Agenda: Item 4

Taxi Driver Health Care: an Updated Report on the Taxi Commission's Health Care Subcommittee's Report [INFORMATION AND POSSIBLE ACTION]

Taxi Driver Health Care: Policy Recommendations

Presented by

The Taxi Drivers' Health Care Working Group

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Preface: The Working Group on Taxi Driver Healthcare

The Working Group ("Group") on Taxi Driver Healthcare was formed June 27, 2006 pursuant to Resolution 2006-80. *Exhibit A*. The Group, an advisory body to the Taxi Commission, was comprised of the following individuals:

Voting Members:

Tom Oneto, Chair; Labor Representative, Taxi Commission
Ruach Graffis, United Taxi Workers
Dennis Korkos, Medallion Holders Association
Paul Gillespie, Driver Representative, Taxi Commission
Brian Browne, nominated by the Taxi Owners Association

Non-Voting Members

Jim Soos, Department of Public Health
Todd Rydstrom, Controller's Office
Ken Jacobs, UC Berkeley Labor Institute
Ellen Kaiser, San Francisco Health Plan
Carrie Winsten, Private Healthcare Consultant
Ilene Levinson, Private Healthcare Consultant
Tom Owen, Office of the City Attorney
Lane Kasselman, Mayor's Office

Staff

Heidi Machen, Executive Director
Jordanna Thigpen, Deputy Director

The Group met from October 2006 to March 2007. Minutes and agendas from the meeting are available at the Taxi Commission's website, http://www.sfgov.org/taxicommission.

Acknowledgements

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Tom Oneto
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Special thanks to members of the public who contributed on a consistent basis (every meeting – or close to it!):

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SAN FRANCISCO

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MAYOR GAVIN NEWSOM

WORKING GROUP SUBCOMITTEE MEMBERS

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BRIAN BROWNE
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PAUL GILLESPIE
DENNIS KORKOS

HEIDI MACHEN, EXECUTIVE DIRECTOR

March 7, 2007

Dear Friends:

On behalf of the Taxi Driver's Health Care Working Group, we are pleased to announce a plan that can make it possible for all working taxi drivers to have access to affordable health insurance.

Much preceded this Group's efforts, perhaps going back at least as far as the early 90's when President Bill Clinton focused the nation's attention on the health care crisis facing all of us. Notably, his administration spearheaded the 500-member Task Force on National Health Care reform, headed by first lady Hillary Rodham Clinton. It produced a complex 1000 plus page proposal that was ultimately deemed a colossal political failure but may have succeeded at least in capturing the attention of policy-makers at state and local levels.

At a local level, San Francisco was in the throes of discussion and planning for Universal Health Care by the mid-90's. It took more than a decade, but San Francisco policy-makers, led by Mayor Gavin Newsom and City Supervisor Tom Ammiano recently signed into law the Health Care Security Ordinance, creating a Health Access Program (HAP) offering comprehensive healthcare services to uninsured San Franciscans and their employers at a reasonable cost. It sets a minimum health spending requirement for medium-sized and large businesses which helps level the playing field for the majority of businesses that already pay workers' health care coverage and discourages companies from dumping more of their workers into the taxpayer-financed public health system. Today, many different jurisdictions are experimenting with health care reform, including the states of Massachusetts and Maryland, the cities of New York, Chicago, and Los Angeles.

Specific to taxi drivers, the San Francisco Board of Supervisors took up the issue of health care in 2002, when it passed an increase to the per-shift amount taxi companies could charge taxi drivers for driving and tied that increase to an implementation schedule for providing driver health care. Pursuant to this direction, in 2003, the San Francisco Controller's Office released a report entitled *Health Benefits for San Francisco Taxi Drivers*. Then, in March 2006, the San Francisco Health Plan and Department of Public Health released its report, for which it had received a $100,000 grant, entitled *Establishing a San Francisco Taxi Driver Health Care Coverage Program*. This report declared that health care coverage for taxi drivers was "within reach."

The San Francisco Board of Supervisors at the Board's annual review of taxi fare and gate caps again prompted attention to the issue of drivers' health care. The Board agreed to revisit the issue of meter and gates during 2007 if the Commission returned an implementation plan for drivers' health care by

not later than April 1, 2007. June 27, 2006, the Taxi Commission approved a resolution creating the Taxi Driver's Health Care Working Group. The Commission appointed members to the working group in late 2006 and convened its first meeting on October 17, 2006, conscious of the approach of a quick deadline.

A debt of gratitude goes to the 5 voting and 7 non-voting committee members who sacrificed several hours each month to work on this issue – including at least twice monthly meetings of two hours each between October 2006 and March 2007.

Taxi Commission staff also deserves recognition for many hours spent compiling survey information and researching issues for presentation at the Working Group meetings while also conforming to Brown and Sunshine Acts with noticing, preparation of agendas and minutes, and ensuring adequate opportunity for public input. Thanks, too, for the public who involved themselves in the process by attending meetings and offering valuable input.

Everyone came to the table with one shared goal: to develop an implementation plan that would make health care accessible and affordable to working drivers. It has taken a while for us to get to this point – but, the end is in sight. We sincerely hope that this plan provides clear direction in reaching that end point.

Respectfully submitted,

Heidi Machen
Executive Director Taxi Commission

Taxi Commissioner Tom Oneto
Chair, Taxi Driver's Health Care Working Group

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Introduction

This report was prepared in response to Ordinance No. 2006-80, which requires the Taxi Commission to submit a recommendation on a taxi driver health plan to the Board of Supervisors by April 1, 2007. This Ordinance tied the setting of the gate and meter adjustments to the issuance of the health plan.

The Working Group assumed that the health care implementation plan they were creating was for working taxi drivers. The idea of creating affordable health care for taxi drivers as a benefit of their employment has been brewing for some time, prompted by the following policy reasons:

- Healthier taxi drivers serve the public interest by becoming less a source of contagion– much like restaurant workers who are encouraged to obtain certain inoculations and, of course, practice good sanitary habits, they have a high level of contact with their customers;
- In addition, job benefits leads to retention of a stable workforce – the public gains in having more seasoned career taxi drivers having greater road experience;
- Similar to In-Home Support Services workers, taxi drivers are low-income workers serving the public and thus deserving of societal encouragement;
- Health care for taxi drivers adds one more piece toward the realization of the City's goal of universal health care.

Although the Group recognized that it did not have all the fine details, it made some working cost assumptions based on ballpark numbers provided by the Health Department's plan for taxi driver health care and supplemented previously researched information with updated numbers from experts serving as non-voting members. The Group was committed to arriving at a final plan, even if it meant choosing percentages where actual dollar amounts remained as broad estimates.

Policy Problem: National Lack of Universal Health Insurance Coverage

As of 2005, the lack of universal health insurance coverage adversely affects an estimated 46.6 million Americans – some 15.9% of the population. In California, the problem is worse with nearly 1 in 5 people or 19% lacking health insurance coverage.

The exact percentage of those who are independent contractors, such as taxi drivers, is unknown, but is likely quite high. These drivers are denied the option to be covered under a typical employer-based plan and no group plan has lasted

through the years. This report addresses the recommendations of the Group to solve the health care problem for taxi drivers.

Summary of Recommendations

Providing health benefits to drivers is possible, but only with all possible stakeholders contributing to pay for the plan. Depending on the alternative, the cost of benefits could range from $77.85 to $295.45 per person per month. Although a 2003 Controller's Report, *Health Benefits for San Francisco Taxi Drivers*, stated that private market solutions were limited, the Working Group on Taxi Driver Healthcare found that private market solutions are most likely to succeed at this juncture.

Health benefits could be provided using any of the following three alternatives: (1) health savings accounts; (2) a local direct health service program or (3) use of an existing group to obtain private plan coverage. The Group recommends working with a third-party administrator which can provide a menu of options, and funding at a moderately low cost option. The Group believes that it is important for drivers to have the opportunity to upgrade to a higher cost plan and add vision and dental and dependents as they see fit.

Providing coverage through the San Francisco Health Plan is not recommended.

As to the San Francisco Health Access Plan, this is not "health insurance" because it is not a contract. Also, it is only intended for those with no other options, and here, the Board has an opportunity to provide choices for taxi drivers.

Costs for any one of the three alternatives must be distributed across multiple funding sources, including drivers, medallion holders, color schemes, the riding public, and CCSF itself. Selection of a benefit alternative or alternatives and the funding structure are decisions for the Board. The San Francisco Health Plan and/or the Department of Public Health are not expected to have high levels of involvement.

The Group recommends a Taft-Hartley Trust with a memorandum of understanding and/or some entity serving as employer of record, in order to coordinate driver membership in the plan.

Health Insurance in America

The United States faces an unprecedented crisis in health care, as Table 1 below demonstrates. This crisis is only expected to worsen due to an aging population and a lack of consensus at the federal level to solve the problems.

Table 1. Health Insurance Coverage, 2001 to 2005*

	Uninsured		Medicaid/ SCHIP	Employer-sponsored Insurance	Individually-purchased Insurance	Medicare	Military Health Care
	Number (millions)	Percent	Percent	Percent	Percent	Percent	Percent
2005	46.6	15.9%	13.0%	59.5%	9.1%	13.7%	3.8%
2004	45.3	15.6%	13.0%	59.8%	9.3%	13.6%	3.7%
2003	45.0	15.6%	12.4%	60.4%	9.2%	13.7%	3.5%
2002	43.6	15.2%	11.6%	61.3%	9.3%	13.4%	3.5%
2001	41.2	14.6%	11.2%	62.6%	9.2%	13.5%	3.4%

* Based on Current Population Surveys. Percentages do not sum to 100% because some people have more than one type of coverage.

There are many types of entities which provide health benefits, as described below.

Private Health Insurance

The United States relies on employer-based private insurance for the majority of coverage, but in the past several years many employers have been forced to drop coverage due to the cost. The development of employer-based insurance occurred because of several factors unique to the United States: the rise of unions in the first half of the 20th century, World War II, and resistance from the private sector to creating a national health care system, a factor which continues today.

There are two types of private health insurance: self-funded employee benefit plans and state-licensed health providing organizations. Self-funded employee benefit plans are selected by the employer, who pays premiums and deals with the insurance company through a third-party administrator. The plans are subject to federal law, including ERISA.

State-licensed health providing organizations are regulated under state law, although they too are subject to ERISA. There are four central types of state-licensed health providing organizations: commercial health insurers, Blue

Cross/Blue Shield, Health Maintenance Organizations (HMOs), and blended HMO plans.

Commercial health insurers are also known as indemnity insurers. Under this model, the patient pays their own medical bills and submits a claim for reimbursement to the insurance company. These plans typically require the patient to pay a deductible and a share of the cost for each medical service. Blue Cross/Blue Shield was developed by physicians and surgeons in response to requests from the public for more expensive treatments. In 1931, Blue Cross was developed as a hospital insurance plan, and Blue Shield followed in 1939 with physician services.[1] At this time Blue Cross/Blue Shield is a collection of locally operated and independent health plans. Blue Cross/Blue Shield is currently the largest insurer of private non-group individuals in America. Within Blue Cross/Blue Shield, the 14-state Wellpoint is the largest member.

In 1973, Richard Nixon and Congress passed the HMO Act of 1973 due to huge rises in the cost of medical care throughout the 1960s and 1970s. An HMO operates as both an insurer and a provider by offering health care services within a specified network of providers. The customer pays a fixed monthly premium to the HMO and receives access to the network and services offered by the HMO. HMOs are further organized by Individual Practice Associations (independent physicians who come together to contract with an HMO), staff model HMOs (such as Kaiser Permanente), group model HMOs (multi-specialty groups of physicians who contract with an HMO), and network model HMOs (more than one physician group which contracts with an HMO.)[2]

There are also blended HMOs, including Point of Service (POS) Plans and Preferred Provider Organizations (PPOs). In both of these, the customer still belongs to an HMO but has greater flexibility to make choices about where s/he is obtaining care and pays a higher premium for those providers outside of the network.

Excluding no-responses, 1,146, or 28.77% percent of taxi drivers, stated that they have some form of individual (private) insurance in the 2006/2007 Driver Survey.

Public Health Benefits

The largest public health program is Medicare, a national program for American citizens over age 65 who have contributed to the Social Security system. In 2005, Medicare covered 13.7% of Americans.[3] Without serious reform, Medicare will suffer greatly in the next twenty years as unprecedented numbers of Baby Boomers retire and begin drawing on the system rather than contributing to it.

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[1] Ruth, Erin. *Health Insurance in America.* 2005. Found at www.amsa.org/uhc/2005_health_insurance.pdf. March 5, 2007.
[2] Id.
[3] Center for Budget Priorities and Policy. *The Number of Uninsured Americans is at an All-Time High.* August 29, 2006. http://www.cbpp.org/8-29-06health.htm. March 4, 2007.

Medicare consists of several parts. Part A covers inpatient hospital services, short-term care in nursing facilities, hospice care, and home health costs. The cost depends on the number of Medicare-covered quarters of employment that the enrollee has accumulated. Most people pay no fee for Part A. Part B covers physician services, laboratory and x-rays, preventive services, and some medical equipment costs. In 2007, the premium for Part B was $93.50, although those earning over $80,000 pay an additional amount.[4] Parts C and D refer to additional options for coverage.

6% of taxi drivers stated in the 2006/2007 Driver Survey that they were covered by Medicare.

It is important to note that Medicare is not completely free health care and does not provide total coverage for all expenses. Medicare also does not cover vision or dental.
Many Medicare recipients supplement this public benefit with private insurance, either through an employer, spouse, or other source.

Another public program is Medicaid. Medicaid is a blanket term for state programs which provide health care to low-income individuals. In California, the program is known as Medi-Cal. Medi-Cal is required to cover pregnant women and children under age six with family income below 133% of the federal poverty level; older children with family incomes below 100% of the federal poverty level; parents with income below states' welfare eligibility levels; and most elderly and disabled individuals who receive some form of cash assistance are eligible for Medi-Cal.

10% of taxi drivers stated that they are covered by Medi-Cal.

Finally, it is important to note that many taxi drivers are covered by the Veteran's Administration (VA). The VA provides a standard benefits plan available to all enrolled veterans, which emphasizes preventive and primary care, and offers a range of outpatient and inpatient services within the VA health care system.

The VA maintains an annual enrollment system to manage the provision of quality hospital and outpatient medical care and treatment to all enrolled veterans. A priority system ensures that veterans with service-connected disabilities and those below the low-income threshold are able to be enrolled in VA's health care system.[5]

35 taxi drivers stated that they were covered by the VA.

[4] Official Medicare Website. http://www.medicare.gov/. March 4, 2007.
[5] Official VA website. http://www.va.gov/healtheligibility/. March 4, 2006.

Background of the Taxi Industry

Based on data from the Treasurer/Tax Collector's Office, approximately 7,000 drivers hold the "A" card permit necessary to drive a taxi in San Francisco. As of 2004, these drivers provide approximately 40,000 to 50,000 trips per day for residents and visitors. Taxis are part of the city's Transit First Policy and play a critical role in MUNI's paratransit program by providing service to members of the disabled community.

The Working Group on Taxi Driver Healthcare conducted a Driver's Survey in the course of the 2007 A-card renewal process. Thanks to the Treasurer/Tax Collector's Office, the Working Group was able to receive and compile over 4000 responses to specific questions about the coverage status of San Francisco taxi drivers. The survey revealed that 42% of San Francisco taxi drivers are not covered as a result of an inability to afford insurance. The results are described in more detail below.

Regulatory History

The taxi industry in San Francisco is subject to a complex regulatory scheme based on Proposition K, passed by the voters in 1978. The collapse of the Westgate-California company, which resulted in widespread disruption of taxi service, led to Proposition K's original passage. Proposition K substantially changed the regulation of medallions (city-issued permits which allow a vehicle to operate as a taxi) by disallowing any new corporate ownership and making medallions public property, among other changes. In 1998, voters approved a ballot measure which authorized the Taxi Commission to assume duties previously held by the Police Commission. The Taxi Commission oversees and regulates the industry, and is charged with setting policy to improve taxi service in the City.

Medallions held after the passage of Proposition K ("post-K medallions") are held by individuals who must drive at least 800 hours or 156 shifts of at least four hours each. Prior to Proposition K, medallions were owned by companies and individuals, some of whom were drivers and some of whom were simply investors. Permits issued prior to the passage of Proposition K are called "pre-K medallions" and are not subject to the driving requirement. Some of these are held by corporate owners.

Proposition K also contributed to cause a change in driver status from employees of color schemes to independent contractors. Drivers in many metropolitan areas share the same status. Las Vegas, Nevada is unique in that all drivers there are employees and all have health benefits.

Color schemes in San Francisco do not remit payroll tax to the city because of the independent contractor status of the drivers. Thus, the City may collect payroll tax for the bookkeepers and managers and other taxi company personnel but not for the thousands of independent contractor drivers. The City Treasurer has just begun collecting a business tax from individual drivers who have the nebulous status of "independent contractors."

Major Industry Relationships

The San Francisco taxi industry has three major components: medallion (permit) holders, color schemes (taxi companies), and drivers. There are currently 34 taxi companies in San Francisco. 12 companies control 86 percent of the market. The largest company, Yellow Cab, currently holds approximately 475 permits. There are currently 1381 permits in service, which is expected to increase by 25 ramp medallions and 25 "regular" medallions in 2007. The Taxi Commission reviews the number of medallions each year to see whether there is a sufficient amount to serve San Francisco.

It is not clear how many of the 7,000 individuals possessing A-cards actually drive, since some have suggested that they renew their A-card but do not actually drive. The Controller's 2003 Report estimated that approximately 6,000 individuals are working drivers based on two 10-hour shifts per day per year for all 1381 medallions. Of the 6000 drivers, there are 956 medallion holders with a driving requirement. Some medallion holders might lease to particular drivers, who in turn might lease to other drivers or operate the vehicles themselves. Some medallion holders have chosen to operate their own vehicles under their own color scheme. Most medallion holders lease their permits to the color schemes, which in turn provide drivers with vehicles, insurance, dispatch, and other services. The color schemes then charge a "gate fee," or rental charge to operate the vehicle during a shift. The gate fee is capped by the Board of Supervisors on recommendation of the Controller and currently, must average no more than $91.50 per ten-hour shift. In market practice this results in a higher gate fee being charged on busy Fridays and Saturdays, with a lower gate fee charged for slower weekdays.

In most situations, medallion holders rent their medallions to taxicab operating companies. This is currently a non-regulated transaction. Although the Controller's 2003 Report estimated the market value of this transaction at $1,800 per month, investigations have revealed that some medallion holders are receiving in excess of $6,000 per month for their medallion.

Currently, for Internal Revenue Service and California Franchise Tax Board purposes, drivers are considered independent contractors. However, for worker's compensation and liability insurance purposes, drivers are treated as employees. The law surrounding independent contractors and employees is considered murky at best. In *Yellow Cab Cooperative, Inc. v. Workers' Comp. Appeals Bd.* (1991) 226 Cal.App.3d 1288, the court applied what is known as the Economic

Realities Test. The court held that taxi drivers who pay a daily lease fee to a taxi company for the right to drive a taxi are employees rather than independent contractors, despite the company's contention that the drivers did not have to take radio calls, could drive wherever they wanted, could use the taxi to run personal errands or carry non-paying passengers, and could choose to work whenever they wanted. The court, while noting the absence of control over work details, reasoned that "to the extent [a driver's] freedom might appear to exceed that of a typical employee, it was largely illusory. If he wanted to earn a livelihood, he had to work productively and that meant carrying paying passengers." (*Yellow Cab Cooperative,* 226 Cal.App.3d at p. 1299) The absence of control over details is of no consequence "where the principal retains pervasive control over the operation as a whole, the worker's duties are an integral part of the operation, the nature of the work makes detailed control unnecessary, and adherence to statutory purpose favors a finding of [employment]." (*Id.,* 226 Cal. App. at p. 1295). Despite this decision, color schemes continue to treat drivers as independent contractors.

The independent contractor status of drivers is one reason that companies have not provided employee group health plans for drivers, since there is no single employer or group of employers who can serve as the group policyholder for drivers.

Driver Income

Driver income has been estimated by various groups as ranging anywhere from $24,000 to $70,000 per year. Driver income depends on many variables, including the driver's own driving habits and the current economic climate. A driver's income comes down to how much money he generates over and above the gate fee s/he has paid for that particular shift.

Driver income is an extremely important aspect of any health plan which is ultimately approved. Of those drivers who do not have coverage, 79% stated that the primary reason is affordability.

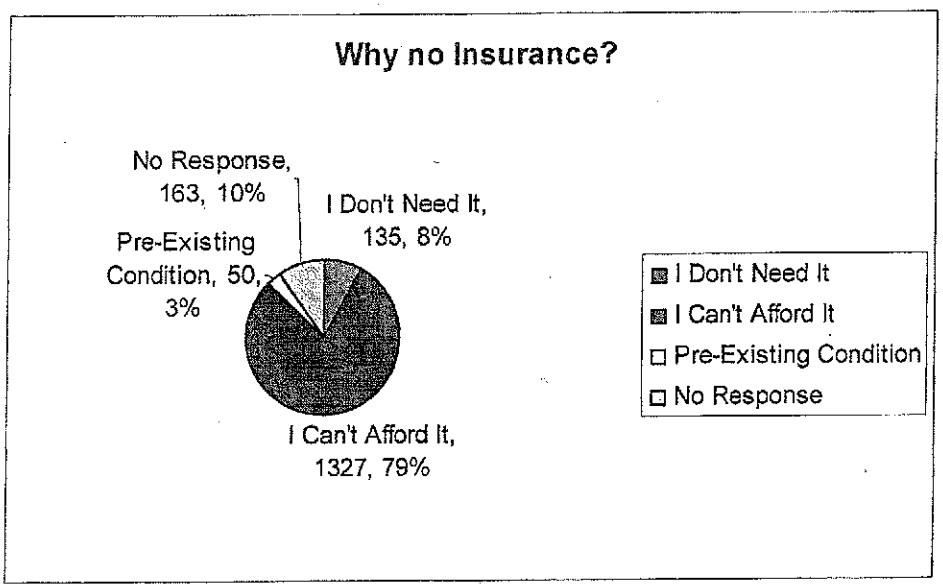

Table 2. Why Drivers Do Not Have Insurance

Coverage for Drivers: Past and Present

Current Coverage

In the 2006/2007 Driver Survey, of responding drivers, 53% of drivers responded that they have some form of insurance, while 39% responded that they do not and 8% gave no response at all.

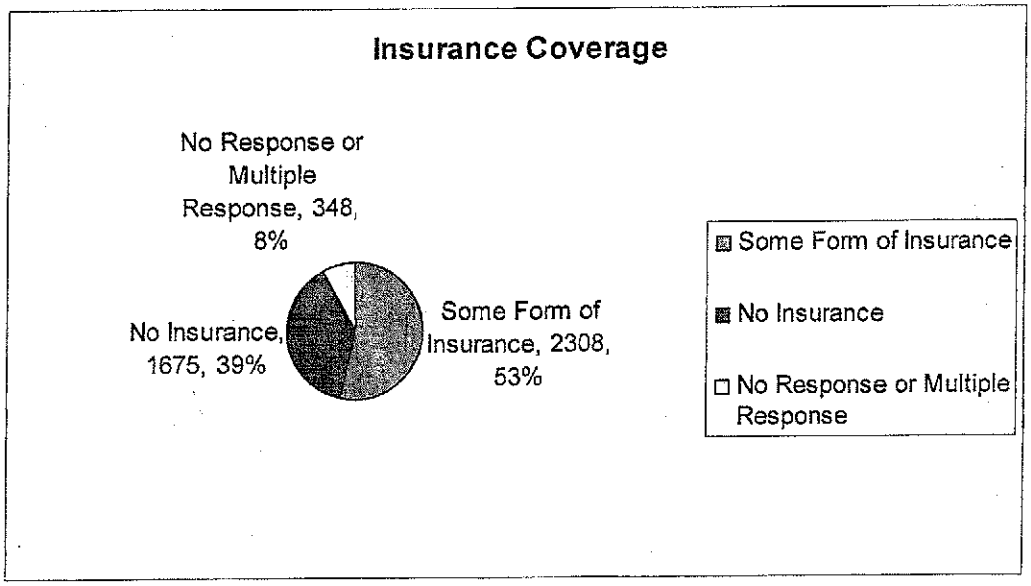

Table 3. Insurance Coverage for Drivers

Although some drivers have coverage through publicly funded programs such as Medicare, Medi-Cal, or the Veteran's Administration, most who do have insurance coverage state that they have coverage through individual insurance.

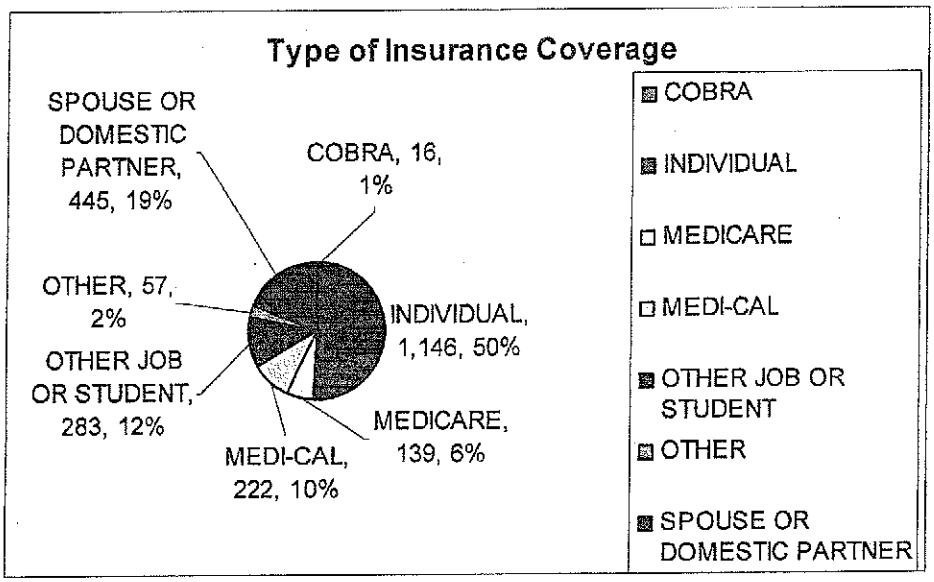

Table 4. Type of Insurance Coverage

As stated above, the status of drivers as independent contractors has made obtaining health coverage difficult. The City of San Francisco Treasurer and Tax Collector's Office treats taxi drivers as independent contractors for purposes of registering themselves as business owners. However, cab companies are required to comply with state worker's compensation laws and provide coverage for their "employees," the drivers. Finally, the IRS classifications consider taxi drivers independent contractors.

The problem with the independent contractor status is that it makes employer-sponsored coverage nonexistent. As of 2003, 62% of all non-elderly Americans received health insurance through their employer.[6]

The Kaiser Plan

Between 1997 and 2002, drivers had access to a Kaiser Permanente Group Health Plan. This Plan was administered by the National Association of Socially Responsible Organizations (NASRO), a nonprofit association which specializes in providing health coverage for small businesses and the self-employed, such as independent contractors. The plan was available through the United Taxicab Workers (UTW) and the San Francisco Taxi Permitholders and Drivers Association (PDA). The plan cost $216 per month for individual coverage and $575 for family coverage in 2002 and included comprehensive health services with a $10 co-pay. The Controller estimated that only 30-80 drivers were enrolled in the plan at any given time, which may have been due to the price.

[6] Blumenthal, David. *Employer-Sponsored Healthcare in the United States – Origins and Implications.* The New England Journal of Medicine, Health Policy Report. Vol. 355:82-88, July 6, 2006.

Kaiser discontinued its contract with NASRO in 2002, and NASRO offered alternative plans which excluded treatment for pre-existing conditions or potentially disqualified the least healthy. The San Francisco Health Plan reported in the March 2006 report that at least two drivers participated after the Kaiser Plan was discontinued.[7]

The Board of Supervisors' Health Coverage Mandate for Drivers

After the demise of the Kaiser Plan, health coverage for the city's drivers became a topic of increasing interest. In 2002, an increase in the "gate cap," or charge that drivers pay a taxi company at the beginning of each shift, passed at the Board of Supervisors. This increase was made contingent in part on the fulfillment of reporting requirements and the provision of worker's compensation by the cab companies. MPC § 1135.1(g)(ii) also tied the increase in the gate fee cap to health care for drivers, as follows:

> By no later than October 1, 2003, the Controller shall submit a recommendation to the Board of Supervisors for enactment of a program that would make a substantial and reasonable degree of health insurance or health benefits available to all taxi drivers. The Controller's recommendation shall be based on his study of the health insurance/health benefits issue, which shall include consultation with City departments having expertise in one or more dimensions of the issue. If, within 90 days of the Controller's submission of a recommendation, or, if the Controller fails to meet the deadline for submitting a recommendation, by no later than January 1, 2004, the City fails to enact into law an ordinance that establishes a program that makes a substantial and reasonable degree of health insurance or health benefits available to all taxi drivers, subsection (b) [establishing the cap of $91.50] shall expire, unless the Controller certifies that it is not feasible for the City to establish such a program.

As a result of this ordinance, the Controller completed a report in October 2003 entitled *Health Benefits for San Francisco Taxi Drivers: Health Plan Alternatives, Funding, & Implementation.* The report determined that "[p]roviding health benefits to drivers is possible, but comes with a cost."[8] The report also made clear that all stakeholders possible would have to contribute to the cost.

The Controller provided three alternative strategies for the provision of health benefits for drivers: (1) medical savings accounts; (2) a local direct health service

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[7] San Francisco Health Plan and CCSF Department of Public Health. *Establishing a San Francisco Taxi Driver Health Care Coverage Program: Administration, Cost, and Funding Options.* March 2006. P.9.

[8] San Francisco Office of the Controller. 2003. *Health Benefits for San Francisco Taxi Drivers: Health Plan Alternatives, Funding, & Implementation.* P.1

program or (2) health insurance. The Controller's Office concluded that health insurance provided the greatest benefit although also came with the greatest cost. The Controller's Office suggested that

> ...providing health insurance through the San Francisco Health Plan, using the Healthy Workers program if health insurance for local In-Home Supportive Service workers as the prototype, is a possible solution that could move San Francisco another step closer to universal health insurance coverage.

The Controller determined that a direct health service program would have to be designed with the participation of the Department of Public Health. The Department of Public Health then obtained a grant from the California Healthcare Foundation to develop a proposal for a taxi driver insurance program. The Department of Public Health then produced the March 2006 *Establishing a San Francisco Taxi Driver Health Care Coverage Program: Administration, Cost, and Funding Options*, providing details of possible health plan options for taxi drivers provided by the San Francisco Health Plan.

Overview of the Taxi Industry: Existing Stakeholders

As has been repeatedly stressed in various reports and throughout the Group meetings from October 2006 to March 2007, providing taxi driver health coverage will only be possible if every stakeholder contributes.

The taxicab industry in San Francisco includes three primary groups: drivers, medallion (permit) holders, and color schemes (taxi companies.) Other stakeholders include the "riding public," who will be contributing through an increased charge in the flag drop, and CCSF, which will contribute a dollar amount based on estimated savings by taking uninsured drivers out of the current SFGH/clinic system.

Drivers

Approximately 7,000 A-Card permits for drivers are in circulation at any given time, although the number fluctuates based on many factors. The San Francisco Police Department's Taxi Detail oversees regulatory compliance for the industry, and approximately half the Taxi Commission annual budget goes to fund SFPD salaries and an overtime enforcement fund.

- 55% of drivers are married, 2.2% have a domestic partner, and 39.5% are single
- 70.1% of drivers are male and 3.2% are female

- The mean age of a driver is 45 years, and the median age of a driver is 44 years
- The mean number of children for a driver was 2
- 54.2% of drivers live in San Francisco County; 14% live in San Mateo County, 10% live in Alameda County, 5% live in Contra Costa County, and the remainder reside elsewhere
- The mean number of years that a driver has been driving a taxi in San Francisco is 9 years and 7 months. The median number of years is 7.

Source: 2006/2007 Driver Survey

The majority of drivers operate under the gas and gate system, in which they purchase their own gas and pay a gate fee to the companies in exchange for services the companies provide. Meter fares and tips go directly to the driver, out of which they pay driving-related expenses (e.g., gas). Thus, any increase in the "flag drop" would be an increase in driver income.

In addition to the gate fee, drivers usually pay the dispatcher, and possibly the managers as well, a "tip" at the beginning and end of each shift. This amount could range from $2-$20 depending on the shift.

The 2006/2007 Driver Survey included a question regarding driving arrangements and the vast majority of drivers who responded reported that they paid daily gas and gates, although many had other driving arrangements.

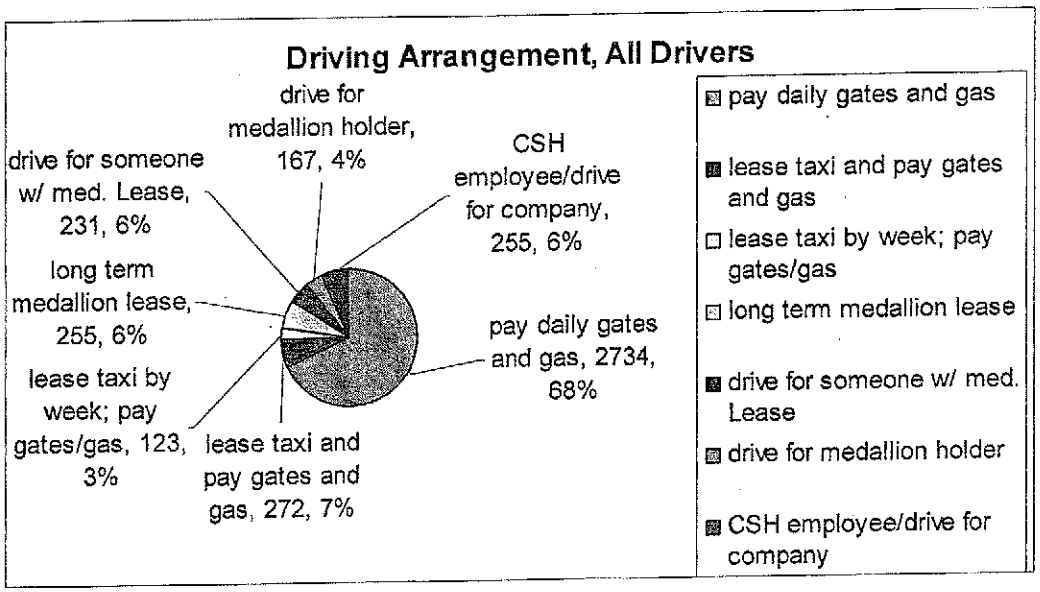

Table 5. Driving Arrangement, All Drivers

Medallion Holders

The number of cabs presently in operation in San Francisco is 1,381. This includes 1306 so-called "regular" medallions, and 75 "ramp" medallions for wheelchair service. The Taxi Commission voted on February 13, 2007 to

increase the number of regular medallions by 25 and the number of ramp medallions by 25, although this increase is pending certification by the Controller.

Prior to 1978, medallions were private assets that could be sold and transferred at will for the market rate, or $15,000 in 1978. In 1976, however, the largest private cab company went bankrupt and the bankruptcy judge froze the medallions as assets of the bankruptcy estate. This precipitated a meltdown in cab service in the City and a call for reform. Then-Supervisor Quentin Kopp authored Proposition K, which the voters passed, making medallions public property of the City to be given to working taxi drivers only and to prevent corporate ownership. The present value of a medallion, were it to be sold on the open market, is estimated at $180,000 by the Controller.

Proposition K set up driving requirements for medallion holders consisting of 156 4-hour shifts per year or 800 hours. Those who owned their medallions prior to the passage of Proposition K do not have any driving requirement. Approximately 956 of the current 1381 medallions are so-called "post-K" medallions held by drivers, while the rest are pre-K. There are many issues with both pre and post K medallions that are beyond the scope of this report.

Drivers who wish to obtain a medallion may place their name on a waiting list. Usually 40 to 50 become available in the fiscal year due to driver attrition for various reasons. Taxi drivers can remain on the waiting list for more than a decade before obtaining the right to take possession of a medallion. The 2006-2007 Survey shows the percentage of medallion holders and those on the waiting list:

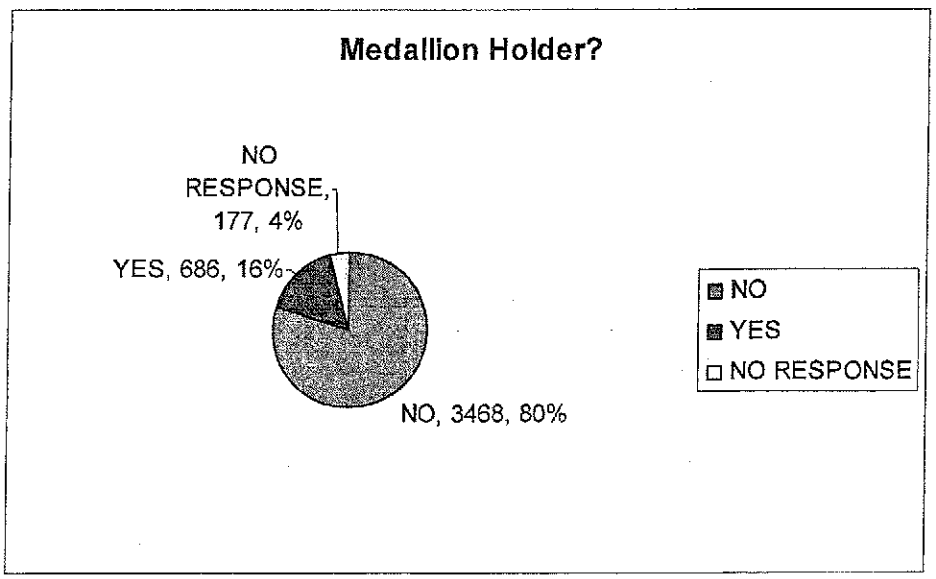

Table 6. Medallion Holders

As noted by the Group, the actual number of individuals who responded "Yes" to the medallion holder question is lower than the actual number of medallion

holders. This is due in part to the fact that the 4,331 is not a complete sampling of all A-card holders, and in part to non response on the question.

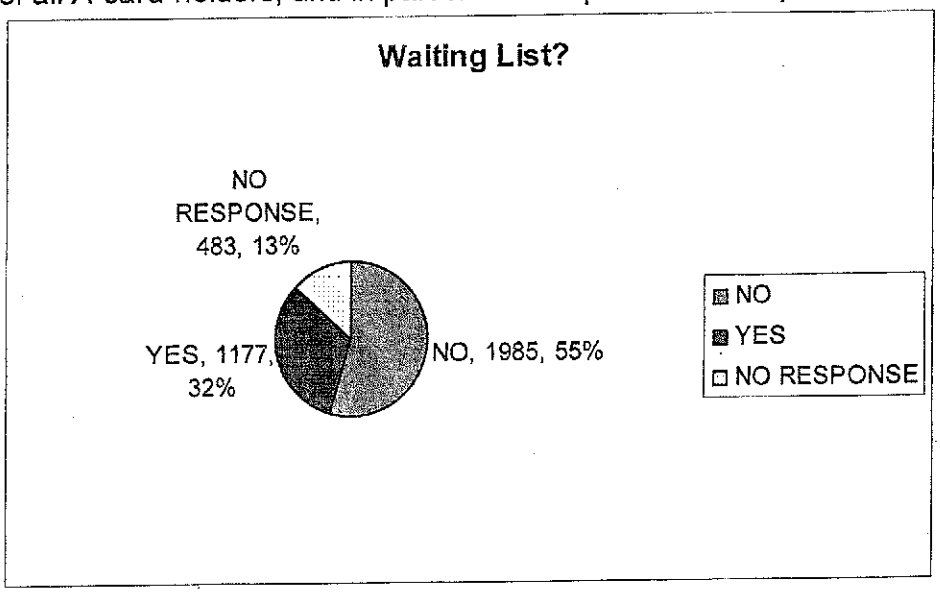

Table 7. Waiting List

Medallions are a supplemental source of income for the drivers who hold them, because the driver can lease the medallion to a taxi company, who in turn can rent it to other driyers who work when the medallion holder is not actually fulfilling his driving requirement. Certain medallions are more valuable than others, due to the necessity of post-K medallion holders needing to fulfill their driving requirement. The most highly valued medallions are those "pre-K" medallions held by individuals or corporations, since there is no driving requirement. The second most highly valued class of medallion are those which are held by key personnel to a taxi company, since the Board of Supervisors recently passed legislation modifying the driving requirement for these types of medallion holders. Key personnel who also hold medallions need fill only 12 shifts per year starting in 2007. The least valuable medallions are those post-K medallions which are held by drivers who work full-time driving their own cab. Lease fees which a cab company pays to a medallion holder range from $1800/month to $3500/month, and cab companies can lease a medallion to a driver for a monthly fee of up to $6,000.

Taxi companies compete for the ability to lease medallions from medallion holders by attempting to entice those individuals at the top of the waiting list as well as luring medallion holders from other companies.

Taxi Companies

Taxi Companies, or "color schemes" (so called because of the different automobile paint colors used to differentiate among the various companies) must register with the City and pay fees to create and maintain their color schemes. There are currently 34 color schemes in San Francisco, plus one that has recently been approved by the Taxi Commission.

Cab companies can be subdivided into three categories: large companies that control the majority of medallions and operate primarily by charging drivers gate fees, medium-sized companies that exhibit the most variation in relationships with medallion-holders and with other drivers, and small companies that consist of one or a few medallion-holders with several drivers. One third of the taxicab companies control 85% of the city's medallions. Exhibit B shows the number of medallions held by each taxi company.

Over the past five years, the industry has experienced considerable turnover among smaller taxi companies. Several smaller companies have disbanded and eight additional companies have been established since 2001.

Taxi companies provide a variety of services to drivers that vary depending on the size of the company. Minimum services include use of the color scheme and dispatch, but can also include insurance, vehicles to drive, and maintenance of the vehicles. Of course, all companies are required to provide worker's compensation for their drivers.

Income for taxi companies is ultimately derived from the medallions which they hold, and includes the drivers' gate fees, advertising, medallion subleases, interest, and gasoline sales. Gate fees are currently capped at $91.50 per ten-hour shift, although as will be shown below, this amount may be adjusted based on the type of health plan that is ultimately offered. This means that the *average* gate fee cannot exceed $91.50 per shift over a one week period, with Fridays and Saturday evenings generally having the highest gate.

Medallion lease payments to medallion holders constitute the major expense for taxi companies. Other expenses include worker's compensation, vehicle insurance, radio dispatch, car parts, general administration, marketing and operating costs. Large companies maintain repair shops on their premises and employ mechanics.

MUNI Paratransit Program

The MUNI Paratransit Program is relevant for administrative and for legal reasons as well. To comply with the Americans with Disabilities Act of 1990 (ADA), the City requires each taxi company to provide transportation to eligible ambulatory and wheelchair-bound residents through the City's paratransit program. The program operates through a decentralized brokerage model, in which a private broker handles tasks such as eligibility certification, customer service, and outreach. Taxis supply the majority of paratransit trips under the program, and customers pay $4 for scrip books worth $30 of metered taxi service. A swipe card program has been in development for several years to replace the scrip books.

The program requires cost calculations by the color schemes and reimbursement of fees to the San Francisco Paratransit office, and thus provides a framework for

how color schemes could distribute funds for a health plan. The flag drop immediately preceding the most recent stopgap increase was from $2.75 to $2.85. This .10 was intended for the Paratransit Program specifically. The mean gate fee of $91.50 also included a $1.50 subsidy to help fund the program.

The cost of the paratransit program was determined monthly by the companies and the San Francisco Paratransit broker and subsequently billed to taxi companies based on the number of affiliated medallions.

Enforcement of this process is shared jointly between the San Francisco Municipal Railway, which oversees the Accessible Service program, and the San Francisco Taxi Commission, which is responsible for regulating taxi companies.

The Paratransit Program must be considered when considering any increases to the meter, since it will affect the cost of MTA's Budget.

Controller's Report

The Controller submitted a report in October 2003 entitled *Health Benefits for San Francisco Taxi Drivers*. The report was prepared in response to Ordinance Number 228-02, which required the Controller to submit a recommendation to the Board of Supervisors by October 1, 2003 for enactment of a taxi driver health plan.

In that report, the Controller found that "[p]roviding 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."[9]

The Controller considered private market coverage and public sector programs. As to private market coverage, the Controller reviewed two major individual coverage options available at that time, including Kaiser HMO Personal Advantage and Blue Cross HMO Saver. The biggest barrier in both circumstances was the cost and the issue of pre-existing conditions.

The Controller reviewed California state-sponsored programs such as the Major Risk Medical Insurance Program (MRMIP) and Medi-Cal, as well as local public sector insurance programs such as the San Francisco Health Plan and the In-Home Support Services Healthy Workers Program.

There were three health benefit plan alternatives that the Controller reviewed for feasibility: medical savings accounts, a local direct health services program, and

[9] Controller's Office. *Health Benefits for San Francisco Taxi Drivers*. October 2003. P.2.

health insurance. Based on the three alternatives, the Controller then reviewed the funding alternatives with different stakeholders contributing.

Based on the findings, the Controller recommended that health benefits could be provided by any of the three alternatives: (1) medical savings accounts; (2) a local direct health service program and (3) health insurance. Spreading costs among all possible stakeholders was also recommended. The Controller cautioned that "any direct health service program or health insurance plan would have to be designed with the 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."

The Controller made several recommendations, including conducting a comprehensive Driver Survey (which was completed during the A-card renewal process with 4,331 responses), and legislative changes. The report also noted implementation issues around drivers, the administrator, providers, and CCSF. These appear in Table 8 of the Controller's Report and are attached as Exhibit C to this report for ease of viewing. One of the most notable is the suggestion that the Paratransit program cost would likely increase if fares were increased to pay for benefits.

The San Francisco Health Plan/Department of Public Health Report

In March 2006, the San Francisco Health Plan and the Department of Public Health released a report of their own entitled *Establishing a San Francisco Taxi Driver Health Care Coverage Program: Administration, Cost, and Funding Options.* This excellent report described the various stakeholders in the industry and provided an explanation of the difference in making the plan mandatory vs. voluntary. The report noted that "the challenges of implementing a taxi health care program are substantial given the need to balance the financial health of industry participants against the need for affordable transportation for the City."[10]

The report outlined the way in which the San Francisco Health Plan would cover taxi drivers under various funding models. The report broke down the levels of contribution necessary to fund a plan at both the voluntary and mandatory levels, with mandatory being considerably more expensive. Legal challenges to potential funding sources were described, and many administrative challenges to implementation were also noted.

Three separate funding options were explored in greater detail. The first was a Fee/Fare Option generating revenue without voter initiative and solely through increasing the A-card fees and a meter increase. The second was a Tax option generating revenue through voter initiative to levy a special tax on cab

[10] *Establishing....*at p. 62

companies, medallion holders or a combination of the two. The third was a combination of the Fee/Fare and Tax options.

Ultimately, the Report recommended as follows:

- a health plan for taxi drivers in San Francisco be created and be directly administered by the San Francisco Health Plan
- that the standards used for the Healthy Workers Program be applied to drivers, with coverage limited to A-card holders who had worked at least 25 hours in one of the previous two months to qualify for health care coverage, and that coverage be limited to drivers who had held an A-card for at least six months with proof of employment as a taxi driver and who are ineligible for no-cost Medi-Cal
- that cab companies be responsible for maintaining the appropriate driver participation data and for providing this information to the San Francisco Health Plan
- the use of per medallion rates if cab companies are taxed to fund this program

The Report also listed several policy decisions that needed to be made, all of which were addressed by the Group's work.

The 2007 Driver Survey

With the incredible efforts of the Treasurer/Tax Collector's Office, the Group was able to obtain 4,331 completed surveys from drivers during the annual A-card renewal. A copy of the survey and the results are attached as Exhibit D.

This survey provided interesting data about the driver population and their current insurance needs, as well as some details about the industry. The Controller's Office performed cross-tabulations that illustrate more detailed preferences and demographics about those who stated they were medallion holders.

Notable statistics from the survey are woven throughout this report and appear in the Exhibits attached.

- On seeking medical care, 42.2% had none in the last 12 months, 23.3% sought medical care from SFGH or SF clinics, and 18.7% sought medical care from a private doctor
- 38.4% of drivers stated they would be willing to contribute to a health plan, while 32.3% of drivers stated they would or could not contribute
- Of those who stated they were medallion holders, 40.6% said they would contribute to a health plan, and 59.4% said they would or could not contribute

- Of those who stated they would contribute to a health plan, 74.14% had no coverage, and 36.14% had coverage
- Of those who stated they would not contribute to a health plan, 25.86% stated they did not have coverage, while 63.86% had coverage
- Of those who stated they would contribute and responded to the second part of the question, 56.18% stated that the maximum they could afford to contribute is $10-$50 per month, while 27.86% stated they could afford $50-$100, and 15.95% stated that they could afford more than $100 per month
- Of those who said they were medallion holders and said they could contribute something to a health plan, 52.15% stated they could contribute $10-$50, while 24.54% stated they could contribute $50-$100, and 30.67% stated they could contribute in excess of $100
- Of those who said they were not medallion holders, 26.3% stated they drive 40-49 hours per week; 20.4% stated that they drive 30-39 hours per week, 14.8% stated they drive 20-29 hours per week, 11.5% stated they drive 9 or fewer hours per week, 11.1% stated they drive 50-59 hours per week and 6.5% stated they drive more than 60 hours per week
- Of those who stated they are medallion holders, 30% stated they drive 40-49 hours per week, 22% stated they drive 30-39 hours per week, 17% stated that they drive 20-29 hours per week, and the remaining 31% drive other amounts
- 51.3% of drivers stated that they favored part of the funding for a health plan to come out of a meter increase, while 48.7% stated that they did not

Key Group Policy Decisions

Following the recommendations of the earlier Controller's and SFHP/DPH Reports, the Group had key votes on several important issues.

Eligibility

Discussion: The Group acknowledged that this health care plan is intended for working drivers and sought to prevent someone from getting health care benefits simply for the price of an A-card, whether or not the person was actually a "full-time driver." The group also noted that "full-time driver" is defined in the Municipal Police Code as applicable to those who drive as little as 800 hours or 156 4-hour shifts per year.

Recommendation: To establish initial eligibility for health care, a driver would have to drive at least 1000 hours during a year; to maintain eligibility, s/he would have to drive 800 hours per year, a standard consistent with the Proposition K requirement for medallion holders. In addition, the group recommended biennial reporting by taxi companies to develop the list of eligible drivers.

Mandatory vs. Voluntary Coverage

Discussion: The Group sought to avoid the issue of adverse selection in creating a group plan for health care. Adverse selection, the instance in which

the group formed is disparately composed of those who are less healthy and thus have greater need for health care, tends to drive up the overall group costs. In addition, the Group feared employment discrimination against drivers who sought coverage – or that taxi companies might have reason to discourage drivers from signing up for coverage if it was voluntary. Finally, if a public benefit is to be derived from the program, it will best be realized by having all drivers who are in contact with the public to have access to health care.

Recommendation: The Group voted to make coverage mandatory and to later decide exemptions. One approved exemption: those already having health care from another source (e.g. spouse, Veteran's, other job, student coverage), could opt out of the plan by providing proof that they are otherwise covered.

Funding the Proposal: Stakeholder Participation

As previously noted, providing health care for taxi drivers is an expensive undertaking that could range between $4 million and as high as $19 million per year. The Group examined all of the funding mechanisms that the SFHP/DPH *Establishing a Health Care Plan for Taxi Drivers* considered, including taxi drivers (both participating and non-participating), medallion holders, taxi companies, and the riding public through a meter increase.

In addition, the Group considered three more sources: City and County of San Francisco, specially created Health Care medallions, and receipt of a transfer tax the City could obtain by creating a medallion system that allowed buying and selling of medallions, known as "transferability."

Although *Establishing a Health Care Plan for Taxi Drivers* questioned whether medallion holders and companies could be included as sources of funding without triggering a need to go to the ballot, most members agreed that the subsidy for the Paratransit Program previously collected directly from taxi companies through Municipal Police Code § 1137.5 set some precedent. Since that subsidy did not trigger a need to go to the ballot, Commission staff suggested that the health care plan could use it as a model and thus also avoid going to the ballot. There is more elaboration on the distinction between fees and taxes below.

Finally, the Group considered how to collect the money and ways in which to help defray costs for certain stakeholders.

Distinction Between Fees and Taxes

The SFHP/DPH Report contained an excellent description of the distinction between fees and taxes. The Report made clear that since federal and states funds are not available, all financing has to come directly from the industry and from CCSF. There are California laws regarding the imposition of fees vs. taxes.

The Legislature defines a fee as any charge implemented on an individual, business, or other organization for a service or facility provided directly to the individual or organization. A fee cannot exceed the cost of providing the service or facility – otherwise, it is considered a special tax. Local governments are not required to gain voter approval for a new or increased fee, but they must hold a public hearing on the proposed fee and notify the public of the hearing 10 days in advance.[11]

A tax is a charge against an individual or organization for the provision of general service or facility benefits. Unlike fees, taxes do not have to confer a specific benefit to the taxpayer. There are two types of taxes: general and special. General taxes generate revenue for the general option of government and may be used for any purpose. A special tax is one whose proceeds can only be used for a specified purpose.

Under Propositions 62 and 218, state and local governments must get majority voter approval before levying any new general taxes or increasing an existing general tax. The State Constitution requires that special taxes be approved by two-thirds of voters.[12]

Flag drop and gate increases, by contrast, are controlled by the Board of Supervisors and do not require voter approval.

While it is true that fees cannot "simply be raised" to pay for a health plan, there are other options.[13] The City can require that as a condition of obtaining an A-card, drivers show proof of health coverage. It can also require that as a condition of obtaining color scheme renewal, color schemes demonstrate that all drivers under their color scheme have health coverage. Similarly, as a condition of obtaining a medallion renewal, medallion holders must be required to show how many drivers are affiliated with each medallion, and that these drivers have health coverage.

As the SFHP/DPH Report noted, the City could also lower gate fees. The gate fees were set at $90.00 (plus $1.50 for the Paratransit Program) to pay for a health program. The extra money has been going to the color schemes in the meantime, with no corresponding responsibility for a health program. The City could lower the fee, which would provide drivers with additional income to pay for a health program. This may or may not be done in conjunction with an increase in the flag drop.

Individual Stakeholder Contributions

One issue the Board will have to address in greater detail is how the money will be collected from each source and turned over to the plan administrator. The

[11] California Budget Project Budget Brief. 1996. "What are the Differences between Assessments, Fees, and Taxes?" http://www.disclosuresource.com/downloads/calbudget.pdf. March 4, 2007.
[12] Id.
[13] *Establishing*...at p.16

Group voted to make the following sources responsible for funding the program, in the following percentages and setting some mechanisms for collection.

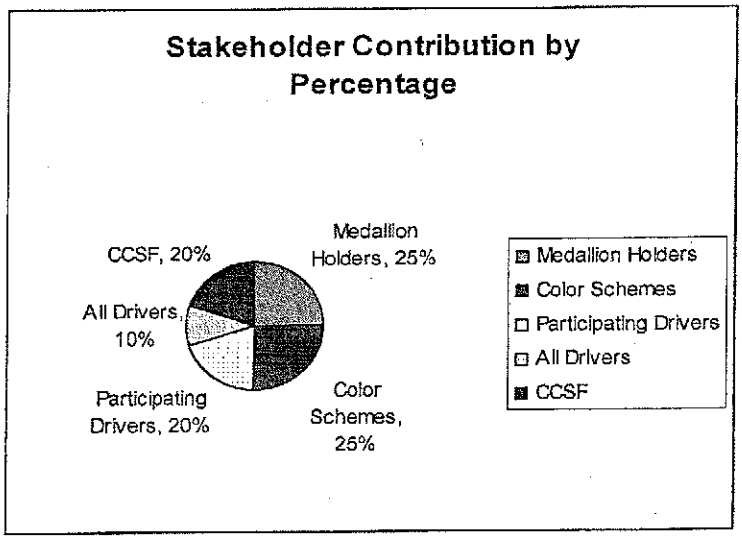

Table 8. Stakeholder Contribution by Percentage

Should Drivers Participate Toward Funding a Health Care Plan?

For funding purposes, the Group chose to divide drivers into two groups: all drivers and participating drivers.

Discussion on All Drivers: As stated, the Group elected to make the program mandatory: one way of doing that would be to create a new condition for becoming a taxi driver: you must be covered by health insurance. Just as students have an "activity fee" that helps pay for programs such as campus health care that some students may never use, the group decided it was appropriate to have all drivers contribute at least a small amount, whether or not that driver opted out of this health care plan. Using numbers derived from the SFHP/DPH *Establishing a Health Care Plan for Taxi Drivers* this contribution was thought to result in drivers paying between $10-20 per month toward the funding. The Subcommittee recognized and was sensitive to the fact that even such a nominal contribution could double the cost of an A-card.

The Group recognized the possibility of collecting this fee through the annual A-card renewal or to bill all drivers on a quarterly basis. The question remains how these funds would be transferred from the Taxi Commission fund at the Treasurer/Tax Collector's Office to the actual health plan.

Recommendation: The Group voted unanimously to have all drivers contribute 10% towards the cost of a plan.

Discussion on Participating Drivers: Without exception, everyone agreed that those directly benefiting from this health care plan should pay something for it. While the Group did not go into many details on how billing would work, an

administrator could theoretically bill participants on a quarterly basis or through direct bank account deductions.

Recommendation: The Group voted to have participating drivers pay the additional sum of 20% of the total cost of a plan on top of the 10% contribution absorbed by all drivers. In addition, the group voted to allow drivers who could prove they had health care coverage from another source – including individual insurance, insurance through a spouse or domestic partner, Medicare, Medi-Cal, the VA, and others – would not pay the additional fee but instead could opt out.

Should Medallion Holders Contribute to Health Care Plan for Drivers?

Discussion: This was a challenging discussion, with medallion holders strongly opposed to a reduction in income derived from renting out their medallion.

Recommendation: From the perspective of parity, the Group voted to have medallion holders contribute 25% of the funding. Committee members recognized that medallion holders could be making as little as $1800 a month from lease fees, thus causing medallion holders to potentially contribute more than one month of their income toward health care. Depending on the final plan, the Group anticipated the 25% share to require as much as a $4 million cumulative annual contribution from medallion holders.

While the Group voted to have medallion holders contribute to the plan by 25%, their contribution maybe subject to legal challenge for the reasons stated in an earlier section of this Report.

One possible solution is to adopt a rule change that the Taxi Commission now has authority to ensure that health care is being provided for all drivers, and to regulate lease amounts. The Commission could set a rule about lease charges, specifically that they must include a certain amount paid to the color scheme as a healthcare surcharge.

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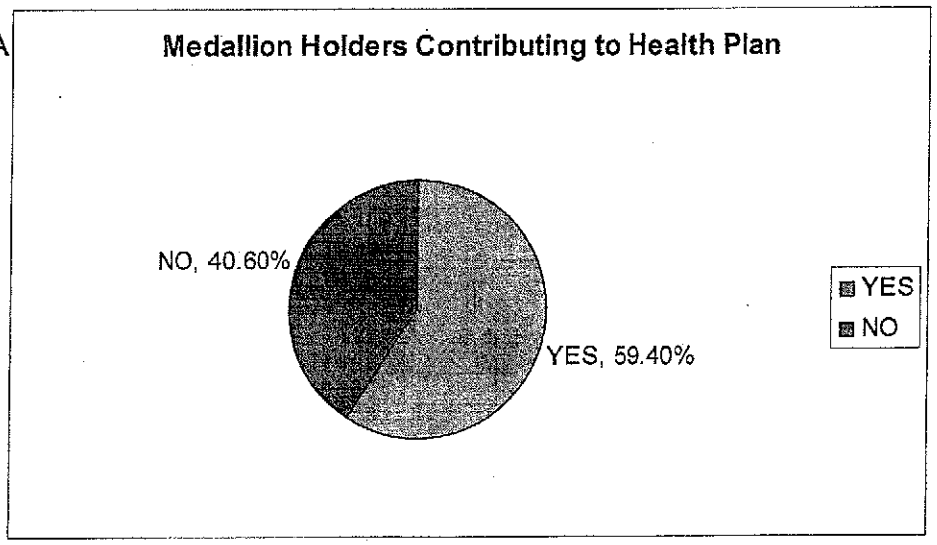

Table 9. Percentage of Medallion Holders Who Would Contribute to the Health Plan

Should Color Schemes Contribute to a Health Care Plan for Drivers?

Discussion: Taxi companies have suffered increasing costs of doing business over the last several years. For instance, companies are shouldering increasing costs for workers compensation insurance and also buying costlier CNG/hybrid vehicles. In addition, the Group recognized that companies would have some administrative burden in supplying reports on driver eligibility and processing invoices in much the same way companies previously processed Paratransit scrip.

Recommendation: The Group voted to give taxi companies a financial off-set for any administrative costs, such as compiling and forwarding a list of eligible drivers, in an amount likely to be determined by the Controller.

That being said, the Group set the baseline contribution at 25%, the same as for medallion holders. This amount is anticipated to raise as much as $4 million per year and to be collected with the cost levied *per medallion* rather than per driver or per qualified driver.

The color scheme contribution may be subject to the same problems as the medallion holder contribution above. However, it should be noted that the Paratransit Program, although it requires a contribution from cab companies based on the number of affiliated medallions, did not have to go to the ballot.

An additional issue, as asserted repeatedly by company and medallion holder representatives on the Group, is that the color schemes will "pass on" their share to the medallion holders by simply offering lower lease rates. This means that the medallion holders will "pay twice."

Should the City and County of San Francisco Contribute to a Health Care Plan for Drivers?

Discussion: The Group recognized that the City is presently shouldering the burden of uninsured taxi drivers through SF General and City Clinics by an estimated $1-$3 million per year.

Recommendation: The Group voted to have the City contribute 20% toward the health care plan, generally thought to be an amount no greater than $3 million. The Group considered but rejected the idea of having the City fund any shortfall in funding due to the impossibility of budgeting for a general "shortfall."

Notably, 23.3% of drivers responding to the 2006/2007 Driver Survey stated they had received care from SFGH or SF Clinics in the past 12 months.

Should the Riding Public Contribute Toward a Health Care Plan for Drivers, and, Should a Meter Increase Defray the Cost to Particular Stakeholders?

Responses to the survey indicate that drivers are nearly evenly split on the question of whether the flag drop or meter should be increased. Of those drivers who did respond, 51.3% said yes, and 48.7% said no, they would not favor a meter increase. Of medallion holders, however, a significantly larger portion said no, they did not favor an increase.

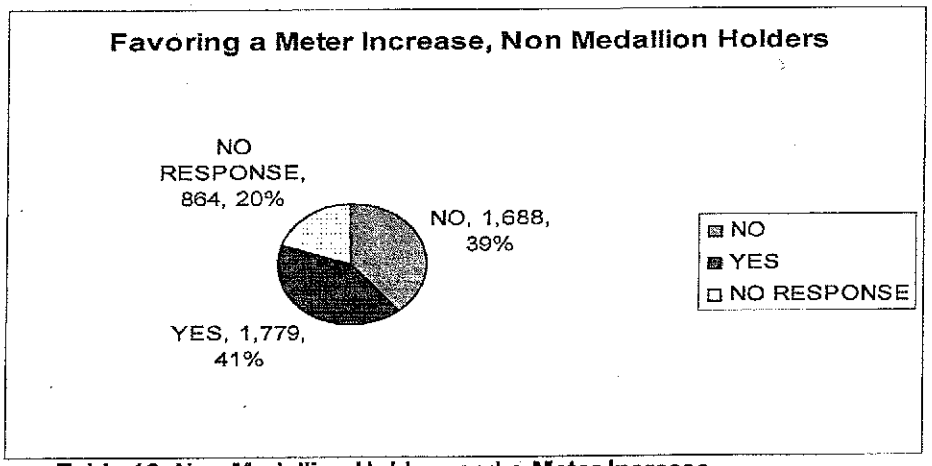

Table 10. Non Medallion Holders and a Meter Increase

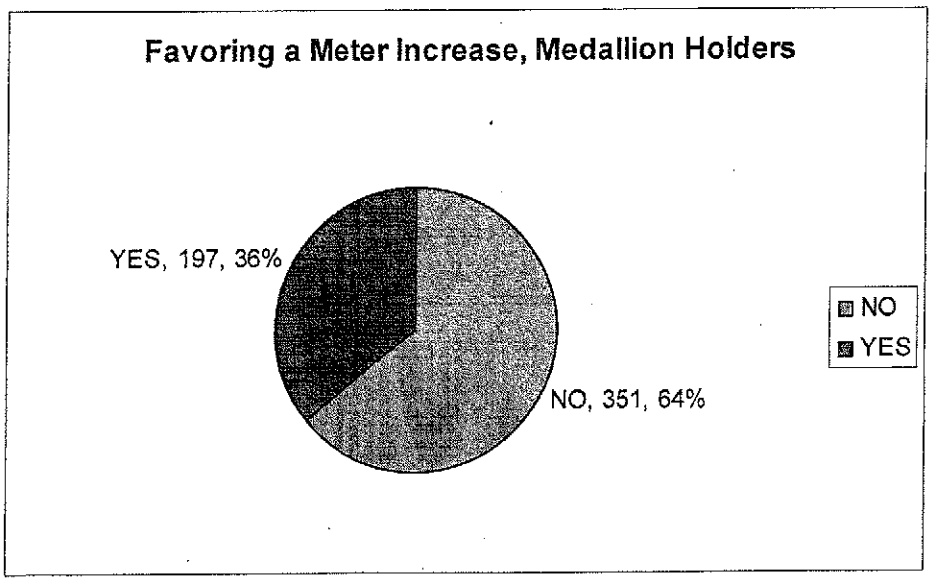

Table 11. Medallion Holders and a Meter Increase

Discussion: It is estimated that each driver picks up 14-20 fares during an average shift. Therefore, for every .25 increased on the flag drop, the Group estimated that a driver earns an additional $3.50-$5.00. Given the concept of elasticity of demand, or the degree to which the higher cost of taking a taxi may result in a decrease in ridership, the Group discussed whether to cap the amount of a meter increase. Essentially, the goal is to find a balance between the amount

necessary to find this health plan, and the amount at which the riding public will revolt and refuse to take taxis. Other factors must also be considered – the COLA increase and the cost to the Paratransit program.

A main topic of discussion for the Subcommittee around the contribution from the riding public, through a potential flag drop or waiting time increase, was elasticity of demand.

Elasticity of demand measures how much demand for a service declines in response to a price increase for such service. For example, if elasticity equals -.3, a 10% increase in the average taxi fare would result in an estimated 3% decline in ridership demanded, though an estimated 7% increase in total drive revenue.[14] Essentially, the goal is to find the balance between the amount necessary to fund this health plan, and the amount at which the riding public will revolt and refuse to take taxis, due to the cost.

The SFHP/DPH Report reviewed other elasticity studies and supply and demand factors affecting the San Francisco taxicab industry. The Report concluded that a San Francisco elasticity of demand would be similar to that experienced by New York, or -.22. Bruce Schaller apparently believed that elasticity in San Francisco would be in the -.20 to -.35 range.

The Controller's Office reviewed several elasticity studies conducted in other jurisdictions and submitted a comprehensive report to the Group on January 16, 2007. A copy is attached as Exhibit E.

The Group discussed having the color scheme contribution come from the riding public, due to the problems described above with the color scheme contribution, and with a perceived inability of color schemes to contribute their share to the funding package.

Recommendation: The Group voted to recommend a .50 increase in the flag drop to go specifically to health care. Recognizing that .50 would likely result in a $10 per shift increase in a driver's earnings, the Group voted to increase the gate fee by $5 to help taxi companies pay their share toward the Health Care Plan, leaving approximately $5 to help drivers defray their contribution costs. Color schemes would be required to turn this amount over to the selected plan. Any excess could be held in trust to pay for shortages. The Group also voted that the .25 cent stopgap increase which was issued by the Board of Supervisors in October 2006 would go towards the price of gasoline and would remain in effect.

Additional Sources of Funding Considered

Could the Oil Industry Help Pay for Health Care for Taxi Drivers?

[14] Controller's Office. *Price Elasticity of Demand: Report to Subcommittee.* January 16, 2007.

At the last Working Group meeting on March 6, 2007, member Paul Gillespie offered a proposal to fund the health plan from a gate increase alone – with no contribution from color schemes, medallion holders, or drivers.

This proposal could not be considered or discussed due to noticing requirements, but it can be considered at the Taxi Commission on March 13, 2007.

The proposal would work as follows: all taxis would become CNG/hybrid vehicles. This is in compliance with the Mayor's 2006 direction in his State of the City address that by 2011 the entire fleet become clean and green. It would also result in a savings of approximately $15-$20 in gasoline per shift. Drivers could receive an increased gate charge of $15 per shift. $5 of this would be earmarked for a cost of living allowance for color schemes. $5 would be earmarked for subsidizing color scheme purchase of CNG/hybrid vehicles. The final $5 would be allocated to pay for health care.

This would result in a tremendous victory for the environment, for the public, and for the industry. The taxi fleet would be 100% new, green, and clean within a short period. There are many social benefits to this proposal which can be explored at the Commission level. However, it should be noted that this proposal would take a minimum of three years to effect. Thus, it may be more appropriate to use the CNG/Hybrid taxi to ensure sustainability for the health care plan. As health care costs are anticipated to rise, this would be a new pot of money from which to derive funding.

Health Care Medallions and Transferability

Working Group member Dennis Korkos also introduced the proposal of so-called "Health Care Medallions" and the concept of making all medallions transferable. Health Care Medallions would be a special class of medallion created and operated for purpose of providing funds for a healthcare program. The Group considered but rejected this idea.

Proponents of this program also argued that were the City to convert to a system of transferability, from the current Proposition-K based system, the City would have more than enough funds to provide for an SFHP-based program. Because the Board had placed the Taxi Commission on an abbreviated timeline to develop a program, and because of the complexity of transferability and the necessity of going to the voters for approval, the Group did not recommend considering transferability as a method of paying for the proffered health plan.

The San Francisco Health Plan Proposal

SFHP has developed a potential plan for taxi drivers. The Group did not recommend the SFHP proposal.

Coverage provided to taxi drivers through the SFHP would include medical benefits only, and vision and dental would not be included. Benefits would include hospitalization ($200 per admission deductible;) outpatient and maternity services ($15 per visit co-payment); emergency services ($50/visit co-payment), prescription drugs (limited formulary); and mental health/chemical dependency covered through DPH's Community Behavioral Health Services. The provider network would include SFHP's network of providers including the DPH Community Network and private hospitals and physicians.

There has been a perception that the SFHP proposal would only be applicable to San Francisco residents, but in fact "[t]here would be no requirement that a driver live in San Francisco" as the plan would apply to drivers who worked in San Francisco as well, which would encompass 100% of drivers.[15]

As shown, the SFHP had the highest cost of any plan considered by the Group. DPH had hired Michael Schionning, an actuary who specializes in healthcare, to determine the unexpected monthly cost of providing medical coverage to San Francisco's uninsured taxi drivers.[16] He provided three sets of numbers: estimated baseline costs under various co-pays and contribution rates, costs running 5% lower than the projected baseline, and costs exceeding the baseline by 5%. Costs for the program were based on an assumption of immediate 100% uptake. Schionning included cost estimates for $10 and $15 co-pays, although the SFHP elected to use $15 co-pays to provide for adequate funding. He also used different participant contribution rates of 10%, 15%, and 20%. The Group voted that participant contribution should be at 20% so only those figures will be examined. The Group also voted to make the program mandatory, so only the mandatory figures are relevant.

Driver Contribution Rate	20%
Number of Participants	5,600
Total Plan Cost	$19,205,021
Total Driver Contributions	$3,841,004
Net Cost	$15,364,017

Table 12. SFHP Plan: Mandatory Plan with Total Costs 5% Higher Than Expected with 80% Contribution

Because of the high price of the SFHP plan, when the percentages are applied to the total cost, some of them become simply unworkable.

[15] *Establishing*...at p.20
[16] Id. p. 25

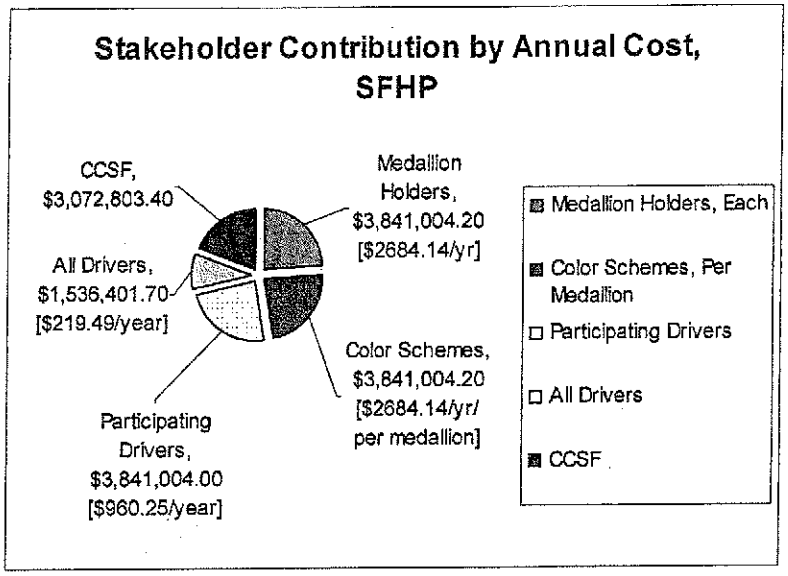

Table 13. SFHP: Percentage Breakdown for Stakeholders, with Individual Annual Contributions

Additionally, the SFHP proposal will not cover spouses and dependents, a core goal for members of the Group.

For all of these reasons, the SFHP proposal is not recommended.

Health Access Program

The Health Access Program (HAP) was created by the Health Care Security Ordinance in 2006. It arose out of the recommendations of the Universal Healthcare Council, which met in 2006. The HAP takes advantage of the existing network and structure of the SF Health Plan.

The HAP is designed to link uninsured residents to primary care providers, facilitate an individual receiving care in a timely manner, providing a payment mechanism for services that uninsured residents might otherwise not receive, and invest in innovations at the delivery of care.[17]

All San Francisco residents are eligible for HAP regardless of employment or immigration status. There are no exclusions for pre-existing conditions. San Franciscans enrolled in the program as a condition of employment may continue as individuals if they lose or change their jobs. In order to join the HAP, an individual must prove lack of insurance, live in San Francisco, and be willing to apply for state and federal benefits to which s/he is eligible.[18]

[17] San Francisco Health Access Program: Serving Uninsured Adults. Universal Healthcare Council, June 23, 2006, p.8

[18] Id.

HAP is estimated to cost $201.25 in 2006 dollars and is funded from a variety of sources, including businesses which contribute on a per-employee basis. Of course, taxi companies are exempt from contributing to the HAP because taxi drivers are considered independent contractors and not employees, so the contribution requirement does not apply.

The SFHP plan specifically for taxi drivers was estimated at a higher cost than HAP, due to many factors including the size of the pool that is covered. It is important to note that while all currently uninsured drivers who are also San Francisco residents are eligible to participate in the HAP, the Board should encourage drivers to enroll in the Taxi Driver Health Plan which is adopted, to ensure a large pool for the Taxi Driver Plan.

Getting Value for Our Money: Which Plans Will Provide the Best Value and Who Will Administer Them?

Discussion on Plans

The Group considered a variety of plans ranging from minimal lowest cost to expensive plans, or as one member of the public said, "Do you want a champagne and caviar plan or a beer and taco plan?" The lowest cost plans come with the caveat that those who use them will end up having to pay a lot out of pocket at the time of a claim, particularly for hospitalization, surgery or other major service. Ultimately, the Group favored compromise and went with a mid-cost higher coverage plan.

Among options considered and ultimately rejected included the lowest cost plan, a "safety net" health indemnity plan, which would break down accordingly:

Contributor	Total # of Contributors	Percentage Contribution	Total Contribution	Total Rate
All Drivers	7000	10%	$373,200	$53.31/year; $4.44/month
Participating Drivers	4000	20%	$746,400	$186.60/year; $15.55/month
Medallion Holders	1431	25%	$933,000	$651.99/year, $54.33/month
Color Scheme Holders	32	25%	$933,000	Per medallion: $651.99/year, $54.33/month
CCSF	1	20%	$746,400	$746,400/year
Total			$3,732,000	$3,732,000

Table 14. Stakeholder Contribution for Low Cost Alternative

Another indemnity plan that was discussed but rejected because it does not offer access to traditional major medical plans and was not meant to provide the same level of protection as a major plan but rather to act as a basic safety net:

Contributor	Total # of Contributors	Percentage Contribution	Total Contribution	Total Rate
All Drivers	7000	10%	$482,784.00	$68.97/year; $5.75/month
Participating Drivers	4000	20%	$965,568.00	$241.39/year; $20.12/month
Medallion Holders	1431	25%	$1,206,960.00	$843.43/year; $70.29/month
Color Scheme Holders	32	25%	$1,206,960.00	Per medallion: $843.43/year; $70.29/month
CCSF	1	20%	$965,568.00	$965,568.00/year
Total			$4,827,840.00	$4,827,840.00

Table 15. Stakeholder Contribution for Option B: Mid-Range Alternative

Recommendation: The group voted to approve a higher cost alternative, comparable to the attached "Select Benefits Enhanced Option," which would provide more benefits for drivers, and give individual drivers the option of upgrading to an even better plan. This plan was presented by Dublin Insurance, who had negotiated for lower price with certain providers such as Chinese Community Health Plan and Kaiser Permanente. A copy of the proposed costs is attached as Exhibit F. The figures offered are a sample of what this alternative could look like; it includes administrative costs.

Contributor	Total # of Contributors	Percentage Contribution	Total Contribution	Total Rate
All Drivers	7000	10%	$1,156,800	$165.26/year; $13.77/month
Participating Drivers	4000	20%	$2,313,600	$578.40/year; $48.20/month
Medallion Holders	1431	25%	$2,892,000	$2020.96/year; $168.41/month
Color Scheme Holders	32	25%	$2,892,000	Per Medallion $2020.96/year; $168.41/month
CCSF	1	20%	$2,313,600	$2,313,600/year
Total			$11,568,000	$11,568,000

Table 16. Stakeholder Contribution: Option C: Higher Cost Alternative

The Select Benefits plan offers drivers a range of differing levels of coverage from basic coverage to comprehensive coverage. Should a driver wish to upgrade to a higher cost plan, such as Kaiser Permanent's higher cost plans, he could be offered that option – at cost to the driver who will benefit from an increase in benefits. For example, if drivers elected to upgrade to a Kaiser

Permanente Option, they would pay an additional $54.45 per month, or a per month total of $116.42 including their additional A-card, participating driver fee, and plan upgrade fee.

Discussion on Administration: Taft-Hartley Trust

Pension plans and Health and Welfare plans sponsored by labor unions for the benefit of their members came to be known as "Taft-Hartley plans" following passage of the Taft-Hartley Act in 1947. These benefit plans are funded by contributions from the employers that hire the union workers, and the money is held in a trust fund (a "Taft-Hartley Trust") established specifically for that purpose. The Trust is then managed jointly by Employer and Union representatives, and by a qualified licensed third-party administrator (TPA) licensed by the California Department of Insurance.

The Taft-Hartley model is attractive because the money to fund the plan would be collected and safeguarded and subject to oversight in a centralized location. However, it raises some legal questions. There is no traditional employer-employee relationship, and thus no "employer of record." Once again, CCSF or another existing entity could serve as the employer of record – a policy decision for the Board.

There is also some doubt over whether a Taft-Hartley Trust would be subject to ERISA. Under ERISA, an employer cannot be compelled to contribute to employee health coverage. With the Health Access Plan, San Francisco has attempted to offer the employer a choice: provide health coverage or pay an equivalent sum to the city as a fee for not providing coverage. Currently, a legal challenge is pending in San Francisco Superior Court to the Health Access Plan.

Recommendation: The Group voted to have the plan administered by a Taft-Hartley Trust with an employer of record or Memorandum of Understanding with some entity such as the Taxi Commission, the City and County, or some existing taxi industry group such as the United Taxi Drivers or Medallion Holders Association serving as employer of record. In addition, the Group voted to have a full range of services be provided by a trust administrator on an ongoing basis, including but not limited to the following:

Marketing Plans to Drivers: educating about and promoting plan options

Billing and Eligibility: the trust should be accountable for all funds received. A report must be provided on a monthly basis identifying monies received and premiums paid to each carrier.

Enrollment Services: must be provided in a variety of languages at in-service meetings; customized "Welcome" letters developed to ensure all drivers and dependents enrolled are provided with information regarding their new coverage.

Customer Service: toll-free number available to all drivers to answer benefit questions and/or assist with enrollment

New Coverage Review and Analysis: direct access to all insurance companies; ability to request, negotiate, and administer all lines of coverage

Additional Ideas

Health Savings Accounts

Health Savings Accounts (HSAs) are a growing part of the health coverage scheme in America. As of January 2006, there were 3.2 million HSAs, compared to 438,000 in November 2002. The Treasury estimates that there will be 14-21 million by 2010. 60% of HAS participation is at small employers, and one third of HSA participants were previously uninsured.[19]

HSAs were established by Congress with the Medicare Reform Bill and became effective January 2004. HSAs are tax-advantaged savings accounts owned by an individual to pay for current and future medical expenses. They are available only with a "High Deductible Health Plan (HDHP) and are available for any individual covered under an HDHP who has no other first-dollar medical coverage, is not enrolled in Medicare, and cannot be claimed as a dependent on anyone else's tax return.

HSAs are popular because of the tax savings for individuals using them. Contributions to the account are not taxable, nor are withdrawals from the account. Naturally, there is also no tax on the investment growth. The account earns interest each month and there are thousands of eligible uses for the money.

Although the Group did not officially vote to include them, HSAs are an option that the Board may wish to explore in tandem with a health plan.

SFHP and the IHSS Program

The San Francisco Health Authority was established in 1994 to serve low and middle income residents of San Francisco, and it organized the SF Health Plan to qualified residents of San Francisco. The SFHP began enrolling members in 1997 and now provides coverage to more than 50,000 San Francisco residents. Due to the implementation of the Health Access Program, the SFHP will take on an estimated additional 80,000 uninsured residents over the course of the next year. Because of this, there has been criticism that the service level of the SFHP will not compare to that of private sector offerings.

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[19] Health Savings Accounts...a new way to save for current and future healthcare expenses. Presented by Ilene Levinson, Working Group member, on November 21, 2006

SFHP currently serves Medi-Cal, Healthy Families, Healthy Kids & Young Adults and Healthy Workers beneficiaries. The Healthy Families Program provides health, dental, and vision coverage for children of families with incomes that are too high to qualify for Medi-Cal but are less than 250% of federal poverty guidelines. The Healthy Workers Program offers health benefits to IHSS workers in San Francisco.

The SFHP has indicated that it could provide coverage for San Francisco's drivers, but it cannot be responsible for monitoring eligibility. It would want to receive a comprehensive list of those eligible from some central entity which would ensure that those on the list were actually eligible.

The SFHP's Report noted that there is similarity between IHSS workers and taxi drivers for a variety of reasons, including independent contractor status and low income levels. Under the IHSS program, caretakers are considered independent contractors for the purposes of hiring and firing, and they work directly for the persons they care for. The City has created the IHSS Public Authority, a legally separate entity, which provides IHSS workers with benefits through the SFHP's Healthy Workers coverage plan. The IHSS Public Authority acts as the employer of record, a key component which is missing so far from any taxi driver proposal. In fact, the Report specifically stated that the "IHSS model is not applicable to the taxicab industry in San Francisco."[20]

For that reason, the Report recommended that rather than having a Public Authority, the SFHP directly administer a plan if the Board elects to adopt the SFHP option. However, for reasons stated above, the Committee does not recommend the SFHP plan.

Taxi Industry Public Authority (TIPA)

This solution has been proposed by Mark Gruberg of the United Taxi Workers. Essentially, the Public Authority would function in a manner similar to the IHSS Public Authority. The TIPA would contract with a private insurer or health plan provider on behalf of drivers. The TIPA would purportedly be created by ordinance by the Board of Supervisors.

Mr. Gruberg's proposal states that the TIPA's power to contract with a private insurer would "be based upon the city's regulatory authority over the industry. Under those circumstances, I don't believe an employer-of-record would be required for providing coverage." However, the private health plans that have been offered have made it clear that an employer of record is required. It is not clear that the TIPA, as a quasi-governmental entity, would be able to function as employer of record.

Nor is it clear that the TIPA would survive an ERISA challenge. ERISA prohibits the creation of a group solely for purposes of providing health benefits.

[20] Id. at p. 20

Conclusion

The Group attempted to resolve outstanding policy issues and also to provide a framework for discussion going forward about the many complex legal issues surrounding the formation of a Taxi Driver Health Plan.

The Group chose not to recommend a single option, but instead chose to offer a variety of choices for the Board in the course of implementing a Taxi Driver Health Plan and setting the meter and gate charges going forward.

The Group feels, as did the SFHP, the DPH, and the Controller in making earlier recommendations, that a Taxi Driver Health Plan is within reach: but only if everyone comes together for our shared goal of a healthier city.

Exhibit A

CITY AND COUNTY OF
SAN FRANCISCO

TAXI COMMISSION
MAYOR GAVIN C. NEWSOM

July 5, 2006

At the meeting of the Taxi Commission on Tuesday, 27 June, 2006 the following resolution and findings were adopted:

RESOLUTION NO. 2006-80
FORMING A DRIVERS' HEALTH CARE WORKING GROUP COMPRISED OF INDUSTRY AND CITY REPRESENTATIVES TO DEVELOP AND PRESENT AN IMPLEMENTATION PLAN WITHIN ONE YEAR OF CONVENING

Whereas, in March 2006, the San Francisco Health Plan released a study on funding a Health Care Plan for taxi drivers, based in part on earlier financial studies performed by the Controller, which included various alternative funding scenarios; and,

Whereas, the Taxi Commission has reviewed and discussed this plan; and,

Whereas, several taxi industry constituencies have interest in establishing an efficient, effective health care plan for taxi drivers; and,

Whereas, in order to proceed, these constituencies will be helpful in developing an implementation process and in recommending an optimal funding mechanism; now

Therefore, be it resolved that the President of the Taxi Commission is hereby authorized to appoint a sub-committee of the Taxi Commission comprised of three members who shall recommend 5 voting members and 7 non-voting members of the Taxi Driver Health Care Implementation Plan working group; and further

Be it resolved, that the 7 non-voting members shall be drawn from each of the following: 1 SF Health Department staff, 1 SF Health Plan staff, 2 private health care experts, 1 Mayor's Office staff, 1 Controller's office staff, and 1 City Attorney; and further

Be it resolved, that the working group will submit a plan for implementing Drivers Health Care to the Commission for review within four months of convening.

AYES: Breslin; McGuire; Gillespie; Kwok; Smith
NOES: Paek
ABSENT: None
RECUSED: None

Respectfully submitted,

Tristan Bettencourt
Acting Executive Director

Exhibit B

Total number of taxicabs per San Francisco taxicab company

Color Scheme	Total Cabs:
Yellow Cab Co-op	473
Luxor Cab	185
DeSoto Cab	109
Bay Cab	72
Arrow Cab	68
National Cab	62
Town Taxi	55
Black & White Checker	52
Royal Taxi	43
United Cab	36
Metro Cab	35
Regents Cab Company	35
Big Dog City	23
American Taxicab	19
Union Cab	19
Veterans Cab Company	18
Fog City Cab	13
Worldwide Cab	11
Crown Cab	8
San Francisco Taxicab	8
Alliance Cab	7
Delta Cab	7
Max Cab	3
Best Cab	2
San Francisco Super Cab	2
USA Cab	2
ABC Taxicab	1
Central Cab	1
Comfort Cab	1
Executive Cab	1
Gold Star Taxi	1
Grasshopper Taxicab	1
KSJ Taxi	1
Lucky Cab	1

Exhibit C

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.

Exhibit D

City & County of San Francisco
Taxicab Commission

2007
Driver Survey Results

TAXI COMMISSION
25 Van Ness Avenue, Suite 420, San Francisco, CA 94102
(415) 503-2180 Fax (415) 503-2186
Email: taxicommission@sfgov.org
Website: www.sfgov.org/taxicommission

Health Care Subcommittee

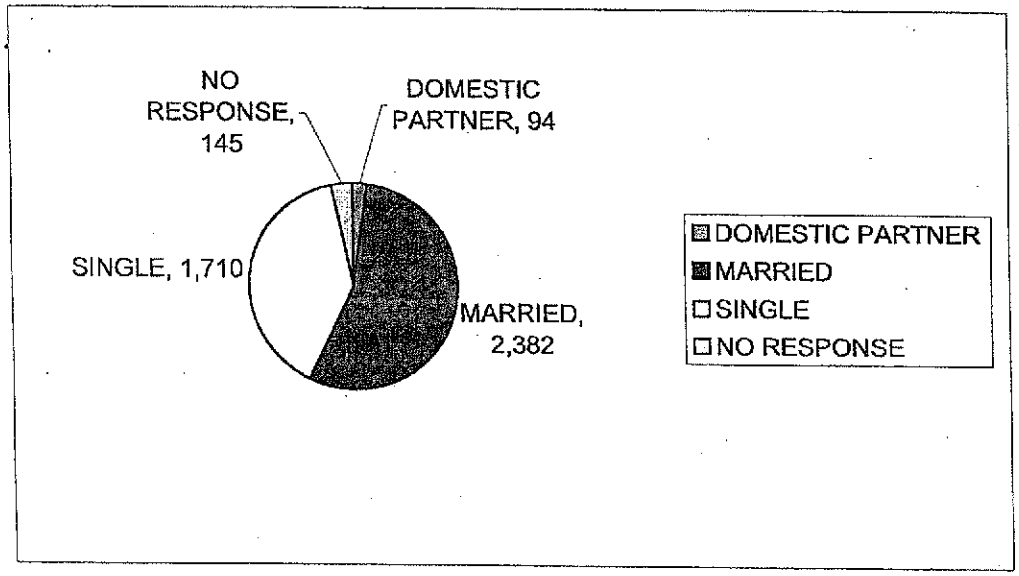
Driver Survey

The San Francisco Taxi Commission has formed a Working Group on Taxi Driver Health Care. Your responses to the following questions are extremely important to determining the needs of San Francisco taxi drivers. Please complete the following survey; your responses are completely anonymous.

1. **Marital Status:** ☐ Single ☐ Married ☐ Domestic Partner
   Sex: M F **Age:**_____ **Number of Children:**_____
2. **Are you a resident of San Francisco?** ☐ Yes ☐ No
   If not, what county? _____
3. **Do you currently hold a medallion?** ☐ Yes ☐ No
   If no, are you on the waiting list? ☐ Yes ☐ No
4. **Do you currently have health insurance?**
   - ☐ Yes, I'm currently covered through individual insurance.
   - ☐ Yes, I'm currently covered through a spouse or domestic partner's insurance.
   - ☐ Yes, I'm currently covered through my other (non-taxi) job or as a student.
   - ☐ Yes, I'm currently covered through COBRA.
   - ☐ Yes, I'm currently covered through Medi-Cal.
   - ☐ Yes, I'm currently covered through Medicare.
   - ☐ No, I'm not covered.
   - ☐ Other (explain):_____
5. **If you do not have health insurance, why?**
   - ☐ I don't believe I need it.
   - ☐ I can't afford coverage.
   - ☐ I can't get coverage because I have a pre-existing condition(s).
   - ☐ Other (please explain):_____
6. **If you do not have health insurance, do other members of your family have health insurance? Please check all that apply.**
   - ☐ My spouse/domestic partner has coverage.
   - ☐ My children have coverage.
   - ☐ No, my spouse/domestic partner does not have coverage.
   - ☐ No, one or more of my children do not have coverage.
7. **If you do not have coverage, where did you get medical care over the past 12 months? Please check all that apply.**
   - ☐ SF Health Clinics and/or SF General Hospital (SFGH)
   - ☐ Emergency Department at a San Francisco hospital other than SFGH
   - ☐ Clinic and/or Hospital outside of San Francisco
   - ☐ Private Doctor
   - ☐ I did not seek any medical care in over the last 12 months.
   - ☐ Other (explain)_____
8. **Would you be willing to contribute a monthly fee towards a health plan to cover you?** ☐ Yes ☐ No
   If yes, what is the maximum you could contribute?
   ☐ $10-$50 ☐ $50-$100 ☐ $100-$150 ☐ $150-$200
   ☐ $200-$250 ☐ $250-300
9. **Driving Arrangement...Please check all that apply to you.**
   - ☐ I pay daily gates and gas by the shift.
   - ☐ I lease the taxi for the full day and pay gates and gas.
   - ☐ I lease a taxi by the week or the month and pay gates and gas.
   - ☐ I have a long term lease of a medallion.
   - ☐ I drive for someone who has a long-term lease of a medallion holder.
   - ☐ I am an employee of a color scheme and drive for a company.
10. **On average, over the past 12 months, how many hours did you drive per week?**
    - ☐ 9 or fewer
    - ☐ 10 to 19
    - ☐ 20 to 29
    - ☐ 30 to 39
    - ☐ 40 to 49
    - ☐ 50 to 59
    - ☐ 60 or more
11. **On average, over the past 12 months, how many weeks did you drive per year?**
    - ☐ 0 to 13
    - ☐ 13 to 26
    - ☐ 27 to 39
    - ☐ 39 to 52
12. **How long have you been driving a taxi in San Francisco?**
    _____
13. **Do you favor part of the funding for a driver's health care plan coming out of a meter increase?** ☐ Yes ☐ No

1.1 Marital Status

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	DOMESTIC PARTNER	94	2.2	2.2	2.2
	MARRIED	2,382	55.0	56.9	59.1
	SINGLE	1,710	39.5	40.9	100.0
	Total	4,186	96.7	100.0	
Missing		145	3.3		
Total		4,331	100.0		



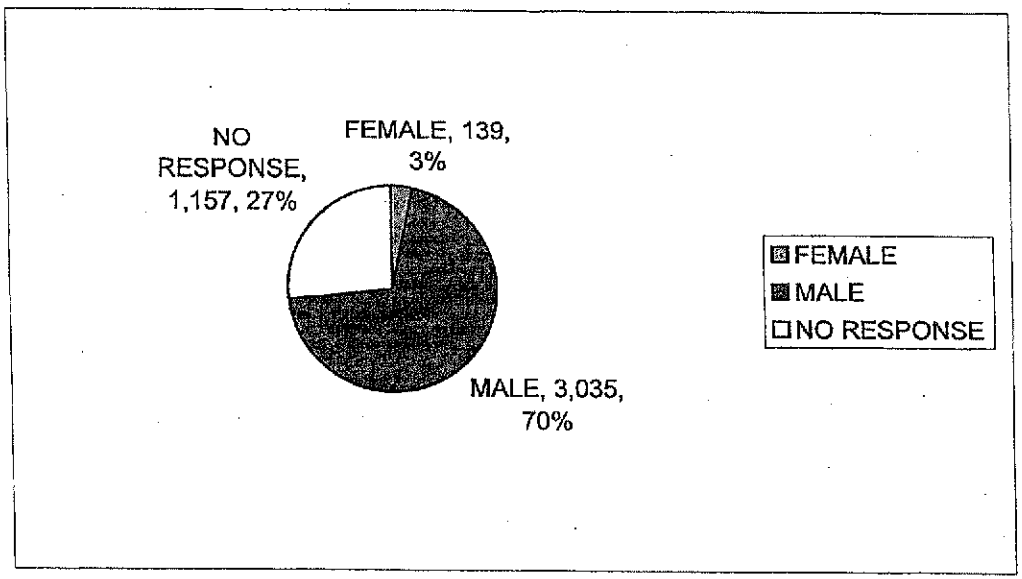
1.3 Age

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	20	1	0.0	0.0	0.0
	21	7	0.2	0.2	0.2
	22	9	0.2	0.2	0.4
	23	15	0.3	0.4	0.8
	24	28	0.6	0.7	1.6
	25	43	1.0	1.1	2.7
	26	58	1.3	1.5	4.2
	27	47	1.1	1.2	5.5
	28	61	1.4	1.6	7.1
	29	65	1.5	1.7	8.8
	30	84	1.9	2.2	11.0
	31	85	2.0	2.2	13.2
	32	100	2.3	2.6	15.8
	33	84	1.9	2.2	18.0
	34	98	2.3	2.6	20.6
	35	122	2.8	3.2	23.8
	36	121	2.8	3.2	27.0
	37	92	2.1	2.4	29.4
	38	119	2.7	3.1	32.5
	39	118	2.7	3.1	35.6
	40	128	3.0	3.4	39.0
	41	112	2.6	2.9	41.9
	42	123	2.8	3.2	45.2
	43	99	2.3	2.6	47.8
	44	98	2.3	2.6	50.4
	45	113	2.6	3.0	53.3
	46	105	2.4	2.8	56.1
	47	86	2.0	2.3	58.3
	48	86	2.0	2.3	60.6
	49	101	2.3	2.7	63.3
	50	141	3.3	3.7	67.0
	51	83	1.9	2.2	69.1
	52	81	1.9	2.1	71.3
	53	104	2.4	2.7	74.0
	54	78	1.8	2.0	76.0
	55	107	2.5	2.8	78.9
	56	110	2.5	2.9	81.7
	57	96	2.2	2.5	84.3
	58	75	1.7	2.0	86.2
	59	88	2.0	2.3	88.5
	60	77	1.8	2.0	90.6
	61	51	1.2	1.3	91.9
	62	57	1.3	1.5	93.4
	63	42	1.0	1.1	94.5
	64	30	0.7	0.8	95.3
	65	30	0.7	0.8	96.1
	66	21	0.5	0.6	96.6
	67	32	0.7	0.8	97.5
	68	20	0.5	0.5	98.0

	69	11	0.3	0.3	98.3
	70	13	0.3	0.3	98.6
	71	9	0.2	0.2	98.9
	72	7	0.2	0.2	99.1
	73	7	0.2	0.2	99.2
	74	6	0.1	0.2	99.4
	75	8	0.2	0.2	99.6
	76	3	0.1	0.1	99.7
	77	2	0.0	0.1	99.7
	78	1	0.0	0.0	99.8
	81	2	0.0	0.1	99.8
	82	2	0.0	0.1	99.9
	83	3	0.1	0.1	99.9
	86	2	0.0	0.1	100.0
	Total	3,807	87.9	100.0	

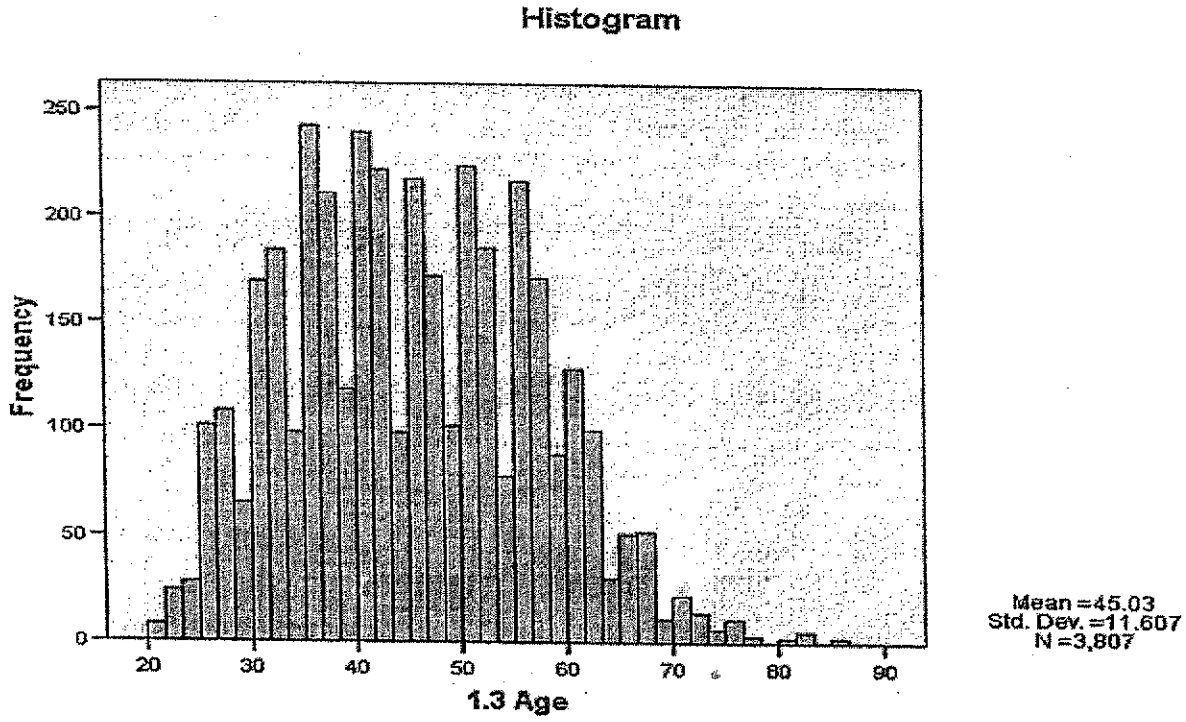
1.2 Sex

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	FEMALE	139	3.2	4.4	4.4
	MALE	3,035	70.1	95.6	100.0
	Total	3,174	73.3	100.0	
Missing		1,157	26.7		
Total		4,331	100.0		



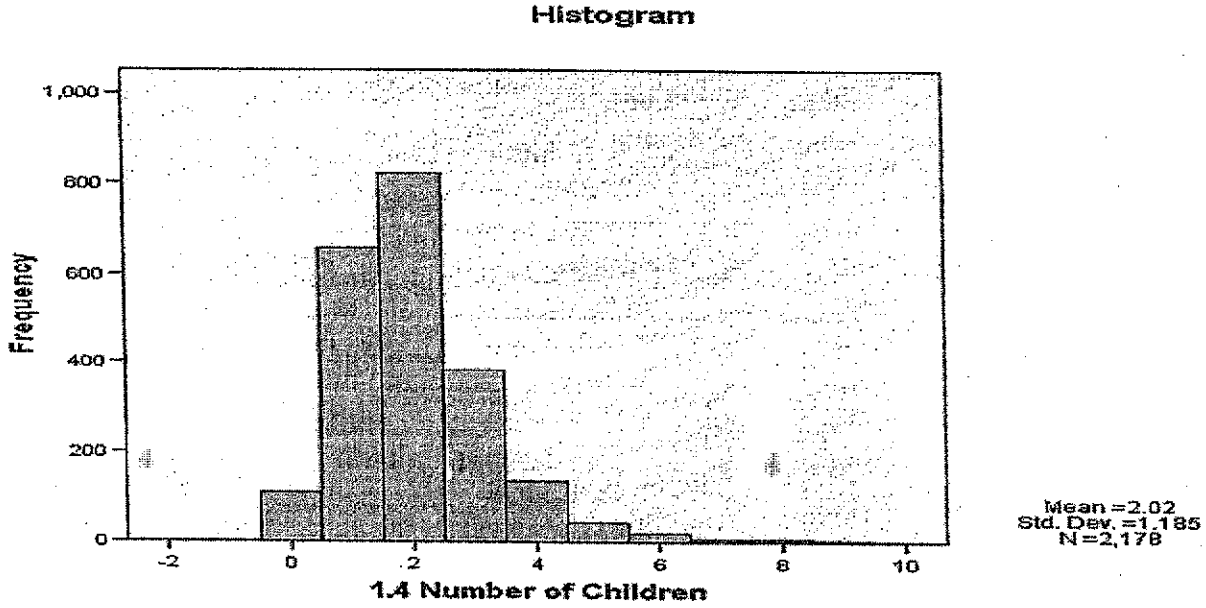
1.3 Age

	Valid	3,807
	Missing	524
Mean		45.03
Median		44.00
Std. Deviation		11.607
Percentiles	25	36.00
	50	44.00
	75	54.00



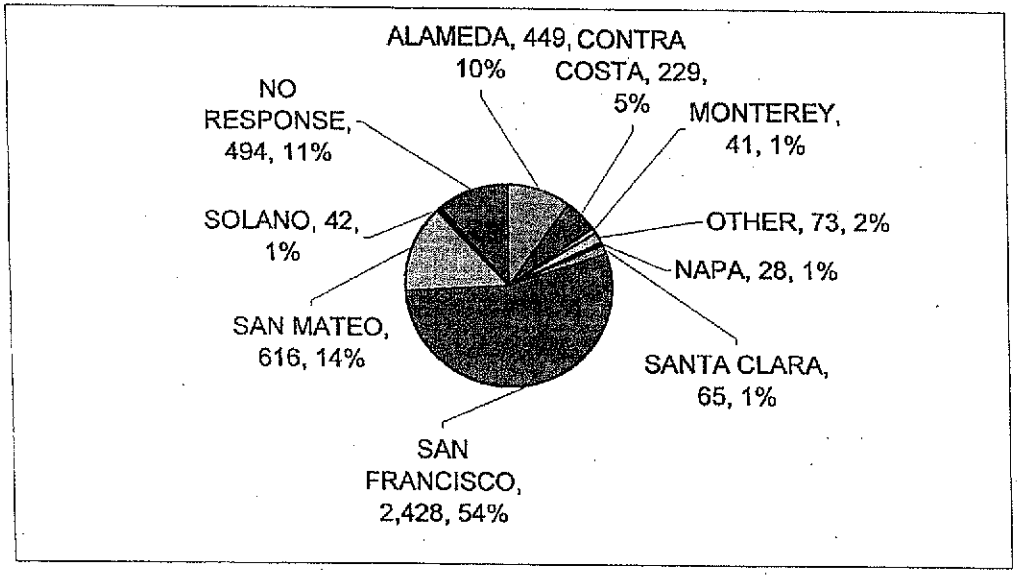
1.4 Number of Children

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0	110	2.5	5.1	5.1
	1	658	15.2	30.2	35.3
	2	820	18.9	37.6	72.9
	3	382	8.8	17.5	90.4
	4	136	3.1	6.2	96.7
	5	42	1.0	1.9	98.6
	6	19	0.4	0.9	99.5
	7	5	0.1	0.2	99.7
	8	5	0.1	0.2	100.0
	9	1	0.0	0.0	100.0
	Total	2,178	50.3	100.0	
Missing	System	2,153	49.7		
Total		4,331	100.0		



2.1 SF resident?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	NO	1,769	40.8	42.1	42.1
	YES	2,428	56.1	57.9	100.0
	Total	4,197	96.9	100.0	
Missing		134	3.1		
Total		4,331	100.0		

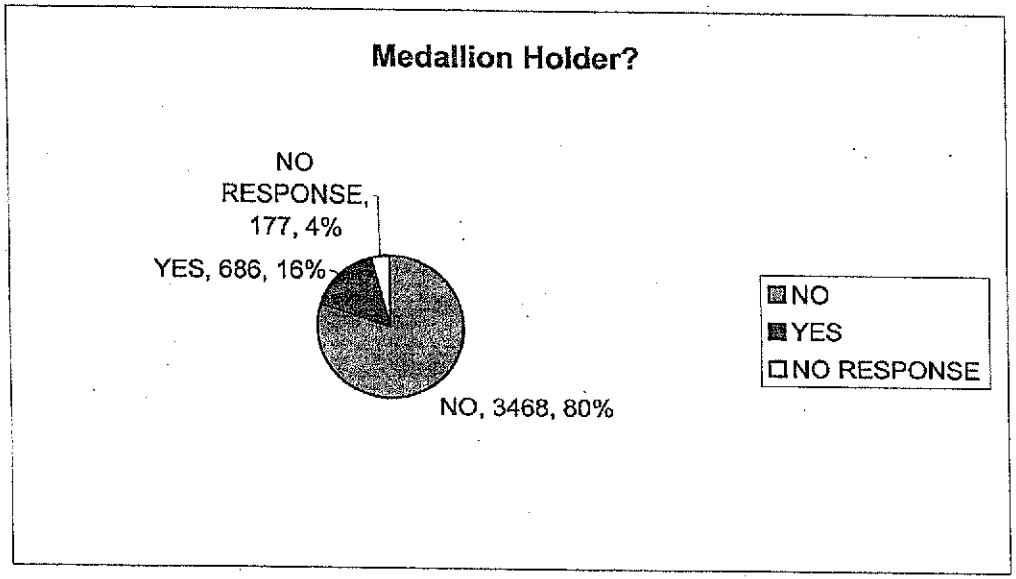


2.2 What county?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	ALAMEDA	449	10.4	29.1	29.1
	BUTTE	2	0.0	0.1	29.2
	CONTRA COSTA	229	5.3	14.8	44.1
	EL DORADO	1	0.0	0.1	44.1
	MENDOCINO	1	0.0	0.1	44.2
	MONTEREY	41	0.9	2.7	46.9
	NAPA	28	0.6	1.8	48.7
	PLACERVILLE	1	0.0	0.1	48.7
	SAC	16	0.4	1.0	49.8
	SAN BENITO	4	0.1	0.3	50.0
	SANTA CLARA	65	1.5	4.2	54.2
	SANTA CRUZ	4	0.1	0.3	54.5
	SAN JOAQUIN	11	0.3	0.7	55.2
	SAN MATEO	616	14.2	39.9	95.1
	SOLANO	42	1.0	2.7	97.9
	SONOMA	9	0.2	0.6	98.4
	STANISLAUS	9	0.2	0.6	99.0
	SUTTER	1	0.0	0.1	99.1
	TRINITY	1	0.0	0.1	99.2
	TULARE	2	0.0	0.1	99.3
	YOLO	11	0.3	0.7	100.0
	Total	1,543	35.6	100.0	
Missing		2,788	64.4		
Total		4,331	100.0		

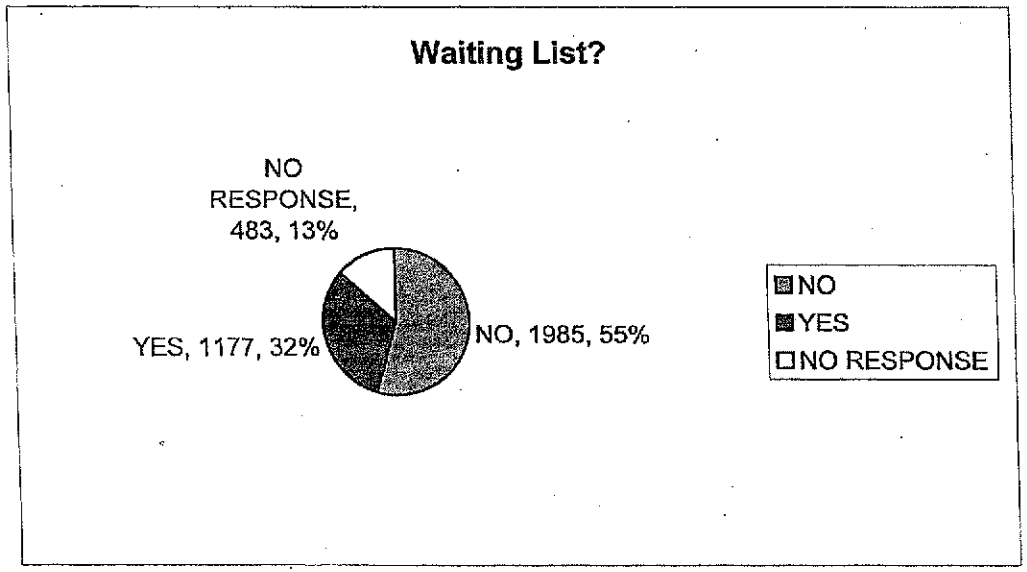
3.1 Medallion Holder?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	NO	3,468	80.1	83.5	83.5
	YES	686	15.8	16.5	100.0
	Total	4,154	95.9	100.0	
Missing		177	4.1		
Total		4,331	100.0		



3.2 Waiting List?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	NO	1,985	45.8	62.8	62.8
	YES	1,177	27.2	37.2	100.0
	Total	3,162	73.0	100.0	
Missing		1,169	27.0		
Total		4,331	100.0		



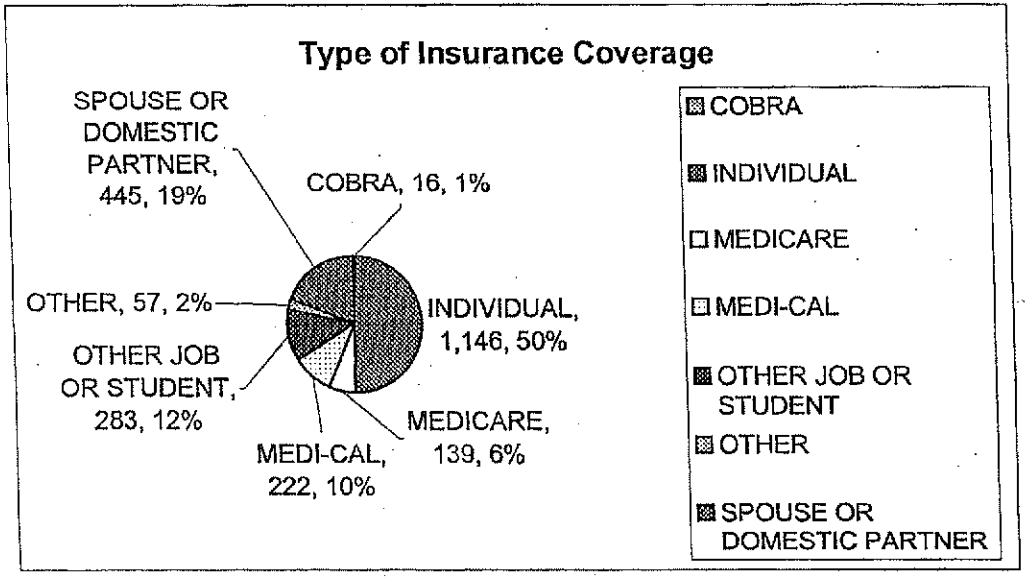
4. Individual Insurance

		Frequency	Percent	Valid Percent
Valid	COBRA	16	0.4	0.4
	COBRA/MEDICAL/MEDICARE/NONE	2	0.0	0.0
	INDIVIDUAL	1,146	26.5	28.5
	INDIVIDUAL/NONE	2	0.0	0.0
	MEDICARE	139	3.2	3.5
	MEDICAL	222	5.1	5.5
	MEDICAL/MEDICARE	23	0.5	0.6
	NONE	1,675	38.7	41.6
	OTHER	8	0.2	0.2
	OTHER/COMPANY	1	0.0	0.0
	OTHER/COUNTY HEALTH	1	0.0	0.0
	OTHER JOB OR STUDENT/MEDICARE	1	0.0	0.0
	OTHER JOB OR STUDENT/MEDICAL	5	0.1	0.1
	OTHER/PRE-PAID BEFORE VISIT	1	0.0	0.0
	OTHER/RETIRED	1	0.0	0.0
	OTHER/SAN MATEO WELLNESS PROGRAM	4	0.1	0.1
	OTHER/VA	35	0.8	0.9
	OTHER JOB OR STUDENT	283	6.5	7.0
	SPOUSE OR DOMESTIC PARTNER/COBRA	2	0.0	0.0
	SPOUSE OR DOMESTIC PARTNER/MEDICARE	3	0.1	0.1
	SPOUSE OR DOMESTIC PARTNER/MEDICAL	2	0.0	0.0
	SPOUSE OR DOMESTIC PARTNER/MEDICAL/MEDICARE	6	0.1	0.1
	SPOUSE OR DOMESTIC PARTNER/OTHER JOB OR STUDENT	3	0.1	0.1
	SPOUSE OR DOMESTIC PARTNER/OTHER JOB OR STUDENT/COBRA/MEDICAL	2	0.0	0.0
	SPOUSE OR DOMESTIC PARTNER	445	10.3	11.0
	Total	4,028	93.0	100.0
Missing		303	7.0	
Total		4,331	100.0	

Insurance Coverage

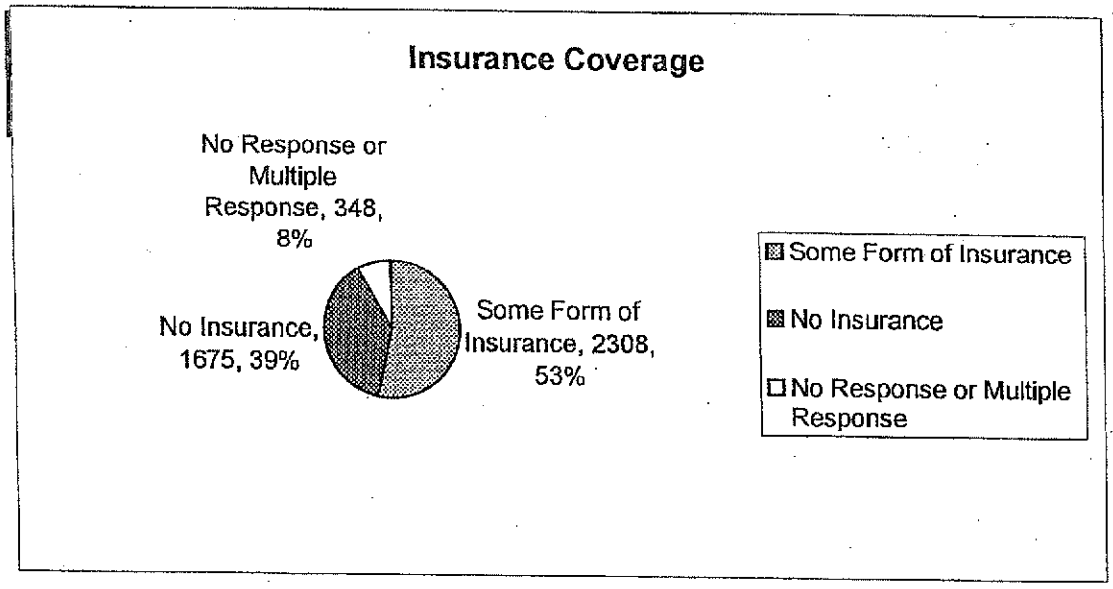
Just counting those who checked one box:

Response	Frequency		% excluding	% including NR
COBRA		16	0.40%	0.37%
INDIVIDUAL		1,146	28.77%	26.46%
MEDICARE		139	3.49%	3.21%
MEDI-CAL		222	5.57%	5.13%
OTHER JOB OR STUDENT		283	7.11%	6.53%
OTHER		57	1.43%	1.32%
SPOUSE OR DOMESTIC PARTNER		445	11.17%	10.27%
NONE		1,675	42.05%	38.67%
TOTAL RESPONSES	3,983		100%	91.96%
No Response or Multiple Re		348		8.04%
TOTAL RESPONSES		4331		100.00%



Insurance coverage can be broken down further into:

	#	% excluding NR	% including NR
Some Form of Insurance	2308	57.95%	53.29%
No Insurance	1675	42.05%	38.67%
Total Responses	3983	100.00%	91.96%
No Response or Multiple Response	348		8.04%
Total	4331		100.00%



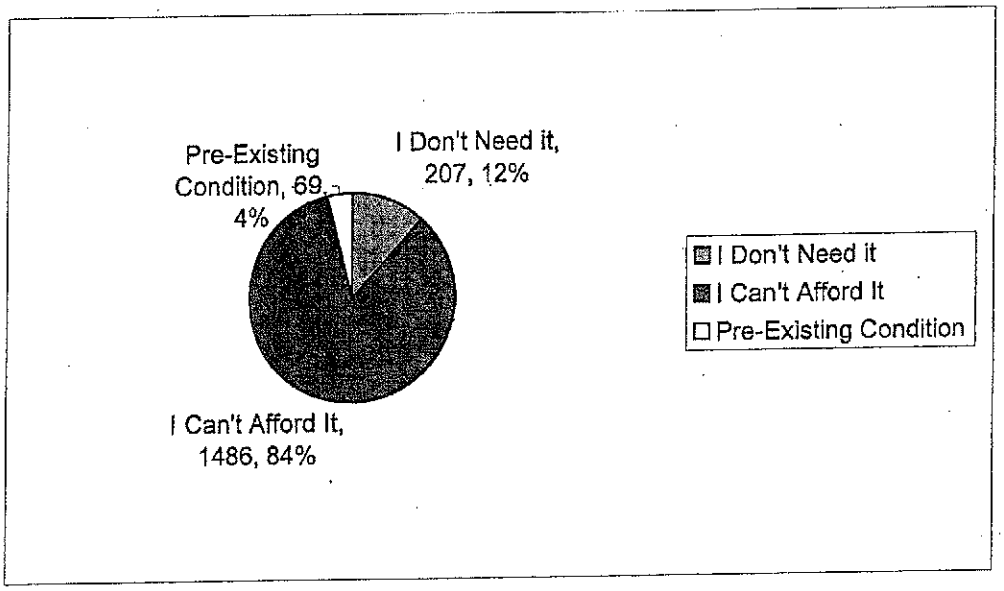
Responses for people who checked "Other":

5. Other

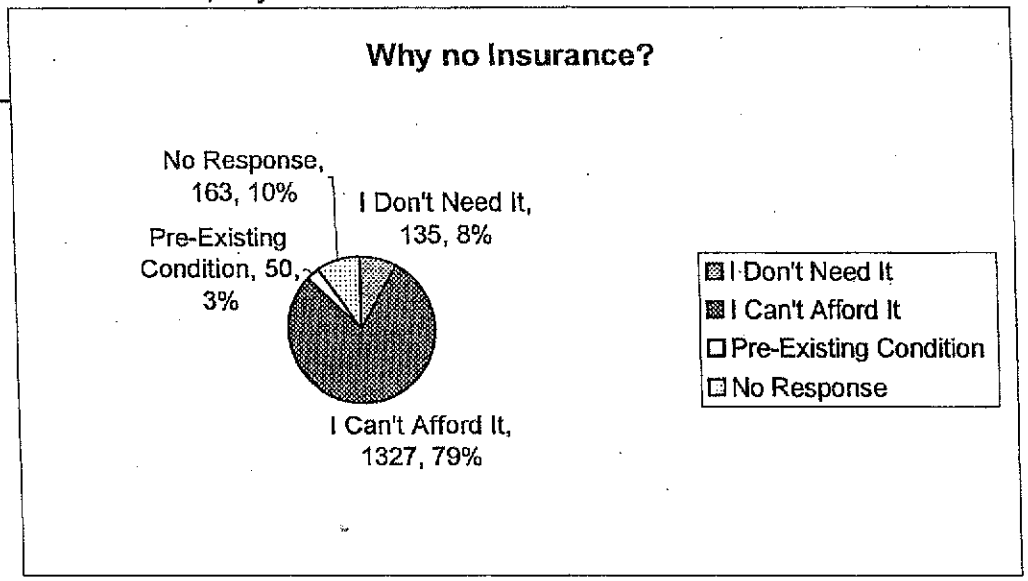
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid		4,281	98.8	98.8	98.8
	"WE'RE NOT HUMAN"	3	0.1	0.1	98.9
	1-plans to get soon	3	0.1	0.1	99.0
	1-VA	3	0.1	0.1	99.1
	1	5	0.1	0.1	99.2
	APPLYING NOW	2	0.0	0.0	99.2
	CHEAP BASTARD	1	0.0	0.0	99.2
	DON'T HAVE MONEY	1	0.0	0.0	99.3
	FAT	1	0.0	0.0	99.3
	has mexican and thai doctor	3	0.1	0.1	99.4
	HMOS ARE A BAD IDEA	1	0.0	0.0	99.4
	I'm a contractor	3	0.1	0.1	99.4
	I EXERCISE SO I DON'T NEED COVERAGE	1	0.0	0.0	99.5
	I have to find one.	1	0.0	0.0	99.5
	I SHOULD GET IT MYSELF, NOT THROUGH THE CITY	1	0.0	0.0	99.5
	in process of getting insurance	3	0.1	0.1	99.6
	JUST CHANGED JOBS	1	0.0	0.0	99.6
	JUST EXPIRED	1	0.0	0.0	99.6
	LAZY	1	0.0	0.0	99.7
	looking for a good program right now	2	0.0	0.0	99.7
	LOVE TO HAVE IT	1	0.0	0.0	99.7
	LUXOR FIRED ME BECAUSE I WAS INVOLVED IN AN ACCIDENT	1	0.0	0.0	99.7
	N/A	1	0.0	0.0	99.8
	NEW JOB	1	0.0	0.0	99.8
	OTHER COUNTY INSURANCE	1	0.0	0.0	99.8
	POT	1	0.0	0.0	99.8
	VA	1	0.0	0.0	99.9
	VERY EXPENSIVE	2	0.0	0.0	99.9
	WHERE DO I BUY IT?	2	0.0	0.0	100.0
	WILL BUY THIS MONTH	1	0.0	0.0	100.0
	willing to pay at reasonable price	1	0.0	0.0	100.0
	Total	4,331	100.0	100.0	

Counting all who responded to question: Why no insurance?

Response	Overall		Medallion Holder?			
			No		Yes	
	#	%	#	%	#	%
I Don't Need It	207	11.75%	165	10.58%	33	21.71%
I Can't Afford It	1486	84.34%	1348	86.41%	105	69.08%
Pre-Existing Condition	69	3.92%	47	3.01%	14	9.21%
Total	1762	100.00%	1560	100.00%	152	100.00%



5. If you do not have health insurance, why not?

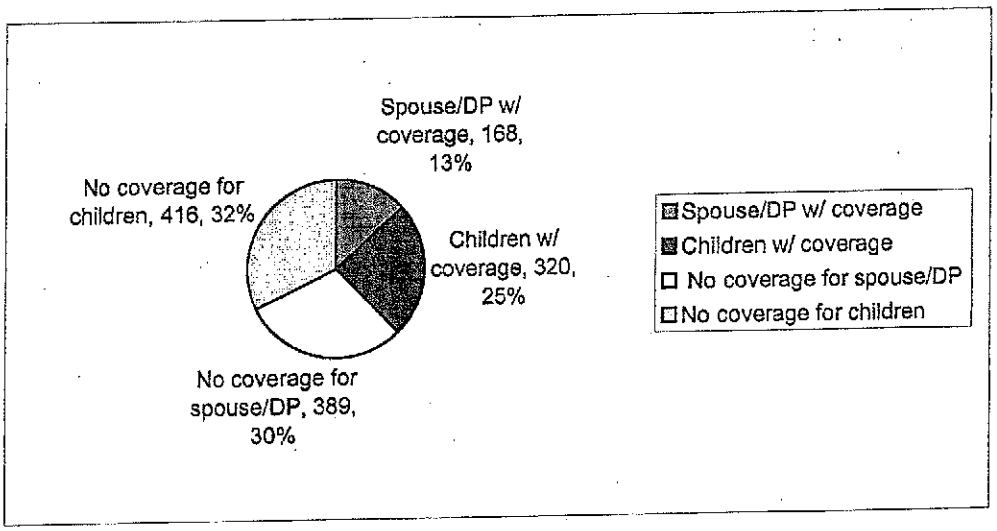


Counting only those who responded "No, I'm not covered" to question 4

Response	Overall			Medallion Holder?			
				No		Yes	
	#	% excluding NR	% including NR	#	%	#	%
I Don't Need It	135	8.93%	8.06%	115	8.39%	17	14.91%
I Can't Afford It	1327	87.76%	79.22%	1219	88.98%	86	75.44%
Pre-Existing Condition	50	3.31%	2.99%	36	2.63%	11	9.65%
Total Responses	1512	100.00%	90.27%	1370	100.00%	114	100.00%
No response	163		9.73%				
Total	1675		100.00%				

6. If you do not have health insurance, do other members of your family have health insurance?

Spouse/DP w/ coverage	168
Children w/ coverage	320
No coverage for spouse/DP	389
No coverage for children	416



6. If you do not have health insurance, do other members of your family have health insurance?

Counting all who responded to question

		Responses			Medallion Holder?			
					No		Yes	
		N	Percent	Percent of Cases	#	%	#	%
Family Coverage	6. Spouse/DP w/ coverage	535	25.47619048	29.72222	402	22.84%	115	40.78%
	6. Children w/ coverage	620	29.52380952	34.44444	512	29.09%	94	33.33%
	6. No coverage for spouse/DP	459	21.85714286	25.5	411	23.35%	33	11.70%
	6. No coverage for children	486	23.14285714	27	435	24.72%	40	14.18%
Total	Total Responses	2100	100	116.6667	1760	100.00%	282	100.00%
	Total Surveys	4331						

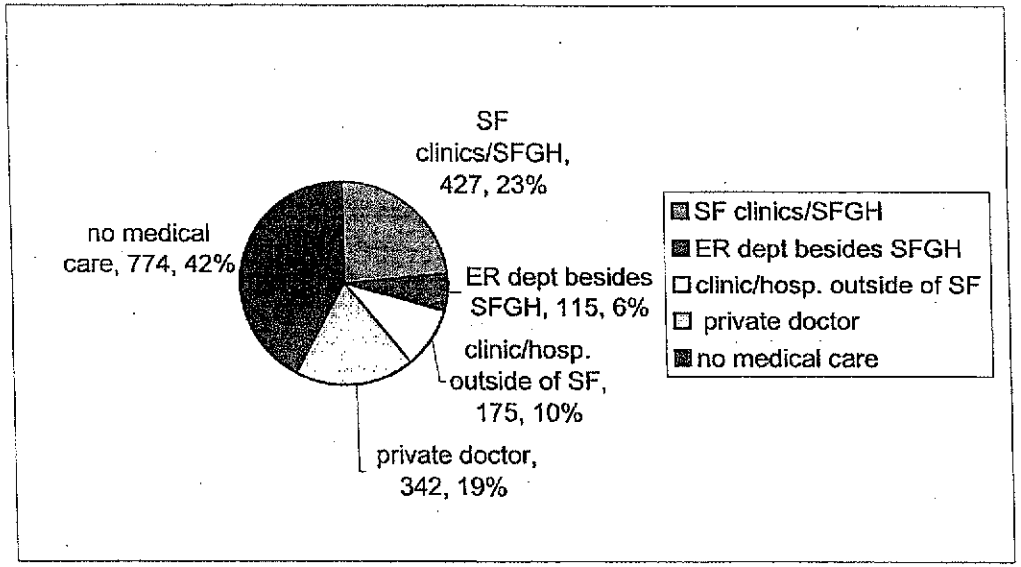
Counting only those who responded "No, I'm not covered" to question 4

		Responses			Medallion Holder?			
					No		Yes	
		N	Percent	Percent of Cases	#	%	#	%
Family Coverage	6. Spouse/DP w/ coverage	168	12.99303944	14.48276	149	12.67%	15	16.13%
	6. Children w/ coverage	320	24.74864656	27.58621	287	24.40%	29	31.18%
	6. No coverage for spouse/DP	389	30.08507347	33.53448	359	30.53%	23	24.73%
	6. No coverage for children	416	32.17324053	35.86207	381	32.40%	26	27.96%
	Total Responses	1293	100	111.4655	1176	100.00%	93	100.00%
	Total Respondents	1675		100.00%				

7. If you do not have coverage, where did you get medical care over the past 12 months?

Counting all who responded to question

		Responses		Percent of	Percent of All Respondents
		N	Percent	Cases	(including NR)
$Medical_Care(a)	7. SF clinics/SFGH	427	23.3%	24.3%	9.86%
	7. ER dept besides SFGH	115	6.3%	6.6%	2.66%
	7. clinic/hosp. outside of SF	175	9.5%	10.0%	4.04%
	7. private doctor	342	18.7%	19.5%	7.90%
	7. no medical care	774	42.2%	44.1%	17.87%
	Total Responses	1,833	100.0%	104.5%	
	Total Respondents	4,331			

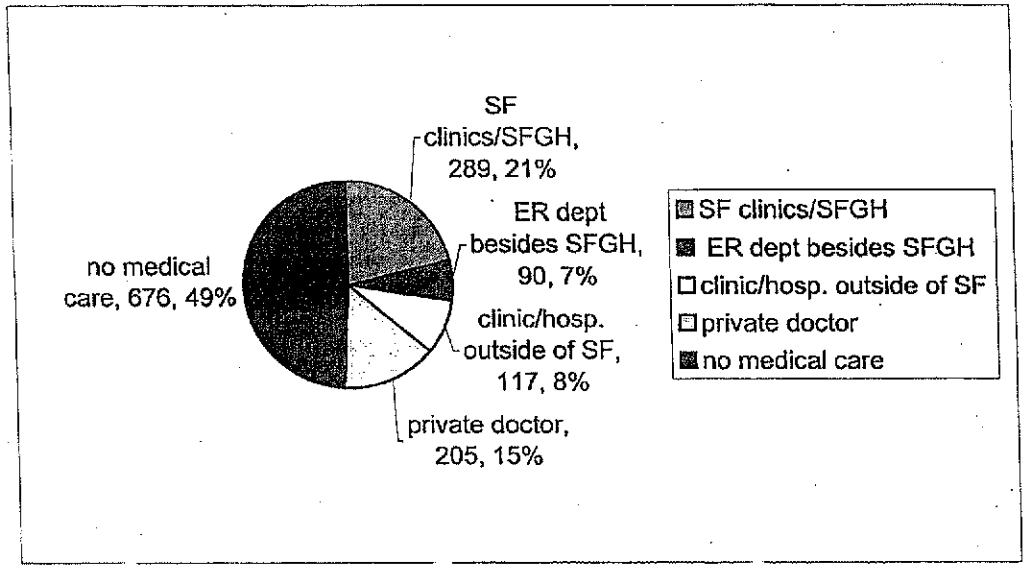


Counting only those who responded "No, I'm not covered" to question 4

		Responses		Percent of Cases	Percent of All Respondents (including NR)
		N	Percent		
$Medical_Care(a)	SF clinics/SFGH	289	21.0%	21.9%	17.25%
	ER dept besides SFGH	90	6.5%	6.8%	5.37%
	clinic/hosp. outside of SF	117	8.5%	8.9%	6.99%
	private doctor	205	14.9%	15.5%	12.24%
	no medical care	676	49.1%	51.2%	40.36%
	Total Responses	1,377	100.0%	104.2%	
	Total Respondents	1,675			

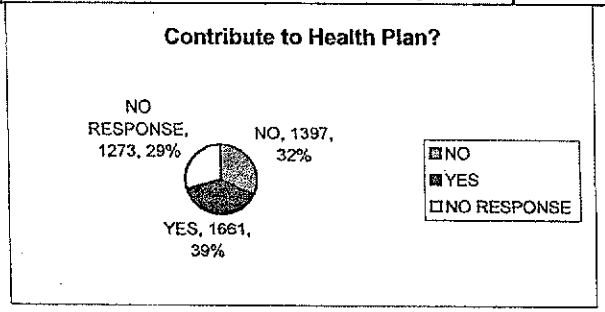
Note: Percent of responses is out of all responses (i.e. some respondents checked multiple boxes);

percent of cases is out of the number of respondents who checked at least one box.



8. Contribute to health plan?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	NO	1,397	32.3	45.7	45.7
	YES	1,661	38.4	54.3	100.0
	Total	3,058	70.6	100.0	
Missing		1,273	29.4		
Total		4,331	100.0		



YES	59.40%
NO	40.60%

Crosstab of Contribute to health plan by Medallion Holder

		Medallion Holder?				Total	
		# NO	% NO	# YES	% YES		
8. Contribute to health plan?	NO	1,080	43.2%	282	59.4%	1,362	45.8%
	YES	1,421	56.8%	193	40.6%	1,614	54.2%
	Total	2,501	100.0%	475	100.0%	2,976	100.0%

Crosstab of Contribute to health plan by Individual Insurance?

		8. Contribute to health plan?				
		NO	% NO	YES	% YES	Total
4. Individual Insurance	COBRA	5	62.50%	3	37.50%	8
	INDIVIDUAL	448	61.37%	282	38.63%	730
	INDIVIDUAL/NONE	2	100.00%	0	0.00%	2
	MEDICARE	51	52.58%	46	47.42%	97
	MEDICAL	83	69.17%	37	30.83%	120
	MEDICAL/MEDICARE	9	81.82%	2	18.18%	11
	NONE	368	25.86%	1,055	74.14%	1,423
	OTHER	8	100.00%	0	0.00%	8
	OTHER/COMPANY	1	100.00%	0	0.00%	1
	OTHER/COUNTY HEALTH	0	0.00%	1	100.00%	1
	OTHER JOB OR STUDENT/MEDICARE	1	100.00%	0	0.00%	1
	OTHER JOB OR STUDENT/MEDICAL	1	20.00%	4	80.00%	5
	OTHER/PRE-PAID BEFORE VISIT	0	0.00%	1	100.00%	1
	OTHER/SAN MATEO WELLNESS PROGRAM	0	0.00%	4	100.00%	4
	OTHER/VA	22	75.86%	7	24.14%	29
	OTHER JOB OR STUDENT	122	68.93%	55	31.07%	177
	SPOUSE OR DOMESTIC PARTNER/COBRA	1	50.00%	1	50.00%	2
	SPOUSE OR DOMESTIC PARTNER/MEDICARE	0	0.00%	3	100.00%	3
	SPOUSE OR DOMESTIC PARTNER/MEDICAL/MEDICARE	0	0.00%	2	100.00%	2
	SPOUSE OR DOMESTIC PARTNER/OTHER JOB OR STUDENT	1	100.00%	0	0.00%	1
	SPOUSE OR DOMESTIC PARTNER/OTHER JOB OR STUDENT/COBRA/MEDICAL	0	0.00%	2	100.00%	2
	SPOUSE OR DOMESTIC PARTNER	192	69.06%	86	30.94%	278
Total		1,315	45.25%	1,591	54.75%	2,906

This breaks down to:

		Contribute?					
		# NO	% NO	# YES	% YES	TOTAL	
Insurance?	NO	368	25.86%	1055	74.14%	1423	100.00%
	YES (SOME FORM)	947	63.86%	536	36.14%	1483	100.00%
	TOTAL	1315	45.25%	1591	54.75%	2906	100.00%

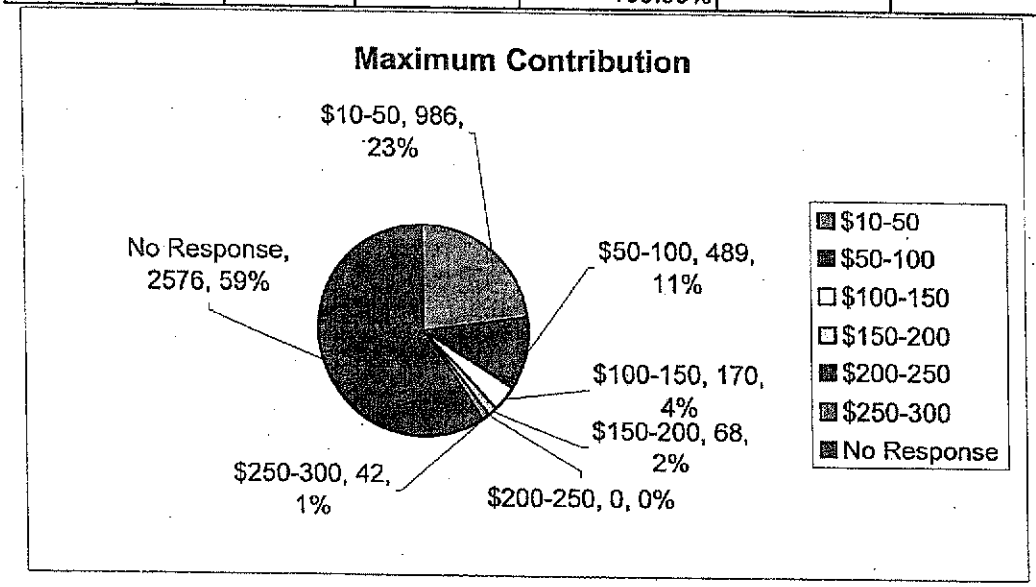
Crosstab of "5. I can't afford it." by " 8. Contribute to health plan?"

			8. Contribute to health plan?		Total
			NO	YES	
5. I can't afford it.	NO	Count	1,108	682	1,790
		% within 5. I can't afford it.	61.9%	38.1%	100.0%
		% within 8. Contribute to health plan?	79.3%	41.1%	58.5%
	YES	Count	289	979	1,268
		% within 5. I can't afford it.	22.8%	77.2%	100.0%
		% within 8. Contribute to health plan?	20.7%	58.9%	41.5%
Total		Count	1,397	1,661	3,058
		% within 5. I can't afford it.	45.7%	54.3%	100.0%
		% within 8. Contribute to health plan?	100.0%	100.0%	100.0%

8.2 If yes, what is the maximum you could contribute?

Counting all who responded to question

Response	Overall			Medallion Holder?				
				No		Yes		Total
	#	% excluding NR	% including NR	#	%	#	%	#
$10-50	986	56.18%	22.77%	869	57.02%	85	52.15%	954
$50-100	489	27.86%	11.29%	433	28.41%	40	24.54%	473
$100-150	170	9.69%	3.93%	143	9.38%	24	14.72%	167
$150-200	68	3.87%	1.57%	51	3.35%	14	8.59%	65
$200-250	0	0.00%	0.00%	0	0.00%	0	0.00%	0
$250-300	42	2.39%	0.97%	28	1.84%	12	7.36%	40
Total Responses	1755	100.00%	40.52%	1524	100.00%	163	100.00%	1687
No Response	2576		59.48%					
Total	4331		100.00%					



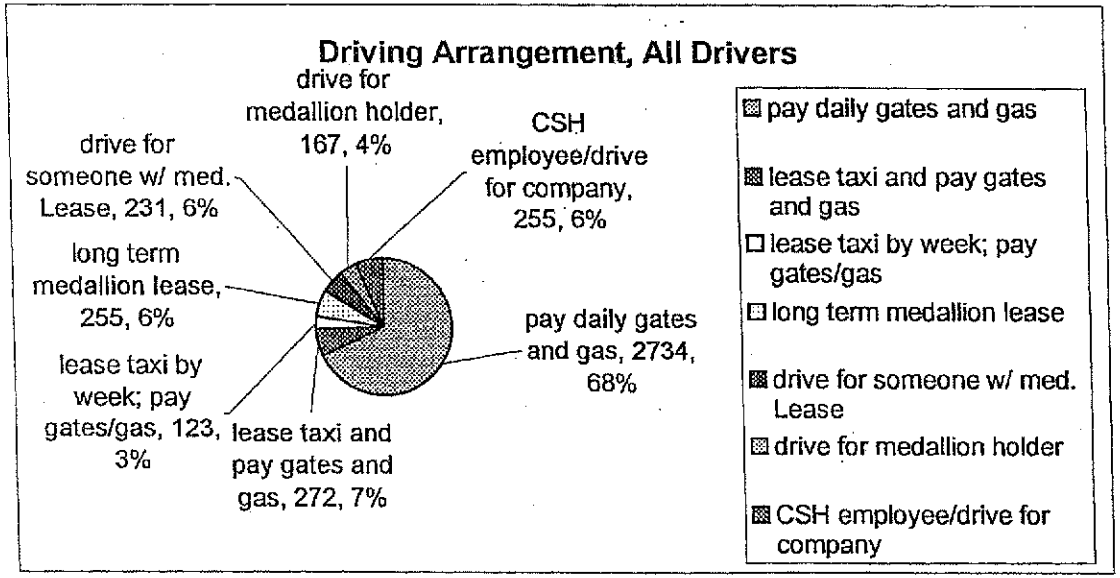
Counting only those who responded "No, I'm not covered" to question 4

Response	Overall			Medallion Holder?					
				No			Yes		
	#	% excluding NR	% including NR	#	% excluding NR	% including NR	#	% excluding NR	% including NR
$10-50	698	61.88%	41.67%	650	63.11%	43.13%	36	45.57%	27.27%
$50-100	310	27.48%	18.51%	283	27.48%	18.78%	23	29.11%	17.42%
$100-150	84	7.45%	5.01%	75	7.28%	4.98%	8	10.13%	6.06%
$150-200	25	2.22%	1.49%	17	1.65%	1.13%	6	7.59%	4.55%
$200-250	0	0.00%	0.00%	0	0.00%	0.00%	0	0.00%	0.00%
$250-300	11	0.98%	0.66%	5	0.49%	0.33%	6	7.59%	4.55%
Total Responses	1128	100.00%	67.34%	1030	100.00%	68.35%	79	100.00%	59.85%
No Response	547		32.66%	477		31.65%	53		40.15%
Total	1675		100.00%	1507		100.00%	132		100.00%

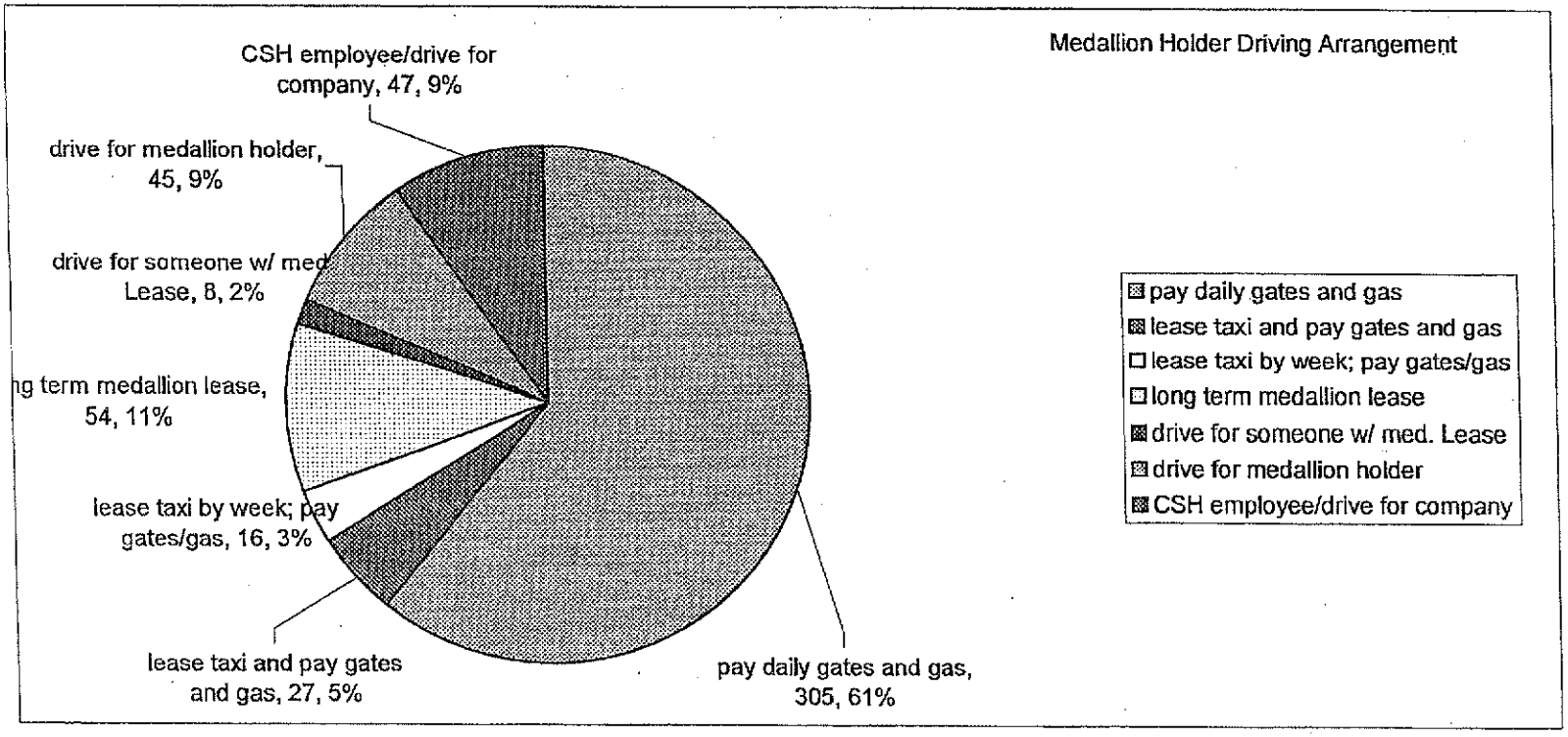
9. Driving arrangement...Please check all that apply to you.

Driving Arrangement Frequencies

		Responses		Percent of Cases	Percent of Surveys
		N	Percent		
Driving Arrangement(a)	**pay daily gates and gas**	2734	67.7235571	76.41140302	63.13%
	lease taxi and pay gates and gas	272	6.737676492	7.602012297	6.28%
	lease taxi by week; pay gates/gas	123	3.046816943	3.437674679	2.84%
	long term medallion lease	255	6.316571712	7.126886529	5.89%
	drive for someone w/ med. Lease	231	5.722070845	6.456120738	5.33%
	drive for medallion holder	167	4.136735199	4.667411962	3.86%
	CSH employee/drive for company	255	6.316571712	7.126886529	5.89%
	Total Responses	4037	100	112.8283958	
	Total Surveys	4331			100.00%

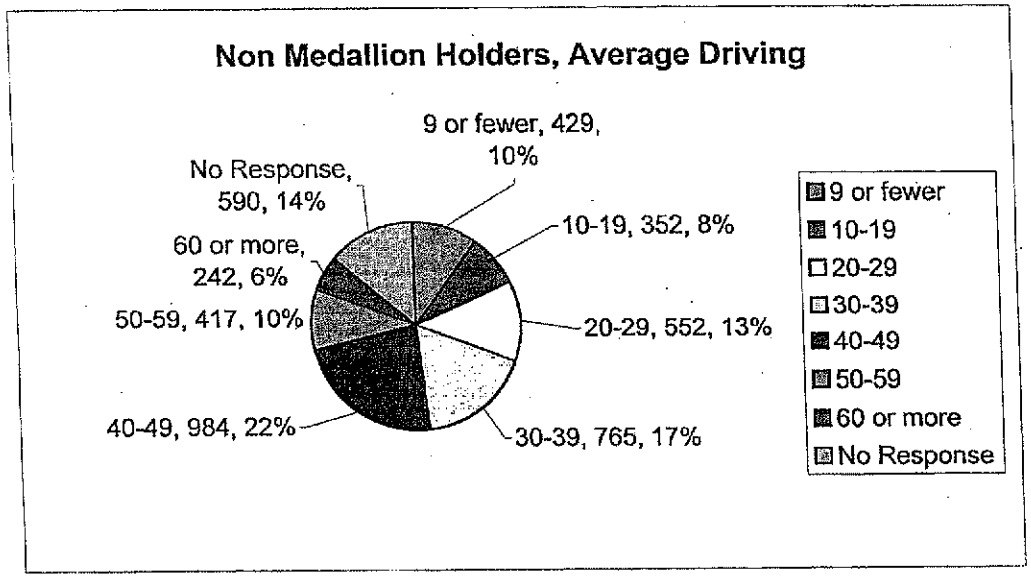


Medallion Holder?				
	No		Yes	
	#	% excluding	#	% excluding NR
pay daily gates and gas	2362	69.17%	305	60.76%
lease taxi and pay gates and gas	232	6.79%	27	5.38%
lease taxi by week; pay gates/gas	98	2.87%	16	3.19%
long term medallion lease	196	5.74%	54	10.76%
drive for someone w/ med. Lease	213	6.24%	8	1.59%
drive for medallion holder	118	3.46%	45	8.96%
CSH employee/drive for company	196	5.74%	47	9.36%
	3415	100.00%	502	100.00%



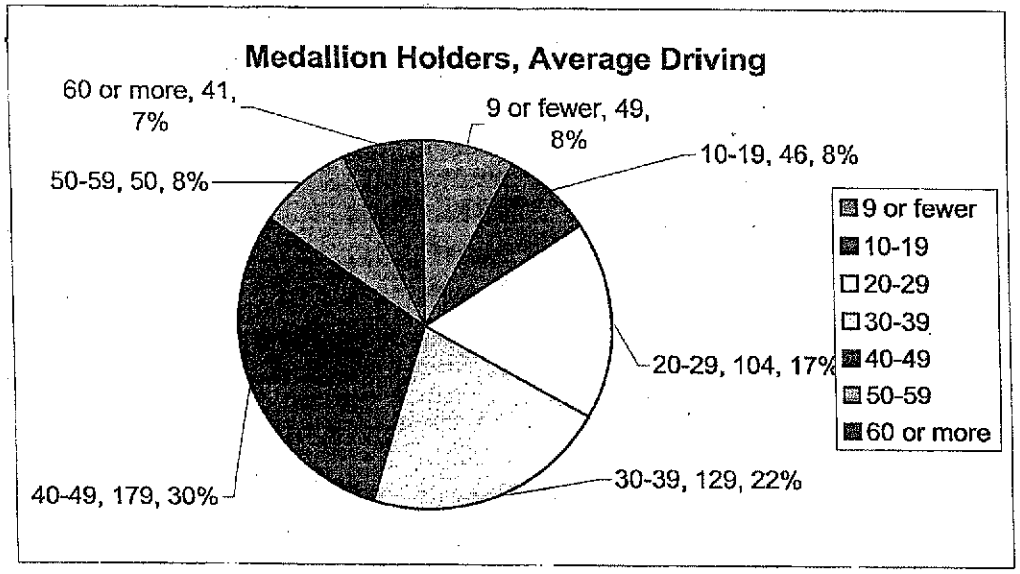
10. On average, over the past 12 months, how many hours did you drive per week?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	9 or fewer	429	9.9	11.5	100.0
	10-19	352	8.1	9.4	9.4
	20-29	552	12.7	14.8	24.2
	30-39	765	17.7	20.4	44.6
	40-49	984	22.7	26.3	70.9
	50-59	417	9.6	11.1	82.1
	60 or more	242	5.6	6.5	88.5
	Total	3,741	86.4	100.0	
Missing	System	590	13.6		
Total		4,331	100.0		



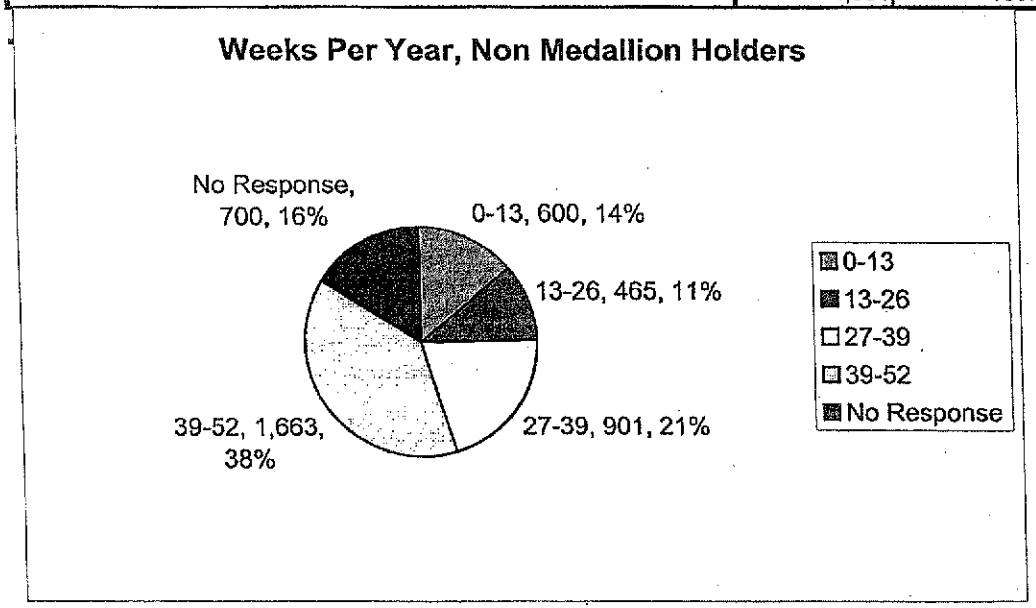
Crosstab: Hours per week by Medallion holder

		3.1 Medallion Holder?				
		# NO	% NO	# YES	% Yes	Total
Hours per Week	9 or fewer	355	11.70%	49	8.19%	404
	10-19	299	9.86%	46	7.69%	345
	20-29	429	14.14%	104	17.39%	533
	30-39	617	20.34%	129	21.57%	746
	40-49	781	25.75%	179	29.93%	960
	50-59	356	11.74%	50	8.36%	406
	60 or more	196	6.46%	41	6.86%	237
Total		3,033	100.00%	598	100.00%	3,631



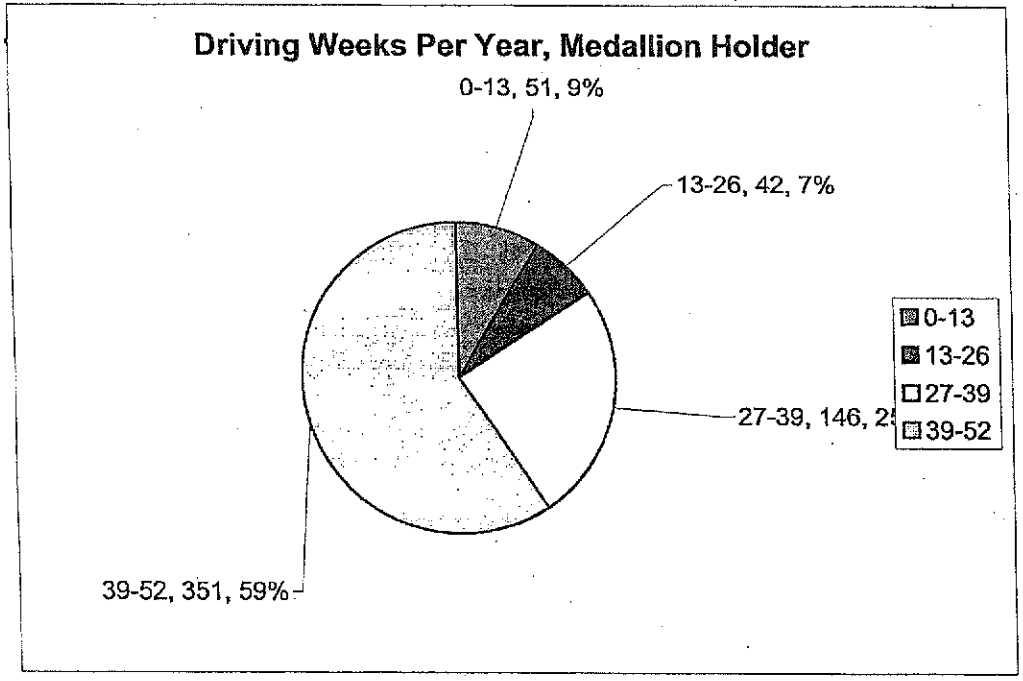
11. On average, over the past 12 months, how many weeks did you drive per year?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0-13	600	13.9	16.5	16.5
	13-26	465	10.7	12.8	29.4
	27-39	901	20.8	24.8	54.2
	39-52	1,663	38.4	45.8	100.0
	Total	3,631	83.8	100.0	
Missing	System	700	16.2		
Total		4,331	100.0		



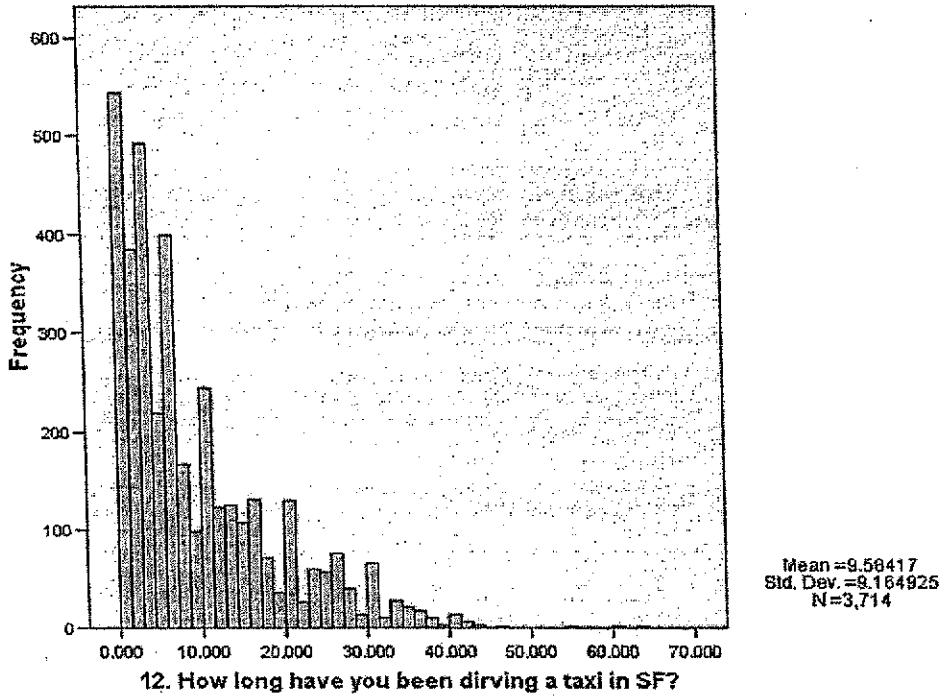
Crosstab of Weeks per Year by Medallion Holder

		3.1 Medallion Holder?				
		NO	% NO	YES	% Yes	Total
Weeks per year	0-13	522	17.78%	51	8.64%	573
	13-26	414	14.10%	42	7.12%	456
	27-39	734	25.00%	146	24.75%	880
	39-52	1,266	43.12%	351	59.49%	1,617
Total		2,936	100.00%	590	100.00%	3,526



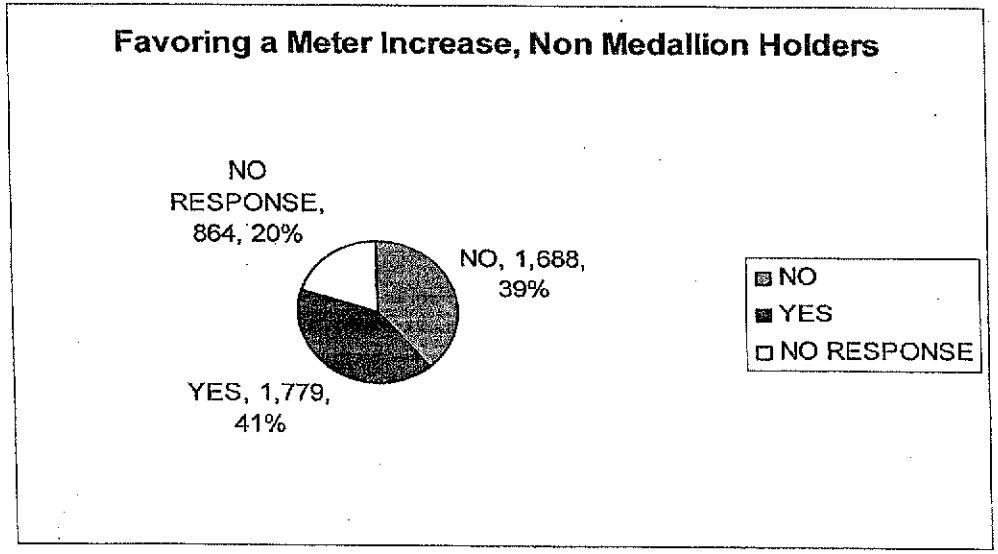
12. How long have you been driving a taxi in SF?

N	Valid	3,714
	Missing	617
Mean		9.58417
Median		7.00000
Percentiles	25	2.87500
	50	7.00000
	75	14.00000



13. Do you favor part of funding ... meter increase?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	NO	1,688	39.0	48.7	48.7
	YES	1,779	41.1	51.3	100.0
	Total	3,467	80.1	100.0	
Missing		864	19.9		
Total		4,331	100.0		



Crosstab of Do you favor part of funding ... meter increase by Medallion Holder

			3.1 Medallion Holder?				Total
			NO	% NO	YES	% YES	
13. Do you favor part of funding ... meter	NO	Count	1,285	45.50%	351	64.05%	1,636
	YES	Count	1,539	54.50%	197	35.95%	1,736
	Total	Count	2,824	100.00%	548	100.00%	3,372

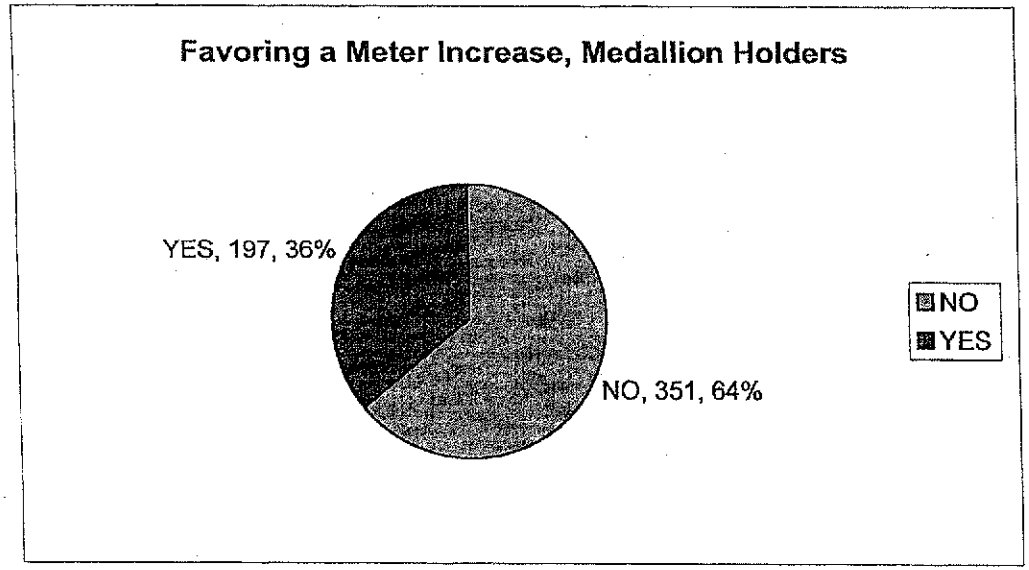


Exhibit E

Price Elasticity of Demand

- Measures how much demand for a service declines in response to a price increase for such service.
- If Elasticity equals -0.3, a 10% increase in the average taxi fare would result in an estimated 3% decline in ridership demanded, though an estimated 7% increase in total driver revenue.

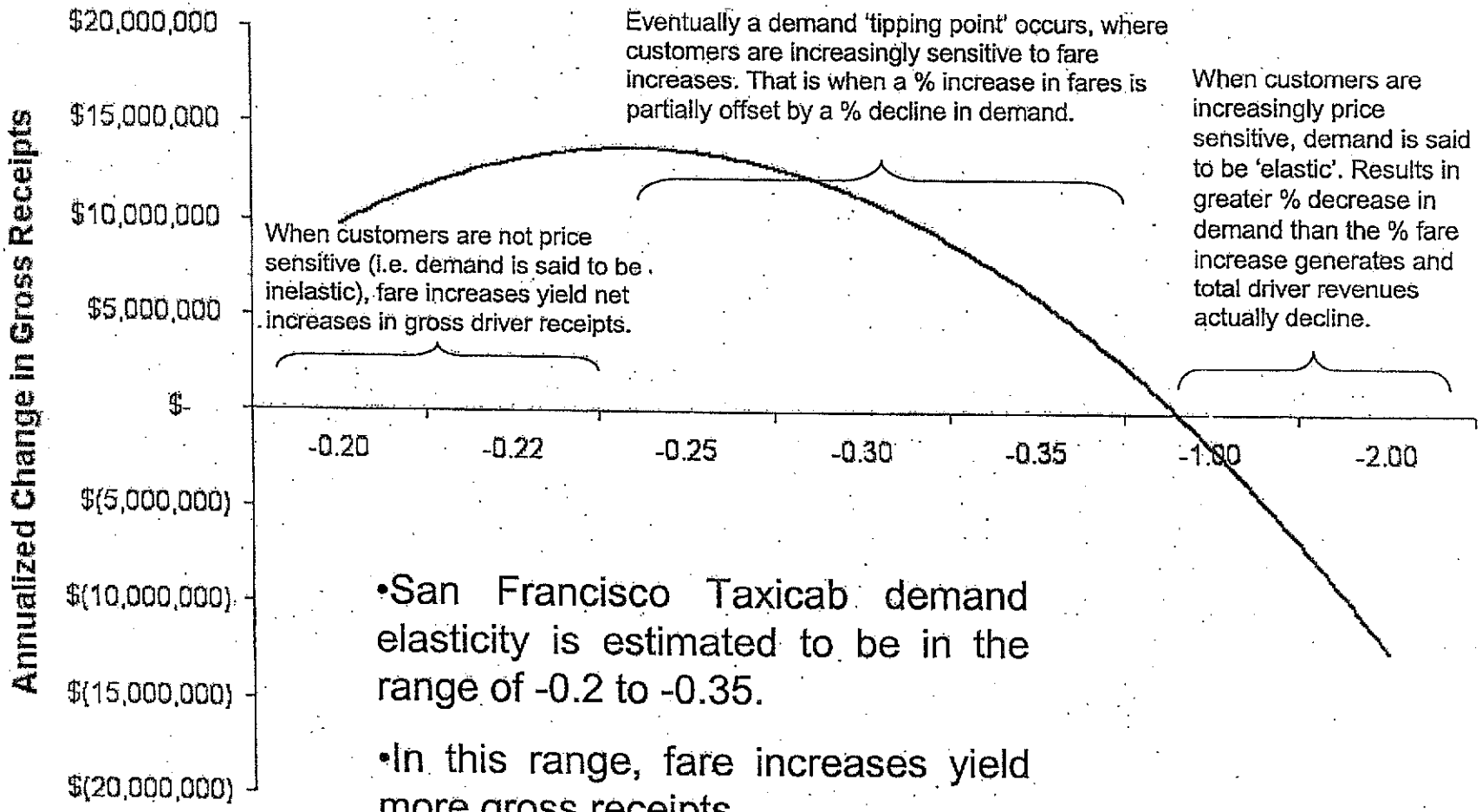
Effect on Driver Revenue

- The DPH March 2006 Study reviewed other elasticity studies, concluding that San Francisco would most likely be similar to the -0.22 elasticity of demand observed in New York City.
- Schaller believed elasticity in San Francisco would most likely be in the -0.20 to -0.35 range.
- When elasticity is between 0 and -1, fare increases result in total driver revenue increasing.
- Only when the price elasticity of demand is below -1.0 will fare increases result in total driver revenue declining.

Taxicab Industry Studies Reviewed

Authors (Year)	Elasticity Estimates	Market Studied
Schaller (1999)	-0.22	New York, USA
Booz Allen Hamilton (1993)	-0.36	Canberra, Australia
Anas and Moses (1984)	-1.307	Seoul, South Korea
Geltner and Barros (1984)	-1.88	Maceio, Brazil
Booz Allen Hamilton (1993)	-0.3 to -0.8	International
Boroski and Mildner (1998)	-0.5 to -1.0	International

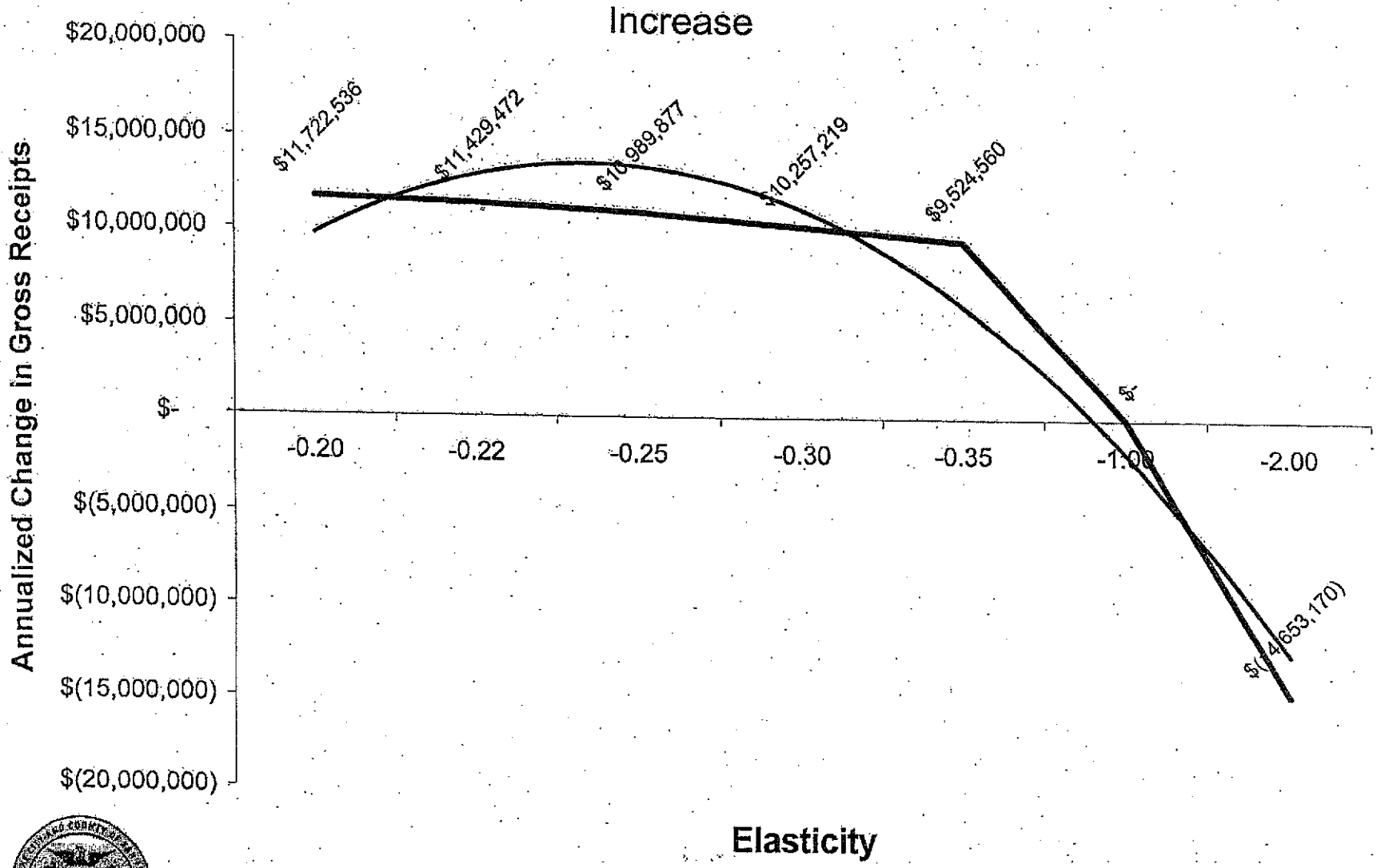
Change in Total Revenues From a 6% Increase in Fares



- San Francisco Taxicab demand elasticity is estimated to be in the range of -0.2 to -0.35.
- In this range, fare increases yield more gross receipts.

Elasticity

Estimated Change in Total Fare Revenue From a 6% Fare Increase



Estimated Change in Total Driver Revenue under various Elasticity & Fare Rate Change Assumptions

Potential Fare Increase (Percent)	Average Increase	Avg. Fare	Increase	Estimated Total Driver Revenue Effect				
				Elasticity Possibilities				
				-0.20	-0.22	-0.25	-0.30	-0.35
	0%	$16.15		$ -	$ -	$ -	$ -	$ -
	1%	$16.31	$ 0.16	$ 1,953,756	$ 1,904,912	$ 1,831,646	$ 1,709,536	$ 1,587,427
	2%	$16.47	$ 0.32	$ 3,907,512	$ 3,809,824	$ 3,663,292	$ 3,419,073	$ 3,174,853
	3%	$16.63	$ 0.48	$ 5,861,268	$ 5,714,736	$ 5,494,939	$ 5,128,609	$ 4,762,280
	4%	$16.80	$ 0.65	$ 7,815,024	$ 7,619,648	$ 7,326,585	$ 6,838,146	$ 6,349,707
	5%	$16.96	$ 0.81	$ 9,768,780	$ 9,524,560	$ 9,158,231	$ 8,547,682	$ 7,937,134
	6%	$17.12	$ 0.97	$ 11,722,536	$ 11,429,472	$ 10,989,877	$ 10,257,219	$ 9,524,560
	7%	$17.28	$ 1.13	$ 13,676,292	$ 13,334,384	$ 12,821,523	$ 11,966,755	$ 11,111,987
	8%	$17.44	$ 1.29	$ 15,630,048	$ 15,239,296	$ 14,653,170	$ 13,676,292	$ 12,699,414
	9%	$17.60	$ 1.45	$ 17,583,803	$ 17,144,208	$ 16,484,816	$ 15,385,828	$ 14,286,840
	10%	$17.77	$ 1.62	$ 19,537,559	$ 19,049,120	$ 18,316,462	$ 17,095,364	$ 15,874,267
	11%	$17.93	$ 1.78	$ 21,491,315	$ 20,954,032	$ 20,148,108	$ 18,804,901	$ 17,461,694
	12%	$18.09	$ 1.94	$ 23,445,071	$ 22,858,944	$ 21,979,754	$ 20,514,437	$ 19,049,120
	13%	$18.25	$ 2.10	$ 25,398,827	$ 24,763,857	$ 23,811,401	$ 22,223,974	$ 20,636,547
	14%	$18.41	$ 2.26	$ 27,352,583	$ 26,668,769	$ 25,643,047	$ 23,933,510	$ 22,223,974
	15%	$18.57	$ 2.42	$ 29,306,339	$ 28,573,681	$ 27,474,693	$ 25,643,047	$ 23,811,401

Estimated Change in Total Driver Revenue under various Elasticity & Fare Rate Change Assumptions

Average Increase	Avg. Fare	Estimated Total Driver Revenue Effect				
		Elasticity Possibilities				
		-0.20	-0.22	-0.25	-0.30	-0.35
0%	$16.15	0.00%	0.00%	0.00%	0.00%	0.00%
1%	$16.31	-0.20%	-0.22%	-0.25%	-0.30%	-0.35%
2%	$16.47	-0.40%	-0.44%	-0.50%	-0.60%	-0.70%
3%	$16.63	-0.60%	-0.66%	-0.75%	-0.90%	-1.05%
4%	$16.80	-0.80%	-0.88%	-1.00%	-1.20%	-1.40%
5%	$16.96	-1.00%	-1.10%	-1.25%	-1.50%	-1.75%
6%	$17.12	-1.20%	-1.32%	-1.50%	-1.80%	-2.10%
7%	$17.28	-1.40%	-1.54%	-1.75%	-2.10%	-2.45%
8%	$17.44	-1.60%	-1.76%	-2.00%	-2.40%	-2.80%
9%	$17.60	-1.80%	-1.98%	-2.25%	-2.70%	-3.15%
10%	$17.77	-2.00%	-2.20%	-2.50%	-3.00%	-3.50%
11%	$17.93	-2.20%	-2.42%	-2.75%	-3.30%	-3.85%
12%	$18.09	-2.40%	-2.64%	-3.00%	-3.60%	-4.20%
13%	$18.25	-2.60%	-2.86%	-3.25%	-3.90%	-4.55%
14%	$18.41	-2.80%	-3.08%	-3.50%	-4.20%	-4.90%
15%	$18.57	-3.00%	-3.30%	-3.75%	-4.50%	-5.25%

Potential Fare Increase (Percent)

Market Conditions
Before Fare Increase
Used to Support Driver Healthcare

Est. Average Fare	$ 16.15
Est. No. Fares per Year	15,121,950
Driver Gross Receipts	$ 244,219,493

Summary of Health Plan Alternatives

	City Studies & Estimates			Proposals
	DPH Plan - Mandatory with 80% Participation	DPH Plan - Mandatory with 100% Participation	SF Health Access Plan	UTW Proposed Mandatory Program
Total Estimated Cost	$ 19,205,021	$ 24,006,276	$ 16,905,000	$ 17,092,768
Estimated Cost				
per member per year	$ 3,429	$ 3,429	$ 2,415	$ 4,273
per member per month	$ 286	$ 286	$ 201	$ 356
Covered Members	5,600	7,000	7,000	4,000
A-Card Holders, Taxi Drivers	7,000	7,000	7,000	7,000
Variance	1,400	-	-	3,000
% Variance	20%	0%	0%	43%

Illustration of Potential Stakeholder Contribution Rates	DPH Plan - Mandatory with 80% Participation	DPH Plan - Mandatory with 100% Participation	SF Health Access Plan	UTW Proposed Mandatory Program
10%	$ 1,921,000	$ 2,401,000	$ 1,691,000	$ 1,709,000
15%	$ 2,881,000	$ 3,601,000	$ 2,536,000	$ 2,564,000
20%	$ 3,841,000	$ 4,801,000	$ 3,381,000	$ 3,419,000
25%	$ 4,801,000	$ 6,002,000	$ 4,226,000	$ 4,273,000
30%	$ 5,762,000	$ 7,202,000	$ 5,072,000	$ 5,128,000
35%	$ 6,722,000	$ 8,402,000	$ 5,917,000	$ 5,982,000
40%	$ 7,682,000	$ 9,603,000	$ 6,762,000	$ 6,837,000
45%	$ 8,642,000	$ 10,803,000	$ 7,607,000	$ 7,692,000
50%	$ 9,603,000	$ 12,003,000	$ 8,453,000	$ 8,546,000
55%	$ 10,563,000	$ 13,203,000	$ 9,298,000	$ 9,401,000
60%	$ 11,523,000	$ 14,404,000	$ 10,143,000	$ 10,256,000
65%	$ 12,483,000	$ 15,604,000	$ 10,988,000	$ 11,110,000
70%	$ 13,444,000	$ 16,804,000	$ 11,834,000	$ 11,965,000
75%	$ 14,404,000	$ 18,005,000	$ 12,679,000	$ 12,820,000
80%	$ 15,364,000	$ 19,205,000	$ 13,524,000	$ 13,674,000
85%	$ 16,324,000	$ 20,405,000	$ 14,369,000	$ 14,529,000
90%	$ 17,285,000	$ 21,606,000	$ 15,215,000	$ 15,383,000
95%	$ 18,245,000	$ 22,806,000	$ 16,060,000	$ 16,238,000
100%	$ 19,205,000	$ 24,006,000	$ 16,905,000	$ 17,093,000

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	$ 250
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	$ 23,400,000
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	$ 23.21
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	$ 12.50
b) add to annual A-Card renewal fee	$ 2,400	$ 2,520	$ 2,640	$ 2,760	$ 2,880	$ 3,000
2. Paid by Taxicab Operating Companies						
a) fee per medallion	$ 13,555	$ 14,233	$ 14,911	$ 15,589	$ 16,266	$ 16,944
b) fee per driver	$ 2,400	$ 2,520	$ 2,640	$ 2,760	$ 2,880	$ 3,000
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	$ 16,944
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	$ 1.16
b) Assuming 19 fares per 10-hour shift	$ 0.98	$ 1.03	$ 1.08	$ 1.12	$ 1.17	$ 1.22
c) Assuming 18 fares per 10-hour shift	$ 1.03	$ 1.08	$ 1.13	$ 1.19	$ 1.24	$ 1.29
d) Assuming 17 fares per 10-hour shift	$ 1.09	$ 1.15	$ 1.20	$ 1.26	$ 1.31	$ 1.37
e) Assuming 16 fares per 10-hour shift	$ 1.16	$ 1.22	$ 1.28	$ 1.33	$ 1.39	$ 1.45
f) Assuming 15 fares per 10-hour shift	$ 1.24	$ 1.30	$ 1.36	$ 1.42	$ 1.49	$ 1.55
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	$ 5,000

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

Exhibit F

San Francisco Taxi Drivers Health Plan

Proposed Costs

	SELECT BENEFITS		CCHP		Kaiser		
	Base Plan	Enhanced Plan	Option A	Option B	Option A	Option B	Option C
# of Drivers*	4000	4000	4000	4000	4000	4000	4000
Total Monthly Rate per Driver	$205.00	$241.00	$296.00	$314.00	$295.45	$351.36	$382.33
Total Monthly Cost	$820,000	$964,000	$1,184,000	$1,256,000	$1,181,800	$1,405,440	$1,529,320
Total Net Annual Cost	$9,840,000	$11,568,000	$14,208,000	$15,072,000	$14,181,600	$16,865,280	$18,351,840
Administrative Costs	Included	Included	Included	Included	Included	Included	Included
Marketing Costs	Included	Included	Included	Included	Included	Included	Included

*Minimum participation required: 500 drivers enrolled in any combination of plans shown

Additional Plans Available

	Dental		VSP
	Low	High	
	Delta Dental PMI	Delta Dental DPO	
Total Monthly Rate per Driver	$12.99	$37.26	$6.43

Notes:
1) Other Plan designs available, for higher or lower costs than shown – provided upon request
2) Dependent coverage available, rates provided upon request
3) This is a summary of proposed rates only. THIS IS NOT A CONTRACT. Full details (including plan limitations, exclusions, etc.) are described in actual plan documents.

SF TAXI DRIVERS

Select Benefits Plan Benefit Options

	SELECT BENEFITS Plan Pays the Following (unless otherwise noted)	
	Base Plan	**Enhanced Plan**
Annual Deductible	NONE	
Additional Umbrella Coverage	N/A	All coverage below (except: vision, dental & RX) is enhanced by an ***additional $10,000*** per member per year
Hospital Care ○ Inpatient ○ Intensive Care ○ Mental Illness ○ Chemical Dependency	$1000 per day (30 days per year) $2000 per day (30 days per year) $500 per day (30 days per year) $1000 per day (30 days per year)	
Accident ○ Emergency Room	$1000 Additional Benefit Paid $50 co-pay (Paid by Member)	
Skilled Nursing Facility	$500 per day (60 day max per stay)	
Physician Services ○ Office Visit ○ Preventive Care	$60 per visit ($600 Annual Max) $150 per visit ($150 Annual Max)	
Outpatient Lab and X-Ray	$60 ($600 Annual max)	
Outpatient Surgery	$2000 Annual Max	
Prescription Drugs	$15 Generic / $30 Brand Co-pay (Paid by Member) ($1500 Annual Max)	
Other Plan Features		
Provider Network	Can utilize any provider; however using Network Providers will result in lower out-of-pocket costs	
Vision Care (Exam/Lenses/Frames)	Covered at 80% ($300 Annual Max)	
Dental Benefit	After $50 Deductible, plan pays 80% of Preventive and Basic dental care, 50% of special dental care ($1000 Annual Max)	
Pharmacy Discount	Included	
Survivor Benefit	If member dies while insured, coverage for covered dependents will remain in force with premium waived for 2 years.	

Note: This is a summery of proposed benefits only. THIS IS NOT A CONTRACT. Full details (including plan limitations, exclusions, etc.) are described in actual plan documents.

SF TAXI DRIVERS

Kaiser Plan Benefit Options

	KAISER PERMANENTE		
	Option A	Option B	Option C
Annual Deductible	$1000	$250	NONE
Annual Out Of Pocket Max	$3,000	$3,000	$1,500
Lifetime Maximum Benefit	Unlimited		
Hospital Care - Inpatient	20% per admit	10% per admit	$250 Copay per admit
Accident - Ambulance - Emergency Room	$150 Copay (No deductible) 20% per admit	$150 Copay (No deductible) 10% per admit	$50 Copay $50 Copay
Hospice Care	Covered In Full (No deductible)		
Home Health Care	Covered In Full (No deductible) (100 days per year)		
Skilled Nursing Facility	20% Copay (100 days per year)	10% Copay (No deductible) (100 days per year)	Covered in Full (100 days per year)
Physician Services - Office Visit - Routine Physical	$20 Copay (No deductible) $20 Copay (No deductible)	$10 Copay (No deductible) $10 Copay (No deductible)	$15 Copay $15 Copay
Outpatient Lab and X-Ray	$10 Copay	$10 Copay (No deductible)	Covered in Full
Outpatient Surgery	20% Copay	10% Copay	$15 Copay
Mental Health - Inpatient - Outpatient	20% per admit (30 days per year) $20 Copay (No deductible) (20 visits per year)	10% per admit (30 days per year) $10 Copay (No deductible) (20 visits per year)	$250 per admit (45 days per year) $15 per visit (20 visits per year)
Chemical Dependency - Inpatient - Outpatient	20% per admit $20 Copay (No deductible) (20 visits per year)	10% per admit $10 Copay (No deductible) (20 visits per year)	$250 per admit $15 per visit (20 visits per year)
Prescription Drugs	$10 Generic / $30 Brand Copay 100 Day Supply/$100 RX Deductible for Brand Name	$10-30 Generic/ $30-90 Brand Copay Depends on Supply (No deductible)	$15 Copay 100 day supply

Note: This is a summery of proposed benefits only. THIS IS NOT A CONTRACT. Full details (including plan limitations, exclusions, etc.) are described in actual plan documents.

SF TAXI DRIVERS

Chinese Community Health Plan Benefit Options

	CHINESE COMMUNITY HEALTH PLAN	
	Option A	Option B
Annual Deductible	NONE	
Annual Out-of-Pocket Max	$2000	
Lifetime Maximum Benefit	Unlimited	
Hospital Care - Inpatient	$500 per admit	$100 per admit
Accident - Ambulance - Emergency Room	Covered in Full $50 Copay	Covered in Full $25 Copay
Hospice Care	N/A	
Home Health Care	Covered in Full	
Skilled Nursing Facility	Covered in Full (30 days per year)	
Physician Services - Office Visit - Routine Physical	$20 Copay $20 Copay	$10 Copay $20 Copay
Outpatient Lab and X-Ray	Covered in Full	
Outpatient Surgery	Covered in Full	
Mental Health - Inpatient - Outpatient	$500 per admit (30 days per year) $20 per visit (20 days per year)	$100 per admit (30 days per year) $10 per visit (20 days per year)
Chemical Dependency - Inpatient - Outpatient	$500 per admit Covered as part of Mental Health	$100 per admit Covered as part of Mental Health
Prescription Drugs	$10 Generic Copay / $30 Brand Copay (34 Day Supply)	

Note: This is a summary of proposed benefits only. THIS IS NOT A CONTRACT. Full details (including plan limitations, exclusions, etc.) are described in actual plan documents.