Attachment A

Regional Health Plan Pilot Phase One Report

King County 2019-2020 Biennial Budget Ordinance, Ordinance 18853, Section 95, Proviso P3

June 26, 2019

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Executive Summary

This is the Phase One response to the adopted King County 2019-2020 Biennial Budget Ordinance, Ordinance 18853, Section 95, Proviso P3, which makes appropriations to the Public Health Fund. This report explores the feasibility of expanding access to health care coverage and services for residents of King County who are uninsured, focusing on those who, due to their immigration status, are not eligible for coverage through existing public programs such as Medicaid, Medicare, or a Qualified Health Plan offered through the Washington Health Benefit Exchange.

As requested by the King County Council, the response includes a description of the demographic characteristics of this focus population and explores a range of policy options to expand access and coverage. We rule out opportunities to sponsor or "buy-in" this population to existing group coverage programs due to regulatory and legal obstacles and identify a range of five County-based coverage options that are potentially feasible. Financial analysis of five potential options estimate annual costs ranging from $2 million to $181 million per year. The report concludes with a discussion of funding options and recommended action steps.

Focus population: As a result of the Affordable Care Act (ACA), the percentage of King County adults who are uninsured has been reduced by half. Despite this progress, approximately 147,000 adults in King County remain uninsured. Of these, more than one-third—an estimated 52,000 adults—are recent immigrants who do not have U.S. citizenship. The focus population for this report is the subset of this group who are undocumented and are therefore ineligible for public programs such as Medicaid, Medicare, and subsidized health insurance under the ACA. We do not know the exact size of the focus population.

Demographic analysis of all uninsured non-citizen adults in King County shows that 61 percent are Hispanic and while most (92 percent) are working, 62 percent have incomes less than twice the poverty level. Being uninsured is associated with delaying and foregoing needed health care, worse health outcomes, and higher overall system costs. Within King County, neighborhoods with the highest concentrations of immigrants have the lowest life expectancies and the highest rates of chronic disease.

Methods: This Phase One proviso response builds on a recent report by Northwest Health Law Advocates (NoHLA), *County-Based Coverage for Adult Immigrants*. Staff from Public Health – Seattle & King County (PHSKC) reviewed that report and other relevant research; conducted informal interviews with key stakeholders; and collaborated with NoHLA and HealthierHere, the Accountable Community of Health for King County. NoHLA leveraged funding from the City of Seattle to engage a consulting firm, HealthTrends, to develop cost estimates for the five alternative policy options. The King County Office of Performance, Strategy and Budget reviewed these cost estimates and provided the analysis of revenue sources.

Buy-in options, legal and regulatory analysis: Through this research, we document that under current law it is not permissible to sponsor or buy-in individuals who are undocumented to existing federal, state, or local public health insurance programs. However, it would be feasible for King County to pay premiums and cost sharing for low-income undocumented residents for health insurance plans offered in the off-Exchange individual market. Alternatively, King County could follow the lead of other local governments in California and New York by establishing a more limited "coverage and access" program. Coverage and access programs contract with health care providers to deliver services to a designated group of low-income uninsured residents instead of using an insurance mechanism.

Coverage options and cost estimates: This report includes high-level descriptions and cost estimates for five coverage options that could be feasible for King County, depending on available funding. These range from premium assistance for comprehensive insurance to a partial benefit package that wraps around existing services to more narrowly defined programs that would increase access to specialty care, primary care and/or dental services.

Cost estimates assume eligibility for adults who are uninsured non-citizens and use lower and higher income eligibility options that align with other Washington public coverage programs. Approximately 50 percent of eligible participants are expected to enroll.

Coverage option	Lowest income only 10,000 enrollees (up to 138 percent of poverty)	Higher income eligibility 22,260 enrollees (up to 317 percent of poverty)
Comprehensive Insurance	$85 million	$181 million
Partial Benefit Wrap Around	$25 million	$61 million
Specialty Care	$7 million	$16 million
Primary Care	$3.5 million	$7 million
Dental Care	$2 million	$4 million

Revenue sources: Developing and implementing any of the options above would require identifying new sustainable revenue sources. Within the King County budget, the only flexible source of funds is the General Fund, over 80 percent of which consists of property and sales tax revenue. Funding a new program through the General Fund would require reductions in other programs currently budgeted or a voter-approved levy to raise new revenue for this purpose. Private funding, through philanthropy or health care provider contributions, is potentially feasible but difficult to predict and likely to be unsustainable.

Recommendation: We do not recommend proceeding with a Phase Two as described in the Proviso, which calls for the development of an evaluation plan and a road map for the full-scale implementation a Regional Health Plan. Instead, we recommend action steps that focus on laying the groundwork for a longer-term statewide solution while also providing modest immediate benefit to the focus population. These include identifying health access for undocumented individuals as a priority on the 2020 King County legislative agenda; studying the feasibility of re-opening the Washington State Health Insurance Pool (WSHIP); engaging the King County Immigrant and Refugee Commission; and enhancing outreach to connect more undocumented individuals to services for which they are currently eligible.

Section 1: Introduction

This is the Phase One response to the adopted King County 2019-2020 Biennial Budget Ordinance, Ordinance 18853, Section 95, Proviso P3 (see Appendix A for full text of the budget proviso). This report explores the feasibility of expanding access to health care for residents of King County who are uninsured, focusing on those who, due to their immigration status, are not eligible for coverage through existing public programs such as Medicare, Medicaid, or the Qualified Health Plans offered through the Washington Health Benefit Exchange. Phase Two of the proviso includes stakeholder coordination and developing an evaluation plan and an implementation road map due December 31, 2019.

Across the U.S., immigrants who do not have legal status too often struggle to obtain health care and end up delaying necessary care for themselves and their families. Barriers to primary care and prevention drive high-cost emergency department care, poor health outcomes, and wider health inequities.

At the federal level, anti-immigrant policies and ongoing efforts to undermine the Affordable Care Act (ACA) are deepening this problem. In the near term, progress on this front will be driven by actions taken at the state and local level. The King County Council has taken a significant step forward by requesting information on this important issue.

Local governments are responsible for protecting the health and safety of their communities. Counties, in particular, play a key role in providing emergency medical transportation, public health services, and care for uninsured residents. Following passage of the ACA, as the number of uninsured declined, federal and state funding for local governments to provide these duties has also fallen.[1] In Washington State and in King County, this fiscal challenge is exacerbated by the absence of a robust stable funding source for public health services.

This report explores how—if funding were available—King County could improve access to health care for adults who remain uninsured due to their immigration status. This research builds on a recent report by the Northwest Health Law Advocates (NoHLA), *County-Based Coverage for Adult Immigrants*, which documents efforts by county governments in California and other states to address this challenge.[2]

[1] Brief of Amici Curiae 35 Counties, Cities, and Towns and California State Association of Counties in Support of Intervenor Defendants-Appellants, State of Texas versus USA, No. 19-10011 in the U.S. Court of Appeals for the Fifth Circuit, April 2, 2019: 12, https://www.sccgov.org/sites/opa/newsroom/Documents/City%20and%20County%20amicus%20brief%20FILED_040219.pdf.

[2] NoHLA, *County-Based Health Coverage for Adult Immigrants: A Proposal for Counties in Washington State,* April 2018, https://nohla.org/index.php/2018/04/26/county-based-coverage-addresses-health-inequities.

Phase One requests and response

The Proviso requests that the Phase One response include six specific issues which are addressed in this report as follows:

Proviso request	Response
Request #1: Complete demographic analysis of the 2019 uninsured population (or the latest years of which data are available), disaggregated by age, gender, race, ethnicity, household poverty status, and city of residence.	Section 2 describes an estimated 52,000 people in King County who are uninsured non-citizens. National trends suggest that a significant portion of this group may be undocumented and therefore ineligible for public programs such as Medicaid, Medicare, and subsidized health insurance under the ACA. This is the focus population for this report. Demographic data in Section 2, Appendix C and D illustrate that the focus population is younger, lower income, more likely to be Hispanic, and more likely to live in south King County than the overall County population. Section 2 and Appendix F and G also describe the safety net system that this population relies on, including gaps in coverage and barriers to care that they face.
Request #2: Assessment of the legal and regulatory considerations of establishing a pilot program.	Section 4 and Appendix H review a range of "coverage and access" programs implemented by other local governments and illustrates why expanding health care access in King County through these approaches would be more challenging than it has been in other localities.
Request #3: Options for a "buy-in" or similar program to provide health coverage for low-income County residents.	Section 3 explores the feasibility of buying-in or sponsoring this population to participate in an already existing public or private health insurance plans.
Request #4: Potential eligibility requirements for the pilot program.	Section 5 and Appendix I and J describe five options for expanding access to care for the focus population with alternative eligibility criteria based on income. The options described include comprehensive insurance coverage, a partial benefit wrap, and more limited programs focus on specialty, primary or dental care.
Request #5: Financial analysis and funding options that should evaluate both existing and new revenue sources.	Section 5 and Appendix I and J include cost estimates for the five options. Costs range from $2 million per year to increase access to dental care to $181 million for comprehensive insurance. Section 6 explores existing and new revenue sources and concludes that there is not easily identifiable sustainable funding option.
Request #6: Recommendation on whether to proceed with Phase Two and what resources would be required for that work.	Section 7 recommends not to proceed with Phase Two, but instead to encourage a statewide solution, engage the King County Immigrant and Refugee Commission, study the feasibility of expanding the Washington State Health Insurance Pool (WSHIP), and enhance County capacity to connect people to services for which they are currently eligible.

Methods

To produce this report, Public Health – Seattle & King County (PHSKC) staff reviewed relevant literature and collaborated with NoHLA and HealthierHere, as specified by the proviso. No funding was allocated to PHSKC to prepare this response, thus research for this response did not include a formal community engagement process nor an in-depth landscape analysis to understand how the focus population currently accesses care.

Funding allocated by the Seattle City Council to NoHLA was used to support their participation and to engage the HealthTrends consulting firm to conduct the cost estimates of alternative coverage options. In addition, PHSKC staff conducted informal key informant interviews with safety net providers, payers, other counties, immigrant rights organizations, relevant County staff, State agency officials, and legal counsel.

To identify the focus population of individuals ineligible for public programs such as Medicare, Medicaid, or Qualified Health Plans, PHSKC's data and assessment staff used census bureau data on the number of adults in King County who respond not only as being uninsured but who also report their status as non-citizen in the American Community Survey.

Children are not included in this report because since 2007 Washington Apple Health (Medicaid) has covered children in low-income families regardless of immigration status.[3] In 2009, up to 15 percent of Hispanic children were uninsured in King County. By 2017, the percentage of Hispanic children who were uninsured had fallen to 4 percent. Only 2 percent of all children in King County were uninsured in 2017.[4] While the policy options outlined in this paper do not include eligibility for children, they could have a positive indirect impact which would further reduce the number of children who remain uninsured. Outreach efforts to enroll adults would start with checking eligibility for existing programs with a focus on the entire family. This outreach could well increase health coverage for children who are currently eligible for but not enrolled in Washington's Apple Health for Kids.

Equity and social justice

King County government is committed to equity and social justice for all residents; it affirms that we are a welcoming community for all, including those who come here from other countries in search of greater freedom and opportunity. The County does not deny access to public health services based on immigration status.[5] The King County Board of Health passed Resolution 18-01 in January 2018 in support of expanding coverage and lowering barriers for low-income residents, regardless of immigration status, who are unable to afford private insurance and unable to access Medicaid.[6]

The Council's interest in exploring the feasibility of expanding access to health care for this focus population is aligned with local government core values, as expressed in the King County Equity and Social Justice Ordinance and Strategic Plan.[7] The Immigrant and Refugee Commission is a new permanent body committed to integrating, strengthening, and valuing immigrant and refugee communities and upholding the County's commitment to be a welcoming community.[8] This new Commission began

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[3] Washington Apple Health, *Eligibility Overview: Washington Apple Health (Medicaid) Programs,* April 2019:5, https://www.hca.wa.gov/assets/free-or-low-cost/22-315.pdf.

[4] PHSKC, Community Health Indicators, "No health insurance, children, by race/ethnicity, 2008-2017," https://tableau.kingcounty.gov/t/Public/views/ACAenrollment/Trends?iframeSizedToWindow=true&Adult/Children=children&:embed=y&:display_count=no&:showAppBanner=false&:showVizHome=no.

[5] King County Equity and Social Justice Office, "Pledge to Building Inclusive Communities," https://www.kingcounty.gov/elected/executive/equity-social-justice/Immigrant-and-Refugee/Pledge-BuldingInclusiveCommunities.

[6] King County Board of Health, "Resolution 18-01 in Support of Full Access to Health Care," January 19, 2018, https://www.kingcounty.gov/depts/health/board-of-health/~/media/depts/health/board-of-health/documents/resolutions/BOH-resolution-18-01.

[7] King County, "Equity and Social Justice Strategic Plan, 2016-2022," www.kingcounty.gov/equity.

[8] King County Immigrant and Refugee Commission, https://www.kingcounty.gov/elected/executive/equity-social-justice/Immigrant-and-Refugee/Immigrant-Refugee-Commission.

meeting in October 2018 and will serve as a valuable advisor and liaison to improve access to health for immigrants.

As this proviso response illustrates, there is a compelling gap in access to care for the focus population and addressing this would be complex and costly. This information provides the Council with key baseline information to guide a path forward. By describing what is feasible, what is not, and the estimated costs of alternative approaches, this Phase One response sets the stage for further action at both the local and state levels.

Section 2: Demographic Analysis of Uninsured King County Population

After the implementation of the health coverage expansions of the Affordable Care Act (ACA), King County successfully reduced the percentage of the population that is uninsured by half. The rate dropped from 16 percent in 2013 to 8 percent in 2017 (see Appendix B).[9] Innovative outreach by all County departments and many community partners created a network of navigators at libraries, food banks, hospitals and other locations helped King County achieve these coverage expansions.

Today, almost half a million King County residents are covered by Washington Apple Health or the Washington Health Benefit Exchange, with 190,000 County residents qualifying through the ACA coverage expansions.

The focus population

Despite this progress in expanding coverage, up to 147,000 adults in King County remain uninsured as of 2017. Of this group, more than a third—approximately 52,000—are non-citizens (see Figure 1).[10] An unknown percentage of the 52,000 adults are undocumented and are therefore not eligible for public programs such as Medicaid, Medicare, and Qualified Health Plans (see Appendix E). This is the focus population for this report.

Nationally, about 60 percent of non-citizens are lawfully present in the U.S. This group includes green card holders, refugees, asylees, and other authorized residents. With some limitations, these individuals can qualify for public coverage programs.[11] A statewide study found that undocumented immigrants are 11 times more likely to be uninsured as U.S.-born Washington residents after controlling for demographic and socio-economic factors.[12]

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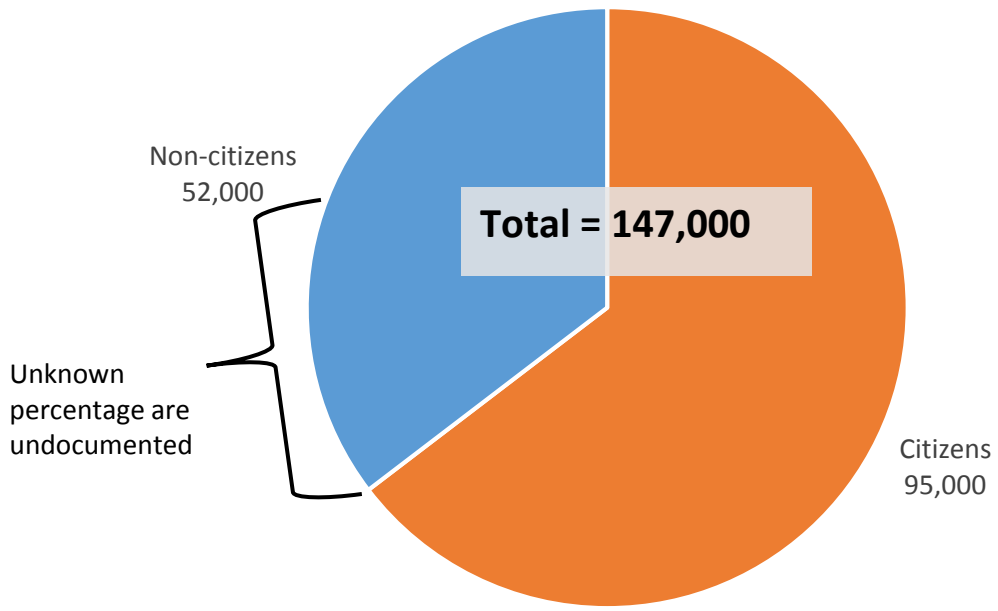
[9] King County Hospitals for a Healthier Community, *Community Health Needs Assessment 2018/2019,* 39.

[10] The number of uninsured non-citizen adults in King County is estimated to be between 50,700 and 52,000 depending on which data source is used. The 52,000 figure is the best estimate of the total number and the 50,700 figure is used when the group is divided into smaller demographic categories.

[11] Kaiser Family Foundation, "Health Coverage of Immigrants," February 15, 2019, https://www.kff.org/disparities-policy/fact-sheet/health-coverage-of-immigrants.

[12] Office of Financial Management, Washington State, "Health Coverage Disparities Associated with Immigration Status in Washington State's Non-elderly Adult Population: 2010-17," May 2019, https://www.ofm.wa.gov/washington-data-research/health-care.

Figure 1: Uninsured adults in King County by immigration status, 2017



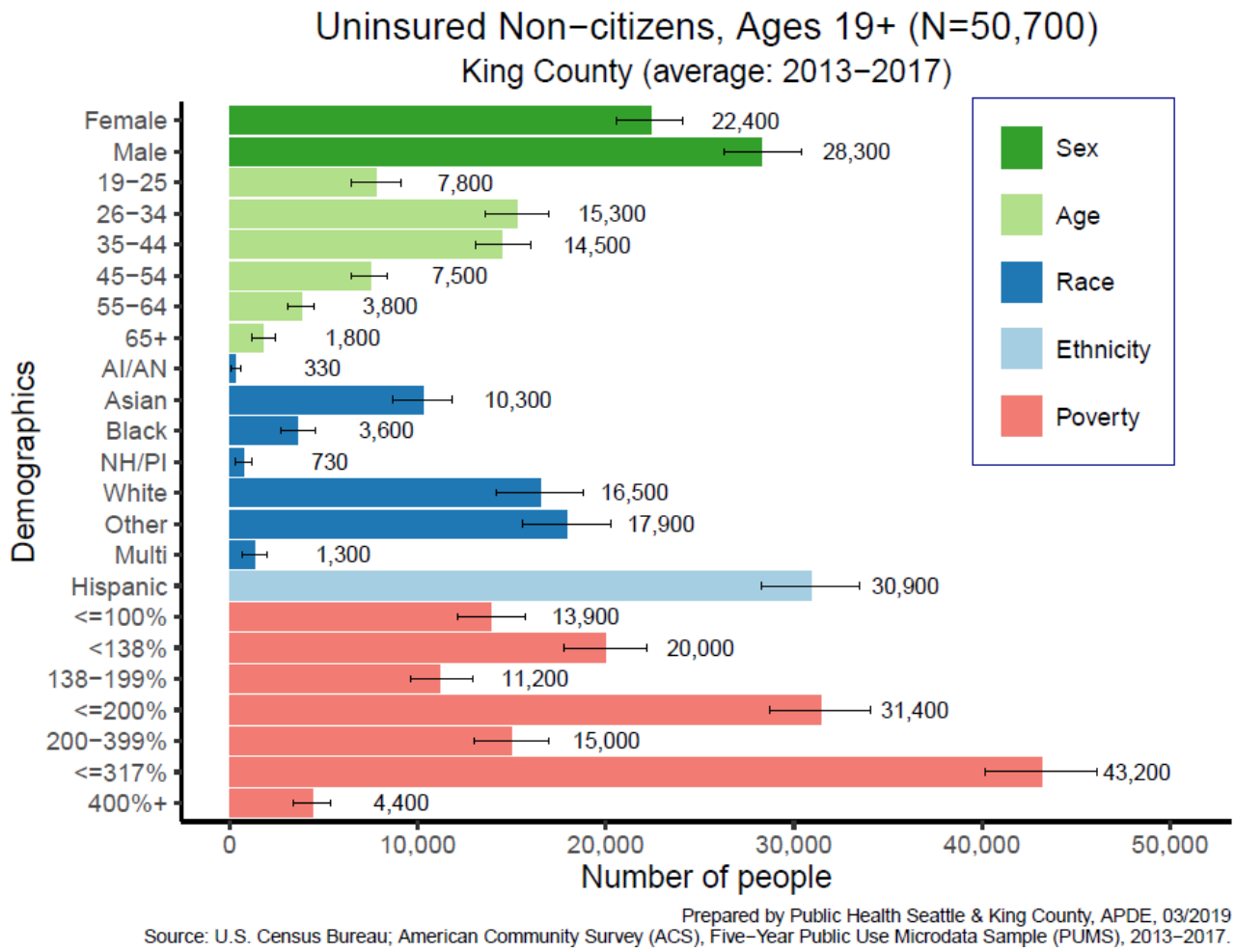
Source: U.S. Census Bureau, 2013-2017 American Community Survey 5-year Estimates, prepared by PHSKC, Assessment, Policy Development and Evaluation Unit, April 2019.

Uninsured non-citizen adults: The estimated 50,700 to 52,000 uninsured non-citizen adults are younger than the overall King County population; 74 percent are between ages 19 and 44. More than half (56 percent) are male. Uninsured non-citizens are more likely to be Asian (20 percent) and Hispanic (61 percent) than the overall population. See Figure 2 and Appendix C.

Income and employment: Almost two-thirds are low-income, with 62 percent having incomes less than 200 percent of the federal poverty level (FPL), about $25,000/year for one person and $42,700/year for a family of three.[13] Only 9 percent have incomes above 400 percent FPL, about $50,000 for one person or $85,000 for a family of three. Notably, the vast majority (92 percent) are employed (see Appendix C), but data are not available to indicate the percentage who have access to health insurance through their job, or if available, at what cost.

[13] U.S. Department of Health & Human Services, "HHS Poverty Guidelines for 2019," February 1, 2019, https://aspe.hhs.gov/poverty-guidelines.

Figure 2: Demographics of uninsured non-citizens, ages 19 and older, King County, 2013-2017 averages



Note: AI/AN=American Indian/Alaska Native, NH/PI=Native Hawaiian/Pacific Islander.

Geography: Like all uninsured adults, uninsured non-citizens are more likely to live in south King County. In Burien and Des Moines, more than 40 percent of non-citizens are uninsured versus less than 10 percent in higher income cities. See Appendix D for more information on the rate of uninsurance by King County region and city.

Health care services and coverage currently available to 52,000 uninsured non-citizen adults: In King County, the safety net system that low-income uninsured non-citizens rely on is a complex network of access points operated primarily by non-profit community-based providers, with a coordination and assurance role for physical health played by PHSKC, and for behavioral health, by the King County Department of Community and Human services.

Coverage for care provided in these settings is limited and dependent on complying with immigration and other documentation. Washington State funds some health programs that cover low-income undocumented immigrants for some health benefits, including for children, pregnant women, hospital emergency care, and limited cancer treatment and dialysis coverage. Uninsured adult non-citizens may access primary care at Federally Qualified Health Centers (FQHCs) with cost sharing, and are eligible for Apple Health for Pregnant Women, Family Planning Only (10 months of coverage after pregnancy), Alien Emergency Medical (AEM), and hospital charity care.

The types of services available to uninsured non-citizen adults and number of uninsured people who use these services are described in Appendix F and are summarized below.

Table 1: Summary of health care services and coverage currently available to uninsured adults in King County, 2016 and 2017

	Number of uninsured adults served	Estimated percentage of 147,000 uninsured adults served
Primary care	42,470	28.9%
Specialty care, Project Access NW	2,400	1.6%
Dental care	19,464	13.2%
Health Care for the Homeless	1,450	1.0%
Communicable disease	All are served	Not applicable
Pregnancy care	All are served	Not applicable
Breast, cervical and colon cancer	3,932	2.7%
Behavioral health	8,818	6.0%
Substance use disorder treatment	958	0.7%
Alien Emergency Medical specialized hospital care	251	0.2%
Charity care	Not available	Not available
Seattle/King County Clinic	1,757	1.2%

Note: Sources are from publicly reported data and timeframes in Appendix F and likely undercount the number of people served. An unknown number of uninsured County residents receive services from providers that do not report data to the local or state health departments.

Table 1 shows that safety net providers reach a relatively small portion of uninsured King County residents for services ranging from primary care to specialized hospital services. While several types of services are available to low-income residents in King County, it is evident that the system is not easily accessible to all uninsured people. In addition, the services and coverage are delivered within complex and fragmented systems. Due to significant coverage gaps, health care services for the uninsured are not user-friendly and do not provide individuals with the security of knowing that care will be there when they need it.

Health consequences

Non-citizens who cannot afford private insurance and who are not eligible for public programs avoid and delay needed care, and when necessary, struggle to access care through the complicated patchwork of access points and partial coverage options described above. Without coverage, many do not receive preventive services and routine primary care, which can lessen the need for later treatment. As a result, they go without needed acute and chronic care services and face later potentially avoidable

hospitalizations, poor health, and higher costs.[14] When uninsured people are sick or injured and obtain care, they risk their financial wellbeing and may end up with unaffordable medical debt.[15]

A broad body of research illustrates that even modest co-payments can deter low-income populations from accessing care.[16] Yet, it is routine and required for community health centers to request some level of co-pay based on a sliding scale. In addition to cost and lack of insurance, additional barriers identified in King County and consistent with the literature include long waits, difficulty obtaining an appointment when needed, distance from providers, lack of linguistically accessible care, and conflicts with work schedules.[17] See local data from HealthierHere and the Center for MultiCultural Health's documentation of access barriers for over 900 King County residents—including 9 percent who lack insurance—in Appendix G.

While some benefits and services are available to some uninsured non-citizen adults, many individuals still cannot easily and affordably secure health care services, as shown in Table 1 and Appendix G and amplified by our stakeholder interviews.

[14] Steven P. Wallace, Jacqueline Torres, Tabashir Sadegh-Nobari, Nadereh Pourat, E. Richard Brown, *Undocumented Immigrants and Health Care Reform,* UCLA Center for Health Policy Research, August 31, 2012, www.healthpolicy.ucla.edu.

[15] Amy Finkelstein, Sarah Taubman, Bill Wright, Mira Bernstein, Jonathan Gruber, Joseph P. Newhouse, Heidi Allen, Katherine Baicker and Oregon Health Study Group, "The Oregon Health Insurance Experiment: Evidence from the First Year," *The Quarterly Journal of Economics* 127, no. 3, (August 2012: 1089).

[16] Kaiser Family Foundation, "How Does Cost Affect Access to Care?" January 22, 2019, https://www.healthsystemtracker.org/chart-collection/cost-affect-access-care and Jonathan Gruber, *The Role of Consumer Copayments for Health Care: Lessons from the RAND Health Insurance Experiment and Beyond,* Kaiser Family Foundation, October 2006, 7, https://kaiserfamilyfoundation.files.wordpress.com/2013/01/7566.pdf.

[17] HealthierHere, "Consumer Voice Listening Project," and Healthy People 2020, "Access to Health Services," https://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services.

Section 3. Feasibility of Buy-Ins to Existing Coverage Plans

In this section, we review buy-in possibilities for low-income uninsured non-citizen adults and the feasibility of providing health coverage for the target population through existing health insurance programs. As this section illustrates, absent changes to federal and state law, it is not currently feasible to buy-in to any existing public or County-administered health insurance programs. The only feasible option for a comprehensive insurance buy-in is to purchase individual policy coverage outside of the Washington Health Benefit Exchange, as described below.

Medicare, Medicaid, and the Washington State Health Benefit Exchange

The federal rules described in Appendix E that bar undocumented individuals from eligibility for these programs would also prohibit a state or local government entity from sponsoring undocumented individuals to participate. For the Exchange, this is true for all qualified health plans available through Washington Healthplanfinder, including currently offered plans and the new standard plans and State-procured Cascade Care/public option plans that will be available starting Nov 1, 2020 for 2021 coverage. One mechanism to sponsor people into these programs would be to create a state-only-funded "look-alike" program that does not mix federal and state funds, as Washington State does with children and pregnant women and which it has done in the past through the Basic Health Plan (BHP).

Washington Basic Health Plan history

From 1987 through 2013, the Washington BHP offered state-subsidized health coverage to low-income Washington residents regardless of immigration status, with sliding scale premiums and a basic set of benefits. A state-sponsored program first created as a pilot project in 1987 and expanded in 1993, the BHP offered a limited set of health benefits with premium sharing that could be sponsored by third parties. The sponsorship program allowed non-profit organizations and tribes to pay an enrollee's monthly premium and cost sharing so that the BHP would impose no cost to the enrollee. Enrollment was capped in alignment with state appropriations and it reached an enrollment of 220,000 in 1996. The State downsized the BHP after the 2008 recession. Only 65,000 were enrolled in 2010 and there was a waiting list of 6,600. In that year, an estimated 876,000 Washington residents were uninsured. The State ended the BHP program when the ACA was passed, and with the ACA's Medicaid expansion, many former BHP enrollees received coverage, but undocumented enrollees lost coverage.[18]

King County employee health coverage

Under current regulatory structures, King County could not buy-in or sponsor the focus population into the health plan for King County employees. King County operates a state-approved self-insured local government employee health benefit program. According to Revised Code of Washington (RCW) 48.62, the local government self-insurance statute, it is not possible to add non-employees to the County employee health plan.[19]

Washington State Health Insurance Pool

The Washington State Health Insurance Pool (WSHIP) —also known as the high-risk pool—has two programs: one providing full-scope insurance for high-risk individuals and the other providing supplemental coverage for Medicare enrollees who have been denied such coverage by commercial insurers. WSHIP is currently closed to new enrollment for non-Medicare enrollees. Approximately 300 such people are currently enrolled, with 61 percent of enrollees sponsored either by the Evergreen Health Insurance

[18] Cody Preston, "Basic Health Plan," Council of State Governments, 2012, https://www.csg.org/policy/documents/WAStateBasicHealth.
[19] Washington Department of Business Enterprises, Local Government and Non-profit self-insurance program, https://des.wa.gov/services/risk-management/local-government-self-insurance.

program for people living with HIV/AIDS or the American Kidney Foundation primarily for those on dialysis. A change in state law would be needed to re-open WSHIP for full-scope health coverage and the premiums may be prohibitively expensive as they reflect a high-risk pool. The non-Medicare WSHIP program incurs about $7,000 per member per month in health care costs now.[20] Because undocumented individuals are generally younger and healthier than the individuals currently in the WSHIP, monthly per member per month costs would likely be lower and could be in line with the full-scope coverage option described in Section 5.

Off-Exchange individual and group coverage

One possible way to buy uninsured non-citizens into coverage is through the commercial insurance market outside of the federally subsidized Washington Health Benefit Exchange. Kaiser Permanente is the only health plan offering off-Exchange individual coverage in King County. It appears that King County could purchase individual policies on behalf of low-income uninsured undocumented adults, however more legal analysis related to both feasibility and implementation factors would be required in a possible Phase Two of this proviso if this option (described as Option 1 in Section 5) were to be pursued.

[20] WSHIP, *2018 Annual Report,* May 2019, pages 9 and 15, https://www.wship.org.

Section 4. How Other Jurisdictions are Expanding Access

This report builds on research published by NoHLA in April 2018 in *County-Based Coverage for Adult Immigrants,* which explored how county governments across the country are addressing the challenge of assuring health care for all residents. The NoHLA report profiled six county-based health programs in California, Maryland, Nevada, and New York for non-citizen low-income immigrants.[21] These are summarized in Table 2 below and detailed in Appendix H along with similar information about a New York City program, NYC Care, which will launch in summer 2019. Exploring how these counties approached this access issue offers important information and lessons learned for King County's consideration.

Table 2: Overview of selected county-based health coverage programs for adult immigrants

County-based program	Estimated number of enrollees	Benefits
Healthy San Francisco	14,200	Comprehensive, within a defined network of public and non-profit providers and facilities
My Health LA	137,200	Primary care, specialty, limited hospital within a defined network of county-operated facilities and 213 non-profit clinics
Contra Costa Cares	Capped at 4,100 out of 19,000 eligible	Primary care within a defined network of seven sites
Montgomery Cares, Maryland	25,530	Primary care, behavioral health, limited specialty, and dental
Nevada Medical Discount Program[22]	12,000	Comprehensive coverage through a network of participating providers paid discounted rates directly by enrollees
Action Health NYC	1,300 pilot	Comprehensive within a defined network of publicly owned facilities and non-profit clinics
NYC Care[23]	600,000 eligible, starting in the Bronx in 2019	Comprehensive within a defined network of publicly owned facilities

Sources: NoHLA, *County-Based Regional Health Coverage for Adult Immigrants* and personal communication with NYC Care staff, 3/27/19.

A small number of local jurisdictions in other states have created a health insurance plan for uninsured residents and a larger number have directly funded safety net health care providers through "coverage and access" programs. Coverage and access programs fund services through an extensive network of publicly owned and non-profit safety net providers. In most cases, the county or city operates many of the primary care clinics and public hospitals that receive funding to provide services to undocumented low-income adults.

[21] NoHLA, County-Based Health Coverage, 8-23.
[22] Pauline Bartolone, "Medical Discount Plan in Nevada Skips Insurers," *NPR*, August 13, 2013, https://www.npr.org/sections/health-shots/2013/08/13/211643763/medical-discount-plan-in-nevada-skips-insurers.
[23] New York City, "Mayor de Blasio Announces Plan to Guarantee Health Care for all New Yorkers," January 8, 2019, https://www1.nyc.gov/office-of-the-mayor/news/017-19/mayor-de-blasio-plan-guarantee-health-care-all-new-yorkers#/0.

Some of the programs did not require legislation and were implemented through budget transfers to public providers and in some cases to non-profit safety net providers. In King County, implementation would likely be more complex because local government does not directly own and operate the bulk of the safety net system. PHSKC runs 4 out of the 43 community health centers in King County and sees fewer than 5 percent of all patients seen at community health centers (11,343 patients out of 231,575 in 2017). Also important, King County does not operate public hospitals.

In California and other states, some counties use state provider tax or motor vehicle excise tax (MVET) revenue dedicated to addressing the needs of the uninsured. These options are not currently available here and King County primarily funds services for the uninsured through federal sources and flexible County General Fund dollars.[24] See Section 6 for more local revenue information.

Two key conditions distinguish the landscape that these counties are operating in from the one in King County. Unlike major metropolitan areas such as New York, Los Angeles and San Francisco:

1.) King County does not have a dedicated funding source for this purpose, although it could allocate funding after deciding to implement a program. With the repeal of the MVET in 1999 and the diversion of later MVET taxes from public health, unlike California counties, this revenue source is not a current option. In 2019, a new state tax on vaping products will support population-based public health activities, but it is not intended for medical care spending. The California counties and New York City also receive tax revenues from health care providers and other sources, such as state and city income taxes.

2.) King County does not own and operate the majority of the safety net system. San Francisco, Los Angeles, and New York operate a network of clinics and hospitals, unlike the system in King County, which is primarily run by non-profit entities. While New York and California cities could expand access to non-citizens through a budget mechanism that increases funding for health care providers employed by the county or city, this option is more limited in King County. In California and New York, the public system has financial incentives to prevent avoidable health conditions treated in their hospitals by increasing access to primary care and preventive services. In King County, these savings would accrue to Medicaid managed care plans or to hospitals.

Notably, none of the profiled counties chose to buy commercially available or publicly sponsored health insurance for this population. These decisions reflect the host of legal and regulatory barriers described in the previous section and Appendix E. Almost none of the counties established a plan with full-scope coverage through a wide network of private health care providers, comparable to Medicaid or an individual private health plan, which is likely due to high costs. Healthy San Francisco comes the closest to offering a broad network of providers and comprehensive benefits.

While counties and regions innovate, recent developments suggests that efforts to expand coverage to undocumented individuals may shift to state level-solutions. For example, a budget agreement in California, not yet finalized as this report goes to print, would expand Medicaid equivalent coverage to low-income, undocumented adults between the ages of 19 and 25. This proposal is projected to cover 90,000 individuals at a cost of $98 million per year.[25]

[24] Health Resources & Services Administration, "What is a Health Center?" https://bphc.hsa.gov/about/what-is-a-health-center.
[25] Adam Beam, "California lawmakers agree to health benefits for immigrants," Associated Press in the *Seattle Times*, June 9, 2019, https://www.seattletimes.com/seattle-news/health/california-lawmakers-agree-to-health-benefits-for-immigrants.

Section 5. Coverage Options for King County

This section provides analysis of five coverage options to expand health care access for King County residents who are uninsured low-income non-citizen adults. Unlike most of the buy-in options described in Section 3, these options are potentially feasible within current federal and state legal and regulatory frameworks, although the first option may require more legal review if it is chosen. These options include:

1. Comprehensive insurance;
2. Partial benefits wrap around (which creates full scope coverage when combined with existing coverage);
3. Specialty care;
4. Primary care; and
5. Dental care.

We selected and evaluated five options for expanding coverage to low-income uninsured non-citizen adults to offer a range of costs and benefits. The first is the most comprehensive option, covering full scope benefits through an insurance product offered in the individual or group markets that includes all ACA essential benefits. This option is projected to cost $85 to $181 million per year to cover either 10,000 adults with incomes less than 138 percent of poverty or 22,260 adults with incomes up to 317 percent of poverty—or about half the number of uninsured non-citizen adults at those income levels in King County. We use a low estimate of enrollment for all five options (48 percent of eligible) to account for the increasing reluctance of many low-income non-citizens to engage in government programs because of public charge, detention and deportation fears.

Four less costly options would not use an insurance mechanism; instead, they would fund services through provider contracts. A partial benefit wrap around is estimated to cost between $25 million and $61 million per year, would fund services currently not available to the focus population and would expand primary care services. As above, the low end of the cost estimate would cover about 10,000 adults with incomes under 138 percent of poverty and the high end would cover about 22,260 adults earning less than 317 percent of poverty. More narrow options would cover specialty services only ($7 million to $16 million), primary care only ($3.5 million to $7 million), or dental care only ($2 million to $4 million). Detail on the fiscal analysis and methods is in Appendix I and Appendix J.

Table 3: Policy options for King County and estimated annual costs

Option	Definition	Cost estimate/year up to 138% and up to 317% FPL
Comprehensive insurance	Comprehensive insurance coverage equivalent to Medicaid or a Qualified Health Plan that covers a full range of essential benefits, offered by a private health plan, such as Kaiser Permanente of Washington.	$65 million to $181 million
Partial benefit wrap around (full scope)	Access to a range of benefits that is less than the full range of essential benefits and does not include coverage for benefits to which the target population already has access. Implemented by contracting with health care providers to expand access to low-income uninsured non-citizen adults. Not offered through an insurance product. When combined with existing services, this option would provide close to a comprehensive benefits.	$25 million to $61 million

Option	Definition	Cost estimate/year up to 138% and up to 317% FPL
Specialty Care	All non-primary care events in an office setting, such as gastroenterology, gynecology, otolaryngology, cardiology, ophthalmology, radiology, and neurology. Implemented by contracting with specialty health care providers to expand access.	$7 million to $16 million
Primary Care	General practice, family practice, and internal medicine primary care and behavioral health delivered in an office setting. Implemented by contracting with health care providers and/or by expanding public health centers.	$3.5 million to $7 million
Dental Care	Dental visits. Implemented by contracting with health care providers and/or by expanding dental services at public health centers.	$2 million to $4 million

Income Eligibility Assumptions

The population demographic and financial analyses use the following income eligibility categories based on a percentage of the federal poverty level (FPL):

- Below 138 percent FPL
- 138 to 199 percent FPL
- 200 to 317 percent FPL

Zero to 138 percent FPL is the income cut-off for Apple Health for Adult (Medicaid) coverage. Apple Health for Pregnant Women provides coverage for those earning below 198 percent of poverty. Apple Health for Children is available with no premium for families earning up to 200 percent FPL and with a premium between 200 and 317 percent. The Exchange offers subsidized coverage for individuals and families up to 250 percent FPL for cost sharing, and tax credits are available for those earning up to 400 percent of FPL. All financial analyses in this report use two income cut-offs—138 percent and 317 percent of poverty—in order to align with state programs.

In the five options, it is assumed that many currently available services and coverage will continue, such as Apple Health for Pregnant Women and charity care at hospitals for those earning less than 200 percent FPL. All five options include a 13 percent administration factor to cover routine administrative costs, outreach, enhanced language access, and care coordination for that option. This figure is an estimate and could vary based on the details of a specific plan and the extent to which specialized services, such as outreach and enrollment, are needed.

Cost estimation methods

All cost estimates were completed by HealthTrends, a Shoreline, Washington health care consulting company, under contract to NoHLA. HealthTrends developed the cost estimates in the April 2018 NoHLA report on County-based health coverage for adult immigrants, as well. For this proviso response, HealthTrends conducted an age, gender, demographic, employment status, and income-weighted analysis to derive cost estimates and benchmarked these with other sources of health care cost information. Their analysis used a three-year pool (2014-2016) of Medical Expenditure Panel Survey (MEPS) data, a national set of data from individuals, medical providers and employers across the U.S. collected by the Agency for

Healthcare Research and Quality. HealthTrends describes strengths and limitations of MEPS data.[26] The Assessment, Policy Development and Evaluation unit of PHSKC provided the population estimates used in the cost analysis.

Option 1. Comprehensive insurance – The most comprehensive and expensive option for expanding access to care for the focus population would be to pay for a full scope benefits insurance coverage offered by an existing health plan, with benefits similar to Medicaid or a Qualified Health Plans, likely through Kaiser Permanente of Washington, the only off-Exchange individual market offering in King County.

King County could purchase individual coverage for a designated number of low-income uninsured people based on the budget allocated for this purpose. This option would require additional legal review to ensure compliance with Washington State Office of the Insurance Commissioner laws. In this option, the County could be paying for some services that are already covered under existing Medicaid programs, such as Apple Health for Pregnant Women, and for services currently provided to some low-income individuals not eligible for Medicaid, such as through hospital charity care programs.

This option would cover all services deemed "essential health benefits." Essential health benefits include doctor visits and hospital stays; trips to the emergency room; care before and after a baby is born; mental health and substance use disorder treatment services; prescription drugs; services and devices to help recover after injury or to help with a disability or chronic condition; lab tests; preventive services, including counseling and screenings and vaccination; management of a chronic disease; and pediatric care.[27] Other ACA requirements would need to be researched. Protected health information (PHI) for enrollees would be held confidential by the health plan as required by the Health Insurance Portability and Accountability Act (HIPAA).

Comprehensive health coverage for 10,000 to 22,260 people per year is estimated to cost $85 million to $181 million depending on whether enrollees have incomes up to 138 percent or 317 percent of poverty. The per member per month (PMPM) cost is estimated to be $677. The cost estimate includes an expected 9 percent administrative cost plus 4 percent for enhanced language access and care coordination. These cost estimates are in line with local benchmark costs such as Kaiser Permanente monthly premiums of $247 (age 19) to $789 (ages 64 and over) and Medicaid per enrollee expenditure is $668 per month.[28]

Option 2. Partial benefits that wrap around currently available services – To avoid duplication of services already covered, King County could design and implement a partial benefit wrap option, similar in mechanism to the county "coverage and access" programs in California and New York. This option would not be an insured product and as such would not cover all of the essential benefits required by the ACA. Instead, in this option—and all following options which cover specific components of this option—the County would contract to directly pay health care providers to provide health services currently not widely available to low-income uninsured non-citizen adults. The combination of already-covered services and the complementary wraparound would together offer comprehensive coverage.

This option would "wrap around" current services and coverage for low-income uninsured non-citizens. Many implementation issues would have to be resolved in later work should this option be chosen,

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[26] MEPS description and notes from HealthTrends: "MEPS is highly regarded by the research community as a statistically robust data set, and the two-part model incorporated in developing the specific models within this analysis is recommended for applied health econometric analysis given its merits in addressing common pitfalls in analyzing health care expenditures and utilization (e.g. large zero mass, heavy right skew). However, despite attempts to control for several socio-demographic information available and employing many recommended statistical techniques, the estimates cannot account for omitted variables such as health status, institutional differences, regional market characteristics, or changing health care utilization patterns, among others. There are also limitations to identifying suitable available benchmarks for the partial benefit wrap services given the unique service and eligibility carve-outs, including Alien Emergency Medical, Apple Health for Pregnant Women and hospital charity care for patients earning less than 200 percent FPL."

[27] Washington Health Benefit Exchange, "Essential health benefits," August 27, 2015, https://www.wahbexchange.org/glossary/essential-health-benefits.

[28] Office of the Insurance Commissioner, Kaiser Foundation Health Plan of Washington Rate Schedule, 2019:3, https://www.insurance.wa.gov/sites/default/files/2018-09/kaiser-wa-2019-plans-premiums.pdf and

including how to protect PHI in accordance with HIPAA. We would expect to build on the County's and the contracted health care providers' current HIPAA compliance procedures.

Services covered in this option include: primary care (to increase access that currently often entails long waits and co-payments), behavioral health, specialty, hospital outpatient, emergency room and inpatient (to the extent that hospital charity care is not available), limited home health related to acute conditions, and other medical services—such as supplies, prescription drugs, lab, diagnostic, and dental care. See Appendix J for the costs estimates of each of these services.

The services covered in this option would alleviate many current barriers to care. For example, the HealthierHere and Center for MultiCultural Health Community Voice Listening Project results in Appendix G showed that 60 percent of respondents had a hard time paying for prescription drugs. This option assumes that Alien Emergency Medical (AEM), Apple Health for Pregnant Women, and charity care for patients with incomes less than 200 percent of poverty will continue.

The costs of this option is estimated at $25 million to $61 million per year based on a per member per month cost estimate of $227 and the same number of enrollees (10,000 or 22,260) as above. This option includes a 13 percent administrative, outreach, enhanced language access, and care coordination factor, as well. This option and the next three would leverage existing systems to fill important coverage gaps.

Option 3. Specialty care – King County could focus on expanding specialty care only, a key care gap for the focus population. While there is some level of access today in King County for primary and hospital-based care, there is no system-wide safety net for specialty care services.

Specialty care means all non-primary care events in an office setting, such as gastroenterology, gynecology, otolaryngology, cardiology, ophthalmology, radiology, and neurology. Specialty care could be covered through a defined benefit of up to a specific dollar amount per year or could be implemented through a substantial expansion of the existing specialty access program in King County, Project Access Northwest.

Specialists voluntarily contribute time and services to Project Access Northwest now, but it is not known whether they may do so to the degree needed for an expansion of this size. Project Access Northwest also provides care coordination and logistics support to enrollees, which similarly would need to be factored into the expansion plans. Care coordination is an important part of the spectrum of services offered by Project Access Northwest and it results in a less than 5 percent no-show rate at appointments. Alternatively, the County could contract directly for services with specialty providers and provide or contract for care coordination.

Specialty care for 10,000 adults earning up to 138 percent of poverty is expected to cost $7 million per year and for 22,260 adults earning up to 317 percent of poverty is expected to cost $16 million per year, based on a PMPM of $58 for health care services, administration, outreach, enhanced language access, and care coordination.

There are population health shortcomings to providing access to specialty care only. Without a primary care provider or other health care services, the need for specialty care may not be identified or the problems that could be adequately addressed may go unaddressed and require the care of a specialist, e.g., uncontrolled diabetes for lack of primary care access results in vision or kidney problems, requiring the care of a specialist.

Option 4. Primary care – Primary care refers to services delivered by general practice, family practice, and internal medicine providers in an office setting and includes behavioral health in a primary care setting. This option also includes outreach, enhanced language access, and care coordination. While 29 percent of uninsured King County adults now obtain primary care services from FQHCs, our stakeholder input and the HealthierHere and Center for MultiCultural Health's Community Voice Listening Project results indicate that barriers to primary care access persist. Co-pays, even those that are modest and based on a sliding

scale, are a key barrier, as are wait times and the difficulty of schedule an appointment without missing work. Still others face language barriers.

Primary care is largely underfunded in the U.S. compared to other countries. Other countries spend less on health care services and have better health outcomes than the U.S., and they also invest more in primary care. They spend about 20 percent of health care dollars on primary care while the U.S. spends 7 percent. Researchers have shown that robust access to primary care is associated with lower per capita health costs, better health, and fewer health disparities.[29] In King County, access to primary care providers is associated with ethnicity. While 77 percent of White and 75 percent of Black adults have a regular primary care provider, only 57 percent of Hispanic adults do.[30]

This option would increase the level of resources available to the primary care safety net which would help prevent avoidable complications and late treatment of health conditions. Enhanced primary care services also tend to increase population-wide delivery of preventive services like immunizations, which have benefits for everyone.

Expanded primary care is expected to cost between $3.5 million and $7 million per year, with a PMPM of $27. This option would be more straightforward than others for PHSKC to implement since it already has contracts with FQHCs and could increase current per visit rates to include an add-on for enhanced language access and care coordination.

Option 5. Dental care – Dental care means full- or partial-coverage for dental services. The great demand for dental care at the annual Seattle/King County Clinic and at Project Access Northwest are two measures of the barriers to dental access faced by many King County residents. The King County Hospitals for a Healthier Community needs assessment from 2018 and 2019 shows that while 26 percent of White adults did not see a dentist in the prior year, almost twice the percentage of Hispanic (43 percent), Native American (46 percent) and Black (49 percent) adults did not. Untreated dental conditions can lead to preventable health problems as well.

A dental-only option is expected to cost $2 million to $4 million per year, with a PMPM of $16. Similar to the primary care option, PHSKC has contracts in place with FQHC dental providers and the logistics could be relatively straightforward to enhance access for adults at these providers.

Summary

This section illustrates a broad range of approaches, from full-scope comprehensive coverage to less costly options, like wrap-around coverage to fill gaps or focusing funding to bolster specialty, primary, or dental care. Any of these options could be fully scaled to cover the entire focus population earning up to 317 percent of the poverty level, or they could be more narrowly targeted to cover lower income individuals with incomes up to 138 percent of poverty. It is the role of policy makers to weigh the benefits and costs associated with these approaches and consider what is viable based on available funding.

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[29] Allan H. Horoll, "Does Primary Care Add Sufficient Value to Deserve Better Funding?" *JAMA Internal Medicine* 179, no. 3, January 28, 2019:372-373, https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2721034.

[30] PHSKC, Community Health Indicators, "Adults without a Usual Primary Care Provider, King County, 2000 to 2015," January 2018, https://tableau.kingcounty.gov/t/Public/views/BRFSS-multipleindicators/Trends?:embed=y&shortname=Primary%20care%20provider&:display_count=no&:showVizHome=no

Section 6. Evaluation of Existing and New Revenue Sources

This section analyzes funding options to expand access to care for the focus population, including both existing and new revenue sources.

As detailed in the 2019-2020 Biennial Budget Executive Summary, King County has access to many different revenue streams to pay for services; however, state law and the King County Charter restrict the use of many revenues.[31] For example, revenues collected from solid waste disposal charges must be used for solid waste programs and cannot be diverted to other purposes. The only truly flexible source of funds is the General Fund, which is also the major source of funding for Public Health. The analysis below evaluates the feasibility of tapping these two existing funds and the potential for developing new revenue sources.

General Fund: No major new investment could be funded through the General Fund without cuts to existing programs. After deducting contract revenues and reimbursements for services provided to other County agencies and other governments, over 80 percent of the General Fund consists of property and sales tax revenue. These funds are already fully allocated. In addition, existing laws limit the County's ability to increase either of these revenue sources to reflect growing needs or to implement new programs, resulting in a structural deficit.

Since 2001, State law has limited revenue growth in most property taxes, including County General Funds, to 1 percent per year. In addition, the value of new construction is added to the tax base and represents only between about 0.5 percent and 2 percent additional growth, depending on economic conditions. This limited growth has substantially lagged below inflation and population growth.

Sales tax revenue is also not keeping pace. Despite strong overall economic growth, sales taxes are not as productive a revenue tool as they were in the past, driven largely by changing spending trends. Additionally, the split of sales tax revenue between cities and counties is a challenge for King County because 97 percent of the sales tax is collected in cities. If a sale occurs in the unincorporated area, the County receives the entire 1 percent local sales tax. If a sale occurs within a city, the County receives only 0.15 percent, and the city receives the remaining 0.85 percent. As urban areas incorporated or were annexed to cities per the State Growth Management Act, by 2017 only 3.3 percent of taxable retail sales occurred in the unincorporated area, far lower than other urban counties in the State.

Public Health Fund: PHSKC does not have existing resources that could be dedicated for this purpose. Current funding for public health includes restricted funds such as federal, state, and private grants dedicated to a specific purpose and limited General Fund dollars. Previously, Public Health received stable funding derived from the required contributions from all 39 cities in the County (mandate eliminated in 1993) and State Motor Vehicle Excise Tax (MVET) from the State (eliminated in 1999). While limited funding from the State and from the City of Seattle continues, it is not keeping pace with inflation and growing needs.

A recent assessment identified a $225 million per year gap in 2018 statewide funding for public health versus the estimated actual cost of providing foundational public health services defined a core public health functions necessary to comport with federal and state mandates.[32] The gap in King County was at least $25 million in 2018. The State legislature has responded with small investments towards addressing

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[31] King County, *2019-2020 Biennial Budget Executive Summary,* September 2018: 18, https://www.kingcounty.gov/~/media/depts/executive/performance-strategy-budget/budget/2019-2020/19-20_Budget-Book/19-20_Biennial_Budget_Executive_Summary.ashx?la=en.

[32] Washington State Department of Health, *Washington State Public Health Transformation Assessment Report for State and Local Public Agencies*, September 2018, https://bit.ly/2WTt6Tg.

this gap in the past two legislative sessions.[33] Despite this incremental progress, there continues to be a public health funding crisis in our state, which precludes local health jurisdictions from having the flexibility to expand many types of needed and necessary services.

Property tax levy: Beyond the General Fund, the County could consider a levy lid lift to exceed the 1 percent growth limit for property tax revenues. Doing so would involve a ballot measure for County voters and typically last six years, however, the County could propose a permanent lid lift for this purpose.[34] Existing levy lid lifts, such as the Veterans, Seniors, and Human Services levy, are also potential revenue sources; however, implementation plans have already allocated funding, meaning use of such an existing levy lid lift would either risk reducing expenditures already committed to various community organizations or use reserves, potentially running counter to Council-adopted policies on fund reserve management.

Contributions from the private sector: Other revenue options involve partnerships with other entities and institutions. For example, funding for this program could involve health care systems' and providers' support through community benefit programs or other arrangements, or philanthropic organizations, but availability of funding from these or similar sources typically only extends to pilot programs after which government resources are expected to provide ongoing support. As noted above, such ongoing resources are not presently available. In other regions, health care expansion programs have leveraged taxes or contributions from employers, hospitals, or health care providers. The County partnership with the University of Washington and Harborview Medical Center is structured differently from how public health care is financed in other regions cited in the NoHLA report—namely San Francisco and Los Angeles.

Sugary beverage tax: Until recently, another option in Washington was a sugar sweetened beverage tax such as the one imposed in 2018 by Seattle. The City of Seattle sugary beverage tax funds healthy eating promotion and education programs, along with the city general fund.[35] The November 2018 election included Initiative 1634, which passed and prevented any further such tax in the State.

Summary

This section documents the fiscal challenge of funding a County-based program to expand access for the focus population. As illustrated, it is not viable to tap the existing property or sales tax revenues held in the General Fund or the Public Health fund. Developing new revenue sources would require a voter-approved levy specifically for this purpose, reductions in essential public health services, or be contingent on private sources of funding which may or may not be sustainable over time.

[33] Washington State Association of Counties, "Hits and Misses for Local Public Health Funding," April 29, 2019, https://wsac.org/hits-and-misses-for-local-public-health-funding.

[34] RCW 84.55.050.

[35] Seattle Times, "Seattle's Soda-tax Collections Top $16 Million in 9 Months," December 20, 2018, https://www.seattletimes.com/seattle-news/politics/seattles-soda-tax-collections-top-16-million-in-9-months-surpass-first-year-estimate.

Section 7. Recommendations on Phase Two and Requested Resources

While 93 percent of King County adults have health care coverage, significantly, 7 percent do not, including 19 percent of non-citizen adults. This report focused on the 52,000 uninsured non-citizens in the County, a significant portion of whom are likely ineligible for affordable public coverage programs due to their immigration status. Using King County's "fair and just" principle, there is an equity and social justice concern about access to health care for this group of County residents.

In accordance with the County's commitment to equity and social justice, action to address the needs of this population is essential; the question is what mechanism to use and how to fund it. At this time, we do not recommend proceeding with Phase Two, as described in the proviso language. As outlined below, the action steps requested in Phase Two are not feasible within the prescribed timeline and would not be meaningful, absent the identification of a sustainable funding source. Rather, we recommend action steps which focus on laying the groundwork for a longer-term, statewide solution while also providing modest immediate benefits to the focus population.

Phase Two as described in the budget proviso

As indicated in the proviso language, Phase Two would require the County, in coordination with all Federally Qualified Health Centers (FQHCs) in the County and other health care providers that offer health care services the uninsured, to develop the following by December 31, 2019:

1.) An evaluation plan, which would include:
    a. An assessment of usage of a pilot program;
    b. Measurement of health outcomes of those benefiting from a pilot program;
    c. A cost-benefit analysis comparing the overall cost of a pilot program and savings to the overall health care system as a result of a pilot program; and
    d. An estimate of the annual cost of operating a full-scale regional health plan for the County and the annual savings to the overall health care system as a result of a County regional health plan.
2.) An implementation road map, which would include:
    a. A timeline for implementing a pilot program;
    b. A timeline for evaluating a pilot program; and
    c. A timeline of when a full-scale implementation may be implemented, should a pilot program confirm the feasibility of a regional health plan for the County.

For numerous reasons, developing these plans absent the identification of a sustainable funding source to fund the pilot program and within a six-month period is not feasible in our assessment.

Prior to developing an evaluation plan, it would be necessary to develop a full blueprint for the establishment and operational implementation of a pilot program. This would require a stakeholder and community engagement process to define the scope and structure of the pilot program, choosing from the policy options outlined in this paper, or identifying an alternative.

Once this blueprint or policy framework was defined, program planning would require extensive legal and actuarial analysis, with the cost and duration of this analysis and planning dependent on the scope of the policy framework.

Similarly, developing an implementation road map and timeline for implementing a pilot and full-scale program would not be feasible without the detailed scoping of a blueprint mentioned previously, and would not be meaningful absent a decision to include funding for such a program in the next biennial budget.

Recommended next steps

Rather than proceed with Phase Two, we recommend the following four action steps for the July–December 2019 period. These actions focus on building momentum for longer-term change while providing modest short-term assistance to improve access to health care for the focus population. They include two no-cost recommendations which County staff are prepared to implement within existing resources and two low-cost action steps which could be carried out at Council's direction if funding is made available.

1. Encourage a statewide solution

We recommend that County leaders partner with State officials to identify viable options to address this statewide challenge with a statewide solution.

Health care access for undocumented non-citizens is a statewide challenge that requires a statewide solution. At the federal level, the current administration is deepening this crisis, through a series of policy changes that undermine immigrant rights and deter people from accessing public benefits. In this atmosphere, it is critical that we partner with State officials.

Policymakers are actively exploring policy solutions to ensure health security for all, regardless of citizenship status. Several bills were debated in the 2019 legislative session. For example, a bill to expand Apple Health to include all youth and young adults, including undocumented, up to age 26 was introduced but failed to pass. Language was included in the budget to expand access to the Take Charge family planning services for all individuals, regardless of citizenship, earning up to 260 percent of poverty. Finally, the 2019 legislature established a Universal Coverage workgroup, a cross-sector stakeholder group that will consider options for achieving universal health coverage for all.

To pursue a continued, robust effort at the state level to address the needs of this population, we recommend that health care access for low-income uninsured non-citizen adults be added as a priority to King County's 2020 State legislative agenda, and that County leaders actively engage in encouraging policies to address the health care needs of this population.

2. Study the feasibility of re-opening the Washington State Health Insurance Pool (WSHIP)

As illustrated in this report, there is currently no viable statewide group insurance plan that undocumented individuals can participate in through a sponsorship program, as they did previously through the Basic Health Plan (BHP). If there were such as plan, King County or other entities could buy people in or sponsor participation in an existing plan, and therefore avoid the high startup costs of creating a new County-based program.

Prior to the Affordable Care Act (ACA), State officials established the WSHIP as a vehicle for coverage for high-risk individuals who would otherwise be denied insurance based on pre-existing conditions. While this plan is currently closed, State officials could amend current law to re-open it. As a state-only funded plan, it would not be subject to federal rules that preclude undocumented individuals from participating.

The current WSHIP plan members includes a very small group of individuals with very high health care needs (approximately 300 people in the non-Medicare program in 2018 who incurred on average $7,047 per member per month in health care costs).[36] We recommend a study of the feasibility of re-opening this plan, including an analysis of the impact on rates of enlarging the risk pool to a much bigger population of younger and healthier individuals.

If funding were available, this research could be completed by a public policy institute with expertise in this area, in coordination with the Office of the Insurance Commissioner. The cost estimate for

[36] WSHIP, *2018 Annual Report,* May 2019, pages 9 and 15, https://www.wship.org.

completing this research is $100,000. Depending on the results, this study could provide State legislators with a potentially viable policy solution to introduce in the 2020 State legislative session.

3. Engage the King County Immigrant and Refugee Commission

The King County Immigrant and Refugee Commission, a permanent body formed in late 2018, is committed to integrating, strengthening, and valuing immigrant and refugee communities and upholding the County's commitment as a welcoming community. This group is well positioned to disseminate the findings of this Phase One report and identify community priorities.

We propose that the Commission review this report and discuss the health care access challenges with the diverse immigrant communities whom they represent. With support from staff, Commission members could be encouraged to assess how undocumented individuals in their communities are currently accessing care and what their top areas of concern are. Leaders from the Commission could share their findings with the Executive and Council and play a key role in Recommendation 1, encouraging a statewide solution.

4. Connect undocumented people to existing care options

As illustrated in this paper and detailed in Appendix F, a complex array of programs and services are available to address the care needs of individuals who are uninsured, including primary care at FQHCs, charity care at hospitals, and more. While these coverage options are not complete, and do not ensure affordable access to the full scope of necessary services, they are important resources that help people meet basic needs.

Informal interviews that informed this report suggest that many people do not know these programs exist or understand how to access them. This problem is exacerbated in the current political climate, as anti-immigrant policies such as changes to the public charge rule create a chilling effect that keep people from accessing government benefits, including those for which they are eligible.

To address this issue, we recommend increasing capacity at the King County Access and Outreach Program to include a team of two additional care navigators with specialized knowledge of services available to the focus population. These individuals would assist residents and provide training and support to other navigators and referral coordinators who work with immigrant communities.

This action step will not be feasible without additional resources. The estimated cost of this item is $200,000 for the October 2019 – December 2020 time period.

Conclusion

We recommend that the King County Council not proceed with Phase Two as written, including the evaluation plan and road map outlined in the proviso. Much of the analysis requested in Phase Two is not feasible prior to the actual implementation of a new program. In addition, detailed planning to establish a new County-based program, absent the identification of a sustainable revenue stream to fund such a program, is not an efficient use of resources.

Instead, we recommend action steps to encourage a statewide solution, engage local partners, and provide some immediate assistance to uninsured immigrant families. These include no-cost actions that County staff are prepared to execute within existing resources and low-cost items that Council could decide to fund.

King County is a welcoming place for all of its residents and is committed to ensuring that we can all obtain health care when we need it. We appreciate the Proviso request to research this important issue and look forward to active participation in next steps. We have made significant progress in King County in improving access to health care over the years and we are confident that we can continue to do so for our uninsured non-citizen neighbors.

Appendix A. Public Health Proviso 3 in 2019-2020 budget

P3 PROVIDED FURTHER THAT:

Of this appropriation, $500,000 shall not be expended or encumbered until: (1) the executive transmits a plan, produced in two phases, to implement a regional health plan pilot program that would provide health care to low-income county residents who are not eligible to access health care through public programs such as Medicaid, Medicare and subsidized health insurance under the Affordable Care Act; (2) the executive transmits motions for both phases of the plan and that should acknowledge receipt of the respective phases of the plan and reference the subject matter, the proviso's ordinance, ordinance section and proviso number in both the title and body of the motion; and (3) except as otherwise provided herein, a motion acknowledging receipt of each phase of the plan is passed by the council.

The plan shall be developed in two phases.

A. Phase One shall include:

   1. Complete demographic analysis of the 2019, or the latest year of which data are available, uninsured population, disaggregated based on age, gender, race and ethnicity, household poverty status and city of residence;
   2. Assessment of the legal and regulatory considerations of establishing a pilot program;
   3. Options for a "buy in" or similar program to provide health coverage for low-income county residents;
   4. Potential eligibility requirements for the pilot program;
   5. Financial analysis and funding options that should evaluate both existing and new revenue sources; and
   6. Recommendation on whether to proceed with Phase Two and what resources would be required for that work.

Phase One shall be developed in collaboration with HealthierHere, Northwest Health Law Advocates who authored the April 2018 report entitled *County-Based Health Coverage for Adult Immigrants: A Proposal for Counties in Washington State*, and other organizations that are involved with county health care issues.[37]

The executive should file the Phase One plan and a motion required by this proviso by June 30, 2019, in the form of a paper original and an electronic copy with the clerk of the council, who shall retain the original and provide an electronic copy to all councilmembers, the council chief of staff and the lead staff for the health, housing and human services committee, or its successor.

B. Following the filing of the Phase One portion of the plan by the executive, if, instead of passing a motion acknowledging receipt of the Phase One portion of the plan, the council passes a motion determining that the executive need not perform Phase Two of the plan, then this proviso shall have been satisfied and the $500,000 shall be unencumbered. Otherwise, following the passage of a motion acknowledging receipt of the Phase One portion of the plan, then the executive shall proceed to develop Phase Two of the plan, which shall include, but not be limited to, the following:

   1. Coordination with all Federally Qualified Health Centers (FQHCs) in the County and other health care providers that offer health care services to the underinsured;
   2. An evaluation plan that should include, but not be limited to, an assessment of usage of a pilot program, a measurement of health outcomes of those benefitting from a pilot program, a cost-benefit analysis comparing the overall cost of a pilot program and savings to the overall health

[37] NoHLA, *County-Based Health Coverage*.

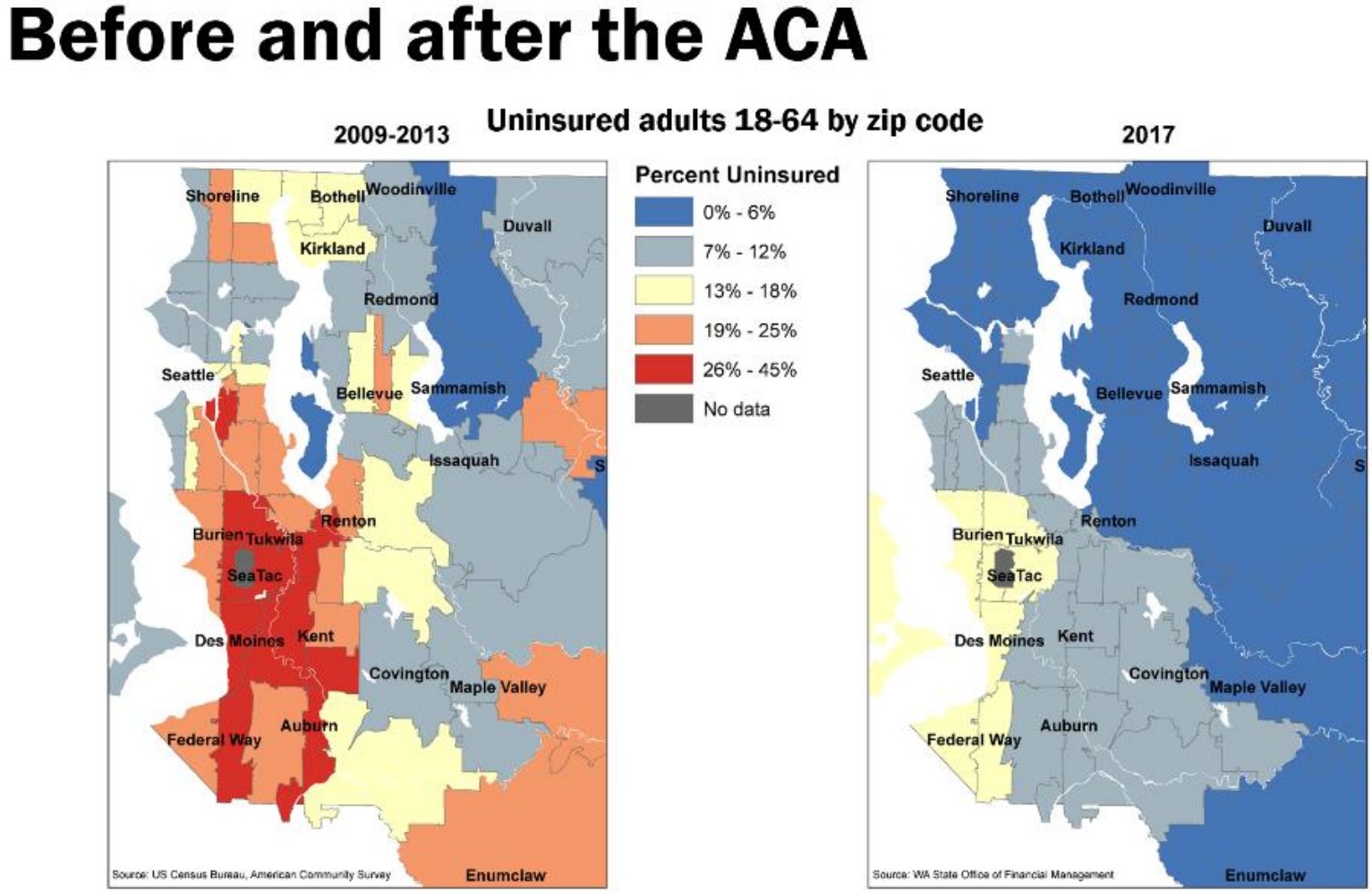
care system as a result of a pilot program, an estimate of the annual cost of operating a full-scale regional health plan for the County and the annual savings to the overall health care system as a result of a County regional health plan; and

3. A roadmap, which should include a timeline for implementing a pilot program, a timeline for evaluating a pilot program and a timeline of when a full-scale implementation may be implemented, should a pilot program confirm the feasibility of a regional health plan for the County.

Unless the council passes a motion determining that the executive need not perform Phase Two of the plan, the executive should file the Phase Two plan and a motion required by this proviso by December 31, 2019, in the form of a paper original and an electronic copy with the clerk of the council, who shall retain the original and provide an electronic copy to all councilmembers, the council chief of staff and the lead staff for the health, housing and human services committee, or its successor.[38]

[38] King County, *2019-2020 Budget Ordinance 18835,* November 14, 2018: 90-92, https://kingcounty.gov/council/budget.aspx.

Appendix B. Affordable Care Act (ACA), before and after, uninsured adults, 2009-2017



Appendix C. Demographic detail of uninsured non-citizen adults, King County, 2017

Percent of the population and number of uninsured King County adults who are not citizens.

Category	Percent	Number
Uninsured non-citizen adults	2.4%	50,700
Age		
19-25	15%	7,800
26-34	30%	15,300
35-44	29%	14,500
45-54	15%	7,500
55-64	8%	3,800
65+	4%	1,800
Gender		
Male	56%	28,300
Female	44%	22,400
Race/ethnicity		
White	33%	16,500
Black	7%	3,600
American Indian/ Alaska Native	1%	330
Asian	20%	10,300
Native Hawaiian/ Pacific Islander	1%	730
Other	35%	17,900
Multiple races	3%	1,300
Hispanic	61%	30,900

Category	Percent	Number
Income as a percent of federal poverty level (FPL)		
<=100%	28%	13,900
<138%	40%	20,000
138-199%	22%	11,200
200-399%	30%	15,000
<=317%	85%	43,200
400%+	9%	4,400
Employment status		
Employed	92%	46,500
Unemployed	8%	4,200

Source and notes: Assessment, Policy Development and Epidemiology, PHSKC, March 6, 2019 analysis. The American Indian estimate is based on a small sample size should be interpreted with caution. Citizens include those born in the U.S., Puerto Rico, Guam, U.S. Virgin Islands, or the Northern Marianas, those born abroad to American parent(s), and naturalized citizens. All others were designated not a citizen of the U.S., but the survey responses do not provide information to discern green card or visa status.

Data definitions for Appendix C and Figure 2.

Column Name	Definition
Indicator	Demographic (i.e., race or ethnicity)
Category	Specific demographic grouping (i.e., American Indian / Alaskan Native under race)
Percent	Percentage of KC population who are uninsured, non-citizens, and of the given demographic and age group
Number	Number of people in the KC population who are uninsured, non-citizens, and of the given demographic and age group
Note	Too few cases of American Indian, Alaska Native to meet precision standards, interpret with caution

Citizenship: Citizens include those born in the U.S., Puerto Rico, Guam, U.S. Virgin Islands, or the Northern Marianas, those born abroad to American parent(s), and naturalized citizens. All others were designated not a citizen of the U.S., without the ability to discern green card or visa status.

Insurance: Insured individuals answered "yes" to having had one the following sources of insurance:

1.) Provided by current / former employer or union,
2.) Purchased directly from insurance company,
3.) Medicare,
4.) Medicaid or similar government assistance plan,
5.) TRICARE or other military care,
6.) VA, or
7.) Indian Health Service

Denominator for unemployed excludes those who are not in the labor force.

Hispanic ethnicity is considered independent of race.

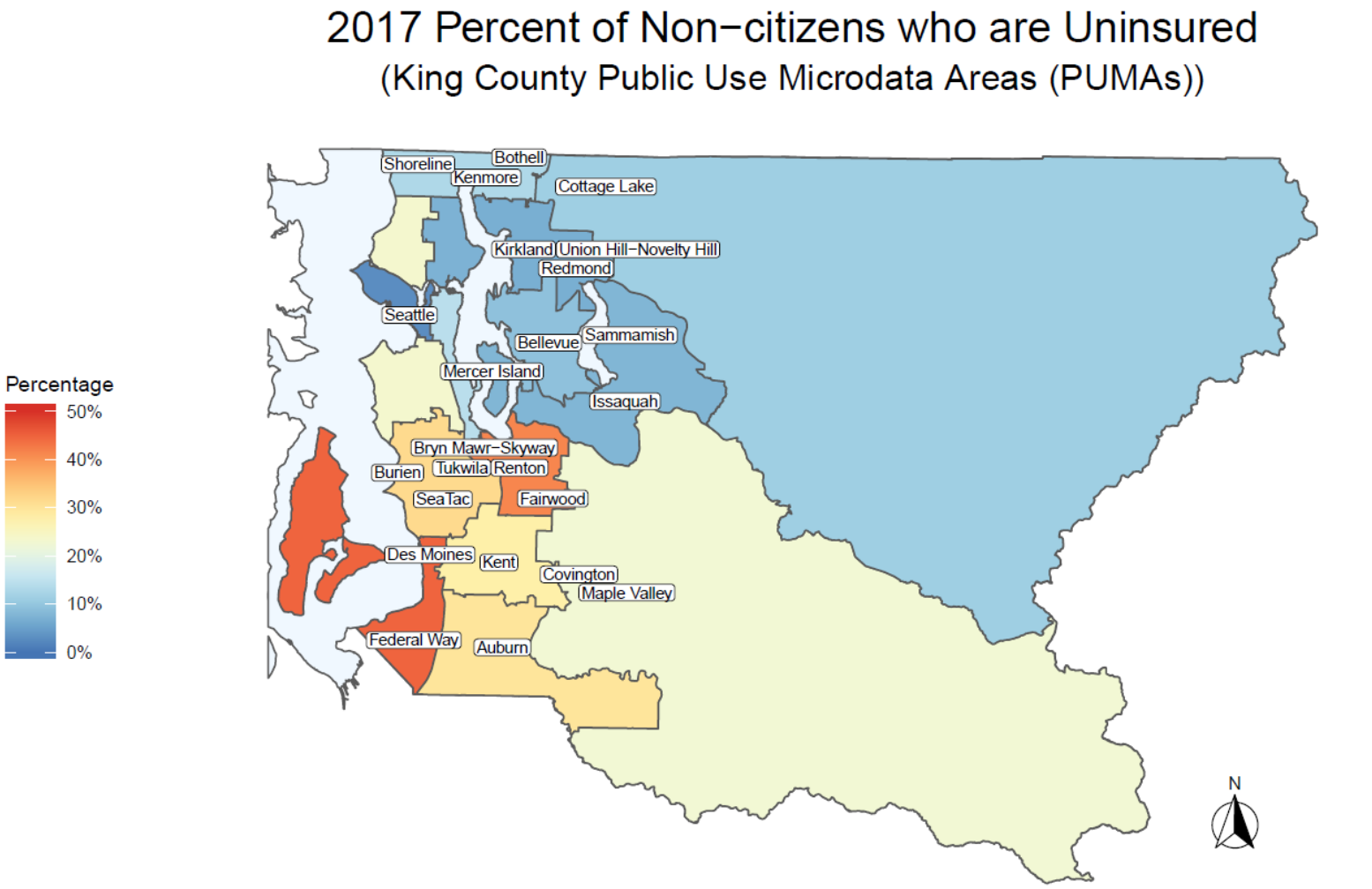
AI/AN stands for American Indian / Alaska Native.

NH/PI stands for Native Hawaiian / Pacific Islander.

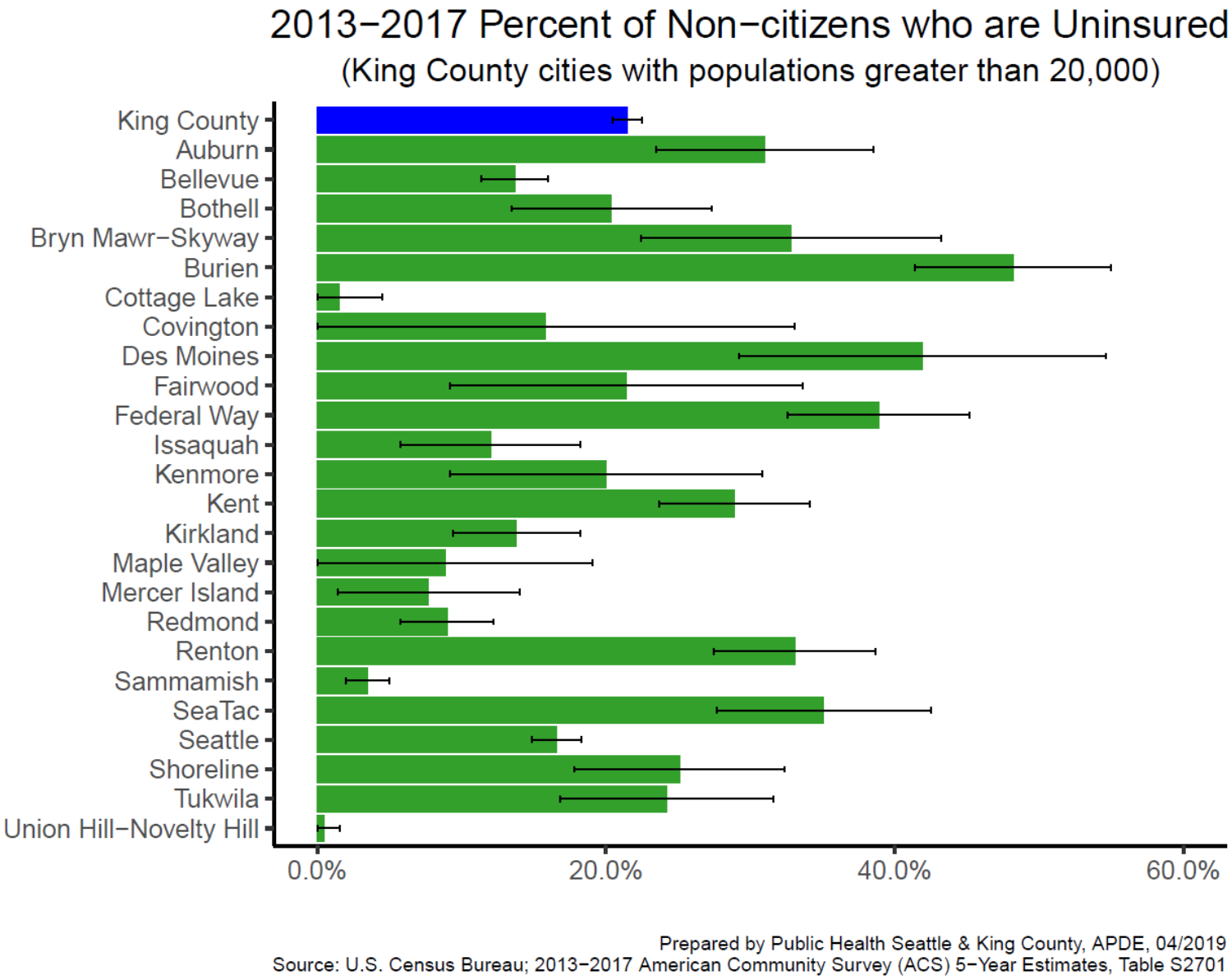
Data sources: U.S. Census Bureau; American Community Survey (ACS), Five-Year Public Use Microdata Sample (PUMS), 2012-2016. ACS data were downloaded from the Census Bureau website and analyzed to account for the complex survey design and replicate weights. Population estimates were calculated by multiplying ACS percentages by the Washington State Office of Financial Management population estimate for King County in 2017. All data were analyzed by the PHSKC's Assessment, Policy Development and Evaluation unit and fully account for the survey design. These estimates are intended for assessment purposes and are not official population counts, and are subject to change.

For additional information, please see: https://www.census.gov/programs-surveys/acs/data/pums.html

Appendix D. Map and bar chart of uninsured non-citizen adults in King County, by region and city, 2017



Prepared by Public Health Seattle & King County, APDE, 04/2019
Source: U.S. Census Bureau; 2017 American Community Survey (ACS), 1−Year Public Use Microdata Sample (PUMS)



Appendix D. Map and bar chart of uninsured non-citizen adults in King County, by region and city, 2017

Appendix E. Medicaid, Medicare, and qualified health plan eligibility information by immigration status

Medicaid – Federal rules also bar most undocumented immigrants from being eligible for Medicaid, but leave open the opportunity for state-funded exceptions. Lawfully present immigrants must be in the U.S. for five years before they are eligible for Apple Health for Adults.[39] In Washington, a state-only-funded option of Apple Health for Kids makes Medicaid coverage available to all children regardless of immigration status in families up to 317 percent FPL. Apple Health for Pregnant Women similarly makes Medicaid coverage available to pregnant women, regardless of immigration status, whose incomes are less than 198 percent FPL. A few hundred King County non-citizens receive Alien Emergency Medical (AEM) coverage for specialized hospital care.

Medicare – Undocumented immigrants are ineligible for Medicare due to federal eligibility requirements which require beneficiaries to be U.S. citizens or meet lawful presence and residency requirements. Medicare is available to people age 65 or older, younger people with disabilities, and people with End State Renal Disease. People are eligible for premium-free Part A (hospital insurance) if they or their spouse worked and paid Medicare taxes for at least 10 years. Everyone eligible for Medicare pays for Part B and has access to prescription drug coverage. Medicare beneficiaries can choose to receive their benefits through managed care or Medicare Advantage. Due to the lawful presence and a residency requirement of 10 years of work in the U.S., many elderly immigrants do not qualify for Medicare. [40] As seen in Figure 2, 1,800 adults age 65 plus in King County are uninsured.

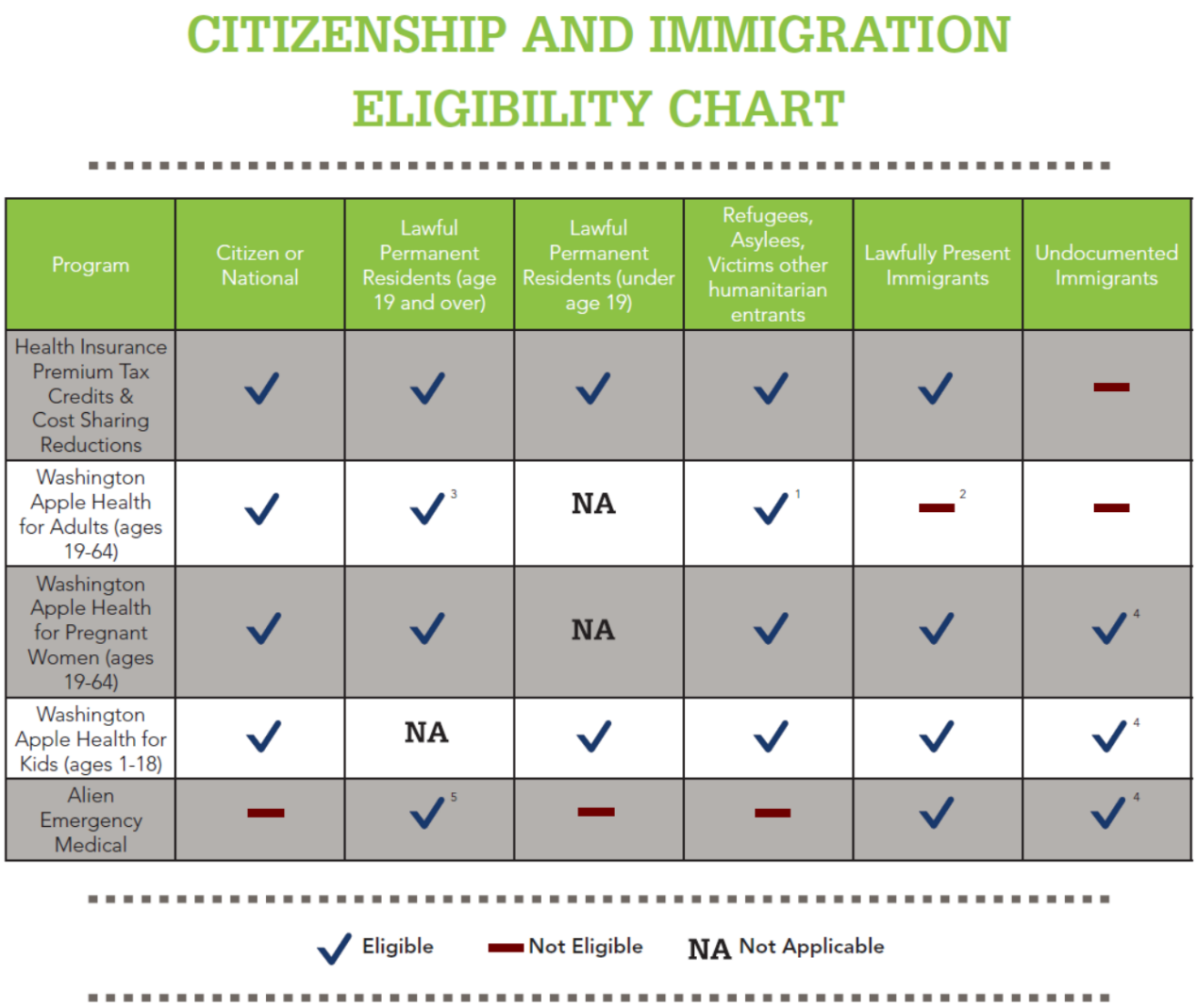
Washington Health Benefit Exchange – Undocumented immigrants are also ineligible to purchase Qualified Health Plans offered by private insurance companies on the Washington Health Benefit Exchange and for federal financial assistance due to federal eligibility requirements.[41] States have the option of running their own Exchange, as Washington State does, or connecting to a national exchange. In either case, undocumented individuals are ineligible for the federal subsidies and cost sharing available to low-income individuals through the Exchanges and are also barred from purchasing plans through the Exchanges at full cost. See Chart 1 below.

[39] Washington State Health Care Authority, "Citizenship and Alien Status Guide," April 2019, https://www.hca.wa.gov/assets/free-or-low-cost/citizenship_alien_status_guide.

[40] US Department of Health and Human Services, "Who is eligible for Medicare?" https://www.hhs.gov/answers/medicare-and-medicaid/who-is-elibible-for-medicare and Justice in Aging, "Older Immigrants and Medicare," April 2019, https://www.justiceinaging.org/issue-brief-older-immigrants-and-medicare.

[41] Washington Health Benefit Exchange, "Immigrants," https://www.wahbexchange.org/new-customers/who-can-sign-up/immigrants.

Chart 1. Washington Health Benefit Exchange eligibility by immigration status



Source: Washington Health Benefit Exchange. The eligibility chart is available online in multiple languages (along with a quick guide) here: https://www.wahbexchange.org/partners/partners-toolkit.

Appendix F. Health care services available to uninsured King County residents, including uninsured non-citizens

Primary Care – Uninsured non-citizens can access primary care and pharmacy benefits at 43 clinic sites run by eight Federally Qualified Health Center (FQHC) agencies in King County. The majority are owned and operated by private, non-profit agencies such as HealthPoint, NeighborCare Health and Sea Mar Community Health Centers. The largest three agencies serve 70 percent of all patients. The smaller agencies are Country Doctor, International Community Health Services, Pioneer Square Clinic, PHSKC clinics, and the Seattle Indian Health Board.

These clinics receive an enhanced reimbursement rate for publicly insured patients to help offset the costs of care they are required to deliver to patients regardless of their insurance status. The FQHCs saw 42,470 uninsured patients in 2017 or 29 percent of the number of uninsured. About half of the uninsured patients seen at FQHCs were Hispanic. Overall, 19 percent of FQHC patients were uninsured but there is considerable variation among the agencies; 6 percent of International Community Health Services patients were uninsured and 48 percent of PHSKC clinic patients were.[42] There are also smaller scale volunteer-run free clinics in the County.

Specialty Care – Uninsured non-citizens may be referred from the FQHCs and other primary care providers to specialists offering pro-bono services through Project Access Northwest—a non-profit formed in 2006 to improve access to specialty health care for low-income uninsured patients. It matches volunteer specialty care providers and hospital partners with pre-screened patients in need of care. It provides care coordination to assure services are received and to keep no-show rates at a minimum.

In 2017, Project Access NW served approximately 5,000 people, of whom about 2,400 were uninsured.[43] Thus, only 1.6 percent of the 147,000 uninsured obtained access to specialty services through Project Access Northwest. Project Access Northwest also offers a premium assistance program and a health home program. Project Access Northwest serves an important systemwide coordinating function for services that were previously unconnected and for County residents who would otherwise likely go without needed care.

There are other smaller arrangements to connect uninsured patients to low-cost specialty care, such as through informal arrangements for pro-bono or low-cost care with individual providers or within hospital and group practice systems. Data are not available on the number of people served in these arrangements.

Dental Care – Similar to primary care, uninsured non-citizens can access dental services at safety net providers. Six of the eight FQHC agencies offer dental services at 30 clinic sites. A total of 114,492 patients were treated in 2017 and 17 percent were uninsured (19,464 patients).[44] In addition to FQHC dental services, there are other charity, low-cost, and no-cost dental services available at churches, non-profits, and training sites and through individual arrangements with dentists.[45]

Health Care for the Homeless – Since 1995, the Health Care for the Homeless Network (HCHN) has provided federally funded health care services for people experiencing homelessness in King County through PHSKC clinics, the mobile medical program, Harborview, FQHCs and other providers. In 2017, the HCHN of providers served over 20,707 people, many living outside and disconnected from needed services, with 93 percent being insured; 1,450 patients were uninsured.[46] Approximately 30,000 individuals

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[42] PHSKC, Community Health Partnerships, "Health Safety Net System, 2017 Demographic Highlights for Medical Users," June 2018.
[43] Project Access NW, *Annual Report 2017*, 2, https://projectaccessnw.org/publications/PANW_AR2017_web.pdf.
[44] PHSKC. Community Health Partnerships, "Health Safety Net System, 2017 Demographic Highlights for Dental Users," June 2018.
[45] PHSKC, "Oral Health program," https://www.kingcounty.gov/depts/health/locations/dental/oral-health-program.
[46] PHSKC, *Health Care for the Homeless Network 2017 Annual Report,* 5, https://www.kingcounty.gov/depts/health/locations/homeless-health/healthcare-for-the-homeless/2017-annual-report.

were homeless in King County for some or all of 2017. From patients' perspectives, a "series of individual and systemic factors that can make accessing care 'feel like an obstacle course.'"[47]

Communicable Disease – PHSKC conducts prevention efforts, testing, and provides treatment for communicable diseases including HIV, tuberculosis, and sexually transmitted diseases for County residents regardless of immigration or insurance status. In 2018, 161 people in King County were diagnosed with HIV with 92 percent linked to care.[48] That same year, 93 people were diagnosed with tuberculosis.[49] PHSKC Communicable Disease specialists also monitor and share data on these reportable communicable diseases.

Pregnancy Care – Uninsured non-citizens who are pregnant or breastfeeding can access a range of health care and maternity support services at FQHCs and public health clinics, including Women, Infants and Children (WIC), Access to Baby and Child Dentistry, maternity support services, infant case management, and the nurse-family partnership program.

Apple Health for Pregnant Women (Medicaid) provides full-scope health coverage for pregnant women regardless of immigration status when their income is less than 198 percent FPL, as it does for children under age 19 in families earning under 317 percent FPL. Apple Health for Pregnant Women ends two months after the pregnancy ends, and then women have 10 months of family planning services. Apple Health's Take Charge is an additional program that provides family planning services to prevent unintended pregnancies for individuals up to 260 percent of the poverty level. A Take Charge look-alike program to provide family planning coverage to undocumented Washingtonians will begin in 2020.

Breast, Cervical and Colon Cancer Care – Since 1993, the Breast, Cervical and Colon Health program has served uninsured people in Washington with these cancers. In 2018, approximately 3,900 uninsured people received screening and treatment services. Uninsured non-citizens who have diagnosed breast, cervical or color cancer can receive cancer treatment services through this program if their incomes are lower than 300 percent FPL.[50]

Behavioral Health – The King County Behavioral Health Administrative Service Organization contracted with private non-profit behavioral health providers that served 55,649 patients in 2016 and 16 percent (8,818) were uninsured. There are about 40 agencies providing behavioral health services; the top three by volume are Sound Health, Navos, and Valley Cities Behavioral Health Care. A total of 5,421 adults received crisis stabilization services and 4,322 adults received inpatient care. In addition, 9,583 adults received substance use disorder treatment and 10 percent were uninsured.[51]

Emergency and Specialized Hospital Care – When a person earning less than $17,236 per year (138 percent FPL) who is an immigrant not otherwise qualified for Medicaid is in need of hospital treatment for an emergency condition, cancer or dialysis care, they may be eligible for a small State program called Alien Emergency Medical (AEM) program. In a typical month in 2017, the Department of Social and Health Services covered 135 people statewide through its fee for service AEM program. The Health Care

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[47] PHSKC, *Health Care for the Homeless Network Community Needs Assessment 2016-2017,* 8, 37, https://www.kingcounty.gov/depts/health/locations/homeless-health/healthcare-for-the-homeless/data-reports.

[48] HIV/AIDS Epidemiology Unit, PHSKC and Infectious Disease Assessment Unit, Washington State Department of Health, *HIV/AIDS Epidemiology Report 2018,* Volume 87, 35, https://www.kingcounty.gov/depts/health/communicable-diseases/hiv-std/patients/epidemiology/annual-reports.

[49] PHSKC, Communicable Disease and Immunizations, *2018 Tuberculosis (TB) Data Summary,* https://www.kingcounty.gov/depts/health/communicable-diseases/tuberculosis/data.

[50] PHSKC, Breast, Cervical and Colon Health program, *BCCHP Program Guide*, www.kingcounty.gov/cancer.

[51] King County Department of Community and Human Services, *Behavioral Health Organization 2016 Report Card,* May 2017, https://www.kingcounty.gov/~/media/depts/community-human-services/behavioral-health/documents/2016-Q4_BHO_Report_Card.ashx?la=en.

Authority covers Medicaid expansion adults through managed care plan contracts. In 2019, 126 additional adults in King County qualified for AEM with incomes between 75 percent and 138 percent FPL.[52]

Charity Care – State law requires that hospitals provide free care to people with incomes below the FPL and discounted care to patients with incomes less than 200 percent FPL. Charity care programs are hospital-specific and most hospitals in King County allow patients to apply for charity care when their income is below 300 percent of the FPL.[53] All hospitals in King County use a similar charity care application and each has their own approval process.[54]

As shown in Figure 2 and Appendix C, 85 percent of uninsured non-citizens have incomes less than 317 percent FPL, so most would be expected to qualify for free or discounted hospital care, but patients sometimes do not know that they are eligible to apply and approval rates are not reported. Hospitals in Washington provide charity care valued at 3 percent of revenues. UW Medicine/Harborview provided the most charity care in King County and Washington State, at $33 million out of an operating revenue of $998 million in 2017.[55] While the dollar value of services are known, there are no countywide publicly available data on how many people apply for and receive hospital charity care.

Seattle/King County Clinic – The Seattle/King County Clinic, a free annual four-day clinic hosted by the Seattle Center, also serves uninsured King County residents with medical and dental care regardless of immigration status on a temporary basis. Of the 3,661 patients treated during the four-day September 2018 clinic:

- 25 percent were Hispanic and 18 percent were Asian;
- Almost half had no health insurance; and
- Dental and medical services were in high demand—59 percent of patients received dental care, 58 percent received medical care, and 33 percent received vision services.

This all-volunteer effort provides other benefits to patients as well, including offering several services in one location, respect, camaraderie, and a sense of community. Significant donations to the Seattle/King County Clinic are made by Ballmer Group, Kaiser Permanente, and a host of health care providers, foundations, employers, and individuals in the region.[56]

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[52] Health Care Authority, Apple Health (Medicaid) reports, "Apple Health enrollment by county," February 2019, https://www.hca.wa.gov/about-hca/apple-health-medicaid-reports and Department of Social and Health Services, Economic Security Administration, Briefing Book 2018, "Medical Assistance chapter," 4, https://www.dshs.wa.gov/sites/default/files/ESA/briefing-manual/2018Medical_Assistance.pdf.

[53] NoHLA, County-Based Health Coverage, 4-6.

[54] Department of Health, Washington State, "Hospital Charity Care Policies," https://www.doh.wa.gov/DataandStatisticalReports/HealthcareinWashington/HospitalandPatientData/HospitalPolicies.

[55] Washington State Department of Health, *2017 Charity Care in Washington Hospitals,* January 2019, 8, https://www.doh.wa.gov/Portals/1/Documents/2300/HospPatientData/2017CharityCareReportFinal and University of Washington Board of Regents, *UW Medicine Annual Financial Report*, February 8, 2018: 6, https://www.washington.edu/regents/files/2018/01/2018-02-B-2.

[56] Seattle/King County Clinic, *2018 Final Report,* http://seattlecenter.org/skcclinic.

Appendix G. HealthierHere and the Center for MultiCultural Health Consumer Voice Listening Project findings on barriers to care

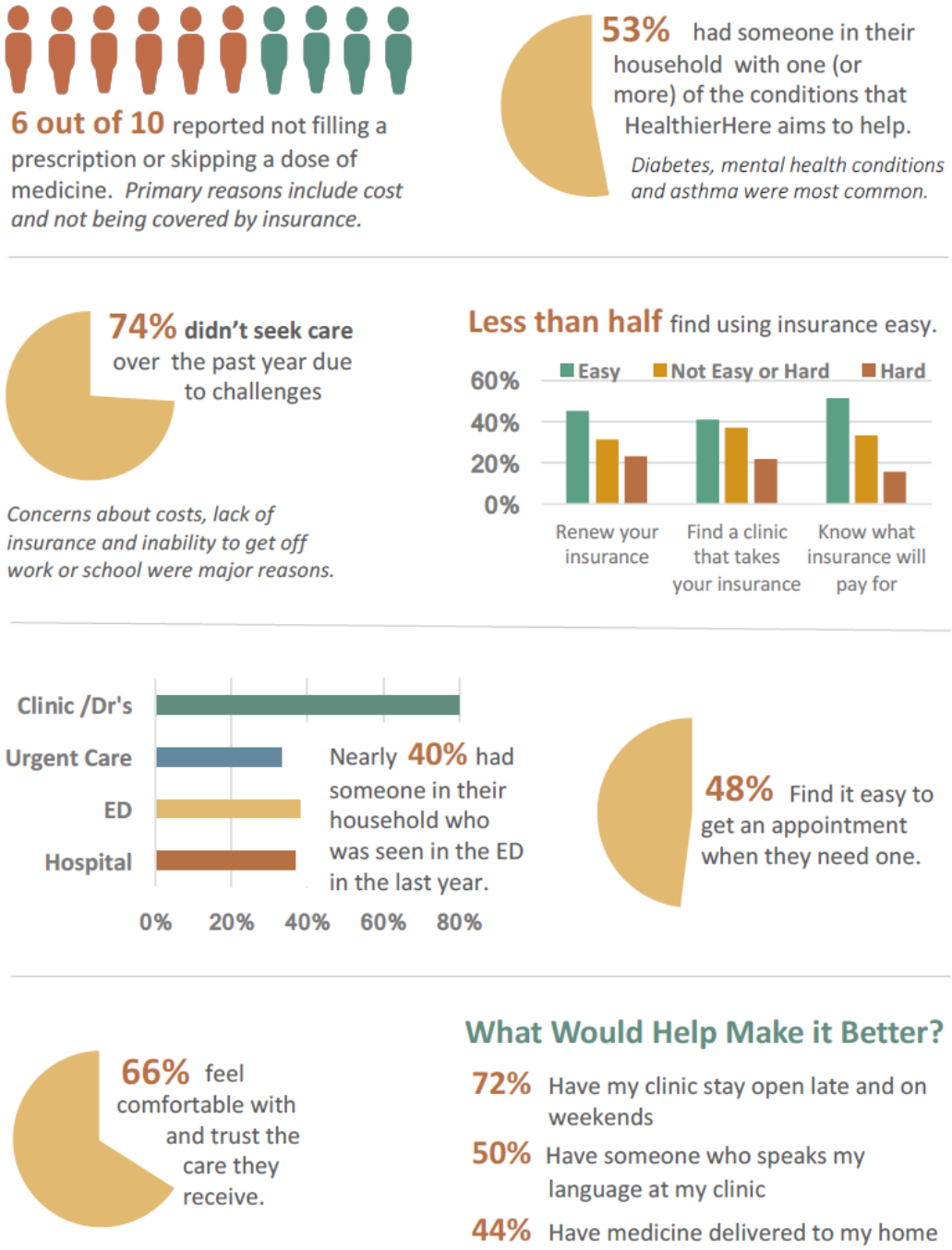
HealthierHere, the Accountable Community of Health in King County, in partnership with the Center for MultiCultural Health, a health-focused community-based organization in King County, conducted listening sessions and collected surveys in 2018 to better understand community issues and barriers to care for low-income King County residents. The research collected data from over 900 County residents, 91 percent with Medicaid coverage and 9 percent who were uninsured. The results add more information to our knowledge of gaps in services and barriers to care in King County.

The Consumer Voice Listening Project was conducted through small grants to 22 community organizations and grassroots groups serving 33 ethnic communities. The community organizations used the grant funds to provide trusting, culturally relevant forums for community members to share their experiences with the health care system—what works, what does not, and what could make it better.

Consumer Listening Project participants completed surveys and participated in focus groups provided in 11 languages. The coordinated surveys and focus groups gathered feedback about consumers' experiences with Medicaid and accessing care.[57] Although most respondents had Medicaid coverage, the access barriers surfaced by this comprehensive effort are relevant to improving access for low-income uninsured non-citizens as well. The 9 percent of participants without health insurance faced greater access barriers than those with Medicaid. For example, while 11 percent of participants with Medicaid said they had difficulty getting a physician visit, 25 percent of uninsured respondents did. See https://www.healthierhere.org/listen.

[57] HealthierHere, "Consumer Voice Listening Project," 2019, http://www.healthierhere.org/listen.

Figure 3. Survey and listening session results from 908 King County residents, 2018



Source: HealthierHere and Center for MultiCultural Health Consumer Voice Listening Project, April 2019. ED stands for emergency department.

The results show that even with health coverage, access barriers can be substantial. Challenges included the costs of prescription drugs, difficulty navigating insurance procedures, feeling comfortable with health care system providers, language access and limited clinic hours. Any effort to expand coverage should more deeply explore these barriers.

Appendix H. County-based health coverage programs in other states

Overview of selected county-based health coverage programs for adult immigrants.

County-Based Program	Estimated number of enrollees	Benefits	Per member per month (PMPM)	Annual budget
Healthy San Francisco	14,200	Comprehensive, within a defined network of public and non-profit providers and facilities	$160 PMPM	$74 million
My Health LA	137,200	Primary care, specialty, limited hospital within a defined network of county-operated facilities and 213 non-profit clinics	$32 PMPM	$65 million
Contra Costa Cares	Capped at 4,100 out of 19,000 eligible	Primary care within a defined network of seven sites	$28 PMPM	$1.5 million
Montgomery Cares, Maryland	25,530	Primary care, behavioral health, limited specialty, and dental	Not applicable (NA), $73 paid per visit	$12 million
Nevada Medical Discount program[58]	12,000	Comprehensive coverage through a network of participating providers paid discounted rates directly by enrollees	NA, enrollees pay providers according to a discounted rate schedule	Approximately $5 million from fees
Action Health NYC	1,300 pilot	Comprehensive within a defined network of publicly owned facilities and non-profit clinics	$59 PMPM ($35 for primary care and $24 PMPM for specialty)	$6 million, including research-level evaluation
NYC Care[59]	600,000 eligible, starting in the Bronx in 2019	Comprehensive within a defined network of publicly owned facilities	NA, providers are employees of NYC Health + Hospitals	$100 million

Sources: NoHLA, *County-Based Regional Health Coverage for Adult Immigrants* and personal communication with NYC Care staff, 3/27/19.

[58] Pauline Bartolone, "Medical Discount Plan in Nevada Skips Insurers," *NPR*, August 13, 2013, https://www.npr.org/sections/health-shots/2013/08/13/211643763/medical-discount-plan-in-nevada-skips-insurers.

[59] New York City, "Mayor de Blasio Announces Plan to Guarantee Health Care for all New Yorkers," January 8, 2019, https://www1.nyc.gov/office-of-the-mayor/news/017-19/mayor-de-blasio-plan-guarantee-health-care-all-new-yorkers#/0.

Appendix I. Financial estimates detail and assumptions

Health Trends produced financial estimates for the five benefits options.

	Less than 138% FPL	138 to 199% FPL	200% to 317% FPL	Total less than 317% FPL	Member Months
Non-Citizen 19+ Population	21,816	11,880	12,852	46,548	
Estimated Enrollment (see Assumptions below)	10,438	5,664	6,161	22,263	267,150
OPTIONS	**Less than 138% FPL**	**138 to 199% FPL**	**200% to 317% FPL**	**Total less than 317% FPL**	**Average PMPM (0-317% FPL)**
Comprehensive insurance (Kaiser Flex Silver HD – 19 Buy-In)	$84,948,886	$45,694,827	$50,337,741	$180,981,454	$677
+Includes premiums (70% of expenditures) and out-of-pocket expenses (30% of expenditures)					
Partial Benefit Wrap	$24,920,146	$12,832,980	$22,919,128	$60,672,254	$227
+Includes primary care, behavioral health, specialty, hospital services, limited home health, prescribed medications, dental, and 'Other Medical Expenses' (Medical Expenditure Panel Survey definitions)					
Specialty	$6,726,105	$3,359,419	$5,499,620	$15,585,144	$58
+Includes specialty (office-based) and hospital outpatient services.					
Primary + Behavioral Health (Office-Based)	$3,486,842	$1,795,537	$1,971,504	$7,253,883	$27
Dental	$1,880,017	$1,067,946	$1,206,101	$4,154,064	$16

Population estimates from Assessment, Policy Development, and Evaluation; PHSKC, January 2019. Minor adjustments to population estimates made by Hunter Plumer, MHA. FPL stands for federal poverty level; PMPM stands for per member per month. The PMPM cost estimates are for income eligibility up to 317 percent FPL. They would be lower at lower income eligibility levels due to demographic differences, e.g. younger residents. For example, the PMPM for the Partial Benefit Wrap for < 138% FPL is $199 rather than $227. This analysis is available upon request.

Notes

(1) See Assumptions and Modeling Framework, and Partial Benefits worksheets for methodology applied to non-'Full Benefit' models.

(2) Estimates subject to considerable variation due to predictions based socio-economic and demographic estimates without historical health care services utilization experience data (e.g. clinical condition prevalence, prior cost data). Recommend limiting pilot option at beginning to accumulate experience to inform further expansion. Individual or group stop-loss insurance could protect against large claims and lower costs.

ELIGIBILITY Assumption, '1' assumes eligibility

Income Category	Eligibility Status
<138 percent federal poverty level	1
138 to 199 percent federal poverty level	1
200 to 317 percent federal poverty level	1
318 to 399 percent federal poverty level	0
> 400 percent federal poverty level	0

ENROLLMENT Assumption

Age Category	Eligible* Assumption	Enrollment Assumption	Enrolled Population*
19 to 25	7,569	30%	2,271
26 to 34	14,089	40%	5,636
35 to 44	12,791	50%	6,396
45 to 54	6,526	60%	3,916
55 to 64	4,181	70%	2,927
65+	1,398	80%	1,118
Total	46,554	47.8%	22,263

*Population count subject to income eligibility status definition applied above

Annual TREND Assumption

	Professional / Other	Hospital-Based	RX
Annual Trend	2.5%	0.5%	3.7%

Pro/Hospital Source: See estimates provided in Table II-4 in Appendix A of Health Care Authority's *Holding Managed Care Rates at Calendar Year 2016 Level* Report (October 1, 2016)

RX Source: Express Scripts 2017 Drug Trend Report. p. 10

Note: Hospital-based represents a weighted average—88/12 weights to hospital (non-maternity) and professional rates, respectively. Weights based on 2016 MEPS Medicaid adults 19+ years old (excluding 19-64 dual-eligible) for facility and provider sum total payments in a hospital outpatient, inpatient, and emergency room setting.

CHARITY CARE (Hospital-Based) Assumption
'0' assumes charity care eligibility—defined as full discount to hospital-based payments

Income Category	Charity Indicator	Charity Care Discount?
<138 percent federal poverty level	0	Yes
138 to 199 percent federal poverty level	0	Yes
200 to 317 percent federal poverty level	1	No
318 to 399 percent federal poverty level	1	No
> 400 percent federal poverty level	1	No

ADMINISTRATION Assumption

Description	Percentage
Administration and Outreach	8.9%
Language Access and Care Coordination	4%
Total	13%

Appendix J. Cost components of coverage options for eligibility to 317 percent FPL, 22,260 enrollees

	Partial Benefit Wrap		Specialty		Primary Care		Dental	
	Total	Per member per month	Total	Per member per month	Total	Per member per month	Total	Per member per month
Primary Care and Behavioral Health	$6,425,051	$24			$6,425,051	$24		
Specialty	$12,442,539	$47	$12,442,539	$47				
Hospital Outpatient	$1,361,840	$5	$1,361,840	$5				
Emergency Room	$1,302,380	$5						
Inpatient	$5,009,558	$19						
Limited Home Health	$828,554	$3						
Other Medical Expenditures	$1,019,615	$4						
Prescription Drugs	$21,670,861	$81						
Dental	$3,679,419	$14					$3,679,419	$14
Health Care Subtotal	*$53,739,818*	*$201*	*$13,804,379*	*$52*	*$6,425,051*	*$24*	*$3,679,419*	*$14*
Subtotal + Outreach, Language Access, Admin	**$60,672,254**	**$227**	**$15,585,144**	**$58**	**$7,253,883**	**$27**	**$4,154,064**	**$16**

Source: HealthTrends analysis, March 2019. Cost components for lower income eligibility cut offs available.