

THE IMPACT OF HEALTH CARE REFORM ON CALIFORNIA COUNTIES

Explanation of Methodology for Estimating Fiscal Effects

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INTRODUCTION

The California Health Care Foundation engaged the Blue Sky Consulting Group to estimate the fiscal impact on counties of the health care reform proposals developed by the Governor and the Legislature (i.e. Nunez/Perata AB8).¹ This paper presents an overview of the methodology that was developed and applied to these two proposals. The results of this analysis were presented in a companion Power Point presentation.

WHY MEASURE THE COUNTY IMPACT?

Counties are the health care providers of last resort for California adults who cannot afford care (known as Medically Indigent Adults or MIAs). Each year, California counties provide billions of dollars in health care services. In addition, 14 counties own and operate 19 hospitals statewide and four counties contract with University of California hospitals. Despite increasing budgetary pressures, these facilities disproportionately serve the state's uninsured, providing 55 percent of hospital care and over half of hospital-based outpatient visits to the uninsured, although they only make up six percent of all hospitals.

As the number of insured Californians increases due to health care reform, the number of people relying on county MIA programs will decrease. Our research seeks to measure the fiscal impact on counties of these changes. Specifically, our model estimates how much county-funded indigent health care programs will save when eligible recipients move to newly expanded public, employer-based, and private insurance programs.

HOW THE PLANS WOULD AFFECT COUNTIES

Both the Governor's and Legislature's plans would require some form of "pay or play" that would reduce the number of employed uninsured. The legislature's proposal (which was vetoed by the Governor) offered subsidized coverage to employed low-income adults earning less than 300 percent of the federal poverty level (FPL). The Governor's plan mandates individual coverage, and expands MediCal eligibility to all legal residents under 100 percent FPL and to 19 and 20 year olds up to 250 percent FPL. The Governor's plan also offers subsidized coverage to legally resident adults up to 350 percent FPL, either in the form of a statewide pool or a tax credit. In addition, the

¹ Although the Legislature's plan has been vetoed by the Governor, we present the method used to analyze it here since it comprised part of our original work for the Foundation and may continue to be a part of the ongoing health care reform discussions in Sacramento.

Governor’s plan creates Local Coverage Options to assist counties with public hospitals in retaining patients and funding. Both plans also seek to expand coverage for children under 300 percent FPL. In addition, the Governor’s plan would require several changes to the way counties pay for indigent care, including payments from counties to the state in order to offset increased state costs for indigent care. Table 1 below presents an overview of the two plans.

Table 1: Overview of the Plans

	AB8: Nunez/Perata	Governor’s Proposal
<p><i>Who Gets Coverage?</i> Uninsured individuals currently eligible for county programs or who use county hospital services without payment, including:</p>	<ul style="list-style-type: none"> • Documented children between 250% and 300% of FPL and undocumented children below 300% FPL. • Part-time and full-time workers, who take-up employer coverage. • Unemployed resident parents below 300% FPL 	<ul style="list-style-type: none"> • Documented children between 250% and 300% of FPL and undocumented children below 300% FPL. • Documented adults that enroll in programs for subsidized care up to 250% FPL • Adults above 250% FPL that privately insure to comply with the mandate (including those up to 350% FPL who get tax credit).

	AB8: Nunez/Perata	Governor’s Proposal
<p><i>What Funding Changes?</i></p>	<ul style="list-style-type: none"> • No direct funding changes. • Counties become employers of record for IHSS providers. 	<ul style="list-style-type: none"> • Participation payment related to the cost of providing coverage to individuals currently relying on counties for medical services • Increase in Medi-Cal reimbursements to county hospitals • Transfer of 4% of gross revenues from county hospitals • Other (proposed) changes including transfer of safety net care pool funds and federal waiver funds.

ESTIMATING THE COUNTY FISCAL IMPACT

Our basic estimation approach was to determine the total reduction in medically indigent adult (MIA) program caseload that counties would experience as a result of reform, and apply that percent reduction to total MIA program expenditures.

This involved three basic steps. First, we estimated the fraction of the population eligible for county-provided indigent care services that would obtain insurance under each of the plans. Next, we weighted the population for acuity (i.e. how sick are the people leaving and staying). Finally, we applied the percent reduction in acuity-weighted population to the total county MIA program expenditures to estimate the county costs avoided.

Step 1: Estimate Fraction of Population to Obtain Insurance

To estimate the fraction of the county MIA program eligible population that would obtain insurance under reform, we relied on data from the 2005 California Health Interview Survey (CHIS). This survey, conducted by the UCLA Center for Health Policy Research, contains detailed data on the characteristics of a large sample of the California population. Specifically, the CHIS survey collects information on the income, age, and assets as well as insurance, citizenship, employment, and parental status of survey respondents, among other variables.

Using CHIS data, we were able to construct a sample of Californians that met the eligibility criteria for county MIA programs. That is, we limited the CHIS population to just those individuals who met the income, age, and citizenship status eligibility requirements. Because eligibility rules vary across counties, we performed this operation for each county. For example, if a county serves legal residents with incomes up to 200 percent of the Federal Poverty Level, we limited the CHIS sample to include just those individuals who met these criteria for purposes of constructing a sample representative of that county's MIA-eligible population. We applied five key eligibility criteria:

1. Age
2. Citizenship status
3. Income
4. Assets
5. Insurance status

By applying these five criteria to the population in the CHIS data, we were able to limit the sample to a population that approximates the characteristics of the eligible population in each county.

Estimating the size of the homeless population

The CHIS data includes a representative sample of California households, but excludes those living in institutional settings – such as homeless shelters – and the homeless without a residence of any kind. Because this group is an especially costly subpopulation eligible for county medical services, we separately estimated the size of the homeless population in each county.

To estimate the size of the homeless population, we used the Department of Housing and Urban Development's unduplicated January 2005 count. The count is conducted by 38 California counties that participate in the department's Continuum of Care program. These counties contain 95 percent of California's population, so we adjusted the HUD numbers to account for counties that did not participate. In addition, not all of the homeless are uninsured. According to an Urban Institute

analysis of the 1996 National Survey of Homeless Assistance Providers and Clients (NSHAPC), 55 percent of the homeless were uninsured. Therefore, we used a number equal to 55 percent of the HUD count in our calculations.

Dividing the population into groups based on “reason uninsured” and income

After limiting the CHIS sample to those citizens eligible for county MIA programs, we divided this eligible population into a series of groups or “buckets” according to several factors. For the Governor’s plan, the two factors were (1) responses to the reason uninsured question on the CHIS survey and (2) income level. For the legislature’s plan, the factors were (1) employment and parental status and (2) income level. Dividing the population into these subpopulations allowed us to apply more individualized take-up rates that varied according to the characteristics of subpopulations. For example, because the subsidies offered under the Governor’s plan vary depending on income, we were able to estimate and apply take up rates that varied according to income. Similarly, we were able to estimate and apply take up rates that varied depending on the stated reason for being uninsured, such as the temporarily uninsured or those denied coverage due to a pre-existing condition.

For ineligible non-citizens, we used CHIS to estimate the number of uninsured by income bucket (although we did not divide the group into subpopulations by reason uninsured). For the legislature’s plan, we did separate the undocumented employed from the unemployed in order to reflect the employment-based nature of the proposal.

With the CHIS population divided into subpopulations, we applied take up rates to each bucket to estimate the fraction of the population in each group that would take-up insurance, thereby relieving the county of some portion of its MIA responsibility.

Estimating Take-Up Rates

Because there is considerable uncertainty with respect to how individuals and employers will respond to health care reform, we estimated upper and lower bound take-up rates. These estimates truly represent bounds, which the actual number is very unlikely to exceed.

To estimate take-up rates, we relied on a series of data sources, which we applied to each subpopulation. Specifically, we examined the following data sources in order to estimate upper and lower bound take up rates for each group:

Take-Up Rate Data Sources

- *Lewin Group analysis of price elasticity.* The Lewin Group has developed a Health Benefits Simulation Model that predicts take-up of insurance based on income. Because both plans provide a subsidy to low-income Californians, we applied these results to estimate the price-based response that can be expected from reform.
- *GAO Medicaid Citizenship Report.* Congress adopted citizenship documentation requirements for Medicaid eligibility. Studying the effects of this citizenship requirement, the GAO reported that approximately 15 percent of those previously enrolled in MediCaid were not able to prove citizenship and reenroll. This figure is used to adjust (downward) the take-up rate for those eligible for no cost MediCal coverage.

- *RAND information effects.* RAND analyzed non-price barriers to individual insurance purchase. The researchers asked consumers to agree or disagree with statements about the difficulty of searching for information relating to health insurance coverage and the burden of disclosure requirements. They found that if a policy could reduce the perceived cost of searching from the “average” to a “modest” level, purchase rates would increase by 9 percent. Availability of pool coverage and mandated employer offerings likely will reduce the search cost for insurance coverage and increase the take-up of individual insurance plans.
- *Massachusetts experience.* We used preliminary results from health insurance reform in Massachusetts as a guide for our own estimates. On the eve of the implementation of the individual mandate, the pooled coverage and subsidy options for low-income individuals had already lead to over 100 percent take-up for individuals under 100 percent of the FPL.² But participation declined sharply as income increased and subsidies diminished. Only 21 percent of individuals between 100 and 300 percent of the FPL had enrolled as of the reporting date. These results are in line with our price-only effects, which serve as our lower-bound.
- *MRMIP survey.* The California Major Risk Medical Insurance Program (MRMIP) provides health insurance to individuals unable to purchase private insurance due to coverage denial or unaffordable rates. Subscribers are charged a monthly premium between 125 and 137.5 percent of their plan’s standard average individual rate after adjustment for MRMIP benefit standards. Premiums are subsidized and, due to funding limitations, participation is capped. A 2005 survey of participants found that, without the program, 31 percent would not receive medical services. We used this figure as a proxy for the lower bound estimate of the willingness of uninsured individuals with pre-existing conditions to pay for subsidized coverage.
- *SSI enrollment rates.* According to a 1999 Urban Institute analysis of the National Survey of Homeless Assistance Providers and Clients, about 40 percent of homeless people may be eligible for Supplemental Security Income (SSI) even though only 11 percent were receiving payments.³ This SSI “participation rate” is a proxy for homeless participation in no-cost MediCal coverage.

Application of take up rates

We estimated and applied take up rates to six individual groups, based on responses to the CHIS “reason uninsured” question (See Table 2).

Table 2: Survey Responses that Determine "Reason Uninsured" Classifications

"Reason Uninsured"	Sample Survey Responses
Base Case	Can't afford, employer doesn't offer, not eligible
Pre-existing Condition	Ineligible due to health problems
Unwilling	Don't believe in insurance
Temporarily Uninsured	Changed employer, lost job

² Take-up rates in excess of 100 percent were a result of an initial underestimate of the size of the eligible population.

³ As quoted by the San Francisco Ten Year Planning Council.

Table 3 (below) presents the data sources used to assign estimated take up rates to each sub population as well as the resulting range of take up rates associated with each group. Because the take up rates vary based on income (and the varying subsidy provided as a function of income), a range of take up rates is presented for each group.

Table 2: Basis and Range for Lower Bound Take-Up Rates for Governor’s Plan

Subpopulation	Data Sources	Range of Take-Up Rates Used for FPL buckets
Citizen Eligible: Base Case	Lewin Group subsidy-effect, GAO Medi-Cal citizenship effect, RAND information effect	22-65%
Citizen Eligible: Pre-existing Condition	Lewin Group subsidy effect, GAO Medi-Cal citizenship effect, MRMIP participant response	48-65%
Citizen Eligible: Unwilling	Lewin Group subsidy-effect, GAO Medi-Cal citizenship effect	22-65%
Citizen Eligible: Temporarily Uninsured	Lewin Group subsidy-effect, GAO Medi-Cal citizenship effect, CHIS ratio of unemployed with insurance to employed with insurance	9-65%
Homeless	SSI enrollment rates	28%
Undocumented Immigrants	Half of Governor's assumption	10%

Step 2: Weight Populations by Acuity

Because those taking up insurance may be healthier or sicker than the average MIA-eligible person – with significant cost implications for the health care provider or insurer – we sought to weight the eligible population for “acuity.” Acuity is a measure of the state of health of the population in each group relative to the healthfulness of the average eligible person.

To weight the population for acuity, we relied on two key factors: the number of chronic diseases that people reported to CHIS and an analysis of Medical Expenditure Panel Survey (MEPS) data for California that revealed the relative cost of providing health care to people with varying numbers of chronic diseases. Chronic conditions available for measurement in CHIS were asthma, heart disease, high blood pressure, and diabetes. We used chronic disease as a cost barometer because nearly 75 percent of all health care costs are attributable to chronic diseases.⁵

MEPS data provides national and regional estimates of health care use, expenditures, sources of payment, and insurance coverage of the civilian non-institutionalized population. According to Dr.

⁵ Anderson, Gerard F. and Katherine B. Wilson. *Chronic Disease in California: Facts and Figures*. California Health Care Foundation. Oct. 2006

Gerard Anderson's MEPS analysis, Californians with no chronic diseases have 1/3rd the health care expenditures of the average Californian. On the other hand, a person with one chronic disease costs over twice as much as the average. Those California with two chronic diseases are over four times as expensive, while those with three or more chronic diseases are over six times as expensive.

Using this study and the number of Chronic diseases reported to CHIS, we weighted the population in each of the "reason uninsured"/"income" buckets as follows:

- No chronic diseases = 1/3 avg. cost/person
- 1 chronic disease = 2x avg. cost/person
- 2 chronic diseases = 4x avg. cost/person
- 3 or more chronic diseases = 6x avg. cost/person

Applying the Acuity Weights

Applying the acuity weights was a straightforward matter of determining the number of chronic diseases for each CHIS respondent in each of the buckets, multiplying by the appropriate weight, summing the results and dividing by the total (unweighted) number of people in each bucket. The result of this calculation is the acuity-weighted population in each bucket. By applying these weights to both the take-up and county responsibility groups, we arrive at the acuity-weighted percent of the eligible population that either takes-up insurance or remains a county responsibility.

Homeless Acuity Weight

Because the homeless are not covered by CHIS, we needed to estimate the acuity weight for the homeless without relying on a measure of the frequency of chronic diseases among this population.

Acuity for homeless not included in CHIS was estimated based on a measure of homeless hospitalization rates relative to the national average. A 2001 study by Kushel et al. found that the homeless have hospitalization rates that are about four times the national average.⁶

Discussions with county health experts indicated that this still did not capture the true cost of this population given the large percent of psychiatric diagnoses. Using a National Health Care for the Homeless Estimate that a third of the homeless are mentally ill and a repeatedly cited figure that a psychiatric ER visit costs three times more than an average visit, we calculated that 1/3rd of the homeless actually had costs that were 12 times the cost for the average California. Combining this with the two-thirds that have only 4 times the average costs, we arrived at a homeless acuity weight equal to 6.7 times the average cost/person.

Step 3: Estimate Cost Impact

By multiplying the acuity-weighted take-up percentages as calculated in Step 2 above times the total county expenditures for MIA programs, we estimated the percent reduction in the eligible population and, consequently, of county expenditures. These are county expenditures that would no longer be required following health care reform.

⁶ Kushel, Margot. B et al. "Factors Associated With the Health Care Utilization of Homeless Persons." Journal of the American Medical Association. Vol. 285, No. 2. Jan 2001

County Expenditures

To determine total county expenditures on MIA programs, we relied on the CMSP total expenditure data as reported on the CMSP website, and on the Medically Indigent Care Reporting System (MICRS) total expenditures data for MISP counties.

For CMSP counties, we obtained 2004-05 data on ER costs for the undocumented and total service expenditures for all others.

For MISP counties, we utilized the 2002-03 MICRS data on expenditures by service. This data provided the amount paid by counties to inpatient, outpatient, ER, and other services. The MICRS data includes spending on all ages. Since most counties’ MIA programs cover only ages 21 to 64, we used Tables 4 through 7 of the MICRS reporting forms, which break down services expenditures by age, in order to limit our cost estimate to those costs incurred for the appropriate age group.⁷

Both sets of expenditures were adjusted for inflation to bring spending to 2007 dollars.

To estimate the county savings, we multiplied the total expenditures by the overall weighted take-up rates for each county. Because eligibility for the undocumented varies by county, we applied take up rates accordingly. For example, in counties that provide ER services only for the undocumented, we applied the citizen and undocumented take up rate to the total ER costs (since this total includes costs for both citizens and non-citizens). For the remaining (non-emergency) services, we calculated a citizen-only take up rate and applied it to the total non-ER costs for the county. Due to these adjustments, counties that provide citizen-only coverage will have a larger reduction in costs than counties that provide services to the undocumented as well, since more citizens will be covered under both plans.

Recap: Steps used to estimate fiscal impact

Table 4 presents a summary of the steps used to estimate the fiscal impact of the health care reform proposals.

<p>Table 4.</p> <p>Step 1 - Estimate the fraction of the population eligible for county-provided indigent care services that would obtain insurance under each of the plans.</p> <p>Step 2 - Weight the results to reflect how sick “leavers” and “stayers” are, and calculate the percent reduction in acuity-weighted population.</p> <p>Step 3 - Apply the percent reduction in acuity to the total county MIA program expenditures to estimate county savings.</p>
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⁷ Counties that serve populations outside of this age range would experience additional savings not reflected in our results.

Calculating the Overall (net) Fiscal Effect

Because the Governor’s plan would require counties to make a substantial payment to the state, the overall net fiscal effect on counties is equal to the (gross) amount of the county savings as calculated above plus any increases (e.g. medical rate increases) less the amount of any payments or funding reductions.

The proposal originally submitted by the Governor and analyzed by us had several specific funding changes. First, under the proposal counties would be required to pay up to one billion dollars to the state. According to conversations with the administration, the size of the payment would be adjusted based on the relative success/stage of the implementation.⁸ In other words, if fewer Californians take-up insurance than anticipated, the payment to the state would be adjusted accordingly.

For purposes of this analysis, we modeled the effects of a proportional payment. That is, if 50 percent of the anticipated population takes-up insurance, our model calculates the county payment at 50 percent of the maximum payment, or \$500 million. Under our upper bound assumption, we assume that all of the one billion dollars would be paid by counties to the state. Under our lower bound assumption we assume that approximately one-third of the payment would be made (based on the estimated overall acuity weighted take-up).

In addition to these county “repayments,” our fiscal estimates include a reduction of \$316 in Safety Net care pool funds and an increase in county revenues of \$599 million due to increased MediCal reimbursement rates.⁹

Note that our results do not explicitly include the fiscal impact of two other policy changes proposed by the administration: a shift of \$180 million in federal waiver funds for program expansions and the impact of the four percent provider fee that county hospitals would need to pay.

The federal waiver funds are for program expansions that would, presumably, not be needed following health care reform. In addition, to the extent that the counties do not receive these funds, the program expansions for which they are intended would not be required. Therefore, the counties would “save” an amount equal to the \$180 million “cost” of losing these funds.

The impact of the four percent provider fee was not separately estimated as part of this analysis. We note however, that these payments would be offset by a reduction in uncompensated care currently provided by county hospitals. According our analysis, if county hospitals experience a 36 percent reduction in uncompensated care, they will “break even.” In other words, if about one-third more people currently receiving uncompensated care obtain insurance, the county hospital savings will equal the amount of the provider fee.

WHAT OUR MODEL DOES AND DOES NOT CALCULATE

The model developed estimates the acuity-weighted reduction in the size of the population eligible for county MIA program services and applies this percentage to the total county MIA program expenditures. These are the “primary effects” of health care reform.

⁸ Based on conversations with Richard Figueroa and Stan Rosenstein.

⁹ Safety Net Care Pool and MediCal rate change figures were provided by the administration.

Our results do not reflect secondary effects, such as the impact on county hospital payer mixes or the county-by-county effect of reform. That is, the fiscal effects of reform will vary significantly from one county to the next. Some counties likely will have substantial savings while others may have net costs. We recommend that county-by-county impacts be calculated, and payments to state adjusted to ensure that no county experiences a net loss. In addition, county funding reductions should be linked to actual patient reductions and cost savings.

Lastly, it should be noted that our results do not reflect the savings or additional costs for other county health programs aside from the MIA programs, nor do they include an estimate of any cost savings for services to children. Any savings or costs for these programs would need to be added or subtracted to the amounts calculated by our model.

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