearly two thirds as likely to receive physician care compared with their insured counterparts.¹⁸⁰ In summary, not only the healthy, but also the chronically ill and acutely ill persons who are uninsured tend to forego some level of care.

¹⁷⁸ Anderson M. et al. (2012). See Table 4, page 16, for the reduction in emergency department visits and Table 7, page 20, for the inpatient admission decline.

¹⁷⁹ Centers for Disease Control and Prevention (2010).

¹⁸⁰ Hafner-Eaton, H. (1993).

A. MEPS-based Empirical Demonstration of the Insurance Effect on Healthcare Utilization

Tables 3 and 4 below display the projected number of visits, admissions, and events per member per year by for King County and Yakima County. These estimates are derived from the MEPS-calibrated two-part utilization¹⁸¹ models for each clinical setting that control for each counties' respective sociodemographic profiles and conditional on the exclusion criteria applied. Tables 4 and 5 demonstrate a dramatic decrease in utilization by the uninsured even when controlling for age, sex, ethnicity, education, and income level. Therefore, these findings suggest enrollees of the proposed county-based health coverage program would show far higher rates of utilization for all services defined in this analysis than if they would remain uninsured.¹⁸² Though, Hospital Outpatient, Emergency, and Inpatient rates for uninsured may be slightly underestimated if Washington State patients have greater access to eligibility and provision of charity care than the MEPS-based national cohort. In other words, lower income Washington State patients may have a low/no financial burden for hospital care if eligible under hospital charity care policies, in effect partially offsetting the lack of health coverage and the gap with Medicaid rates.

Table 3. MEPS/MPI Estimate of Average Per Member Annual Utilization – King County

King County	Uninsured	Medicaid and Other Public	
Clinical Setting	Per Member Per Year	Per Member Per Year	Uninsured as % of Insured
Primary Care (Office-Based)	0.37	1.03	36.0%
Specialty Care (Office-Based)	0.74	2.90	25.5%
Hospital Outpatient	0.10	0.26	40.1%
Emergency	0.06	0.15	40.6%
Inpatient	0.03	0.10	26.1%
Home Health	0.01	0.10	7.7%
Dental	0.23	0.57	40.0%

(1) Includes utilization incurred where 'Other 3rd Party Payment' may have been available

(2) Prescribed medications and other medical expenses not included

Table 4. MEPS/MPI Estimate of Average Per Member Annual Utilization – Yakima County

Yakima County	Uninsured	Assuming Health Coverage	
Clinical Setting	Per Member Per Year	Per Member Per Year	Uninsured as % of Insured
Primary Care (Office-Based)	0.40	1.13	35.4%
Specialty Care (Office-Based)	0.51	2.21	23.2%
Hospital Outpatient	0.09	0.22	39.3%
Emergency	0.07	0.17	40.9%
Inpatient	0.03	0.10	25.9%
Home Health	0.01	0.16	7.5%
Dental	0.15	0.41	36.9%

(1) Includes utilization incurred where 'Other 3rd Party Payment' may have been available

(2) Prescribed medications and other medical expenses not included

¹⁸¹ Zero-inflated negative binomial regression

¹⁸² Certain precautions should be made toward the precision of estimates for services indicating a low use rate (e.g. inpatient, home health).

B. MEPS-based Empirical Demonstration of the Insurance Effect on Healthcare Expenditure

Tables 5 and 6 below feature per member per month expenditures for out-of-pocket and primary payer expenditures, defined in the methodology above, for King and Yakima County.¹⁸³ The tables also contain forecasted expenditures by clinical setting expected if the program were implemented in 2020 (*annual program costs for aggregate direct medical expenditures and indirect administrative expenses from CY2019 to CY2025 will be provided in latter sections*). The target forecast year and all associated findings can be adjusted to earlier (e.g. 2019) or later (e.g. 2022, 2025) time frames by adjusting the population counts based on the population growth (2.0% for King and 0.3% for Yakima) and/or PMPM figures adjusted based on average annual medical cost inflation (3.02%). These estimates are derived from the MEPS-calibrated two-part expenditure¹⁸⁴ models for each clinical setting that control for each counties' respective sociodemographic profiles and conditional on the exclusion criteria applied. Tables 5 and 6 demonstrate that despite the lower utilization rates seen before, uninsured individuals incur greater out of pocket expenses than those with Medicaid and other public insurance. The tables also suggest that the proposed programs would be expected to provide considerable payments to account for increased utilization and overall healthcare expenditures, as shown in the high primary payer column figures. Also, note that the hospital outpatient, emergency room, and inpatient forecasts are all for anticipated members with incomes greater than 300% FPL. See Appendix 1 for explanation of exclusion of expenditures for persons below 300% FPL due to assumed eligibility for hospital charity care that would discount payment responsibility effectively by 100%.

Table 5. MEPS/MPI-Based Simulations of Direct Medical Expenditures [Excluding Pharmacy] in CY2020 by Insurance Status – King County (Projected 35,430 Members)

King County		Expenditures (Total)		Expenditures (PMPM)	
Insurance Status	Clinical Setting	Out-of-Pocket	Primary Payer	Out-of-Pocket	Primary Payer
<i>Uninsured</i>	Primary Care (Office-Based)	\$716,574	N/A	\$1.7	N/A
	Specialty Care (Office-Based)	2,074,325	N/A	4.9	N/A
	Hospital Outpatient (301+% FPL)	152,718	N/A	0.4	N/A
	Emergency (301+% FPL)	380,467	N/A	0.9	N/A
	Inpatient (301+% FPL)	371,324	N/A	0.9	N/A
	Home Health	8,949	N/A	0.0	N/A
	Dental	2,200,658	N/A	5.2	N/A
	Other Medical	587,402	N/A	1.4	N/A
Total		\$6,492,416	N/A	\$15	N/A
<i>Assuming Insurance Comparable to Medicaid-Coverage [with proposed scope of service]</i>	Primary Care (Office-Based)	\$229,487	\$4,531,775	\$0.5	10.7
	Specialty Care (Office-Based)	1,087,487	15,352,818	2.6	36.1
	Hospital Outpatient (301+% FPL)	29,879	1,517,151	0.1	3.6
	Emergency (301+% FPL)	63,606	1,267,915	0.1	3.0
	Inpatient (301+% FPL)	124,228	11,378,176	0.3	26.8
	Home Health	2,397	2,568,064	0.0	6.0
	Dental	1,496,950	4,124,447	3.5	9.7
	Other Medical	565,083	1,018,686	1.3	2.4
Total		\$3,599,117	\$41,759,031	\$8	\$98

¹⁸³ Excludes pharmacy related services and 'other third party' (i.e. non-primary payer) payment sources. Medicaid patients in MEPS also show similar levels of 'other third party' payment despite health coverage. Other third-party payments are expected to be outside the scope of the propose program as uninsured patients are expected to continue having access to such provisions similar to what MEPS Medicaid and uninsured patients alike reported.

¹⁸⁴ Zero-inflated generalized linear model with a log link and gamma distribution.

Table 6. MEPS/MPI-Based Simulations of Direct Medical Expenditures [Excluding Pharmacy] in CY2020 by Insurance Status – Yakima County (Projected 15,563 Members)

Yakima County		Expenditures (Total)		Expenditures (PMPM)	
Insurance Status	Clinical Setting	Out-of-Pocket	Primary Payer	Out-of-Pocket	Primary Payer
<i>Uninsured</i>	Primary Care (Office-Based)	\$282,128	N/A	\$1.5	N/A
	Specialty Care (Office-Based)	454,517	N/A	2.4	N/A
	Hospital Outpatient (301+% FPL)	53,284	N/A	0.3	N/A
	Emergency (301+% FPL)	97,817	N/A	0.5	N/A
	Inpatient (301+% FPL)	58,362	N/A	0.3	N/A
	Home Health	113	N/A	0.0	N/A
	Dental	633,903	N/A	3.4	N/A
	Other Medical	164,520	N/A	0.9	N/A
	Total	\$1,744,644	N/A	\$9	N/A
<i>Assuming Insurance Comparable to Medicaid-Coverage [with proposed scope of service]</i>	Primary Care (Office-Based)	\$89,757	\$2,210,517	\$0.5	11.8
	Specialty Care (Office-Based)	234,732	5,599,803	1.3	30.0
	Hospital Outpatient (301+% FPL)	10,408	354,399	0.1	1.9
	Emergency (301+% FPL)	16,362	361,827	0.1	1.9
	Inpatient (301+% FPL)	19,520	2,496,349	0.1	13.4
	Home Health	30	1,656,223	0.0	8.9
	Dental	426,932	1,492,953	2.3	8.0
	Other Medical	158,883	280,912	0.9	1.5
	Total	\$956,624	\$14,452,982	\$5	\$77

Estimated Direct Medical Expenditures

See Table 7 below for direct medical expenditures forecasted in 2020 by clinical setting that combine MEPS-MPI based estimates (*Total* represents the sum of out-of-pocket and primary payer estimates from Tables 5 and 6) with pharmacy related service expenditure projections calculated by the PMPM method identified in Table 1.

Hospital Outpatient, Emergency, and Inpatient expenditures listed in Table 7 are for visits/stays for members with incomes 301+% FPL which are not assumed to be eligible for charity care. The program costs for these specific clinical settings can be interpreted as covering the out-of-pocket expenses and Medicaid-similar payments for visits/stays incurred by the 301+% FPL members.

As previously discussed for the expenditure simulation models, the target forecast year (2020) and all associated findings can be adjusted to earlier or later time frames by adjusting the population counts and/or PMPM figures based on the population growth (2.0% for King and 0.3% for Yakima) and average annual medical cost inflation (3.02%). Table 8 below presents aggregate direct medical expenditures by year from CY2019-2025

Table 7. MEPS/MPI-Based Forecast of Total Direct Medical Expenditures in CY2020 for King County and Yakima County

Clinical Setting	King County		Yakima County	
	Total	PMPM	Total	PMPM
Primary Care (Office-Based)	\$4,761,261	\$11.2	\$2,300,274	\$12.3
Specialty Care (Office-Based)	16,440,305	38.7	5,834,535	31.2
Hospital Outpatient	1,547,030	3.6	364,807	2.0
Emergency	1,331,521	3.1	378,189	2.0
Inpatient	11,502,404	27.1	2,515,869	13.5
Home Health	2,570,461	6.0	1,656,253	8.9
Dental	5,621,397	13.2	1,919,885	10.3
Other Medical	1,583,769	3.7	439,795	2.4
Pharmacy	1,899,163	4.5	834,211	4.5
Total Expenditures (2020)	\$47,257,312	\$111	\$16,243,817	\$87
Member Base (2020)	35,430		15,563	

Table 8. MEPS/MPI-Based Forecast of Aggregate Direct Medical Expenditures in King County and Yakima County for CY2019-2025

		2019	2020	2021	2022	2023	2024	2025
King County	PMPM	\$108	\$111	\$115	\$118	\$122	\$125	\$129
	Members	34,748	35,430	36,125	36,833	37,556	38,292	39,043
	Total	\$44,991,329	\$47,257,312	\$49,637,420	\$52,137,403	\$54,763,297	\$57,521,443	\$60,418,504
Yakima County	PMPM	\$84	\$87	\$90	\$92	\$95	\$98	\$101
	Members	15,513	15,563	15,612	15,662	15,713	15,763	15,813
	Total	\$15,717,939	\$16,243,817	\$16,787,290	\$17,348,947	\$17,929,394	\$18,529,262	\$19,149,200

Projected Administrative Expenses

Administrative expenses for the proposed program were calculated by developing a medical loss ratio benchmark of other county-based program financial actuals. Despite limitations in the public availability of other programs' budget data and allocations specific to administration and operations, the following programs' administrative cost structures were assessed: Healthy San Francisco, Montgomery Cares, and California Medical Services Program.

Healthy San Francisco: estimates are from the Table H1 of its 2015-2016 Annual Report. For the purposes of this study, administrative expenses were defined as HSF administration, Third-Party Administration, Eligibility/Enrollment System (One-e-App), and Siemens Information Technology. Medical expenditures were defined as Cost of Services, Behavioral Health, Non-SFDPH Provider Reimbursement, and Private Medical Homes Net HSF Expenditures (estimated charity care expenditures were not included for the purposes of the study). The sum of these two expenses calculated total applicable costs. Annual administrative expenses for years 2013 to 2015, expressed as a percent of total applicable costs, were estimated to be 6.1%, 7.6%, and 13.8%.

Montgomery Cares: estimates are from their Annual Report (Fiscal Year 2017). Page 8 of that report states that Montgomery Cares Program Administration and Information Technology/EHR comprised 16% of the FY2017 Budget (11% and 5% respectively).

California Medical Services Program: Budgeted Expenditures for FY 2015–2016 were retrieved from Table 2 of an October 2016 Report by authors from the University of California, Berkeley Center for Labor Research and Education.¹⁸⁵ Administrative expense were defined as Administration, Eligibility and Enrollment, ad "Other: legal, consultants, contractors, data marts, misc. " that summed to a total of \$3,861,000, whereas total applicable costs equaled \$10,261,000. Therefore, its 2015-2016 budgeted administrative expense as a percent of total expenditures was 37.6%.

It was determined due to dramatic changes in enrollment and financial infeasibility concerns that the California Medical Services Program administrative expense cost structure should be excluded from the analysis. Therefore, an average of the remaining four estimates (2013-2015 HSF and 2017 Montgomery Cares) was used in developing an administration expense benchmark; this resulted in a figure of 10.9%. The converse of the administrative expense benchmark can be interpreted as the medical loss ratio, which in this case would be 89.1% (i.e. 100% minus 10.9%). Because we do not have total expenditures for our study, we must convert these two percentages as a ratio between the two to calculate an 'medical loss to administration ratio' (i.e. 89.1% divided by 10.9% = 8.2). From here, administrative expense forecast for the proposed program is projected by dividing the estimated direct medical expenditures provided in Table 8 by the 'medical loss to administration ratio' (8.2). See Table 9 for administrative expense projections for CY2019-2025.¹⁸⁶

Table 9. Forecast of Aggregate Administrative Expenses in King County and Yakima County for CY2019-2025

	2019	2020	2021	2022	2023	2024	2025
<i>King</i>	\$5,484,342	\$5,760,560	\$6,050,690	\$6,355,432	\$6,675,523	\$7,011,735	\$7,364,880
<i>Yakima</i>	\$1,915,981	\$1,980,085	\$2,046,333	\$2,114,798	\$2,185,553	\$2,258,675	\$2,334,244

Projected Total Program Costs

Total projected program costs for King County and Yakima County are presented below in Table 10 and is calculated by summing the direct medical expenditures from Table 8 and administrative expenses in Table 9.

Table 10. Forecast of Total Program Costs in King County and Yakima County for CY2019-2025

	2019	2020	2021	2022	2023	2024	2025
<i>King</i>	\$50,475,671	\$53,017,871	\$55,688,110	\$58,492,835	\$61,438,819	\$64,533,178	\$67,783,384
<i>Yakima</i>	\$17,633,920	\$18,223,902	\$18,833,623	\$19,463,744	\$20,114,947	\$20,787,938	\$21,483,444

¹⁸⁵ Rojas & Dietz. Providing Health Care to Undocumented Residents: Program details and lessons learned from three California county health programs. University of California, Berkely Center for Labor Research and Education

¹⁸⁶ Limitations to administrative expenses benchmarks include reliance on aggregate statistics that does not account for the differences between the other county-based program and proposed King County and Yakima programs, such as financing, existing information technology capabilities of program and/or partners, etc.



G. Analytic Limitations

MEPS is highly regarded by the research community as a statistically robust data set, and the two-part model incorporated in calibrating the specific models within this analysis is advocated by the health econometric community given its merits in addressing common pitfalls in analyzing healthcare expenditures and utilization. However, despite attempts to control for several sociodemographic information available and employing many recommended statistical techniques, the estimates cannot account for omitted variables such as health status, differences in institutional differences¹⁸⁷ between the nationally representative MEPS survey and King and Yakima counties, or changing healthcare utilization patterns, among others. This is because the local market and micro-patient detail along the continuum of care needed for statistical analysis and financial projections is not readily accessible in any comprehensive manner. In addition to the above limitations, there are also other potential issues such as sampling bias, measurement error, and reporting error.

Pertaining to enrollment, the model assumes full registration of the population base as of year 1 (2019) which may need to subsequently be adjusted. The model is constructed in a flexible manner for independent analysis to correct for the estimated the number of person covered via PMPM statistics and not solely relying on aggregate program costs. Also, other county-based program benchmarks (i.e. pharmacy and administrative expense ratio) used in this study suffer from potential limitations if benchmark and proposed scope of services, financing, operation and technology infrastructure, etc significantly differ. Again, the model is designed for independent analysis to revise PMPM statistics for these benchmarks so revised total anticipated programs costs can be obtained.

¹⁸⁷ For instance, difference State Medicaid agencies' scope of services



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HealthTrends Appendix 1

Overview of Exclusion Methodology

Rationale

To exclude (1) health services not anticipated to be covered by the program and (2) covered services the uninsured population currently have access to from other state programs or health service organizations.

Examples include:

- **Alien emergency medical program (AEM)**
- **Apple Health for Pregnant Women**
- **Hospital Charity Care for persons \leq 300% of the Federal Poverty Level.**

General Exclusions

Full-Year Consolidated

MEPS HC-181: 2015 Full Year Consolidated Data File

- + All persons younger than 19 years old were excluded from the analysis.
- + Any person ID that did not have complete responses (i.e. non-missing) to variables relevant to insurance status and sociodemographic covariate detail were excluded.
- + Individuals classified as uninsured, but reporting a positive sum of expenditures by Veteran's Administration/CHAMPVA, were excluded.
- + After the filters above were applied, there were 24,680 observation person IDs remaining.

Is kidney dialysis an excluded service?

Dialysis treatment for end stage renal disease

- + According to WAC 182-507-0120, dialysis treatment for end stage renal disease is a scope of service category for those eligible under the Alien emergency medical program.
- + Patients undergoing dialysis treatment would have CCS code 158, indicating chronic kidney disease ("CKD"), reported in the MEPS medical conditions file.
- + However, there were no patients in MEPS 2015 with CKD according to medical conditions file. Therefore, no patient in the MEPS 2015 cohort would be expected to incur dialysis treatment; eliminating the need for additional exclusions pertaining to dialysis.

(Continued on the following pages are MEPS clinical setting-specific exclusion criteria)

Primary Care (Office-Based)

• *MEPS Household Component Event file: Office-Based Medical Provider Visits*

• **Primary care designation based on definition used in MEPS Statistical Brief #381.**¹⁸⁸

+ “MEPS respondents who reported an office-based visit in which a medical doctor was seen were asked to identify the doctor’s specialty (the questionnaire contains 34 response categories for coding the specialty type reported). In this Statistical Brief, the categories for general practice, family practice, internal medicine (internist), and pediatrics were combined because it may be difficult for respondents to distinguish between these types of primary care.”

• **Summary Exclusions:**

- + Cancer treatment
- + Dialysis treatment for end stage renal disease
- + Prenatal care, labor and delivery

• **Cancer Treatment**

- + According to WAC 182-507-0120, cancer treatment is a scope of service category for those eligible under the Alien emergency medical program.
- + Modified Adjusted Gross Income (MAGI) eligibility rules apply.¹⁸⁹ Coverage to adults with countable income at or below 133 percent of the FPL.¹⁹⁰
- + Incorporated cancer classification from MEPS Statistical Brief #443¹⁹¹ - "Conditions with CCS codes 11-45 were classified as cancer."
- + Therefore, all medical services across all clinical settings with a primary CCS code of 11-45 and for patients <=133% of the FPL were identified and excluded from the analysis.

• **Dialysis treatment for end stage renal disease**

- + See ‘Overview of Exclusions’

• **Prenatal care, labor, and delivery**

- + Pregnancy-related healthcare coverage is available through Apple Health for Pregnant Women, without regard to citizenship or immigration status.¹⁹²
- + Income eligibility rules do apply. Coverage for women with countable income at or below 193 percent of the FPL.¹⁹³
- + Event-level medical services in MEPS reported as "PREGNANCY-RELATED (INC PRENATAL/ DELV)" under the MEPS variable VSTCTGRY for persons <=193% FPL were excluded from the analysis.

¹⁸⁸ Davis, K. and Carper, K. Use and Expenses for Office-Based Physician Visits by Specialty, 2009: Estimates for the U.S. Civilian Noninstitutionalized Population. Statistical Brief #381. August 2012. Agency for Healthcare Research and Quality, Rockville, MD. http://www.meps.ahrq.gov/mepsweb/data_files/publications/st381/stat381.pdf

¹⁸⁹ Washington Apple Health (Medicaid) Programs - Eligibility Overview (April 2017). p 7

¹⁹⁰ *Ibid.* p 3

¹⁹¹ https://meps.ahrq.gov/data_files/publications/st443/stat443.pdf

¹⁹² *Ibid.* p 4

¹⁹³ *Ibid.*

Specialty Care (Office-Based)

MEPS Household Component Event file: Office-Based Medical Provider Visits

Specialty care designation

- + *Specialty care is defined in this study as all non-primary care events in an office-based setting.*
- + *Therefore, in contrast to the Primary Care methodology, the Specialty Care analysis filters the MEPS Office-Based Medical Provider Visit files to exclude all classified primary care events.*
- + *See the Primary Care methodology above for the definition used to classify primary care events*

Summary Exclusions:

- + Cancer treatment
- + Dialysis treatment for end stage renal disease
- + Prenatal care, labor and delivery

Cancer Treatment

- + See Primary Care (Office-Based) Methodology above.

Dialysis treatment for end stage renal disease

- + See 'Overview of Exclusions'

Prenatal care, labor, and delivery

- + See Primary Care (Office-Based) Methodology above.

Hospital Outpatient

MEPS Household Component Event file: Outpatient Visits

Summary Exclusions:

- + Cancer treatment
- + Dialysis treatment for end stage renal disease
- + Prenatal care, labor and delivery
- + Outpatient Surgery
- + Charity Care Discounts

Cancer Treatment

- + See Primary Care (Office-Based) Methodology above.

Dialysis treatment for end stage renal disease

- + See 'Overview of Exclusions'

Prenatal care, labor, and delivery

- + See Primary Care (Office-Based) Methodology above.

Outpatient Surgery

- + According to WAC 182-507-0115(1)(b)(ii), Outpatient Surgery is a qualifying emergency condition covered under the Alien emergency medical program.
- + Modified Adjusted Gross Income (MAGI) eligibility rules apply.¹⁹⁴ Coverage to adults with countable income at or below 133 percent of the FPL.¹⁹⁵
- + Event-level medical services in MEPS reporting as "YES" under the MEPS variable SURGPROC for persons $\leq 133\%$ FPL were excluded from the analysis.

Charity Care Discounts

- + Based on review of UW Medicine, Swedish Health Services, Virginia Mason Medical Center, Franciscan Health Services (Catholic Health Initiatives), and MultiCare Health System's hospital charity care policies, all patient/family responsibilities of hospital-related charges for persons below 300% of the poverty level were discounted at 100%.¹⁹⁶
- + Further, because the proposed program does not intend to cover services where a person may be broadly covered by charity care, all payment data for persons below 300% of the poverty level was discounted at 100% as well. As a result, all payment statistics for this clinical setting under the projections are for care provided to persons 300+% of the poverty level. However, utilization statistics for this clinical setting is for all encounters excluding the AEM and Apple Health events identified above.

¹⁹⁴ Washington Apple Health (Medicaid) Programs - Eligibility Overview (April 2017). p 7

¹⁹⁵ *Ibid.* p 3

¹⁹⁶ Individual hospital charity care policies can be found at

<http://www.doh.wa.gov/DataandStatisticalReports/HealthcareinWashington/HospitalandPatientData/HospitalPolicies/u14251q/4B696E67/u14251c/436F756E7479/u14251m/contain>



Emergency Room

MEPS Household Component Event file: Emergency Room Visits

Summary Exclusions:

- + Cancer treatment
- + Dialysis treatment for end stage renal disease
- + Prenatal care, labor and delivery
- + Emergency Conditions
- + Charity Care Discounts

Cancer Treatment

- + See Primary Care (Office-Based) Methodology above.

Dialysis treatment for end stage renal disease

- + See 'Overview of Exclusions'

Prenatal care, labor, and delivery

- + See Primary Care (Office-Based) Methodology above.

Emergency Conditions

- + According to WAC 182-507-0115(1)(b)(iii), Emergency room services is a qualifying emergency condition covered under the Alien emergency medical program.
- + Modified Adjusted Gross Income (MAGI) eligibility rules apply.¹⁹⁷ Coverage to adults with countable income at or below 133 percent of the FPL.¹⁹⁸
- + Emergency room encounters were classified as emergent/urgent if either (1) the event reported as “Emergency” or “psychotherapy/mental health counseling” under the MEPS variable VSTCTGRY; (2) the event has a corresponding hospital stay ID reported under the MEPS variable ERHEVIDX; or (3) surgery reported under the MEPS variable SURGPROC.
- + Event-level medical services in MEPS classified as emergent/urgent for persons <=133% FPL were excluded from the analysis.

Charity Care Discounts

- + See Hospital Outpatient Methodology above.

¹⁹⁷ Washington Apple Health (Medicaid) Programs - Eligibility Overview (April 2017). p 7

¹⁹⁸ ibid. p 3



Inpatient

• *MEPS Household Component Event file: Hospital Inpatient Stays*

• **Summary Exclusions:**

+ Charity Care Discounts

• **Charity Care Discounts**

+ See Hospital Outpatient Methodology above.

+ Further, because the proposed program does not intend to cover services where a person may be broadly covered by charity care, all payment data for persons $\leq 300\%$ of the poverty level was discounted at 100% as well. As a result, all payment statistics for this clinical setting under the projections are for care provided to persons 301+% of the poverty level. However, utilization statistics for this clinical setting is for all persons (no exclusions applied).

Home Health

• *MEPS Household Component Event file: Home Health*

• **Summary Exclusions:**

+ Personal Care

+ Hospice

• **Personal Care**

+ Event-level medical services in MEPS reporting "YES" under the "PERSONAL" MEPS variable, indicating the type of health care worker is a personal care attendant, were excluding from the analysis.

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• **Hospice**

+ Event-level medical services in MEPS reporting "YES" under the "HOSPICE" MEPS variable, indicating the type of health care worker is a hospice worker, were excluding from the analysis.

+ Hospice was a service requested to also be included in an alternate model. However, small sample size issues and unknown scope of services as it relates to hospice home health by Medicaid agencies covering MEPS respondents led to imprecise estimates and were consequently excluded outright.

Dental (No Exclusions)

MEPS Household Component Event file: Dental Visits

Other Medical Expenses (No Exclusions)

MEPS Household Component Event file: Other Medical Expenses