California Health Care Foundation

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Issue Brief

Ensuring Health Plan Mergers Benefit the Community: California Regulators and Infrastructure Investment Programs

Three for-profit health plan mergers have occurred in California since 2004 — Anthem and WellPoint in 2004, UnitedHealth and PacifiCare in 2005, and Centene and Health Net in 2016. As conditions of these mergers, California regulators required the plans to make investments in the infrastructure of the state's health care delivery system. The Anthem and UnitedHealth infrastructure investment programs have been in place for over a decade, and Centene just launched its program. This paper describes these three infrastructure investment programs, the process for identification and review of potential investments, results to date, challenges encountered, and opportunities going forward.

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Regulators and Undertakings

Two agencies that regulate the state's health plans — the Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI) — reviewed and approved these three mergers. DMHC primarily regulates prepaid plans, including health maintenance organizations (HMOs) and some preferred provider organization (PPO) plans; it regulated 68 plans in 2016, covering about 95% of Californians enrolled in commercial and public plans.[1] CDI regulates health insurance, including some PPOs and indemnity plans; it regulated 67 plans covering about 5% of enrollees in commercial and public plans in 2016.[2]

Because insurance market consolidation has the potential to harm consumers, DMHC and CDI have sought to ensure that the rights and interests of enrollees are protected and that they have continued access to health insurance coverage that is affordable, particularly in the small group

and individual markets. Prior to these three mergers between for-profit plans, CDI had reviewed and approved requests from several health plans with nonprofit (tax exempt) status seeking to convert to for-profit status.[3] Faced with a different situation and less precedent on which to rely when the for-profit plans sought approval to merge beginning in 2004 and 2005, DMHC and CDI built on the same principle of ensuring that California and its residents would benefit from the mergers.

DMHC and CDI negotiated extensive requirements, known as undertakings, with the plans involved in each merger to achieve various goals including serving the public interest and maintaining competition in the market.[4] Specific undertakings relate to supporting California's health care delivery system and helping to build the state's rural and safety-net infrastructure. DMHC and CDI sought to retain assets for these purposes in California, as plan assets may have been transferred to other states absent these undertakings.[5]

For the Anthem and UnitedHealth mergers, DMHC and CDI jointly required the plans to make two types of financial contributions: (1) grants or donations to safety-net providers or educational institutions to advance specified charitable purposes such as technology improvements or medical education programs in traditionally underserved California communities — these funds are not repaid, and (2) infrastructure investments of $200 million per plan that safety-net providers can borrow but that must be repaid (see Table 1). There were no set requirements for how much money each plan would need to invest per year, but it was expected that the ultimate investment would be greater than $200 million as repaid funds would be made available for subsequent borrowing within the 20-year period.

For the Centene merger, DMHC and CDI independently negotiated separate undertakings: DMHC required $65 million to be made available for grants and $75 million to be made available in an infrastructure investment fund over seven years, and CDI required an investment of $30 million over five years to the California Organized Investment Network (COIN).[6] This paper focuses on the joint DMHC/CDI infrastructure investment requirements for Anthem and UnitedHealth, as well as the DMHC requirement for Centene.

Ensuring Benefits for Californians

In 2004, DMHC, CDI, and Anthem agreed that the plan would make $200 million in infrastructure investment funds available over a 20-year period. The majority of these funds were made available as low-interest loans to safety-net providers.[7] Anthem set aside $40 million of the $200 million for a Small Issuance Program targeted to smaller health care providers who needed smaller amounts of capital (less than $5 million) and provided additional wraparound support to make capital more accessible. This additional support included financial reviews to help providers become creditworthy — for example, by encouraging the development of business plans and analysis of revenue streams — and reduced loan issuance costs.

Table 1. Grant/Donation and Infrastructure Investment Program Characteristics

		Infrastructure Investment Programs			
Plan (Merger Date)	**Required Grants/ Donations**	**Required Funds**	**Number of Years Required**	**Program End Date**	**Funds Set Aside for Small Projects**
Anthem (2004)	$65M	$200M	20	2024	$40M
UnitedHealth (2005)	$50M	$200M	20	2030	$70M
Centene-DMHC (2016)	$65M	$75M	7	2023	N/A
Centene-CDI (2016)	N/A	$30M*	5	2021	N/A

*To CDI COIN program.

Source: DMHC and CDI undertakings; author communication with Anthem and UnitedHealth program directors.

In 2005, DMHC and CDI negotiated undertakings with UnitedHealth that required the plan to make $200 million in infrastructure investment funds available over a 20-year period that commenced once investments totaling $200 million were made. As part of the $200 million, the plan created a Small Issuance Program with an initial $35 million that later was expanded to $70 million. Borrowers in its Small Issuance Program often did not have to pay for the costs of loan issuance, which could reach 15% of the loan amount, as these were paid by UnitedHealth using funds from its grant program. UnitedHealth also set aside $20 million of the $200 million for an electronic health record / health information technology (EHR/HIT) program that has assisted 11 critical access hospitals across the state with the implementation of EHR systems.

In 2016, the two regulators approved separate undertakings attendant to the Centene/Health Net merger. As noted above, DMHC required $75 million to be made available in an infrastructure investment fund, similar in structure to the Anthem and UnitedHealth programs, over seven years, and CDI required an investment of $30 million over five years to the COIN program. Because the COIN program operates quite differently than the other infrastructure investment programs that are the focus of this paper, information on the CDI undertakings for Centene will not be covered in detail here.

The qualification criteria for the Anthem and UnitedHealth infrastructure investment programs are similar to each other and focus on specific provider designations, service areas, and populations served (see Table 2). While some of the potential investments identified in the Centene undertakings are similar to those in the UnitedHealth undertakings, the Centene undertakings reflect the health care environment of 2016 and embrace ideas related to the use of technology, such as enhanced telehealth capabilities, alternative payment models, and quality improvement activities.

Table 2. Qualification Criteria / Potential Projects for Infrastructure Investment Programs, by Plan

Anthem (2004)*

Health Care Provider Designations

- Disproportionate share hospital, safety-net hospital, safety-net clinic, private essential access hospital, critical access hospital, public hospital, and clinic (medical clinic, mental health, addiction, dental, other services, 1204(a) licensed clinic)[1]

Service Area

- Medically underserved area or population (MUA/MUP), Health Professional Shortage Area (HPSA), rural (population of approximately 250 per square mile), frontier (population of approximately 11 per square mile)

Populations Served

- Low-income and uninsured populations — percentage of population at or below 200% of the federal poverty level (FPL) equal to or greater than the average for the state; high percentage of payer mix with Medi-Cal and/or Medicare patients

Other Considerations

- Entities that provide access to specific health care services in geographical or service areas where alternative facilities, services, or medical personnel are limited but do not easily fit into one of the categories above

UnitedHealth (2005)*

Health Care Provider Designations

- Disproportionate share hospital, safety-net hospital or clinic, private essential access hospital, critical access hospital, public hospital, and 1204(a) licensed clinic

Service Area

- MUA/MUP, HPSA, rural, frontier

Populations Served

- Low-income and/or uninsured populations, income at or below 200% of FPL

Other Considerations

- Communities and populations served that do not easily fit the criteria above but meet the spirit of the investment program

Centene (2016)†

- Expand and upgrade physical and technological infrastructure, including, but not limited to, telehealth capabilities for safety-net and low-income providers
- Strengthen access to health care resources for, and improve the health status of, low-income urban and rural underserved Californians
- Improve electronic health care technology
- Support the coordinated care model
- Implement value-based payment programs
- Promote systems changes for quality improvement activities that result in improved health outcomes
- Leverage other investment opportunities

* Qualification criteria specified by plans in program brochures.

† Potential investments identified in undertakings.

‡ Providers licensed as a "community clinic" or "free clinic" under California Health and Safety Code 1204(a).

Source: Author review of Anthem and UnitedHealth program brochures; DMHC undertakings.

Program Benefits to Safety-Net Providers

The goal of the three infrastructure investment programs is to offer a cost-effective financing option for providers serving underserved communities or populations in California. These programs feature:

- A lower cost of borrowing than would be available in the marketplace (e.g., from commercial lenders)
- More flexibility in maturity and term structures (e.g., 30-year maturities) with 100% loan-to-value financing
- Access to institutional investment pricing, research, and support.[8] Some borrowers have received additional assistance through the plans' Small Issuance Programs to help them achieve creditworthiness and be able to borrow funds in the capital market and successfully repay them.

To date, the infrastructure investment projects have focused on service expansion, facility construction, and equipment purchases for safety-net providers and facilities that primarily serve Medi-Cal enrollees. Safety-net providers also have used these programs to refinance higher-cost debt — basically paying off funds that were borrowed at higher interest rates and using funds obtained at lower interest rates to finance projects.

Projects Funded to Date

Before making any infrastructure investment funds available for projects, each health plan is required to convene an advisory committee. These committees include representatives from safety-net providers, professional associations, and philanthropy, as well as other health care experts and state regulators; they are relied upon initially to develop criteria for evaluating projects and subsequently to identify potential investment opportunities. Advisory committee members for each of the three plans are shown in the appendix.

Since the origination of the infrastructure investment programs, about 80 hospitals, clinics, and long-term care and behavioral health providers in the safety net have borrowed funds through either the Anthem or UnitedHealth programs (see Table 3).[9] Of these, about half of the clinic projects and one-fifth of the hospital projects involved borrowing $5 million or less (part of the Small Issuance Programs described above). The

Table 3. Infrastructure Investment Projects of Safety-Net Providers, 2006–17

Health Plan	Provider Type	Number of Entities Borrowing Funds	Geographic Distribution	Urban/ Rural	Smallest Borrowing	Largest Borrowing	Total $ Value of Projects
Anthem	Clinic	12	7 Southern 5 Northern	11 urban 1 rural	$1.4M	$18.5M	$78M
	Hospital	20	7 Southern 7 Central 6 Northern	3 urban 17 rural	$2.5M	$33.9M	$253M
	Total	**32**	**14 Southern** **7 Central** **11 Northern**	**14 urban** **18 rural**			**$331M**
United-Health	Clinic	26	9 Southern 8 Central 9 Northern	15 urban 11 rural	$1.4M	$14.3M	$137M
	Hospital	23	6 Southern 8 Central 9 Northern	3 urban 20 rural	$3.0M	$23.4M	$243M
	Total	**49**	**15 Southern** **16 Central** **18 Northern**	**18 urban** **31 rural**			**$380M**

Source: McDonnell Investment Management analysis of transactions, 2018.

funds were borrowed by a mix of rural and urban providers that were distributed geographically across the state. Figure 1 on page six shows currently funded infrastructure investment projects across California for the three plans.

For Anthem and UnitedHealth, whose programs are more mature, many projects have been completed and the initial investments repaid. After reaching their initial $200 million commitments, Anthem and UnitedHealth have reinvested repaid funds in additional projects, resulting in each of these plans making available funds far in excess of the $200 million required in the undertakings (see Table 3). The largest numbers of projects were initiated in 2008 and then in 2010 and 2011 after the passage of the Affordable Care Act (ACA) (see Table 4).

Centene made its first infrastructure investment in June 2018. This project provides funding to help a Federally Qualified Health Center (FQHC) in the Central Valley expand its services. Of note, this $23 million project was financed by all three plans with infrastructure investment obligations — the first time that all three plans have jointly funded a project.

Examples of projects funded by the Anthem and UnitedHealth infrastructure investment programs include:

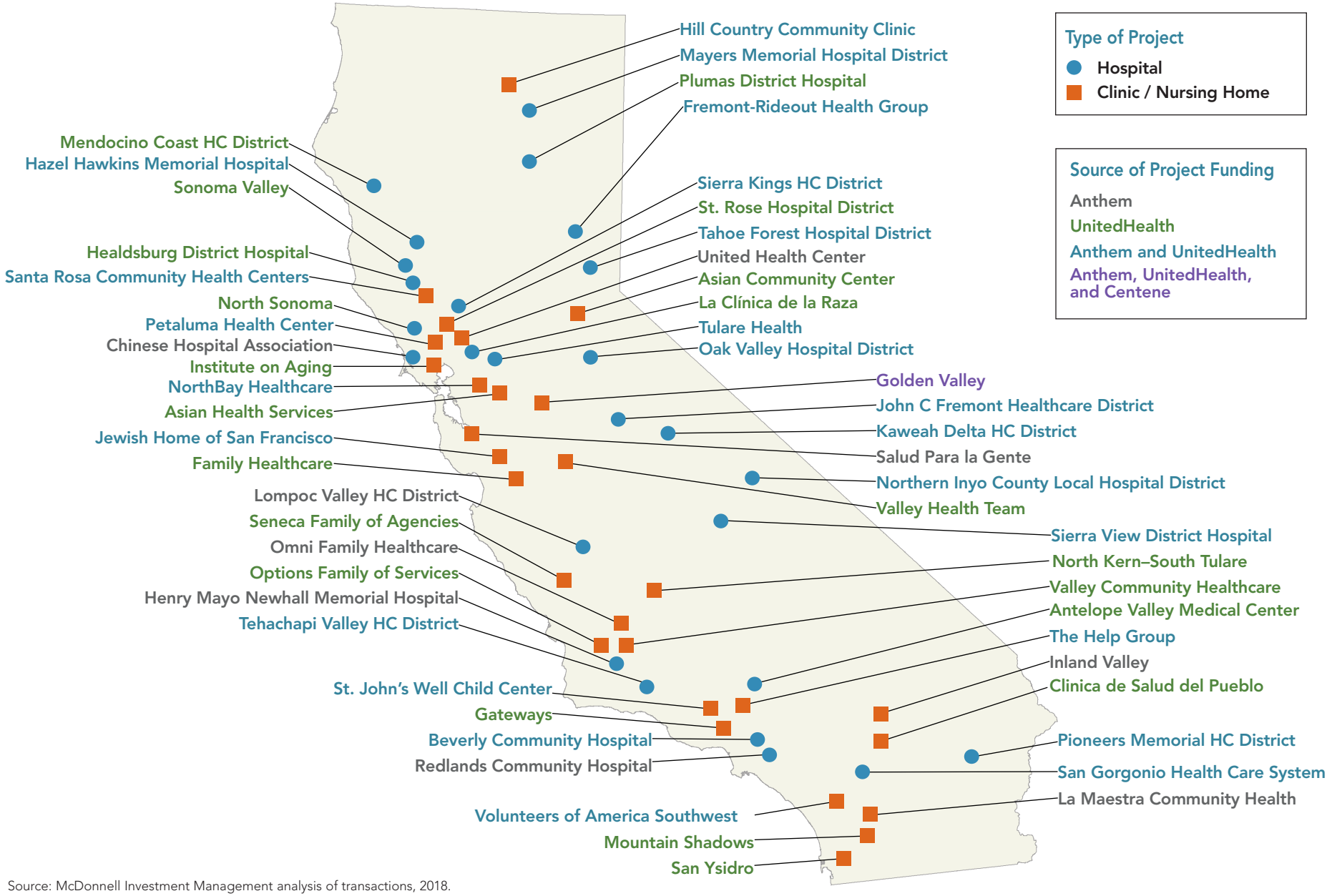
- $27 million to a rural northern disproportionate share hospital (DSH) for the construction, improvement, expansion, and equipping of additional senior living facilities.
- $13.4 million to a rural Central Valley health care district, designated a DSH, for the construction of a women's center and to refund outstanding bonds (i.e., to retire old debt and replace it with new debt at better terms).
- $8.5 million to an urban Southern California nonprofit clinic to rehabilitate a 28,000-square-foot building housing an autism clinic, special education facility, research facility, and training room.
- $4 million to a rural Southern California FQHC for the payment of outstanding balances of higher-cost debt associated with the expansion of a rural clinic facility and the construction of a clinic that includes women's health services, pediatric services, and family medicine.
- $7.9 million to a rural Central Valley FQHC for the construction of a 27,000-square-foot, two-story health center, and the addition of 4,000 square feet to another health center, together adding a total of 24 dental operatories and 44 medical exam rooms.

Table 4. Number of Safety-Net Provider Infrastructure Investment Projects Initiated per Year, 2006–17

Plan/Provider Type	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	Total
Anthem													
Clinic	3	2	5	2	4	6	0	1	0	0	4	2	29
Hospital	2	2	1	1	3	0	2	3	3	3	3	1	24
Total	**5**	**4**	**6**	**3**	**7**	**6**	**2**	**4**	**3**	**3**	**7**	**3**	**53**
UnitedHealth													
Clinic	1	1	5	3	5	6	0	1	0	0	3	1	26
Hospital	1	3	4	2	5	3	1	3	1	2	1	1	27
Total	**2**	**4**	**9**	**5**	**10**	**9**	**1**	**4**	**1**	**2**	**4**	**2**	**53**

Source: McDonnell Investment Management analysis of transactions, 2018.

Figure 1. Infrastructure Investment Projects Funded Through June 2018



Source: McDonnell Investment Management analysis of transactions, 2018.

Behind the Scenes: Project Financing

Anthem, UnitedHealth, and Centene have each retained the services of McDonnell Investment Management (McDonnell), a registered investment advisor based in Illinois that manages approximately $11.6 billion in assets for clients across the US. McDonnell plays a key role in identifying potential infrastructure investment projects, researching them from a financial perspective, contacting the plans to assess interest in funding a specific project, and monitoring project progress. McDonnell previously worked with borrowers to help them achieve creditworthiness but is now prohibited by federal regulations from providing this service. Each of the plans compensates McDonnell for its services, with McDonnell's payments based on the total market value of funds it is actively managing for a plan.

Once McDonnell determines that a potential project is a good fit for an infrastructure investment, it approaches the health plan(s) to assess interest in the project. Projects are distributed based on the plans' investment criteria, availability of funds, and a fair distribution of projects across plans so that all of them can fulfill their financial obligation in terms of investment requirements.[10] Each plan also reviews potential projects vis-à-vis their company's investment policies or requirements.

Each of the projects funded by the infrastructure investment programs is expected to make a reasonably competitive rate of return for the health plan. McDonnell and the plans noted that the expectations regarding return on investment (ROI) are neither as low as desired or as anticipated by some borrowers, nor as high as plans might be able to achieve through other investments; typical expected returns were described as slightly under the rate available in the bond market. Payments are often structured over a 10- to 20-year period with initial payments being low and borrowers paying primarily interest in the early years and more of the principal over time. Typically, the additional revenues that safety-net providers generate due to capital investments or expansion of services are used to repay borrowed funds.

The process for obtaining funding for a project varies somewhat by plan. For example, one plan's program director is involved in the initial review of all funding requests while the other plan's review is conducted at the corporate level. McDonnell takes responsibility for researching a potential project from a financial perspective, and each plan also has financial and other criteria that each project must meet. In addition to legal counsel, there are various other parties involved in funding a project — these include investment bankers, financial advisors who assist the borrower in obtaining the most favorable debt terms, bond underwriters (e.g., Piper Jaffray) that work with applicants to complete any needed paperwork and with McDonnell on pricing and terms, a conduit or bond issuer (e.g., the California Health Facilities Financing Authority, hospital districts), and a bond insurer (typically Cal-Mortgage, which basically guarantees that the funds will be repaid, resulting in lower interest rates for eligible health care facilities when they borrow money for capital needs). Figure 2 on page eight shows the key steps involved in securing funding for an infrastructure investment project through these programs.

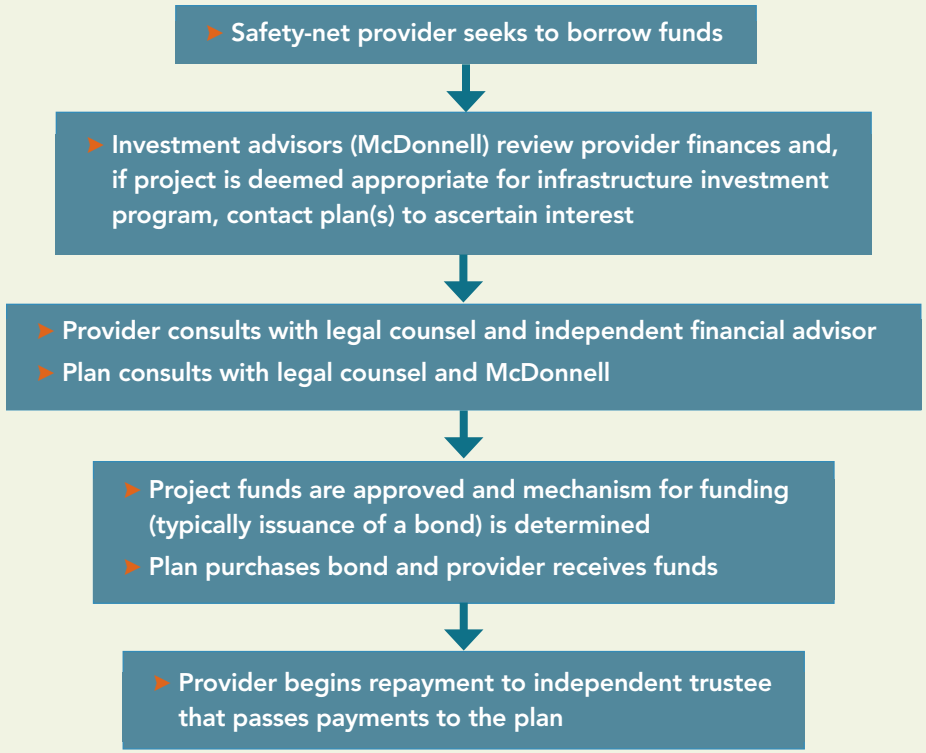
Projects are typically funded via double-barreled bonds, meaning that two distinct entities (the safety-net provider and a taxing authority or other guarantor) pledge to pay the interest and principal so that in the case of default, an alternative source of payments is known. For example, if a safety-net provider borrows money for a project

CASE STUDY

Mendocino Coast Health Care District

California law recognizes local health care districts as special districts that are authorized to build and operate hospitals and other health care facilities in underserved areas, and to recruit and support physicians. Health care districts can also create debt to borrow money needed for capital projects such as hospital construction. In 2010, the Mendocino Coast Health Care District located in rural Northern California's Fort Bragg obtained $12.5 million in funding through UnitedHealth's infrastructure investment program for its 25-bed critical access hospital that provides emergency, inpatient, and outpatient services as well as health care education to prevent, manage, and treat chronic and acute conditions. Funds were used for a capital project, which included constructing and equipping an 8,000-square-foot diagnostic imaging facility connected to the hospital by a corridor. In addition, the hospital district obtained grant funding to use toward some of the bond-issuance expenses.

Figure 2. Key Steps Involved in Securing Funding for an Infrastructure Investment Project



and then defaults, the payments will be obtained from a backup source, such as taxes levied in the community or funds of the guarantor. McDonnell tracks funded projects to make sure that payments are made on schedule and indicates that, to date, there have been no instances of missed payments or defaults on funds borrowed within the infrastructure investment programs. Each of the plans also tracks the progress of its investments using McDonnell's quarterly written reports and more extensive annual reviews, as well as informal updates via phone conversations.

Program Impacts

Assessing the impact of these infrastructure investment programs is important but has proven challenging. In 2005, McDonnell developed a measure of *interest cost savings* by providers who secured financing for projects through infrastructure investments from Anthem or UnitedHealth relative to the market rates paid by similarly rated entities. Although the actual savings vary, the targeted rate of savings is 3%. McDonnell has calculated the savings for some of the larger projects to exceed $1 million each and to total from $15 million to $17 million for each plan's portfolio of projects.

Other important benefits of the infrastructure investment programs include:

- Funding for additional projects once initial borrowed funds are repaid, ultimately making more funds available than initially required (for Anthem and UnitedHealth) and encouraging ongoing engagement from the health plans.
- Assistance for safety-net providers to become financially stable and continue meeting the needs of underserved populations.
- Longer loan repayment periods (e.g., 20–30 years) than are typically available from commercial lenders (e.g., 7–10 years).
- Payments are often structured so that the borrower can exit the financial arrangement after a certain number of years (often without a prepayment penalty), which they may wish to do if more favorable lending terms are available.

Other potential measures of program impact related to increased capacity (e.g., buildings purchased, beds built, exam rooms or programs added, additional patients served) are tracked by McDonnell but have not been the focus of its analysis of program impact.

Assessing the impact of these infrastructure investment programs is important but has proven challenging.

Challenges

Setting up each of these infrastructure investment programs, including determining the process by which health plans identified, vetted, and approved potential advisory committee members, was time-consuming. For one plan, assembling an advisory committee was more challenging as it excludes organizations that have a representative on the committee from obtaining funding for an infrastructure investment project; thus, the advisory committee applicant pool was smaller than it would have otherwise been.

The initial phases of setting up agreements between health plans and recipients of the investment funds was difficult and required a delicate balance between addressing the needs of the receiving entity and the need to create a portfolio that would generate a positive ROI for the health plan. Anthem and UnitedHealth overcame these challenges, however, as each has identified, researched, and funded dozens of projects over the past decade.

The cycles inherent in capital markets mean that access to financing for safety-net institutions and programs varies considerably from year to year. Nonetheless, the implementation of the ACA beginning in 2014 and the associated expansion in coverage and benefits led many organizations to seek capital for infrastructure expansion projects. Tax policy also impacts the demand for infrastructure investment. McDonnell indicated that, in late 2017, health care organizations rushed to obtain funding for any remaining infrastructure projects due to uncertainty about the impact of changes in the tax bill set to take effect on January 1, 2018. This burst of activity in recent years means that there are now fewer infrastructure investment needs in the health care safety-net provider community and less demand for this type of funding.

Considerable uncertainty about the federal government's commitment to health coverage for the indigent may also have a chilling effect on the desire of safety-net providers to borrow funds. While the decrease in demand for these types of funds may be cyclical, in 2018 it is challenging for the plans and McDonnell to identify potential projects. Despite the recent drop-off in demand for funding capital projects, the plans are required to continue making infrastructure investments for several more years (see Table 1).

CASE STUDY

La Maestra Community Health Centers, San Diego

Opened as part of La Maestra Amnesty Center in 1990 to meet the medical needs of immigrants, refugees, and low-income residents, La Maestra Family Clinic expanded over time to provide a variety of services to its clients in 14 converted residential buildings on one city block.

Ultimately becoming an independent nonprofit, La Maestra provided primary care, dental, vision, behavioral health, and geriatric care, as well as related social services such as job placement, transportation, translation, housing assistance, and a food pantry. La Maestra's CEO, Zara Marselian, had a vision for a state-of-the-art building where all of these services could be provided under one roof in an energy efficient and environmentally responsible manner. After exploring 28 different potential funding sources and being turned down multiple times, La Maestra obtained $18.5 million of low-interest, 30-year bond financing for a 34,660-square foot Gold Leadership in Energy and Environmental Design (LEED)-certified building through Anthem's infrastructure investment program. Securing this funding has allowed for the location of medical and social services in one building, supporting La Maestra's holistic Circle of Care approach that integrates efforts to address the social determinants of health into service provision. Programs to address social determinants include micro-enterprise assistance for green janitorial and laundry services; training culturally sensitive, multilingual liaisons / medical assistants; microcredit for women to operate sustainable businesses; job training; housing assistance; and transitional housing.

Opportunities

The plans and McDonnell all noted that there is a shortage of projects relative to the funds available, so they are working with regulators to identify future potential areas of investment that address unmet health needs of California's population. For the three plans to successfully make future infrastructure investments, it may be necessary to expand current thinking regarding what qualifies as an acceptable investment and/or modify the current criteria as described below. Several of these ideas are interrelated and could be considered together as well as separately:

1) **Expand on what is considered a positive ROI for projects and ultimately for the health plans.** Rather than relying solely on financial returns, consider other indicators of positive return on investment, such as improved population health, increased health plan enrollment, better quality scores (e.g., Healthcare Effectiveness Data and Information Set [HEDIS]), and enhanced human capital resulting from staff training or educational programs. For example, plans might choose to invest in the development of a robust telehealth infrastructure for specialty access in remote or hard-to-serve areas. This type of investment would address a business need of the plan (expanding timely access) and may provide a positive ROI to the plan if it is able to expand enrollment capacity. Alternatively, the infrastructure investment funds could be used as state matching funds to draw down federal funds for HIT infrastructure development if a mechanism can be developed for repayment of the plans' funds.

Plan representatives indicate strong support of the programs and a commitment to making positive contributions through investments going forward.

2) **Invest in new or innovative financing mechanisms such as social impact bonds or community wellness funds.** Plans could invest in social impact bonds as a mechanism to leverage plan investment funds while also advancing broader social and health goals. Projects that target the social determinants of health — such as housing, education and schools, transportation, neighborhood safety, and economic opportunity — may be ripe for infrastructure investments since improvements in these areas can lead to the ultimate desired outcome of improved health and have an acceptable ROI for the plan. Plans could invest in local wellness funds designed to blend various funding streams to improve community health. The California Accountable Communities for Health Initiative[11] represents six communities that are piloting this concept. Each community consists of multisector partnerships — including public health and health care, education, justice, and social services — that are tackling cardiovascular disease, asthma, diabetes, trauma, and violence, among other issues, and launching projects within a portfolio of mutually reinforcing interventions.

3) **Expand facility types eligible to borrow infrastructure investment funds to include assisted living facilities, respite centers or recuperative care beds for people who are homeless, complex care facilities for seniors, and school-based health centers, among others.** While some investments have been made in residential group homes and senior living facilities, most have focused on FQHC- and hospital-based capital projects.

4) **Seek more opportunities for plans with investment obligations to partner with each other or with other organizations to fund larger projects than a single health plan may be able to support or than meets the risk profile for one plan.** The June 2018 FQHC project that was jointly funded by the three plans may serve as a good example going forward. The plans could also partner with other philanthropic or community-based organizations supporting areas such as housing, education, employment, or criminal justice that support health.

5) **Leverage investment projects with targeted grant funds or leverage grant project goals with investment project goals.** Building on the experience of the UnitedHealth Small Issuance Program where grant funds were used to pay the issuance fees, health plans could be encouraged to coordinate their undertaking-related grant obligations and investment obligations in order to maximize public benefit. Grant funds to implement or upgrade EHR/HIT systems, for example, could be paired with an infrastructure loan to add telehealth capacity.

Representatives of the two health plans that have been making infrastructure investments for over a decade indicate strong support of the programs and a commitment to making positive contributions through investments going forward. Described by the plans as a valued partner, McDonnell is also highly committed to the programs and plays an important role in identifying and researching projects, working closely with borrowers, and tracking progress and impact over time.

The health plans' infrastructure investment programs have relied largely on informal relationships and word-of-mouth to identify potential borrowers. Given the current imbalance in the demand for funds versus funds available for borrowing, a more systematic and statewide campaign to inform potential borrowers of the availability of these funds could be useful. This may involve development and widespread dissemination of program brochures; in-person presentations by health plan representatives or presence at a booth at professional meetings (e.g., conferences/convenings, training sessions) of organizations such as the California Primary Care Association (CPCA) and California Association of Public Hospitals and Health Systems (CAPH); outreach to professional partners including investment bankers, underwriters, and various others involved in getting a project funded; and peer-to-peer outreach by organizations that have received or are currently receiving capital for their infrastructure or related projects.

CASE STUDY

Mountain Shadows Support Group

Currently serving about 170 residents and clients with developmental disabilities in 27 homes in the California cities of Escondido, San Marcos, and Riverside, Mountain Shadows Support Group (MSSG) has evolved to serve more and different types of clients since its inception in 1988. MSSG encourages the growth and independence of its residents, who typically stay in their facilities for more than 10 years, in their physical, social, educational, occupational, and vocational development. MSSG also operates a day program that started in 2007 and provides enrichment programs to expand life, leisure, and vocational skills and opportunities for over 100 intellectually disabled adults. Most of MSSG's funding comes through Medi-Cal reimbursement. In 2016, MSSG borrowed $7.4 million in funds through UnitedHealth's infrastructure investment program. These funds were used both to refinance debt at more favorable terms and to fund improvements to group homes including doors, patio covers, an administrative office, parking, and lighting.

Appendix: Advisory Committee Members

Anthem

- Philip Cohen, Chief Executive Officer, Monterey Park Hospital
- Mark Diel, MPH
  Executive Director, California Coverage & Health Initiative
- Elizabeth Benson Forer, MSW, MPH
  Chief Executive Officer, Venice Family Clinic
- Meaghan McCamman, MPA
  Assistant Director of Policy, California Primary Care Association
- Roderick Seamster, MD, MPH
  President and Chief Executive Officer, Watts Healthcare
- Art Sponseller, JD
  President and Chief Executive Officer, Hospital Council of Northern & Central California
- Andrea Williams, MPA
  Executive Director, Southside Coalition of Community Health Centers

UnitedHealth*

- Steven Henry, CFA
  Director of Investment Management, UnitedHealth Group (program director)
- Joy Higa, Vice President of Regulatory Affairs, UnitedHealth Group
- Barb Johnston, MSN, MLM
  President, The Castleton Group
- Michael Matull, MBA
  Principal Consultant, Matull and Associates
- Robert Miller, PhD
  Emeritus Professor of Health Economics, University of California, San Francisco
- Kathie Powell, MSHA, MA
  Chief Executive Officer, Petaluma Health Center

Centene

- Andrew Bindman, MD
  Professor of Medicine, Health Policy, and Epidemiology and Biostatistics, University of California, San Francisco
- William Barcellona, JD
  Senior Vice President of Government Affairs, America's Physician Groups (formerly CAPG)
- Castulo de la Rocha, JD
  President and Chief Executive Officer, AltaMed
- David Ford, Executive Director, CalHIPSO
- Christopher Isaak, Senior Vice President, Corporate Controller and Chief Accounting Officer, Centene
- Carol Kim, MPP
  Vice President of Community Investments and Public Affairs, Health Net
- Jeff Rideout, MD, MA
  President and Chief Executive Officer, Integrated Healthcare Association
- Shelley Rouillard, Director, DMHC
- Sandra Shewry, MPH, MSW
  Vice President of External Engagement, California Health Care Foundation
- Marion Standish, JD
  Vice President of Enterprise Programs, The California Endowment
- Michael Wilkening, MA
  Secretary, California Department of Health and Human Services

* Representatives from DMHC and CDI participate in the UnitedHealth Advisory Committee.

About the Author

Karen Shore, PhD, is an independent health policy consultant. Shore previously served as program director for the Institute for Clinical and Economic Review, where she ran the California Technology Assessment Forum, and as the president and CEO of the Center for Health Improvement.

About the Foundation

The California Health Care Foundation is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

For more information, visit www.chcf.org.

Endnotes

1. *California Health Insurers, Enrollment*, California Health Care Foundation, February 2018. www.chcf.org (PDF).
2. Ibid.
3. For example, Blue Cross of California began its conversion in 1993 and was ultimately required to distribute its assets of $3.2 billion to compensate the state for the tax savings the plan realized as a nonprofit; these assets were used to create two nonprofit health foundations (The California Endowment and California Health Care Foundation) that would work to advance the health of Californians. Similarly, Health Net's conversion from nonprofit to for-profit status in 1992 and Foundation Health Plan's conversion in 1984 led to the creation of The California Wellness Foundation and Sierra Health Foundation, respectively.
4. See the following websites for the undertakings or descriptions of the infrastructure investment program requirements: Anthem, www.sec.gov; www.dmhc.ca.gov (PDF); www.sec.gov. UnitedHealth, www.dmhc.ca.gov. Centene, www.dmhc.ca.gov (PDF); www.insurance.ca.gov (PDF).
5. Cindy Ehnes, *Investment Programs That Ensure That Californians Receive Benefits from Proposed Mergers*, Cope Health Solutions, October 2015.
6. COIN is a voluntary program that facilitates insurance industry investments to benefit California's environment and its underserved and rural communities. Details on the COIN program are available on the CDI website: www.insurance.ca.gov.
7. The term "loan" is used in this paper for convenience; the financing mechanism via which safety-net providers actually obtain funds for projects are bonds. Bonds can be traded and are issued by companies or governments to raise money, while loans are individual debt obligations between a borrower and a lender.
8. Ehnes, *Investment Programs*.
9. No comprehensive list of infrastructure investment projects is publicly available, although information on each project that is publicly financed can be obtained online (https://emma.msrb.org/), and the plans have issued press releases for some projects.
10. As Chartered Financial Analysts (CFA), McDonnell advisors must abide by the CFA Institute Code of Ethics and Standards of Professional Conduct including "Standard III-B: Fair Dealing," which requires that they deal fairly and objectively with all clients when providing investment analysis, making investment recommendations, taking investment action, or engaging in other professional activities.
11. California Accountable Communities for Health Initiative, cachi.org.