Local Access to Universal Health Care in Lewis & Clark County

A Report from the City-County Board of Health Task Force

February 2011 Version (as updated)

Phase II Report: Recommendations and Action Plan

I. Executive Summary

The Task Force on Local Access to Universal Health Care (Task Force) has completed its two-year review of health care needs and access barriers in Lewis & Clark County, carried out on the basis of the Lewis & Clark City-County Board of Health resolution of December 2008, which recognized the human right to health and the government's obligation to ensure universal access to care. With this report the Task Force submits five principal recommendations for action to the Board of Health and to the people of Lewis & Clark County.

Summary of recommendations to the Board of Health:

1. **Ensure that St. Peter's Hospital meets the community's health care needs:**
   a) Start a dialogue with the hospital and increase community participation in hospital planning and operations
   b) Raise awareness of St. Peter's legal obligation to the community, derived from its tax-exempt status, which could potentially be challenged in the courts, if necessary
   c) Consider starting the process of creating a public hospital taxing district to increase funding to expand access to health care services at the hospital and the Cooperative Health Center

2. **Create a new, community-based health care plan in the county:**
   a) Start the process of setting up a CO-OP health plan to apply for federal funding by 2013
   b) Assess the feasibility of other alternative health plans, including a Canadian-type plan and publicly financed programs established by other counties across the United States
   c) Start the process of funding health care expansion through a local option income tax

3. **Expand the health services at the Cooperative Health Center, including primary care, dental, and mental health services, and expand the geographical areas served**

4. **Initiate a statewide referendum to recognize the human right to health care across Montana**

5. **Continue taking incremental steps to expand access to health care and increase affordability:**
   a) Improve emergency and non-emergency transportation to ensure everyone can access care where and when they need to
   b) Advocate for streamlining health administration and record management across the sector

II. Introduction

With this report the Task Force submits its recommendations for action to the Lewis & Clark City-County Board of Health (Board) and to the people of Lewis & Clark County. The Task Force carried out its charge based on the resolution adopted by the Board in December 2008. This resolution recognized the human right to health and health care, along with the corresponding government obligation to guarantee universal access to care. It created the Task Force and charged it with assessing the community's health needs and recommending actions to meet those needs and ensure universal access. The Task Force, comprised of members volunteering their time – including county residents, health care providers and other health sector representatives – has now completed this two year, multi-phased project.

The Task Force submitted its Phase I report, with findings of the community health needs assessment, to the Board in October 2010. These findings confirmed that the lack of access to appropriate health care is a serious problem in Lewis & Clark County, demanding action at the local level. Community members and health providers alike highlighted the increasing shortage of primary care professionals, which deprives communities of essential care and puts significant stress on existing providers. The cost of insurance and services was identified as another key barrier to universal and equitable health care access. Both uninsured and insured residents expressed concerns not only about the cost of insurance, but also the financial burden of deductibles and co-pays, and many suggested that access to care should not depend upon payment. Payment was seen as the main reason why some members of the community had better access to care than others, and many perceived this as an inequality that stood in the way of creating a healthy community. The majority of residents consulted by the Task Force recognized these access barriers as a human rights problem.

Grounded in the Board resolution and the responses received from residents, the Task Force used human right to health principles as guidance for developing its action recommendations. This meant placing people's health needs at the heart of its deliberations, tackling administrative and commercial barriers to patient care, and treating health care as a public good shared by the community as a whole. The Task Force recommendations respond to the identified health needs and aim to ensure access to equal high quality health care for all county residents.

As required by the Board resolution, Phase II of the Task Force work included developing an action plan that:

- identifies and prioritizes specific actions the Board and Lewis & Clark City-County Health Department (the Department) should consider to address the lack of access to health care, with particular emphasis on local options for universal health care;
- sets principles, objectives and benchmarks for preferred options, and
- identifies specific strategies, actions and recommendations that local government officials should make to state and federal leaders regarding the best options for addressing the lack of access to health care and achieving universal health care in Lewis & Clark County.

III. Methodology

In Phase I, the Task Force used primary and secondary data to assess the community's health needs, barriers to accessing care, and residents' views of the health care system in Lewis & Clark County. The Task Force conducted research with community members, community organizations, and health professionals to compile a detailed picture of health care access in Lewis & Clark County.

Phase II of the Task Force work utilized and expanded this research in several ways. Most importantly, the findings of Phase I provided the evidence base for the Task Force recommendations. The multitude of health care needs identified in Phase I revealed a range of health care access problems in Lewis & Clark County, which the Task Force prioritized as a basis for developing actionable solutions. In this process, additional research was carried out to test the feasibility of potential solutions. This secondary research included:

- analyzing health care financing in Lewis & Clark County (Appendix A);
- assessing the likely impact of the Patient Protection and Affordable Care Act (PPACA) on Montana and Lewis & Clark County, and evaluating local reform options in the context of federal opportunities and requirements (Appendix B: Implementing Federal Health Insurance Reform-B1, ERISA-B2, Non-Profit Hospitals-B3, CO-OP Program-B4); and
- collecting examples of reforms implemented in local communities elsewhere (Appendix C: County Health Care Initiatives-C1, Local Health Care Interventions-C2, Local income Tax-C3, Oregon Case Study-C4, Public Hospital Districts-C5).
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Using this additional research, the Task Force assessed the feasibility of potential reforms, developed strategies for implementation, and prioritized its recommendations accordingly. Key factors in this prioritization were the urgency and pervasive nature of the identified problems, the opportunity to affect systemic change, the County's ability to intervene, and the timeframe for solutions to take effect. Achieving universal, equitable access to care is the human rights principle underlying all recommendations.

IV. Recommendations: Local Solutions for Securing Universal Access to Health Care

1. Ensure that St. Peter's Hospital meets the community's health care needs

One of the most frequent issues raised in the Phase I research with residents was the role of St. Peter's Hospital in serving the community's health needs. As the County's only general hospital, based in Helena, St. Peter's occupies a central place in the local health care system. It has to serve the entire community, including residents in remote areas as well as poor and low-income people. Yet many residents feel that the hospital has fallen short of meeting the community's needs. They urged the Task

Force to address a range of issues related to the hospital, including administrative, financial, and access issues, as well as some quality concerns. Primary care physicians participating in the research also raised concerns about the hospital, particularly about interactions with hospital management.

Given St. Peter's crucial role in the community, **the Task Force recommends that the Board begin an immediate and ongoing dialogue with the hospital,** focusing on the goals of securing adequate hospital services to low-income patients and improving collaboration with primary care physicians. This dialogue should also seek to increase transparency in the hospital's planning processes, and to establish effective mechanisms of community participation in hospital planning and operations.

As St. Peter's is a non-profit, tax-exempt hospital, the Task Force points to the specific obligations this status confers on St. Peter's (Appendix B-3). At the federal level, as well as in a range of states and counties across the United States, regulations and standards for tax-exempt hospitals have been tightened over the past few years to ensure that these hospitals comply with charity care and community benefit standards. For example, federal law now requires tax-exempt hospitals to conduct regular community needs assessments with input from the community. The Task Force hopes that a regular dialogue with St. Peter's will be helpful in supporting the hospital to be better equipped to meet the requirements linked to its tax-exempt status. According to the 2010 hospital report prepared for the Montana Attorney General, St. Peter's community benefit costs as a percentage of the value of its tax exemption remain among the lowest in Montana, even though the level of charitable care provided by St. Peter's has increased over the past three years.[1]

The Task Force recommends raising awareness about St. Peter's Hospital legal obligation to the community, derived from its tax-exempt status, which could potentially be challenged in the courts, if necessary. If St. Peter's Hospital were required to pay local property taxes, those payments could be placed into a fund that is administered to pay for improving the hospital's services to the community, expanding access.

The Task Force is also aware that additional funds may have to be raised to enable both the hospital and the Cooperative Health Center to meet the community's health needs. It therefore **recommends that the Board seriously consider embarking on a process of creating a public hospital tax district,** in accordance with MT Statute (7-34-2101) (Appendix C5). If adopted by voters, this district could levy taxes for increased health care access and community services provided by St. Peter's Hospital and by the Cooperative Health Center.

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[1] Of Montana's 11 major non-profit hospitals, St. Peter's Hospital ranks as the bottom third in terms of overall community benefit provided as a percentage of the value of its tax exemption. Reflecting a general trend across Montana hospitals, the charity care St Peter's provides has increased as a percentage of operating costs from 1.41% in 2006 to 2.70% in 2008. Lawrence L. White Jr. et al., *Montana's Hospitals: Issues and Facts Related to the Charitable Purposes of Our Hospitals and the Protection of Montana's Consumers*, June 2010, Montana Office of Consumer Protection: 2010, p. 12 (http://www.doj.mt.gov/consumer/consumer/hospital/hospitalreport2010.pdf)

2. Create an alternative health care plan in the county

Residents and health care providers alike pointed to the high cost of private health insurance (premiums and out-of-pocket costs) as the main access barrier to health services. Community members highlighted both the problem of uninsurance and underinsurance, especially for low-income people ineligible for public programs. Providers pointed to the bureaucracy entailed in dealing with insurance companies, and the high administrative costs incurred as a result, which diverts funds away from actual health care services.

An analysis prepared for the financing work group of the Task Force shows that even after full implementation of the federal health law (PPACA), a large percentage of currently uninsured county residents would remain uninsured (Appendix B1). Given that official rates of uninsured residents vary (between 14% and 21%, see Phase I report), it can only be approximated how many County residents may be affected and left without health care coverage (between 3,500 and 5,350 people). In addition, the problem of underinsurance is likely to be much greater, as the Task Force's research with residents revealed. PPACA cannot be relied on to solve this problem, as premium and out-of-pocket costs are projected to remain a great burden even for subsidized policyholders, particularly those at the lower income spectrum.

To ensure universal access to health care on an equal basis, the Task Force recommends creating a new, community-based health care plan in the county as an alternative to private insurance plans. Several options should be explored simultaneously; all of which should have largely reduced overhead costs compared to private carriers and thus reduce the cost of health insurance in Lewis & Clark County.

First, **the Task Force recommends that community members in collaboration with providers begin the process of setting up a CO-OP plan**, which would enable them to apply for federal grant funding under PPACA (Appendix B4). A CO-OP is a non-profit, member-run health insurance plan that collaborates with providers, such as St. Peter's Hospital and the Cooperative Health Center, to offer coverage to individuals and small groups. The Task Force recommends that in developing the plan and its governance structure, stakeholders in neighboring counties are invited to join the discussions to consider a regional plan with greater service availability and membership.

Second, **the Task Force recommends that the Board of Health consider the feasibility of other alternative health plan models, including a Canadian-type plan or other publicly financed programs.** Local examples from counties across the United States range from near universal plans funded through employer assessments and county budgets to partnerships between providers and local government to make care available to everyone who is unable to pay (Appendix C1). In almost all cases, significant collaboration between the various stakeholders is required, and the Task Force urges the Board to facilitate a closer cooperation between individual providers, the hospital, the Cooperative Health Center, community organizations, patient advocacy groups, and employers.

Thirdly, **the Task Force recommends pursuing the option of funding a health care expansion through levying a local income tax.** Receipts from a local income tax could be used to fund needed health services or an alternative health care plan. A number of other counties across the county have adopted this approach (Appendix C3). As a first step, legislation would have to be introduced in the state legislature to give Montana counties the authority to propose a local income tax.

3. Expand services at the Cooperative Health Center

The prevalence of cost-related access barriers, which emerged from the Phase I research, points to the Cooperative Health Center as an obvious solution, at least with regard to primary care. As a federally qualified health center (FQHC), the Cooperative Health Center, based in Helena with a satellite clinic in Lincoln, provides primary care services on a sliding fee scale. Patients do not have to be insured, and no one is turned away because of inability to pay. As the health center already serves some of the most vulnerable patients, it is well-placed to expand its services to ensure universal primary care in Lewis & Clark County.

An expansion of primary care services through the health center would also address the growing primary care physician shortage, which the Task Force explored in its Phase I research. Many residents reported difficulties finding and keeping a family physician, and many providers felt the strain of their own dwindling numbers. Any expansion of access to care will have to start at the primary care level, which has the greatest potential for keeping the community healthy and preventing the need for more costly medical interventions.

An expanded health center could also play a role in supporting and retaining private primary care physicians. The health center could provide an umbrella for private doctors, including OB/GYNs, under which these doctors could receive malpractice insurance and other administrative services to enable their private practices to operate more efficiently.

Task Force research with local communities revealed that the Cooperative Health Center was not sufficiently known among residents. Among those who had used its services it is largely well regarded. Concerns were raised, however, that the health center was already operating at the limits of its capacity, and that outreach to potential new patients would have to be combined with an expansion of services. The health center's capacity to provide dental care would also have to be significantly expanded to meet the community's demand for affordable dental care of equal range and quality as offered by private dentists. An expansion of dental care at the health center was also suggested by dentists participating in the research.

Additionally, the research with residents demonstrated a need for more mental health providers, with an emphasis on patient-oriented services, including for children. The Task Force sees a potential for expanding such services at the Cooperative Health Center. The Task Force also recognizes a need for additional public health services, particularly health screening programs (e.g. for diabetes).

An expansion of the Cooperative Health Center should also have a geographical component. Residents in the more remote areas are clearly underserved, as Task Force research has shown, and many research participants pointed to access difficulties resulting from the centralization of health services in Helena. Similarly, residents also suggested expanding providers' office hours to enable more flexible access to care outside work time. An expanded Cooperative Health Center would be in a good position to respond to this demand.

Therefore, the Task Force recommends that funding for the FQHC be increased in order to allow for a significant expansion of services, with a view of making primary care universally accessible. Such an expansion would eliminate cost as a barrier to accessing primary care, in addition to presenting a cost-effective and efficient alternative to administratively expensive insurance options. It could be financed through the taxation options mentioned above (local income tax or public hospital district tax), or, at least partially, through federal grants and demonstration projects (Appendix C2). It could also be supported through designated residency slots at the FQHC through the WWAMI medical education program (led by the University of Washington Medical School), provided the County advocated for such opportunities.

4. Propose a statewide referendum to recognize health care as a human right

The Task Force found that most residents who participated in the survey and focus groups agreed with the Board and considered health care to be a human right. Participants also expressed appreciation for the initiative taken in Lewis & Clark County to protect this right at the local level through seeking to ensure universal access to care. Many Task Force members perceived their work, and the process underlying it, as a way of holding local leaders accountable, on behalf of participants and the wider community. The Task Force proposes that the accountability for realizing universal access to health care be extended to the state of Montana, whose policies affect all county residents. Therefore, it **recommends initiating a statewide referendum to recognize the human right to health care in Montana.**

The Board resolution on the human right to health initiated an important process to ensure universal access to care in Lewis & Clark County. The Task Force expects that its recommendations will lead to concrete actions and thus enable more community members to meet their health needs. This positive example set in Lewis & Clark County should be replicated statewide. Much can be done to improve health care at the local level, as the Task Force's recommendations show, yet the state has even more leverage to ensure that Montanans can exercise their right to health care. Therefore, the Task Force recommends that the Board and other local leaders seek to expand support for the human right to health care beyond Lewis & Clark County and catalyze action by the state through supporting a statewide ballot initiative campaign for the human right to health care in Montana.

5. **Implement incremental measures for expanding access and increasing affordability**

The Task Force recommends that the Board and health care providers continue taking incremental steps to expand access and increase affordability. Residents and providers who participated in the research made a range of suggestions (see Phase I report, especially Appendix 3A) for immediate measures that may be adopted or promoted. Among these, the Task Force recommends that the following two examples are particularly worth pursuing.

First, the Board should seek to **improve emergency and non-emergency transportation to ensure everyone can access care where and when they need to.** Residents voiced concerns about the barriers encountered by rural, older, and poorer people in physically getting to health facilities. The Board should consider adding mobile services or telemedicine for rural locations, and advocating for improving public transit in Helena to enable patients without cars to better access care. Residents also discussed the different emergency transportation options; with rural residents praising their local volunteer ambulances but others expressing concerns about the cost of St. Peter's Hospital's ambulance service. In the first instance, the Board should investigate whether cost-effectiveness issues in Helena could be addressed by avoiding ambulance service duplication, which arises when both the City Fire Department and the hospital respond to emergency calls.

Second, in preparing for structural changes to health care financing and management in Lewis & Clark County, the Board and the City-County Commissioners should **advocate for streamlining health administration and records management across the sector**. Discussions with key stakeholders should explore the feasibility of payment reforms leading to uniform costs of services and a uniform billing format. Similarly, the Board should advocate for and explore with stakeholders the introduction of improved electronic charting and patient records management systems, which could increase care coordination, safety, and efficiency.

V. Action Plan for Implementation of Recommendations

All recommendations in this report require the active leadership of the Board to secure their timely, practical implementation. As the role of the Task Force is officially coming to an end, Task Force members are urging the Board to take over the health reform process initiated by the Board resolution on the human right to health.

Initial follow-up actions by the Board should include:

a. Outreach to the media about the Task Force report and action plan
b. Outreach to the community as a follow-up to the community survey in Phase I
c. Outreach to Boards of Health in neighboring counties to present the reform process and discuss their potential involvement and collaboration in the action plan

d. Participation in legislative advocacy at the state level, in line with the resolution and Task Force recommendations
e. Taking a lead in implementing the action plan prepared by the Task force; implementing measures within the Board's direct authority, and facilitating, initiating or advocating for implementation of other measures that are beyond the Board's authority

The following is an action plan matrix that provides guidance for implementing the Task Force recommendations.

Recommendations	Objectives	Strategy	Lead role	Stakeholders	Timeline	Initial Benchmarks
1. Address issues at St. Peter's Hospital	**Ensure that hospital meets community health needs**					
a) Dialogue with Hospital Board	Improve collaboration with primary care physicians; improve hospital services to low-income patients; increase transparency and community participation	Engage Hospital Board in public dialogue and agree to short-term measures	Board of Health	Hospital Board, community members	Short-term: asap	• Letter(s) sent to Hospital Board • Public meetings held • Short-term measures agreed • First measure implemented • Subsequent measures implemented
b) Raise awareness of and potentially challenge hospital's non-profit status	Ensure that hospital fully meets the requirements of its tax-exempt status	Raise awareness of tax-exempt requirements; explore legal challenge, which could result in placing hospital's property tax payment into a new charity care fund	Board of Health, community members	Hospital Board, Board of Health	Short to medium-term, in parallel with a)	• Raise awareness of tax-exempt requirements • Potentially identify parties interested in bringing legal challenge • Communicate with Hospital Board • • Prepare establishment of new charity care fund
c) Consider creating a public hospital district	Raise funds for better meeting community health needs	Develop and submit petition to County Commissioners; pass proposal in election; set up district and levy taxes for defined purpose	Board of Health, City-County Commission	Hospital Board, City-County Commissioners, community members	Medium-term, in parallel with a)	• Draft petition • Gather signatures • Submit to County Commissioners • Present at hearings • Election campaign • Set up governing Board

2. Create an alternative health care plan	**Ensure universal access to care on an equal basis**					
a) CO-OP plan	Ensure that everyone can access insurance through a community operated health care plan	Develop CO-OP plan and assemble governance Board - potentially in conjunction with other counties - to apply for federal loans and grants	Board of Health, community members	Cooperative Health Center, Hospital Board, health departments and providers in other counties, employers	Short to medium-term	• Consult with potential CO-OP partners • Develop plan with partners, including providers • Reach out to other counties for collaboration • Set up CO-OP Board • Apply for federal funding before July 2013
b) Canada-type plan	Ensure universal access through efficiency savings in a publicly financed and administered system	Explore feasibility of Canadian-type public health care plan and support public discussion of this	Board of Health, City-County Commissioners	Other county government, state government, community members, employers	Medium to long-term	• Reach out to other county health Boards • Develop feasibility study • Facilitate public discussion
c) Adopt a local income tax to fund health care for all	Raise funds in an equitable way to ensure access to care for all	Introduce state legislation to give counties the authority to raise a local income tax; if successful, develop universal health plan (see b) and propose local income tax and PPACA subsidies as funding mechanism	Board of Health, City-County Commissioners, state legislature	State government	Medium to long-term	• Identify state legislator to sponsor legislation • Introduce and adopt legislation • Develop universal health plan (see b) • Propose local income tax
3. Expand health services at the Cooperative Health Center	**Ensure availability of primary care for everyone, independent of**					

	payment; improve community health					
a) Expand primary, dental and mental health care services	Increase capacity of Cooperative Health Center and expand services and service area	Explore funding opportunities through residency programs , demonstration projects and collaborations, hospital district or local income tax	Board of Health, CHC Board	CHC, County Health Department	Short to medium-term	• Work with CHC Board to develop business plan for expanded services if funding is secured • Explore residency opportunities • Explore opportunities for medical home networks and funding • Explore opportunities for collaborative care models and funding • Allocate new resources
b) Expand public health services	Increase capacity of public health services	Explore demonstration projects and collaborations, increase funding through hospital district or local income tax or mill levy	Board of Health, CHC Board	County Health Department, CHC	Short to medium-term	• Plan service expansion based on need • Explore opportunities for demonstration projects and collaborations • Identify and allocate new resources
4. Propose statewide human right to health care referendum	**Hold the state accountable for realizing universal access to care for Montanans**					
a) Propose a statewide referendum	Expand support for the right to health care beyond L&C County and catalyze action by the state	Initiate and support a statewide ballot initiative campaign	Board of Health, community members	City-County Commission, state legislators	Short to medium-term	• Identify potential campaign sponsors and supporters • Convene stakeholder groups to launch campaign • Agree to petition language

						• Convene public meetings • Gather signatures
5. Take steps for incremental reforms	**Expand access and increase affordability**					
a) Improve emergency and non-emergency transportation	Ensure that everyone can physically access care where and when they need to	Discuss mobile services and telemedicine with providers; advocate for mobile services and additional public transit; investigate duplication of ambulance services	Board of Health, City-County Commission	Hospital Board, CHC, Helena fire department, Helena City Commission	Short-term	• Raise mobile services and transport issues with key providers • Advocate at City-County Commission for improved public transit • Collaborate with efforts to create urban transit district • Discuss emergency response with Hospital and Fire Department
b) Advocate for streamlining administration and record management across the sector	Increase care coordination, safety, efficiency, and cost-effectiveness	Initiate discussion among insurers and providers; facilitate increased collaboration among providers; identify and advocate for funding	Board of Health	Insurers, Hospital, CHC, other providers, Montana legislature	Short-term	• Discuss payment reform with insurers and providers • Discuss improved collaboration with providers • Research and identify funding opportunities • Advocate for state and federal funding

VI. Conclusion

The Task Force found the Lewis & Clark County health care system to fall woefully short of protecting and realizing County residents' human right to health care, yet it also identified clear opportunities for local action. It is the expressed view of the Task Force that the Board and local leaders have the responsibility and the opportunity to significantly improve the health and lives of people living in Lewis & Clark County by implementing the recommendations entailed in this report. While many functions of our health system are centralized at the state or federal level, there are important decisions and actions that can be taken at the local level, where health care is delivered, with and by the people the health care system is supposed to serve. The Task Force urges the Board and local leaders to make full use of these opportunities and to involve community members in this process.

The Board and local leaders also have a key role to play in helping to improve the community benefits delivered by the hospital, and enhancing the collaboration among local providers. This will increase access to hospital care as well as the quality of services rendered. The Board should pursue all recommended options for increasing equity in health care access by initiating an alternative health care plan that is community based or publicly financed, so that receiving needed care no longer depends upon having a certain level of income or wealth in order to buy access to care as a market commodity. Instead, the health care providers in Lewis & Clark County should start working toward the provision of health care as a public good, shared by and directly accountable to county residents. This is how the Cooperative Health Center largely functions already, and the Board and local leaders should support an expansion of the crucial services delivered by the health center, with a view to ensuring universal access to primary care.

The Task Force concludes that the local health reform process – launched by the Board of Health resolution on the human right to health care – has been very valuable already, in large part because it brings accountability to local government for ensuring that all community members can access health care. The Task Force would like to see this accountability extended to the state of Montana.

Most importantly, the Task Force urges the Board and local leaders to continue this process and implement the recommendations for actions, so that the entire community can begin to see tangible results, leading to universal access to health care on an equal basis for all.

Appendix – Phase II Report

A. Analysis of health care financing in Lewis & Clark County

1. Financing Options for Local Healthcare Access

B. Federal context for health reform

1. Implementing Federal Health Insurance Reform in Rural Regions: Implications for Insurance Coverage in Lewis and Clark County
2. ERISA, the Employee Retirement Income Security Act of 1974: Obstacle to local and state-based health reform?
3. Non-Profit, Tax-Exempt Hospitals: New Laws and Policies
4. The Consumer Operated and Oriented Plan (CO-OP) Program

C. Reforms implemented in other local communities

1. Examples of County Health Care Initiatives across the United States
2. Local Health Care Interventions: Examples from Across the Country
3. Personal Income Tax at the Local Level: Examples
4. Multnomah County, Oregon: Case Study of Voter-Approved Temporary Local Income Tax
5. Public Hospital Districts in Montana

Appendix A. Analysis of healthcare financing in Lewis & Clark County:

Financing Options for Local Healthcare Access

In order for the Lewis and Clark County community to consider opportunities for local reform that moves toward universal access to health care, it is important to have an understanding of the quantity of dollars that are being spent in the county on health care. Potential reform options will require funding so that knowing how many dollars change hands in the county for health care and knowing the source of those dollars will help guide options to reallocate those dollars toward reform proposals.

According to a study by Dr. Steve Seninger[1] total spending for health care in Montana was $5.4 billion in 2006, $5.8 billion in 2007, and $6.2 billion in 2008. Unfortunately, there has been no study that details the amount of spending by Montana Counties, but extrapolating from the above data indicates that in Lewis and Clark County, which comprises 6.2 percent of the Montana population, the following dollar amounts were spent for health care:

- 2006 = $334.8 million
- 2007 = $359.6 million
- 2008 = $384.4 million

According to the U.S. Census Bureau Population Division, the population of Lewis and Clark County was 60,925 in 2008. Therefore, in 2008 there was about $6,309 spent for health care in the county for every man, woman, and child.

Also drawing upon the work and research of Dr. Seninger, and correlated with the Kaiser Family Foundation data on state level data[2], the following are the projected percentages of the types of healthcare insurance coverage for the Lewis and Clark County population:

- 50% employment-based insurance (47.8% in Montana, 2008, Kaiser)
- 14% Medicare coverage (14.8% Montana, plus other public 2.1%)
- 12% Medicaid/CHIP coverage (12.2% Montana)
- 8% purchase their own individual health insurance (7.2% Montana)

These percentages illustrate that approximately 58 percent of the healthcare dollars spent in Lewis and Clark County are controlled by the policy decisions of the public/private employers that purchase coverage for their employees and the individual choices of those covered employees as well as those individual who purchase their own private insurance plan.

Therefore, correlating all of the above data, approximately $222.9 million spent on healthcare in the county in 2008 is controlled by local decision making so that proposals to reform healthcare at the local level could conceivably redirect these dollars. Specifically, local employers could be convinced to invest their insurance benefit dollars differently and individual health insurance

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[1] See email dated August 27, 2009 (attached as addendum).

[2] Ibid; http://www.statehealthfacts.org/profileind.jsp?cmprgn=1&cat=3&rgn=28&ind=125&sub=39

policyholders could be convinced to utilize the local system differently in order to maximize their healthcare dollars.

The major employers in Lewis and Clark County include government (with 10,117 employees, of which 2177 are in local government), retail (4,019 employees), and health care and social assistance (3,731 employees)[3]…***seeking public vs. private…in order to know who it is that would need to be influenced to make different policy decisions…*** While the state government is the single largest employer, over two thirds of all employees (around 23,753) are in the private sector. The largest private employers in the county are Blue Cross Blue Shield and St. Peter's Hospital (both in the category of 500 - 999 employees), followed by Wal-Mart, Carroll College and the Rocky Mountain Development Council (all in the category of 250-499 employees).[4] 40.2% of private employers in Montana offer health coverage (96.2% of firms with over 50 employees, and 29.4% of small businesses).[5]

In addition, according to Himmelstein et al.[6] ***an average of 31 %*** of our healthcare spending is actually spent on administrative costs (insurance overhead, employers' costs to administer health benefits, hospital administration, nursing home administration, practitioners' overhead, and home care agency administration .) rather than actual patient care. Based on 2003 expenditure projections, administrative savings in Montana could have totaled $784 million in that year. Deducting 31% percent from the 2008 dollars spent in the county on healthcare would leave a total of ***$265.2 million*** that actually pay for patient care, so that the approximately $222.9 million that is controlled by local decision makers actually represents around 84***% of the dollars*** currently used for patient care in Lewis and Clark County.

Granted, all of the above calculations are inexact and not certain enough to use for a local budget, but the point of this is to make clear that a local community, in this case Lewis and Clark County, does indeed have sufficient buying power and local decision makers do indeed have control over enough dollars that it is possible to consider local options for healthcare reform that could move toward universal local access to care.

With that local control and local economy clearly established, what remains is for the local community to begin to consider what options, what reallocation decisions could be made with the approximately $222.9 million that could be spent differently in order to create a more universally accessible local healthcare system.

Potential Options for Consideration

1. Redirect funding ($222.9 million per year) to the community health center to provide primary care for all…

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[3] Montana Department of Labor and Industry and Montana Department of Commerce, *Demographic and Economic Information for Lewis and Clark County.* Helena, MT, 2009
http://www.ourfactsyourfuture.org/admin/uploadedPublications/3481_CF09_Lewis.pdf

[4] http://www.ourfactsyourfuture.org/admin/uploadedPublications/3481_CF09_Lewis.pdf

[5] http://www.statehealthfacts.org/profileind.jsp?cat=3&sub=46&rgn=28

[6] Himmelstein, D./Woolhandler S,/Wolfe S., "Administrative Waste in the US Health Care System in 2003: The Cost to the Nation, the States and District of Columbia, with State Specific Estimates of Potential Savings," *Int J Health Services* 2004;34:79-86.
http://www.pnhp.org/PDF_files/IJHSAdminStateEstimates.pdf

Imagine for a moment a primary care clinic system that serves a population of 61,000 people…this is done in many urban areas…

2. Redirect funding ($222.9 million per year) to the local hospital to provide hospitalization for all…
   Imagine for a moment a hospital system that serves a population of 61,000 people…this is done in many urban areas…
3. Create a countywide healthcare insurance pool (seeded by the $222.9 million per year) that all county citizens are required to buy into, with subsidized opportunity for low income individuals and families, which is used to pay for services not available in the county…
4. Create a publicly administered healthcare payment pool/plan, which public and private employers could agree to pay into (resulting in funding of up to $222.9 million per year, but probably a lot less, given the exceptions noted above and the county's inability to force employers to do this - ERISA), in lieu of their existing insurance plans, and disburse this money to participating providers (this would have to include the CHC, St Peter's and a good percentage of private doctors) based on a global budgeting formula. All employees and their families (if not eligible for Medicare, Medicaid/CHIP, VA) would get automatic access to those providers. Out-of-county providers would bill the plan based on prior arrangements.

<u>Addendum:</u> Email from Dr. Steve Seninger, University of Montana

From: Seninger, Steve (Dr)
[mailto:Steve.Seninger@business.umt.edu]
Sent: Thursday, August 27, 2009 2:49 PM
To: Alan Peura
Subject: RE: Seeking Assistance/Advice for City-County Universal Healthcare Task Force

Hello Alan--You have a lot of data you're trying to collect and I'm not sure where one can find many of the items you've listed. I do have a few numbers that may be of use:

a) total health spending in Montana--2006=$5.4 billion; 2007=$5.8 billion; 2008=$6.2 billion and since Lewis/Clark county = about 6.2% of total state population then I would take .062*$6.2 billion for 2008 or approximately $385 million estimate of total health spending in Lewis/Clark county;

b) On types of coverage--using my own research and correlating with Kaiser Family Foundation data on state level data http://facts.kff.org/ I would use these state data to apply to Lewis/Clark County total population: 50%=job/employer based; 12%=Medicaid and CHIP; 14%=Medicare; 8%=individual insurance; 16%=uninsured.

NOTE: the 16% uninsured does not include 'underinsured' for which you could take 10% of insured population and add to uninsured.
I would use the above percentages applied to the $385 million estimate to figure out your funding sources and total dollars spent by source/type of coverage.

I wish I could say that there are more health care spending data available at the county level but, unfortunately that is not the case.

I hope some of my numbers and estimates are of use to you.

Steve Seninger, Senior Research Professor, UM, Missoula

B 1

Implementing Federal Health Insurance Reform in Rural Regions

Implications for Insurance Coverage in Lewis and Clark County

What is the Patient Protection and Affordable Care Act (P.L. 111-148)?

Signed into law by President Obama on March 23, 2010, the PPACA, together with the Health Care and Education Reconciliation Act (P.L. 111-152), expands Medicaid and tightens some insurance industry regulations, while leaving the current market-based system largely intact. Many provisions of the law will come into effect in 2014, including the requirement for most individuals to buy coverage. State-based insurance exchanges, or marketplaces, will facilitate the purchase of private plans, which will be subsidized for those earning less than 400% of the federal poverty level. Small businesses will be offered tax credits for providing coverage to their employees.

Why can't Lewis & Clark County residents not simply get insurance through their employers?

Rural economies are supported by a greater proportion of small business, part-time and seasonal employment through which it is more difficult to obtain or afford employer-sponsored coverage. While Lewis & Clark County is somewhat unique in its dependence on government as the largest employer – with public employees eligible for the federal and state employee health benefits programs - there are few private employers with more than 500 workers and instead a large number of small businesses that employ fewer than 50 people. These small firms tend to have difficulty affording co- insurance plans for their employees.

- Nearly 70% of the currently uninsured in Montana are in households with at least one full-time worker[1], who are likely employed by a small business that does not offer health insurance.
- Firms of less than 9 employees constitute more than 23% of the non-government workforce in Montana and more than 70% of firms of this size did not offer health insurance in 2009[2]
- Only 54.5% of firms with between 10-24 employees offer insurance plans[3]
- In total, 44.2% of firms with less than 50 Employees did not offer insurance[4]
- 23.5% of families with a full time worker were self -insured[5]
- Just a third of families supported by part-time workers were insured in 2008[6]

Even when coverage is offered by an employer, it can be too expensive to enroll:

- In Montana over 19.5% of employees who are eligible for coverage with their employer in firms with 10-24 employees do not enroll[7]

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[1] Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2008 and 2009 Current Population Survey (CPS: Annual Social and Economic Supplements).

[2] Medical Expenditure Panel Survey- Insurance Component (2009) Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends

[3] ibid

[4] ibid

[5] American Community Survey (2009)US Census Bureau

[6] Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2008 and 2009 Current Population Survey (CPS: Annual Social and Economic Supplements).

Will federal health reform make it easier to get employer-sponsored health insurance?

Long before federal health reform, Montana set up its own program to help small businesses offer health insurance to their workers. The **Insure Montana** program currently offers two types of small business coverage assistance that helps both employers and employees afford coverage.

- However, Insure Montana reached capacity in 2009 with 1600 subscribing employers supporting 8000 employees[8]
- Insure Montana covers less than 8% of eligible firms (more than 21,000 firms with less than 9 employees) [9]

Employer provisions and subsidies under federal reform: Firms with 50 or more employees will have to pay a small penalty if they don't offer sponsored coverage plans to their employees. However, among this size of firm in Montana, the current coverage rate is already 98.7%[10]

- Firms of less than 50 employees, which employ 45.8% Montanans, are not mandated to offer coverage. Of these firms, only 44.2% in Montana currently do.[11]
    - In 2008, Lewis and Clark County had over 2000 small businesses with less than 50 employees that currently employ between 9970 and 22,000 people in the county
- The PPACA offers tax credits to small businesses for offering coverage to their employees, and almost all small employers in L&C County are eligible (approx. 1900 firms with no more than 25 employees). Currently these tax credits will pay 35% of an employer's health insurance costs, if the employer contributes at least 50% of the premium payment, with the other half paid by the employee. Once the insurance exchanges become operational in 2014, tax credits will increase to 50% of an employer's costs.
    - Employers are only eligible if they don't pay their employees an annual income of more than $50,000 per person
    - Employers may receive both Insure Montana and federal tax credits, but the amount of federal credits will be calculated from the premium amount paid by the employer after Insure Montana credits have been offered.
    - These tax credits do not offer assistance to employees, who must pay the remaining 50% of the insurance premium. Therefore, even when coverage is offered, workers may find it too expensive to enroll

Will subsidies for small businesses reduce the number of uninsured employees?

The Centers for Medicaid and Medicare Services at the U.S. Department of Health estimates that despite $31 billion in employer tax credits, there will be a net overall decrease in employer sponsored coverage by 1 million people by 2019.[12]

- While around 13 million people would become newly covered as a result of additional employers offering coverage, another 14 million people would be dropped from employer coverage or choose different forms of coverage.

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[7] Medical Expenditure Panel Survey- Insurance Component (2009) Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends

[8] Carey, R (2010) RWJF

[9] US Census Bureau, Survey of Business Owners (2007)

[10] ibid

[11] ibid

[12] Centers for Medicaid and Medicare Services, Office of the Actuary, Estimated Financial Effects of PPACA as amended, April 2010

The Congressional Budget Office estimates this drop in employer coverage to affect 3 million people.[13]

- Between 6 and 7 million people would be newly covered by an employer-sponsored plan (largely because the mandate for individuals to be insured would increase workers' demand for coverage through their employers).
- Between 8 and 9 million people would no longer be offered coverage. Firms that would choose not to offer coverage would tend to be smaller employers and employers that predominantly employ lower wage workers, who may be eligible for subsidies through the exchanges.
- Between 1 and 2 million people would move from employer coverage to obtaining coverage on their own in the insurance exchanges.

Will the federal health reform law help people who won't be covered by employers?

From 2014, people earning between 133% and 400% of the federal poverty level can buy private insurance on the state-based exchanges, and this purchase would be subsidized on a sliding scale.

- In 2008, the median household income of Lewis and Clark County was $49,000.[14] For a family of four, this would be 203% FPL, indicating a sizable portion of the community would be eligible for subsidies, if their employers did not offer insurance.
- These subsidies for insurance plans would not be available to those with the option of employer sponsored coverage, unless the employer option would require them to pay over 9.5% of income.
    - The average family premium in Montana in 2009 was $11,365 per year. If an employer offered a premium assistance plan of 50%, this would leave $5,682.50 to be covered by the employee, which for a family of four at median Montana income exceeds the 9.5% limit, so this resident would be eligible for tax credits in the exchange.
- Despite subsidies, health care costs will remain high: for a family earning between 300% to 400% FPL, subsidized premiums would be close to 9.5% of income, in addition to up to $7,973 out-of-pocket costs per year. Moreover, coverage will not fully pay for care (as little as 60% of costs) nor cover all health needs (e.g. adult dental care). Low-income people are likely to continue forgoing or delaying care at a higher rate than wealthier people.
- The PPACA includes an individual insurance mandate, which means that from 2014 all persons (with some exceptions) will be required to provide proof of insurance coverage on federal tax returns or pay a tax penalty of up to 2.5%. However, if the lowest available premium exceeds 8% of a person's household income, people are not required to purchase insurance.
    - For families this is likely to require that all households with incomes in excess of 500% of the FPL must obtain coverage.
    - For individuals, those with incomes exceeding 400% of FPL will be required to buy
    - Lower-income people may not be required to buy insurance, nor be able to afford premiums and co-pays, despite subsidies.

Will these provisions of the federal reform close the coverage gap in Lewis & Clark County?

Based on published estimates for Montana, the implementation of PPACA would affect the rate of uninsured people as follows:

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[13] Congressional Budget Office, "Estimated Effects of the Insurance Coverage Provisions of the Reconciliation Proposal Combined with H.R. 3590 as Passed by the Senate," March 20, 2010.

[14] American Community Survey (ACS)2006-2008 3yr Estimates

- 38% of the currently uninsured have incomes below 133% of the FPL and may become eligible for Medicaid after the expansion[15]
- 48% of the currently uninsured have incomes between 133-400% of the FPL and may become eligible for subsidies in the insurance exchange.
- Around 14% of currently uninsured people in Montana would be left without health coverage, if they didn't have access to affordable employer coverage.

However, this estimate is based on eligibility rates, not on participation expectations. Enrollment in benefits programs does not typically reach capacity, as current participation in Montana's Medicaid and SCHIP programs shows (at less than 70%).[16] Enrollment barriers are plentiful, and both employer-sponsored coverage and premium subsidies in the exchanges may be too expensive for some to afford. This is supported by the Actuary's estimate that roughly 37% of those eligible for subsidized coverage in the exchanges would chose not to join.[17] They found that penalty amounts were too low to fully effect the decision to obtain either subsidized or employer sponsored coverage.

Therefore, the probable change in insurance coverage in Montana can be estimated as follows:

- 38% of currently uninsured eligible for Medicaid after the expansion *0.69 rate of participation (actual) = **26% of the currently uninsured will enroll in Medicaid**
- 48% of currently uninsured eligible for subsidies in insurance exchange *0.67 rate of participation (exp) =**32% of the currently uninsured will be self-insured through the exchange**
- The number of those added to employer-sponsored coverage will be roughly equal to the number of those who will be dropped
- **This means that 41.8% of the currently uninsured in Montana would remain uninsured**: nearly 76,000 people statewide and approximately **3500 to 5350 people in Lewis and Clark County**.

[15] Current Population Survey (2008-2009) Annual Social and Economic Supplements, US Census Bureau

[16] For children's participation rate, see Kaiser State Health Facts, "Montana: Children's Medicaid/CHIP Participation Rates, 2008," http://statehealthfacts.org/profileind.jsp?ind=868&cat=4&rgn=28&cmprgn=1; for adult participation rate, see B. Sommers/ A. Epstein, "Medicaid Expansion — The Soft Underbelly of Health Care Reform?" in: *New England Journal of Medicine*, November 2010.

[17] Office of the Actuary, Estimated Financial Effects of PPACA as amended, April 2010

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B 2

ERISA, the Employee Retirement Income Security Act of 1974: Obstacle to local and state-based health reform?

Brief prepared by NESRI, July 8, 2010

What is ERISA?

ERISA sets federal standards for all private sector employee benefit plans and establishes the federal government as the regulator of these plans, preempting state and local laws. The plans include health benefit plans and other welfare benefit plans, primarily pension plans and also disability and group life insurance.

ERISA explicitly preempts states' authority to regulate employee benefit plans:

- **ERISA preempts state laws "relating to" employee benefit plans.** Section 514 of ERISA states that Title V (Administration and Enforcement) and Title IV (Fiduciary Responsibility) of ERISA "shall supersede any and all State laws insofar as they may now or hereinafter relate to any employee benefit plan described in section 4(a) and not exempt under 4(b)."
- **ERISA prohibits "any State tax law relating to employee benefit plans."** Sec. 504 (5)(B)(i)
- More specifically, **ERISA also denies the states the authority to regulate as health insurance the self-insured employee benefit plans** that use large insurers only as plan administrators. Self-funding is mainly used by large employers, but many smaller firms also now self-insure to avoid state insurance laws and liability for premium tax payments. ERISA's "deemer" clause (Sec.514(b)(2)(B)) prevents states from deeming employee welfare benefit plans to be in the business of insurance.

The definition of "state" includes all local jurisdictions: ERISA applies to "a state, any political subdivisions thereof, or any agency or instrumentality of either which purports to regulate, *directly or indirectly*, the terms and conditions of employee benefit plans covered by this subchapter [of ERISA]." ERISA § 514(c)(2), 29 U.S.C. § 1144(c)(2).
The authoity to regulate the insurance industry, however, lies with the state.

Divided federal and state regulatory authority[1]

	ERISA/Federal	State	Neither
Types of plans	Private group employee benefits plans Fully insured* Self-insured** Taft-Hartley trusts***	Commercial health insurance Nongroup (individual) health insurance	Sponsored by: Religious Government Charitable Labor Union Fed govt: Medicare, etc.
Activities regulated (selected)	Remedies Reporting & disclosure Fiduciary requirements	Mandated benefits Any Willing Provider	

* Insured (employers buy their insurance from an insurance company)
** Self-insured plans pay for health benefits directly, and are usually sponsored by large employers.
*** Union-employer joint trusts, known as Taft-Hartley plans.

[1] This table is taken from Center for Policy Analysis, "Pre-Empting ERISA: Legislating for a State Single Payer Plan," June 2009 (modified March, 2010) http://www.centerforpolicyanalysis.org/id47.html.

ERISA and health reform

For state and local health reformers, ERISA is relevant in so far as it affects the ability of states/localities to introduce so-called "fair share" or "pay or play" laws that require employers to contribute in some form to expanding health care access. Rules relating to employers' contributions must be designed carefully to avoid an ERISA challenge.

Existing "pay or play" laws at state and local level

- **Massachusetts:** 2006 Massachusetts health reform, a model for the federal health reform law, includes a "pay or play" provision that has not been challenged in court
- **Vermont:** an employer assessment to help pay for Catamount Health Plan, which offers subsidized health insurance products to uninsured people; it has not been challenged in court
- **Hawaii:** has an employer mandate to provide coverage, facilitated by a 1983 amendment to ERISA for this specific case
- **San Francisco:** a "pay or play" provision that has prevailed over legal challenges (see below)

Landmark legal cases

1. Affirmation of ERISA preemption:

The **4th Circuit Court of Appeals** decided in January 2007 that Maryland's "Fair Share Act" of 2006 was preempted by ERISA because of its "connection with" an employee health benefits program. Based on the stated intent of the sponsors to craft the law so that would compel coverage for employees of one employer, WalMart, the Court ruled that the state law was a mandate that one employer cover its workers, creating an "irresistible incentive" for that employer to expand its existing ERISA health plan. The law was preempted because it regulated an existing health plan structure by obligating a designated employer to provide "a certain level of benefits" or paying into a general fund. The Court held that that there was no sufficient alternative in place for the employer to spend the required funds on behalf of its own employees.

2. Limits to ERISA preemption:

On June 28, 2010, **the U.S. Supreme Court** denied an appeal by an employers' association that had brought an ERISA challenge to San Francisco's universal health care program. "Healthy San Francisco" provides care to more than 53,000 uninsured people and includes a "pay or play" provision.

The **federal government submitted an amicus brief** requesting that the appeal of the 9th Circuit decision (see below) be denied. In its brief, the government stated that a key criterion for judging ERISA challenges to health reform efforts was "whether an employer's role under the city-payment option more closely resembles the collection and payment of a payroll tax to support a government health program (which does not involve the creation of an ERISA plan) than it does the purchase of health insurance from a private company (which does involve the creation of an ERISA plan)." The government brief compared the decision by the 4th Circuit with that of the 9th Circuit and agreed that the Maryland law effectively forced the single affected employer to alter its ERISA plan, whereas the San Francisco law does not require employers to alter or create any ERISA plans.

The government brief also included interesting observations on the potential interpretation of the new health reform law (the Patient Protection and Affordable Care Act – PPACA) in relation to the role of states and localities.

> The brief referenced "a provision saving certain state laws from preemption by the newly enacted federal provisions. See *id.* § 1321(d) ('Nothing in this title shall be construed to preempt any State law that does not prevent the application of the provisions of this title.'). The "responsible federal Departments and the courts

have not [yet] addressed whether the PPACA's savings provision applies to laws enacted by state subdivisions [...] or only to laws enacted by the States themselves."

If "local health care programs were saved from preemption under the new health care legislation, that consequence could, in turn, alter the analysis of whether those programs would be preempted by ERISA, perhaps depending on the relationship between the local programs and the implementation of the new legislation. As a general matter, a savings provision, such as Section 1321(d) of the PPACA, that shields state (or local) laws from preemption by only one federal statute has no effect on preemption by other federal statutes. But, unlike most other federal statutes, ERISA expressly provides that it shall not 'be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States.' 29 U.S.C. 1144(d). When state or local laws are integral to the operation of a federal law other than ERISA, Section 1144(d)'s prohibition on 'impair[ing]' other federal laws may shield those state or local laws from ERISA preemption. See *Shaw*, 463 U.S. at 100-102."

"At this early stage, the responsible federal Departments and the courts have not addressed the possible relationship between state or local laws [...] and the new federal legislation—*e.g.*, whether such laws might form the basis for waivers under Section 1332 of the PPACA of provisions concerning the creation of insurance exchanges. There accordingly is not yet a foundation for assessing whether or how ERISA Section 1144(d) could be implicated by the implementation of the new health care legislation."[2]

In other words, the government indicated in this brief that compliance with or exemption from the provisions of the federal reform law (PPACA) may be more relevant to future state and local health reform efforts than the relation to ERISA.

In September 2008, the **9th Circuit Court of Appeals** upheld the San Francisco ordinance against an ERISA preemption challenge. The Court held that the law is not connected with ERISA plans because its only employer obligation is to make a payment (not to maintain an ERISA plan or provide particular benefits), so the law does not "bind plan administrators to a particular choice." The court reasoned that, unlike the Maryland law, which gave employers no realistic method of compliance that did not involve an ERISA plan, the San Francisco law gives employers the city-payment option, which does not entail creation of an ERISA plan. Thus, the city-payment option is a realistic alternative for employers because, unlike the state-payment option under the Maryland law, the city-payment option gives employers something in return for their payments—health care benefits for their employees. Therefore, using an ERISA plan to meet the law's requirements is the employer's choice but not required by the law. The Court further held that record-keeping requirements were not connected with ERISA plans because they exist for all employers regardless of whether they offer ERISA plans. The Court also held that the city's ordinance does not refer to ERISA plans because it does not act on ERISA plans – involving only employer spending and not benefits or plan administration. Furthermore, enforcement of the ordinance does not depend on the existence of an ERISA plan, because it is effective even if no employers have ERISA plans.

In a 1995 landmark *Travelers Insurance* (514 U.S. 645, 1995) decision, the **U.S Supreme Court** narrowed the reach of ERISA's preemption clause by limiting the types of state law impacts on ERISA plans that cause preemption. It held that the impact of the 24% hospital surcharge imposed by New York state was too insignificant to be pre-empted under ERISA, even though the legislation imposed some costs on ERISA health plans because it made buying coverage from commercial insurers more expensive than coverage from Blue Cross plans. This case was the first Supreme Court ruling that seemed to narrow the previously broad interpretation of the "relates to" clause, leading some observers to suggest that the states will have

[2] U.S. Government amicus curiae brief to the U.S. Supreme Court, *Golden Gate Restaurant Association, petitioner v. City and County of San Francisco, California*, et al., May 2010
http://www.centerforpolicyanalysis.org/sitebuildercontent/sitebuilderfiles/goldengate.08-1515.invitation.brf.pdf

more flexibility to impose laws of general applicability even if they have an impact on employee benefit plans.

Designing employer contributions to avoid ERISA preemption[3]

Health policy makers can craft pay or play programs to avoid similarities with the Maryland law that caused it to be preempted and take advantage of elements of the San Francisco ordinance that helped it overcome its preemption challenge.

- **Do not require employers to offer health coverage to their workers.** A direct employer mandate would be preempted, even if drafted as a tax or other assessment targeting specific types of employers. The goal must not be to force employers to create or expand ERISA plans.

- **Establish a broad-based universal health care program funded in part with employer assessments for which paying employers' workers are eligible.** Under the 9th Circuit's reasoning, a health reform law should overcome an ERISA challenge if the state's objective is to establish a broadly-financed public health care or coverage program but allow employers the choice to spend funds directly on their employees. Under the 9th Circuit's analysis, allowing the employees of "pay" employers to be eligible for the public program constitutes a "tangible benefit" that provides a realistic choice between paying and playing.

- **Remain neutral on whether employers offer health insurance or pay the assessment.** If the objective is to assure universal access to care, the state/county/city should be explicitly neutral with respect to whether an employer pays the assessment or "plays" by offering coverage for its employees. Employers must have the choice.

- **Impose no conditions on employer coverage to qualify for the credit against the assessment.** Despite a state's concerns about whether a "play" employer's health benefit, cost sharing, and premium contributions are adequate, it is risky to condition a credit on meeting qualifications that will directly affect an ERISA plan's benefits or structure. Even the 9th Circuit, which characterized the city's employer assessment as a spending requirement (contrasted with the 4th Circuit's depiction of the Maryland law as a benefits mandate), noted that the city ordinance does not specify the benefits employers must offer.

- **Minimize administrative impacts on ERISA plans.** States/localities cannot tax ERISA plans directly; the pay or play assessment must be imposed on employers. Designing a pay or play program to be administered with other state/local tax laws can help overcome arguments that the state law imposes impermissible administrative burdens.

- **Minimize statutory references to ERISA plans.** A state/locality could minimize the risk of a preemption challenge by drafting a pay or play law without explicit reference to ERISA plans but rather refer to employer spending obligations and the credit allowed against them.

- **Be cautious about moving private employees into public employees' health plans.** If this is partly financed through an employer assessment, ERISA concerns may arise. Allowing lower income workers to participate in public employee coverage purchasing arrangements may be problematic if

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[3] This section is based on *Including Employer Financing in State Health Reform Initiatives: Implications of Recent Court Decisions*, Robert Wood Johnson Foundation's State Coverage Initiatives, January 2009, http://www.statecoverage.org/files/Jan%202009%20ERISA%20Update%20FINAL.pdf

private employers pay to participate. In that case, previously exempt public employee benefit plans become subjected to ERISA. In holding that the San Francisco Health Access Program was not an employer-sponsored plan (noting that city employees were not eligible for that program), the 9th Circuit dismissed this potential complication. But allowing private employers to contribute (on behalf of their employees) to a health coverage pool that includes public employees risks subjecting the public plan to ERISA requirements.

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B 3

Non-Profit, Tax Exempt Hospitals: New Laws and Policies

A. St. Peter's Hospital: Facts & Figures

In 2006, uncompensated care averaged 5.7% of hospital total expenses nationally, yet St. Peter's uncompensated care amounted to 4.49% of expenses.[1] St. Peter's combined charity care and Medicaid costs in excess of reimbursement totaled $3,118,127, yet its estimated total tax exemption was $4,746,083. As such, St. Peter's charitable care and Medicaid costs in excess of reimbursement only accounted for 66% of the estimated value of the tax exemption the hospital enjoyed in 2006.[2] St. Peters Hospital also receives a federal Disproportionate Share Hospital (DSH) adjustment of 4.44%, intended to compensate for a disproportionate number of uninsured patients.

B. Changes to Tax Exempt Status under PPACA

The Patient Protection and Affordable Care Act (PPACA), Section 9007, added new requirements private non-profit hospitals must meet as a condition of their federal tax-exempt status. PPACA also increased reporting and oversight mechanisms to ensure compliance with hospital charity care and community benefit standards while increasing transparency. Most of these requirements come into effect in 2010, subject to detailed regulations to be released by the U.S. Department of Health and Human Services.

IRS Notice 2010-39 outlined the requirements exempt hospitals must complete to retain their tax code Section 501(c)(3) exemption: complete a community health needs assessment, determine eligibility for assistance, and limit amounts charged for emergency care to not more than the amounts generally billed to people who have insurance covering such care. The hospitals also must forgo extraordinary collection actions against those who do not pay.[3]

Section 9007 of the PPACA amends Section 501(c)(3) of the Internal Revenue Code by adding four new conditions that private hospitals must meet in order to qualify for federal tax-exempt status. **Hospitals must:**[4]

1. **Develop written financial assistance policies**
   At a minimum, the policy must state:
   - Whether the hospital offers free or discounted care
   - Eligibility criteria for receiving financial assistance
   - The basis used to decide how much patients are charged for care

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[1] Lawrence L. White Jr., *Montana's Hospitals: Issues and Facts Related to the Charitable Purposes of Our Hospitals and the Protection of Montana's Consumers*, January 2008, Montana Office of Consumer Protection: 2008; http://www.doj.mt.gov/consumer/consumer/hospital/hospitalreport200801.pdf

[2] Id.

[3] BNA, "Three-Year Hospital Reviews Do Not Mean Audit Every Three Years, IRS Official Says," September 2010.

[4] The following list is based on Community Catalyst, *Protecting Consumers, Encouraging Community Dialogue: Reform's New Requirements for Non-Profit Hospitals*, May 2010

- A description of how to apply for financial assistance
- Steps the hospital might take to collect payment, unless the hospital has a separate billing and debt collection policy already in place
- Measures to publicize the policy widely in the community the hospital serves

2. **Limit what they charge for services**
   Hospitals must not use "gross charges" to calculate financial assistance. If patients need care and qualify for the hospital's financial assistance policy, they may only be charged the "amounts generally billed" to insured patients for the same services. Senator Grassley said in a statement that Congress intended that the financial assistance policies be applied to the lower, adjusted rates, not by starting with gross charges. "Charitable hospitals should be doing everything possible to make sure those who qualify for financial assistance pay the least amount of money." (Grassley)[5]
3. **Observe fair billing and debt collection practices**
   The new law prohibits non-profit hospitals from engaging in "extraordinary collection actions" before making a "reasonable effort" to determine whether a person qualifies for the hospital's financial assistance policy.
4. **Conduct regular community needs assessments**
   Hospitals must conduct a community needs assessment at least once every three years. In doing so, they must seek input from people who "represent the broad interests" of the hospital's community, including public health experts. Hospitals must make their assessments available to the public, and they must adopt strategies to meet the community health needs identified. This requirement goes into effect for tax years after March 23, 2012, giving hospitals two years to begin the assessment process.
   Penalty: $50,000.00 excise tax for failure to comply.

New reporting requirements: Non-profit hospitals must attach audited financial statements and descriptions of how they are addressing community needs, as identified through their community needs assessments, to the tax reports they file annually with the Internal Revenue Service (IRS). Hospitals that are *not* meeting certain needs must give an explanation. The Secretary of the Treasury must review each private, non-profit hospital's community benefit activities at least every three years.

Key Recommendation from Community Catalyst:[6] Hospitals should look for opportunities to collaborate with community organizations to ensure that charity care, billing and debt collection policies respond to the needs of the populations they both serve.

C. History of 501(c)(3) Requirements and Recent Increased Scrutiny of 501(c)(3) Hospitals

The federal tax code provides that nonprofit hospitals that qualify under Internal Revenue Code section 501(c)(3) are exempt from federal income taxes and that donations to these hospitals are tax deductible. Montana state law further provides that property used

[5] BNA, "As IRS Grapples With Section 501(r) Issues, Senator Says Hospitals Should Maximize Aid," October 8, 2010.
[6] Community Catalyst, *Best Kept Secrets: Are Non-profit Hospitals Informing Patients About Charity Care Programs?* (May 2010) http://www.communitycatalyst.org/doc_store/publications/Best_Kept_Secrets_May_2010.pdf

exclusively for nonprofit health care facilities is exempt from property taxes (MCA 15-6-201) and from income tax (MCA 15-31-102).[7] After the enactment of the Medicare and Medicaid programs in 1965, the Internal Revenue Service (IRS) revised its guidelines for determining if a hospital qualifies as a charitable organization under section 501(c)(3) by creating a "community benefit" standard. Many factors go into the IRS determination and, over time, the courts have ruled that "community benefit is a flexible standard based on the totality of the circumstances and that a hospital need not demonstrate every factor to be exempt." Factors that have been used to demonstrate benefit to the community include charity care for those unable to pay, medical training programs, education programs, medical research, and emergency services.[8]

Starting around the year 2000, some state jurisdictions as well as the IRS began questioning whether hospitals were providing a community benefit proportionate to their tax exemption. The definition of what constituted a community benefit also came under active discussion around the same time. In 2006, at the federal level the Senate Finance Committee and the IRS, as well as many states including Montana, launched evaluations of nonprofit hospitals' community benefits.[9] On December 20, 2007, the IRS formally promulgated a final decision regarding the proposed changes to Schedule H wherein hospitals are required to file an annual report of their community benefits beginning in 2009. The new Schedule H includes the following factors in measuring the community benefit a hospital provides:

1) Charity care at cost, which is the cost of free or discounted health services provided to individuals unable to pay and who meet the hospital's criteria for charity care, and does not include bad debts;
2) Unreimbursed Medicaid costs, which are the costs of providing care to Medicaid patients in excess of the reimbursements received;
3) Unreimbursed costs of other government programs, which are the costs of providing care to patients paid for by other government programs (such as SCHIP) in excess of reimbursements received (this does not include Medicare);
4) Community health improvement services and community benefit operations, which are the cost of activities carried out to improve the health of the community, such as health education programs, free clinics, self-help groups (i.e.: weight loss, smoking cessation), and community health needs assessments;
5) Health professions education, which includes the unpaid costs of clinical training programs for physicians, nurses and other health professionals;
6) Subsidized health services, which constitute unreimbursed costs of clinical services provided as a community benefit to meet identified community needs such as burn units, renal dialysis, addiction treatment and mental health (such services would not include any services required as a condition of licensure);
7) Research, which would comprise the unreimbursed costs of clinical and community health research; and
8) Cash and in-kind contributions, which comprise the cost of donations to individuals or community groups.[10]

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[7] See *Montana's Hospitals: Issues and Facts Related to the Charitable Purposes of Our Hospitals and the Protection of Montana's Consumers*
[8] Id. at 1.
[9] Id. at 2.
[10] Id. at 4.

In 2006, the IRS completed a study on tax-exempt hospitals and, among other factors, how they report about the community benefits they provide.[11] The findings of the report, namely that fewer than one-fifth of the surveyed hospitals accounted for 78% of the aggregate community benefit expenditures and that 58% of the hospitals reported uncompensated care amounts of less than or equal to 5% of total revenue, have inspired many key players on the national and local levels to take action.[12] The cause for alarm about the low level of community benefit being provided by the majority of the hospitals in the study is that nonprofit hospitals account for the majority of hospitals in the U.S. and are expected to provide benefits to their communities, including charity care in exchange for not paying taxes.[13]

D. Illinois: A State Court Strips a Hospital of its Tax Exempt Status

A recent Illinois Supreme Court decision[14] was an instance of a state judiciary taking the review of a tax exempt hospital into its own hands. In that decision, which caught national attention, the Illinois high court upheld the revocation of Provena Covenant Medical Center's property tax exemption status after finding that the medical center did not provide enough charity care in 2002 to qualify for its $1.1 million tax break. According to the court, "[b]oth the number of uninsured patients receiving free or discounted care and the dollar value of the care they received were [minimal]." Rather than charity care being its primary purpose, "with very little exception, the property was devoted to the care and treatment of patients in exchange for compensation through private insurance, Medicare and Medicaid," or other fee-based sources. The ruling affirmed a 2003 decision by a local tax review board to deny Provena's tax exemption status after learning that the Catholic hospital's charity services amounted to less than 1% of its 2002 total revenues.[15]

While the court did not dispute that Provena offered treatment to all who requested it, regardless of their ability to pay, the court took issue with certain obstacles the hospital created for indigent patients, rather than making charity care freely available. Examples of obstacles created for indigent patients by the medical center that the court identified included the fact that Provena did not advertise the availability of charity care, that patients were routinely billed, and unpaid bills automatically were referred to collection agencies, and that hospital charges were discounted only after patients proved that they qualified for charitable programs. "As a practical matter, there was little to distinguish the way in which [Provena] dispensed its 'charity' from the way in which a for-profit institution would write off bad debt," the court said.[16]

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[11] IRS Exempt Organizations (TE/GE) Hospital Compliance Project Final Report; http://www.irs.gov/pub/irs-tege/frepthospproj.pdf

[12] Wall Street Journal, "Minority of Tax-Exempt Hospitals Provide Most Charity Care," February 13, 2009; http://online.wsj.com/article/SB123446379679978451.html

[13] See Congressional Budget Office, *Health Care Trends and the Tax Treatment of Health Care Institutions*; http://www.cbo.gov/ftpdocs/48xx/doc4836/doc39.pdf

[14] Provena Covenant Medical Center v. Department of Revenue, 2010 WL 966858, 10 (2010).

[15] American Hospital Association, "Hospitals' Tax Exempt Status;" www.aha.org/aha/content/2009/pdf/09-ip-tax-exempt.pdf

[16] Id.

B 4

The Consumer Operated and Oriented Plan (CO-OP) Program

The Patient Protection and Affordable Care Act, in Section 1322, created the Consumer Operated and Oriented Plan (CO-OP) program to foster the creation of non-profit, member-run health insurance groups in all 50 states to offer qualified health plans. $6 billion have been appropriated to finance the program and award loans and grants to establish CO-OPs no later than July 1, 2013.

To be eligible to receive federal funds, an organization must

- not be an existing health insurer or sponsored by a state or local government,
- all of its activities must consist of the issuance of qualified health benefit plans,
- governance of the organization must be subject to a majority vote of its members,
- operate with a strong consumer focus, and
- any profits must be used to lower premiums, improve benefits, or improve the quality of health care delivered to its members.

➔ *Consideration for Lewis & Clark Co.:* the Board of Health (or the public health department) could not directly be involved in setting up the CO-OP, but it could initiative a process of bringing interested parties together (e.g. small businesses and non-profits, with CHC and hospital as collaborators)

In 2013, the Consumer Operated and Oriented Plan (CO-OP) program will be developed along with the exchanges, for the creation of qualified, nonprofit member-run health insurance issuers to offer qualified health plans in the individual and small group markets in the states. The U.S. Department of Health and Human Services (HHS) will provide awards to parties applying to become qualified nonprofit health insurers through loans and grants for start-up costs and implementation. In awarding loans and grants under the CO-OP program, HHS will consider recommendations from an advisory board.

HHS is supposed to give priority to applicants that will

- offer the health plans on a statewide basis,
- utilize integrated care models, and
- have significant private support

HHS will ensure that there is sufficient funding to establish at least one qualified nonprofit health insurance issuer in each state.

➔ *Consideration for Lewis & Clark Co.:* while the CO-OP would not initially be state-wide (though regional collaborations could be explored), there may not be another interested party in Montana planning to set up such a state-wide CO-OP. If there were, the county could collaborate with them.

On June 23, 2010, the U.S. Government Accountability Office (GAO) announced the appointment of 15 members to the Advisory Board of the CO-OP Program. The Board will make recommendations to HHS on grants and loans to establish CO-OPs by July, 2013. PPACA

required board members to have expertise in health insurance and health care delivery but without significant interests in the insurance sector.

➔ *Consideration for Lewis & Clark Co.:* none of the advisory board members appear to be from Montana, but rural and Western states are overrepresented.

Start-Up Strategies for Health Insurance Cooperatives under PPACA[1]

Focus on the individual and small group insurance

Not only are these 'market segments' requirements for CO-OPs, they are also the segments where the collective ownership and aggregating strengths of traditional cooperative business models are likely to be most effective.

Form the new CO-OP according to the 'consumer' cooperative model, with practices and governance that ensure qualification for federal grants and loans

The availability of low-cost capital from federal sources is the basis for the formation of a new CO-OP. CO-OPs formed under the reform guidelines will also be able to take advantage of special IRS tax status provisions that will allow them to compete more effectively with traditional non-profit and mutual carriers whom they most closely resemble. Tax exempt status will also assist the new organizations in maintaining their low profile on overhead costs.

Partner with providers

The need to establish high-quality, efficient, low-cost provider networks is the single biggest barrier for new health insurers. New CO-OPs should take their cue from the successes of established CO-OPs that include a fully integrated provider organization in their formal structures. Historically, these organizations have been able to leverage the benefits of joint ownership and operation of health care delivery and insurance to the benefit of both. Health care reform will have profound impacts on provider organizations, as well as on payers, particularly in the areas of reimbursement reform and the reorganization of clinical processes to meet quality and efficiency goals. The new CO-OPs may have an advantage in forming effective relationships with providers in the post-health care reform environment simply because they are not traditional commercial carriers. Nothing in PPACA prevents alliances, partnerships or collaboration with provider organizations, and in fact CO-OPs that include integrated delivery networks are identified as high-priority recipients for loans and grants.

Examples of existing or planned health care cooperatives:

- Two traditional, large co-operatives in Minnesota and Seattle; they work much like non-profit insurers/providers
- *40 Square Cooperative Solutions*, Minnesota: under development. Targets agricultural community http://www.cooperativenetwork.coop/wm/coopcare/40square/web/40square.html
- *Cooperative Health Choices of Western Wisconsin*: a new purchasing co-operative (insurance is carried by an insurer) http://www.cooperativehealthchoices.org/about.htm
- *Farmers Health Cooperative, Wisconsin*: same as a above, for farmers http://www.farmershealthcooperative.com/aboutus.asp

[1] Battani, J., Health Insurance Cooperatives — A Real Reform Alternative? June 2010

C 1 - Examples of County Health Care Initiatives across the United States

	Action Taken to Expand Access	Cost and Funding	Results	Replicability for Lewis & Clark County, MT
Healthy San Francisco (HSF) (San Francisco, CA)	• Healthy San Francisco (HSF) is a universal health care delivery system • Targets uninsured adult residents (income is ≤ 500% FPL); does not discriminate based on employment, immigration status, or pre-existing health conditions • Delivers care and services through a strong network of safety net providers centered on the public hospital and community health centers and organized around a medical home model. Expanded this network to non-profit hospitals and private practices.	• The **City** redirects to HSF $100-115M of its funds that would otherwise be spent on uncompensated care • San Francisco is annually allotted $24,370,000 through California's 1115 Waiver • Estimated cost is $2,415 per person per year • **Employers** contribute around 11% of HSF funding • HSF members pay participation and point of service fees based on an income sliding scale starting at zero	• HSF enrolls around 53,000 of the estimated 60,000 uninsured population in SF as of June 2010 • A poll done by the Kaiser Family Foundation found that 94% of users expressed satisfaction with HSF • In the first year, emergency room visits at the public hospital dropped by 27%.	• ERISA may not be a problem for an employer spending requirement in Lewis & Clark Co.: the U.S. Supreme Court refused to review an ERISA appeal that challenged San Francisco's pay or play law (June 28, 2010) • Montana could utilize its 1115 Medicaid waiver to federally fund county health initiatives • SF did not start a new insurance plan but expanded an already existing health care "safety net" system, bringing public and nonprofit providers into an integrated system centered on medical homes. Lewis & Clark Co. could utilize the Cooperative Health Center as the basis for an expanded medical home model, combined with a cooperating agreement with the non-profit hospital • SF has appointed a panel to study how the new federal health law will affect the program. It is anticipated that the program will remain in place beyond 2014 to serve those unable to afford or obtain coverage under the new federal law
Healthy Howard Health Plan (Howard, MD)	• The Healthy Howard Health Plan (HHHP) is a "public-private health care program" that connects uninsured people to health services along with compulsory health coaching • Targets uninsured adult (19-64 y/o) county residents who do not qualify for federal coverage and whose household income is ≤ 300% FPL • HHHP works directly with care providers and "bypasses" insurance companies	• Operating costs are funded by **member fees**, county funding, and private donations. The first-year budget was $2.8 million, with $1.6 million coming from participant fees, $500,000 from the county and the rest from private sector donations • HHHP members, who pay a monthly fee from $50-$85 depending on their income, contribute about 60% of the funding	• HHHP had 512 active members, the majority of whom were women, as of December 2009 (the county has approximately 20,000 uninsured adults, of which an estimated 8000 to 10,000 are estimated to be eligible for HHHP) • Out of the initial 2841 residents who applied, nearly 77% (2199) were found ineligible due to factors such as income, residency, etc.	• HHHP is noteworthy for not using insurance companies and instead establishing an access program that connects people with providers. In Lewis & Clark Co. such a program could potentially be funded though member and employer contributions/donations • HHHP planners are re-visiting the program in light of the new federal health law's insurance mandate. HHHP may be turned into an insurance co-op • Enrolment has been extremely low, indicating issues with program outreach, application process, and fee structure
Access Health – The Three-Shares Plan (Muskegon County, MI)	• Access Health is a community-based not-for-profit organization that offers health coverage through an employer-sponsored program • Access Health provides two service plans: a "standard plan" or a "C3" plan (the C3 plan encourages accountability in keeping a healthy work environment and life choices. Employers and employees must meet annual requirements for the C3 plan and in return have lower monthly costs and co-payments)	• Initial funds came from a $400,000 (approx.) grant from W.K. Kellogg Foundation • Monthly cost per individual is estimated to be $140 and the payment is broken down into a "Three Shares Plan": o **Employers and employees** each pay approximately 30% ($35-50 per month) o The county makes up the remaining amount, partly by using Medicaid DSH funds	• Access Health has 1,100 worker-enrollees (total population is 175,000) as of March 2010 and was serving more than 420 employers by 2004 • The county paid $62 per person in 2003	• Muskegon is a small Midwestern county with a tradition in manufacturing and a large population of low-wage workers • This is an employer-based program that could be of interest to small employers in Lewis & Clark Co. who may want to work together to offer coverage to their employees • Five other states - Oregon, Virginia, Minnesota, New York and Colorado - have received federal grants for running local "three-share" programs. Some of these programs are explicitly not insurance programs to avoid their state's minimum benefit rules for insurers. Enrolment has been relatively low • Lewis & Clark Co. may not have access to a large charitable foundation or to federal grants to initiate such a program. However, the county could request that federal or state funds be used to match funds raised through contributions

DC Healthcare Alliance (Alliance) Washington D.C.	• Alliance is a public program between the city and private healthcare providers that offers free coverage to uninsured residents (family income ≤ 200% FPL) • Participants must choose from 3 plans (each plan covers the same basic services, however the doctors on these plans differ) • Alliance covers the same services as DC Healthy Families, a Medicaid program, except mental health services and drug and alcohol treatment	• Alliance is funded by the **district** through Department of Health Care Finance (DHCF) • FY 2010 proposed budget for the Alliance Program is about $107 million • Estimated cost of care is $179 per patient visit for which providers submit reimbursement claims to Alliance (reimbursement rates increased from $65 to $95 in FY 2009)	• Alliance had 40,148 enrollees as of September 2006; estimate for 2010 is 40,000 DC residents (50,000 of the resident population was estimated to be uninsured in 2003)	• Though Alliance demonstrates the benefits of state and federal funding, especially when it comes to serving a large portion of the uninsured, a completely state-funded program may not be feasibly in Lewis & Clark Co.
1115 Waiver Coverage Expansion Initiatives (9 Counties in California)	Common features of the 9 County Initiatives: • Extends coverage to uninsured adult (18-64y/o) residents who do not qualify for federal health programs and whose income is ≤ 200% FPL • Services emphasize primary and preventative care Notable differences: • LA extends coverage to 94,000 adults (income ≤ 133 1/3% FPL) in a county of 2 million uninsured residents • Alameda County specifically targets people with chronic disease conditions • Contra Costa County targets the homeless	• California's 1115 **Medicaid Waiver** annually allocates anywhere from $7,564,172 (San Mateo) to $20,700,000 (Santa Clara) • Estimated cost for one year of coverage per participant ranges from $3,325 (Santa Clara) to $4,162.76 (Kern County) • Providers are generally paid on a fee-for-service basis • Out-of-pocket fees are generally on an income sliding scale Notable differences: • LA is allocated $54,000,000 annually for coverage that is estimated to cost $1,189 per person per year • Orange County's physicians work on a "pay-for-performance" incentive plan • Kern County has no enrollment fees or co-payments; LA has no out-of-pocket fees	• Number of individuals covered ranges from 2,100 (San Mateo County) to 12,500 (Ventura County & Santa Clara County) • Counties have anywhere from 52,000 (San Mateo County) to 403,000 (Orange County) uninsured residents • DRA citizenship requirements pose a problem for enrollment in most counties • Many counties fear exceeding funding or having to raise service costs, due to a higher number of clinic visits than anticipated and an underestimation of services needed	• The demographics of each of these California counties vary geographically, financially, racially, ethnically and in the size of their populations. This indicates that this model could be applied in any location, funding permitting • Montana has a 1115 Waiver, but it is unclear whether this can be used for health reform efforts in Lewis & Clark Co. • The traditional fee-for-service payment model may not be affordable for Lewis & Clark County • Targeting vulnerable people first may be a necessary measure, but does not necessarily lead to universal health care
Access to Care – Defining a Healthy Seminole County (Seminole County, FL)	• The Seminole County Health Department (SCHD) provides access to an all-volunteer acute primary health clinic and a secondary care referral system to the uninsured residents of the county • The all-volunteer force draws from a network of public, private, and religious organizations • Providers offer services on a volunteer and in-kind basis (including laboratory, radiology, pharmacy, dental and mental health services) • Eligibility extends to all uninsured residents who have been denied Medicaid (denial cannot be for failure to follow through an application process)	• Seminole County Health Department (SCHD) obtained $100,000 from the county government to hire a full time project manager to coordinate implementation • A **grant** obtained by Shepherd's Hope, Inc. enables 5000 clinic visits annually by the uninsured • Other funds come from **in-kind and volunteer** services from providers, community groups, grants, and donations • Contributions made by community partners and local providers (e.g. donation of services, medications, monetary, or in-kind services), accumulate to a sufficient amount to sustain the program	• From Jan-Sept 2009, The Shepherd's Hope Health Clinic of Oviedo served 1286 patients (56,000 residence were uninsured in 2004) • The county government has seen a return on their investment of $15 for each dollar they invested • In 2008, NACCHO recognized the utilization of the MAPP process to partner public, private and religious organizations as "an emerging best practice"	• A faith-based clinic as the primary provider of free care could be comparable to the role of the Cooperative Health Center in Lewis & Clark Co., if additional funding for the Health Center could be obtained • Coordination of the Cooperative Health Center with other providers - and recruitment of such providers to offer services to the uninsured - could be taken on by a new dedicated county staff person • This model is based solely on voluntary in-kind contributions and donations, and may thus not be sufficiently sustainable or appropriate to meet long-term needs

Project Access (Buncombe County, NC)	• Project Access (PA) is a Buncombe County Medical Society (BCMS) physician volunteer based health care program. BCMS is a chartered component of the NC Medical Society and the AMA. PA is not health insurance but a short-term program designed to give patients access at the time of need • To enroll, a patient must be referred to the program by a local clinic or physician. Any county resident, regardless of citizenship status, can be referred, as long as they have an income at or below 200% FPL, are uninsured, ineligible (or lingering in the application process) for federal programs, and have a "medical need" • Although primary care is offered, PA focuses mostly on access to urgent, episodic or short-term care • PA is connects private physicians with public, community and charitable care centers. The Network is supported by hospitals, pharmacists and the County	• Buncombe County contributed approx $400,000 a year for prescription medication ($350,000) and administration of BCMS Project Access • Limited-term **grants** (e.g. RWJ) and private funding partners also provide some funds • Community clinics pay the local match (5%) to pull-down state and federal funds which then pay for enrollment workers stationed in the clinics. • Physicians and medical professionals are strictly **volunteers**, and services and medical equipment are donated. (The state's liability shield law protects physicians who volunteer through an organized charity care program) • Medications require a $4 co-pay; all other services are free	• In 2007, over 3,400 individual patients were enrolled and PA usually averages 1,100 patients at any given time. An estimated 38,000 people are low-income and uninsured in Buncombe County. • Over 625 BCMS physicians participated, donating approximately $7 million of services in 2007 • Due to the strong focus on specialty referrals for acute or episodic illness, 6 months is the average duration a patient stays with the program. Very few patients remain beyond a year. • PA has received many awards since its inception in 1996 and is the model for similar efforts elsewhere	• Robert Wood Johnson Foundation states that if "this structural model could be coupled with financing sources to pay for a greater portion of care, then potentially it could be replicated in any location with adequate provider capacity and community commitment." • Replication elsewhere: the first rural Project Access program, the Appalachian Healthcare Project, serves Watauga and Avery Counties. Watauga County has a population of 42,857 people with 25 primary care providers and 60 specialists. Avery County has a population of 17,610 with 17 primary care providers and two specialists. Between 2001-2004, 600 people received care under this project • The problem of consistent access to health care persists with this model, as it focuses mostly on access to urgent, episodic or short-term care • This model is based solely on voluntary in-kind contributions and may therefore not be sufficiently sustainable or appropriate to meet long-term needs
Hillsborough County Health Care Program (Hillsborough County, Florida)	• Hillsborough County Health Care Program (HCHCP) is a managed care program that utilizes a network of 600 primary care physicians, 12 clinics, and 5 hospitals. • To be eligible, an individual must not qualify for public programs, be a legal U.S. resident and county resident, have an income ≤100% FPL, and not be convicted of three felony offenses (3 strike policy)	• 0.5 cents **local sales tax** (roughly $85 million) is deposited into an Indigent Health Care Trust Fund used solely to provide health care for poor and under-served residents (85.2% -- $105,884,857 in 2008--of Trust Fund goes toward HCHCP) • Trust Fund dollars are leveraged to obtain additional federal and state funds for participating county hospitals and federal qualified health centers. • Participants pay no premiums but make co-payments for pharmaceuticals and for some services • Estimated cost per member per month: $473	• HCHCP has provided services to over 160,000 (2008) in a population of 1,180,784 (Hillsborough County includes Tampa, population 343,890 in 2009) • HCHCP is predicting financial hardship as the weak economy not only increases the number of people in need, but also yields a historically low sales tax collection (in FY 2007-2008 membership rose by 5.7%, while sales tax revenue dropped by 9.6 %)	• HCHCP demonstrates another financing mechanism by utilizing a local sales tax. However, sales tax is a regressive tax that affects lower-income individuals disproportionately. Moreover, it might be difficult to implement in Montana, a state without sales tax. • Setting up a local trust fund may be an efficient and accountable way to channel public monies to health care providers

Carelink (Bexar County, Texas)	• Carelink is a financial assistance program of University Health System, a public academic medical center. It offers a monthly payment plan for health care access based on income and family size • Eligible families are residents of Bexar County with incomes ≤ 300% of the FPL who, once accepted, make monthly membership payments and service co-payments based on their income level • CareLink does not provide any medical services. Instead the program refers patients to providers in a network of private practice physicians and the medical school.	• A voter approved **county hospital district tax**,[1] equaling 25 cents per $100 valuation of property, is the primary funding source • Medicaid DSH funds also provide funding for services • Members pay monthly fees and co-pays. Fees are based on an income sliding scale, and there are no costs for those with incomes at or below 75% FPL • The estimated cost of Carelink is $175/ member/ month • The annual budget/revenue is about $95 million (2005) • Providers are paid on a fee-for-service basis and Carelink pays the hospital, physicians, and clinics at Medicaid rates	• 50,000 low-income uninsured residents have received medical services with assistance of this program • CareLink's adult enrollment comprises 20% of the county's low-income uninsured population (Bexar County includes San Antonio, population of 1,373,668 in 2009)	• The hospital district as a taxing body is an interesting financing mechanism and may be replicable for Lewis & Clark Co. Although property tax is a regressive tax, revenue can be applied in a targeted way to benefit disadvantaged populations, including by channeling revenue to community health centers. However, the feasibility of this funding option also depends on the role of the local hospital in the community • A financial assistance program may not be sustainable in the long run as it maintains the existing system rather than addressing the underlying causes of high costs and other barriers to access. Paying providers at Medicaid rates may limit patients' access to providers, without offering meaningful cost containment solutions.
Fairfax County Community Health Care Network, Virginia	• The Fairfax County Community Health Care Network is a 20 year old partnership of health professionals, physicians, hospitals and local government. • It provides primary health services for low income, uninsured county residents who cannot afford primary medical care services for themselves and their families. • Services are provided at three public clinics operated by a private, national company	• **Public** funding and provider **contributions** (no details available)	• Over 20,000 residents were enrolled in 2009, and three clinics provided more than 50,000 primary health care visits.	• A publicly funded primary care safety net could be expanded to universal primary care through a network led by the community health center.

Funding streams: volunteer contributions from providers, grants, employers, *patients' or members' fees, new sales tax*, new hospital tax, federal Medicaid funds, local government funding

Target groups: uninsured, low-income, those not eligible for Medicaid, everyone under 500% FPL, employees from participating employers

Services: *navigation/referrals only*, primary care, all health care

Underlined: most desirable from a human rights perspective (fosters universality and equity)
Italics: least desirable from a human rights perspective (may be inequitable or not insufficient)

[1] **"Hospital Districts:** A hospital district must be approved by the voters, and each district can determine eligibility standards and services to be provided. The hospital district has the authority to impose property taxes annually in an amount not to exceed the limit approved by voters, and in no event in excess of 75 cents on each $100 valuation of all taxable property in the district. (http://www.window.state.tx.us/specialrpt/hcs/pg57.html) **According to Montana Code: 7-34-2133. Levy of district taxes.** Subject to 15-10-420, the board of county commissioners shall, annually at the time of levying county taxes, fix and levy a tax on the taxable value of all taxable property within the hospital district clearly sufficient to raise the amount certified by the board of hospital trustees under 7-34-2132." (http://law.justia.com/montana/codes/7/7_34_21.html)

Prospective County Health Care Initiatives

The Cape Care Campaign (Barnstable County, MA)	• Human rights-based campaign for universal health care through county-level, community-owned self-insurance • The Cape Care Community Health Trust would be the self-insurance core; managed by a new not-for-profit organization called Cape Care. This public entity will have its own community-based, elected and representative Board of Trustees, responsible for the collection and disbursement of funds, plan management, and policy development and decisions	• Half of the funding would come from current federal and state payments, which would be directed to the Cape Care Community Health Trust, through the Trust's participation as a health plan in existing federal and state programs • Residual funding would be through a Barnstable County Health Tax, and a payroll-based employer health contribution	• A local ballot initiative for a human rights based single payer system was passed, a majority of town halls approved Cape Care, the County Assembly recommended the plan, and legislation for the Community Health Trust was drafted and introduced in the Massachusetts State House • County employers have expressed agreement with a 7 to 8% health care assessment • The campaign continues to discuss county level financing mechanisms and determine the tax authority needed to implement an appropriate mechanism	• Barnstable County is a designated rural area which has a higher rate of uninsured people than Massachusetts average, a problem with retaining providers, and high health care costs • Massachusetts has already implemented health care reform along the lines of the new federal law, yet this has not solved local problems • The campaign has a well-developed plan for implementing universal care, which could be of interest to Lewis & Clark Co. • County authority and financing mechanisms have emerged as challenges, comparable to the situation in Lewis & Clark Co.

C 2

Local Health Care Interventions: Examples from Across the Country

Summary

Guided by the issues raised in the community health needs assessment, we examine a number of potential strategic responses, illustrated by local examples from across the country.

- To *address shortages in the health care workforce*, Community Health Centers have partnered with local and state bodies to **create residency programs** that increase their patient capacities as well as the supply of physicians, nurses, and dentists ready to work with underserved populations in rural areas.
- To *foster collaboration between providers* – primary care physicians, hospital, Community Health Center – counties and providers have undertaken demonstration and pilot projects to provide a continuum of care, often setting up new **networks** and combining **practice re-design** with supportive **learning collaboratives**.
- Many counties have taken the initiative *to move toward universal health care* by reinforcing health services to **support low-income, uninsured and under-insured people** as a first step towards creating a comprehensive community health system. By buttressing existing community resources such as safety-net programs, access to health services is divorced from the ability to pay or access to insurance and is reinforced as a public good that can be expanded to include everyone.
- Provisions of the Patient Protection and Affordable Care Act (PPACA) can provide both springboards and roadblocks to local initiatives. We take a look at the relevant policy and funding context.

Introduction

As the Universal Access to Health Care Task Force faces the final task of developing an action plan, it is useful to consider that other localities around the country are dealing with similar issues and may have lessons to share.

While each of the following strategies can be adopted separately, it is important to note that many counties have, in fact, adopted a multi-faceted approach that incorporates several different types of interventions to achieve a holistic effect. For example, expanding the safety net is often accompanied by encouraging collaborative care networks, or establishing a medical home network for the region.

A. Addressing Workforce Shortages

Residency and workforce training programs in Community Health Centers

With their mandate to improve access to care for the medically underserved, Community Health Centers are an ideal location for residency and training programs in underserved areas. Residency programs training medical professionals in rural areas have been shown to produce greater numbers of rural physicians, with similar trends for those trained in Community Health Centers (CHC).[1] Nationwide, the

[1] Several studies point to this trend, among them Morris, C. G., and F. M. Chen. "Training Residents in Community Health Centers: Facilitators and Barriers." *Annals of Family Medicine* 7.6 (2009): 488-94.; Morris, Carl, Brian Johnson, Sara Kim, and Frederick Chen. "Training Family Physicians in Community Health Centers: A Health Workforce Solution." *Health Services Research*40.4 (2008): 271-76; Blossom, H. J., T. Pitts, and V. P. Huerta. "Training Family Practice Residents at Community Health Centers." *Academic Medicine* 69.5 (1994): 431; *Health Centers' Contributions to Training Tomorrow's Physicians*. Issue brief. Washington: Division of Public Policy and Research , National Association of Community Health Centers, 2010, *Education Health Center Initiative Survey*. Accessed at TeachingHealthCenter.org

rate of establishment of a variety of residency programs through FQHCs has been increasing, and PPACA provisions can assist in the establishment or expansion of such teaching health centers.[2] One such program exists in Montana and can act as a model for recruiting and retaining more physicians in CHCs.

Montana Family Practice Residency Program- Billings, MT[3]

In conjunction with the University of Washington Medical School, the non-profit Montana Family Practice Residence was formed in Billings to provide an opportunity to train in rural practice, as well as to demonstrate the effects of these residency programs on underserved practice participation. Administrators of the program report that 70% of participants who graduate from the residency program continue to work in rural practice. In order to accommodate the clinical rotations of a medical program, a number of medical facilities have been incorporated including: St. Vincent Healthcare, Deaconess Medical Center, DCHC, Montana Associated Physicians Inc., Billings Clinic, and the Missouri and Yellowstone Rural Training Sites of Glasgow and Sidney Montana.

Other teaching health centers (Physician residency programs at CHCs)

Heart of Texas Community Health Center in Waco, Texas
La Familia Medical Center in Sante Fe, New Mexico
Community Health of Central Washington in Yakima, Washington
Greater Lawrence Family Practice Residency, Massachusetts

Northwest Dental Residency Program[4] AEGD (Advanced Education in Dental Residency) program:[5]

The Northwest Dental Residency Program is a one-year dental residency program in Washington State sponsored by the Yakima Valley Farm Workers Clinic (YVFWC), a multi-site health center with clinics in central and eastern Washington. The program is designed to provide residents with clinical experience in FQHCs that will enable them to provide comprehensive dental care to the broadest possible spectrum of the population, and experience in the complexities of care for special patient groups such as children, those who are immuno-compromised, special-needs patients, geriatric patients, etc.. Since the program began, 12 residents have completed the program and entered the dental workforce. Of these, 9 are practicing in dental health professional shortage areas, 8 are practicing in Washington State, 4 are practicing in Federally Qualified Health Centers.

Nurse Practitioner Residency Training Program, CT[6]

Two residency sites – Meridian and New Britain Health Centers

This residency program for nurse practitioners is designed to provide comprehensive training while offering residents the experience of work in a FQHC. The curriculum explores advanced access scheduling, planned care, the chronic care model, integrated behavioral health/primary care, team-based, with expert use of health information technology and electronic health records. This is among the first NP residency programs in the nation to be established in a Community Health Center.

Regional Resources

Area Health Education Center System (AHEC)[7]

Collaboration between many CHCs and their regional AHEC has produced innovative approaches to recruit graduates to rural and underserved areas. In Montana, the AHEC programs help to expose young people and students to health careers early on; many rotations take place at CHC.[8] In other states, the relationships to CHCs have been more direct, where regional AHECs

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[2] *Summary of PPACA Grants, Demonstration Projects and Other Funding Opportunities*, Healthcare Informational Series Part II, Vol. 2, Shipman and Goldman, LLP, 2010.

[3] Montana Family Residency Program website: http://www.mfmr.org/index.html; "The Montana Model Program Details" NACCHO Model Practices Database, National Association of City and County Health Officials, 2004. http://www.naccho.org/topics/modelpractices/database/practice.cfm?practiceID=71

[4] "Recruitment and Retention Programs" Washington Association of Community and Migrant Health Centers, http://wacmhc.org/programs-and-services/workforce-development/resources-for-chcs/recruitment-retention/ .

[5] "Message from the Director" from Northwest Dental Residency Program: http://www.aegdnorthwest.org/mess_director.asp

[6] "Program Goals" Nurse Practitioner Residency Training Program, http://www.npresidency.com/program.php

[7] AHEC and CHC Collaboration: Effective partnerships for the recruitment of health professionals. National Area Health Education Center Organization. 2006

[8] *K-12 Student Programs*. South Central Montana Area Health Education Center. http://www.scmtahec.org/k12students.html

have initiated loan repayment programs for clinics to recruit new physicians, assisted in the development of health training, fellowship and residency programs, provided training to support telemedicine initiatives, developed continuing education programs and opportunities for rural areas to help recruit and retain quality physicians. In North Carolina, AHEC complemented recruitment with support programs to help retain physicians, such as technical assistance for health center development.[9]

B. Improving Care Delivery and Quality: Collaborations and Integrated Provider Networks

Especially in rural areas with limited facilities, collaboration between providers is essential to enhance access for patients and ensure quality care. Such collaboration is likely to require support and resources in order to make changes to established, often competitive, practices.

Community Health Center demonstration projects

Small-scale, issue oriented demonstration projects allow Community Health Centers and county health facilities to target specific needs and service gaps in their local health system, drawing on opportunities of federal and institutional grants. PPACA has made funding available for local governments and CHCs to initiate projects on a variety of issues, such as chronic disease management, bundled treatment strategies, preventative health and health technologies.

A sampling of demonstration projects:

Community Health Center Urgent Care, Behavioral Health Services Demonstration projects-Massachusetts[10]

Suffolk County Asthma demonstration project, New York[11]

Open Door Family Medical Center –HIT and Decision making tools for managing Hypertension at CHC Demonstration Project[12]

Comprehensive Health Home Networks

Many localities across the country have expanded access and improved quality through engaging providers in health home networks, which seeking to buttress indigent care as well as improve care quality across the board. The terms 'medical home' and health home have become buzz words among health policymakers. As it was originally defined by the American Association of Pediatrics in 1967, a medical home describes a provider group that organizes primary care to be patient oriented, continuous, comprehensive, accessible, coordinated, compassionate and culturally effective.[13] In more recent years, a few basic features have been used to define providers acting as medical homes, namely that the health needs of an individual are coordinated by a primary care physician but delivered by a multi-disciplinary team, are supported by information technologies that support self care, and provided by an institution that adheres to evidence-based clinical practices. [14]

Central to such models is making care more responsive to patients with chronic conditions that historically have not been well addressed in the conventional 'volume-based' model of care. Many of these patients receive inadequate or uncoordinated care that is difficult to complement with self care in

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[9] Takah, M. *Community Health Centers and Health Reform: Highlights from a National Academy for State Health Policy Forum*. Issue brief. Portland: National Academy for State Health Policy, 2010

[10] Health Safety Net Demonstration Projects, Massachusetts Division of Health Care Finance and Policy; 2009 http://www.mass.gov/Eeohhs2/docs/dhcfp/r/pubs/09/hsn_demo_report_2009_06_10.pdf

[11] "Suffolk County Asthma Demonstration Project." *Suffolk County Government*. Levy, Steve. Web. http://www.co.suffolk.ny.us/departments/healthservices/Articles/asthma.aspx

[12] Kopal. H. 2008. Evaluation of a Computerized Clinical Decision Support System and Electronic Health Record (EHR)-Linked Registry to Improve Management of Hypertension in Community-Based Health Centers, Primary Care Development Corporation.

[13] American Academy of Pediatrics, "Medical Home." *Children's Health Topics,"* 31 Aug 2007. http://www.aap.org/healthtopics/medicalhome.cfm

[14] The Patient Centered Primary Care Collaborative. http://http://www.pcpcc.net

their daily lives, and as a result their quality of life declines. In addition, significant costs in re-hospitalization and emergency room visits are accrued when these conditions are mismanaged.[15] In response to what could be deemed a crisis in chronic care management, medical home models are being developed and tested across the county, as practices attempt to redesign themselves to provide primary care that is patient-centered and responsive. While a medical home can describe one practice, the ultimate goal in this model of care is a medical home network, where every person in a region has their designated primary care destination, which acts as a navigating site for secondary and tertiary care.

Participation in such initiatives may require additional resources for collaborating providers. To motivate and compensate providers to make changes such as employing multi-disciplinary staff, moving to electronic medical records and volume-based care, practices may be offered performance and quality based incentives by their public and private payers. Current literature references more than 100 pilot projects of nearly 5,000 practices, many of which have only begun in the past year.[16] Nearly all pilot medical home networks involve a learning collaborative that provides an explicit forum for practices in transition to support each other and draw on pooled resources to seek expert advice. Below are listed several examples of smaller and rural based pilot projects that may be reproducible in Lewis and Clark County.

New Jersey FQHC Medical Home Pilot[17]

This 3-year demonstration project only began in February of 2010, and includes three New Jersey providers, including the Community Health Center, that have contracted with regional health plans. They seek to provide a medical home network of care, specially focused on improving the access to and quality of care for low-income and underserved in the community, as well as improving coordination between regional hospitals and health centers. Initial changes were to incorporate electronic medical records and other technologies to improve patient disclosure in their own care as well as hire patient navigators to help enroll uninsured patients in assistance programs.

Guided Care demonstration pilot and study – Baltimore, MD[18]

Eight community based primary care practices in the DC area sought to test the quality of a specific model of a patient centered medical home by employing registered nurses as the holistic care provider and primary point of contact for patients with chronic conditions and caregivers, in close consultation with a team of physicians. Each patient's designated nurse is responsible for assisting in the patient's self care, the continuous monitoring of a patient's condition, incorporating new technologies to make more information available to patients, as well as navigating with patients between sites and providers. This RN is also a resource for family and caregivers of these patients in coordinating and managing care for chronic conditions. After one year a randomized trial study revealed some positive initial results demonstrating that among the practices incorporating this model,. "Guided Care" patients were twice as likely as usual care patients to rate the quality of their care highly, and to experience reduced strain and depression among family caregivers. Compared to the physicians in the control group, the physicians who practiced "Guided Care" reported, after six months, significant positive effects on communicating with patients, communicating with family caregivers, educating family caregivers, motivating patients to participate in their care, referrals to community resources, and knowing patients' medications.[19]

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[15] *Medical Home 2.0: The Present, The Future.* Deloitte Center for Health Solutions. Available at http://www.deloitte.com/us/medicalhome.

[16] Model Practices Database. The Patient Centered Primary Care Collaborative. Web. http://http://www.pcpcc.net/pcpcc-pilot-projects ; For further reference materials see Calvo et al. *A Comprehensive Health Home: Using The Expanded Care Model of the Collaboratives.* Institute for Alternative Futures.; Bitton, A et al., *A Nationwide Survey of Patient Centered Medical Home Demonstration Projects*, J. Gen. Intern. Med. 25.6 (2010): 584-92.
Boult C, Karm L, Groves C. *Improving Chronic Care: The "Guided Care" Model.* The Permanente Journal Winter 2008;12(1):50-54; Web based resources : http://medhomeinfo.org/resources.htm, http://www.transformed.com/resources/PCMH.cfm, http://www.medicalhomeinfo.org/

[17] "NJ FQHC Medical Home Pilot." Patient Centered Primary Care Collaborative 2009. http://www.pcpcc.net/content/nj-fqhc-medical-home-pilot; Medical Homes, Deloitte Paper.

[18] "Guided Care." Patient Centered Primary Care Collaborative. <http://www.pcpcc.net/content/guided-care>; "The Guided Care Solution" Guided Care, http://www.guidedcare.org/solution.asp; Leff B et al. *Guided Care and the Cost of Complex Health Care*, Am J Manag Care 2009; 15(8):555-559

[19] "Guided Care" PCPCC

Adirondack Region Medical Home Pilot[20]

Started in 2004, this rural medical home network operating in 5 counties of upstate NY is now one of the largest demonstration projects of its kind in the country. The premise of the pilot is to emphasize preventive care and chronic disease management through a network of health care providers and contracts with insurers. The primary care providers assigned to a patient are rewarded through performance based payment for keeping patients healthy and proper management of chronic conditions. The cost of the program is translated to higher costs for primary care appointments that are covered by private insurers and Medicare. There is no membership fee to residents, they are considered participating if they have been seen by a participating physician in the past two years. Additionally, the project has used federal and state funding to support a network-wide move to electronic medical records to help limit costs to practices as well as payers, and in 2010 received an additional grant from Medicare. It did not appear that this network included any FQHC or look-alikes at this time.

Collaborative Care

Learning Collaboratives among health care providers complement pilot projects that attempt to demonstrate the feasibility, quality, and cost effectiveness of new delivery models, such as medical homes, safety nets, residency programs, health IT or community-driven health strategies. They act as sites of support and integration within new networks and projects. These collaboratives are formed by groups of physicians and other providers to facilitate an exchange about the changes they must make to incorporate these models into existing practices, and can provide resources for overcoming barriers. Oftentimes a medical home network is described as a learning collaborative when referring to a group of practices or health centers attempting to test a hypothesis that a specific model of patient centered care produces better outcomes, saves money, or reduces risk.

Collaborative care networks (CCN) pool knowledge and resources to target specific issues in primary care. CCN have been tested in states such as Michigan, Pennsylvania, and North Carolina for pediatric care and chronic disease management, and offer models for how such initiatives can improve community health. These programs can be jumpstarted by funding or incentives for providers to join. Studies from a Pennsylvania demonstration project suggested that practitioners in a collaborative felt that improvement in their personal job satisfaction was a huge strength. This may be an opportunity for collaboration with other counties.

Oral Health Collaborative - Community Health Partners Dental Practice, in Bozeman[21]

Community Health Partners is one of four clinics in the country to be recently accepted into the HRSA Pilot Oral Health Collaborative for testing patient centered models in dental care, and aimed at establishing successful prevention of dental disease from infancy. Since the project began in 1995, dental practices have reported dramatic successes in their service to their target population.

Great Start Pediatric Care in Barry County, MI[22] (and other Michigan counties):

The Barry County Great Start Collaborative is a partnership of community agencies and early childhood providers who have established and maintained a network of supports and services for children and families. This collaborative is not only a resource for providers, but attempts to raise community awareness of early childhood issues and act as an advocate in regional debate on early childhood programs and services.

Bexar County Community Health Collaborative, San Antonio Texas[23]

This network of local organizations, citizens, private and non-profit providers, has a goal to provide a vehicle for collaboration and coordination between private and public health centers to pave "a more robust, less duplicative, more synergistic approach to solving critical community health needs, while

[20] Adirondack Region Medical Home Pilot. http://www.adkmedicalhome.org/

[21] Community Health Partners. http://www.chphealthmt.org/; "Oral Health Collaborative Pilot." *Healthcare Communities*. HRSA Health Disparities. http://www.healthcarecommunities.org

[22] *Barry Great Start Collaborative*. http://www.barrygreatstart.org/

[23] "About Us." *Bexar County Health Collaborative*. Web. http://www.healthcollaborative.net/about-us

efficiently utilizing resources."[24] With investment from the county health department and local charitable and faith-based organizations, the collaborative initiated projects in the community to target childhood obesity, youth health literacy, and to improve provider patient communication. The initial health assessment conducted in 2005 revealed the gaps that health providers wanted to target through a cooperative effort. A forthcoming 2010 health assessment will discuss progress made.

Chronic Care Management Collaborative, Pennsylvania[25]

This demonstration program in Pennsylvania adopted a member-developed chronic care model on a wide regional scale. To support the transition, state funds were made available to help providers, including health centers, to redesign their practices to include multi-disciplinary teams with greater proportions of mid-level practitioners. These groups - and notably the FQHC - won contracts with insurers to further help fund these transformations. Approximately 150 primary care practices are part of the initiative.

National Resources

The Patient-Centered Primary Care Collaborative[26]

As a national forum for physician practices and networks of health centers moving towards a health home model of primary care, the collaborative seeks to provide resources to local groups hoping to adopt this model in their community health system.

C. Ensuring Universal Access to Health Care

To move toward universal access to care, some localities have created publicly sponsored health care plans or programs that collaborate with local providers to provide care for all who need it, or at least for those who need it most. Such programs, whose public backing makes them more accountable and affordable, can act as stepping stones towards guaranteeing universal access by beginning with uninsured and underinsured populations. These networks often use a medical home model, whereby enrollees have a designated destination for primary care, a regular physician, and are often supported by a discount pharmaceutical plan. Programs may also act as an enrollment site for a variety of social assistance programs and help make the system more navigable for patients and their families. These programs may be funded by sliding scale premium contributions or co-pays, a local tax, state or local funding, or employer buy-in, or by the voluntary participation of providers.

Healthy San Francisco:[27] *Public and Employer Funded Model*

With the long term goal of realizing universal access to health services, this health care program established a network of non-profit and public providers, centered on the public hospital and community health centers, to ensure all residents have access to care and a medical home. This program makes health care available to those under a certain income at low-cost or free, with a sliding scale membership fee. Specialty care services are provided by incorporating specialty physicians and nurse practitioners into chronic care management teams within high-volume primary care sites at FQHCs associated with San Francisco General Hospital. Thus these clinics operate multiple medical home models depending on the condition being treated. This program successfully enrolled over 80% of the uninsured population of San Francisco and has helped reduce emergency room visits at the public hospital by 27%. It is funded in part by a Medicaid waiver and also by a local employer payroll tax, which is expected to continue once the federal employer mandate comes into force.

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[24] ibid

[25] *Strategic Plan.*, The Pennslyvania Chronic Care Management, Reimbursement and Cost Reduction Commission. Feb 2008; "Southeastern Pennsylvania: Rollout of the Chronic Care Initiative." *American College of Physicians.* http://www.acponline.org/advocacy/where_we_stand/medical_home/cci.htm

[26] *The Patient Centered Primary Care Collaborative.* http://www.pcpcc.net/

[27] *Healthy San Francisco*, http://www.healthysanfrancisco.org/; Ackerman, J. *How to Strengthen Local Healthcare Safety Net Systems: Lessons from Healthy San Francisco*. Diss. University of California, Berkley, 2010.

Hillsborough County Health Care Program, FL[28]*: Sales Tax Model*

This publically financed program offers a variety of health care access options that support those without insurance and of low income, while developing a more integrated and coordinated care system across providers and payers. The program is largely supported by a local sales tax and operates a network of over 600 primary care physicians and 5 hospitals in the city of Tampa. The program charges no premiums but has a very low income eligibility, which may expand when the majority of its participants become eligible for Medicaid in 2014.

Anne Arundel County REACH program: Provider Discounting Model

The program provides access to primary, specialty, and ancillary care to uninsured, low-income residents through a local network of 440 providers, who formally agreed to accept discounted fees for services provided. REACH members pay a sliding scale fee directly to providers at the time of service, eliminating the need for billing and collection. The REACH network is supplemented by the use of existing Department of Health programs that are free, low-cost or subsidized, including referrals to various pharmaceutical subsidy programs.

D. Federal Reform: Challenges and Opportunities

PPACA Impact on Existing Programs

PPACA's impact on local access programs such as the Hillsborough County Health Program or Healthy San Francisco is far from evident. As these programs do not offer insurance, they will not meet the controversial individual mandate requirement. However, it is anticipated that the need for these programs will continue, even as the demographics of participants changes. San Francisco has appointed a task force to examine the impact of health reform and to plan adjustments to the program. The task force has reported that PPACA will leave around 20,000 San Francisco residents without access to insurance.

Employer-sponsored coverage and premium subsidies in the state-based exchanges may be too expensive for some to afford. Penalties of the individual mandate come into effect only if coverage can be purchased at a rate lower than 8% of individual income. At 2.5% of income, the mandate penalty is sufficiently lower than the cost of insurance, and the government estimates that nearly 37% of those eligible for subsidies in the exchange would chose not to join.[29] Moreover, enrollment in public programs does not typically reach capacity, as current participation in Montana's Medicaid and SCHIP programs shows (at less than 70%).[30] In Montana, this means approximately 42% of the currently uninsured will continue to lack access, which includes 3,500 to 5,350 people in Lewis and Clark County.[31]

Some publicly funded health programs that were started as safety net expansions are considering a shift in structure to become insurance CO-OPs, the new non-profit, member-run insurance plans that are eligible for PPACA funding and meet the individual mandate requirements. For example, the Healthy Howard Health Plan, a program that currently provides direct access to care rather than insurance coverage, may seek to convert into an insurance CO-OP.

A Sampling of PPACA Grant Opportunities

Federal reform has made grant opportunities available that would support a variety of systemic changes initiated at the local level. The following small selection of federal grants is available to local governments and FQHCs.[32] Additional funds are also available at the state and regional level.

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[28] "HCHCP,' *Hillsborough County Government Online*, http://www.hillsboroughcounty.org/hss/healthcare/about/home.cfm

[29] Office of the Actuary, Estimated Financial Effects of PPACA as amended, April 2010

[30] For children's participation rate, see Kaiser State Health Facts, "Montana: Children's Medicaid/CHIP Participation Rates, 2008," http://statehealthfacts.org/profileind.jsp?ind=868&cat=4&rgn=28&cmprgn=1; for adult participation rate, see B. Sommers/ A. Epstein, "Medicaid Expansion - The Soft Underbelly of Health Care Reform?" in: *New England Journal of Medicine*, November 2010.

[31] NESRI calculation based on estimates from the Office of the Actuary and participation rates, op. cit.

[32] See also: http://www.hhs.gov/grants/

To expand access to health insurance

- Title I Sec 1322: Consumer Operated and Oriented Plan (CO-OP) Program: for the creation of non-profit member-run health insurance issuers to offer qualified health plans in the individual and small group markets. Grant and loans will be available to start at least one CO-OP in each state no later than July 2013.

To facilitate collaboration in health care delivery

- Title X Sec 10333: Community Based Collaborative Care Network Program: consortium of health care providers with a joint governance structure that provides coordinated care to low income populations
- Title III Sec 3501: Quality Improvement Technical Assistance Program: when a provider network, health department or FQHC is attempting to adopt a model of practice identified in research by the Center for Quality Improvement and Patient Safety, federal funds are available to coordinate the technical assistance required for such a change

To expand the health care workforce

- Title V Sec 5508: Teaching Health Centers Development Grant: Establishing or expanding primary care residency training programs at teaching health centers[33]
- Title X Sec 10501: Demonstration grants to establish a one-year accelerated training program for family nurse practitioners as primary care providers at FQHC and Nurse Managed health centers
- Title V Sec 5313 : Expand the use and practice of community health workers to promote positive health behaviors and outcomes for medically underserved communities

To improve community health

- Title IV Sec 4201: Community Transformation Grants: implement evidence based prevention program to reduce chronic disease, prevent the development of secondary conditions, address health disparities

[33]"Teaching Health Center Graduate Medical Education Payments Program." *Center for Federal Domestic Assistance: Programs*. Web. https://www.cfda.gov/?s=program&mode=form&tab=step1&id=f7626fc9e1a2ca3ac24155120c449d2c

C 3 - Personal Income Tax at the Local Level: Examples

In general, income tax is paid at the federal and – with some exceptions - state level, whereas property tax is collected at the county level. Nonetheless, in addition to some major cities (New York City, Philadelphia, etc.), a host of states[1] have counties and municipalities that impose a local income tax (generally ranging from 0.5% - 3.98%). The counties listed below make specific reference to using their local income tax revenue for health related services.

The counties/municipalities below demonstrate a varied sampling of:

- Local ability to impose an income tax – approval process, tax regulations, state legislation, authorizing bodies, etc.;
- Local reasons for imposing an income tax – with the exception of Multnomah County, income tax is collected as a general measure to fund local governments, rather than a special or emergency measure;
- Use of a portion of the local income tax revenue for health related services.

County/Municipality	Use of Local Income Tax
Multnomah, OR[2]	Established a three-year (2003-2005) personal income tax under County Ballot Measure 26-48 in order to fund county services and schools and mitigate the impact of state budget cuts. Approximately 12.5% of the tax went to fund healthcare, disability, and senior services[3]. No further approval was needed from the state once county voters approved this tax. Parents groups played a major role in advising the local government as to how it should be dispersed.[4] Multnomah County includes the city of Portland. See case study in appendix C 4.
Concord, MA[5]	Planned to implement a progressive income tax that would be applied to public services such as education and health care; however, recent information from the Financial Department indicates that this initiative may have been abandoned[6]. If it had been implemented it would have been separate from state or federal income tax regulations and approved and implemented through Town Hall meetings.
Appanoose, IA	Imposed a 1% local income surtax to fund Emergency Medical Services (EMS) programs. This surtax is in accordance with Iowa Code Chapter 422D, must not exceed 1%, and is voted on every 5 years by Appanoose County voters.

All 92 Counties in Indiana[7]	Impose up to 1% income tax on residents and nonresidents in accordance with the Indiana Code. Local Option Income Tax (LOIT) was established to provide property tax relief and an alternative source for county funding. The regulation LOIT is left to the counties.[8] Indiana law mandates that as long as a county applies CAGIT[9] or COIT[10] incrementally and uses the revenue to provide property tax relief, it may also impose an additional CAGIT or COIT tax rate of up to 0.25% for public safety – which includes police, fire and emergency medical services, pensions and facilities[11].
City of Lakewood, OH[12]	Collects a 1.5% income tax ($18,523,000 in 2009) from residents and non-residents who work in the city. A portion of the money supports General Fund Expenditures (GFE). Of GFE, 4% goes toward Human Services, which include Health & Wellness services for the aging, and a mental health emergency hotline for youths. It is unclear what portion of the Human Services funding comes specifically from local income tax revenue.
City of Miamisburg, OH[13]	Imposes an income tax (city's largest source of revenue) which pays for basic services, including police, fire/EMS, street maintenance and recreation services. In 2009 this income tax generated $10.1 million. Many counties and cities in Ohio put income tax toward funding fire/EMS services; however, the counties have control over raising and maintaining these income tax rates.

NOTES

[1] Such as Alabama, Delaware (municipal), Indiana (county and municipal), Iowa (only school district), Kansas, Kentucky, Maryland, Michigan, Missouri, New York, Ohio, Oregon, Pennsylvania, and Tennessee; www.taxfoundation.org/files/localincometaxes-20080711.pdf

[2] Multnomah County Personal Income Tax Return Form MC TR 2005 and Instructions. 2005

[3] Programs funded included (July 2003-June 2004): primary health care coverage for uninsured clients, WIC, dental care for low-income patients, outpatient and urgent walk-in clinics for mental health and development disability patients, outpatient drug and alcohol treatment and services, prescription assistance for seniors, Oregon Project Independence & Medicaid long-term care program funding for senior services, and funding for state health plan coverage programs; www.co.multnomah.or.us/priorities

[4]Phone conversations with Assistant Tax Administrator, Satish Nath (503) 988-3432; transcripts available.

[5] "Concord Proposal for a Local Income Tax - Is it Time for the State to make our Tax System more Progressive?" One Massachusetts. Feb 17, 2010; http://onemassachusetts.org/taxonomy/term/307

[6] Phone conversation with a representative in the Concord Department of Finance, (978) 318-3090; transcript available.

[7] Indiana Local Government Information Website. Indiana's Local Income Taxes. January 2009 http://www.agecon.purdue.edu/crd/localgov/topics/Essays/Income_Tax_Local.htm

[8] Under Indiana law, all local option income tax (LOIT) increases must be approved by at least two of the county's three largest taxing bodies. For example, in St. Joseph County, this is the South Bend Common Council, Mishawaka Common Council and St. Joseph County Council. http://www.wsbt.com/news/local/46132332.html

[9] Ibid. CAGIT = County Adjusted Gross Income Tax (I.C.6-3.5-1.1). Adopting body: County Council. Rate: 0.5, 0.75 or 1.0% (some counties have specially authorized higher rates). "CAGIT adopting counties face stricter limits on their maximum property tax levies in the year of adoption. This means that adopting CAGIT reduces the amount of property tax that local units are allowed to raise. While the CAGIT law shows one-quarter of CAGIT revenue as devoted to property tax relief, the added restrictions on the maximum property tax levy mean that more than half of CAGIT revenue actually is devoted to property tax relief."

[10] Ibid. COIT= County Option Income Tax (I.C. 6-3.5-6). Adopting Body: County Income Tax Council (COIT Council), made up of the fiscal bodies of the county, cities and towns, with 100 votes divided based on shares in county population. Rate: "0.2% in first year rising to 0.6%; then to 1% at 0.1 annual increments. COIT council make fix rate at any intermediate level (some counties have specially authorized higher rates)."

[11] Local Option Income Tax Fact Sheet. Indiana Department of Local Government Finance. October 2007.

[12] Lakewood Ohio, Department of Human Services, Financial Overview – City of Lakewood – Fiscal Year 2009; http://onelakewood.com/HumanServices/Default.aspx

[13] http://www.daytondailynews.com/news/community/miamisburg/miamisburg-levy-vital-to-sustaining-city-services-654781.html

C 4

Multnomah County, Oregon: Case Study of Voter-Approved Temporary Local Income Tax

Dates tax was applied: 2003-2005

Rate: 1.25% personal income tax (with initial $2500 exemption) directed to pay for schools, health programs, and public safety.

Approval Method: The Board of County Commissioners placed Measure 26-48, the option for a temporary income tax, on the Ballot in the May 2003 county primary elections.[1] It was approved, and once the voters approved the tax, no further state approval was required.

Results: The tax generated roughly $128 million per year for Fiscal Years 2004, 2005, and 2006. During the three years, 12.5% (about $16 million) was directed to health programs and senior citizen assistance programs. The County's records show that on an annual basis, $3,092,555 was given to health services.[2]

Motivation for Tax: The Health Department used this tax revenue to prevent the under-funding or loss of programs that might have resulted from the plummeting property tax revenue, which is the department's main source of funding, and state budget cuts.

Program Expenditure:

Specific health program cuts prevented:[3]

- Primary Care for the Uninsured $990,000
- Communicable Disease and Environmental Health $321,000
- Rockwood Neighborhood Health Access Site $350,000
- Women, Infants, Children (WIC) Program $600,000
- Corrections Health $597,000
- Dental Services $225,000

Summary of health programs funded with temporary income tax July 2003 – June 2004:[4]

- Mental Health and Developmental Disability Services $7,958,415
  - Operation of urgent walk-in clinics, a mobile response unit, and a crisis call center
  - Treatment for low-income patients who have lost Oregon Health Plan coverage
  - Counselors in schools
  - Case managers for developmental disability clients

- Health Care Services $3,092,555
  - Oregon Health Plan payments to prevent low-income clients from losing health care coverage

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[1] http://www.co.multnomah.or.us/dbcs/elections/2003-05/26-48.shtml

[2] http://www.co.multnomah.or.us/tax/goes.shtml

[3] http://www2.co.multnomah.or.us/Departments/County_Management/Budget/budget/web_page_04_adopted/web_page_04_adopted/hd_adp_04_narr_pdf.pdf

[4] Data obtained from Multnomah County Voter-Approved Temporary Income Tax Brief Summary of county Programs Funded and Clients Served, July 2003-June 2004, http://www.multcotax.org.

- Communicable disease control and prevention (i.e., West Nile, Tuberculosis, etc.)
- Basic dental services
- Food vouchers and nutrition education for low-income pregnant women and infants

- Aging and Disability Services $2,693,950
  - In-home assistance for seniors to enable them to remain in their homes
  - Prescription drug assistance for low-income seniors and people with disabilities
  - Medical transportation for low-income seniors
  - Housing for seniors and people with disabilities who are homeless

Impact on County: There was an increase in treatment received by uninsured people, likely due to the nearly $1 million boost for FY04. More specifically, data shows that in late 2004, there was a sharp jump in Verity enrollee numbers; Verity is the county's managed care program for mental health clients. This jump coincided with the period during which funding would have been disbursed to the department that reflected a budget modification linked to the availability of the levy revenues. The Oregon Health Plan eligible enrollees also manifested a slight bump at that time, probably for similar reasons. As revenue fell, data indicated a slight enrollment decline over time, with a sharp decline of enrollment and clients served after mid-2007, when the levy expired.

Reason for Discontinuation: Exact reason is unknown. However, it is believed that the Board of County Commissioners felt it would be an uphill struggle to renew the tax, and might damage their chances of getting other emergency levies passed in the future, due to widely supported anti-tax movements, notably the Oregon Tax Revolt, which have been gaining support since the 1990s.

Lessons Learned: The data demonstrate that the Health Department relied on the levy to provide a more stable funding stream than property taxes have historically; yet the tax was temporary from the outset, designed as a stop-gap measure. Multnomah County's essential problem is their dependency on funds - either tax revenue or grants - that have expiration dates, and thus lack the consistency and continuity required for sustainable programming. This is problematic for clients who receive health services for three years and then, when the funds are depleted, are triaged based on care needs. It is crucial to develop a well-defined, long-term plan of action that offers more than a stop-gap intervention. If temporary income streams are considered, a careful exit strategy must be put in place.

Demographics of Multnomah County: The population of Multnomah County, Oregon, is 726,855 (2009), which includes the city of Portland with a population of 537,081 (2006). County median household income is $51,372 (2008).[5] Multnomah County contains rural and urban areas; however, the majority of the population is urban. Nonetheless, rural health programs make up a fair chunk of the health budget, so any tax levy funds allocated to the departmental budget would also have been disbursed to them.

Reference:

Background information and interpretation provided by Andrew Riley, Policy Analyst, Center for Intercultural Organizing (formerly with Multnomah County), email exchange July 16, 2010

[5] www.quickfacts.census.gov

C 5

Public Hospital Districts in Montana

Public Hospital Districts in Montana: "These districts are established by the board of county commissioners upon petition of property owners, after public hearing and referendum. An elected board of trustees governs each district. The districts may collect rates for services, issue bonds, and determine the amount of revenue to be raised from ad valorem taxes." [1]

Montana Code. Title 7: Chapter 34
MEDICAL SERVICES AND BOARDING HOMES FOR THE AGED> Part 21 — Hospital Districts

"**7-34-2101. Purpose of part.** The purpose of this part is to authorize the establishment of public hospital districts which shall have power to supply hospital facilities and services and health care facilities and services to residents of districts and, as herein authorized, to others.

7-34-2102. Definitions. As used in this part, unless the context requires otherwise, the following definitions apply:

(1) "Hospital facilities" means a hospital or a hospital-related facility, including outpatient centers for primary care, outpatient centers for surgical services, rehabilitation facilities, long-term care facilities, infirmaries, and health care facilities, all as defined in 50-5-101. The term includes public health centers.

(2) "Public health center" means a publicly owned facility providing health services, including laboratories, clinics, and administrative offices."

7-34-2103. Petition required to create hospital district. Proceedings for creation of a hospital district shall be initiated by a petition signed by not less than 30% of the qualified electors of the proposed hospital district who are taxpayers upon property within the proposed hospital district and whose names appear on the last-completed assessment roll for state and county taxes.

7-34-2106. Presentation of petition to board of county commissioners -- hearing required.

(1) The county clerk and recorder shall present the petition and the clerk's certificate to the board of county commissioners at its first meeting held after the clerk has attached the certificate.

(2) The board shall carefully examine the petition, and if it is found that the petition is in proper form and bears the requisite number of signatures of qualified petitioners, the board shall by resolution call a hearing on the creation of the hospital district.

7-34-2109. Election on question of creating hospital district. The board of county commissioners, upon completion of the hearing provided for in 7-34-2106 through 7-34-2108, shall proceed by resolution to refer the question of the creation of such district to the persons qualified to vote on such proposition.

7-34-2111. Territory of hospital district. A public hospital district may contain the entire territory embraced within a county or any portion or subdivision thereof.

7-34-2122. Powers of district. A hospital district has all powers necessary and convenient to the acquisition, betterment, operation, maintenance, and administration of hospital facilities that its board of trustees considers necessary and expedient. In addition to the general grant of powers, a hospital district, acting by its board of trustees, may:

(1) employ nursing, administrative, and other personnel, legal counsel, engineers, architects, accountants, and other qualified persons, who may be paid for their services by monthly salaries, hourly wages, and pension benefits or by fees that may be agreed upon;

(2) cause reports, plans, studies, and recommendations to be prepared;

(3) lease, purchase, and contract for the purchase of real and personal property by option, contract for deed, or otherwise and acquire real or personal property by gift;

(4) lease or construct, equip, furnish, and maintain necessary buildings and grounds;

(5) adopt, by resolution, rules for the operation and administration of hospital facilities under its control and for the admission of persons to the facilities;

(6) impose by resolution and collect charges for all services and facilities provided and made available by it;

(7) subject to 15-10-420, levy taxes as prescribed in this part;

(8) borrow money by the issuance of its bonds as prescribed in this part;

(9) borrow money by the issuance of notes;

(10) procure insurance against liability of the district or its officers and employees, or both, for torts committed within the scope of their official duties, whether governmental or proprietary, and against damage to or destruction of any of its facilities, equipment, or other property;

(11) sell or lease any of its facilities or equipment as may be considered expedient;

(12) cause audits to be made of its accounts, books, vouchers, and funds by competent public accountants; and

(13) provide educational benefits to qualified individuals, including the payment of tuition, room and board, educational materials, and stipends and the repayment of student loans in return for an agreement by those persons to provide services to the district.

7-34-2133. Levy of district taxes.

Subject to 15-10-420, the board of county commissioners shall, annually at the time of levying county taxes, fix and levy a tax on the taxable value of all taxable property within the hospital district clearly sufficient to raise the amount certified by the board of hospital trustees under 7-34-2132."

7-34-2137. Collection of taxes and disposition of funds.

(1) The procedures for the collection of the tax shall be in accordance with the existing laws of Montana.

(2) The funds collected under the tax levy shall be held by the county treasurer, who shall be, ex officio, the treasurer for the hospital district, and such treasurer shall keep a detailed account of all tax money paid into the fund, of all other money from any source received by the district, and of all payments and disbursements from the fund. Funds shall be paid out on warrants issued by direction of the board of trustees, signed by the majority of its membership.

Examples of public hospital districts in Montana

Musselshell County[2] (Nov 2006)

"Voters approved 1,085 to 1,017 a levy to raise $112,496 annually for each of two years for the Musselshell County Hospital District. The money would provide for physician recruitment, malpractice insurance, general liability insurance and capital expenditures in the hospital, an extended care unit and clinic, including, but not limited to, a new boiler, audiometer, gurneys for the emergency department, monitoring devices for defibrillator, clinic exam tables, recliners for

hospital patient rooms, furniture for the ECU and cardiac monitoring system. The levy replaces the $31,613 approved by voters in June 2004 and expired June 2006. The effect on a home valued at $100,000 would be an annual tax increase of $34.67."

Roosevelt County[3] (Nov 2006)

"Voters approved 606 to 384 a levy to raise $19,525 per year for emergency medical operations at Poplar Community Hospital. Property taxes on a home valued at $100,000 would be an additional $9.42 a year. Only property in hospital districts 1 and 9 would be taxed."

Conclusion

- It appears that this provision of the Montana Code has never been challenged in court. The only Montana case to ever substantively discuss public hospital districts is Sorenson v. Board of County Com'rs of Teton County, 176 Mont. 232 (1978). In that case, several residents petition for the removal of their land from a public hospital district. The case does not deal with the legitimacy of creating a district and leveraging taxes for a hospital since the legitimacy of the law is not in question. The case states residents of a neighborhood can petition to withdraw from a district if they have sufficient votes.

- Furthermore, although Montana is not a home rule state, the Montana constitution grants localities self government powers in Article XI, Section 5 ("A local government unit adopting a self-government charter may exercise any power not prohibited by this constitution, law, or charter"). Essentially this means that a governmental unit with self-governing power can enact any laws not prohibited by the state constitution. Nothing in the Constitution prohibits the creation of this public hospital districts.

- There is nothing prohibiting Lewis and Clark County from creating a public hospital district. Residents of certain areas may petition for withdrawal from the district if they find that they are better served by another hospital. To withdraw a petition has to be signed by 51% of taxpayers within the area that desires to be removed.[4]

Notes

[1] http://www2.census.gov/govs/cog/2007/mt.pdf

[2] http://billingsgazette.com/news/state-and-regional/montana/article_9dadeb99-4f54-5f1d-82fb-7a03c0bca1e8.html

[3] Ibid

[4] "Any portion of a public hospital district may be withdrawn therefrom as in this section provided, upon receipt of a petition signed by fifty-one per centum (51%) of the taxpayers, or more, residing in and owning property within the area desired to be withdrawn from any public hospital district, on the grounds that such area will not be benefited by remaining in said district. The board of county commissioners shall, upon the filing of such a petition, fix a time for the hearing of such withdrawal petition * * * The board shall consider the petition and all objections thereto, and pass upon the merits thereof, and make its order in accordance therewith. * * * Such order is subject to review by the district court of the county, and appeal may be taken from the final judgment of such district court to the supreme court of Montana." 176 Mont. 232, 234 (1978)