

**STATUS REPORT ON THE IMPLEMENTATION OF THE
SAN FRANCISCO
HEALTH CARE SECURITY ORDINANCE**

**A Report of
the Department of Public Health and
the Office of Labor Standards Enforcement**

**Submitted to the
San Francisco Board of Supervisors**

June 2010

TABLE OF CONTENTS

Executive Summary	3
I. Introduction	5
II. Golden Gate Restaurant Association Lawsuit	6
III. Employer Spending Requirement	8
IV. Healthy San Francisco	11
V. Federal Health Reform and Health Care Security Ordinance	18

EXECUTIVE SUMMARY

In July 2006, the San Francisco Board of Supervisors adopted the San Francisco Health Care Security Ordinance (Ordinance No. 218-06) and further amended it in April 2007 (Ordinance No. 69-07). The Ordinance created two City and County programs, the Employer Spending Requirement (ESR) and Healthy San Francisco (HSF). Both program components of the Ordinance work in tandem and are designed to address the health needs of San Francisco's uninsured residents and workers. The Office of Labor Standards Enforcement (OLSE) oversees enforcement of the ESR while the Department of Public Health (DPH) oversees HSF.

The Ordinance requires regular reporting to the Board of Supervisors on the status of both programs (ESR and HSF) from July 2007 to June 2010. Quarterly reports were required during the period from July 1, 2007 through June 30, 2008 and semi-annual reports from July 1, 2008 through June 30, 2010. The last report was submitted in January 2010 and this report provides an update on the implementation and operation of the Ordinance since that time. This report meets the mandated reporting requirement and constitutes the final report based on Section 14.4(f) of the Ordinance.

Golden Gate Restaurant Association Lawsuit

Since the filing of the last status report, the most significant event to occur with respect to the Ordinance is that on June 28, 2010, the U.S. Supreme Court declined to hear the Golden Gate Restaurant Association's (GGRA) federal lawsuit challenging the validity of the ESR. As a result of denying GGRA's petition for review, the U.S. Supreme Court effectively sustained the September 30, 2008 U.S. Ninth Circuit Court of Appeals ruling upholding the legality of the City's employer spending requirement for health care. The ESR remains in effect for all covered businesses.

In October 2009, the Supreme Court had invited the U.S. Solicitor General to file a brief expressing the federal government's views on the GGRA case. On May 28, 2010, U. S. Solicitor General filed its brief which urged the Supreme Court not to take the case. The Solicitor General stated that the U.S. Ninth Circuit Court of Appeal's ruling in favor of the City and County did not conflict with any prior ERISA preemption decision of the Supreme Court. The Solicitor General also noted that passage of federal health care reform had dramatically changed the landscape regarding health coverage, making it much less likely that state and local governments would seek to enact programs like San Francisco's, thereby rendering the ERISA preemption question presented in the GGRA case much less important.

OLSE and DPH Activities

Specifically, the following activities have occurred:

- The Office of Labor Standards Enforcement (OLSE):
 - As of June 23, 2010, OLSE had opened 330 cases regarding employer compliance with the Employer Spending Requirement. Of those, 123 have been closed and 207 are still open.

- OLSE has assessed penalties in a total amount of approximately \$20,000.
- OLSE worked with a student from UC Berkeley's Goldman School of Public Policy to determine whether Health Spending Accounts, one of the options employers may choose to satisfy the Employer Spending Requirement, adequately meet the goal of providing reasonable access to health care to those who work in San Francisco. OLSE anticipates releasing the report shortly.
- OLSE completed its analysis of the 2008 HCSO Annual Reporting Forms and the data indicates:
 - ❖ When sorted by employer size, all categories of employers (500+ employees, 100-499 employees, 50-99 employees, 20-49 employees) report their primary method of making health care expenditures to be group health insurance (84% of all employers).
 - ❖ There is a correlation between employer size and participation in the City Option (Healthy San Francisco): the larger the employer, the more likely it will enroll employees in the City Option.
 - ❖ When sorted by industry sectors, Construction was most likely to use health insurance (92%), the Administrative, Support, Waste Management, and Remediation Services was most likely use the City Option (21%) and the Accommodation and Food Services was most likely use health spending account administered by a third-party administrator (42%).
 - ❖ Of employers who chose to use health spending accounts administered by third parties, 80% reported reimbursing 50% or less of the minimum expenditure required under the law. Fifty-seven percent reported reimbursing 10% or less than the minimum expenditure.
- The Department of Public Health (DPH):
 - Reached enrollment of 53,294 uninsured San Francisco adult residents in Healthy San Francisco (88% of estimated 60,000 uninsured adults).
 - Completed components of an independent program evaluation.
 - Developed new program materials in response to data revealed by the 2009 *Survey of Healthy San Francisco Participants*.
 - Collaborated with the San Francisco Health Plan and St. Francis Hospital to launch a Patient Navigator Pilot.
 - Retained a graduate student to develop and write a policy brief on lessons learned from the development, planning and implementation of Healthy San Francisco as technical assistance tool for other localities contemplating similar health care delivery systems.

I. INTRODUCTION

An estimated 60,000 adult San Francisco residents are uninsured.¹ These residents have limited access to routine preventative care, delay seeking treatment when ill, suffer from poorer health outcomes and ultimately rely on more costly episodic or emergency care for health conditions that could have been treated in primary care settings.

In July 2006, the San Francisco Board of Supervisors adopted the San Francisco Health Care Security Ordinance (Ordinance No. 218-06) which created two new City and County programs, the Employer Spending Requirement (ESR) and Healthy San Francisco (HSF). The programs work in tandem and are designed to address the health needs of San Francisco's uninsured residents and workers.

The ESR requires medium and large businesses to spend a minimum amount on health care for their employees. Employers have flexibility in how they make their required expenditure, as long as it used for health care for their employees. In order to provide affordable health care options, the Ordinance also created HSF. HSF provides universal, comprehensive, affordable health care to uninsured adults irrespective of the person's income level, employment status, immigration status or pre-existing medical conditions. It integrates public and private providers into a single system to provide universal care without relying on health insurance.

HSF became operational on July 2, 2007. The ESR went into effect on January 9, 2008 for San Francisco employers with 50 or more employees and on April 1, 2008 for for-profit employers with 20-49 employees.

The Ordinance specifies the roles and responsibilities of various City and County agencies in the development and maintenance of this Ordinance. They are:

- Office of Labor Standards Enforcement (OLSE) – Enforces the ESR provisions.
- Department of Public Health (DPH) – Administers the HSF program.
- Controller's Office – Ensures that any required health care expenditures made by an employer to the City are kept separate and apart from general funds and limits use of these funds to HSF.
- Office of Treasurer and Tax Collector – Provides to OLSE all non-financial information necessary for OLSE to fulfill its responsibilities.

¹ Estimate is based on the 2007 California Health Interview Survey (CHIS) which is the nation's largest state health survey. CHIS provides detailed data on the health and health care needs of California residents. It is conducted by the UCLA Center for Health Policy Research.

II. GOLDEN GATE RESTAURANT ASSOCIATION LAWSUIT

In November 2006, the Golden Gate Restaurant Association filed a lawsuit against the City and County of San Francisco challenging the Employer Spending Requirement (“ESR”) of the Health Care Security Ordinance (“Ordinance”) on the grounds that it conflicted with the federal Employee Retirement Income Security Act (“ERISA”). The lawsuit did not challenge the legality of the Healthy San Francisco program.

On December 26, 2007, the United States District Court (“Court”) issued an order granting the motion for summary judgment filed by the Golden Gate Restaurant Association. The Court ruled that the City and County San Francisco could not implement the ESR provisions of the Ordinance because of federal ERISA preemption.

On December 27, 2007, the San Francisco City Attorney filed a petition with the United States Court of Appeals for the Ninth Circuit (“Ninth Circuit”) asking for an emergency stay pending appeal of the lower court’s decision.

On January 9, 2008, the Ninth Circuit granted the City Attorney’s petition which allowed the Health Care Security Ordinance to go into effect on January 9, 2008, pending the City and County’s appeal of the Court’s decision. As a result of the Ninth Circuit ruling, the ESR became effective on January 9, 2008 for employers with 50 or more employees. The effective date for for-profit employers with 20-49 employees was April 1, 2008.

On February 7, 2008, the Golden Gate Restaurant Association (GGRA) filed an application to the U. S. Supreme Court, seeking to lift the Court of Appeals’ ruling.

On February 21, 2008, United States Supreme Court denied the GGRA’s application.

On April 17, 2008, Ninth Circuit heard oral arguments on the appeal. On September 30, 2008, a three-judge panel of the Ninth Circuit issued a unanimous ruling that the ESR enacted under the Ordinance was not pre-empted by federal law. The decision overturned the December 26, 2007 United States District Court decision and allowed for continued operation of the ESR.

On October 21, 2008, the GGRA filed a petition with the Ninth Circuit for “Rehearing En Banc.” The petition asks the full panel of judges in the Ninth Circuit to review the decision of the three-judge panel.

On March 9, 2009, the Ninth Circuit denied GGRA’s request for a rehearing of the three-judge panel decision that the ESR was not pre-empted by federal law.

On March 18, 2009, GGRA filed an emergency application to the U.S. Supreme Court, seeking to prevent the City and County from continuing to implement the ESR while GGRA prepared its appeal, which was due June 8, 2009.

On March 30, 2009, U.S. Supreme Court Justice Kennedy denied GGRA's emergency application and the ESR continued to be in effect.

On June 8, 2009, GGRA filed a petition with the U.S. Supreme Court requesting that the Supreme Court rule on the legality of the ESR of the Health Care Security Ordinance.

On October 5, 2009, the Supreme Court invited the U.S. Solicitor General to file a brief expressing the federal government's views on the case.

On May 28, 2010, the United States Solicitor General filed its brief to the United States Supreme Court urging the Supreme Court not to take the case. The Solicitor General stated that the U.S. Ninth Circuit Court of Appeal's ruling in favor of the City and County did not conflict with any prior ERISA preemption decision of the Supreme Court. The Solicitor General also noted that passage of federal health care reform has dramatically changed the landscape regarding health coverage, making it much less likely that state and local governments will seek to enact programs like San Francisco's, thereby rendering the ERISA preemption question presented by this case much less important.

On June 7, 2010, GGRA filed a reply to the United States Solicitor General's brief.

On June 9, 2010, the City and County of San Francisco Attorney General filed a supplemental brief in response to the United States Solicitor General's brief.

On June 28, 2010, the U.S. Supreme Court announced that it would not hear GGRA's petition. As a result, the U.S. Ninth Circuit Court of Appeal's September 30, 2008 decision upholding the Employer Spending Requirement remains in effect for all covered businesses.

III. EMPLOYER SPENDING REQUIREMENT

Pursuant to Section 14.4(h) of the Ordinance, this section provides an update on the enforcement and administration of the employer obligations under the Health Care Security Ordinance (HCSO).

The OLSE continues to respond to public inquiries regarding the Employer Spending Requirement and to review employer compliance with the ESR. The extreme uptick in the number of telephone calls and emails in April was the result of the annual mailing to employers of the Annual Reporting Forms.

Month (2010)	HCSO E-mails	HCSO Calls*
January	122	106
February	120	114
March	116	160
April	221	895
May	29	234
June (as of 6/15/10)	10	59
Total	618	1,568

**Note: Reflects unduplicated (new) calls only*

As of June 23, 2010, the OLSE had opened 330 cases. One hundred and twenty-three (123) HCSO cases (37% of total cases) have been resolved/closed by the OLSE and 207 (63% of total cases) are open. While the percentage of closed cases has increased, the number of open cases has continued to grow. Of the 207 open cases, 92 cases (44%) were initiated by worker complaints and 16 cases (8%) were audits initiated by the OLSE, after the agency received evidence that the business was either not in compliance or experiencing difficulties coming into compliance. The remaining 99 cases (48%) were initiated by employers who voluntarily contacted the OLSE to seek assistance in coming into ESR compliance.

	12/19/08	1/22/09	6/12/09	12/10/09	6/23/10
Total Cases Ever Opened	115	138	230	278	330
Closed Cases	21 (18%)	24 (17%)	43 (19%)	73 (26%)	123 (37%)
Open Cases/Backlog	94 (82%)	114 (83%)	187 (81%)	205 (74%)	207 (63%)

Source of Open Cases	94	114	187	205	207
Initiated by Worker Complaint	58 (62%)	69 (61%)	76 (41%)	80 (39%)	92 (44%)
Initiated by OLSE Audit	14 (15%)	14 (12%)	13 (7%)	17 (8%)	16 (8%)
Initiated by Voluntary Compliance	22 (23%)	31 (27%)	98 (52%)	108 (53%)	99 (48%)

OLSE has instituted efficiencies that allow the office to resolve cases where employers have requested assistance with coming into compliance with the HCSO. OLSE has also developed a standardized methodology for assessing penalties against employers that are found in violation of the law. To date, OLSE has assessed penalties in a total amount of approximately \$20,000.

The following are highlights of OLSE's analysis of the 2008 Annual Reporting Forms:

- When sorted by employer size, all categories of employers (500+ employees, 100-499 employees, 50-99 employees, 20-49 employees) report their primary method of making health care expenditures to be group health insurance. Eight-four percent of all employers report group health insurance or self-insured plans to be their primary method of making health care expenditures.
- There is a correlation between employer size and participation in the City Option (Healthy San Francisco): the larger the employer, the more likely it will enroll employees in the City Option.

Primary Expenditure Type by Business Size

(counts each employer once, in the category that they used for most employees)

Employer Size (# of employees)		Group Health Insurance	Self- Insured Plan	Health Spending Account (administered by TPA)	Direct Reimbursement by Covered Employer	City Option
Medium Employers	20-49	83%	3%	8%	3%	4%
	50-99	80%	2%	10%	2%	6%
Large Employers	100- 499	78%	9%	6%	1%	6%
	500+	44%	38%	5%	1%	12%
Total		72%	12%	7%	2%	7%

- When sorted by industry, Construction was the sector most likely to make health care expenditures through health insurance (92%). Administrative, Support, Waste Management, and Remediation Services was the sector most likely to make health care expenditures through the City Option (21%). Accommodation and Food Services was the sector most likely to make health care expenditures through a health spending account administered by a third-party administrator (42%).

Expenditure Type, by Industry

(counts each employer once, in the category that they used for most employees)

NAICS Industry Code	No. of Businesses	Group Health Insurance	Self- Insured Plan	Health Spending Acct (administered by TPA)	Direct Reimbursement by Employer	City Option
Accommodation and Food Services	152	38%	1%	42%	5%	14%
Admin, Support, Waste Management and Remediation Services	97	59%	9%	9%	2%	21%
Retail Trade	145	61%	15%	11%	5%	8%
N/A (industry code not available)	986	67%	15%	8%	1%	9%
Other	115	72%	10%	9%	3%	7%
Manufacturing	83	76%	16%	2%	6%	n/a
Wholesale Trade	73	80%	16%	n/a	n/a	4%

NAICS Industry Code	No. of Businesses	Group Health Insurance	Self-Insured Plan	Health Spending Acct (administered by TPA)	Direct Reimbursement by Employer	City Option
Information	115	80%	14%	2%	0%	4%
Finance and Insurance	92	82%	16%	1%	0%	1%
Professional, Scientific, and Technical Services	390	83%	10%	2%	2%	3%
Real Estate and Rental and Leasing	68	84%	9%	4%	2%	2%
Construction	198	92%	3%	2.0%	1%	2%

- Of employers who chose to use health spending accounts administered by third parties, 80 percent reported reimbursing 50 percent or less of the minimum expenditure required under the law. Fifty-seven percent reported reimbursing 10 percent or less than the minimum expenditure required under the law.

OLSE is currently processing the 2009 Annual Reporting Forms, which were recently submitted by employers to the office. With data from the 2008 and 2009 reporting, an analysis of trends among employer cohorts will be possible, shedding further light on employer health care spending.

In March 2010, OLSE's lead (and only full time) staffperson for HCSO education and enforcement began a one-year leave of absence. OLSE shifted staff resources and a newly hired compliance officer has been assigned to HCSO enforcement. OLSE has also received approval to backfill the vacant HCSO supervisor position. The entire OLSE staff is teaming up again this year, with the help of a summer intern from UC Berkeley, to process and analyze the annual reporting forms.

In the academic spring semester (January to May 2010), the OLSE worked with a student from UC Berkeley's Goldman School of Public Policy to determine whether Health Reimbursement Accounts (HRAs), one of the options employers may choose to satisfy the Employer Spending Requirement, adequately meet the goal of providing reasonable access to health care to those who work in San Francisco. OLSE anticipates that this report will be released shortly.

IV. HEALTHY SAN FRANCISCO

This section provides a summary of Healthy San Francisco and Medical Reimbursement Account components of the Health Care Security Ordinance. The Department of Public Health (DPH) is responsible for implementing and administering these components.

A. Major Activities since Submission of July 2009 Status Report

Since the January 2010 status report to the Board of Supervisors, DPH has:

1. Reached enrollment of over 53,000 uninsured San Francisco adult residents into Healthy San Francisco. Based on an estimated 60,000 uninsured adults, to date, the program has enrolled 88% of the population.
2. Entered into discussions and negotiations with other non-profit providers for their potential participation in the Healthy San Francisco provider network.
3. Completed several secondary and primary data gathering components of an independent program evaluation.
4. Developed, issued and distributed new program materials in response to data revealed by the August 2009 Kaiser Family Foundation independent *Survey of Healthy San Francisco Participants*.
5. Collaborated with the San Francisco Health Plan and St. Francis Hospital to launch a Patient Navigator Pilot.
6. Retained the assistance of a graduate student from the University of California at Berkeley, Goldman School for Public Policy to develop a policy brief on lessons learned from the development, planning and implementation of Healthy San Francisco.

B. Healthy San Francisco Enrollment

As of late June 2010, there were 53,294 participant residents enrolled in HSF. This represents 89% of the estimated number of uninsured adults (60,000). The estimated number of uninsured is taken from data in the 2007 California Health Interview Survey which estimated 60,000 uninsured adults residing in San Francisco. Because HSF is a voluntary program, it is not anticipated that all uninsured residents will elect to enroll. As a result, the number of participants will be less than the number of uninsured adults.

The following chart provides basic demographic information based on the participants:

Age	10% are 18 - 24; 42% are 25 - 44; 24% are 45 - 54; 24% are 55 - 64
Ethnicity	38% Asian/Pacific Islander; 24% Latino; 20% Caucasian; 9% African-American, 3% Other; less than 1% Native American; 5% Not Provided
Gender	47% female; 53% male
Income	69% at/below 100% FPL; 23% between 101 – 200% FPL; 7% between 201 – 300% FPL; 1% at/above 301% FPL
Language	53% English; 26% Cantonese/Mandarin; 18% Spanish; 1% Filipino (Tagalog and Ilocano); 2% Other

Twenty-six percent (26%) of Healthy San Francisco participants reside in the Excelsior or Mission districts. Homeless individuals comprise 14% of all HSF participants.

The HSF program has expanded access to care. The program routinely collects information on whether participants are existing clients or are new to the health care delivery system. Obtaining this information has been helpful in ascertaining the extent to which HSF serves an uninsured population that previously did not seek or receive services. To date, 20% of all those enrolled were not previous users of the health care delivery system (i.e., “new” -- defined as an individual who indicates that they have not received clinical services from the primary care medical home they selected within the last two years). The remaining 80% of program participants are existing patients.

Providing program participants with a primary care medical home is a principal feature of HSF. The program is premised on the notion that primary care settings provide a more efficient mechanism to deliver preventive and primary care services, conduct disease management, and coordinate care across providers and service settings. HSF has five primary care medical home delivery systems. As of late June 2010, the distribution of participants across these systems is as follows:

- Chinese Community Health Care Association – 2.01% (1,072 participants)
- Department of Public Health – 48.30% (25,737 participants)
- Kaiser Permanente – 5.09% (2,712 participants)
- San Francisco Community Clinic Consortium – 42.83% (21,139 participants)
- Sister Mary Philippa Health Center – 2.22% (1,184 participants)

The Department regularly monitors and analyzes participant disenrollments from HSF. Disenrollments can occur because participants no longer meet the program eligibility criteria, no longer choose to remain in the program and voluntarily disenroll, do not pay the required quarterly participation fee, etc. Individuals who are disenrolled from the program have the option to re-enroll at any time.

In the area of disenrollment, DPH continues to focus its efforts on reducing the number of HSF participants who fail to renew in the program before their annual eligibility period ends. In late June 2010, 64% of all disenrollments were due to incomplete annual renewals. Approximately 77% of the individuals disenrolled for not completing the annual renewal process had annual incomes at or below 100% of the Federal Poverty Level. Individuals at this income level pay no participation fees or point-of-service fees (with the exception of fees for emergency care, when appropriate). As a result, there should be no financial barriers to their program renewal. This fiscal year, DPH augmented its renewal activities by: (1) instituting an automated telephone call reminding participants to renew on time, (2) including renewal reminders in each issue of Heart Beat, the HSF participant newsletter and (3) launching a renewal lottery incentive program. These activities are done in addition to the mailed renewal notices (90, 60, and 30 days prior to the end of their annual term) that participants receive.

Individuals who are disenrolled from the program can re-enroll at any time, if eligible. The Department tracks the enrollment history of participants to determine enrollment patterns. Re-enrollment into the program can be viewed as an indicator of continued interest in and value of the program to participants. As of late June 2010, there were 11,964 individuals who had voluntarily elected to re-enroll in the program after being disenrolled and were current HSF participants again. The data notes that the majority of the re-enrollments (81%) occur for those individuals who were originally disenrolled because they did not complete their annual renewal on time.

C. Provider Network Expansion

The Department continues to engage with private (non-profit and for-profit) providers about participating in the Healthy San Francisco provider network. Interest has been expressed by some of these providers and the Department is working with each to determine the scope of Healthy San Francisco services that would be provided by any one of the delivery systems. It is anticipated that expansion of the provider network will occur during fiscal year 2010-11.

The Department views expansion of the network as a two-pronged strategy. First, it helps ensure continued appropriate access to care as the number of participants in the program increases. Second, it will offer those private (non-profit and for-profit) providers with limited experience serving low-income and moderate income uninsured individuals more of an opportunity to serve this population which will be beneficial to them as the nation prepares to expand health insurance to uninsured residents under federal Health Reform.

D. Evaluation

As noted in the July 2009 report, DPH selected Mathematica Policy Research, Inc. to conduct the independent program evaluation. Since the January 2010 report, the following evaluation activities have occurred:

- Mathematica conducted the second round of in-depth stakeholder interviews in February 2010 with Department and non-profit providers, funders and other key entities.
- Mathematica developed and fielded the Healthy San Francisco provider survey designed to obtain valuable feedback from those of you delivering services to HSF participants in the medical home setting. The survey was in the field during the months of May and June 2010.

E. Survey of Healthy San Francisco Participants

As reported in the January 2010 report, results from the by Kaiser Family Foundation funded and administered Healthy San Francisco participant survey were released. While the survey findings were quite promising, at the same time, because HSF was still relatively new at the time the survey was administered, there were some challenges that survey respondents identified which are more reflective of the start-up nature of the program. Specifically:

- Some program awareness/education challenges (e.g., not health insurance, services only in San Francisco, annual program renewal) for those in fair or poor health and those with lower levels of education.
- Non-English speakers report slightly more challenges with the enrollment process and written materials.
- Participants made recommendations on program improvements, most notably streamlining the medical appointment process to further ensure access to care.

To help address issues related to program awareness and understanding of the program among participants, the Department developed a Healthy San Francisco “Next Steps” tool for both application assistors and participants. The purpose of the “Next Steps” document is to improve understanding of the program among newly enrolled participants as it relates service coverage, payments, included services, and other key information. The document is distributed to all new, renewing, re-enrolling participants. Assistors explain the document’s content to participants and note the medical home and re-enrollment date prior to handing it to the newly enrolled participant. The document is in three languages: English, Chinese and Spanish.

F. Patient Navigator Pilot

The Patient Navigator Pilot is a partnership between the Department of Public Health, St. Francis Hospital, participating Healthy San Francisco medical homes and San Francisco Health Plan to conduct on-site patient navigation (non-medical) at St. Francis Hospital. The goals of the program include reducing avoidable emergency services use and linking patients with a medical home provider upon hospital discharge. The pilot launched in May 2010.

G. Policy Brief: Lessons from Healthy San Francisco

The Department retained a graduate student from the University of California at Berkeley, Goldman School for Public Policy to develop a policy brief on lessons learned from the development, planning and implementation of Healthy San Francisco. The policy brief components were to:

- Describe key implementation and design features that have contributed to the program’s success.
- Outline key features of the political and fiscal environment in the City and County of San Francisco that have contributed to the program’s success.
- Understand the smart practices and transferability literature
- Determine which program components (e.g., eligibility, policies, scope of services, structure, etc.) were transferable to other communities.

The policy brief notes that Healthy San Francisco offers a model for improving access and the delivery of care to low-income uninsured individuals through the health care safety net. San Francisco’s experience illuminates three important ways of strengthening the local health system:

- the program created a simpler, more transparent system of care to reduce barriers to needed services (“patient-centered reform”),

- the program restructured the county indigent health system to emphasize preventive care and continuity in primary care, rather than costly episodic and emergency care (“delivery system reform”) and
- the program expanded access to care to all uninsured adult residents of San Francisco (“coverage expansion”).

The policy brief notes that policymakers will need to decide which of these health reforms is most important to pursue based on the local health needs, political will and resources of their communities. It describes the essential design functions and features of Healthy San Francisco that achieve each type of reform:

Patient-centered reform

1. *By providing information and materials to facilitate program participation, communities can reduce difficulties patients experience in accessing services and create a sense of membership in an organized health care program that is less likely be perceived as charity care by participants.* Program materials may take a variety of forms, including a program website, enrollment identification cards, a participant handbook, preventive health care mailers, educational materials, newsletters, renewal reminder notices, etc.
2. *Offering customer service for personal inquiries and complaints is a simple but important way to help safety net users navigate the health delivery system.* Similarly, health insurance exchanges will be required to maintain a call center for customer service under the new health reform law.
3. *Participation fees should be both predictable and affordable to reduce anxiety about the cost of care and to provide incentives for appropriate utilization of primary and preventive health care services.* The fee structure should be within recognized health care affordability standards, and it should be evaluated regularly to ensure individual contributions do not impede access to care for the near-poor population.
4. *A single, streamlined eligibility determination and enrollment system for multiple health programs simplifies the screening and enrollment process, maximizes access to public funding streams and creates a comprehensive database for planning and evaluation.* This is also a stated goal of the reform legislation.

Delivery system reform

5. *Although insurance coverage is preferable, an access model provides an affordable alternative to health insurance and allows counties to continue to leverage state and federal funds to support the uninsured.*
6. *Assigning participants to a primary care medical home reduces duplication and improves care coordination.* As opposed to a crisis delivery approach, the medical home model provides a more appropriate setting for delivering routine

primary and preventive care services, managing chronic conditions and coordinating access to care across providers and service settings.

7. *Cooperation between public and private providers maximizes available resources to care for the uninsured.* To start, communities should integrate existing public and non-profit/private providers serving the safety net population into a coordinated health network. Bringing relevant entities, including public hospitals and clinics, community-based groups, charitable hospitals, physicians organizations and others, into the program's planning process increases buy-in.
8. *An organized health delivery system provides a better framework for monitoring patterns of care and identifying opportunities for improving access and quality.* To assess areas for clinical and administrative improvement, safety net programs should examine utilization patterns, access and clinical data for participants and compare performance to recognized quality standards.

Coverage expansion

9. *Through a shared responsibility approach, communities can achieve a sustainable funding base for expanding access to care.*

The policy brief further notes that underlying San Francisco's health reforms is a set of conditions and circumstances, which made reform achievable at the local level. In addition to the political support for comprehensive reform, San Francisco had the advantages of a strong existing public health infrastructure, a unified local government and critical administrative partners. These factors both shaped and supported the policy development of the city's health care law. Finally, it notes that while many of San Francisco's reforms can be adopted in other jurisdictions, each policy will necessarily look different depending on the local context.

The report was finalized in May 2010 and was posted on the HSF website at: http://healthysanfrancisco.org/files/PDF/Lessons_From_Healthy_San_Francisco.pdf.

H. Employer Selection of City Option to Meet Employer Spending Requirement

San Francisco employers are selecting the City Option to meet the Employer Spending Requirement (ESR) of the Health Care Security Ordinance. When an employer chooses the City Option, their employees will receive either Healthy San Francisco or a Medical Reimbursement Account depending upon the employee's eligibility.

If the employee is eligible for HSF, the employee will be notified and must complete the HSF application process to get enrolled in the program. An employer does not enroll an employee into HSF. If the employee is ineligible for HSF, then they will be given a Medical Reimbursement Account (MRA). All funds contributed on the employee's behalf by the employer are deposited into this account and the employee can access these funds to reimburse for out-of-pocket health care expenses.

Since implementation of the ESR (January 2008) to end of May 2010, 1,118 employers had elected to use the City Option. These employers have committed \$79,560 million on behalf of 55,125 employees (eligible for either HSF or MRA). Of that amount, roughly half (46%) is for employees are potentially eligible for HSF (\$36,762 million) and the other half (54%) are potentially eligible for MRA (\$42,798 million). Of the total funds committed by employers, \$78,923 million in health care expenditures (99%) have been collected to date.

Employer payments are submitted to the HSF Third-Party Administrator (the San Francisco Health Plan) for processing. The Third-Party Administrator transfers the Healthy San Francisco component of the employer payments to DPH on a periodic basis. DPH then submits these funds to the City Controller's Office for processing and deposit. In accordance with the Health Care Security Ordinance, those funds are used for the HSF program. To date, \$38.58 million in funds have been transferred from the Third-Party Administrator to the City and County of San Francisco. The amount transferred includes any employer contributions and HSF program participation fees paid by enrollees on a quarterly basis.

Employer health care expenditures designated for a Medical Reimbursement Account are not transferred to the City and County of San Francisco. Participant eligibility and contribution information is forwarded to the Medical Reimbursement Account vendor and accounts are created for each employee to use for reimbursable health care expenses. Funds are transferred weekly to the MRA vendor for claims and monthly for administrative fees.

V. FEDERAL HEALTH REFORM AND HEALTH CARE SECURITY ORDINANCE

In March 2010, President Obama signed H.R. 3590, the Patient Protection and Affordable Care Act, and H.R. 4872, the Health Care and Education Reconciliation Act of 2010. These bills make historic changes to the U.S. health care system and are referred to herein together as “Health Reform.”

Health Reform is projected to insure 32 million people who are uninsured today, of which 7.3 million are uninsured Californians. Ultimately, 92 percent of U.S. residents will have health insurance by 2016.

U.S. citizens and legal residents will be required to have health insurance. To help individuals meet that requirement, Health Reform expands eligibility for Medicaid, creates health insurance exchanges to allow individuals and small businesses to purchase coverage, and creates new requirements for private health insurance providers to make health insurance more accessible and affordable. Health Reform makes a number of tax changes and includes cost containment measures as well as provisions to improve quality and performance. In addition, Health Reform makes investments in public health, including prevention and wellness programs, and the healthcare workforce.

Within the framework for Health Reform, there lies ahead a significant amount of work on interpretation and implementation that must be accomplished at the federal and state levels. For that reason, it is too early to state with any certainty or specificity what impact these reforms will have on San Francisco. However, Health Reform will have a potential impact on aspects of the Health Care Security Ordinance. But, the impact would likely not occur until 2014 when the major components of Health Reform become effective.

A. Employer Spending Requirement (ESR)

The Employer Spending Requirement (ESR) and Health Reform share a similar objective; namely, to ensure that employers provide health benefits to their employees. However, each provision approaches this common goal differently with respect to employer obligation, business size, covered employee and employer expenditure.

Health Reform is narrower in its intent and impact than ESR. The significant differences between Health Reform and ESR are:

1. Health Reform does not create an employer mandate, while ESR is an employer mandate.
2. Health Reform applies to a smaller number of employers (i.e., size of business based on number of employees) and employees (i.e., eligible employees based on hours worked) than ESR.

The chart on the following page provides a side-by-side comparison of both pieces of legislation.

Health Reform and ESR -- Side-By-Side Comparison of Major Provisions

Legislation	Employer Mandate	Business Size	Eligible Employees	Employer Expenditure/Penalty
CCSF Employer Spending Requirement	Yes. Mandated provision to make health care expenditures.	<ul style="list-style-type: none"> • All for-profit businesses with 20+ employees • All non-profit businesses with 50+ employees 	At least 8 hours per week (after 90 days of work); includes seasonal workers	<ul style="list-style-type: none"> • Amount based on formula (size of employer and annual expenditure rate). • For 2010, \$1.31 for medium sized (20 -99) and \$1.96 for large sized (100+). • Adjusted annually.
Federal Health Care and Education Reconciliation of 2010	<p>No. Provision of health coverage or payment of assessed fee.</p> <p>Note: Employers with 200 or more employees must automatically enroll employee into insurance plan.</p>	All businesses with 50+ employees	Full-time employees (30 hours a week; excludes seasonal workers)	<ul style="list-style-type: none"> • If employer does not offer health insurance and at least one employee is in Exchange, annual penalty is \$2,000 per full-time employee (excluding first 30 employees). • If employer does offer health insurance and at least one employee is in Exchange, pay lesser of \$3,000 per employee in Exchange or \$2,000 per full-time employee. • Employees with 50 or fewer employees are exempt from penalties. • Penalty limit • Penalty amounts indexed after 2014.

The assessment to date is that the ESR will remain in effect under Health Reform. The City and County (City Attorney Office, Office of Labor Standard Enforcement or Department of Public Health) is aware of no language in Health Reform which suggests an intent by the federal government to interfere with San Francisco's ESR. Although the City Attorney's Office is analyzing Health Reform in more detail, the City and County will operate under the assumption that it remains fully authorized to operate the ESR. As noted above, the federal employer requirement does not take effect until 2014. To the extent any inconsistency may arise in the implementation of Health Reform and ESR, these can presumably be addressed with federal or local regulation between now and 2014.

B. Healthy San Francisco (HSF)

Full implementation of the Health Reform (after 2014) will decrease the number of adults San Francisco residents eligible for and enrolled in HSF by an estimated 60%. However, because the major health insurance expansion components of the Health Reform do not take effect until January 2014, DPH does not anticipate an immediate or significant reduction in HSF enrollment or HSF General Fund expenditures at this time.

In addition, the HSF program will still be needed after Health Reform is fully implemented.

Health Reform is beneficial to San Francisco on two fronts:

1. Health Reform provides health insurance opportunities for uninsured some HSF participants. Health insurance is preferable to HSF.
2. Some health care services costs now incurred by the City and County's General Fund for the HSF program will be funded by federal/state funds post 2014.

At the same time, full implementation of Health Reform (post 2014) will not dismantle HSF. The City and County will still need to maintain and operate the HSF program, albeit serving fewer people. The HSF program will continue because:

1. Health Reform does not cover all uninsured individuals (e.g., those with exemptions).
2. While Health Reform creates an individual mandate for health insurance, it is unlikely that all uninsured individuals will comply with this mandate. Some uninsured individuals may elect not to enroll in the subsidized health insurance exchanges or purchase private insurance for various reasons (e.g., financial, inability to complete paperwork, etc.). Financially, some may decide that the cost of getting health insurance through the exchange is more than the combined cost of participating in HSF and paying the penalty for not having health insurance.
3. Some individuals may be unable to provide sufficient documentation of public health insurance eligibility, etc.

Because HSF is not health insurance, it could not be a health insurance product in any health exchange established by the State nor does enrollment in HSF meet the individual health insurance mandate. The Department of Public Health is not recommending that HSF be converted to a health insurance plan or product. Over the course of next three years, the Department will re-examine key features of the HSF program (eligibility, fee/subsidy structure, network, etc.) to determine if changes are needed as components of the Health Reform legislation are implemented.

In many respects, implementation of Healthy San Francisco and the Department's participation in the Health Care Coverage Initiative will help prepare San Francisco's uninsured residents and providers for Health Reform. For example through HSF, the Department has:

- Created a single, streamlined eligibility determination and enrollment for multiple health programs – a stated goal in the Health Reform legislation
- Expanded the network of providers serving uninsured residents – this has been critical to ensuring access and combating preconceived notions related to serving uninsured persons
- Promoted the use of primary care medical homes – critical to reducing episodic care
- Data identifying uninsured adults that are potentially eligible for Medi-Cal – this will enable the City and County to work effectively and efficiently to assist individuals in the Medi-Cal application process.