City and County of San Francisco
Office of the Controller

Health Benefits For San Francisco Taxi Drivers

Health Plan Alternatives, Funding & Implementation

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Executive Summary

This report was prepared in response to Ordinance Number 228-02, which requires the Controller to submit a recommendation to the Board of Supervisors by October 1, 2003 for enactment of a program that would make health insurance or health benefits available to all taxi drivers.

Policy Problem: Nationwide Lack of Universal Health Insurance Coverage

In the United States, the lack of universal health insurance coverage adversely affects 43.6 million people or some 15.2 percent of the nation's population. In California, the problem is worse with nearly 1 in 5 people or 19.0 percent lacking health insurance coverage. This report addresses alternative solutions to this problem for the approximately 7,800 San Francisco taxi drivers—a group comprised primarily of independent contractors who typically do not have the opportunity to be covered under a group health insurance plan.

Executive Summary

Recommendations

Providing health benefits to drivers is possible, but comes with a cost. Depending upon the alternative selected benefit costs could likely range from as little as $50 to $200 per person per month. The private market solutions appear to be limited due to multiple obstacles, including the independent contractor status of taxi drivers. Obstacles to commercial insurance coverage are detailed in Chapter 1.

Based on our research and the tradeoffs of potential solutions, we believe that health benefits could be provided using any of the following three alternatives: 1) medical savings accounts, 2) a local direct health service program, or 3) health insurance. Health insurance would be the most complex program to implement but would also offer the greatest potential benefit. Additionally, providing health insurance through the San Francisco Health Plan, using the HealthyWorkers program of health insurance for local In-Home Supportive Services workers as the prototype, is a possible solution that could move San Francisco another step closer to universal health insurance coverage.

Costs for any one of the three alternatives could be distributed across multiple funding sources, including drivers, medallion holders, customers, operating companies and public support. Selection of a benefit alternative and funding structure are ultimately policy decisions for the Board. Any direct health service program or health insurance plan would have to be designed with full participation of the Department of Public Health. The San Francisco Health Plan would also need to be involved in the case of a health insurance plan or the medical savings account alternative. While this report describes existing and potential alternatives, a number of key unknowns and risks will need to be addressed. Regardless of the alternative selected, we suggest an initial two- to three-year time limit to allow for implementation and evaluation.

1: Market Forces

This chapter provides a review of some of the market and legal forces that shape the taxi and health insurance industries and contribute to the current lack of health insurance for taxi drivers.

Taxicab Industry in San Francisco

Regulatory History

The legal foundation underpinning many important aspects of the taxi industry in San Francisco is Proposition K, passed by the voters in 1978. Proposition K substantially changed the regulation of medallions (or permits). A medallion is a city-issued permit giving the holder the right to operate a taxicab. When a permit becomes available, the City's Taxi Commission grants it to the person at the top of the waiting list. Permit holders are subject to a driving requirement of at least one four-hour shift every 24 hours on three quarters of the business days in a calendar year. The City's Taxi Commission is charged with administering industry regulation.

Medallions issued after the passage of Proposition K are held by individuals who drive and may not be sold or transferred. Prior to Proposition K, medallions were owned by companies and individuals, some of whom were drivers and others who used the medallions simply as a financial investment. Permits issued prior to 1978 are called "pre-K" medallions, are transferable, and are not subject to the driving requirement. The number of medallions, currently 1,381, is regulated by the Taxi Commission. It is important to understand the allocation of permits because, as we discuss below, they confer an economic benefit on their holders that has a significant impact on driver income.

Proposition K also helped create an environment that changed the status of drivers from employees of taxicab operating companies, which held most permits, to independent contractors, a change in status which has been the trend in major cities across the country. As drivers became medallion holders or had the potential to become future medallion holders, more became entrepreneurial, operating as independent contractors or small businesses. This situation was also promoted by companies as they sought to be relieved of employer tax burdens - including for example employee benefits and payroll tax costs.

Current Relationships Among Industry Players

The San Francisco taxi industry is comprised of three major components: medallion (or permit) holders, color schemes (or taxicab companies), and drivers. There are currently about 33 taxicab companies in San Francisco, of which 12 companies control 86 percent of the market, or 1,189 of the 1,381 total permits in service. The high concentration of medallion market share also results in the effective concentration of driver association with this one-third of the taxicab operating companies.

According to the Tax Collector's Office, there are currently some 7,800 approved A-cards (the taxi driver license that all drivers must renew annually). It is not known how many of these are held by active drivers or what percentage of the time drivers are working, but the most commonly cited figure for the number of taxi drivers operating in San Francisco is approximately 6,000[1]. Of these, 912 are medallion holders. Most often these medallion holders rent their permits to a large taxicab operating company, which in turn provides taxicab drivers (both medallion holders and non-medallion holders) with vehicles, insurance, dispatch and other taxi support services. In consideration of these services the taxicab operating companies charge a fee to drivers commonly referred to as a "gate fee." In the case of larger companies the gate fee typically covers a wide range of services - from taxicab with color scheme identification, radio dispatch, worker's compensation and liability insurance to car maintenance. For smaller companies, services can range from full service to limited service, for example only color scheme detailing and radio dispatch.

To fully explain the San Francisco taxicab industry, it is critical to understand the relationship of taxicab operating companies (or color schemes), medallion holders and drivers. In most cases, medallion holders rent their medallions to taxicab operating companies. This currently non-regulated transaction has been valued at approximately $1,800 per month by market forces. In turn, taxicab operating companies provide drivers (both medallion holder and non-medallion holder) with a vehicle, insurance, and dispatch services for a consideration known as the "gate fee." Under City regulation, the gate fee cannot exceed an average of $91.50 for a ten-hour shift - some shifts may be higher, some lower but the average across all shifts can be no more than $91.50 for a ten-hour period.

Smaller taxicab operating companies may offer a limited range of services and operating arrangements, depending on the company. Typically, the small company secures drivers who are associated with secondary drivers and who provide their own vehicles and associated cost; dispatch services and color scheme are the only provided services. In these cases, a $91.50 gate fee cap may be a moot point as the cost of the average gate is less than the $91.50 cap because drivers are paying for a limited range of services.

The status of drivers, that is, whether they are medallion holders or not, and the associated relationship with taxicab operating companies has important implications. Under the current system, drivers are generally considered to be self-employed. For Internal Revenue Service (IRS) or Franchise Tax Board (FTB) purposes, drivers are typically deemed to be independent contractors, but for workers' compensation and general liability purposes the distinction between entities is less clear. At the same time, taxicab operating companies recognize the potential benefits of transferring in part related operating costs, whether it is related to insurance or car maintenance. As an example, vehicle ownership among drivers who hold medallions has been promoted as operating companies may be encouraging ownership as a means to further underscores the nature of the driver, being separate and distinct legal entity from the taxicab operating company.

Understanding the relationships between taxicab drivers and operating companies is particularly important in the context of health benefits because it underlies one of the main reasons commercial group health insurance, which provides risk/cost sharing across a group of participants and related economies of scale, is then effectively unavailable for taxi drivers.

[1] If all 1,381 medallions were in constant use, approximately 5,800 drivers working 40-hours per week would absorb all the available driving hours. If medallions were used for an average of two 10-hour shifts per day, approximately 4,200 full-time equivalent drivers could service the 1,008,130 shifts per year. (Here full-time equivalent driver is assumed to drive 20 10-hour shifts per month.) However, many drivers work part time, and some drivers may have other employment.

That is, because drivers are independent contractors rather than employees of the operating companies, there is no single employer or group of employers who can serve as a group policyholder for them.

Driver Income

The structure and regulation of the industry also affect driver income, which in turn affects their willingness and ability to pay for health insurance. Drivers pay varying gate fees depending upon the shift and taxicab operating company (and associated support services provided). A driver's income is therefore determined by how much revenue he or she can earn during each shift in excess of gate fees and gas costs. Assuming that in the current weak economic climate a driver has 15 paying fares per 10-hour shift with an average fare generating $15.90, a driver would have gross receipts of $238.50 per shift. After paying a $91.50 gate fee, an estimated $25 of gasoline costs, and self-employment taxes (currently 12.4% for Social Security and 2.90% for Medicare) this translates to an effective 'employee' equivalent annual salary of approximately $25,000 to $30,000 per year for a driver working five 10-hour shifts per week, 52 weeks per year. Many drivers do not work such hours, choosing instead to drive part time as a second job, to drive intermittently, or to work even longer hours to increase income. We therefore estimate that incomes actually span a broader range of $15,000 to $40,000 per year depending on the individual and the economy.

Health Insurance Industry

Underwriting – Who Gets Insurance and How

State law and insurers' underwriting practices have a substantial role in determining which individuals or groups of individuals are eligible for group insurance coverage. The process of underwriting insurance involves evaluating the risk of insuring a person or group, determining whether to accept an application for insurance, and setting premiums and benefits. Groups often enjoy lower premium costs than individuals because of the economies of scale involved in underwriting, selling, enrolling and administering a single group contract versus numerous individual contracts. Group plans also offer insurers the opportunity to spread the risk of high health care costs for one or a few individuals over the entire group. In addition, and perhaps most importantly, group insurance works because coverage is often mandatory, that is, all people in the group must purchase the insurance, not just those who are sick. Most insurers require that employers require employees to participate, unless they can prove they have other coverage.

There are three types of relationships between group policyholders and insured individuals: 1) employee—employer, 2) debtor—creditor, and 3) member—union. Voluntary trade associations, labor unions, professional associations, fraternal and religious organizations are all examples of groups that may be eligible for coverage. Underwriters seek certain characteristics in groups applying for insurance. First of all, the group must have permanency, meaning that there is a strong and cohesive bond among members. A group that exists only for insurance purposes is not considered permanent because it will tend to attract only higher risk individuals and is more likely to dissolve, making it difficult for the insurer to collect contributions in an efficient and reliable way. Insurers seek groups that have a stable, centralized administrative capacity to enroll members, collect and send contributions, and keep records. They prefer groups that have automated collection of contributions (such as payroll deductions), and good credit ratings—that is, groups that will

pay their members' premiums on time. They may also have requirements on minimum group size and percentage of group enrolled.

Underwriters pay particular attention to a group's prior claim experience. If there is no claim experience, because the group has never been covered, they will rely more heavily on other factors including group size, the industry in which its members are employed, and its composition in terms of age, sex, dependents, income, and geographic location. The larger the group, the easier it is to predict claim costs, because large individual variations are averaged out over the many group members. In general, people employed in seasonal businesses with high turnover, such as restaurants and parking garages, are considered a greater insurance risk because they have a high ratio of claims to premiums paid and volatile enrollment levels. Extreme youth or age are seen as risk factors, because very young members often have high turnover and older members often have chronic conditions. Women generally seek and receive more health care services than men. Income distribution is considered important, as those with very high incomes may demand expensive treatments, while those with very low incomes are often perceived to be a poor insurance risk because of their work type or location. Group members with dependents present the risk of duplicate coverage for those dependents, who may be covered under a spouse or domestic partner's group plan. Additionally, certain regions of the country have particularly high health care costs.

Underwriters will examine the way in which the policyholder and group members plan to share costs. Full payment by the policyholder (usually an employer) is preferred because it assures full participation by the group (i.e. reduced adverse selection[2]) and is easier to administer. Some insurers will not accept plans where participants pay most or all of the costs, because it suggests a lack of interest by the employer that could hamper administration, and the costs could discourage participation (i.e. increase adverse selection risk). As mentioned above, the policyholder must have adequate administrative capacity to process enrollments and terminations, prepare and pay premiums on time, certify eligibility of coverage, and perform other administrative tasks. Finally, insurers seek groups that they expect will maintain the policy for at least three years in order to cover the costs of acquiring the group. They avoid groups that change insurers often, are temporary in nature, or have financial difficulties.

Entities besides employers can serve as the policyholder for a group, although there may be more restrictions on such policies. For example, few insurers write policies for labor unions, for several reasons. First, most union members receive coverage through an employer. Second, often union plans require members to pay the entire premium cost, making it difficult to ensure high and stable participation levels. There is also the risk of adverse selection if union membership is not compulsory. For trade associations, insurers often include stringent preexisting conditions clauses unless a very high proportion (from 50% to 100%) of members are guaranteed to participate. Professional associations, clubs, and fraternal organizations are less likely than employers to obtain coverage because as with labor unions, most members will have an employee-sponsored plan, and thus the risk of adverse selection is high. Also, some states do not allow group insurance for professional associations.

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[2] Insurers base premium costs on the average expected costs for all members of a group. Adverse selection occurs when a disproportionate number of people with higher than expected health care costs enroll in an insurance plan. Insurers have higher costs than they expected and lose money.

Underwriting San Francisco's Taxicab Drivers

The brokerage and underwriting professionals we contacted reported that purchasing commercial group health insurance for taxi drivers would be difficult for several reasons. Most importantly, drivers are generally independent contractors, not employees of cab companies. Thus, there is no employer or group of employers to serve as the policyholder. Additionally, there is currently no other entity, such as a union or professional association where the majority of drivers are active members,[3] with the ability to collect contributions, make premium payments on a consistent basis, and guarantee high participation levels for the group. The relative instability of the taxicab driver group and perceived hazards of the job make it an unattractive risk to underwrite.[4] One certified insurance broker we worked with during the development of this report stated that she was unable to identify any private insurers who were willing to bid on a policy for this group or even quote a premium level at which they would provide coverage because, again, they were not an employee group and did not meet industry underwriting guidelines. Based on these findings, it appears that the private market alternatives are only feasible if mandatory participation in a single group were required of drivers and that premium contributions were collected and remitted through a single payer on behalf of all drivers. Even with these necessary conditions, initial start-up of any program would likely be difficult.

[3] The United Taxicab Workers (UTW) reported that they have approximately 150 dues-paying members out of a total 6,000 estimated drivers (or 7,800 A-card holders). The San Francisco Taxicab Permitholders and Drivers Association (PDA) has approximately 60 dues-paying members, out of the estimated 1,000 individual medallion holders. In both cases, the organizations represent a small portion of the total insurable population.

[4] The individuals we contacted cited no taxi industry-specific details. However, according to a 2000 study conducted by the Occupational Safety & Health Administration, taxi drivers have the third highest rate of violent assaults of any occupation, lower than only police officers and private security guards. They work alone, sometimes at night and in high-crime areas, and generally carry cash.

2: Potential Solutions

This chapter provides a review of current or recent public and private sector health insurance options in California as well as efforts to provide health care to taxi drivers in other jurisdictions.

Private Market – Group Coverage Through Industry Associations

From 1997 to 2002, UTW and PDA members had the option of enrolling in a Kaiser Permanente Group Health Plan. The plan administrator was the National Association of Socially Responsible Organizations (NASRO). Benefits included comprehensive health services, with drivers paying $216 per month in 2002 individual coverage or $575 for family coverage, plus $10 co-pays for office visits and prescriptions. Given these rates, an individual participant would pay $2,592 per year, and a family would pay $6,900 per year, not including membership dues or copays. Midway through the period when the plan was offered, NASRO started to require individual drivers to pay annual dues of $50 if they wanted to enroll. Drivers were also required to be dues-paying members of either UTW or PDA to enroll.

We were not able to find data on the exact number of drivers who participated, however, estimates range from 30 to 80 individuals enrolled at any given time. The program ended in 2002, when Kaiser discontinued its contract with NASRO. At that point, NASRO contacted enrollees and offered them alternative plans that either excluded treatment for preexisting conditions or required a medical questionnaire, which could potentially disqualify those who needed coverage the most. According to UTW and PDA staff, no one elected any of the alternative plans offered.

Private Market – Individual Coverage Through Private Insurers

We reviewed two major individual coverage options currently available: Kaiser HMO Personal Advantage and Blue Cross HMO Saver. Average monthly premium costs for a 45-year old are $250 for a single person and $624 for a family of three. Appendix A, Individual Insurance – Premiums and Driver Income, illustrates the estimated increases in driver income required to cover premium costs in this market. For example, a driver with an adjusted gross income of $25,000 per year would spend approximately 12% of that income for individual coverage, and 30% for a family of three. A driver with a $40,000 income would spend 8% of it for individual and 19% for family coverage. These are only for premium costs. Kaiser's HMO Personal Advantage plan charges $20 co-pays for primary care visits, and $10-$35 co-pays for prescriptions. While the cost of insurance is partially deductible from state and federal taxes for self-employed individuals, cost will still be the major deterrent to obtaining individual or family coverage given the likely annual income range of $15,000 to $40,000 per taxicab driver.

Cost is not the only determining factor in obtaining individual coverage. Insurance companies establish insurability through medical questionnaires and medical exams before issuing a policy, and will reject applicants for whom they estimate they will pay more in claims than

receive in premiums, or will deny coverage for preexisting conditions. In addition to higher cost, this lack of guaranteed coverage in individually purchased insurance is the most significant difference between individual and group insurance plans.

Public Sector Programs

California State-Sponsored Programs

The California Managed Risk Medical Insurance Board (MRMIB) offers insurance coverage through three programs. In general, coverage provided through these programs is for children, pregnant women, and adults who have been denied, but are willing to pay for, individual insurance in the private market. These programs may help the dependents of drivers, but are unlikely to serve the majority of drivers themselves, unless they have been denied coverage in the past and have the ability to pay for costly MRMIP coverage.

Major Risk Medical Insurance Program (MRMIP)
MRMIP provides health insurance for uninsured California residents who are not eligible for Medicare and who have been denied individual coverage in the private insurance market. Services are delivered through contracts between the MRMIP Board and health insurance providers, including Blue Cross, Blue Shield, and Kaiser Permanente. Participants pay premiums for their coverage, and the MRMIP uses tobacco tax funds to supplement the premiums to cover any additional costs of care. Participants can be enrolled in MRMIP for a maximum of 36 months, at which time they are dis-enrolled and offered guaranteed-issue coverage in the individual insurance market.

The primary purpose of MRMIP is to provide coverage to individuals who have been denied it due to pre-existing conditions. As a result of the higher health care needs of the targeted population, premium rates are higher than those in the private individual insurance market, ranging from $332 to $611 per month for a 45-year old subscriber. In addition, providers generally charge either fixed amount co-payments or 20-25% co-payments depending upon the service. The maximum co-payment per year is $2,500 for individuals and $4,000 for households, and benefits are capped at $75,000 per year and $750,000 in a lifetime. A 45-year old driver who selected the coverage with the lowest premium cost and paid $200 in co-payments, which would represent a very minimal amount of services actually consumed, would spend $4,184 per year. Given these costs, it seems likely that even fewer drivers would seek coverage through this program than participated in the NASRO Kaiser plan, which had monthly premiums of approximately $216 for individuals and $574 for families.

Healthy Families Program (HFP)
MRMIB also administers two other programs that offer coverage for children and pregnant women. HFP provides health and dental insurance to children ages 0-18 whose family incomes are too high to qualify for no-cost Medi-Cal yet below 250% of the federal poverty guidelines. A family of three would have to have annual income just below $38,150 to qualify. Families pay between $4-9 per child per month in premiums, with all other costs covered by federal and state monies.

Access for Infants and Mothers (AIM)
Through MRMIB, AIM provides health insurance to low-income, uninsured pregnant women and infant children. The typical subscriber is a married woman with household income

between 200%-300% of the federal poverty guidelines. A family of three would have to have income of $30,520-$45,780 per year, and would pay 2% of their income after deductions, or approximately $610-$916 annually for coverage. AIM is funded through tobacco tax monies. These two programs may assist drivers' dependents, but will not provide coverage for the majority of the driver population.

Medi-Cal
The California Department of Health Services administers Medi-Cal, the state's Medicaid program, which provides health coverage to low-income children, their parents, and certain disabled adults. Although there are 165 categories under which individuals and families may qualify, two of the largest are those who receive or are eligible for CalWORKs and SSI. Families and individuals who meet certain deprivation criteria are eligible for low-cost Medi-Cal, through which they would pay the difference between their income and the "maintenance need income level," which is $600 per month ($7,200 annually) for a family size of one and $934 per month ($11,208 annually) for a family of three.

PacAdvantage
Finally, the state sponsors Pacific Health Advantage (PacAdvantage, formerly known as the Health Insurance Plan of California, or HIPC), the country's largest insurance pool for small businesses and non-profits employing 2-50 people. The consolidated purchasing power of PacAdvantage lets small employers offer health plans of a quality and price generally available only to larger employers. All plans are guaranteed issue, and include the standard HMO and PPO benefits and rates offered by Kaiser, Blue Shield, HealthNet, and others.

Local Public Sector Insurance Programs - The San Francisco Health Plan

In 1993 California began implementing a plan to move most Medi-Cal beneficiaries from traditional fee-for-service to HMO or other managed-care delivery systems. A key part of this implementation was the creation of locally operated health plans to serve Medi-Cal clients. There are eight local health plans in California, serving primarily urban populations. The local health plan in San Francisco is the San Francisco Health Plan (SFHP), created in 1994 as a separate legal entity from the City, directed by a board representing the Department of Public Health, the Health Commission, other local health service providers and community members. SFHP has an HMO license from the State Department of Managed Health Care that allows it to provide HMO plans. As with other local health plans, SFHP administers Medi-Cal, Healthy Families, and Healthy Kids programs. In addition, SFHP is the insurer for the HealthyWorkers program, which provides health insurance to In-Home Support Service (IHSS) workers in San Francisco. The IHSS model is of considerable interest to the issue at hand for this report as it may serve as a prototype for covering groups of uninsured workers generally and taxicab drivers in particular. It is further discussed below.

HealthyWorkers Program for IHSS Workers

There are approximately 11,000 IHSS workers in San Francisco who provide personal assistance services to approximately 14,000 low-income residents. Most IHSS workers are independent contractors who are selected, hired, and fired directly by the consumer. Appendix B, IHSS Health Insurance Plan Diagram, is a schematic diagram that illustrates the complex, but necessary, organizational structure required to provide IHSS workers with benefits through San Francisco Health Plan's HealthyWorkers insurance program.

The IHSS Public Authority (Public Authority), a legally separate entity from the City and County established by the Board of Supervisors to manage and deliver in-home supportive services, is the workers' employer of record and health insurance policyholder. Among other tasks, the Authority provides screened provider lists to consumers, conducts training for both workers and consumers, and serves as the employer during collective bargaining over wages and benefits. SEIU Local 250 represents IHSS workers, and their salary, workers' compensation, social security, and health benefit costs are paid by a combination of state, federal, and local funds.

The HealthyWorkers program provides health benefits to IHSS Workers who work in San Francisco. Workers are eligible for coverage if they have been providing services in San Francisco for the last two months for at least 25 hours in one of those months and have completed a 60-day waiting period. The total number of workers who meet these criteria are estimated to number 9,000 out of a total of 11,000. Premiums are $3 per month, and co-payments are very low ($5 for brand name prescriptions, and no co-payments for most services). Benefits are comprehensive and include inpatient and outpatient medical, surgical, mental health, rehabilitative and pharmacy services. There is no deductible or lifetime maximum. The Public Authority contracts with SFHP to provide health benefits. Dental benefits are provided separately through a contract between the Public Authority and Delta Dental.

Medical benefits through HealthyWorkers have been offered since March 1999. The per member per month (pmpm) premium of $146.43 was established at the start of the program based on statewide commercial insurance rates for similar populations adjusted based on local provider data. The premium did not change for several years, but was increased to $201.80 pmpm as of July 1, 2003 to cover the rising costs to the Department of Public Health (DPH) of serving the workers on the plan. The workers' $3 contribution toward premium costs has not changed since program inception in 1999. It was designed to be low enough that it would not deter people from enrolling, but high enough to discourage people from dropping existing insurance.

In addition to the schematic diagram included in Appendix B, the HealthyWorkers program can be summarized both by its funding sources and uses. Total funding sources for FY 2003-04 are summarized in Table 1 below.

Table 1. IHSS HealthyWorkers FY 2003-04 - Funding Sources Summary

			Per Member / Insured		
Funding Sources	**Total**	**% of Total**	**Per Year**	**Per Month**	**% of Total**
Federal Government	$ 8,221,684	43.9%	$ 1,414.12	$ 117.84	43.9%
State Government	$ 3,006,410	16.1%	$ 517.10	$ 43.09	16.1%
Local Government	$ 7,285,077	38.9%	$ 1,253.02	$ 104.42	38.9%
Dept. of Public Health	*$ 6,216,397*	*33.2%*	*$ 1,069.21*	*$ 89.10*	*33.2%*
Dept. of Human Services	*$ 1,068,680*	*5.7%*	*$ 183.81*	*$ 15.32*	*5.7%*
IHSS Workers	$ 209,304	1.1%	$ 36.00	$ 3.00	1.1%
Total Premium Costs	**$ 18,722,475**	**100.0%**	**$ 3,220.24**	**$ 268.35**	**100.0%**

A key financial component of the HealthyWorkers program is that the federal and state governments contribute toward premium costs. DHS is responsible for securing the federal and state funding as well as remitting the City's budgeted contributions to the IHSS Authority. In FY 2003-04, DHS will secure an estimated $8.2 million in federal funding and $3.0 million from state funding, totaling 60% of total projected sources. Another key assumption in the

financing of HealthyWorkers is that the City already pays for medical care for uninsured people, including IHSS workers, who seek services at San Francisco General Hospital and community clinics.[5]

Allocating a portion of Department of Public Health's (DPH) budget for indigent health services to this group accounts for $6.2 million of total funding sources. This $6.2 million is included in DPH's FY 2003-04 budget as a work order to the Department of Human Services (DHS), thereby serving as a funding source for premium costs. Additionally, DHS budgeted $1.1 million to cover the costs of administrative services, health benefits not provided by DPH (including vision care), and dental insurance costs. IHSS workers pay total costs of $36 per year or $3 per month, which is deducted from their paychecks by the State Controller's Office and forwarded to SFHP via their union, SEIU Local 250.

The funding sources described above are used to pay for all various health benefits coverage, including dental, vision, pharmacy and medical. This is accomplished by the IHSS Authority contracting with providers and paying premiums, including premium payments to the San Francisco Health Plan (SFHP), one of the insurers, which in turn uses their premium revenue to cover medical benefits and insurance costs. A summary of the medical costs and associated capitation rates used for FY 2003-04 are outlined in Table 2 below.

Table 2. IHSS HealthyWorkers FY 2003-04 - Funding Capitation Summary

	Total		Per Member / Insured		
Total Uses / Capitation	**Annual Cost**	**% of Total**	**Per Year**	**Per Month**	**% of Total**
Medical					
Group	$ 6,254,833	33.4%	$ 1,075.82	$ 89.65	33.4%
Hospital	$ 4,084,087	21.8%	$ 702.46	$ 58.54	21.8%
Stop Loss	$ 141,629	0.8%	$ 24.36	$ 2.03	0.8%
Subtotal Medical	$ 10,480,549	56.0%	$ 1,802.64	$ 150.22	56.0%
Mental Health	$ 401,864	2.1%	$ 69.12	$ 5.76	2.1%
Vision	$ 171,629	0.9%	$ 29.52	$ 2.46	0.9%
Pharmacy	$ 1,501,407	8.0%	$ 258.24	$ 21.52	8.0%
SFHP Administration	$ 1,314,429	7.0%	$ 226.08	$ 18.84	7.0%
Capitation from IHSS Public Author	**$ 13,869,878**	**74.1%**	**$ 2,385.60**	**$ 198.80**	**74.1%**
Other / Dental	$ 4,852,597	25.9%	$ 834.64	$ 69.55	25.9%
Total Uses	**$ 18,722,475**	**100.0%**	**$ 3,220.24**	**$ 268.35**	**100.0%**

For FY 2003-04, DPH is projected to receive approximately $10.7 million in capitation payments from SFHP to cover associated medical group and hospital costs, along with mental health costs. However, since DPH contributed $6.2 million in funding allocation through its budget, the net departmental funding is really only $4.5 million to cover increased utilization and related health care costs for IHSS workers. Additionally, DHS contributed $1.1 million toward program costs through its FY 2003-04 budget.

Enrollment in the HealthyWorkers program is growing as more people learn about the benefits of the program, including the low cost charged to members, especially as compared to other private market alternatives. Out of an estimated 11,000 IHSS workers, FY 2003-04 program costs are based on projected enrollment of approximately 6,450 by June 2004. DHS estimates that about 50 percent of IHSS workers live in San Francisco, and many of these

[5] The other Public Authorities in California who offer health coverage purchase health insurance coverage for IHSS workers through the private market.

share a home with the individuals to whom they provide care. The other half of IHSS workers live outside of the City.

Taxi Driver Health Programs in Other Jurisdictions

The taxicab industry in San Francisco has evolved over the past two decades following Proposition K in 1978. Today, the norm is that taxi drivers are independent contractors, and as a result they are responsible for purchasing medical insurance individually because they are not represented by an employer or overarching professional association. We contacted several other jurisdictions and found a variety of local responses to the issue of health coverage for drivers. Of those cities we surveyed, only Las Vegas, a city where taxicab drivers are employees of operating companies, affords health benefits to drivers.

New York City

The New York City Taxi and Limousine Commission Health Insurance Program provides outreach and enrollment assistance to link qualifying drivers and their families to New York State's health insurance programs for low-income residents. The Commission's efforts are part of HealthStat, a program managed by the Mayor's Office of Health Insurance Access with the goal of increasing the number of people with health insurance in New York City. Family Health Plus is New York State's public health insurance program for adults between ages 19 and 64 who do not have employer-sponsored coverage, are not eligible for Medicare or Medicaid, and who meet income requirements. The current maximum annual gross income for a single adult is $8,980. Drivers who are ineligible for Family Health Plus are left with individually procured coverage, being covered as a dependent or going without coverage altogether. The $8,980 maximum annual gross income serves to significantly restrict the number of drivers that even qualify for Family Health Plus.

Chicago

The City of Chicago's Department of Consumer Services, which regulates taxicabs, invites a local nonprofit outreach and referral center to provide drivers with information on state or other public health programs for which they might qualify. There are about ten loosely organized drivers' associations in Chicago, each tending to serve a particular ethnic group. There is interest among drivers in obtaining low-cost health insurance benefits through the associations, however, no programs have been established, and drivers must still obtain benefits as individuals.

Seattle

Likewise in Seattle, the Department of Consumer Affairs reports that all drivers are self-employed independent contractors, and although one driver group represents as many as ten percent of drivers, it does not have any health plan. The City of Seattle is not involved in any programs related to drivers.

Los Angeles

Los Angeles has a slightly different regulatory structure from the other cities we contacted. Rather than granting medallions, the city has granted a set number of vehicle authorizations to nine taxi operators. Eight of these are coops of owner-operators, in which no one owner can control more than five percent of the total vehicle authorizations. Authorizations are transferable (i.e. can be bought and sold) only within a franchise. Still, the vast majority of drivers are independent contractors who lease vehicles from operators, and do not have health or any other benefits.

Las Vegas

Las Vegas is the only city we identified where drivers are employees of cab companies and receive health benefits from them. As in all jurisdictions, the industry relationships appear to be directly influenced by taxi regulations. In Clark County, where Las Vegas is located, medallions are issued to cab companies, not individuals, and are not transferable. Companies pay a fee of $100 per medallion per year for each medallion they own. Drivers are employees of the cab companies and receive health and unemployment benefits.

Yellow Checker Star is the largest cab company in Nevada, primarily serving the Las Vegas area. Of approximately 1,500 drivers, 900 are enrolled in the company's PPO plan, under which the insurer covers 80% of medical costs and drivers the remaining 20%. There is an 18-month waiting period after which drivers are automatically enrolled in the plan and charged a $20 per month premium. Participation is mandatory for any driver who becomes eligible, and drivers must work full time to retain coverage. Yellow Checker Star is unusual in that it is self-insured, and pays for the costs of health care directly out of a fund it has established for the purpose. Other companies in the area provide coverage through standard health insurance products. Many of these companies have six-month waiting periods, and require part-time drivers to pay a prorated share of premiums.

3: Health Benefit Plan & Funding Alternatives

This chapter explores two major topics relating to the provision of health benefits: 1) health benefit plan alternatives and 2) funding the cost of those alternatives. The advantages and disadvantages of the specific alternatives and funding arrangements depend greatly on the level of benefits provided, as well as who ultimately shoulders the cost of providing that coverage.

Health Benefit Plan Alternatives

Providing health benefits to taxicab drivers can be achieved through a range of alternatives. The spectrum of possibilities includes utilization of tax-advantaged Medical Savings Accounts for each driver to creating a local benefits plan or even providing a health insurance plan with out of network coverage. The strengths and weaknesses of the three alternatives are discussed in the next section and in Table 3 below, Health Plan Alternatives – Comparative Analysis, which compares these three alternatives in terms of plan design, cost, and administrative criteria.

- **MEDICAL SAVINGS ACCOUNTS (MSA):** We considered two types of MSAs: 1) the local MSA used for San Francisco childcare workers, and 2) the Archer MSA. The Archer MSA was created in 1996 to provide for the accumulation of funds to be used for medical expenses, and may sunset in December 2003 if not extended by Congress. A number of private companies administer these tax-exempt savings accounts, which self-employed individuals use to save and pay for health care costs. One of the requirements of establishing an Archer MSA is that individuals must be covered under a high deductible health plan (HDHP). Archer MSAs may be helpful for drivers who are already covered under some type of qualifying plan and serve to complement this other coverage. A key limitation to this alternative is the HDHP requirement, since many drivers do not have any coverage at all. Confronted with similarly challenging circumstances in trying to insure childcare workers, the City and San Francisco Health Plan established a local form of MSA. Funds in these MSA accounts can be used by the workers to purchase health insurance or to pay for medical costs directly. Any funds not used from one month's allocation accumulate for future use. This local MSA (rather than the Archer MSA) is the option we discuss.

- **LOCAL DIRECT HEALTH SERVICES PROGRAM:** Another option is directly funding the provision of health care through a local network of providers, for example the Department of Public Health's clinics and San Francisco General Hospital. Under

this alternative, drivers would be required to seek medical treatment through the DPH system of care, being required to use only DPH facilities or providers who contract with DPH to provide services to drivers. This alternative limits provider choice to only a select group of local providers, while containing costs and creating very little administrative cost. In addition, it has the benefit of supporting the DPH system.

- **HEALTH INSURANCE:** A third alternative is to provide a traditional health insurance program that is either subsidized or not. This could be through the private market if taxicab drivers were consolidated under a group – either through an association or employer. Because we do not see this as a likely possibility over the near-term, we instead focused this alternative toward the HealthyWorkers program provided by the SFHP to IHSS workers. Coverage from the SFHP could guaranteed if the premium were high enough. We have attached a copy of the schedule of benefits provided under the HealthyWorkers in Appendix C, HealthyWorkers Program Summary of Benefits (for purposes of comparison, benefits schedules for the private market individual plans we reviewed are in Appendix D, Kaiser Permanente Personal Advantage Summary of Benefits and Appendix E, Blue Cross of California HMO Saver Summary of Benefits). While health insurance comes in many forms today – from managed care models such as HMOs and PPOs to conventional indemnity models – we have focused our analysis on a managed care model like the HealthyWorkers program because of the higher costs associated with the other models and their limited availability to drivers until a claims history can be established. Additionally, based on the 2003 Annual Survey of employer health benefits, managed care models are estimated to cover some 95 percent of all people with public or private employer-sponsored insurance in the US today.[6]

Cost Sharing: Contribution Toward Coverage, Deductibles, and Copays

Health Plans and insurance generally require covered individuals to share in some of the cost of care through a premium contribution, deductibles or co-pays for office visits, prescriptions, and other services, in part to discourage unnecessary utilization. According to two recent studies employees typically pay between 15 to 20 percent of the premium cost.[7] The health plans and insurance we reviewed for this study also required co-pays ranging from the IHSS HealthyWorkers program at the low end to Kaiser and Blue Cross at the higher end. Some level of cost sharing is standard, and when set at a reasonable level can actually help to ensure that only medically necessary services are used. The higher the copay the more it can be also be used to cover program costs.

Eligibility

Benefits could be offered to all drivers, regardless of how many hours they drive, as long as the coverage is mandatory. Making coverage mandatory helps to guard against adverse selection, while simplifying administration because any driver with a valid A-card would be an active member. Requiring that a minimum number of hours be worked over a stated period could also serve to restrict benefits to full-time or active drivers.8 This is chiefly a policy

[6] Kaiser Family Foundation / Health Research and Educational Trust, *2003 Annual Employer Health Benefits Survey*. Findings based on a survey of 2,808 randomly selected public and private employers, with an overall response rate of 50 percent. The 95 percent level in 2003 reflects a tidal shift from the 27 percent in managed care plans in 1988.

[7] Kaiser Family Foundation / Health Research and Educational Trust, *2003 Annual Employer Health Benefits Survey*. Towers Perrin Survey of Employers, 19% based on 2004 expected costs. Wall Street Journal, *Health-Care Costs to Rise in 2004*, September 29, 2003.

[8] Post-Proposition K (post-K) medallion holders are subject to a driving requirement. The Taxi Commission reports that this covers 912 of the 1,381 medallion permits issued. The driving requirement for post-K medallion holders is that they drive at least 156 four-hour shifts each year.

decision, but one that will have significant administrative and cost consequences. A driving requirement could instill a sense that benefits should be earned through working a prescribed number of hours, and would guard against individuals working minimal hours for the sole purpose of securing health benefits. However, in this latter case, a 6- to 18-month waiting period could also be used. In the case of IHSS workers, they are eligible for HealthyWorkers only if they have provided services in San Francisco for the last two months for at least 25 hours in one of those months and have completed a 60-day waiting period. This requires on-going monitoring and additional administrative costs for the IHSS Public Authority.

Pros & Cons of Health Benefit Plan Alternatives

Based on our research, we narrowed potential solutions down to three general alternatives given private and public market constraints. Depending on the individual, one health benefit (or combination thereof) alternative may be more or less appealing. Without knowing how many drivers currently have coverage, we are unable to say which alternative may be best for the most drivers. However, we have summarized our findings and key differences of the health benefit plan alternatives in the table below, Health Plan Alternatives – Comparative Analysis, which shows how the three alternatives compare as far as benefits, cost, and administration. Any of these health benefit alternatives could be pursued, although if universal health insurance coverage is the policy goal, health insurance through the SFHP should be selected. The SFHP reports that it is able to provide a health insurance program similar to HealthyWorkers for taxicab drivers, if all drivers are required to purchase the insurance and/or the premiums were adequate.

Table 3. Health Plan Alternatives – Comparative Analysis

	Alternatives		
	Medical Savings Account [Local version, non-Archer]	**Local Direct Health Services Program** [Lacks insurance component]	**Health Insurance**
Benefit Plan Design Components			
Coverage broad and includes common services...	Any qualified medical expense is eligible.	A local health plan can be designed to be as broad as desired, depending upon cost constraints. For example, some may limit high-cost procedures such as transplants in order to keep member costs low. Would not cover services provided by non DPH-providers, such as emergency services at hospitals other than SFGH.	There is an active market for HMO, PPO and indemnity coverage for individuals and groups in the Bay Area, with a broad range of plan coverage options.
Coverage or benefits guaranteed…	No . Individuals who want to use their MSA balance for insurance must must qualify for private market coverage.	Can be designed as guaranteed issue - but mandatory participation would likely be needed to guard against adverse selection.	Insurance usually requires medical questionnaires and exclusions for pre-existing conditions. In order to have guaranteed issuance, traditional insurance program customization would be required as would mandatory participation to guard against adverse selection. This means that a program through SFHP is currently the only alternative until the group has established a claims history.
Access to providers adequate and convenient…	Can generally go to any provider as long as it is for qualified services, but must pay provider's charges for service. Participants are given a discount card that entitles them to discounts off of many providers' standard charges. Participants are given a discount card that entitles them to discounts off many providers' standard charges.	Health benefits would only be available within the local network. A plan could possible insure or cover for out-of-network emergency care, but this would come with increased cost.	Providers are typically limited in managed care models (HMOs and PPOs). Out-of-network coverage typically requires higher co-pays. Traditional indemnity coverage allows greater access to providers, but comes at higher premium costs.
Benefits portable…	No - not portable if a member is no longer part of the group.	No - not portable if a member is no longer part of the group.	Coverage may be continued as required by law, but the insured would be required to pay associated costs.
Flexible in design…	Yes.	Less flexible than insurance plan.	Moderately. May want to use IHSS plan design until the drivers' claims history is established.

	Alternatives		
	Medical Savings Account [Local version, non-Archer]	**Local Direct Health Services Program** [Lacks insurance component]	**Health Insurance**
Funding & Cost Considerations			
Alternative is affordable…	Potential for lowest cost because contributions can be funded at any level. A contribution of $50 per driver per month would result in total annual costs of $600.	Less costly than full insurance. Cost depends on the level of service.	Most expensive because provider / service availability is larger and coverage may be broader. The IHSS Model currently cost approximately $200 per person per month for total annual costs of approximately $2,400.
Costs are tax deductible for the payer…	No.	Probably not.	Self-employed drivers would be able to deduct 100% of the cost of their contributions toward health insurance on their 2003 federal tax returns. Prior to 2003, only partial deduction was allowed.
Benefits are tax free to beneficiary…	Most likely.	Yes.	Yes.
Cost sharing: copays & deductibles	Contribution levels for all entities can be set at any level.	Co-pays could be charged.	Insurance plans typically require copays to cover some of the costs of care. Co-pays range from $5 to $100 depending on the type of service.
Administration			
Cost effective to establish…	Usually no set up fee.	Lower costs than health insurance. Would require additional funding to DPH to set up program.	The San Francisco Health Plan currently administers similar benefits for IHSS workers. There would be some start up costs to administer for drivers.
Cost effective to enroll members and administer…	Usually about $3 per participant per month.	Depends on what enrollment mechanism would be. Health plan provider may coordinate enrollment during A-card renewal process (January). A-cards could also be used by providers to screen for eligible participants.	Probably more costly than local direct services program. The insurer may coordinate enrollment during A-card renewal process (January). A-cards could also be used by providers to screen for eligible participants.
Verification of benefits easy…	Administrator has procedures in place to verify for disbursements / reimbursements.	Service providers could verify benefits eligibility by requiring a driver to show a valid A-card.	Would need a health plan card.

Funding Alternatives

We have identified six potential sources of funding for health benefits, and have calculated specific fees or methods of collection from each source, including:

1. **Taxicab Drivers**
    a. increase to daily gate
    b. create a new Health Plan Fee to coincide with annual A-card renewal

2. **Taxicab Operating Companies**
    a. create fee per medallion
    b. create fee per driver
    c. create fee per color scheme (proportionate share)
    d. create fee per dispatch (proportionate share)

3. **Taxicab Medallion Permit Holders**
    a. create a new Health Plan Fee to coincide with annual medallion renewal

4. **Taxicab Customers**
    a. increase flag drop rate
    b. increase mileage rate
    c. increase wait time rate

5. **Taxicab Driver Benefit Fund**
    a. use accumulated fund balance[9]

6. **City and County of San Francisco, DPH Allocation Subsidy**
    a. allocate a portion of DPH's indigent health services funding

Appendix F, Funding Options, shows the estimated costs per unit that would be required to finance a health insurance program for all of the approximately 7,800 A-card holders, assuming that the average A-card holder drives 54 percent of the time, given the total possible number of shifts that could be driven using the 1,381 medallions on the market for two ten-hour shifts per day. Appendix F calculates the maximum cost by category to fully fund coverage; however, it is more reasonable if multiple funding sources contribute, thereby decreasing the burden to any single payer. We provide two versions of the analysis, one in which the taxicab industry contributes the entire cost of the program, and one in which the City and the industry share the cost. Of course, as with all potential funding sources, no single source need cover the entire cost of the program.

Plan costs could change based on a number of policy decisions. For example, establishing minimum driving requirements would reduce the number of eligible drivers and associated costs. Covering drivers' dependents (family coverage) would make program costs 2.5 to 3.0 times more than that of driver-only coverage. We have assumed single coverage for analytical illustration purposes. If the Board wished to consider providing family coverage at this time, we could update our models accordingly.

[9] These funds are derived from the Taxi Wrap Fee and must be used to benefit drivers.

Total Costs
As illustrated in Appendix F, we estimate that the total annual cost for a program similar to IHSS's HealthyWorkers would cost $18.7 million to insure taxicab drivers, assuming premiums could be set at $200 per member per month (pmpm). If premiums were set at $250 pmpm, the total cost is estimated to be $23.4 million. This range of premiums is based on the HealthyWorkers premiums at the low end ($201.50 pmpm) and individual insurance premiums in the private market for a 45-year old, which are approximately $250 pmpm.

Taxicab Drivers
The first potential funding source is taxicab drivers – the beneficiaries of the proposed program. Drivers would have to pay an additional $18.57 to $23.21 per shift if the entire cost of the program were to be funded through additions to the daily gate, or $2,400 to $3,000 if the entire cost of the program were paid by them at the time of their A-card renewal.

Taxicab Operating Companies
Taxicab operating companies could also contribute to program costs, on a per medallion or per driver basis. Fees under these scenarios could range up to $13,555 to $16,944 per medallion, or $2,400 to $3,000 per driver to fully fund a health insurance program.

Taxicab Medallion Permit Holders
Similar to taxicab operating companies, if medallion holders shouldered the entire cost, the cost per medallion would be $13,555 to $16,944.

Taxicab Customers
Another option is to cover costs by increasing fares, through increased flag drop, mileage, or wait time rates. The rate changes needed to cover premium costs at the $200 pmpm and $250 pmpm levels are outlined in Appendix G, Customer Impact Analysis--Increasing Fares to Fund Health Benefits. If this method were adopted, we would also need to assess the impact to the City's paratransit costs, as those too would increase.

Taxicab Driver Benefit Fund
The fifth source of funds we identified is the Taxicab Driver Benefit Fund, where proceeds from wrap advertisements on taxis are deposited and must be used to benefit taxi drivers. The current fund balance is approximately $5,000, representing a limited, one-time source of funds.

DPH Subsidy – Allocation of Indigent Health Services Funding
Finally, there is the possibility of total cost subsidization of the program by the City, either through direct budget appropriation or via an allocation of DPH indigent health services funding, as occurs with the IHSS HealthyWorkers program. For FY 2003-04, DPH has allocated $6.2 million toward premium costs for premiums in the HealthyWorkers program. Given projected average monthly enrollment of 5,814 workers over FY 2003-04, this represents a shift of $1,069 per member per year or $89 per member per month. Assuming this subsidy effectively reduces the cost of the program by $8.3 million or 36 to 45 percent.

Multiple Funding Sources
In the private and public sectors alike, multiple funding sources are common. A possibility for funding taxicab driver health insurance would be to also have multiple contributors. Tables 4 and 5 below are two illustrations of how this might work for taxicab driver health insurance coverage. In both cases, we have assumed that both drivers and medallion holders contribute 15 percent of the cost of benefits. In Table 4, 15 fares per 10-hour shift are

assumed, to represent a somewhat slower economy. In Table 5, 20 fares per 10-hour shift are assumed, to represent a somewhat improved economy. These scenarios show that the flag drop would have to increase between $0.36 and $0.87 to cover program costs. Appendix H, Multiple Funding Sources Illustration, provides illustrations assuming drivers and medallion holders contribute at the 5, 10, 25 and 20 percent levels.

Table 4. 15% Driver Contribution - Slower Economy - 15 Trips per Shift

	Annual Cost per Driver Covered, assuming No DPH Allocation Subsidy	% of Direct Costs	Flag drop change		Annual Cost per Driver Covered, assuming DPH Allocation Subsidy	% of Direct Costs	Flag drop change	
Drivers	$ 360	15.0%			$ 200	15.0%		
Medallion Permit Holders	$ 360	15.0%			$ 200	15.0%		
Operating Companies*	$ -	0.0%			$ -	0.0%		
Customers	$ 1,680	70.0%	$ 0.87	per flag drop	$ 932	70.0%	$ 0.48	per flag drop
Total - Industry	**$ 2,400**	**100.0%**			**$ 1,331**	**100.0%**		
CCSF - DPH	0				$ 1,069			
Total - Industry & City	**$ 2,400**				**$ 2,400**			

*Operating companies would incur administrative costs, including tracking and remittance of a portion

Table 5. 15% Driver Contribution - Improved Economy - 20 Trips per Shift

	Annual Cost per Driver Covered, assuming No DPH Allocation Subsidy	% of Direct Costs	Flag drop change		Annual Cost per Driver Covered, assuming DPH Allocation Subsidy	% of Direct Costs	Flag drop change	
Drivers	$ 360	15.0%			$ 200	15.0%		
Medallion Permit Holders	$ 360	15.0%			$ 200	15.0%		
Operating Companies*	$ -	0.0%			$ -	0.0%		
Customers	$ 1,680	70.0%	$ 0.65	per flag drop	$ 932	70.0%	$ 0.36	per flag drop
Total - Industry	**$ 2,400**	**100.0%**			**$ 1,331**	**100.0%**		
CCSF - DPH	0				$ 1,069			
Total - Industry & City	**$ 2,400**				**$ 2,400**			

*Operating companies would incur administrative costs, including tracking and remittance of a portion

Pros & Cons of Funding Alternatives

The relative attractiveness of the various funding arrangements depends on the willingness and ability to pay of the stakeholders in the taxi industry and of local government in general to subsidize health care. In our opinion, no funding option poses administrative or collection issues substantial enough to warrant exclusion from consideration. Apart from any possible legal issues, whether or not any stakeholder group contributes, and the level at which it contributes, is a policy decision, and any levels we mention are for illustrative purposes only.

Funding Source 1: Taxicab Drivers

While it is difficult to generalize the opinions of the entire driver population, we did find two sources upon which to report previous respondents' willingness to pay/contribute. First of all, the extremely low rate of participation in UTW and PDAs health benefits offered through Kaiser indicate that very few drivers were either willing or able to participate in a fully self-funded, voluntary program. This may be because they had alternative coverage at lower costs (perhaps they were already covered as a dependent under another plan), or because they preferred to use their income for other purposes and pay cash for health care only when and if they absolutely needed it.

The second source of information is a survey on income and job benefits conducted in October 2002 by UTW. Of the 110 drivers surveyed, 18 were medallion permit holders and 92 were non-medallion permit holders. Though not drawn from a representative sample, the results suggest that the vast majority of drivers want health and disability benefits, and most feel that operating companies should pay for and administer them. Two-thirds of drivers were willing to contribute $5 to $10 per shift toward retirement benefits, and most of the rest would become willing to contribute if operating companies also paid. This willingness to pay for retirement benefits may or may not be true for medical benefits, but if it were, even $5 per shift would represent a significant portion of the program costs. Again, given the limited number of respondents, the generalizability of the response data to the total pool of drivers is questionable.

Overall, however, it seems reasonable that drivers participate in some cost of their health benefits, which is standard even in employer-sponsored health programs nationwide. According to the 2003 Annual Survey of employee health benefits by the Kaiser Family Foundation / Health Research and Educational Trust, 96 percent of covered workers have some type of co-pay or coinsurance for office visits, and 76 percent have worker contributions to single coverage premiums. The average worker contribution toward premium costs for a single plan is $508 per year ($42 per month), or 15 percent of the total annual cost of $3,383. Any deliberation of driver contributions toward medical benefit costs should also take into account the fact that driver income can fluctuate significantly with changing economic conditions.

Funding Source 2: Taxicab Operating Companies

Taxicab companies in San Francisco participated in a nationwide trend to promote the shift of drivers from employees to independent contractors, and in doing so effectively relieved themselves of employer payroll tax and employee benefit cost burdens. Given ever-increasing costs of medical benefits in particular, taxicab operating companies, like many other businesses, have tried to insulate themselves from cost increases. However, as is the case with drivers, taxicab operating companies also are subject to economic cycle, and in particular have seen their cost structure increase due to the continued surge in workers' compensation and liability insurance costs.

Funding Source 3: Medallion Permit Holders

A possible rationale for having medallion holders shoulder part of the cost lies in the regulatory structure governing medallions. That is, medallion permit holders enjoy an economic benefit derived from a publicly owned asset that they did not have to purchase. In exchange for this economic benefit, the public could ask that medallion permit holders contribute toward the policy goal of providing health benefits.

Funding Source 4: Taxicab Customers

One could argue that individuals who enjoy taxi services should shoulder some, if not all, of the cost of providing health benefits to the drivers who provide them service. This quickly raises the question of the price elasticity of demand for taxi services, or just how much demand for taxi services might decrease if fares increase. This is of greatest concern if the required increase is significant, whereas a small increase would likely go less noticed as taxi service is a necessity good for many tourists and business travelers alike. Unfortunately, the

price elasticity of demand is not something we can know exactly, as we lack information regarding how consumers make decisions about taking taxis versus using other types of transportation given the costs of each option. One argument against fare increases is simply that San Francisco already has comparatively high taxi rates, and thus further increases seem unwarranted. However, would a 25 cent (9 percent) increase in the flag drop deter riders from seeking taxi services? Given that drivers bear the burden of any changes in demand, it is interesting to note that in the UTW survey mentioned above, most drivers surveyed did not support fare increases, but became supportive of increases if the proceeds went to pay for medical and disability benefits for drivers. The current flag drop rate of $2.85 would have to increase between $0.93 and $1.24 if consumers were to pay the total cost of providing health benefits. This compares to only $0.51 to $0.69 if a DPH allocation subsidy is assumed to cover $8.3 million of total program costs. Any consumer contributions to the program cost would be collected from the drivers in the form of an increased gate, which would then be remitted to the policyholder through operating companies, in the same manner as paratransit funds are collected.

Funding Source 5: Taxicab Driver Benefit Fund

According to Taxi Commission staff, this fund is intended to be used exclusively for the benefit of taxi drivers. While the amount of funding available through this source is currently very limited, it represents a source of funds which could possibly be expanded by taxi industry stakeholders.

Funding Source 6: City and County of San Francisco, DPH Allocation Subsidy

With regards to subsidizing the program through DPH, it should be noted that according to a DPH evaluation of the first year of the IHSS HealthyWorkers program, only 24 percent of IHSS workers had previously used DPH clinics or SFGH services. Therefore, the expected reduction in indigent care expenses that had been used as the rationale for the reallocation of indigent care dollars did not materialize. Thus, while the program increased access to health care for workers who were not previously receiving services, it also led to new costs for DPH. We do not know how a similar insurance program for taxicab drivers would affect DPH's budget because of our lack of data on their current consumption of public health services in San Francisco. National studies show that the average per capita spending on health services for the uninsured in 2001 was $1,335, paid by a variety of government sources. In San Francisco, we may already pay a portion of that $1,335 annual cost for any drivers who currently receive services at SFGH or CHN clinics. Nevertheless, an initial year allocation subsidy of $8.3 million would be commensurate with the FY 2003-04 allocation for IHSS workers. This would effectively cover an estimated 45 percent of first year costs, assuming $200 per member per month program costs.

Illustration of Taxi Health Assuming an IHSS Capitation Model

Tables 6 and 7 below provide a summary of sources and uses for a health insurance alternative, assuming it is patterned after the IHSS HealthyWorkers model. The assumption shown here is that the plan would contract with the Department of Public Health for all services.

Table 6. Taxi Health Model (based on IHSS) - Funding Sources Summary

* Assumes $200 pmpm, that drivers and medallion holders both contribute 15%, with 15 fares per 10-hour shift.

Funding Sources	Total Annual Cost	% of Total	Per Member / Insured Per Year	Per Month*	% of Total
Taxi Drivers	$ 1,557,022	8.3%	$ 199.62	$ 16.63	8.3%
Taxi Medallion Holders	$ 1,557,022	8.3%	$ 199.62	$ 16.63	8.3%
Taxi Operating Companies	$ -	0.0%	$ -	$ -	0.0%
Taxi Customers (via Flag/Gate)	$ 7,266,104	38.8%	$ 931.55	$ 77.63	38.8%
Subtotal Taxi Industry	$ 10,380,149	55.4%	$ 1,330.79	$ 110.90	55.4%
Local Government	$ 8,339,851	44.6%	$ 1,069.21	$ 89.10	44.6%
Dept. of Public Health	*$ 8,339,851*	*44.6%*	*$ 1,069.21*	*$ 89.10*	44.6%
Taxi Commission - Driver Fund	*$ -*	*0.0%*	*$ -*	*$ -*	0.0%
Total Sources to Cover Premiums	**$ 18,720,000**	**100.0%**	**$ 2,400.00**	**$ 200.00**	**100.0%**

Table 7. Taxi Health Model (based on IHSS) - Funding Uses Summary

* Assumes $200 pmpm, that drivers and medallion holders both contribute 15%, with 15 fares per 10-hour shift.

Total Uses / Capitation	Total Annual Cost	% of Total	Per Member / Insured Per Year	Per Month*	% of Total
Medical					
Group	$ 8,391,417	44.8%	$ 1,075.82	$ 89.65	44.8%
Hospital	$ 5,479,167	29.3%	$ 702.46	$ 58.54	29.3%
Stop Loss	$ 190,008	1.0%	$ 24.36	$ 2.03	1.0%
Subtotal Medical	$ 14,060,592	75.1%	$ 1,802.64	$ 150.22	75.1%
Mental Health	$ 539,136	2.9%	$ 69.12	$ 5.76	2.9%
Vision	$ 230,256	1.2%	$ 29.52	$ 2.46	1.2%
Pharmacy	$ 2,014,272	10.8%	$ 258.24	$ 21.52	10.8%
SFHP Administration	$ 1,763,424	9.4%	$ 226.08	$ 18.84	9.4%
Capitation through SFHP	**$ 18,607,680**	**99.4%**	**$ 2,385.60**	**$ 198.80**	**99.4%**
Other	$ 112,320	0.6%	$ 14.40	$ 1.20	0.6%
Total Uses, Allocation of Premium	**$ 18,720,000**	**100.0%**	**$ 2,400.00**	**$ 200.00**	**100.0%**
Net CCSF Funding / (Cost)					
Medical Group	$ 8,391,417		$ 1,075.82	$ 89.65	
Medical Hospital	$ 5,479,167		$ 702.46	$ 58.54	
Mental Health	$ 539,136		$ 69.12	$ 5.76	
Less DPH Allocation Subsidy	$ (8,339,851)		$ (1,069.21)	$ (89.10)	
Net Funding to Cover Add. Costs	**$ 6,069,869**		**$ 778.19**	**$ 64.85**	

4: Recommendations & Next Steps

Based on our findings discussed above, Chapter 4 offers our recommendations for providing health benefits to taxicab drivers, including initial plan design and implementation steps.

Recommendations

Providing health benefits to drivers is possible, but comes with a cost. The private market solutions appear to be limited due to multiple obstacles previously discussed. Based on our research and the tradeoffs of potential solutions, we believe that health benefits could be provided using any of the following three alternatives: 1) medical savings accounts, 2) a local direct health service program, and 3) health insurance. Health insurance would be the most complex program to implement but would also offer the greatest potential benefit. Additionally, providing health insurance through the San Francisco Health Plan, using the HealthyWorkers program as the prototype, is a possible solution that could move San Francisco another step closer to universal health insurance coverage.

Costs for any one of the three alternatives could be distributed across multiple funding sources, including drivers, medallion holders, customers, operating companies and public support. Selection of a benefit alternative and funding structure are ultimately policy decisions for the Board. However, we must stress that any direct health service program or health insurance plan would have to be designed with full participation of the Department of Public Health. The San Francisco Health Plan would also need to be involved in the case of a health insurance plan or the medical savings account alternative. While this report describes existing and potential alternatives, a number of key unknowns and risks will need to be addressed. Regardless of the alternative selected, it may be prudent to assume a two- to three-year time limit, wherein an alternative could be implemented and reviewed for effectiveness.

The City should also survey San Francisco's taxicab drivers during the upcoming A-card renewal process in January to facilitate data collection and analysis of critical demographic, health care utilization and needs for drivers.[10] Survey distribution and response collection needs to be a collaborative effort between the Tax Collector (who notifies drivers of the annual A-card renewal) and the Taxi Commission to ensure adequate survey response rates.

Next Steps: Implementation

We recommend the following steps be taken to move toward implementation of health insurance benefits for drivers. They are not presented in any order, rather, they should all be addressed concurrently.

[10] The Taxi Commission last surveyed taxicab drivers in 1999.

Collect and analyze data

It is crucial for effective plan design, funding, and administration to know more about the population to be served. Answers to the following key questions will allow us to describe the size and characteristics of this population and get a picture of what services they are likely to need and use:

1) Where do drivers currently receive health care services?
2) How many drivers already have health coverage? How many would participate in a new health plan or program if it were offered and made voluntary?
3) What are the demographic characteristics of this group (age, gender, income, general health status, residence)?
4) What do drivers feel they can afford to contribute toward health insurance costs (i.e. measure drivers' willingness or ability to pay)?

We have developed a prototype survey, attached in Appendix I, Sample Taxicab Driver Survey. Ideally, data would be collected annually. One vehicle for an annual survey would be to ask drivers to complete a short questionnaire when they sign up for their annual 'A' card. After, the program is up and running the San Francisco Health Plan and Department of Public Health will also be able to collect and summarize utilization data. It may even be possible to conduct such an assessment with the assistance of outside funding and non-profit/academic institution support.

Policy review on health plan and funding alternatives by the Board

Policymakers must consider the various health plan and financing options. Among other items, policymakers should consider whether the entire population, or a certain subset, of drivers should be covered (e.g. all full-time drivers, all part-time drivers, requiring a 6- to 18-month waiting period until drivers are eligible). The Board should also weigh the advantages and disadvantages of the various funding alternatives and decide who should share in the cost of coverage.

If the Board chooses to pursue health insurance for drivers, a collaborative effort will be needed including involvement by the Department of Public Health, the San Francisco Health Plan, the Taxi Commission, the taxicab industry (drivers, medallion permit holders, taxicab operating companies), and customers. During your policy review, these entities can be called upon to provide further input in addition to what is summarized in this report.

Legislative changes

This report was prepared in response to Ordinance Number 228-02, which requires the Controller to submit a recommendation to the Board of Supervisors by October 1, 2003 for enactment of a program that would make health insurance or health benefits available to all taxi drivers. This ordinance also provides for the expiration of the current cap on gate fees if no ordinance is enacted by December 31, 2003 that establishes such a program, unless the Controller certifies that the program is not feasible. The Controller has determined that a program could be created and would cost an estimated $18.7 million to fully fund based on initial plan design. The Board should at this time deliberate accordingly and prepare to enact such a law based on its policy considerations, available data, and the input provided by the San Francisco Health Plan, the Department of Public Health and other stakeholders. If either a local direct health services program or health insurance plan is selected, implementation

would take longer than for a medical savings account alternative. If an alternative other than an MSA were selected, the sunset on the gate fee increase would need to be removed.

Implementation issues

More issues will arise as any implementation moves forward. We have included a partial list of some of the key risks and uncertainties for your initial deliberation in Table 8.

Table 8: Key Risks & Uncertainties

Stakeholder	Risks and Uncertainties
Drivers	May not earn enough fares to pay for higher gate. Who should be covered, and how will eligibility be monitored? If all 7,800 A-card holders are covered, then depending upon the funding mechanism, those that work more (and pay higher gates, assuming the gate funding strategy is used) may effectively be subsidizing part-time drivers. Should full-time drivers and all part-time drivers receive equal coverage? And if so, how should costs be 'shared'? Should there be any other requirements for coverage, such as a waiting period?
Administrator / Other	How will drivers be enrolled and dis-enrolled as they move in and out of the workforce? How is eligibility determined and monitored? Various stakeholders, including the San Francisco Health Plan would need to clear state regulatory hurdles. Will a separate legal entity be required to serve as the group policyholder? If this were a separate legal entity created by the Board it would have to be carefully constructed so as not to create financial obligations.
Providers	Utilization will likely increase once drivers go from no coverage to having coverage Additionally, depending on the cost to drivers, they may actually choose to drop existing coverage. Does DPH have the capacity to provide services to this population?
City/County & MTA	Paratransit program cost would likely increase if fares were increased to pay for benefits.

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Appendix A: Individual Insurance – Premiums and Driver Income

Appendix B: IHSS Health Insurance Plan Diagram

Appendix C: HealthyWorkers Program Summary of Benefits

Appendix D: Kaiser Permanente Personal Advantage Summary of Benefits

Appendix E: Blue Cross of California HMO Saver Summary of Benefits

Appendix F: Funding Options

Appendix G: Customer Impact Analysis – Increasing Fares to Fund Health Benefits

Appendix H: Multiple Funding Sources Illustration

Appendix I: Sample Taxicab Driver Survey

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Isaac Dehan, Director of Employee Health Benefits, Yellow Checker Star Transportation, Las Vegas

Tom Drischler, Taxicab Administrator, City of Los Angeles

Jean Fraser, CEO, San Francisco Health Plan

Ruach Graffis, driver and Chair, United Taxi Workers

Mark Gruberg, driver and former Chair, United Taxi Workers

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Mark Jamil, City of Chicago Department of Consumer Services

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Juanita Rodriguez, HealthStat Program, New York City Taxi and Limousine Commission

Gregg Sass, CFO, San Francisco Department of Public Health

Martin Smith, Commissioner, San Francisco Taxicab Commission

Barbara Wells, Liaison to the Administrator, Nevada Taxicab Authority

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Rick Zawadski, President, RTZ Associates

Appendix A

Individual Insurance - Premiums and Driver Income

	Kaiser HMO PA*	Blue Cross HMO Saver	Average
Single	$ 197.00	$ 303.00	$ 250.00
Family (3+)	$ 535.00	$ 713.00	$ 624.00

Assumed **45** Year Old

Assumed **45** Year Old

Taxi Driver Adjusted Gross Income (AGI) Annual	Monthly^	Weekly^	Daily^	Daily Receipts: Daily AGI + Gate Fee of $91.50	Daily Receipts: Daily AGI + Gate + Est. Cost of Gas $ 25.00	Daily Receipts: Daily AGI + Gate + Est. Cost of Gas + Self Empl Tax 7.65%	Est. Avg. Fare per Trip Based on # of Trips @ 15	Required Increase To Cover Health Insurance Premiums: Single Daily Receipts	Single Driver AGI	Family Daily Receipts	Family Driver AGI
$ 15,000	$ 1,250	$ 288	$ 58	$ 149	$ 174	$ 179	$ 11.91	6%	20%	16%	50%
$ 20,000	$ 1,667	$ 385	$ 77	$ 168	$ 193	$ 199	$ 13.29	6%	15%	14%	37%
$ 25,000	$ 2,083	$ 481	$ 96	$ 188	$ 213	$ 220	$ 14.67	5%	12%	13%	30%
$ 30,000	$ 2,500	$ 577	$ 115	$ 207	$ 232	$ 241	$ 16.05	5%	10%	12%	25%
$ 35,000	$ 2,917	$ 673	$ 135	$ 226	$ 251	$ 261	$ 17.43	4%	9%	11%	21%
$ 40,000	$ 3,333	$ 769	$ 154	$ 245	$ 270	$ 282	$ 18.81	4%	8%	10%	19%
$ 45,000	$ 3,750	$ 865	$ 173	$ 265	$ 290	$ 303	$ 20.19	4%	7%	10%	17%
$ 50,000	$ 4,167	$ 962	$ 192	$ 284	$ 309	$ 324	$ 21.57	4%	6%	9%	15%

	Kaiser HMO PA*	Blue Cross HMO Saver	Average
Single	$ 310.00	$ 372.00	$ 341.00
Family (3+)	$ 669.00	$ 845.00	$ 757.00

Assumed **60** Year Old

Assumed **60** Year Old

Taxi Driver Adjusted Gross Income (AGI) Annual	Monthly^	Weekly^	Daily^	Daily Receipts: Daily AGI + Gate Fee of $91.50	Daily Receipts: + Gate + Est. Cost of Gas $ 25.00	Daily Receipts: Daily AGI + Gate + Est. Cost of Gas + Self Empl Tax 7.65%	Est. Avg. Fare per Trip Based on # of Trips @ 15	Required Increase To Cover Health Insurance Premiums: Single Daily Receipts	Single Driver AGI	Family Daily Receipts	Family Driver AGI
$ 15,000	$ 1,250	$ 288	$ 58	$ 149	$ 174	$ 179	$ 11.91	9%	27%	20%	61%
$ 20,000	$ 1,667	$ 385	$ 77	$ 168	$ 193	$ 199	$ 13.29	8%	20%	18%	45%
$ 25,000	$ 2,083	$ 481	$ 96	$ 188	$ 213	$ 220	$ 14.67	7%	16%	16%	36%
$ 30,000	$ 2,500	$ 577	$ 115	$ 207	$ 232	$ 241	$ 16.05	7%	14%	15%	30%
$ 35,000	$ 2,917	$ 673	$ 135	$ 226	$ 251	$ 261	$ 17.43	6%	12%	14%	26%
$ 40,000	$ 3,333	$ 769	$ 154	$ 245	$ 270	$ 282	$ 18.81	6%	10%	13%	23%
$ 45,000	$ 3,750	$ 865	$ 173	$ 265	$ 290	$ 303	$ 20.19	5%	9%	12%	20%
$ 50,000	$ 4,167	$ 962	$ 192	$ 284	$ 309	$ 324	$ 21.57	5%	8%	11%	18%

	Kaiser HMO PA*	Blue Cross HMO Saver	Average
Single	$ 154.00	$ 171.00	$ 162.50
Family (3+)	$ 465.00	$ 554.00	$ 509.50

Assumed **25** Year Old

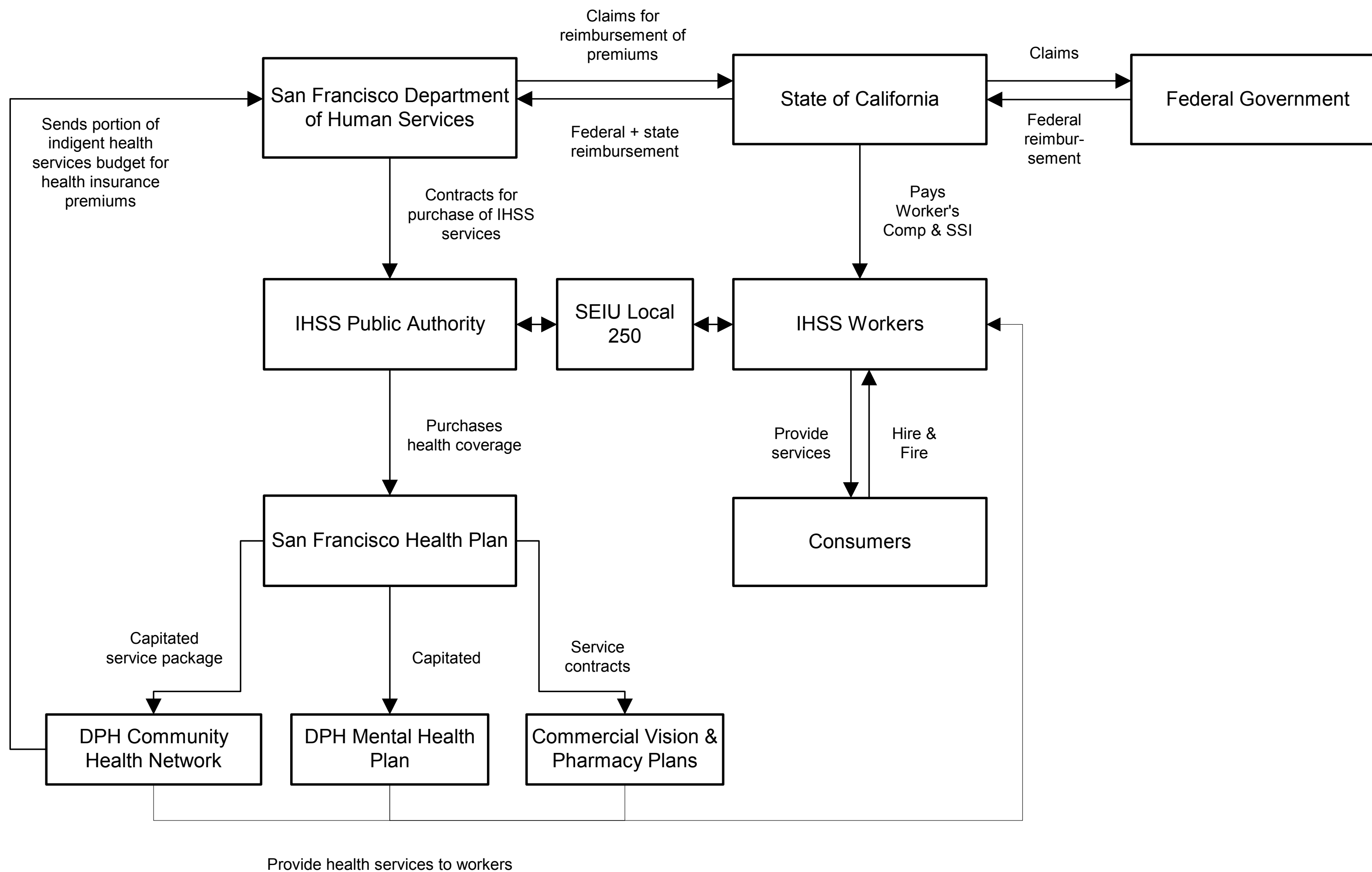
Assumed **25** Year Old

Taxi Driver Adjusted Gross Income (AGI) Annual	Monthly	Weekly	Daily^	Daily Receipts: Daily AGI + Gate Fee of $91.50	Daily Receipts: Daily AGI + Gate + Est. Cost of Gas $ 25.00	Daily Receipts: Daily AGI + Gate + Est. Cost of Gas + Self Empl Tax 7.65%	Est. Avg. Fare per Trip Based on # of Trips @ 15	Required Increase To Cover Health Insurance Premiums: Single Daily Receipts	Single Driver AGI	Family Daily Receipts	Family Driver AGI
$ 15,000	$ 1,250	$ 288	$ 58	$ 149	$ 174	$ 179	$ 11.91	4%	13%	13%	41%
$ 20,000	$ 1,667	$ 385	$ 77	$ 168	$ 193	$ 199	$ 13.29	4%	10%	12%	31%
$ 25,000	$ 2,083	$ 481	$ 96	$ 188	$ 213	$ 220	$ 14.67	3%	8%	11%	24%
$ 30,000	$ 2,500	$ 577	$ 115	$ 207	$ 232	$ 241	$ 16.05	3%	7%	10%	20%
$ 35,000	$ 2,917	$ 673	$ 135	$ 226	$ 251	$ 261	$ 17.43	3%	6%	9%	17%
$ 40,000	$ 3,333	$ 769	$ 154	$ 245	$ 270	$ 282	$ 18.81	3%	5%	8%	15%
$ 45,000	$ 3,750	$ 865	$ 173	$ 265	$ 290	$ 303	$ 20.19	2%	4%	8%	14%
$ 50,000	$ 4,167	$ 962	$ 192	$ 284	$ 309	$ 324	$ 21.57	2%	4%	7%	12%

** Kaiser HMO Personal Advantage Coverage*

^ Daily rate assumes five working days per week.

Appendix B: IHSS Health Insurance Plan Diagram



Appendix C

HealthyWorkers Program Summary of Benefits

Benefit	Covered Services	Member Pays
Deductibles		$0
Lifetime Maximum		Unlimited
Professional Services	In-licensed hospital, skilled nursing facility, hospice, mental health facility, office or home physician visit	No co-payment
Outpatient Services	Chemotherapy, dialysis, surgery, anesthesiology, radiation, and associated medically necessary facility charges	No co-payment
Hospitalization Services	Room and board, general nursing care, ancillary services including operating room, intensive care unit, prescribed drugs, laboratory, and radiology during inpatient stay	No co-payment
Emergency Health Coverage	24-hour care for sudden, serious, and unexpected illness, injury, or condition requiring immediate diagnosis in and out of the Plan	No co-payment if services are obtained at San Francisco General Hospital; $20 co-payment at any other hospital emergency room
Ambulance Services	Ambulance transportation when Medically Necessary	No Co-payment
Prescription Drug Coverage	Oral and injectable generic and brand names drugs (30 day supply); 90 day supply of maintenance drugs; tobacco cessation drugs for 1 cycle per Benefit Year with completion of an SFHP-approved tobacco cessation program Inpatient drugs and drugs administered in a doctor’s office, as well as FDA approved contraceptive drugs and devices	$5 co-payment per prescription for brand name drugs $3 co-payment per prescription for generic drugs $10 co-payment per prescription for contraceptive devices

Durable Medical Equipment	Equipment suitable for use in the home, such as blood glucose monitors, apnea monitors, asthma-related equipment, and supplies	No co-payment
Mental Health Services	Inpatient (limited to 30 days per Benefit Year); other services provided through the local mental health department with referral. Please not that treatment for the diagnosis of severe emotional disturbances and severe mental illness are excluded from the benefits limitations	No Co-payment
Chemical Dependency Services	- Outpatient visits for crisis intervention (up to 20 per Benefit Year) - Inpatient detoxification - Crisis intervention and outpatient alcohol or drug abuse treatment as Medically necessary (up to 20 visits)	$3 visit No co-payment No co-payment
Home Health Services	Medically Necessary skilled care (not custodial); home visits, physical, occupational and speech therapy	No co-payment
OTHER **Hearing Aids/Services**	Audiological evaluations, hearing aids, supplies, visits for fitting, counseling, adjustments, repairs	No co-payment $10 per eye exam
Eye Exams/Supplies	Annual exams to determine the need for corrective lenses	$25 for frames under $75 every 24 months (Member is responsible for amount over $75)
Diagnostic X-ray and Laboratory Services	Therapeutic radiological services, ECG, EEG, mammography, other diagnostic laboratory and radiology tests, laboratory tests for the management of diabetes	No co-payment
Orthoses and Prostheses	Orthoses and prostheses as prescribed by SFHP providers	No co-payment
Skilled Nursing Facilities	Medically Necessary skilled care; room and board; x-ray, laboratory,	No co-payment

	and other ancillary services; medical social services; drugs, medications, and supplies up to 30 days as part of stay; limited to 100 days during any benefit year	
Hospice	Medically Necessary skilled care; counseling; drugs and supplies; short term inpatient care for pain control and system management; bereavement services; homemaker services; physical, speech and occupational therapies; medical social services; short term inpatient and respite care	No co-payment
Transplants	Medically Necessary organ and bone marrow transplant; medical and hospital expenses of a donor or prospective donor; testing expenses and charges associated with procurement of donor organ	No co-payment
Rehabilitative Therapies **Inpatient** **Outpatient**	 Physical, occupational, speech therapy Physical, occupational, speech therapy as Medically Necessary	 No co-payment
Health Education	Health education materials	No co-payment

Appendix D

Kaiser Permanente Personal Advantage Summary of Benefits

Benefit	Covered Services	Member Pays
Outpatient Care	Primary care visits	$20 per visit
	Well-child preventive care visits	No charge
	Outpatient surgery	$100 per procedure
	Allergy injection visits	No charge
	Scheduled prenatal care	No charge
	Emergency department visits	$100 per visit, waived if admitted to hospital
	Blood/blood products and their administration	No charge
Hospital Inpatient Care	Room and board critical care units	$200 per admission
	Obstetrical care and delivery, including cesarean section	$200 per admission
	Physician, surgeon, and surgical services	No charge
	General and special nursing care	No charge
	Anesthesia, prescribed drugs, and medical supplies	No charge
	Blood/blood products and their administration	No charge
	Respiratory therapy	No charge
Ambulance Services	Emergency ambulance services	$75 per trip
	Nonemergency ambulance services	No charge
Mental Health Services	Inpatient psychiatric care	$200 per admission
	Outpatient visits	$20 per visit
	Hospital alternative services	No charge
Chemical Dependency Services	Inpatient detoxification	$200 per admission
	Outpatient individual therapy visits	$20 per visit
	Outpatient group therapy visits	$5 per visit
	Transitional residential recovery services (up to 60 days per calendar year, 120 days in any 5-year period)	$100 per admission
Home Health Care	Covered home health care including physical, occupational, and speech therapy	No charge
Hospice Care	Covered hospice care	No charge
Skilled Nursing Facility	Care in a skilled nursing facility	No charge

Care	(up to 100 days per benefit period)	
Drugs, Supplies, and Supplements	Diabetes urine-testing supplies	No charge up to a 100-day supply
	Insulin-administered drugs	$10 up to a 100-day supply
	Generic drugs*	$10 up to a 100-day supply
	Brand name or compounded products*	$35 up to a 100-day supply
	Amino acid-modified products for certain conditions*	No charge up to a 30-day supply
	Emergency contraceptive pills*	No charge
	Drugs related to the treatment of sexual dysfunction disorders*	50% of charges
	*Covered prescription drugs in accord with formulary when obtained at Plan pharmacies	

Appendix E

Blue Cross of California HMO Saver Summary of Benefits

Benefit	Covered Services	Member Pays
Annual Deductible		$1,500 per member; inpatient hospital services, outpatient ambulatory surgical centers only
Lifetime Maximum		Unlimited
Annual Out-of-Pocket Maximum (includes deductible)		$3,000/single (2-member maximum)
Office Visits		$10
Professional Services	Other office visits, x-ray, lab, anesthesia, surgeon, etc.	Unlimited office visits: $10 per visit. Inpatient hospital – no charge
Hospital Inpatient/Outpatient	Inpatient	No charge
	Outpatient – non-emergency services	20% of negotiated fee
Emergency Services	Participating provider	Inpatient and professional services – no charge when authorized by a medical group within 48 hours of emergency care. Outpatient - $50 co-payment plus 20%
	Non-participating provider	20% for professional services
Maternity		20% of negotiated fee
Preventive Care		$10 co-payment for specific health maintenance services
Ambulance		$50 co-payment unless admitted to hospital
Physical and Occupational Therapy: Chiropractic Services		$10 per visit, limited to 60 consecutive days following illness or injury. No charge for inpatient chiropractic services with medical group referral.
Drug Benefits (retail or mail order: 30-day supply)	Participating provider	$10 generic, $30 brand name. $250 deductible for brand name drugs
	Non-participating provider	$250 brand name deductible, then 50% of drug limited fee schedule within California

Appendix F

Funding Options - Industry Covers Total Program Cost

Assumptions

Unit costs in this table are based on a total program cost of providing a health insurance plan for 7,800 A-Card holders at monthly premiums of between $200 to $250 per member per month (pmpm).

# of Drivers Covered (All A-Card Holders)	**7,800**
# of Medallions	**1,381**
Maximum # of 10-Hour Shifts Assumed	**1,008,130**
# of FTE Drivers Needed to Cover All Shifts	**4,201**
Average Driving Time Based on Above	**54%**

Assuming Industry Covers All Related Costs ...

Cost Per Member Per Month (pmpm)	**$ 200**	**$ 210**	**$ 220**	**$ 230**	**$ 240**
Total Cost Per Year for All 7,800 A-Card Holders	**$ 18,720,000**	**$ 19,656,000**	**$ 20,592,000**	**$ 21,528,000**	**$ 22,464,000**
Potential Funding Sources- May Be Full or Partial					
1. Paid by Taxi Drivers					
a) add to daily gate	$ 18.57	$ 19.50	$ 20.43	$ 21.35	$ 22.28
Assume all 7,800 A-card holders are covered, on average only drive 54%					
Assume drivers must drive 20, 10-hour shifts/month/driver to qualify for coverage	$ 10.00	$ 10.50	$ 11.00	$ 11.50	$ 12.00
b) add to annual A-Card renewal fee	$ 2,400	$ 2,520	$ 2,640	$ 2,760	$ 2,880
2. Paid by Taxicab Operating Companies					
a) fee per medallion	$ 13,555	$ 14,233	$ 14,911	$ 15,589	$ 16,266
b) fee per driver	$ 2,400	$ 2,520	$ 2,640	$ 2,760	$ 2,880
c) fee per color scheme			proportionate share based on number of drivers		
b) fee per dispatch			proportionate share based on number of drivers		
3. Paid by Medallion Holders					
a) add to annual medallion fee	$ 13,555	$ 14,233	$ 14,911	$ 15,589	$ 16,266
4. Paid by Taxicab Customers* (Assumes all 7,800 drivers covered)					
a) Assuming 20 fares per 10-hour shift	$ 0.93	$ 0.97	$ 1.02	$ 1.07	$ 1.11
b) Assuming 19 fares per 10-hour shift	$ 0.98	$ 1.03	$ 1.08	$ 1.12	$ 1.17
c) Assuming 18 fares per 10-hour shift	$ 1.03	$ 1.08	$ 1.13	$ 1.19	$ 1.24
d) Assuming 17 fares per 10-hour shift	$ 1.09	$ 1.15	$ 1.20	$ 1.26	$ 1.31
e) Assuming 16 fares per 10-hour shift	$ 1.16	$ 1.22	$ 1.28	$ 1.33	$ 1.39
f) Assuming 15 fares per 10-hour shift	$ 1.24	$ 1.30	$ 1.36	$ 1.42	$ 1.49
5. Taxi Industry Fund (one-time source)					
Proceeds in this Fund are derived from wrap advertisements on taxis.	$ 5,000	$ 5,000	$ 5,000	$ 5,000	$ 5,000

* May be generaged through by increasing the flag, mileage or wait time rates.
See Appendix F, Customer Impact Analysis, for complete details.

Appendix F

Funding Options - DPH Subsidy, Industry Covers Remaining Costs

Like IHSS, Assuming DPH Contributes Similar Share of Indigent Health Services Budget

Total Annual Contribution by DPH	$ 8,339,851
Annual Contribution per Driver by DPH	$ 1,069
Monthly Contribution per Driver by DPH	$ 89

	Column 1	Column 2	Column 3	Column 4	Column 5
Cost Per Member Per Month (pmpm)	$ 200	$ 210	$ 220	$ 230	$ 240
Cost Per Member Per Month (pmpm) assuming DPH Subsidy	$ 111	$ 121	$ 131	$ 141	$ 151
Total Cost Per Year for All 7,800 A-Card Holders After DPH Subsidy	$ 10,380,149	$ 11,316,149	$ 12,252,149	$ 13,188,149	$ 14,124,149
DPH Subsidy Would Comprise % of Total Cost	*44.6%*	*42.4%*	*40.5%*	*38.7%*	*37.1%*
Potential Funding Sources- May Be Full or Partial					
1. Paid by Taxi Drivers					
a) add to daily gate	$ 10.30	$ 11.22	$ 12.15	$ 13.08	$ 14.01
Assume all 7,800 A-card holders are covered, on average only drive 54%					
Assume drivers must drive 20, 10-hour shifts/month/driver to qualify for coverage	$ 5.54	$ 6.04	$ 6.54	$ 7.04	$ 7.54
b) add to annual A-Card renewal fee	$ 1,331	$ 1,451	$ 1,571	$ 1,691	$ 1,811
2. Paid by Taxicab Operating Companies					
a) fee per medallion	$ 7,516	$ 8,194	$ 8,872	$ 9,550	$ 10,227
b) fee per driver	$ 1,331	$ 1,451	$ 1,571	$ 1,691	$ 1,811
c) fee per color scheme			proportionate share based on number of drivers		
b) fee per dispatch			proportionate share based on number of drivers		
3. Paid by Medallion Holders					
a) add to annual medallion fee	$ 7,516	$ 8,194	$ 8,872	$ 9,550	$ 10,227
4. Paid by Taxicab Customers* (Assumes all 7,800 drivers covered)					
a) Assuming 20 fares per 10-hour shift	$ 0.51	$ 0.56	$ 0.61	$ 0.65	$ 0.70
b) Assuming 19 fares per 10-hour shift	$ 0.54	$ 0.59	$ 0.64	$ 0.69	$ 0.74
c) Assuming 18 fares per 10-hour shift	$ 0.57	$ 0.62	$ 0.68	$ 0.73	$ 0.78
d) Assuming 17 fares per 10-hour shift	$ 0.61	$ 0.66	$ 0.71	$ 0.77	$ 0.82
e) Assuming 16 fares per 10-hour shift	$ 0.64	$ 0.70	$ 0.76	$ 0.82	$ 0.88
f) Assuming 15 fares per 10-hour shift	$ 0.69	$ 0.75	$ 0.81	$ 0.87	$ 0.93
* May be generaged through by increasing the flag, mileage or wait time rates. See Appendix F, Customer Impact Analysis, for complete details.					
5. Taxi Driver Benefit Funding					
Proceeds in this Fund are derived from wrap advertisements on taxis.	$ 5,000	$ 5,000	$ 5,000	$ 5,000	$ 5,000

Customer Impact Analysis - Increasing Fares to Fund Health Benefits

Assumptions: Full-time drivers are covered and that the cost of coverage is distributed to the customer.
^ Average fare is highly variable. Mean fare assumed to be 5 miles with 5 minutes wait time.
* Assumes 15 flag drops per 10-hour shift with 20 shifts worked per month. Equates to 2,400 hours per year or an average of 46.2 hours worked per week.

A Current fare structure

	Cab Company Revenue	Driver Revenue			
	Gate	**Flag**	**Driving Distance**	**Wait Time**	**Est. Average Fare^**
Basis	Avg. per 10 Hr. Shift	First 1/6 Mile or Flag	Each Add. 1/5 Mile	Minute of Waiting	
Current rate	$ 91.50	$ 2.85	$ 0.45	$ 0.45	
Last changed	1/1/2003	1/1/2003	1/1/2003	1/1/2003	
Average fare composition		$ 2.85	$ 10.80	$ 2.25	**$ 15.90**
% of average total fare		17.9%	67.9%	14.2%	100.0%

B Fare increases needed to cover monthly premiums*

Per member per month (pmpm) premium $ 200

	Flag	Driving Distance	Wait Time	Total
On flag only	**0.67**			**$ 0.67**
% Increase on current	**23.4%**			
% Increase on total average fare	**4.2%**			**4.2%**
Accumulated by driver and collected by operating company through gate	**$ 10.00**			**$ 10.00**
Split 50/50 between flag & driving distance	**$ 0.33**	**$ 0.33**		**$ 0.67**
% Increase on current	**11.7%**	**3.1%**		
% Increase on total average fare	**2.1%**	**2.1%**		**4.2%**
Accumulated by driver and collected by operating company through gate	**$ 5.00**	**$ 5.00**		**$ 10.00**
Split 1/3 among flag, driving distance & wait time	**$ 0.22**	**$ 0.22**	**$ 0.22**	**$ 0.67**
% Increase on current	**7.8%**	**2.1%**	**9.9%**	
% Increase on total average fare	**1.4%**	**1.4%**	**1.4%**	**4.2%**
Accumulated by driver and collected by operating company through gate	**$ 3.33**	**$ 3.33**	**$ 3.33**	**$ 10.00**

Per member per month (pmpm) premium $ 250

	Flag	Driving Distance	Wait Time	Total
On flag only	**0.83**			**$ 0.83**
% Increase on current	**29.2%**			
% Increase on total average fare	**5.2%**			**5.2%**
Accumulated by driver and collected by operating company through gate	**$ 12.50**			**$ 12.50**
Split 50/50 between flag & driving distance	**0.42**	**$ 0.42**		**$ 0.83**
% Increase on current	**14.6%**	**3.9%**		
% Increase on total average fare	**2.6%**	**2.6%**		**5.2%**
Accumulated by driver and collected by operating company through gate	**$ 6.25**	**$ 6.25**		**$ 12.50**
Split 1/3 among flag, driving distance & wait time	**0.28**	**$ 0.28**	**$ 0.28**	**$ 0.83**
% Increase on current	**9.7%**	**2.6%**	**12.3%**	
% Increase on total average fare	**1.7%**	**1.7%**	**1.7%**	**5.2%**
Accumulated by driver and collected by operating company through gate	**$ 4.17**	**$ 4.17**	**$ 4.17**	**$ 12.50**

Appendix H

Multiple Funding Sources Illustration

All calculations assume that all 7,800 A-card drivers would be covered by a health benefit program.
In all cases, operating companies would incur administrative costs, including tracking and remittance of a portion of the gate or long-term lease fee.

5% Driver Contribution

Slower economy: assuming 15 trips per shift

		Annual Cost per Driver Covered, assuming No DPH Allocation Subsidy	% of Direct Costs		Flag drop change			Annual Cost per Driver Covered, assuming DPH Allocation Subsidy	% of Direct Costs		Flag drop change	
Drivers	$	120	5.0%				$	67	5.0%			
Medallion Permit Holders	$	120	5.0%				$	67	5.0%			
Operating Companies	$	-	0.0%				$	-	0.0%			
Customers	$	2,160	90.0%	$	1.11	per flag drop	$	1,198	90.0%	$	0.62	per flag drop
Total - Industry	**$**	**2,400**	**100.0%**				**$**	**1,331**	**100.0%**			
CCSF - DPH		0					$	1,069				
Total - Industry & City	**$**	**2,400**					**$**	**2,400**				

Improved economy: assuming 20 trips per shift

		Annual Cost per Driver Covered, assuming No DPH Allocation Subsidy	% of Direct Costs		Flag drop change			Annual Cost per Driver Covered, assuming DPH Allocation Subsidy	% of Direct Costs		Flag drop change	
Drivers	$	120	5.0%				$	67	5.0%			
Medallion Permit Holders	$	120	5.0%				$	67	5.0%			
Operating Companies	$	-	0.0%				$	-	0.0%			
Customers	$	2,160	90.0%	$	0.84	per flag drop	$	1,198	90.0%	$	0.46	per flag drop
Total - Industry	**$**	**2,400**	**100.0%**				**$**	**1,331**	**100.0%**			
CCSF - DPH		0					$	1,069				
Total - Industry & City	**$**	**2,400**					**$**	**2,400**				

10% Driver Contribution

Slower economy: assuming 15 trips per shift

		Annual Cost per Driver Covered, assuming No DPH Allocation Subsidy	% of Direct Costs		Flag drop change			Annual Cost per Driver Covered, assuming DPH Allocation Subsidy	% of Direct Costs		Flag drop change	
Drivers	$	240	10.0%				$	133	10.0%			
Medallion Permit Holders	$	240	10.0%				$	133	10.0%			
Operating Companies	$	-	0.0%				$	-	0.0%			
Customers	$	1,920	80.0%	$	0.99	per flag drop	$	1,065	80.0%	$	0.55	per flag drop
Total - Industry	**$**	**2,400**	**100.0%**				**$**	**1,331**	**100.0%**			
CCSF - DPH		0					$	1,069				
Total - Industry & City	**$**	**2,400**					**$**	**2,400**				

Improved economy: assuming 20 trips per shift

		Annual Cost per Driver Covered, assuming No DPH Allocation Subsidy	% of Direct Costs		Flag drop change			Annual Cost per Driver Covered, assuming DPH Allocation Subsidy	% of Direct Costs		Flag drop change	
Drivers	$	240	10.0%				$	133	10.0%			
Medallion Permit Holders	$	240	10.0%				$	133	10.0%			
Operating Companies	$	-	0.0%				$	-	0.0%			
Customers	$	1,920	80.0%	$	0.74	per flag drop	$	1,065	80.0%	$	0.41	per flag drop
Total - Industry	**$**	**2,400**	**100.0%**				**$**	**1,331**	**100.0%**			
CCSF - DPH		0					$	1,069				
Total - Industry & City	**$**	**2,400**					**$**	**2,400**				

Appendix H

All calculations assume that all 7,800 A-card drivers would be covered by a health benefit program.
In all cases, operating companies would incur administrative costs, including tracking and remittance of a portion of the gate or long-term lease fee.

	Annual Cost per Driver Covered, assuming No DPH Allocation Subsidy	% of Direct Costs	Flag drop change		Annual Cost per Driver Covered, assuming DPH Allocation Subsidy	% of Direct Costs	Flag drop change	
15% Driver Contribution								
Slower economy: assuming 15 trips per shift								
Drivers	$ 360	15.0%			$ 200	15.0%		
Medallion Permit Holders	$ 360	15.0%			$ 200	15.0%		
Operating Companies	$ -	0.0%			$ -	0.0%		
Customers	$ 1,680	70.0%	$ 0.87	per flag drop	$ 932	70.0%	$ 0.48	per flag drop
Total - Industry	**$ 2,400**	**100.0%**			**$ 1,331**	**100.0%**		
CCSF - DPH	0				$ 1,069			
Total - Industry & City	**$ 2,400**				**$ 2,400**			
Improved economy: assuming 20 trips per shift								
Drivers	$ 360	15.0%			$ 200	15.0%		
Medallion Permit Holders	$ 360	15.0%			$ 200	15.0%		
Operating Companies	$ -	0.0%			$ -	0.0%		
Customers	$ 1,680	70.0%	$ 0.65	per flag drop	$ 932	70.0%	$ 0.36	per flag drop
Total - Industry	**$ 2,400**	**100.0%**			**$ 1,331**	**100.0%**		
CCSF - DPH	0				$ 1,069			
Total - Industry & City	**$ 2,400**				**$ 2,400**			
20% Driver Contribution								
Slower economy: assuming 15 trips per shift								
Drivers	$ 480	20.0%			$ 266	20.0%		
Medallion Permit Holders	$ 480	20.0%			$ 266	20.0%		
Operating Companies	$ -	0.0%			$ -	0.0%		
Customers	$ 1,440	60.0%	$ 0.74	per flag drop	$ 798	60.0%	$ 0.41	per flag drop
Total - Industry	**$ 2,400**	**100.0%**			**$ 1,331**	**100.0%**		
CCSF - DPH	0				$ 1,069			
Total - Industry & City	**$ 2,400**				**$ 2,400**			
Improved economy: assuming 20 trips per shift								
Drivers	$ 480	20.0%			$ 266	20.0%		
Medallion Permit Holders	$ 480	20.0%			$ 266	20.0%		
Operating Companies	$ -	0.0%			$ -	0.0%		
Customers	$ 1,440	60.0%	$ 0.56	per flag drop	$ 798	60.0%	$ 0.31	per flag drop
Total - Industry	**$ 2,400**	**100.0%**			**$ 1,331**	**100.0%**		
CCSF - DPH	0				$ 1,069			
Total - Industry & City	**$ 2,400**				**$ 2,400**			

Appendix I

Sample Taxicab Driver Survey

GENERAL DRIVER DEMOGRAPHICS

AGE

- [ ] Under 30
- [ ] 30 to 39
- [ ] 40 to 49
- [ ] 50 to 59
- [ ] 60 or older

GENDER

- [ ] Female
- [ ] Male

PLACE OF RESIDENCE

- [ ] San Francisco
- [ ] Peninsula
- [ ] East Bay
- [ ] North Bay
- [ ] Other: ___________________

ESTIMATED ANNUAL INCOME FROM DRIVING A TAXI

[Take-home pay from driving only, excluding medallion lease fees.]

- [ ] Less than $10,000
- [ ] $10,000 to $14,999
- [ ] $15,000 to $19,999
- [ ] $20,000 to $24,999
- [ ] $25,000 to $29,999
- [ ] $30,000 to $34,999
- [ ] $35,000 to $39,999
- [ ] $40,000 to $44,999
- [ ] $45,000 to $49,999
- [ ] $50,000 or greater

DRIVER CHARACTERISTICS

OVER THE PAST 12 MONTHS, HOW MANY HOURS DID YOU DRIVE PER WEEK?

- [ ] On average, 10 or fewer hours per week.
- [ ] On average, more than 10, but not more than 20 per week.
- [ ] On average, more than 20, but not more than 30 per week.
- [ ] On average, more than 30, but not more than 40 per week.
- [ ] On average, more than 40, but not more than 50 per week.
- [ ] On average, more than 50, but not more than 60 per week.
- [ ] On average, more than 60 per week.

MEDALLION STATUS

- [ ] I am a Medallion Permit Holder.
- [ ] I am a non-medallion driver.

IF YOU HOLD A MEDALLION, INDICATE PRE- or POST-K CLASSIFICATION.

- [ ] I hold a pre-K medallion.
- [ ] I hold a post-K medallion.

DRIVER TYPE

- [ ] I am a daily 'gas and gate' driver.
- [ ] I am a 'gas and gate' driver, but operate under a weekly or monthly lease.
- [ ] I have a long-term lease with a taxi operating company for selected services.
- [ ] I drive for someone who has a long-term lease with a taxi operating company.

DRIVER HEALTHCARE NEEDS

HEALTH STATUS: Please indicate your personal health status.

- [ ] Excellent
- [ ] Good
- [ ] Average
- [ ] Below Average
- [ ] Suffer from chronic illness and require regular medical treatment

HEALTH BENEFITS COVERAGE

- [ ] Currently covered through individual insurance
- [ ] Currently covered through a spouse or domestic partner's plan
- [ ] Not covered
- [ ] Other (please explain): _______________________________

IF YOU DO NOT HAVE HEALTH BENEFITS COVERAGE, Why?

- [ ] I am healthy and don't believe I need it.
- [ ] I cannot afford the cost coverage.
- [ ] I was previously denied coverage due to pre-existing condition(s).
- [ ] Other (please explain): _______________________________

OVER THE PAST 12 MONTHS, WHERE HAVE YOU RECEIVED MEDICAL CARE?

- [ ] City & County Public Health Clinics and/or San Francisco General Hospital
- [ ] I have other coverage so I went to my covered providers.
- [ ] I did not seek any medical care in over the last 12 months.
- [ ] Other (please explain): _______________________________

ASSUMING HEALTH INSURANCE COSTS $200 MONTHLY, INDICATE YOUR WILLINGNESS / ABILITY TO PAY.

I am willing / able to pay…

- [ ] up to 100% or $200 per month.
- [ ] up to 90% or $180 per month.
- [ ] up to 80% or $160 per month.
- [ ] up to 70% or $140 per month.
- [ ] up to 60% or $120 per month.
- [ ] up to 50% or $100 per month.
- [ ] up to 40% or $80 per month.
- [ ] up to 30% or $60 per month.
- [ ] up to 20% or $40 per month.
- [ ] up to 10% or $20 per month.
- [ ] I am not willing/able to pay for any portion of the cost.

ASSUMING YOUR WILLINGNESS/ABILITY TO PAY ABOVE, WOULD YOU PARTICIPATE IN A VOLUNTARY HEALTH INSURANCE PROGRAM?

- [ ] Yes
- [ ] No

TAXICAB CUSTOMER DEMAND CHARACTERISTICS

OVER THE PAST 12 MONTHS, ESTIMATE YOUR CUSTOMER BASE.

- [ ] % are Airport Customers
- [ ] % are Visiting Tourists (Non-Convention Goers)
- [ ] % are Visiting Convention Goers
- [ ] % are Business Travelers
- [ ] % are Paratransit Customers
- [ ] % are Other Local, Non-Paratransit Customers
- [ ] % are Other [please explain]: ________________

100 % Total Customers

OVER THE PAST 12 MONTHS, ESTIMATE YOUR CUSTOMER DEMAND…

Based on a typical 10-hour shift, how many fares did you have?

- [ ] More than 20 fares per typical 10-hour shift
- [ ] 20 fares per 10-hour shift
- [ ] 19 fares per 10-hour shift
- [ ] 18 fares per 10-hour shift
- [ ] 17 fares per 10-hour shift
- [ ] 16 fares per 10-hour shift
- [ ] 15 fares per 10-hour shift
- [ ] 11 to 14 fares per 10-hour shift
- [ ] 10 fares or less per 10-hour shift

OVER THE PAST 12 MONTHS, ESTIMATE YOUR AVERAGE FARE…

- [ ] $20 or greater
- [ ] $19 to $19.99
- [ ] $18 to $18.99
- [ ] $17 to $17.99
- [ ] $16 to $16.99
- [ ] $15 to $15.99
- [ ] $14 to $14.99
- [ ] $13 to $13.99
- [ ] $12 to $12.99
- [ ] $11 to $11.99
- [ ] $10 to $10.99
- [ ] $9 to $9.99
- [ ] $8 to $8.99
- [ ] $7 to $7.99
- [ ] $6 to $6.99
- [ ] $5.99 or less