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Mayor**

**Tangerine M. Brigham
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To: James Illig, President and
Members of the San Francisco Health Commission

From: Tangerine Brigham

Re: Healthy San Francisco Services and Cost Data

Date: March 17, 2009

This memorandum provides an update on the Healthy San Francisco (HSF) program. In August 2008, when the Department delivered its first annual report on HSF it indicated that in early 2009 it would provide the Health Commission with data on HSF service utilization and cost. Specifically, the report provides information on health care utilization, frequency of visits/services, disease prevalence, and quality and access measures.

In the area of costs, the report provides an overall summary of HSF costs from 2006-07 to 2008-09 (estimated) and compares HSF costs to the purchase of health insurance on the individual market.

This report also provides a summary of recent evaluation activities.

The Department anticipates providing the HSF annual program report on fiscal year 2008-09 activity in either August 2009 or September 2009.

HSF SERVICES DATA

Healthy San Francisco (HSF) maintains a clinical data warehouse that is managed by the program's third-party administrator, the San Francisco Health Plan (SFHP). The major functions of the HSF Data Warehouse are to:

- develop and maintain data standards,
- ensure secure collection, transmission protocols, processing and data quality, and
- analyze and report data findings (with specifications).

SFHP oversees the collection and analysis of all encounter data from entities in the provider network. SFHP will provide quarterly and ad hoc reports to the Department in such areas as utilization, access, utilization of preventive services, provider network, quality, chronic care, etc. Collection and analysis of encounter data is one key approach to ascertaining the extent to which the program is meeting its goals.

The data on HSF utilization statistics from July 2007 to December 2008 (unless otherwise noted). It is important to note the following when examining the data that follows:

- There is no comprehensive pre-HSF utilization database that can be used as a baseline since: (1) clinical data from each of the various medical home systems is maintained in different practice management systems and not in a central repository and (2) there was no unduplicated count of uninsured across those various medical home systems pre-HSF.
- The Department cannot establish a baseline for HSF because enrollment has not yet stabilized. From its inception, this program has implemented incremental expansions in eligibility which has resulted in successive increases in enrollment. A baseline is truly only practical once there is stable enrollment that can be benchmarked. The program is not at that stage yet. The likely baseline year when the Department will witness stable enrollment in fiscal year 2010-11.
- Most of the encounter data (90%) is concentrated in two medical home systems (the Department of Public Health and North East Medical Services). Approximately 80% of HSF members are currently receiving primary care services from these medical home systems. The Department and SFHP continue to work with the other HSF providers on the submission of encounter data electronically.
- The hospitalization, emergency department and urgent care data includes all HSF participants, but admissions to hospitals other than San Francisco General Hospital are not yet captured.
- This represents the first set of services data on HSF and as such, it will be refined over time as the program captures data from more providers. The Department will work closely with the San Francisco Health Plan on this component.

- When examining the changes in services data from one year to the next, it is important to remember that initial HSF enrollment occurs at the point of service when participants are receiving or will soon receive a service. In some sense, the enrollment occurs at the point of highest need and use of services. Over time, a fewer percentage of participants will be enrolling at the time of their highest need because they will already be in your system. Over time, on average participants will require less service after their initial medical needs are addressed.
- It is not entirely reasonable to expect or witness system-wide affects of participant behavior in the first year of the program. Any changes in utilization or costs that are observed are most likely due to how participants were enrolled in the program (in this case, at the point of service). Changes in health seeking behavior (e.g., emergency department utilization) due to system changes take time, perhaps two to three years to observe.
- Over 70% of HSF participants have incomes at or below 100% FPL reflecting the targeted phase-in approach to initially enroll the most vulnerable into the program.

Utilization Data

The data in Table 1 indicate that utilization of health care services among HSF participants has decreased or remained relatively constant from fiscal year 2007-08 to the current fiscal year 2008-09 (annualized).

Table 1
HSF Health Care Utilization Data (July 2007 – December 2008)

Service Utilization	FY 2007-08 Actual	FY 2008-09 Annualized
Average visits per participant per year	3.93	3.05
Outpatient laboratory services per participant per year	1.47	1.10
Outpatient radiology services per participant per year	0.55	0.41
Surgical procedures (inpatient & outpatient) per participant per year	0.19	0.15
Average number of prescriptions per participant per year	8.75	6.45
Hospital admissions per 1,000 participants ¹	28.2	18.4
Number of hospital days per 1,000 participants ²	103	61
Average length of stay – hospitalization ³	3.64	3.34
ED visits per 1,000 participants	175	128
Urgent care visits per 1,000 participants	134	131
Average mental health visits per participant (CBHS data only)	1.53	1.33
Average mental health visits per participant (DPH and NEMS)	1.59	1.35
Average substance abuse visits per participant (CBHS data only)	0.60	0.56

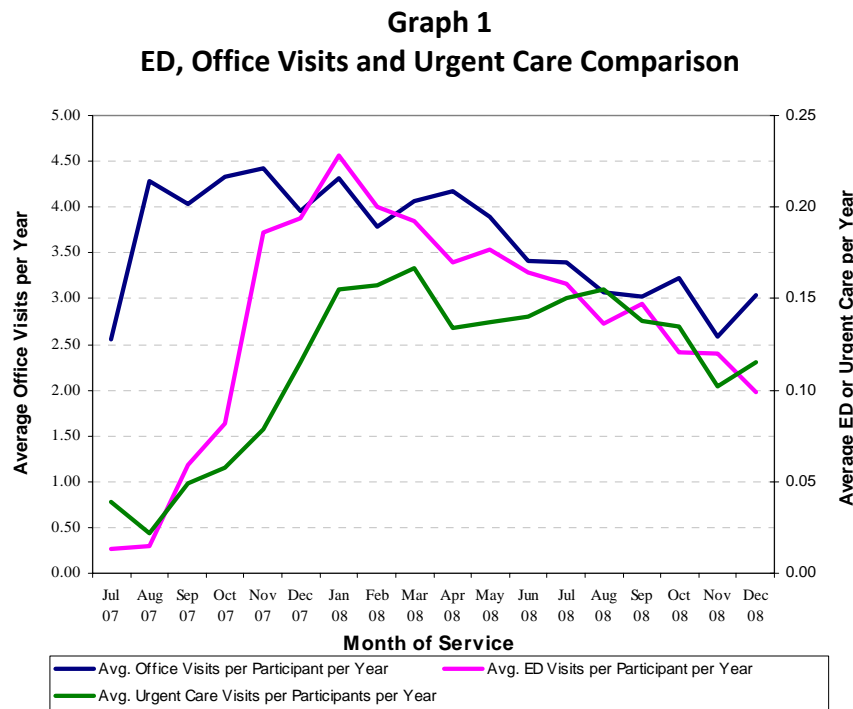
¹ Fiscal year 2008-09 data is for July 2008 – September 2008 only.

² Fiscal year 2008-09 data is for July 2008 – September 2008 only.

³ Fiscal year 2008-09 data is for July 2008 – September 2008 only.

One key goal of HSF is to provide participants with a usual source of care (i.e., primary care medical home) in the hope that this will reduce episodic care, reduce emergency department and urgent care visits and reduce avoidable emergency department visits. The data indicates that 7.3% of the ED visits to date were avoidable which is lower (14.8%) in comparison to San Francisco Health Plan data for adults Medi-Cal recipients.

In addition, the data indicates that the average number of office visits is higher than the average number of emergency department or urgent care visits suggesting that participants are relying more on their medical homes as a usual site of care. Graph 1 notes that average office visits range from zero (0) to five (5) per year (see scale on left side of graph) while average emergency department or urgent care visits range from zero (0) to point two five (0.25) per year (see scale on right side of graph). Generally at any point in time, the average number of office visits is 300% greater than emergency department or urgent care visits.



HSF hospitalization and emergency department data was compared to data from other public health insurance programs within the San Francisco Health Plan (i.e., Medi-Cal [adults only] and Healthy Workers). Table 2 reveals that hospital utilization among HSF participants is lower than that found within the Healthy Workers and Medi-Cal population. The data also indicated that emergency department visits were higher among HSF participants than for Healthy Workers members and similar to or lower than rates experienced in the Medi-Cal population. The emergency department utilization may be a reflection of the fact that 14% of HSF participants are homeless and many of these homeless participants may continue to receive services in the emergency room despite a medical home selection.

Table 2
Selected HSF Utilization Data in Comparison to Public Health Insurance Utilization Data

Service Category	Healthy Workers	Medi-Cal (Adults Only)
Hospital Admissions per 1,000	HSF is Lower Than HW	HSF is Lower Than M-Cal
Number of Hospital Days per 1,000	HSF is Lower Than HW	HSF is Lower Than M-Cal
Average Length of Stay–Hospitalization	HSF is Lower Than HW	HSF is Lower Than M-Cal
ED Visits per 1,000	HSF is Higher Than HW	HSF is Similar to or Lower Than M-Cal

Frequency of Visits/Services

HSF, like any health program, is comprised of those who use services in a given month and those who do not based on clinical needs. In addition, some participants may use services more frequently than others based on their clinical needs. The following provides information on the frequency of certain services over a 12-month period (July 2007 to June 2008).

Table 3
Frequency of Visits/Services – Percentage of Participants

Utilization Category	None	1 – 4	5 – 9	10+
Average Primary and Specialty Office Visits ⁴	48%	41%	9%	2%
Outpatient Laboratory ⁵	62%	36%	2%	--

Utilization Category	None	1 – 2	3+
Outpatient Radiology Services	82%	16%	2%
Surgical Procedures (Inpatient and Outpatient)	93%	7%	.6%

Utilization Category	None	1 – 10	11 – 30	31+
Average Number of Prescriptions ⁶	58%	31%	9%	2%

For some participants enrolling in HSF there may be pent-up demand for health care services. One way to track this is by examining the number of participants who made an appointment for an initial office/well visits within a set period of time after enrolling into the program. The data is for participants who were either existing or new patients. As the Department further refines its data statistics, it will separate this data out for existing and new patients.

Table 4
Frequency of Visits/Services – Percentage of Participants

Utilization Category	Within 30 days	Within 31 - 60 days	None within 60 days
Initial Office/Well Visits within 60 days ⁷	23%	10%	67%

⁴ Data is for the Department and North East Medical Services only.

⁵ Data is for all HSF participants. The service frequency levels are "No," "1 – 4," and "5+."

⁶ Data is for the Department and North East Medical Services only.

⁷ Data is for the Department and North East Medical Services only.

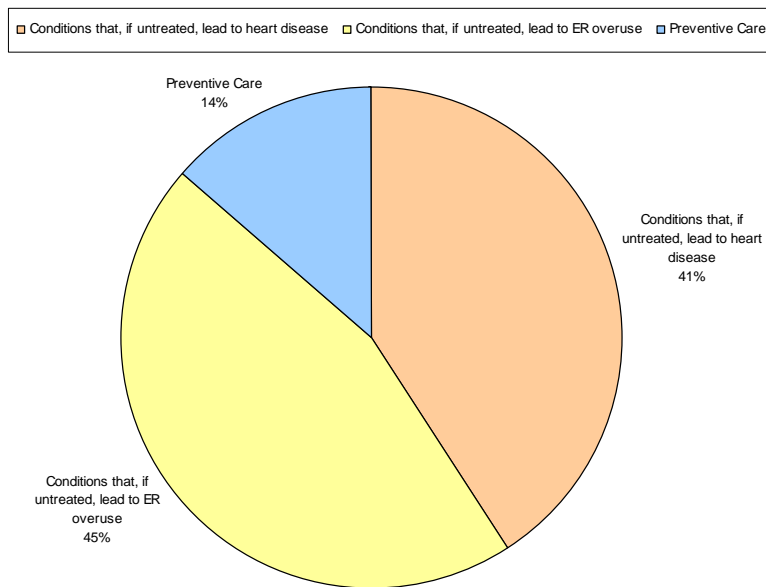
The Department uses a 60-day measure because HSF attempts to ensure that new participants receive their first clinical appointment within 60 days of calling for an appointment. The standard is not within 60 days of enrollment since participants may not call for initial appointments for some days or weeks after enrollment. The lack of a visit within 60 days does not denote an access to care issue; this represents the percentage of the population that most likely did not request an appointment within 60 days of enrollment. For many participants, the value of HSF is in knowing that they can receive care when they need it.

Disease Prevalence

HSF data also examines disease prevalence. This is important in ascertaining the extent of illness and chronic disease in the population. Data for the time period July 2007 to December 2008 reveals that 24% of the HSF population has at least one of the following chronic diseases: asthma, diabetes, hyperlipidemia or hypertension.⁸ HSF expands six clinic-based chronic care redesign projects designed to improve patient care and patient outcomes by enhancing primary care–specialty care collaboration, improving access to specialty care, and increasing chronic care infrastructure. The participating clinics are Family Health Center (back pain, diabetes, mental health within primary care) and General Medicine Clinic (asthma/COPD, heart failure, resident continuity). The projects serve both HSF participants and non-HSF participants.

When the data is examined to determine the primary reason for a clinical visit, the encounter data for the top 20 primary reasons indicates that:

**Graph 2
Encounter Categories**



⁸ Figure is for HSF participants who were enrolled in the program on or before September 30, 2008.

Preventive care encounters include general medical exam, health counseling/ consultation, cancer screening, pre-op examination. Conditions that, if untreated, would lead to ER overuse include, but are not limited to joint pain, respiratory symptoms, back pain, and general symptoms. Conditions that, if untreated, would lead to hear disease are hypertension, diabetes, and high cholesterol. This finding is consistent with analysis of the top 20 medications (by therapeutic class): 6% were miscellaneous, 48% were for conditions that, if untreated, would lead to ER overuse and 42% were for conditions that, if untreated, would lead to hear disease.

Quality and Access Measures

The Department will monitor the quality of care provided within HSF using HEDIS (Healthcare Effectiveness Data and Information Set), a set of performance measures that is widely used in the health care industry. HEDIS is designed to allow consumers to compare health plan performance, facilitate trending of results on an annual basis. HEDIS measures are modified annually either with additions, deletions or revisions.

While HSF collects HEDIS data from encounter data submitted by HSF providers, HEDIS incorporates a continuous enrollment requirement – essentially the number of years that a participant must be enrolled in the health plan in order to report on the measurement. The number of years varies depending upon the quality/access measure as seen in Table 5.

**Table 5
HSF Quality and Access Measures**

Quality/Access Measure	Definition
Comprehensive Diabetes Care <ul style="list-style-type: none"> • Diabetes Eye Exams (blindness prevention) • Diabetes HbA1c (test of average sugar control) • Diabetes LDL (test of cholesterol) • Diabetes Medical Att’n for Nephropathy (prevention of kidney failure) 	HEDIS measure is the percentage of participants with HbA1c screening, LDL screening, eye exam and medical attention for nephropathy (all reported separately), enrolled for 24 months.
Asthma (using controller medication)	HEDIS measure is defined as the percentage of participants with persistent asthma, enrolled for 24 months (allowed two one-month gaps) who were dispensed a controller medication.
Breast Cancer Screening (Mammograms)	HEDIS measure is defined as the percentage of female participants aged 42 to 69, enrolled for 24 months (allowed one-month gap) who had a mammogram in the last 24 months.
Cervical Cancer Screening	HEDIS measure is defined as the percentage of female participants aged 24 to 64, enrolled for 12 months (allowed one-month gap) who had a Pap test in the last 36 months.
Colorectal Cancer Screening	HEDIS measure is defined as the percentage of participants aged 50-80 who had appropriate screening for colorectal cancer.

Quality/Access Measure	Definition
Adult Access to Care	HEDIS measure is defined as the percentage of participants aged 20 and older who have had an ambulatory or preventive care visit during the last 12 months.
Perc. of Mental Health Patients with One Medical Office Visit	Not a HEDIS measure. No benchmark data available.
Perc. of Substance Abuse Patients w/ One Medical Office Visit	Not a HEDIS measure. No benchmark data available

HSF has not been in existence long enough for a significant number of program participants to meet the continuous enrollment requirement. In fact, very few meet the standard. Attempting to derive these HEDIS measures for a current HSF population that does not meet the key enrollment criteria would be neither meaningful nor statistically valid.

HSF FINANCIAL DATA

As the Health Commission is aware, the Department's budget is divided into the following divisions: Health at Home, Jail Health, Laguna Honda, Mental Health, Primary Care, Public Health, San Francisco General Hospital and Substance Abuse. Expenditure and revenue budgets are developed for each of these divisions on an annual basis.

The Department does not have a budget division for Healthy San Francisco. This approach is consistent with how the Department budgeted for the Sliding Scale program (the predecessor to the Healthy San Francisco program). Administrative and service related expenditures for HSF occur in the following divisions:

- Health at Home,
- Mental Health,
- Primary Care,
- San Francisco General Hospital and
- Substance Abuse

The Department tracks expenditures through the financial class that has been created for HSF. The expenditures in each of these divisions are combined to provide an overview of HSF finances. To create a budgetary division for HSF would not be practical since it would involve significant reallocation of expenses from these existing divisions into any new division.

The following HSF financial data is comprised of two components:

- incremental expenditures and revenues and
- total expenditures and revenues.

Incremental Expenditures and Revenues

The following provides data on incremental costs and revenue for the Healthy San Francisco program. In May 2007, the Health Commission adopted an incremental budget for HSF. This detailed the incremental costs and revenue that the Department was anticipated to incur developing and operating HSF in the first year. The 2007-08 incremental budget was based on additional expenditures supported with non-General Fund revenue. At that time, the identified revenue sources were Health Care Coverage Initiative reimbursement, participant fees and contributions from employers while incremental expenditures were in the areas of clinical expansions, delivery system innovations, patient access and administration.

Table 6 on the following page provides information on those revenues and expenditures. In addition, it provides participants based on a participant month calculation. Participant months reflect the number of participants per month aggregated over a 12-month period. To provide the Health Commission with a full picture of costs that were incurred developing planning, designing and implementing Healthy San Francisco, the Department provides information on the 2006-07 start-up costs of approximately \$4.9 million. Costs were in the area of third-party administration (developing infrastructure for the HSF line of business), information technology,

capital (creation of an eligibility and enrollment unit) and general administration. These costs were supported by a General Fund allocation and supplemental appropriation funds.

Table 6 indicates that during the first year of implementation (2007-08), HSF incremental expenditures exceeded revenue. This was not unexpected given necessary ramp-up and the number of participant months during the first year. For 2008-09, anticipated revenue will exceed anticipated expenditures. However, this does not result in Department surplus for HSF. On the contrary, these dollars are used to help fund the prior year's shortfall.

A key feature of HSF is that it is a public-private partnership. This is demonstrated by the equitable distribution of incremental revenue. The Department funded provider reimbursements at \$7.9 million, University of California, San Francisco at \$4.1 million, San Francisco Health Plan at \$5.1 million and behavioral health providers at \$1.1 million.

Table 6
HSF Estimated Incremental Expenditures and Revenues

	2006-07 Start-Up	2007-08 Actual	2008-09 Estimated
ENROLLMENT			
Participant Months	0	126,268	403,864
REVENUE			
General Fund	\$4,866,402	\$0	\$0
Health Care Coverage Initiative	\$0	\$8,136,224	\$15,982,375
Participation Fees	\$0	\$836,493	\$2,202,491
ESR (Health Care Expenditures)	\$0	\$4,187,554	\$19,417,370
Reserve for Unearned Rev. (25%)		(\$1,046,889)	(\$4,854,343)
TOTAL REVENUE	\$4,866,402	\$12,113,382	\$32,747,893
EXPENDITURES			
Administration	\$277,000	\$384,287	\$724,345
Non-Admin Salary/Benefits (New Positions)	\$0	\$2,921,387	\$6,628,020
Behavioral Health Contracted Services	\$0	\$1,117,184	\$1,117,184
Material and Supplies	\$0	\$866,914	\$1,716,950
UCSF Services	\$0	\$3,636,987	\$4,133,569
Operating Expense	\$0	\$45,794	\$386,792
Pharmacy	\$0	\$1,692,000	\$1,128,390
Third-Party Administrator	\$2,306,311	\$3,039,107	\$5,132,291
Provider Reimbursement	\$0	\$2,153,255	\$7,940,677
DPH Eligibility/Enrollment Unit (Capital)	\$885,000	--	--
Eligibility/Enrollment System (OEA)	\$693,091	\$393,300	\$363,708
IT Infrastructure and Siemens	\$705,000	\$200,000	\$200,000
Total Expenditures	\$4,866,402	\$16,450,215	\$29,471,925

Total Expenditures and Revenues

The Department believes that it is important to clearly separate incremental expenditures from total expenditures. The total expenditures and revenues include both incremental costs and existing costs for all services and administrative costs. The financial data indicate that for 2008-09, estimated expenditures for HSF will be \$113.2 million with revenue of \$32.7 million and a General Fund subsidy of \$80.5 million (the difference between expenditures and revenues). Based on estimated participant months, the monthly estimated per participant cost is \$280. This cost represents on average the cost of utilized services by a participant on a monthly basis. This cost recognizes that some participants will not use services in any given month. On an annual basis this would equate to \$3,360.

Table 7
HSF Total Estimated Costs

	2006-07 Start-Up	2007-08 Actual	2008-09 Estimated
ENROLLMENT			
Participants Months	0	126,268	403,864
REVENUE			
General Fund	\$4,866,402	\$0	\$0
Health Care Coverage Initiative	\$0	\$8,136,224	\$15,982,375
Participation Fees	\$0	\$836,493	\$2,202,491
ESR (Health Care Expenditures)	\$0	\$4,187,554	\$19,417,370
Unearned Rev. Reserve (25%)	\$0	(\$1,046,889)	(\$4,854,343)
TOTAL REVENUE	\$4,866,402	\$12,113,382	\$32,747,893
EXPENDITURES			
Administration	\$277,000	\$384,287	\$724,345
Cost of Services - SFGH and Clinics	\$0	\$37,645,942	\$92,042,455
Behavioral Health Contract Services	\$0	\$2,183,284	\$6,825,735
Third-Party Administrator	\$2,306,311	\$3,039,107	\$5,132,291
Provider Reimbursement	\$885,000	\$2,153,255	\$7,940,677
Eligibility/Enrollment System (OEA)	\$693,091	\$393,000	\$363,708
Siemens	\$705,000	\$200,000	\$200,000
Total Expenditures	\$4,866,402	\$45,998,875	\$113,229,211
REVENUE LESS EXPENDITURES (GENERAL FUND SUBSIDY)			
	\$0	(\$33,885,493)	(\$80,481,318)
PER PARTICIPANT EXPENDITURE			
		\$364	\$280
PER PARTICIPANT REVENUE (EXCLUDES GF)			
		\$96	\$81
GENERAL FUND SUBSIDY			
		(\$268)	(\$199)

It is important to note that the costs above are not representative of the entire uninsured population served by the Department; it only represents those enrolled in HSF. The Department provides services to uninsured individuals ineligible for HSF or not yet enrolled in HSF, and provides services that are not in the HSF scope of benefits (e.g., dental) on a sliding scale basis to uninsured individuals. These costs must be provided to give a fuller sense of the costs of serving indigent and uninsured persons. It is estimated that the costs of providing services to uninsured persons not enrolled in HSF is \$64,055,000 for fiscal year 2008-9. As a result, the total estimate costs of serving the uninsured in 2008-09 is \$177,284,000.

Table 8
Total Estimated Costs of Serving Indigent and Uninsured (Fiscal Year 2008-09)

Uninsured Patient Population	Estimated Cost
HSF Uninsured Population	\$113,229,000
Non-HSF Uninsured Population	\$ 64,055,000
Entire Uninsured Population	\$177,284,000

HSF Cost Comparison to Health Insurance

In examining HSF costs, the Department was interested in determining how HSF’s anticipated health care services costs (both for the participant and the overall program) compared to health insurance that an uninsured resident might purchase on the individual market.

There are several individual health insurance plans with a complex array of benefit levels and cost-sharing requirements. For example, a San Francisco resident currently looking for individual health insurance has at least 109 options that range from comprehensive to basic health coverage.⁹ Individual health insurance plans can be costly, provide limited benefits, and the presence of pre-existing medical conditions can lead to an increase in monthly premiums and coverage denials depending on the insurer and state regulations. Based on data from the 2007 California Health Interview Survey (CHIS), eight percent (8%) of San Francisco residents between 18-64 years of age have individual health insurance.

The Department compared the Healthy San Francisco (HSF) program to individual health insurance plans offered by Kaiser Permanente (Northern California) and Anthem Blue Cross (California). The Department chose two high quality health plans for the comparison. As the Department has made clear since the initial planning, HSF is not insurance and individuals who have access to health insurance should obtain it or retain their coverage. The Department’s purpose in comparing the health insurance rates was to demonstrate that as a result of HSF not being insurance and by weaving together the existing safety net delivery system, HSF is able to provide access to services at a cost that is affordable for the City and County of San Francisco. Were the City and County to try to subsidize the cost of health insurance for HSF program participants, it would not be successful due to affordability. If the subsidy that the City

⁹ Check the Label: Helping Consumers Shop for Individual Health Coverage. *California Health Care Foundation Issue Brief*. June 2008

provides to cover the cost of health insurance is too large, it would be unaffordable and unsustainable for the City and County. On the other hand, if the subsidy the City provides to cover the cost of health insurance is too small, it would be unaffordable for program participants.

The Department recognizes the limitations of this type of comparative analysis – principally because HSF is not health insurance. The Department is unable to find an appropriate comparable individual market health insurance product that:

1. Bases health care premiums on income and not age and gender.
2. Is not portable.
3. Does not take into account pre-existing conditions.

For comparative purposes, the Department identified health insurance products that did not have an annual deductible and provided comprehensive benefits (both outpatient and inpatient). Though Kaiser Permanente (KP) and Blue Cross have numerous individual health care plans, only one from each company is most comparable to HSF:

- *KP – Copay 25* – this plan offers broad coverage and office visits have fixed copayments of \$25 and there is no annual deductible.
- *Blue Cross – HMO* – this plan offers broad coverage and office visits have fixed copayments of \$25 and there is no annual deductible

Lastly, as part of this analysis, the Department did a “mystery shopper” survey and contacted both health plans to determine how pre-existing health conditions might affect the cost of any health insurance offered and/or ability to be offered an individual health insurance product.

On the participant level, the data indicate that out-of-pocket costs under HSF are less than those under individually purchased health insurance. The costs are less because HSF:

- has lower point-of-service (called co-payments in health insurance terminology) and participation fees (called premiums in health insurance terminology),
- does not price according to age and gender and
- does not take into account pre-existing medical conditions.

The data indicate the following with respect to overall anticipated costs:

- The monthly standard premium for a somewhat comparable Kaiser product is \$388 (KP – Copay 25).
- The monthly standard premium for a somewhat comparable Blue Cross product (Blue Cross – HMO) is \$618.

It is important to note that both of the premium amounts provided above include costs related to portability and out-of-network expenditures.

There are currently 37,000 HSF program participants. If all of these individuals were enrolled in a comparable Kaiser Permanente or Blue Cross individual health plan for a year, the anticipated costs would range as follows (see next page):

Table 9
Total Estimated Costs of Serving Indigent and Uninsured

	KP-25 45 year old; Fe/Male Avg	Blue Cross – HMO 45 year old; Fe/Male	HSF (Fee not based on demographics)
Monthly Anticipated Premium	\$388	\$618	\$280
# of HSF Participants (assuming no participants have a pre-existing medical condition)	37,000	37,000	37,000
Estimated Monthly Cost	\$14,356,000	\$22,866,000	\$10,360,000
Estimated Annual Cost	\$172,272,000	\$274,392,000	\$124,320,000

If the Department were to attempt to subsidize health insurance for all HSF participants, the costs would be significantly higher than providing services through the current access model. This increase ranges from \$47.95 million (Kaiser) to \$150.07 million (Blue Cross/Anthem). These costs could be lower or higher than what is stated here. They could be lower because the figures do not taken into account any discounts that the Department might obtain through group purchase of coverage for this population. They could be higher because the premiums in the chart above do not reflect costs for those with pre-existing conditions.

To determine the extent to which pre-existing medical conditions may affect an individual’s ability to obtain health insurance, Department staff contacted Kaiser and Blue Cross insurance agents as a “mystery shopper.” It is important to note that the information and quoted monthly premiums were based solely on the hypothetical information provided via telephone (both insurance companies were led to believe they were speaking to an individual interested in obtaining individual health care coverage). More importantly, final monthly premium rates are contingent upon application review, medical questionnaire, and actual enrollment. The Department found that rates would be higher or that the individuals would not be able to obtain health insurance if they had pre-existing conditions. This is consistent with a 2001 study conducted by Georgetown University Institute for Health Care Research and Policy which found that insurance carriers often decline to cover individuals who have pre-existing medical conditions and when they do offer coverage any expenses related to the pre-existing condition will not be covered, and/or monthly premiums can be increased by an average of 38%.¹⁰ The anticipated costs of providing the Kaiser and Blue Cross plans to individuals may be considerably underestimated given the actual cost of these plans based on pre-existing medical conditions.

¹⁰ Individual Health Insurance for consumers in less-than-perfect health? *Georgetown University Institute for Health Care Research and Policy*. June 2001.

EVALUATION

The Department will evaluate HSF to determine if it is achieving its goals to improve access to health services for uninsured adults in a non-health insurance model. To date, little research has been conducted on expanding access to care through this type of model. Research in this area is needed to understand the ability of this model to result in meaningful improvements in access and health outcomes, and why. The Department has developed a multi-pronged approach to the evaluation that takes into account the need to have evaluative information: (1) on the early aspects of the program, (2) on an ongoing basis, (3) both within and outside a formal evaluation process. To date, the evaluation has the following components:

- **Participant Satisfaction Survey:** This telephone survey is designed to ascertain the experience of early HSF enrollees. Questions are in the areas of: enrollment process, knowledge and understanding of HSF, uninsured status, satisfaction with HSF, health status, access to care and health care utilization. This is a representative survey of enrolled participants in Healthy San Francisco as of October 31, 2008. The survey will be administered during the months of March/April 2009. Survey results should be available in May 2009. This survey is being conducted on an in-kind basis with the generous support of the Kaiser Family Foundation.
- **Applicant Health Access Questionnaire:** In December 2008, the HSF eligibility/ enrollment system (One-e-App) was enhanced to include a Health Access Questionnaire for all HSF participants. Participants complete the survey questions at the time of initial enrollment and annually thereafter when they renew their eligibility for the program. The purpose of the survey is to capture applicants' pre- and post- Healthy San Francisco health access experience in a quantifiable fashion. The ten-question survey is offered in English, Spanish, and Chinese. On a regular basis, the Department will be able to extract the responses to this data and analyze it for program and evaluation purposes. This enhancement was funded with the generous support of the California HealthCare Foundation.
- **Evaluation RFP:** On March 19, 2009, the Department will release a Request for Proposals to retain an evaluation consultant. Bids are due April 16, 2009. The evaluation will be structured to provide formative findings, in addition to a summative analysis, that can be used to guide development of any program improvements or modifications. Specific evaluation activities include examining utilization, administrative and financial data. The evaluation will also focus on the lessons learned and replicability. In addition to City and County funding for the evaluation, the Department has received generous support from the Blue Shield of California Foundation and The California Endowment for the evaluation. In addition, the Commonwealth Fund has provided conditional grant funding to this effort.

In addition, the UCLA Center for Healthy Policy Research has a contract with the State Department of Health Care Services to evaluate all ten Health Care Coverage Initiative programs. The Department provides all necessary reports and data to support this evaluation.