Good morning.

My name is Ken Yeager and I am chair of the Board of Supervisors in Santa Clara County and vice chair of CSAC's Health and Human Services Policy Committee.

I appreciate the opportunity to testify before you today on behalf of counties and thank you for convening this important hearing. We appreciate being a part of the discussion and we hope to work with the Legislature and Administration to find a mutually acceptable way to seize the opportunity of national health care reform in California.

I cannot overstate what an incredible opportunity national health reform is for those of us that have been championing the expansion of care and access to residents in our communities. The full expansion of Medi-Cal on January 1, 2014 – with 100 percent federal funding – must be our highest priority so that we can deliver on the promise of health reform to the most needy and vulnerable residents in California.

Counties have been partners with the State in delivering health care to California's poorest and sickest residents over the years. This population is often referred to as medically indigent adults. But there is great diversity in how counties deliver these services.

12 counties own and operate health and hospital systems and are often referred to as "provider counties." Santa Clara is one of those counties, where we own a large trauma-designated public hospital, 9 comprehensive clinics, and partner with over 50 community-based organizations to deliver a vast array of comprehensive health services. In fact, Santa Clara County was the first county to commit to universal coverage for all children, and we continue to make large investments in modern and upgraded facilities to make sure coverage leads to better care and access.

The remaining counties, often referred as "payer counties," pay for services to meet the needs of medically indigent adults in a variety of ways:

35 counties are members of the County Medical Services Program or CMSP, which provides health coverage for low-income, indigent adults in primarily rural counties.

You'll hear more from Mr. Kemper about the CMSP program in a bit. But I wanted to note that not even all CMSP counties are alike. For example, a handful of CMSP counties, including Marin and Tehama, also operate clinics that are important health care access points.

The 11 remaining counties provide services in one of two distinct ways. Five of the counties provide services to indigent adults solely through contracts with hospitals and providers in their community, similar to CMSP's model. The other 6 own and operate clinics but contract for hospital services and sometimes contract with other community providers. For example, Stanislaus County operates a large clinic offering both primary and specialty health services on the grounds of their former hospital, as well as several clinic sites throughout the county that serve Medi-Cal recipients.

In addition to being providers of health care services, counties also provide critical local public health functions and work on the state's behalf to administer eligibility for Medi-Cal and related programs. We look forward working with you and the Administration to ensure counties are adequately resourced to continue this crucial work in our communities.

CSAC's Health and Human policy committee has explored the options proposed by the Governor for implementing health care reform in California by January 1, 2014. The CSAC Board of Directors is meeting today also to discuss this issue.

I want to outline for you some of the risks and unanswered questions that counties have identified during this process. I bring these forward today with a commitment to work with you and the Administration to ensure the timely and successful implementation of health care reform in our great state.

First, will revenues and new program responsibilities match? Under either a state-run or county-run approach, the Administration expects counties to take on new program responsibilities – either for the Medi-Cal program or for additional human services programs.

Many view the proposal to repurpose local health realignment funding for the Medi-Cal expansion or "swap" a new human services program like subsidized child care as a realignment of sorts.

But any effort to realign programs or funding must attempt to align resources with new responsibilities. Counties must also balance any new responsibilities with remaining local public health responsibilities. As you can see, this is an incredibly complex issue, and we will continue to explore the local impacts of any shift in 1991 realignment funding.

Secondly, counties would be at risk for future state and federal legislative actions and litigation. Whether counties take on a new share of cost for Medi-Cal or new human services programs, we would be vulnerable to future state and federal law changes and court decisions. As counties experienced in 1991 realignment, these types of program changes can increase program costs far beyond what was originally projected. This was a primary county concern during discussions about 2011 public safety realignment and was eventually resolved with the constitutional protections contained in Proposition 30.

Another important question for counties is: will the state's proposals take into account residual county responsibilities and ensure adequate resources for these services?

The state's premise for giving counties new responsibilities is that there will be savings to county indigent programs from the Medi-Cal expansion. However, the 1991 health realignment funds are used to provide services for both indigent adults and local public health functions.

The most optimistic estimates show that 3 to 4 million Californians will remain uninsured in 2019. County indigent programs must continue to exist to serve uninsured Californians, along with critical local public health functions. I cannot emphasize enough that these local responsibilities for California's poorest and sickest residents will not change under health reform implementation.

As we move forward in discussions together about implementing health reform in a timely and sustainable manner, I ask you to remember that our counties are diverse and our local health care marketplaces contain critical differences. It is also important to recognize the current service responsibilities that will remain with counties after January 1, 2014.

As I said earlier, counties support the full expansion of Medicaid by the New Year. We have engaged our membership to seek a reasonable solution and share your belief that we must act with urgency and thoughtfulness.

Counties come to the table with a track record of partnership with you and the Governor and believe that health reform presents – and requires – another opportunity for partnership. We continue to study the best path forward, and we – along with you, your colleagues and the Administration – are working toward solutions to ensure that the promise of the Affordable Care Act is fulfilled in California.

I want to thank you again for holding this important hearing and allowing me to speak on behalf of California's Counties today.