HMA

HEALTH MANAGEMENT ASSOCIATES

Addressing Affordability of Health Insurance in San Francisco

Technical Report

PRESENTED TO

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

Research and Consulting in the Fields of Health and Human Services Policy, Health Economics and Finance, Program Evaluation, Data Analysis, and Health System Restructuring

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Executive Summary

The San Francisco Department of Public Health (SFDPH) retained Health Management Associates (HMA) through funding from the California Health Care Foundation to develop a set of options and recommendations for administering a Public Benefit Program (PBP) to support the affordable purchase of health insurance for San Franciscans whose employers make health care expenditures under the Health Care Security Ordinance. The recommendations presented in this report are informed by estimates of the potentially eligible population, take-up, and analyses of health insurance affordability conducted by the University of California, Berkeley Center for Labor Research and Education (UCB-CLRE).

The Need for a Public Benefit Program for San Franciscans

San Franciscans currently benefit from the Health Care Security Ordinance (HCSO), which obligates certain employers to make health care expenditures on behalf of employees working eight hours or more per week. The HCSO was passed by the San Francisco Board of Supervisors in 2006 and established employer responsibilities for contributing toward employee health care costs. Among the options available to employers to meet their HCSO Employer Spending Requirement (ESR) is the City Option. Many employers who do not provide health insurance or offer private health reimbursement accounts choose to meet their ESR requirement by making contributions to the City Option, administered by SFDPH.

The City Option connects employees with access to health care or the means to pay for health care expenses. The City Option consists of two components, Healthy San Francisco and a Medical Reimbursement Account (City MRA) program. Healthy San Francisco is a health care access program designed to make health care services available and affordable to uninsured San Francisco residents. City MRAs are used to pay for eligible health care expenses incurred by the employee, the employee's spouse or domestic partner, or the employee's dependents. Employees in the City Option receive a City MRA if they are ineligible for Healthy San Francisco. However, even among those San Francisco residents who have the City MRA, an estimated 5,200 remain uninsured and are vulnerable to the high costs of healthcare.

The higher cost of living in San Francisco poses a significant barrier to the affordability of health insurance. It is estimated that for San Francisco residents, the calculated poverty threshold is 59% above the federal poverty threshold, meaning that 100% of the Federal Poverty Level (of FPL) for the nation as a whole equates to 159% of FPL in San Francisco.[1] Using this cost of living adjustment, the affordability thresholds in the ACA can be translated as follows for San Francisco: a San Franciscan making up to 219% of FPL is the equivalent of someone elsewhere making up to 138% of FPL, the threshold for receiving completely free care (via Medicaid). In San Francisco, income between 220% and 635% of FPL is equivalent to income between 138% and 399% of FPL elsewhere. Households between 138% and 399% of FPL nationwide pay a maximum of between 3% and 9.5% of their income on Covered California

[1] Sarah Bohn, Caroline Danielson, Matt Levin, Marybeth Mattingly, and Christopher Wimer. "The California Poverty Measure: A New Look at the Social Safety Net." Public Policy Institute of California, October 2013. See especially table B1 in the technical appendix. http://www.ppic.org/main/publication.asp?i=1070

premiums under the ACA and, if otherwise eligible, receive federal Advance Premium Tax Credits (APTCs) to help pay their health insurance premiums. In addition, under the ACA, Cost-sharing Reductions (CSRs) are available to assist with the out-of-pocket expenses incurred for services provided by Qualified Health Plans (QHPs) for those earning up to 250% of FPL, the equivalent of 396% of FPL in San Francisco.

In combination with other data, these adjusted measures of poverty suggest that lower-income San Franciscans may require assistance beyond the federal APTCs and CSRs offered for eligible enrollees in Covered California to purchase health insurance within their household budgets. The goal of a Public Benefit Program in San Francisco is to provide this additional assistance.

Defining Program Assistance

SFDPH identifies those potentially eligible for the PBP as low- to-modest income San Francisco residents who are eligible to purchase health insurance through Covered California and whose employers make an ESR contribution to the City Option. The bounds of eligibility would be informed by the relative affordability of health insurance for San Francisco residents, as demonstrated by UCB-CLRE's analysis (see Appendix VI for detailed information on the UCB-CLRE analysis on health insurance affordability.)

In designing the level of assistance to provide under the PBP, SFDPH must take into account a number of factors, including (1) how to maximize the affordability of health insurance for the greatest number of eligible San Franciscans, (2) how to ensure equity in terms of the current value of the City MRA versus the value of the assistance in the PBP and the availability of federal subsidies, and (3) how to minimize the complexity of the benefit so that program participants will understand it and enrollment assisters can accurately enroll participants in the program. There are innumerable ways to structure the PBP assistance and very limited programs of similar size and scope from which to glean best practices in assistance design. Therefore, HMA prepared the following assistance design scenarios, applying the criteria enumerated above, to reveal the tradeoffs among designs:

1. Premium assistance only, on a two-tiered scale. People under 400% of FPL would receive a 100% premium subsidy, based on the premium of the second-lowest cost silver plan, while those between 400% and 500% of FPL would receive a 40% premium subsidy.
2. Premium assistance at 80%. In this scenario, all eligible participants would receive 80% assistance based on the premium cost of the second-lowest cost silver plan so that they would be responsible for only 20% of the premium cost.
3. Premium assistance at 60% plus cost-sharing. Here, the PBP would offer a 60% premium subsidy for all eligible groups, based on the cost of the second-lowest cost silver plan. The PBP would also offer cost-sharing assistance to address underinsurance by bringing down the beneficiary's cost of the silver plan deductible to 5% of income.

It should be noted that if each design option is to bridge affordability gaps for San Franciscans, PBP-eligible participants would experience some benefit shifts compared to what they receive under a current City MRA. The UCB-CLRE provided detailed analyses of each of the above assistance designs and provided expected take-up rates and assistance costs for each design (see Appendix VI).

HMA also highlighted additional important considerations when determining the level of assistance. For example, SFDPH will need to consider balancing the program assistance to avoid "crowd-out," or the possibility that employers will drop employer-sponsored insurance so that employees get coverage through the PBP.

Administrative Structure Options

In addition to reviewing program assistance designs, HMA also evaluated options for the administrative structure of the PBP. The review of potential structures to administer the PBP was informed by a review of existing premium and cost-sharing assistance programs, interviews with Covered California Qualified Health Plans (QHPs) serving San Francisco and with Covered California staff, and findings from focus groups with HCSO employers and employees. HMA also obtained information from SFDPH pertaining to its current administration of the City MRA.

HMA identified a number of options for premium and cost-sharing assistance administration and eliminated some of the options because of significant operational barriers that would result in prohibitive administrative costs and an unworkable implementation timeline. Additionally, some options were identified as infeasible by Covered California or the QHP issuers HMA consulted. For example, Covered California indicated that, given statewide mandates and resulting system limitations, the Exchange would be unable to explore a potential partnership for San Francisco's PBP until 2017, at the earliest. In addition, QHP issuers indicated that they would be unable to accept multiple forms of payment for a QHP enrollee, given that they are already combining APTC payments from the federal government with enrollee premium payments.

The options chosen for further analysis are the following:

Premium Assistance Options

1. Premium Payments to all San Francisco QHP Issuers via a Third Party Administrator (TPA). SFDPH would utilize a TPA to administer premium assistance payments to QHP issuers selected by program participants. The TPA would bill program participants for their share of premium, if any, and aggregate the participant payment with the San Francisco PBP assistance payment and pay each plan on a monthly basis for each participant.

2. Contract with a Single QHP Issuer to Offer One or More Designated Plans. SFDPH would contract with a single QHP issuer to offer either a single plan established specifically for program participants, or to offer a selection of all of its Covered California plans.

3. Medical Reimbursement Account. SFDPH would leverage its existing City Option infrastructure or contract with a new TPA to implement a MRA for program participants. This reimbursement account could be limited in scope to allow reimbursement for only premium payments and eligible cost-sharing expenses.

4. Debit Card for 100% Premium Assistance and MRA for Less than 100% Premium Assistance. SFDPH would implement a debit card program under the City Option to provide program participants with a debit card as a vehicle for providing premium assistance. The debit card account could have a credit limit for the amount of premium assistance provided. A debit card for premium assistance would be feasible only if the premium assistance covered 100% of the participant's premium because QHP issuers cannot currently accept more than one form of

payment from an enrollee for a given month's premium. For those program participants who are receiving less than 100% premium assistance or who enroll in a family plan, a MRA would be provided so that the program participant could seek reimbursement for premium costs the enrollee would pay upfront.

Cost-Sharing Assistance Options

1. Supplemental Payments. SFDPH would utilize a TPA to pay claims for cost-sharing and out-of-pocket costs incurred by program participants up to a cap per participant. The TPA would need the capability to receive and pay claims and reimburse QHP issuers for out-of-pocket expenditures incurred by program participants.
2. Debit Card. SFDPH would utilize a TPA to provide debit cards to program participants to pay for their out-of-pocket expenditures. This assistance could be combined with premium assistance to allow the participant to utilize one debit card to make both kinds of payments.
3. Medical Reimbursement Account. Similar to the MRA for premium assistance, the existing City MRA infrastructure could be utilized to provide cost-sharing assistance to program participants under this new benefit program, or SFDPH could contract with a new TPA to carry out this work.

Evaluation Criteria

HMA used a number of criteria to evaluate these options including the extent to which each option:

- *Minimizes legal and regulatory barriers*, such as ensuring that the assistance design is consistent with Covered California standardized benefit designs and federal guidance on premium assistance.
- *Minimizes the time to implementation*, allowing SFDPH to begin enrolling program participants for the 2016 Covered California plan year.
- *Maximizes operational feasibility* for QHP issuers, such that they can easily comply with the program.
- *Minimizes the cost to administer* the program to maximize the amount of assistance provided.
- *Maximizes program take-up and ease of use*, ensuring employees and employers can participate.

Administrative Structure Recommendations

Based on this analysis, HMA recommends that SFDPH implement the new Public Benefit Program through both a combination of debit MasterCard and MRAs or via a MRA for all program participants. In terms of cost-sharing assistance, debit cards would be the easiest to use from the perspective of program participants because they allow participants to pay directly from a pool of available funds rather than seek reimbursement, but there are additional administrative expenses associated with mailing of the debit cards to participants, which should be considered.

HMA recommends that SFDPH administer the program within its City Option program to leverage the existing employer contribution intake process as well as the services already in place under the current City Option program. We estimate that implementation of the new program could require as long as six months.

Program Revenues and Costs

HMA compared projections of the costs of administration and program assistance with the total revenue of the PBP under various scenarios. A summary of the revenues generated from the HCSO applicable to this program and the expected assistance and administrative costs is provided in Table I below.

Table I: Projected Program Revenues and Costs over a Five Year Period[23]

Year	Projected Take-up	Projected Annual Employer Contributions	Projected Assistance Costs (average across three design options)	Projected Administrative Costs for MRA Option (under City Option TPA)
2016	3,770	$10,520,000	$9,205,333	$986,000
2017	4,425	$12,525,000	11,246,666	$921,000
2018	5,080	$14,530,000	$13,288,000	$987,000
2019	5,195	$15,465,000	$14,545,000	$1,009,000
2020	5,310	$16,400,000	$15,802,000	$1,021,000

Applicability to Other Counties

As part of this analysis, HMA assessed whether particular administrative structures and approaches would be applicable to other counties that are interested in implementing a program to address the affordability of health insurance for their residents. San Francisco has a unique set of circumstances in that it benefits from its existing HCSO as well as the established City Option administrative structure. However, other counties seeking to lower uncompensated care costs or to increase insurance coverage could apply findings and lessons learned from San Francisco in establishing their own programs to provide assistance to residents purchasing on Covered California. Among the analyses other counties would need to undertake to implement such a program are identification of a funding source, development of an assistance design and administrative structure, and an analysis of the county's context in terms of Medicaid coverage and the commercial insurance market.

The recommendations set forth in this report aim to take advantage of San Francisco's existing funding stream and TPA resources to establish this new program in time for the upcoming 2016 plan year. While each county interested in creating an insurance affordability program would need to consider its own specific circumstances when selecting a programmatic structure, the analyses presented in this report, as well as the infrastructure SFDPH ultimately selects for its program, could provide useful guidance and lessons for moving forward.

[2] Based on estimated take-up of the program under Option 2 – 80% premium assistance.

[3] The values for take-up and employer contributions for 2017 and 2019 were calculated by taking the average of the prior and following years as provided by UCB-CLRE.

Introduction

Health Management Associates (HMA) has been retained by the San Francisco Department of Public Health (SFDPH) through funding from the California Health Care Foundation to assist with the development of a Public Benefit Program (PBP) for eligible San Francisco residents, with the goal of increasing the affordability of health insurance. This report outlines options to provide premium assistance and/or cost-sharing assistance to help eligible San Francisco residents who receive employer contributions to the City Option under San Francisco's Health Care Security Ordinance (HCSO) and are eligible to purchase health insurance from Qualified Health Plans (QHP) through Covered California. The creation of a PBP would provide eligible city residents with additional premium subsidies beyond the Covered California Advanced Premium Tax Credits (APTCs) and Cost-sharing Reductions (CSRs). This additional assistance would lower barriers to purchasing a QHP through Covered California initially and to maintaining health insurance coverage over the long term. The program could also provide assistance for out-of-pocket costs associated with obtaining health care.

HMA undertook two tasks to support an examination of a Public Benefit Program to be developed by SFDPH.

Task One includes an analysis and recommendations of five potential administrative structures for the City/County of San Francisco's consideration. The five pre-identified models are:

1. A Covered California "wrap": SFDPH would work with Covered California and QHP issuers to create a public benefit pilot "wrap" program for local entities. Such a program could be replicated in other counties interested in premium assistance for their indigent populations.
2. Covered San Francisco, as envisioned in legislation proposed in April 2014: SFDPH would provide financial assistance to eligible participants to offset a portion of the cost of health insurance purchased through Covered California.
3. Prospective payments/grants to QHP issuers: SFDPH would make quarterly prospective payments to each QHP to cover the costs of program participants choosing that plan; a reconciliation process would also occur quarterly.
4. Voucher program: SFDPH would provide plan enrollees with payment vouchers in the amount of their qualified public benefit, to lower the premium amount. The voucher would be remitted with plan premiums. QHP issuers would submit the vouchers to SFDPH for payment.
5. Premium assistance through non-profit foundations: SFDPH would provide money to a local or statewide non-profit foundation, which would administer assistance based on specified eligibility criteria.

HMA assesses the viability of each approach and makes recommendations based on an assessment of the ability to implement and sustain each proposed model. HMA has also reviewed additional options based on existing premium assistance programs implemented by states, counties, or other entities. HMA evaluated each approach applying relevant state and federal regulations, practices, and research necessary to determine if the approach was scalable and could be implemented within the City/County of San Francisco.

The work on Task Two activities was shared with the University of California-Berkeley Center for Labor Research and Education, (UCB-CLRE) a project partner that was tasked by SFDPH and CHCF with identifying the eligible population and estimating enrollment for the PBP program. Their analysis used the California Simulation of Insurance Markets (CalSIM) model developed by the UCB-CLRE, with their colleagues at the UCLA Center for Health Policy Research, and included:

- Anticipated trends (1, 3 and 5 years) in health care costs in San Francisco (per-person QHP premiums and out-of-pocket costs) and estimated number of people eligible.
- Analysis of health care affordability, including cost-of-living analysis, for San Franciscans in households with incomes between 138% and 635% of the Federal Poverty Level (of FPL).
- Profile of the population covered by the HCSO City Option, including key characteristics related to eligibility, take-up rates and costs (e.g., income, age, employer size, and work status) and anticipated enrollment/program participation over 1, 3, and 5 years.
- Analysis of impact on program design options on affordability, take-up rates, and program enrollment, including impact on the number of insured and uninsured.

To conduct an analysis of assistance design options for the PBP, HMA utilized the program enrollment estimates and program uptake projections provided by the UCB-CLRE as well as research on other existing premium and cost-sharing assistance programs. In the development of administrative structure recommendations, HMA conducted research with QHP issuers, Covered California, the California Department of Health Care Services (DHCS), and Service Employees International Union (SEIU), which operates the Oregon Home Care Workers premium and cost-sharing assistance program for their membership.

HMA maintained an iterative process with SFDPH, the UCB-CLRE, and the CHCF throughout the project. HMA included all project partners in bi-weekly project update meetings and at various joint application design (JAD) meetings. Topics considered throughout the project included:

- Consulting with SFDPH in the design and development of stakeholder focus groups to inform the project analysis and public debate
- Pros and cons of each potential program structure, including state and federal policies that facilitate or act as barriers, financial and operational feasibility, potential impacts, and applicability/scalability
- Recommendations of option(s) based on the application of feasibility criteria, including rationale/explanations for recommendations and why some options should be/were ruled out

Background

San Francisco's Health Care Security Ordinance and the City Option

San Francisco's landmark HCSO was enacted in 2007 and, in addition to creating the Healthy San Francisco Program, the HCSO established employer responsibilities for employees' health care costs. Employers that do not offer an employer-sponsored plan must contribute in other ways. Effective in

2008, the HCSO Employer Spending Requirement (ESR) obligates all for-profit San Francisco employers with 20 or more employees to make health care expenditures on behalf of employees working eight or more hours per week. Non-profit employers with 50 or more employees are also subject to the ESR. See Table 1 below for 2015 expenditure rates.

Table 1: HCSO Employer Expenditure Rates

2015 Hourly Employer Expenditure Rates by Business Size	
20-99 Employees	$1.65 per hour worked per employee
100 + Employees	$2.48 per hour worked per employee

Employers generally comply with the ESR through one, or a combination, of the following methods:

- Provide employer-sponsored health insurance. In 2013 (the latest data available), 90% of employers offered employer-sponsored health insurance to comply with the HCSO.
- Establish individual Health Reimbursement Accounts (HRA) in accordance with federal and local rules.
- Contribute to the City Option. Depending upon the employee's eligibility, employer contributions to the City Option either provide employees with discounted enrollment in Healthy San Francisco or with a medical reimbursement account. In 2013, 3.5% of employers complied by contributing to the City Option.

This analysis is restricted to the City Option, as the City Option is administered by and within the purview of the SFDPH. The City Option connects employees with access to health care and/or the means to pay for non-covered health care expenses. The City Option is comprised of two components, Healthy San Francisco and the City MRA.

Table 2: Components of the City Option Program

City Option Components	
Healthy San Francisco (HSF)	Healthy San Francisco is a health care access program designed to make health care services available and affordable to uninsured San Francisco residents. Healthy San Francisco Participants access primary and preventive care through their Medical Home. The program also provides access to specialty care, urgent and emergency care, laboratory services, inpatient hospitalization, radiology, and pharmaceuticals.
Medical Reimbursement Account (MRA)	A City MRA can be used for eligible health care expenses incurred by the employee, the employee's spouse or domestic partner, and the employee's dependents. Eligible expenses include: reimbursement for health insurance premiums (including health insurance purchased through Covered California), doctor office visits, dental services, vision services, and prescription and over-the-counter medicines.

Uninsured San Francisco residents whose employers pay into the City Option are automatically enrolled into Healthy San Francisco based on demographic and insurance status information provided by the employer. Employees who are San Francisco residents and have other health insurance, or those who work in San Francisco but reside outside of the city, are enrolled into a City Option MRA. Per policy changes made in 2014, Healthy San Francisco enrollees may elect to transfer their unused employer contributions to a City Option MRA. It is important to note that Healthy San Francisco is not health insurance and is accessible only within San Francisco through a closed network of providers. Healthy San Francisco does not meet the ACA requirements for minimum essential coverage.

Affordability of Health Insurance and Health Care in San Francisco

The cost of living in San Francisco has long been a challenge for many residents. Household budgets of San Francisco residents are stretched by the economic realities of life in the Bay Area. Since the 2012 economic recovery in San Francisco, housing costs have continued to rise, challenging both current and prospective residents. A recent *Huffington Post* article identified San Francisco's cost of living as the highest in the United States, and a *San Francisco Business Times* article from January 2, 2015, identified a Bay area "Middle-Class Exodus" of residents who can no longer afford to live in San Francisco.[4] Residents are faced with the daily realities of the higher cost of living, including higher expenses for food, housing, and utility expenses.

The high cost of living in San Francisco strains residents' ability to afford health care and health insurance. It is estimated that for San Francisco residents, the calculated poverty threshold is 59% above the federal poverty threshold, meaning that 100% of FPL (U.S. average) equates to 159% of FPL in San Francisco.[5] Using this cost of living adjustment, the affordability thresholds in the ACA can be translated as follows for San Francisco: a San Franciscan making up to 219% of FPL is the equivalent of someone making up to 138% of FPL (U.S. average), the threshold for receiving completely free care (via Medicaid). In San Francisco, income between 220% and 635% of FPL is equivalent to income between 138% and 399% of FPL elsewhere. Households between 138% and 399% of FPL pay a maximum of between 3% and 9.5% of their income on Covered California premiums under the ACA and if otherwise eligible, receive federal Advance Premium Tax Credits (APTCs) to help pay their health insurance premiums. In addition, under the ACA, Cost-sharing Reductions (CSRs) are available to assist with the out-of-pocket expenses under silver tier coverage for those earning up to 249% of FPL, the equivalent of 396% of FPL in San Francisco.

Graphing Covered California costs as a percent of household income effectively results in a bell curve, with individuals with incomes between 200% and 500% of FPL paying the highest amount for health care

[4] http://www.bizjournals.com/sanfrancisco/print-edition/2015/01/02/the-housing-crisis-2015-forecast.html?page=all

[5] Sarah Bohn, Caroline Danielson, Matt Levin, Marybeth Mattingly, and Christopher Wimer. "The California Poverty Measure: A New Look at the Social Safety Net." Public Policy Institute of California, October 2013. See especially table B1 in the technical appendix. http://www.ppic.org/main/publication.asp?i=1070

as a proportion of income. The combination of APTCs and CSRs substantially reduces cost burden for those under 200% of FPL, while increasing income mitigates cost burden beyond 500% of FPL.

In addition, depending on the plan selected, participants are subject to varying out-of-pocket expenses beyond premium payments for co-payments, co-insurance requirements, and deductibles. Plans purchased from the Marketplaces include an annual out-of-pocket maximum for each plan year. Annual out-of-pocket costs vary by plan and metal tier but can never exceed the maximum out-of-pocket limits set in federal regulations. For plan year 2015, out-of-pocket maximums are:

2015 Annual Maximum Out-of Pocket Costs*	
Single Self-Only Coverage $6750 (increased from $6350 in 2014)	Other than Self-Only $13,500 (increased from $12,700 in 2014)
* Annual OOP max includes amount spent on annual deductible, which varies by the plan purchased. The maximum annual medical/Rx drug deductible for a silver plan is $2,250.	

Even among those who do have insurance, out-of-pocket expenses and high deductibles can make health care unaffordable. A recent analysis found that a quarter of all non-elderly, non-poor households with only private insurance do not have the liquid assets to pay a mid-range deductible of $1,200 for a single person or $2,400 for a family. More than half of households with incomes of 100% to 250% of FPL lack the liquid assets to do so.[6] This lack of affordability can lead people to avoid or delay seeking care. Having trouble paying for health care even with health insurance is referred to as "underinsurance." The Commonwealth Fund defines underinsurance as having out-of-pocket costs (excluding premiums) that are at least 5% of household income for those under 200% of FPL, or at least 10% of household income for those above 200% of FPL, or having a deductible that is at least 5% of household income. Under this definition, taking into account the standard ACA subsidies, single individuals between 200% and 400% of FPL will face deductibles higher than the Commonwealth threshold, and individuals in all of the categories will be underinsured if they reach the out-of-pocket maximum (see Appendix V).[7]

In understanding the issue of affordability of health insurance, it is also important to consider the impact of the family group structure and how income, household composition, and cost of living affect the point at which a family is able to afford health insurance. Table 3 below provides three examples of the most common household family group compositions and the points at which insurance affordability occurs.

[6] Source: Gary Claxton, Matthew Rae, and Nirmita Panchal. "Consumer Assets and Patient Cost Sharing." Kaiser Family Foundation, February 2015.
[7] *Ibid*.

Table 3: San Francisco Health Insurance Affordability Analysis by Family Size[8]

Household Composition	No Room in Budget	Some Room for Premiums (assuming federal subsidies)	Some Room for Out-of-Pocket Expenses	Can Cover Premiums and Median Out-of-Pocket Expenses
Single Individual (40 years old)	Up to 250% of FPL	255%-285% of FPL	290%-300% of FPL	305% of FPL and above
Two Parents, Two Kids	Up to 320% of FPL	325%-350% of FPL	355% of FPL	360% of FPL and above
Single Parent, Two Kids	Up to 360% of FPL	365%-400% of FPL	405%-410% of FPL	415% of FPL and above

Given this range of FPL thresholds, it is important to understand the family structures of households most likely to be affected by changes to the City Option. Of the San Franciscans eligible for Covered California, in the City Option, the most common family type is a single individual with no children (45%), with the next most common being a married parent (25%).

Appendix V of this report outlines the UCB-CLRE affordability analysis in greater detail and explores the two ways of thinking about affordability in high-cost areas such as San Francisco: first looking at family budgets, and second looking at the affordability thresholds defined by the ACA and adjusting them for San Francisco cost of living.

Addressing Affordability of Health Insurance through a Public Benefit Program

SFDPH is interested in developing a Public Benefit Program (PBP) to provide additional financial assistance for eligible city residents who receive employer contributions for the City Option under the HCSO and are eligible to purchase plans through Covered California. The goal of a Public Benefit Program is to develop a premium assistance and possibly a cost-sharing assistance program that will maximize insurance coverage for San Francisco residents who qualify for the program that is established.

In examining potential structures to operate a PBP, HMA conducted an analysis that reviewed program financing options based on pooling the current employer expenditures collected under the City Option. This approach would allow for the development of a premium and cost-sharing assistance design that would finance the program without the need to obtain additional general fund appropriations. This approach also would help to ensure that there was an equitable distribution of program resources based on individual program participants' financial need and eligibility for federal APTCs or CSRs.

Incorporating UCB-CLRE's affordability analyses, this report explores options for programs that can make purchasing health insurance available through Covered California more affordable for city residents with household modified adjusted gross incomes (MAGI) up to 635% of the FPL. The report first considers the design that could be utilized to provide financial assistance to eligible program participants. The options

[8] For full information, see Appendix V.

for the assistance design explore the provision of both premium assistance and the potential of cost-sharing assistance to eligible enrollees according to different eligibility standards. Assistance design options take into account the available funding from employer contributions to the City Option. The report then evaluates options for the administrative structure of the program in terms of how SFDPH could implement the particular assistance design from an operational perspective.

Defining the Level of Assistance

The sections below examine program options that SFDPH might adopt to provide premium or cost-sharing assistance. We also look at alternatives for determining eligibility. For each option we present the estimated assistance amounts, costs, and remaining out-of-pocket cost burden for program participants. See Appendix II for detailed tables on each of the program assistance options.

To develop these options, HMA utilized the UCB-CLRE's analysis of program take-up, available employer contribution dollars, premium costs for the second-lowest-cost silver plan in the San Francisco market, and expected out-of-pocket costs based on data from SFDPH, the American Community Survey (ACS), the California Health Interview Survey (CHIS), and CalSIM version 1.92. This information was utilized under various program assistance assumptions recalibrated to the HCSO population to develop a set of assistance design options for SFDPH's consideration.

Program Scope

SFDPH identifies those potentially eligible for the PBP as low-to-moderate-income San Francisco residents who are eligible to purchase health insurance from Covered California and whose employers make an ESR contribution to the City Option. The bounds of income eligibility explored in this analysis are informed by the relative affordability of health insurance for San Francisco residents. The Affordable Care Act provides subsidies for people with incomes up to 400% of FPL. However, given the higher cost of living in San Francisco, 400% of FPL on a national scale would translate to 635% of FPL for San Francisco residents. Based on this comparison, this report considers program assistance for people with incomes between 139% and 635% of FPL. People with incomes at or below 138% of FPL are eligible for no-cost insurance through Medi-Cal.

Table 5 shows projections of the number of people expected to be eligible for assistance in 2016 through 2020 and the funds that would be available to fund assistance programs. The projections are based on the analysis done by UCB-CLRE.

Table 5. Eligible Population and Available Funds from Employer Contributions

Year	Total Eligible Population	HCSO Funds Available for Programmatic and Administrative Costs
2016	5,780	$10,520,000
2018	7,110	$14,530,000
2020	7,420	$16,400,000

Program Assistance

In designing the PBP, SFDPH seeks to incorporate an incentives structure that makes coverage affordable and thereby maximizes enrollment of people who need assistance without creating unintended adverse consequences, such as crowd-out or administrative burden. To address these goals, HMA developed a set of design options to provide assistance under the PBP and criteria for assessing the options.

Criteria for Evaluating the Level of Program Assistance

HMA used the following criteria to evaluate a set of program assistance options for both premiums and cost-sharing:

1. **Maximize the number of participants covered.** Given that ESR contributions to the City Option are provided as an alternative to employer-sponsored insurance, one goal of the PBP is to maximize the number of eligible participants who can use the funds to purchase insurance. To quantify this outcome in our analysis, HMA used the UCB-CLRE's estimates of the take-up rate of the public benefit program as compared to the current situation under the current MRA program. These estimates are provided in Appendix I.
2. **Maximize affordability of health care coverage.** In its assessment, "Affordability of Health Insurance and Health Care in San Francisco," the UCB-CLRE presented a number of options for measuring affordability:[9]

   a. *Total health spending (premium and out-of-pocket expenses) as a % of income.* For a single 40 year-old individual who is at 300% of FPL ($35,010), the median expected spending on health care is around 12% of income, while those at the lower and higher brackets of FPL expect to spend closer to 5% or 10% of income.

   b. *Premiums and out-of-pocket costs compared to the household budget.* For a single 40 year-old individual, the income level for which there is room in the budget for health insurance premiums and out-of-pocket costs[10] is around 295% of FPL for a low user of medical services and around 335% of FPL for a high user.

   c. *Underinsurance.* Underinsurance can be defined as having a deductible that exceeds 5% of household income, or having out-of-pocket expenses exceeding 5% of household income for those under 200% of FPL and 10% for incomes above 200% of FPL.

   In assessing the program assistance options presented in the next section, HMA chose to use health spending as a percent of income as the measure of affordability. This method allowed us to ascertain how well the options address affordability for participants in the middle-income bracket who do not receive federal premium and cost-sharing subsidies but also face challenges

[9] Estimates are based on a 40 year old San Franciscan purchasing the 2nd lowest cost Silver plan after advanced premium tax credits.
[10] Assumes applicable tax credits and cost-sharing subsidies are applied

in affording health insurance in San Francisco. HMA used the UCB-CLRE's average expected out-of-pocket cost estimate to quantify the total out-of-pocket cost burden.

3. **Minimize complexity.** The more complex the eligibility criteria, the harder it is for employees to know whether they are eligible. A complex program is more costly to administer because more time is required to train eligibility workers. HMA compared program assistance options in terms of how complex they would be to administer and how difficult to explain to participants and eligibility workers.

Program Assistance Scenarios

There are innumerable ways to structure the PBP assistance program, but there are few programs of similar size and scope from which to glean best practices. HMA identified several assistance approaches as outlined below and applied the three criteria identified above to assess the tradeoffs among designs. In each scenario, the assistance level is based on the beneficiary's cost of the second-lowest cost silver plan to be consistent with the process for determining ACA subsidy amounts.

HMA drew upon expected premium and out-of-pocket cost estimates as well as anticipated take-up rates from the UCB-CLRE's analysis.[11] Detailed calculations can be found in Appendix II and are summarized below.

1. *Premium Assistance Only, Tiered Scale (100%/40% of Second-Lowest Cost Silver Plan Premium)*
   In this scenario, outlined in Table 1 of Appendix II, SFDPH would provide 100% premium assistance for those up to 400% of FPL and 40% for those between 401% and 500% of FPL. The assistance would be benchmarked to the premium of the second-lowest cost silver plan in the San Francisco service area.

   Under this assistance design, expected costs are kept to below 10% of household incomes for individuals below 400% of FPL, with the group between 250% and 400% receiving the highest subsidy per person. Assuming the income eligibility cutoffs are clear and based on the same income determination as Covered California (MAGI), determining the benefit amount should not be complex.

2. *Premium Assistance Only, 80% of Premium for Second-Lowest Cost Silver Plan*
   In this scenario, presented in detail in Table 2 of Appendix II, all eligible individuals up to 635% of FPL would receive the same assistance amount equal to 80% of the premium for the second lowest cost silver plan in the San Francisco service area. This design provides a lower assistance amount than the first option, which would help to avoid the unintended consequence of encouraging employers to cease offering employer-sponsored insurance and shift more employees into the PBP, as well as helping to ensure that employees contribute.

   This design would achieve the goal of bridging affordability gaps for San Franciscans who do not qualify for federal tax credits or from the federal government. However, some individuals between 401 and 500% FPL are still paying more than 5% of their income for health care costs

[11] For the purposes of these scenarios, we treated those eligible for Federal exchange subsidies the same as those ineligible for all income groups due to the potential for margin of error given the small numbers.

under this approach. Given the flat assistance amount, this option would be relatively simple to administer.

3. *Premium Assistance at 60% of 2nd Lowest Cost Silver Plan Premium Plus Cost-Sharing Assistance to Reduce Plan Deductible to 5% of Income*

This scenario, outlined in Table 3 of Appendix II, addresses the issue of underinsurance by providing cost-sharing assistance in addition to 60% premium assistance benchmarked to the premium for the second lowest cost silver plan. The goal of the cost-sharing assistance is to address underinsurance by reducing the Covered California base silver plan deductible to 5% of income for participants over 200% of FPL. Those below 200% of FPL would receive the amount of the enhanced silver deductible as their cost-sharing benefit. The amount of cost-sharing assistance the participant receives depends on the participant's income, as outlined in Table 6, with the assistance amount designed to minimize the cost for the lowest-income individuals.

Under this assistance design, similar to Option 2, the benefit ensures that individuals with the lowest incomes spend a smaller proportion of their income on health care compared to people of the same age at other incomes. Those below 250% of FPL and above 500% of FPL would spend just more than 4% of income on health care costs. The group between 251% and 400% of FPL would spend just above 6% of income on health care costs, while people between 401 and 500% of FPL would pay the highest percentage of income (8.6%) on health care costs. This approach also helps fill the gap for people whose incomes are too high to qualify for federal tax credits and cost-sharing assistance but for whom health insurance is still not affordable, as defined by the UCB-CLRE analysis. This option would be the most complex to administer because of the sliding scale for cost-sharing assistance to reduce the applicable deductible to 5% of income.

Table 6: Assistance Design #3 – Cost-sharing Assistance and Deductible Amounts by FPL

Federal Poverty Level:	<200%	200%-250%	250%-300%	300%-350%-	350%-400%	400%-635%
Program cost-sharing assistance	$550	$673	$779	$485	$190	$0
Remaining deductible as a % of income	2%	5%	5%	5%	5%	5%

Table 7 below summarizes the three program assistance options by expected number of participants (take-up), the total subsidy required for the number of participants, and the resulting cost of health care for an individual San Francisco resident based on the household income examples utilized in the tables in Appendix II.

Table 7: Assistance Design Comparison for Single San Franciscan in 2016

	Option 1	Option 2	Option 3
Assistance	Sliding scale premium assistance (100% for income below 400% of FPL, 40% for income above 400% of FPL) for 2nd Lowest Cost Silver Premium	80% of premiums for 2nd Lowest Cost Silver Plan Premium	60% of premiums for 2nd Lowest Cost Silver Plan, Sliding Scale Cost-sharing Assistance
Take-up	3,680	3,770	3,750
Total subsidy	$7,472,000	$10,960,000	$9,184,000
Remaining cost as % of income[12]	3.7% - 10.5%	3.2% - 6.4%	4.2%-8.6%

Additional Assistance Considerations

Consistency in eligibility determination. To maintain consistency with Covered California and Medi-Cal, the PBP should utilize Modified Adjust Gross Income (MAGI) to determine eligibility for the program. In addition, if program participants apply for a family plan under Covered California, their premium will be calculated for the entire family as opposed to the individual. Therefore, SFDPH would need to develop an algorithm to separate the individual's share of the premium from the family's share to determine the applicable premium assistance amount.

Equity between MRA and Public Benefit participants. The overall benefit provided by the PBP as compared to the City MRA should be considered in determining the benefit amount for PBP participants. The two benefits differ in that the City MRA benefit is restricted based on the number of hours worked, while the PBP assistance amount is based on the relative affordability of health insurance. The PBP benefit may be more valuable than the City MRA, because it is calculated to provide affordable access to comprehensive health insurance. In addition, the scope of eligible expenditures under an MRA should be considered by SFDPH in designing the PBP. For example, if non-San Francisco residents and Medi-Cal eligibles receive a broader scope MRA while the PBP for San Franciscans is limited to funding health insurance coverage, this could result in inequities. Therefore, SFDPH may want to consider placing similar limits on the MRA's scope for non-residents and Medi-Cal beneficiaries or setting the scope of the PBP to match the current MRA.

Uncompensated care costs. Low-income populations who are used to seeking care in the safety net may continue to do so even if they are granted access to a different provider network through their health plan. Some will choose safety net providers because of familiarity, while others will seek care through the safety net to avoid out-of-pocket costs that are perceived to be unaffordable.[13] San Francisco's public health system should plan for continued uncompensated care costs while the newly insured

[12] Based on sample household scenarios as explained in Appendix II.

[13] Kaiser Family Foundation (2015). "Consumer Assets and Patient Cost Sharing". http://files.kff.org/attachment/issue-brief-consumer-assets-and-patient-cost-sharing

populations become familiar and comfortable with the new networks and their out-of-pocket cost burden.

Limited cost-sharing assistance. Given the limited program dollars and the growing affordability concerns in San Francisco, SFDPH may want to begin its operations of the PBP by supplementing the more predictable premium costs and provide only limited cost-sharing assistance. Once the utilization patterns of the population are known, the program will be better able to target and allocate cost-sharing assistance, given available funds; it could increase the level of cost-sharing assistance at that time.

Reserved funds for hardship. There could be certain special circumstances where the assistance eligibility cut-offs do not adequately address affordability for a program participant. For example, if an individual loses his or her job early in the year or develops a serious health condition, the amount of assistance may not be sufficient to ensure access to needed care. SFDPH may want to consider reserving additional program funds to address these hardship cases.

Potential for "crowd-out". Any time there is an expansion of public insurance assistance, there is a danger of reduced private insurance take-up, or "crowd-out." SFDPH will need to establish a level of assistance that does not encourage employers to stop providing insurance and shifting employees to the PBP.

Income tax reconciliation. There may be a portion of program participants who will need to reconcile their assistance payments for tax purposes if they experience income changes during the plan year. For example, if an individual shifts from 148% of FPL to 200% of FPL during the year, the individual would have to repay a portion of the federal tax credit received.[14] In the case that the PBP assistance is counted as household income, eligibility workers will have to work with each individual who enrolls to determine the best financial option given the impact of income changes on tax liability.

Administrative Structure Options

The following sections present an analysis of administrative structure options for the Public Benefit Program.

Methods

Review of Existing Programs

To inform the analysis of administrative structures to support the PBP, HMA began by reviewing other premium and cost-sharing assistance programs' practices, including alternative Medicaid expansions that subsidize the purchase of Marketplace plans, the AIDS Drug Assistance Program (ADAP), MassHealth Premium Assistance, and the Oregon Homecare Workers Supplemental & Benefits Trust. HMA reviewed public literature as well as consulted experts who were familiar with the operations of

[14]Kaiser Family Foundation (2015). "Repayments and Refunds: Estimating the Effects of 2014 Premium Tax Credit Reconciliation". http://kff.org/health-reform/issue-brief/repayments-and-refunds-estimating-the-effects-of-2014-premium-tax-credit-reconciliation/

these programs to understand not only the benefits provided but how the benefits were administered, from eligibility to payment.

Health Insurance Issuer and Covered California Interviews

To gauge operational feasibility from the health insurance issuer perspective, HMA interviewed a number of issuers about their current practices in receiving and tracking third party payments and flagging program enrollment for various populations. HMA invited issuers local to the San Francisco market and those currently serving San Francisco residents through Covered California. Covered California QHP issuers in San Francisco include Anthem Blue Cross of California, Blue Shield of California, Chinese Community Health Plan, Health Net, and Kaiser Permanente. We interviewed representatives from the San Francisco Health Plan, Anthem Blue Cross, Chinese Community Health Plan, and Kaiser Permanente.

HMA also interviewed a representative from Covered California to understand their current processes and how they might be able to support third party payment.

SFDPH Focus Group Findings

The San Francisco Department of Public Health conducted four focus groups in January 2015, two with employers subject to the HCSO and two with employees benefitting from the HCSO. HMA used these findings to help inform employee and employer preferences associated with program assistance design and administrative structure. For example, a finding from the employee focus group suggested that while seeking reimbursement for services was not a barrier to getting care, a debit card would make it easier for beneficiaries to use the assistance. Employers in the HCSO employer focus group reported that ease of administration is a chief concern in their compliance with the City Option program. Therefore, administrative structures that increase employer burden are likely infeasible. Findings from the focus groups are detailed in Appendix VII.

Analysis of Identified Options

Once HMA gathered the necessary information to develop a list of potential administrative structure options, including those identified by SFDPH in the original scope of work as well as additional options based on our knowledge and experience, we developed criteria against which to analyze the options. These are outlined below. HMA then conducted an analysis of regulatory and legal barriers to implementation of a public benefit program before proceeding with a detailed analysis of each administrative structure against the developed criteria. This detailed analysis is described in the following sections. Our recommendations are based on this analysis.

Administrative Structure Options Considered

SFDPH provided an initial set of administrative structure options at the outset of the project. The five options provided are below:

1. **Covered California wrap program** – SFDPH would work with Covered California and QHP issuers to create a public benefit “wrap” program for local entities.

2. **Covered San Francisco as envisioned in legislation proposed in April 2014** – SFDPH would provide financial assistance to eligible participants to offset a portion of the cost of health insurance purchased through Covered California.
3. **Prospective payments/grants to QHP issuers** – SFDPH would make quarterly prospective payments to each QHP, which would be distributed among program participants choosing that plan.
4. **Voucher program** – SFDPH would provide plan enrollees with payment vouchers in the amount of their benefit to lower the employee premium amount. The voucher would be remitted with plan premiums. The QHP issuers would submit the vouchers to SFDPH for payment.
5. **Premium assistance through a non-profit foundation** – SFDPH would deposit funds to a local or statewide non-profit foundation, which would administer assistance based on eligibility criteria.

HMA narrowed down the initial options provided by SFDPH to two sets of options, one for premium assistance and one for cost-sharing assistance. Because of the variance in operational requirements as well as the ability of SFDPH to provide only premium assistance, only cost-sharing assistance, or both, HMA developed and evaluated options for these two types of health insurance affordability assistance separately.

The following table provides HMA's interpretation of the initial five administrative structure options.

Table 8. Original Administrative Structure Options

Original Option	HMA Interpretation
Covered California Wrap Program	A "wrap" program would entail a third party administrator (TPA) or other administrative entity making payments to each participant's selected QHP issuer in the amount of the premium or cost-sharing assistance. This option could be implemented either by utilizing an entity to make payments to all issuers or by making payments to a single pre-selected QHP issuer designated for program participants.
Covered San Francisco	A public program that would coordinate with Covered California to provide financial assistance to eligible participants to offset a portion of the cost of health insurance purchased through Covered California or similar state-administered Exchanges as determined by the Department of Public Health. Participants would include covered employees whose employers make health care expenditures to the city on their behalf, their dependents, and others as determined by the Department of Public Health.
Prospective Payments/Grants to QHP Issuers	This option would entail making prospective payments to QHP issuers to lower the cost of health insurance for eligible program recipients. Program payments would be finalized through a reconciliation process.
Voucher Program	This option would entail providing participants with a paper voucher that could be redeemed through QHP issuers to reduce the premium cost. This option would require manual processing of redeemed vouchers to make payments to issuers.
Non-profit	This option designates a non-profit as a potential TPA for the new Public Benefit Program. A non-profit could carry out any of the options outlined in this analysis as a TPA. This analysis does not consider this as a separate option but rather a variation on a TPA relationship.

Based on this refinement of the options, HMA identified seven options to administer premium assistance and six options to administer cost-sharing assistance. These options are described below in Tables 9 and 10.

Premium Assistance

Premium assistance can be administered either by making payments to health plans or through reimbursement to the participant. Within these basic program structures, we evaluated six mechanisms for providing premium assistance, presented in Table 9.

Table 9. Administrative Structure Options for Premium Assistance

Administrative Structure	Description
Covered San Francisco	• SFDPH would coordinate with Covered California to provide premium assistance to eligible employees whose employers make contributions on their behalf, their dependents, and other populations. • SFDPH would utilize employer contributions under the HCSO and other funds to provide premium assistance.
Direct Payment to all QHP Issuers Offering Coverage in the San Francisco Service Area (Wrap program)	• SFDPH or a contractor makes payments directly to QHP issuers on behalf of program participants. • Plans would identify eligible enrollees through an enrollee roster provided by SFDPH. The roster would also include the subsidy amounts each enrollee would receive. • The plan would charge each enrollee a reduced premium amount net of the SFDPH payment.
Contracted Relationship with a Single QHP Issuer	• SFDPH would contract with a single QHP issuer to administer the public benefit program. Each program participant would select this particular plan during Covered California enrollment. • The QHP would already be approved by Covered California and would comply with all Covered California requirements including offering the standardized set of benefits required by Covered California. • The QHP issuer would bill SFDPH for premiums on behalf of eligible enrollees or draw down from a pool of funds for this purpose. • The issuer would identify eligible enrollees through an enrollee roster provided by SFDPH. The roster would also include the subsidy amounts each enrollee would receive.
Debit Card	• SFDPH via a TPA would provide a debit card to each eligible participant with a credit limit equal to their assistance amount for each quarter or annually. • The participant would utilize the debit card to make electronic premium payments or to pay via phone. • Participants would be able to use the debit card only for eligible expenditures.
Medical Reimbursement Account (MRA)	• Participants would have a medical reimbursement account with funds specifically earmarked for premium payment. • Program participants would make expenditures for premiums and seek reimbursement from the program. • The MRA program would operate as part of the City Option or be carried out by a new TPA.
Prospective Payment	• SFDPH or a TPA would work with QHP issuers serving San Francisco to estimate the number of eligible enrollees for a given quarter. • SFDPH would make payments to issuers based on these estimates on a quarterly basis. • SFDPH would require enrollment reports on eligible participants from issuers on a quarterly basis and reconciles payments accordingly on a quarterly basis. • SFDPH would need to provide a list of eligible participants or a matching service for QHPs.
Vouchers	• SFDPH would provide vouchers to eligible beneficiaries that they use when remitting payment to a QHP.

	• The QHP would submit vouchers to SFDPH for reimbursement.

Cost-Sharing Assistance

Cost-sharing assistance can be administered in multiple ways with varying degrees of operational complexity, including by making payments to providers on behalf of participants, by making payments to plans to reduce cost-sharing requirements, or by providing cost-sharing assistance directly to program participants. Table 10 presents the administrative structure options we evaluated for the implementation of cost-sharing assistance.

Table 10. Administrative Structure Options for Cost-Sharing Assistance

Administrative Structure	Description
Covered San Francisco	• SFDPH would coordinate with Covered California to provide cost-sharing assistance for eligible employees whose employers make contributions on their behalf, their dependents, and other populations. • SFDPH would utilize employer contributions under the HCSO and other funds to provide cost-sharing assistance.
Supplemental Payments for Out-of-pocket Liability	• A TPA would pay claims for coinsurance and deductibles incurred by program enrollees up to a cap per enrollee. • QHP issuers would bill the TPA for reimbursement.
Debit Card	• SFDPH would utilize a TPA to provide program participants with a debit card with a programmed maximum limit that they can use to pay cost-sharing bills from providers.
Medical Reimbursement Account (MRA)	• Participants would have a medical reimbursement account specifically earmarked for cost-sharing expenses. The MRA program would operate as part of the City Option or be administered by a new TPA.
Prospective Payments	• QHP issuers would receive advance payments to reduce cost-sharing for eligible participants. • Issuers would estimate eligible cost-sharing expenditures and submit estimates to SFDPH on a quarterly basis. • SFDPH would reconcile payments each quarter via a claims process with issuers.
Program ID Card/Provider Payment	• Program participants would receive an ID card that instructs providers to bill SFDPH rather than the patient for cost-sharing expenditures. • Providers would submit claims to SFDPH for reimbursement.

Options Deemed Infeasible

To narrow the number of administrative structure options, HMA did a preliminary analysis of the full set of options outlined in the previous two tables. This analysis included discussions with QHP issuers as well as an examination of the operational feasibility of the options based on our existing knowledge and experience. Some of the original options presented significant operational barriers that would not only make implementation difficult but would also result in prohibitive administrative costs. Additionally,

some options were identified by the QHP issuers we consulted as particularly infeasible while others were preferred.

In particular, QHP issuers indicated that accepting multiple forms of payment for a given QHP enrollee is operationally unworkable given that these issuers are already combining APTC payments from the federal government with enrollee premium payments. They indicated that bringing another payer into this process would be extremely difficult and costly and that it would be infeasible to change system protocols for this relatively small population. Another challenge for implementation is the inability of QHP issuers to accept multiple forms of payment from the enrollee under current operations, i.e., the use of two credit or debit cards to make a single premium payment in a given month. This challenge presents operational barriers to the use of debit cards for premium assistance if the assistance does not cover the entire individual premium every month.

The options that were deemed infeasible are presented in Tables 11 and 12.

Table 11. Eliminated Premium Assistance Administrative Structure Options

Administrative Structure	Description	Rationale for Elimination
Covered San Francisco	• SFDPH would coordinate with Covered California to offset a portion of the cost of health insurance purchased through Covered California for eligible employees whose employers make contributions on their behalf, their dependents, and other populations. • SFDPH would utilize employer contributions under the HCSO and other funds to provide premium assistance.	• The scope of eligible populations combined with the necessary administrative costs of implementation present significant barriers to implementation of the program. • QHP issuers have indicated that receiving multiple premium payments for one individual is a barrier. • In addition, Covered California has indicated it is unable at this time to work with any customized programs that require changes to their IT systems.
Prospective Payment	• SFDPH or a contractor would work with QHP issuers serving San Francisco to estimate the number of eligible participants for a given quarter. • SFDPH would make payments to issuers based on these estimates on a quarterly basis. • SFDPH would require enrollment reports on eligible participants from issuers on a quarterly basis and reconcile payments accordingly on a quarterly basis. • SFDPH would need to provide a list of eligible participants or a matching service for QHPs.	• Plans have indicated that accepting multiple forms of payment from multiple entities is a significant operational barrier. • Introducing payment reconciliation in the context of ongoing payment and reconciliation challenges with the federal government presents a level of operational complexity that plans are not likely to accommodate.

Vouchers	• SFDPH would provide vouchers to eligible beneficiaries that they use when remitting payment to a QHP issuer. • The issuer would submit vouchers to SFDPH for reimbursement.	• Plans would not support this approach because processing vouchers through their payment receipt and tracking systems would require significant system changes. • The need for SFDPH to do manual processing would increase staffing needs and result in high administrative costs. • High potential for fraud and abuse.

Table 12. Eliminated Cost-Sharing Assistance Administrative Structure Options

Administrative Structure	Description	Rationale for Elimination
Covered San Francisco	• SFDPH would coordinate with Covered California to offset a portion of the cost of health insurance purchased through Covered California for eligible employees whose employers make contributions on their behalf, their dependents, and other populations. • SFDPH would utilize employer contributions under the HCSO and other funds to provide cost-sharing assistance.	• The scope of eligible populations combined with the necessary administrative costs of implementation present significant barriers to implementation. • Covered California has indicated it is unable to at this time work with any customized programs that require changes to their IT systems.
Prospective Payments	• QHP issuers would receive advance payments to reduce cost-sharing for eligible participants. • Issuers would estimate eligible cost-sharing expenditures and submit estimates to SFDPH on a quarterly basis. • SFDPH would reconcile payments each quarter via a claims process with QHP issuers.	• Plans have indicated that accepting multiple forms of payment from multiple entities is a barrier for them already, so the need to estimate payments and reconcile adds an even greater level of complexity that plans likely would not support. • This approach would require plans to adjust applicable cost-sharing for any plan with a PBP participant, which would likely run afoul of Covered California standardized benefit designs and also require significant system changes. • Would require a significant oversight effort for SFDPH to ensure payment accuracy.

Program ID Card/Provider Payment	• Program participants would receive an ID card that instructs providers to bill SFDPH for cost-sharing expenditures. • Providers would submit claims to SFDPH for reimbursement and SFDPH or a contractor makes payments.	• One plan reported a stigma associated with enrollees having a card for reduced cost-sharing. • Provider compliance challenges. • SFDPH would need to build and operate a claims payment system, which is a significant IT system effort that would require a considerable contract expense and time investment.

Remaining Options

The following options represent those administrative structure options that we considered feasible prior to undertaking an analysis against the evaluation criteria.

Premium Assistance Options

The following options represent administrative structures for the provision of premium assistance to eligible individuals.

1. Premium Payments to all QHP Issuers Serving San Francisco via a TPA

Under this option, SFDPH would utilize a TPA to administer premium assistance payments to Covered California QHP issuers that were selected by program participants. Each program participant would select a plan through Covered California via an enrollment assister. The current City Option TPA or another TPA would bill program participants for their share of premium, if any, aggregate the participant payment with the PBP assistance payment, and pay each plan on a monthly basis for each participant. The TPA would implement a roster or other information sharing tool to verify enrollment in QHPs as recorded by the issuers and to match enrollment with program participants who have been determined eligible. The QHP would communicate disenrollment and any other enrollment changes to the TPA for reconciliation and to stop payment processing.

2. SFDPH Contract with a Single QHP Issuer to Offer a Designated Plan

Under this option, SFDPH would contract with one QHP issuer to offer a designated plan established specifically for program participants, i.e. the San Francisco Public Benefit Plan, or to offer a selection of all of its Covered California plans. This designated QHP issuer would already be contracted with Covered California for the benefit year. The QHP issuer and its plans would undergo the same review and approval process as all other QHP issuers and comply with all associated requirements. SFDPH would likely need to select the QHP issuer through a procurement process and enter into a contractual agreement to operate the PBP through the selected QHP issuer.

SFDPH would inform potential program participants that to get assistance under the new program, they would need to enroll in a plan offered by the selected QHP issuer when purchasing a plan through Covered California. Enrollment assisters would help potential program participants understand their options for receiving premium assistance through the City or for enrolling in any other QHP without the additional assistance.

The selected QHP issuer would work with SFDPH to reconcile participant information and enrollment based on enrollment files it receives from Covered California. SFDPH would make payments to the QHP issuer for premium assistance for program participants. The selected QHP issuer would support additional administrative functions including data management, outreach and education, call center operations, translation services, and other functions in addition to enrollment and premium billing.

Under this approach, there would be no changes to the benefit packages approved by Covered California or to the QHP base premium rates negotiated between the QHP issuer and Covered California. At least in the early stages of the PBP, there would also be no mechanism whereby a potentially eligible San Francisco resident would be directed towards enrollment in a designated plan by the Covered California website through a zip code match or other functionality. The potentially eligible program participant would be assisted by an enrollment assister who would instruct the individual on how to select the designated QHP.

There may be additional policy or legal limitations to the implementation of this option that have yet to be evaluated. A full legal analysis may be needed prior to selection of this option.

3. Medical Reimbursement Account (MRA)

SFDPH would leverage its existing City Option infrastructure or contract with a new TPA to implement a MRA for program participants. This reimbursement account could be limited in scope to allow reimbursement only for premium payments and eligible cost-sharing expenses (cost-sharing is discussed below). Under this approach, program participants would submit receipts for premium payments and receive reimbursement from the MRA.

4. Debit Card for 100% Premium Assistance and MRA for Lower Assistance Amounts

SFDPH would implement a debit card program under the City Option program to provide program participants with a debit card as a vehicle for providing premium assistance. The debit card account could have a set credit limit for the amount of premium assistance provided. The participant could use the debit card to pay premiums either electronically online for via phone. A debit card for premium assistance would be feasible only if the premium assistance covered 100% of the participant's premium; QHP issuers cannot currently accept more than one form of payment from an enrollee for a given month's premium. For participants who are receiving less than 100% premium assistance or who enroll in a family plan, an MRA would be provided so that the program participant could seek reimbursement for premium costs that it would pay upfront.

Cost-Sharing Assistance Options

The following options represent administrative structures for the provision of cost-sharing assistance to eligible individuals. SFDPH may wish to conduct further analysis on expected utilization among program participants before determining whether to offer cost-sharing assistance in the new public benefit program. SFDPH will also want to examine the required time for implementation of this additional assistance.

1. Supplemental Payments to QHP issuers for Out-of-Pocket Liability

SFDPH would utilize a TPA to pay claims for program participants' out-of-pocket deductibles and coinsurance costs, up to a cap per participant. Payments would be made to QHP issuers. The TPA would need the capability to receive and pay claims from QHP issuers.

2. Debit Card

SFDPH would work with its existing TPA contractor or another TPA to provide debit cards to program participants to pay for their out-of-pocket expenditures. This assistance could be combined with premium assistance to allow the participant to utilize one debit card to make both kinds of payments. The limitation related to two payment methods outlined above under premium assistance does not apply for cost-sharing assistance. Each program participant would have a pre-programmed maximum for cost-sharing expenditures and would be able to use the card only up to this limit.

3. Medical Reimbursement Account

Similar to the MRA for premium assistance, the existing MRA infrastructure could be used to provide cost-sharing assistance to program participants, or SFDPH could contract with a new TPA to carry out this work. Eligible expenses could be limited to cost-sharing payments at provider offices to ensure that program funds are used to pay only for appropriate services.

Evaluation Criteria

To evaluate the administrative structure options, HMA utilized the following five criteria. Criteria two through four represent an analysis of the operational feasibility of the various administrative structure options, including time to implement the program, QHP issuer operational feasibility, and administrative cost of implementation.

1. Maximize Program Participant Take-up/Ease of use

   The selected administrative structure should be easy to use for both program participants and employers. Our analysis of this criterion draws upon findings from the employee and employer focus groups conducted by SFDPH.

2. Minimize Legal Barriers

   There may be regulatory or legal barriers that would make a particular implementation approach infeasible or more difficult. For example, there may be existing Covered California program parameters that present challenges for certain administrative structures.

3. Minimize Time for Implementation

   SFDPH has limited time to implement the PBP; it must be in place to begin providing assistance during the 2016 plan year. Ideally, SFDPH would begin providing assistance during the upcoming open enrollment period, which begins on November 1, 2015. Certain options may take longer to implement because of the need to build new information technology infrastructure or contract with a new third party administrator.

4. Maximize Operational Feasibility for QHP Issuers

   Any option selected by SFDPH must be operationally feasible for the QHP issuers operating in the San Francisco market. Health insurers can be required to take on certain program implementation tasks that present barriers and are potentially burdensome, but given the tight timelines, the PBP would be best served by selecting an administrative structure that can be implemented as easily and quickly as possible.

5. Minimize Administrative Cost Burden

   There is a finite pool of funds for the administration of the PBP, and any funds that are used for administrative purposes are not available to assist program participants. Administrative costs should also be minimized to help ensure the financial sustainability of the program. Options that are more operationally complex result in higher administrative costs. For example, new information technology infrastructure needed to support a particular option would result in higher administrative costs. Conversely, if an option can leverage existing program infrastructure such as the City Option, the administrative costs would be lower.

In addition to the above evaluation criteria, SFDPH should also consider the policy/political implications of each of the options presented in this report. This report does not address this consideration.

Regulatory Analysis

To evaluate the administrative structure options, HMA first examined regulatory/legal feasibility of the program. We did not consider any options that presented particularly challenging regulatory or legal barriers. While there are regulations that the PBP must adhere to, including the structure of the HCSO and existing Covered California regulations, we do not consider these regulations to be a barrier to any administrative structure option or to impact the recommended options in any significant way. We considered the following regulatory and legal issues in our initial analysis:

1. San Francisco Health Care Security Ordinance (HCSO)

   The PBP will have to work within the existing HCSO framework unless changes are made to the ordinance to allow certain program parameters. In June of 2014, the Board of Supervisors passed an amendment to the HCSO that requires SFDPH to create a plan to address the affordability of health insurance for city residents in time for the 2016 Covered California plan year.

2. CMS Guidance on Third Party Payment of Premiums

   The federal Centers for Medicare and Medicaid Services (CMS) issued guidance throughout 2014 on the ability of QHP issuers to accept premium and cost-sharing payments from third parties. This guidance and an interim final rule clarify that QHP issuers are required to accept third party premium payments in the following circumstances:

   a. Payments made on behalf of enrollees by the Ryan White HIV/AIDS Program, other federal and state government programs that provide premium and cost-sharing support

for specific individuals, and Indian tribes, tribal organizations, and urban Indian organizations; or

b. Payments made by private, not-for-profit foundations on behalf of QHP enrollees who satisfy defined criteria that are based on financial status and do not consider enrollees' health status. In this situation, CMS expects that premium and cost-sharing payments cover the entire coverage year.[15]

Pursuant to Article 11 of the California Constitution, counties are legal subdivisions of the state.[16] Therefore, it is our interpretation that SFDPH would be able to provide third party payment of premiums and cost-sharing expenditures.

3. Affordable Care Act Market Reforms and Group Health Insurance

Certain insurance market reforms put into place by the Affordable Care Act impact the ability of employers to provide health reimbursement accounts (HRAs) to their employees instead of or in conjunction with a traditional group health plan. These ACA requirements relate to annual dollar limits and preventive services. Questions have been raised about whether an employer is in violation of these requirements if the employer contributes into the City Option and an employee receives a City MRA. It is our interpretation that these MRAs do not constitute group health coverage because they are not offered directly by an employer to an employee and are therefore outside the scope of the Internal Revenue Service regulations and guidance on these issues.[17] Further, the new program is a public benefit program, which is also outside the scope of group health insurance regulation.

4. Covered California QHP Certification Requirements

The federal government and Covered California have set forth the requirements for certification of health plans as QHPs. Any health plan offered on Covered California must be selected through an annual certification process. Covered California QHPs must adhere to both state and federal criteria, including standardized benefit designs set forth by Covered California for each coverage year. Any health plan that would be designated for San Francisco residents and would thereby operationally link plan participants with financial assistance provided by SFDPH would need to be certified by Covered California for the applicable coverage year and adhere to all Covered California requirements, including the standardized benefit design requirements. In addition, regulations related to nonpayment of premiums and grace periods would need to be followed for the eligible population.

[15] Letter from Secretary Kathleen Sebelius to Sister Carol Keehan, May 21, 2014. Available at: http://www.chausa.org/docs/default-source/advocacy/052114-hhs-communication-on-premium-support-from-third-parties.pdf?sfvrsn=2

[16] http://www.leginfo.ca.gov/.const/.article_11

[17] http://www.irs.gov/pub/irs-drop/n-13-54.pdf

5. Open Enrollment and Special Enrollment Periods

   Federal regulations set forth the annual open enrollment period for all health insurance Marketplaces, including Covered California. Covered California has flexibility to extend its open enrollment period to ensure adequate access for all applicants.[18] The 2016 open enrollment period as designated by the federal government will be November 1, 2015, through January 31, 2016.[19] Participants in the PBP will need to enroll in Covered California plans during the annual open enrollment period unless they experience a qualifying event for a special enrollment period as outlined in federal regulations.[20]

6. Guaranteed Availability and Renewability of Coverage

   Under requirements of the Affordable Care Act for individual and small group market health plans, health insurers cannot deny coverage to any individual or employer that applies to buy any of its products, subject to the service area of the plan and financial capacity of the plan.[21] In addition, a health insurance issuer must renew or continue such coverage, subject to certain limitations.[22] These requirements would be relevant if SFDPH contracted with a single QHP issuer to administer premium assistance and wanted to restrict enrollment in the plan only to eligible participants of the PBP. Any eligible Covered California enrollee could technically enroll in that plan, even if they are not eligible for the PBP.

Analysis of the Administrative Structure Options

Table 13 below presents a summary of the assessment of the remaining administrative structure options for premium and cost-sharing assistance. HMA scored each option against each evaluation criterion using a score of 1 for low performance, 2 for medium performance, and 3 for high performance. A higher score indicates better performance. This analysis is described in more detail below.

[18] 45 CFR §155.410 Initial and annual open enrollment periods.
[19] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016. Available at: http://www.gpo.gov/fdsys/pkg/FR-2014-11-26/pdf/2014-27858.pdf
[20] 45 CFR §155.420 Special enrollment periods.
[21] 45 CFR §147.104 Guaranteed availability of coverage.
[22] 45 CFR §147.106 Guaranteed renewability of coverage.

Table 13: Summary of Administrative Structure Options Analysis

	Minimize Regulatory/Legal Barriers	Minimize Time for Implementation	Maximize QHP Issuer Operational Feasibility	Minimize Administrative Cost Burden	Maximize Participant Take-up/ Ease of Use	
Premium Assistance						**Total Score**
Payments to all QHPs via TPA	2	1	1	1	2	**7**
One Plan Contract	2	1	2	2	2	**9**
Medical Reimbursement Account	3	3	3	3	2	**14**
Debit Card for 100% Assistance/MRA for <100%	3	2	3	2	2	**12**
Cost Sharing Assistance						
Supplemental Payments for OOP Liability	2	1	1	1	2	**7**
Debit Card	3	2	3	2	3	**13**
Medical Reimbursement Account	3	3	3	3	2	**14**

Premium Assistance

The following analysis summarizes the results of our evaluation of each of the administrative structure options for premium assistance.

1. Premium Payments to all QHP Issuers Serving San Francisco via a TPA

HMA does not anticipate that this option would present any significant legal or regulatory barriers, but there may be some limitations or complications related to premium payment regulations and the need to adhere to Covered California and federal premium payment grace period requirements.

Implementation of this option would require a high level of administrative effort and could take as long as one year. Additionally, QHP issuers would face challenges with accepting payments from SFDPH on behalf of their enrollees. QHP issuers are already required to accept premium payments from multiple sources and reconcile payments with the federal government. Adding another premium payer would require additional system changes and increased complexity. The scope of these changes and costs make this option less feasible from the issuer perspective. Administrative costs for this option are likely to be relatively high.

Even if SFDPH utilized its existing TPA to carry out this implementation, the TPA would need to change premium billing and payment systems to support payment to QHP issuers as well as matching participant contributions and premium assistance funds. Also, the TPA would have to take on a significant new workload to reconcile enrollment and payment with all five QHP issuers participating in Covered California in San Francisco. A new TPA taking on this role would have to develop capabilities similar to those in place with the current TPA. These capabilities would include a payment and billing system, a participant database and tracking system, a call center capability, outreach and education functions including marketing and mailing of materials, translation services, eligibility capabilities, and program support staff.

While this option would be easy for participants to use because they would not experience up-front out-of-pocket costs for premiums, they may be confused about whether they should pay their portion of the plan premium to the plan or to the county.

2. Contract with a Single QHP Issuer to Offer a Designated Plan or Set of Plans

This option presents a potential risk of encountering legal or regulatory barriers because it limits health plan choice. To obtain assistance, program participants would be required to purchase coverage from a specific QHP issuer, which may present some regulatory and/or legal problems. A full legal analysis should be done before implementing this option.

This approach also requires SFDPH to enter into a contractual agreement with a single QHP issuer, a process that could take six months or more to complete, which would not leave much time for implementation of the program prior to the start of the open enrollment period (November 1, 2015).

This option would be rated as moderately feasible for the QHP: the program would be implemented by an existing QHP issuer, allowing the QHP issuer to utilize its existing infrastructure to implement the program rather than requiring a TPA to newly implement these capabilities. However, some QHP issuers may object to this approach because only one would be able to participate, preventing the other QHP issuers from receiving the additional subsidized enrollment.

Contracting with a single QHP issuer would allow SFDPH to more easily implement the program because payments would be made to only one QHP and because SFDPH could rely on the operations support already in place at the plan. This option would not, however, significantly lower administrative costs because SFDPH still would need to enter into a contract with the QHP that would have to cover administrative costs. But SFDPH would not need to establish an extensive new infrastructure, nor would the QHP issuer, since it could use its existing enrollment and payment systems, call center capability, data storage and tracking systems, translation services, and outreach and marketing capabilities.

Participants would follow the same enrollment process they would for Covered California, and an enrollment assister would direct them to the appropriate plan, so this approach would not be difficult for participants to use. However, any eligible program participant who mistakenly enrolls in the wrong QHP in Covered California would be unable to access this program unless they switched plans, which they could do only during the open enrollment period or a special enrollment period. In addition, some participants would need to change providers if participating in the program, which some in the employee focus group identified as a barrier.

3. Medical Reimbursement Account (MRA)

There do not appear to be any regulatory or legal barriers to providing premium assistance payments to eligible program participants through an MRA. It is by far the simplest option to implement. SFDPH could use its existing MRA capability within the current City Option program. The time needed to implement this new program would be minimized.

In addition, QHP issuers would receive payments directly from participants under this approach, so the operational feasibility of this option for QHP issuers is high. Given the expected participation in the

program, administrative cost would not be significantly greater than under the current City Option program.

Participants in employee focus groups conducted by SFDPH indicated that employees do not consider having to seek reimbursement a barrier to receiving care, just an inconvenience. Therefore participant ease of use is likely high under this option.

4. Debit Card for 100% Premium Assistance and MRA for Lower Assistance Amounts

There do not appear to be any legal or regulatory barriers to providing premium assistance to program participants through a combination of debit cards and MRAs as appropriate. SFDPH could administer debit cards for program participants under the existing City Option program. Minimal new infrastructure would be needed. By leveraging the current program infrastructure, SFDPH would minimize the implementation time.

In addition, because QHP issuers will receive payments from each QHP enrollee either via a debit card or some other form of payment, there are no operational concerns from the perspective of QHP issuers. While using both approaches is slightly more administratively complex, SFDPH already has much of this capability in place under its existing MRA program. Therefore, the administrative costs to implement this approach would be relatively low.

Additionally, debit cards would be easy for participants to use to make electronic premium payments. In employee focus groups conducted by SFDPH, employees indicated that debit cards would make their existing MRAs easier to use. In only one case, Chinese Community Health Plan, is online payment via debit card not available. In that case, debit card payments would need to be made in person at the plan.

Cost-Sharing Assistance

The following analysis summarizes the results of our evaluation of each of the administrative structure options for cost-sharing assistance against the evaluation criteria.

1. Supplemental Payments to QHP issuers for Out-of-Pocket Liability

In terms of legal and regulatory barriers, we expect that an option that aims to reimburse cost-sharing expenses may implicate the standardized benefit designs set forth by Covered California, in that enrollee coinsurance and deductibles would be different for program participants as compared to other enrollees in a given plan. Further analysis would be needed to determine whether there would be any regulatory concerns if this option were selected.

Because of the operational complexity of this approach, HMA anticipates that implementation of this option would take more time than other more streamlined options. If SFDPH needed to contract with a new TPA to carry out this work, the contracting process could take six months or more to complete. In addition, QHP issuers may face operational barriers to accepting payments from a third party for reducing cost-sharing for their QHP enrollees.

HMA expects there would be significant operational complexity and higher administrative burdens to implementing a supplemental payment program for PBP participants, which would also result in significant administrative cost burden. The implementation of a program whereby cost-sharing expenditures are paid on behalf of participants would require a claims payment system, which

represents significant upfront costs. SFDPH would need to fund these administrative costs through its contracting vehicle with the TPA. While the program would likely be fairly easy for participants to use because they would not need to pay a portion of their coinsurance and deductibles, the upfront costs and complexity are likely too significant to make this option viable.

2. Debit Card

As discussed above, there are no apparent regulatory or legal barriers to the implementation of a debit card program. In addition, there is no concern about the need for issuers to accept multiple forms of payment under this option because cost-sharing expenditures would be paid to providers up to the cap placed on the debit account. Provision of debit cards to program participants for the payment of cost-sharing expenditures is not as administratively complex as making payments to QHP issuers and, as discussed above, provides the opportunity for SFDPH to leverage the existing TPA, which reduces the time needed to implement the program. Further, participants would likely be pleased with their ability to make payments for cost-sharing obligations directly to providers with no stigma and in the same manner as participants in employer flexible spending arrangements.

3. Medical Reimbursement Account (MRA)

As discussed above, there are no apparent legal or regulatory barriers to the implementation of an MRA for cost-sharing expenditures for program participants. In addition, SFDPH currently has operations in place that could support providing MRAs to PBP participants, reducing the time and funding needed to implement this approach. Reimbursement accounts are widely used to support the reimbursement of medical expenditures, which suggests that this program would be easy for participants to use.

Administrative Structure Recommendations

Based on the analysis outlined above, we recommend that SFDPH pursue a combination of the following administrative structure options for premium assistance and cost-sharing assistance.

Premium Assistance

To take full advantage of the infrastructure already in place, HMA recommends that SFDPH administer PBP premium assistance through either a combination of debit cards and MRAs or via a MRA for all program participants. These approaches minimize the time and administrative funds needed to implement the program while also meeting the needs of program participants.

Cost-Sharing Assistance

HMA recommends that SFDPH utilize either a debit card approach or MRAs to administer cost-sharing assistance for program participants. Debit cards would be the easiest to use from the perspective of program participants but they do require an additional administrative expense associated with mailing of the debit cards to participants, assuming that the current City Option TPA would administer the debit cards.

Overall Operational Approach

HMA recommends that SFDPH implement the new PBP, either through debit cards and/or MRAs, within its existing City Option program in order to leverage the existing employer contribution intake process as well as the services already in place under the current City Option program, including:

- Employer interface
- Call center and language translation services
- Accounting system
- MRA management
- Participant web portal
- Marketing and outreach functions
- Education and training services
- Eligibility workers

See Appendix III for an implementation timeline.

Operational Process Flows

Appendix IV contains detailed operational flow diagrams that illustrate how the provision of premium and cost-sharing assistance would function under either the debit card or MRA approach. Appendix IV also includes an eligibility process flow diagram.

The process for determining eligibility would be the same under any of the recommended administrative structure options. HMA discussed the operational options for the eligibility process with both SFDPH and the California Department of Health Care Services and developed the process flow included in Appendix IV based on this input. The core of the eligibility process is that it relies on the MAGI and FPL values housed in CalHEERs. Relying on CalHEERs helps to ensure consistency with income determination for Covered California and Medi-Cal and reduces the operational complexity and administrative costs of the program.

Partnerships and Key Contacts

To support the implementation of the PBP, SFDPH will need to establish certain relationships to ensure smooth operations of the program depending on the administrative structure that is selected.

QHP Issuers

Under any option, SFDPH should establish contact with each of the QHP issuers operating in the San Francisco service area to ensure they are aware of the program. Issuers would likely be hesitant to undertake the system changes that would be required to implement the more complicated operational options. However, under the recommended options, resistance is unlikely.

Under the recommended administrative structures, QHP issuers may be receiving debit card payments from program participants; they need to ensure that these payments can be accepted without difficulty.

QHP issuers would also need to be aware that SFDPH is providing premium and potentially cost-sharing assistance on the behalf of some program participants. If SFDPH contracts with a single QHP issuer for the operation of a single designated plan for PBP participants, a much more involved relationship would be established, likely via a formal contracting mechanism with the QHP issuer.

Employers

SFDPH will also need to continue to manage its ongoing relationship with employers who pay into the City Option on behalf of their employees. SFDPH will need to conduct outreach and education programs to inform employers of the new program. Employers will continue to be interested in the way their funds are being utilized. In addition, we recommend that SFDPH work through employers to communicate the parameters of the new program to employees in the city who may be eligible because of their income and contributions into the City Option. Regular notices provided to employees should describe the new program, the eligibility parameters, and the process for obtaining assistance if determined eligible.

Employees

Employee outreach will need to be an integral part of the implementation of the PBP. SFDPH may want to send a notice to all potentially eligible employees outlining the eligibility parameters of the possible assistance they can receive. The notice would also need to instruct employees on how to make an appointment to determine their eligibility.

The PBP will need to communicate regularly with employees about their program assistance funds, including their account balances under a debit card or MRA arrangement and other regular operational communications.

Covered California

SFDPH should maintain a working relationship with Covered California to continue to explore options for streamlining the PBP. Covered California has indicated that they are not currently capable of implementing new information technology infrastructure to support a program like the PBP for a limited population, but they may be amenable to a more integrated approach in the future. In the next few years, Covered California and SFDPH could pursue a partnership whereby San Francisco residents are given the option of enrolling in a designated plan based on the zip code they enter in the Covered California plan selection engine. It may even be possible for Covered California to display a reduced premium amount net of assistance for this limited population via this process. SFDPH should explore these possibilities with Covered California in the coming years.

Enrollment Assisters

As outlined in the eligibility process flow in Appendix IV, enrollment assisters will be utilizing CalHEERs determinations to determine eligibility for the PBP. Assisters will need to be educated about the new program parameters, and a process will need to be established for moving applicants from the eligibility process to the enrollment process. Training materials will need to be developed, and assisters will need a designated contact within the new program to answer questions and provide help as needed.

Safety Net Providers

SFDPH will need to reach out to its safety net providers to inform them of the new program and the changes to the City Option. Safety net providers will likely be asked questions about the new program and how individuals can enroll. They may also need to direct people to an assister who can help them enroll if they think they may be eligible.

Community Groups

Similarly, community groups will likely need to communicate with potentially eligible individuals about the availability of the PBP. SFDPH will need to conduct outreach and education to these stakeholders to inform them about the new program. SFDPH will also likely need to conduct stakeholder engagement activities to inform the final design of the program.

Applicability to other Counties

As part of this analysis, HMA assessed whether particular administrative structures and approaches would be applicable to other counties that are interested in implementing a program to address the affordability of health insurance for their residents. San Francisco has a unique set of circumstances in that it benefits from its existing HCSO, a requirement applying to San Francisco employers that provides a dedicated funding stream that can be used to pay for premium and/or cost-sharing assistance. In addition, SFDPH also benefits from the established operations of a TPA that is already administering its City Option program, which provides the opportunity to leverage existing infrastructure and expertise.

However, other counties seeking to lower uncompensated care costs or to increase insurance coverage could apply findings and lessons learned from San Francisco in establishing their own programs to provide assistance to residents purchasing from Covered California. Counties could explore whether county leadership would approve general funding to support a premium or cost-sharing assistance program or whether a county action could establish a new funding source through assessments similar to San Francisco's HCSO.

In addition to identifying a funding source, counties considering a new program should analyze the cost of living in the county and determine what level of assistance would be needed to make the purchase of coverage on Covered California more affordable for county residents. Similar to what was prepared for this analysis, the county could conduct an analysis of its relative cost of living in comparison to other geographic areas. The county would also need to examine the portion of its population that needs assistance and is not eligible for Medicaid and to ensure that enrollment in Medicaid among those who are eligible is maximized. Based on this analysis, the county could determine the amount of assistance it would provide to county residents and along what measures, whether a sliding scale based on FPL or some other income measure, or a flat benefit amount across income levels up to a set maximum.

Once the assistance design of the program is determined, the county would then need to determine the operational requirements for establishing such a program, such as whether the county would operate the program in-house or procure a TPA to carry out its operation. Under either scenario, the county would need to determine the administrative costs associated with carrying out the program. If the

county were to procure a TPA for support, the TPA would estimate the administrative costs as part of its bid for the contract.

In terms of the administrative structure of the program—how funds would flow, what entities would be involved and how eligibility would be determined—counties can draw upon the analysis of administrative structure options and administrative costs presented in this report as well as the operational process flows provided in Appendix IV. Counties can also examine their current operations to identify efficiencies that can be leveraged, including existing eligibility workers and managed care programs. Finally, when selecting an administrative structure, the county would also need to understand the context of its commercial insurance market, including what QHP issuers are participating in Covered California in the county and how willing those issuers would be to collaborate on the implementation of such a program.

The recommendations set forth in this report aim to take advantage of San Francisco's existing funding stream and TPA resources in order to establish this new program in time for the upcoming 2016 plan year. Under different timing, resources, and circumstances, a different set of recommendations may have emerged. For example, HMA learned from our interviews concerning the Oregon subsidy program that the use of a single contracted plan makes implementation of an assistance program much simpler from an operational perspective. While each county interested in creating an insurance affordability program would need to consider its own specific circumstances when selecting a programmatic structure, the analyses presented in this report, as well as the infrastructure SFDPH ultimately selects for its program, could provide useful guidance and lessons for moving forward.

Program Budget

Employer Contribution Projections

The projections of employer contributions below assume that the PBP is funded solely through pooled ESR contributions to the City Option. Table 18 presents projected revenues to the county from the HCSO employer contribution requirement. HMA used the low projection provided by the UCB-CLRE to ensure a financially stable and sustainable program design and to accommodate real-world deviation from the modeled projections.

Table 17: Projected Employer Contributions

Year	Projected Take-up[23]	Projected Available Funds
2016	3,770	$10,520,000
2017	4,425	$12,525,000
2018	5,080	$14,530,000
2019	5,195	$15,465,000
2020	5,310	$16,400,000

[23] Based on estimated take-up of the program under Option 2 – 80% premium assistance.

Program Assistance Projections

Table 18 provides one, three, and five year projections of program assistance costs for the PBP across the three assistance design options.

Table 18: Projection of Program Assistance Costs by Design Option

Program Assistance Design	2016	Three Year Total[24]	Five Year Total[25]
Option 1 – 100%/40%	$7,472,000	$27,915,000	$53,296,000
Option 2 – 80% Premium Asst.	$10,960,000	$39,732,000	$75,252,000
Option 3 – 60% Premium Asst. /Cost Sharing	$9,184,000	$33,573,000	$63,713,000

Administrative Cost Projections

The following tables provide projected administrative costs for the recommended administrative structures presented in this report, both for MRAs alone as well as for a combination of debit cards and MRAs. Projected administrative costs are provided for implementation of these recommended structures within the existing City Option program as well as under a new TPA contract.

The options presented in this analysis are extensions of the current City Option. The City Option TPA already has experience and operational efficiencies that can be leveraged to control administrative costs. HMA estimated the administrative costs under two circumstances: using the existing TPA and utilizing a new contractor.

MRA Administrative Cost Estimates

The following two tables provide administrative cost projections for the implementation of MRAs for PBP participants. The administrative cost projections for implementing a MRA under the current City Option program take into account only costs that are in addition to those already reflected in the City Option budget. Therefore, the administrative costs outlined in Table 13 below for the MRA under the current City Option represent costs in addition to the current contract. Table 14 presents projected administrative costs if a new contractor were to be procured.

Table 13: Administrative Costs of a MRA under Current City Option Program

Cost Category	2016	Three Year Total[26]	Five Year Total
Marketing and Outreach	$123,000	$264,000	$419,000
IT Infrastructure/Call Center[27]	$157,000	$349,000	$552,000
Eligibility Determination	$213,000	$759,000	$1,354,000

[24] The value for estimated program assistance expenditures in 2017 was calculated by taking the average of the estimated program assistance that would be provided under each assistance design in 2016 and 2018.
[25] The value for estimated program assistance expenditures in 2019 was calculated by taking the average of the estimated program assistance that would be provided under each assistance design in 2018 and 2020.
[26] Three and five-year costs represent cumulative administrative costs over three and five years.
[27] Includes changes to the member portal, accounting system changes, database changes, and changes to call center training and scripts.

Overall Overhead	$25,000	$89,000	$163,000
TPA Personnel	$412,000	$1,261,000	$2,145,000
Additional SFDPH Personnel	$56,000	$171,000	$291,000
Total	***$986,000***	***$2,893,000***	***$4,924,000***

Table 14: Administrative Costs of a MRA with New TPA Contract

Cost Category[28]	2016	Three Year Total	Five Year Total
Marketing and Outreach	$253,000	$569,000	$898,000
IT Infrastructure/Call Center	$253,000	$510,000	$777,000
Overhead	$60,000	$184,000	$313,000
TPA Personnel	$927,000	$2,838,000	$4,825,000
Additional SFDPH Personnel	$355,000	$1,087,000	$1,849,000
Total	***$1,848,000***	***$5,188,000***	***$8,662,000***

MRA and Debit Card Combination Administrative Cost Estimates

The following two tables provide the administrative cost projections for the implementation of a combination of debit cards and MRAs for the PBP. Table 15 projects administrative costs under the current TPA contract. Table 16 presents projected administrative costs if a new contractor were to be procured.

[28] Eligibility determination costs are included in the Additional SFDPH Personnel line for the new TPA contract costs.

Table 15: Administrative Costs of a MRA/Debit Card under Current City Option Program

Cost Category	2016	Three Year Total	Five Year Total
Marketing and Outreach	$123,000	$264,000	$419,000
IT Infrastructure/Call Center[29]	$157,000	$349,000	$552,000
Eligibility Determination	$213,000	$759,000	$1,354,000
Overall Overhead	$25,000	$89,000	$163,000
Debit Card Costs	$80,000	$182,000	$288,000
TPA Personnel	$413,000	$1,264,000	$2,149,000
Additional SFDPH Personnel	$56,000	$172,000	$291,000
Total	***$1,067,000***	***$3,079,000***	***$5,216,000***

Table 16: Administrative Costs of a MRA/Debit Card with New TPA Contract

Cost Category	2016	Three Year Total	Five Year Total
Marketing and Outreach	$253,000	$569,000	$898,000
IT Infrastructure/Call Center	$253,000	$510,000	$777,000
Overall Overhead	$60,000	$184,000	$313,000
Debit Card Costs	$80,000	$182,000	$288,000
TPA Personnel	$927,000	$2,838,000	$4,825,000
Additional SFDPH Personnel	$355,000	$1,087,000	$1,849,000
Total	***$1,928,000***	***$5,370,000***	***$8,950,000***

Summary of Revenues and Costs

Table 19 below provides a summary view of projected annual employer contributions into the City Option as well as costs for the program including assistance costs and administrative costs, over a five year period.

[29] Includes changes to the member portal, accounting system changes, database changes, and changes to call center training and scripts.

Table 19: Estimated Program Revenues and Costs over a Five Year Period[30][31]

Year	Projected Take-up[32]	Projected Annual Employer Contributions	Projected Assistance Costs (average across three design options)	Projected Administrative Costs for MRA Option (under City Option TPA)
2016	3,770	$10,520,000	$9,205,000	$986,000
2017	4,425	$12,525,000	$11,247,000	$921,000
2018	5,080	$14,530,000	$13,288,000	$987,000
2019	5,195	$15,465,000	$14,545,000	$1,009,000
2020	5,310	$16,400,000	$15,802,000	$1,021,000

[30] Based on estimated take-up of the program under Option 2 – 80% premium assistance.
[31] The values for take-up and employer contributions for 2017 and 2019 were calculated by taking the average of the prior and following years as provided by UCB-CLRE.
[32] Based on estimated take-up of the program under Option 2 – 80% premium assistance.

Appendix I: Coverage and Eligibility with No PBP Assistance

Estimated coverage and eligibility for employees with HCSO contributions from employers under current policy in 2014; excluding those residing outside of San Francisco and employees with small contributions to "top off" ESI.

Sources: SFDPH Data, ACS, CHIS and the CalSIM version 1.92, under "standard take up assumptions" recalibrated to HCSO population.

Eligibility and Coverage	Total	ESI	Medi-Cal	Unin-sured	Cov. CA / Non-group	Total Premium Costs after Covered CA Subsidies for Non-group	Expected Out-of-pocket expenses for Non-group	Employer contribu-tions to City Option, <100 employees	Employer contribu-tions to City Option, 100+ employees
2014									
Undocumented Immigrants	1,010	90	-	810	110	400,000	120,000	770,000	2,460,000
Enrolled or Eligible for Medicaid*	3,830	-	3,380	230	220	790,000	80,000	1,140,000	9,900,000
ESI Coverage Via Another Family Member	8,600	8,600	-	-	-	*Not Shown*	*Not Shown*	2,140,000	18,540,000
Eligible for Cov CA subsidies, up to 250% FPL	960	-	-	400	560	740,000	570,000	260,000	2,230,000
Eligible for Cov CA subsidies, up to 251-400% FPL	680	-	-	280	400	1,420,000	710,000	350,000	880,000
Not eligible for Cov CA subsidies, up to 250% FPL	130	-	-	50	80	340,000	80,000	30,000	320,000
Not eligible for Cov CA subsidies, 250-400% FPL	320	-	-	70	250	840,000	290,000	110,000	610,000
401-500% FPL	430	-	-	80	350	1,350,000	470,000	200,000	960,000
501-635% FPL	650	-	-	70	580	2,030,000	700,000	140,000	1,230,000
Above 635% FPL	1050	-	-	210	840	4,700,000	1,630,000	240,000	1,940,000
Subtotal for Covered CA Target Population	**4,220**	**-**	**-**	**1,160**	**3,060**	**$11,420,000**	**$4,450,000**	**$1,330,000**	**$8,170,000**

Appendix II: Benefit Option Analysis

Source: Adapted from UC Berkeley Labor Center's Analysis

1. Premium Assistance Only, Amount by Sliding Scale (100%/40%)

Number Served:				**Complexity:** Given the flat subsidy amounts at specified incomes, this option is only moderately complex.		
2016 Estimated Take-up:	3,680					
2018 Estimated Take-up	5,050					
2020 Estimated Take-up	5,270					
Costs:[33]				**Premium Subsidy:**	**Total Remaining Cost:**	**Sample Remaining Cost as % of Household Income for a Single Individual:**[34]
	Premium	Out of Pocket	Total Costs			
Up to 250% of FPL *100% Premium Covered*	$1,940,000	$1,010,000	$2,950,000	$1,940,000 ($1,702 /person)[35]	$1,010,000 ($886/person)	3.7%
251-400% of FPL *100% Premium Covered*	$4,120,000	$1,660,000	$5,780,000	$4,120,000 ($3,815/person)	$1,660,000 ($1,537/person)	3.7%
401-500% *40% Premium Covered*	$3,530,000	$1,280,000	$4,810,000	$1,412,000 ($2,315/person)	$3,398,000 ($5,570/person)	10.5%
501-635% *MRA*	$3,450,000	$1,200,000	$4,650,000	$0	$4,650,000 ($5,471/person)	7.7%
Totals:	$13,040,000	$5,150,000	$18,190,000	$7,472,000	$10,718,000	

[33] Cost values are based on 2016 estimates.

[34] Scenarios are based on example income levels for a single individual as a % of poverty, as follows: 200% of FPL ($23,540); 350% ($41,195); 450% ($52,965); 600% ($70,620). To calculate these percentages, the Total Remaining Cost was divided by the applicable income value. These percentages would vary by the age of the individual.

[35] Per person Premium Subsidy and Total Remaining Cost amounts across each income group are based on dividing the total premium subsidy and the total remaining costs by the estimated number of individuals who would take up the option.

2. Premium Assistance Only, 80% premium of 2nd lowest cost silver plan

Number Served:				**Complexity:** Least complexity due to the flat benefit amount up to 635% of FPL.		
2016 Estimated Take-up:	3,770					
2018 Estimated Take-up	5,080					
2020 Estimated Take-up	5,310					
Costs:				**Premium Subsidy:**	**Total Remaining Cost:**	**Sample Remaining Cost as % of Household Income for a Single Individual:**
	Premium	OOP	Total Costs			
Up to 250% of FPL *80% Premium Assistance*	$1,900,000	$1,020,000	$2,920,000	$1,520,000 ($1,345/person)	$1,400,000 ($1,239/person)	5.3%
251-400% of FPL *80% Premium Assistance*	$4,040,000	$1,650,000	$5,690,000	$3,232,000 ($2,993/person)	$2,458,000 ($2,276/person)	5.5%
401-500% of FPL *80% Premium Assistance*	$4,030,000	$1,430,000	$5,460,000	$3,224,000 ($4,885/person)	$2,236,000 ($3,388/person)	6.4%
501-635% of FPL *80% Premium Assistance*	$3,730,000	$1,290,000	$5,020,000	$2,984,000 ($3,315/person)	$2,036,000 ($2,262/person)	3.2%
Totals:	$13,700,000	$5,390,000	$19,090,000	$10,960,000	$8,130,000	

3. Premium Assistance and Cost Sharing: 60% of 2nd lowest cost silver plan premium and banded cost-sharing assistance

Number Served:				**Complexity:** Cost-sharing assistance determination adds more complexity because the amount changes based on 50% increments of FPL. Eligibility workers will require more training and quality control measures, and this approach will be more difficult to explain to the public.			
2016 Estimated Take-up:	3,750						
2018 Estimated Take-up	5,070						
2020 Estimated Take-up	5,310						
Costs:				**Premium Subsidy:**	**Cost Sharing Subsidy:**[36]	**Total Remaining Cost:**	**Sample Remaining Cost as % of Household Income for a Single Individual:**
	Premium	OOP	Total Costs				
Up to 250% *60% premium + cost sharing asst.*	$1,860,000	$1,040,000	$2,900,000	$1,116,000 ($988/person)	$660,000 ($584/person)	$1,124,000 ($995/person)	4.2%
251-400% *60% premium + cost sharing asst.*	$3,970,000	$1,650,000	$5,620,000	$2,382,000 ($2,206/person)	$490,000 ($454/person)	$2,748,000 ($2,544/person)	6.2%
401-500% *60% premium*	$3,870,000	$1,400,000	$5,270,000	$2,322,000 ($3,572/person)	$0	$2,948,000 ($4,535/person)	8.6%
501-635% *60% premium*	$3,690,000	$1,290,000	$4,980,000	$2,214,000 ($2,488/person)	$0	$2,766,000 ($3,108/person)	4.4%
Totals:	$13,390,000	$5,380,000	$18,770,000	$8,034,000	$1,150,000	$9,586,000	

[36] Cost sharing subsidy amount is provided on a sliding scale in 50% of FPL increments as follows: Up to 200%of FPL - $550/year; 201-500% of FPL - $673/year; 251-300% of FPL - $779/year; 301-350% of FPL - $485/year; 351-400% of FPL - $190/year.

Appendix III: Timeline to Establish the Public Benefit Program

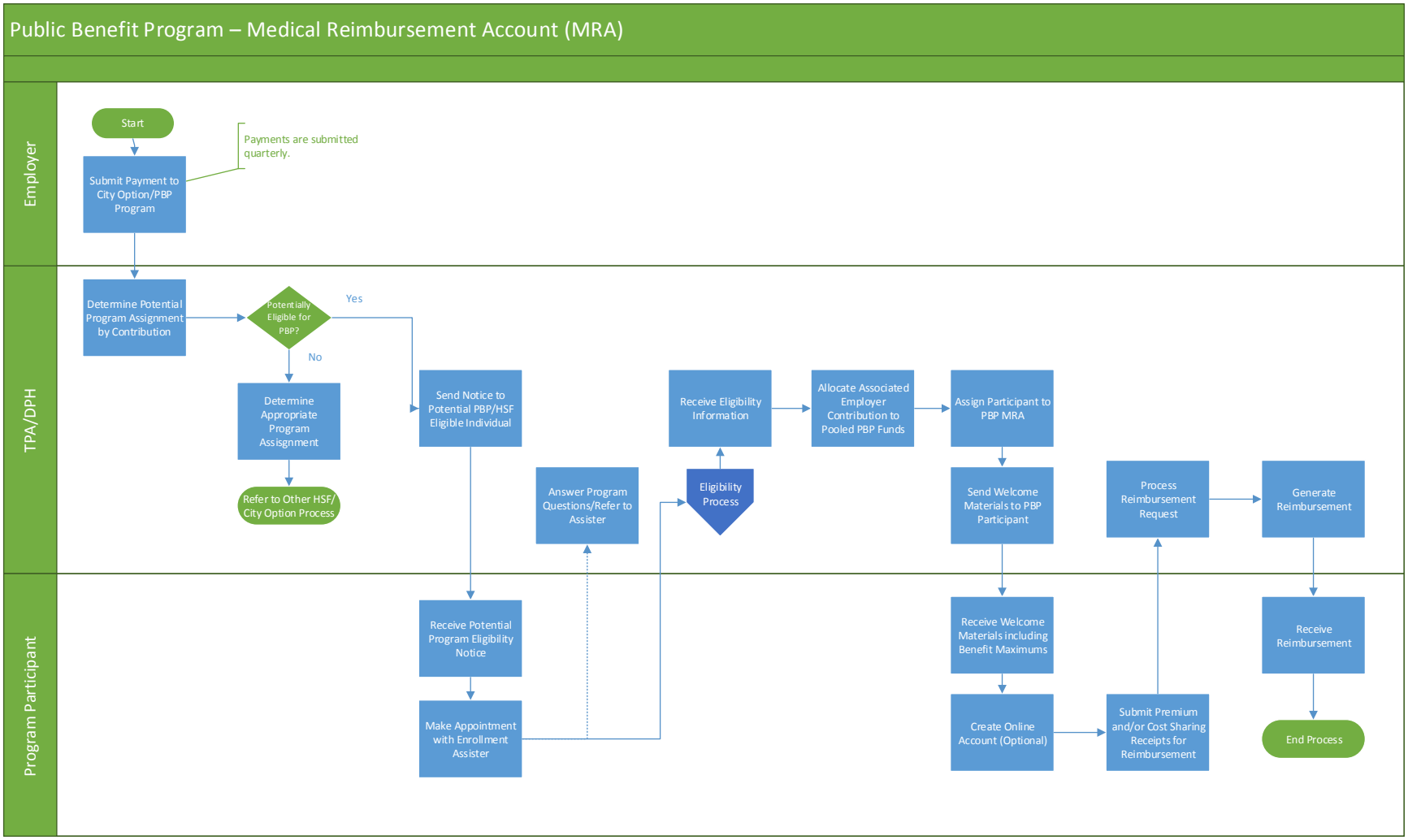
The following timeline outlines the steps and anticipated time needed to establish the Public Benefit Program. This timeline assumes that the program is run through the existing City Option program. The goal is to make the program available to participants by Covered California's 2016 plan year. Open enrollment for the 2016 plan year runs from November 1, 2015 through January 31, 2016.

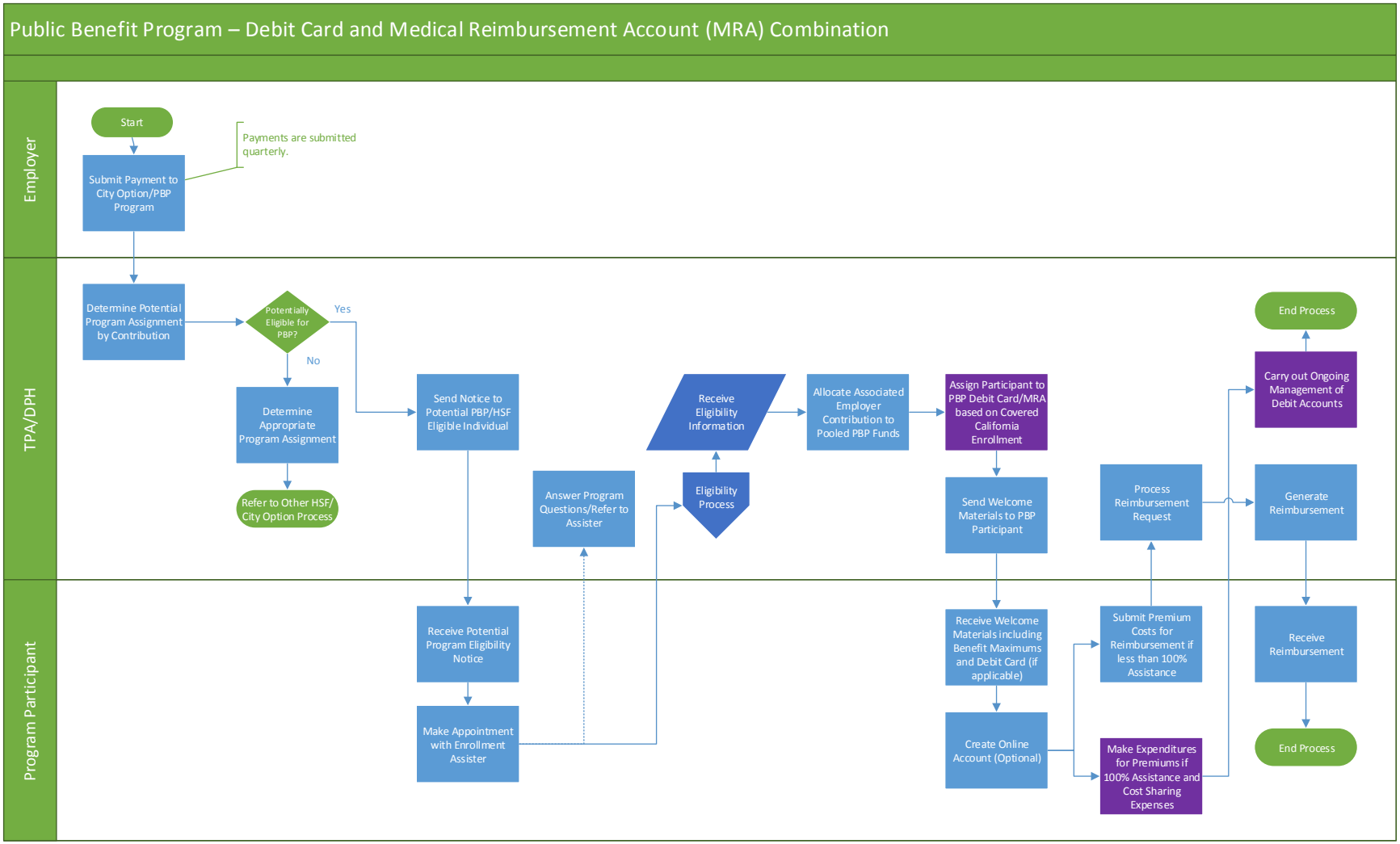
HMA anticipates this process will take approximately six months from implementation to the start of enrollment. Therefore, SFDPH would need to begin the process shortly for PBP enrollment to be available before the end of Covered California's 2016 open enrollment period.

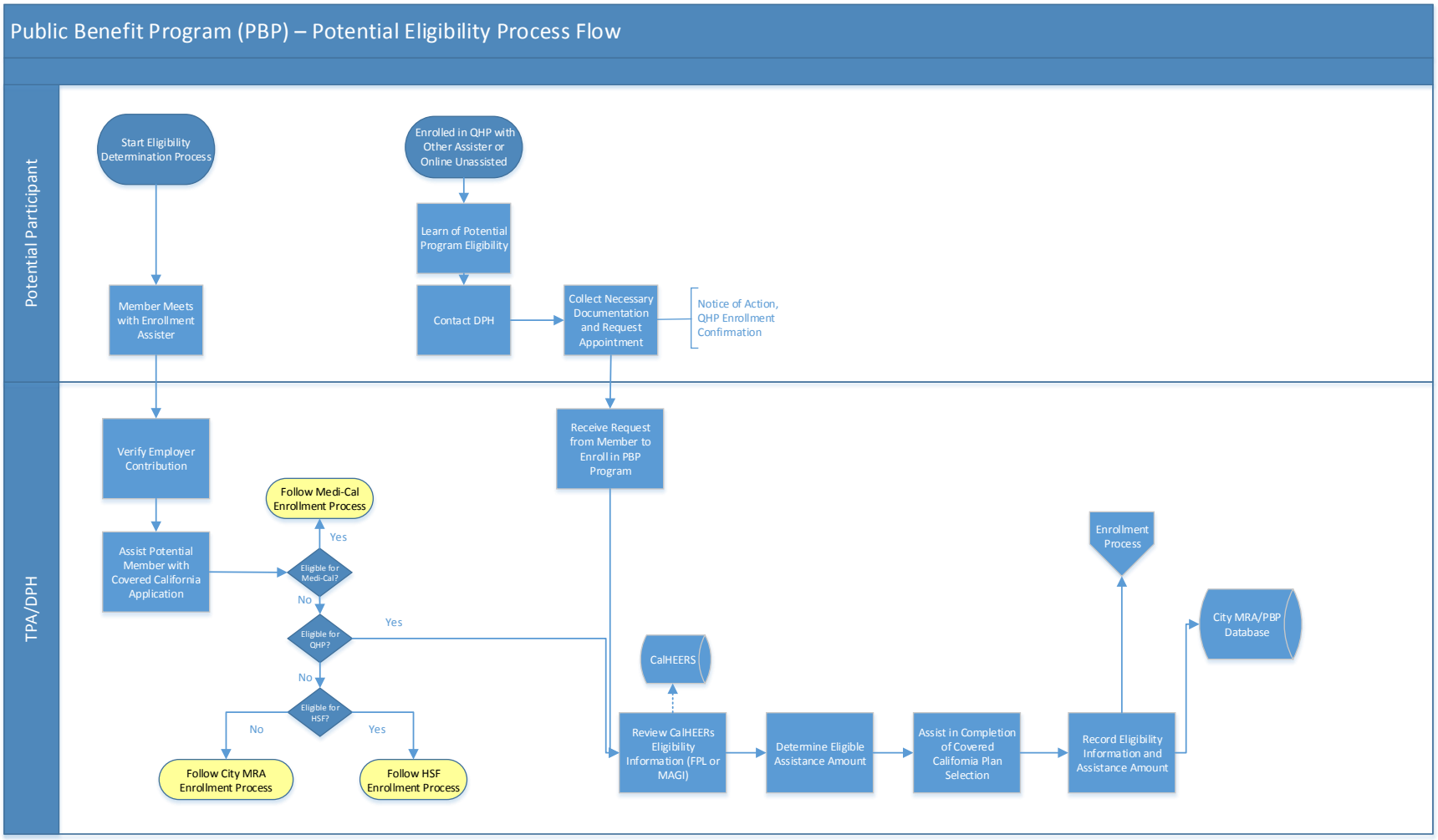
This timeline assumes modifications within the existing City Option program. If SFDPH needs to procure a new TPA vendor through competitive procurement, the contract completion could take longer. A new contractor would likely require more time for start-up as well.

	Month											
Significant Tasks	1	2	3	4	5	6	7	8	9	10	11	12
Finalize critical decisions regarding program eligibility, process flow	x											
Complete contract modifications		x	x									
Establish/modify infrastructure: billing and collection systems			x	x	x							
Hire needed staff			x	x	x							
Develop call center scripts and train customer service representatives			x	x								
Develop program materials, amend website				x	x							
Draft and send initial notices to employers/employees					x	x						
Train eligibility workers					x	x						
Hold educational webinars for employers/employees					x	x	x					
Begin enrollment (open enrollment period)							x	x	x	x	x	x
Establish accounts and allocate program assistance dollars to program participants								x	x	x	x	x
Send participants welcome letter, brochure								x	x	x	x	x
Resolve any inquiries/complaints											x	x

Appendix IV: Operational Process Flow Diagrams




Public Benefit Program – Debit Card and Medical Reimbursement Account (MRA) Combination
Employer
TPA/DPH
Program Participant
Start
Payments are submitted quarterly.
Submit Payment to City Option/PBP Program
Determine Potential Program Assignment by Contribution
Potentially Eligible for PBP?
Yes
No
Determine Appropriate Program Assignment
Refer to Other HSF/ City Option Process
Send Notice to Potential PBP/HSF Eligible Individual
Receive Potential Program Eligibility Notice
Make Appointment with Enrollment Assister
Answer Program Questions/Refer to Assister
Receive Eligibility Information
Eligibility Process
Allocate Associated Employer Contribution to Pooled PBP Funds
Assign Participant to PBP Debit Card/MRA based on Covered California Enrollment
Send Welcome Materials to PBP Participant
Receive Welcome Materials including Benefit Maximums and Debit Card (if applicable)
Create Online Account (Optional)
Submit Premium Costs for Reimbursement if less than 100% Assistance
Make Expenditures for Premiums if 100% Assistance and Cost Sharing Expenses
Process Reimbursement Request
End Process
Carry out Ongoing Management of Debit Accounts
Generate Reimbursement
Receive Reimbursement
End Process


Public Benefit Program (PBP) – Potential Eligibility Process Flow
Potential Participant
TPA/DPH
Start Eligibility Determination Process
Enrolled in QHP with Other Assister or Online Unassisted
Learn of Potential Program Eligibility
Member Meets with Enrollment Assister
Contact DPH
Collect Necessary Documentation and Request Appointment
Notice of Action, QHP Enrollment Confirmation
Verify Employer Contribution
Receive Request from Member to Enroll in PBP Program
Follow Medi-Cal Enrollment Process
Yes
Assist Potential Member with Covered California Application
Eligible for Medi-Cal?
No
Eligible for QHP?
Yes
No
Eligible for HSF?
No
Yes
Follow City MRA Enrollment Process
Follow HSF Enrollment Process
CalHEERS
Review CalHEERs Eligibility Information (FPL or MAGI)
Determine Eligible Assistance Amount
Assist in Completion of Covered California Plan Selection
Record Eligibility Information and Assistance Amount
Enrollment Process
City MRA/PBP Database

Appendix V: Affordability of Health Insurance and Health Care in San Francisco

UC Berkeley Center for Labor Research and Education

April 14, 2015

Spending on health care has increased rapidly over the past decades, and affordability presents a major obstacle in accessing health care. For individuals, the costs of health care include both health insurance premiums and out-of-pocket costs. Affordability of premiums can affect health insurance take-up rates, while the affordability of out-of-pocket costs can affect health care usage and financial stability. According to a Kaiser Family Foundation survey of Californians uninsured in 2014, the majority value insurance and say it is worth the cost. The most common reason for remaining uninsured, cited by 34% of the respondents, was not being able to afford insurance.[37] Even among those who do have insurance, out-of-pocket expenses and high deductibles mean that affordability remains an issue. The lack of affordability can lead people to avoid or delay seeking care. For example, 29% of privately insured adults with a relatively high deductible (5% or more of their income) skipped a doctor-recommended medical test, treatment, or follow up, compared to just 14% of those with a relatively lower deductible (less than 5% of income).[38] A recent analysis found that more than half of non-elderly households with incomes 100% to 250% of the federal poverty line (FPL) lack the liquid assets to pay even a mid-range deductible of $1200 for a single person or $2400 for a family. A quarter of all the non-elderly households above the poverty line that have private insurance do not have the liquid assets to do so.[39]

To make health insurance more affordable for low-income individuals and families, the Affordable Care Act (ACA) provides premium subsidies for those with incomes up to 400% of FPL and cost-sharing subsidies for those with incomes up to 250% of FPL. The premium subsidies are calculated so that no one pays more than a designated percentage of his or her income on premiums. Cost sharing subsidies limit the deductible, out-of-pocket maximum, co-pays and co-insurance.

In Figure 1 below, the first column shows relevant ACA federal poverty level ranges. The second represents the premium assistance from the ACA as a maximum share of income to be spent on premiums at each of FPL threshold. The final columns show the cost sharing subsidies available at each FPL level, and the associated deductible and out-of-pocket spending maximum.

[37] Kaiser Family Foundation, *Where are California's Uninsured Now? Wave 2 of the Kaiser Family Foundation California Longitudinal Panel Survey*, July 2014

[38] Privately insured includes job-based coverage, a marketplace plan, or other individual market plan. Source: Sara R. Collins, Petra W. Rasmussen, Michelle M. Doty, and Sophie Beutel. "Too High a Price: Out-of-Pocket Health Care Costs in the United States: Findings from the Commonwealth Fund Health Care Affordability Tracking Survey, September–October 2014." Commonwealth Fund, November 2014.

[39] Gary Claxton, Matthew Rae, and Nirmita Panchal. "Consumer Assets and Patient Cost Sharing." Kaiser Family Foundation, February 2015.

Figure 1. Affordable Care Act Premium and Cost Sharing Subsidies in Covered California

	Premium Assistance	Cost Sharing		
Federal Poverty Level Threshold	Maximum Premium Percentages as a Share of Income, 2015	Cost Sharing Subsidy	Deductible	Out-of-Pocket Maximum
0% - 138%	0% - Medicaid	None - Medicaid	$0	$0
138% - 149%	3.31% - 4.02%	Enhanced Silver 94	$0	$2,250
150% - 199%	4.02% - 6.34%	Enhanced Silver 87	$550	$2,250
200% - 249%	6.34% - 8.10%	Enhanced Silver 73	$1,850	$5,200
250% - 299%	8.10% - 9.56%	NA	[$2,250 for Silver]	[$6,250 for Silver]
300% - 399%	9.56%	NA	[$2,250 for Silver]	[$6,250 for Silver]

The provisions of the ACA do improve affordability of health care. However, the thresholds codified by the ACA do not necessarily meet other definitions of affordability, and some may gain insurance but remain underinsured. The Commonwealth Fund defines underinsurance as having a deductible that is at least 5% of household income or having out-of-pocket costs (excluding premiums) that are at least 5% of household income for those under 200% of FPL, or at least 10% of household income for those above 200% of FPL. Given the standard ACA subsidies, single individuals between 200% and 400% of the federal poverty level will face deductibles higher than the Commonwealth threshold (Figure 2). Individuals in all of the categories would be underinsured if they were to hit the maximum out-of-pocket costs (listed in Figure 1).[40]

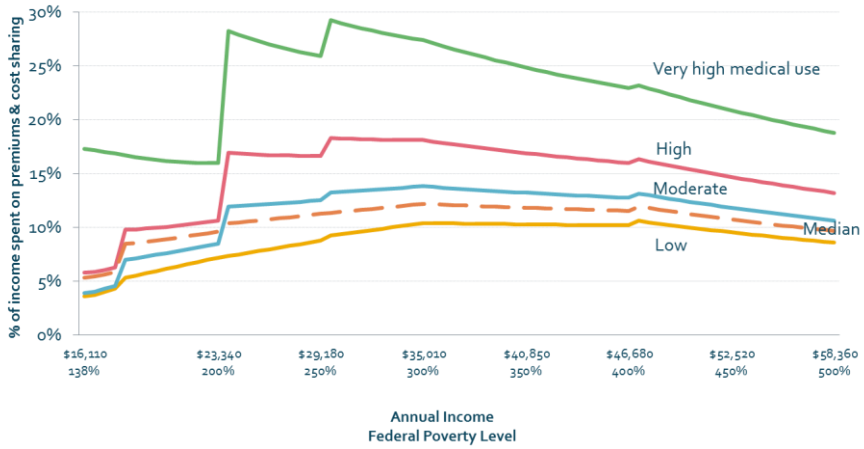
Figure 2. Single Individual: Underinsurance in Covered California Plans

Income as % of FPL	**Health Plan**	**Deductible**	
		Medical + Drug	**% of Income**
144%	Enhanced Silver 94	-	0.0%
175%	Enhanced Silver 87	$550	2.7%
225%	Enhanced Silver 73	$1,850	**7.0%**
275%	Silver 70	$2,250	**7.0%**
325%	Silver 70	$2,250	**5.9%**
375%	Silver 70	$2,250	**5.1%**
425%	Silver 70	$2,250	4.5%
475%	Silver 70	$2,250	4.1%

[40] Collins et al. "Too High a Price: Out-of-Pocket Health Care Costs in the United States: Findings from the Commonwealth Fund Health Care Affordability Tracking Survey, September–October 2014." Commonwealth Fund, November 2014.

To see the potential affordability issues even with ACA subsidies, consider the total expected health spending at various income and spending levels, as shown below in Figure 3. These estimates include premiums and use the Covered California "Plan Preview" tool to estimate out-of-pocket costs for one member of the family at various levels of usage, taking into account premium and cost-sharing subsidies.[41] A single 40 year old enrolled in a Silver plan could spend as much as 30% of income on health care if she had very high medical use. Even assuming only the median level of medical use,[42] spending exceeds 10% of income at most income levels. For a family of four with two working parents, total spending (assuming premium and out-of-pocket spending for just one adult) could be as high as 18% of income and hovers between 5 and 10% of income given median use.

Figure 3. Total Expected Health Spending, Single 40 Year Old



Note: Graph reflects premium and cost sharing after subsidies for 40 year old San Franciscans purchasing the second lowest cost Silver plan through Covered California

[41] The Plan Preview tool is available via the CalHEERS website at https://v.calheers.ca.gov/

[42] Median out-of-pocket costs are calculated as described in the methodological appendix based on Ryan Lore, Jon R. Gabel, Roland McDevitt, and Michael Slover. "Choosing the 'Best' Plan in a Health Insurance Exchange: Actuarial Value Tells Only Part of the Story." Commonwealth Fund, August 2012.

Figure 4. Total Expected Health Spending, Two Working Parents Two Children

Note: Graph reflects premium and cost sharing after subsidies for 40 year old San Franciscans purchasing the second lowest cost Silver plan through Covered California

Concerns about affordability of health care are even more acute in places like San Francisco with a high cost of living. Below we explore two ways of thinking about affordability in high cost areas: first looking at the affordability thresholds defined by the ACA and adjusting them for San Francisco cost of living, and second looking at family budgets.

Adjusting the ACA FPL thresholds to reflect San Francisco cost of living

Given the high cost of living in San Francisco, using the federal poverty threshold for affordability considerations is particularly challenging—the $11,670 poverty threshold for a single person in 2014 buys much less in San Francisco than in less expensive parts of the country. In recent years, alternate poverty measures have emerged, including the Census Bureau's supplemental poverty measure.[43] Building on this, a California-specific poverty measure was developed by researchers at the Public Policy Institute of California and the Stanford Center on Poverty and Inequality. This California-specific poverty measure takes into account the cost of housing by county. For San Francisco renters, the calculated poverty threshold is 59% above the federal poverty threshold, meaning that 100% of FPL equates to 159% of FPL in San Francisco.[44] Using this cost of living adjustment, the affordability thresholds in the ACA can be translated for San Francisco: a San Franciscan making up to 219% of FPL is the equivalent of the average person nationally making up to 138% of FPL, the threshold for receiving completely free care (via Medicaid). San Franciscans earning 220% - 635% of FPL are the equivalent of those earning 138% - 399% of FPL, who pay a maximum of between 3% and 9.5% of their income on Covered California premiums under the ACA. Cost sharing subsidies are available for those earning up to 249% of FPL nation-wide, the equivalent of 396% of FPL in San Francisco.

[43] See, for example, the Census Bureau's webpage on experimental poverty measures, https://www.census.gov/hhes/povmeas/about/index.html

[44] Sarah Bohn, Caroline Danielson, Matt Levin, Marybeth Mattingly, and Christopher Wimer. "The California Poverty Measure: A New Look at the Social Safety Net." Public Policy Institute of California, October 2013. See especially table B1 in the technical appendix. http://www.ppic.org/main/publication.asp?i=1070

Figure 5. Adjusted San Francisco FPL and Associated ACA Subsidies and Cost Sharing

		ACA Subsidies	
San Francisco equivalent FPL Threshold	National FPL Threshold	Maximum Premium Percentages as a Share of Income	Cost Sharing Subsidy
0% - 219%	0% - 138%	0% - Medicaid	Medicaid
220% - 237%	138% - 149%	3.31% - 4.02%	Enhanced Silver 94
238% - 317%	150% - 199%	4.02% - 6.34%	Enhanced Silver 87
318% - 396%	200% - 249%	6.34% - 8.10%	Enhanced Silver 73
397% - 476%	250% - 299%	8.10% - 9.56%	NA
477% - 635%	300% - 399%	9.56%	NA

A budget-based affordability threshold

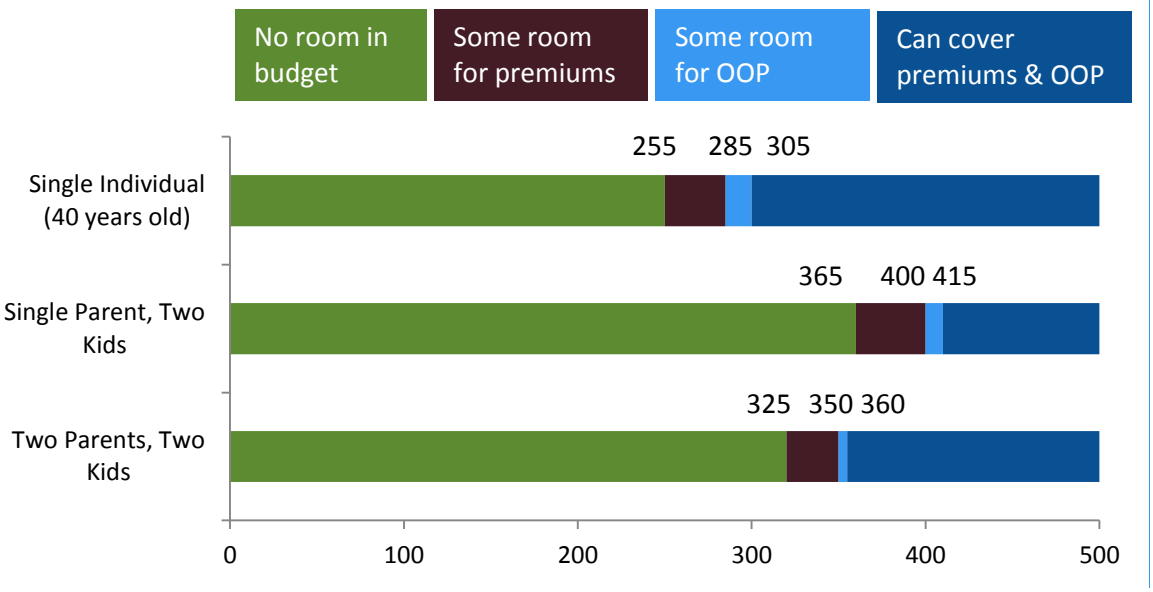
Converting the ACA's FPL thresholds to the cost of living in San Francisco may underestimate the gap between a family's income and their ability to pay for health care, especially at lower income levels. Another approach, similar to that employed by Gruber and Perry at the national level,[45] involves building a family budget to reveal at what point there is room to cover both basic needs and spending on health care. In San Francisco, even a budget that assumes no vacations and no entertainment [46] leaves no room for health care spending for a single person until income goes above $29,180 (250% of FPL). For a San Francisco family with two working parents and two children, income must be over $76,320 (320% of FPL) before there is any money available for spending on health care. Unsurprisingly, high housing costs are a major factor in San Francisco budgets. Using fair market rents for 2015,[47] San Franciscans pay significantly more for housing (including utilities) than the average for the rest of the state—about 40% more for a studio ($1,256), and 50% more for a two-bedroom ($2,062).[48] Even when taking into account the lower cost of housing the East Bay, housing costs in the San Francisco metro area are about 80% higher than for the country as whole.[49]

Using this family budget reveals at what point a family starts to have some money available for health care (shown in Figure 6 below in terms of the FPL). Under that threshold, there is no room to cover both

[45] Jonathan Gruber and Ian Perry. "Realizing Health Reform's Potential: Will the Affordable Care Act Make Health Insurance Affordable?" Commonwealth Fund, April 2011.
[46] See the methodological appendix for more on the calculation of family budgets.
[47] Fair Market Rents (FMRs) are published annually by the US Department of Housing and Urban Development (HUD) and estimate the cost of shelter and utilities, excluding telephone and internet service, in given areas. FMRs generally represent the 40th % of rents paid by recent movers in an area, meaning that the cost of 40 % of rental housing is lower than the FMR and the cost of 60 % is higher. HUD sets FMR values at the 50th % in some metropolitan areas where affordable housing can be difficult to obtain. Individuals and families seeking housing may not be able to locate units at these rents, particularly in parts of the state where housing markets are tight.
[48] See the appendix for a comparison of budgets for San Francisco county, Modoc county, and California as a whole.
[49] For example, the housing component of regional price parity for the San Francisco-Oakland-Hayward metro area indicates that rents are 80 % above the national average. See the Bureau of Economic Analysis Regional Price Parities Data for 2012 at http://www.bea.gov/iTable/index_regional.cfm

basic necessities and spending on health care, requiring a full subsidy for health care to be affordable (the green group of the chart below). Above that threshold and for a narrow income range, families have some leftover money that could be spent on premiums, but not enough to pay their expected share of premium costs through Covered California; these families would need additional subsidies just to cover premium costs (the brown group below). Next, there is a threshold above which families have room in their budget to cover premiums through Covered California given the federal subsidies, but not enough to cover the median out of pocket costs (the light blue group below). Finally, there is a threshold at which families have room in their budget to cover not only expected premiums for Covered California, but also the median out-of-pocket costs (the dark blue group below). These thresholds are summarized below for three types of family structures.

Figure 6. FPL Affordability Thresholds by Family Structure



Note: FPL thresholds are rounded to the nearest 5%; parents are assumed to be 40 years old. Calculations assume take up of federal premium and cost-sharing subsidies. OOP = out of pocket costs.

Given this range of FPL thresholds, it is important to understand the family structures of those most likely to be affected by the proposed public benefit program. Of the San Franciscans eligible for Covered California, in the City Option, and below 500% of FPL, the most common family type is a single individual with no children (45%), with the next most common being a married parent (25%).

Figure 7. City Option Employees Eligible for Covered CA and Below 500% of FPL, 2016 by Family Type

Family Type	Number of individuals	%
Single individual, no kids (average age: 33)	1,610	46%
Married, no kids	430	12%
Single Parent	210	6%
Married Parent	860	25%
Adult dependent, living with parents	360	10%
Total	**3,470**	100%

Note: excludes those residing outside of San Francisco and employees with small contributions to "top off" ESI. Sources: SF DPH Data, ACS, CHIS and the CalSIM version 1.92, under "standard take-up assumptions" recalibrated to City Option employees.

Though we calculate that low- and moderate-income families may not have room in their budgets for health care premiums, out-of-pocket spending, or both, many San Francisco families are nevertheless taking advantage of the subsidies offered through Covered California and signing up for coverage. Of the 33,000 individuals who received subsidies and signed up in 2014, almost half had incomes under 200% of FPL, nearly a quarter had incomes 201%-250% of FPL, and more than a quarter had incomes 250%-400% of FPL.[50] Some may have lower housing costs because of rent control or sharing housing with non-family members, or lower child care costs because of family-provided care, for example. Some may be using Medical Reimbursement Accounts to pay for premiums. Others may value health care over other basic needs.

Conclusion

This brief has shown that despite the available federal subsidies, health care affordability remains a challenge for many low- and moderate-income San Franciscans. Lower-income families may be foregoing spending on other necessities to pay their share of premiums. Moderate-income families not eligible for cost-sharing subsidies under the ACA—those with incomes 250%-400% of FPL—can face particularly high burdens in terms of deductibles and total spending. The goals of the ACA are not only to increase health insurance coverage but also to improve care and reduce costly, preventable hospital admissions through better access to routine care. Recent research on the results of health reform in Massachusetts did not find a reduction in potentially avoidable hospital visits, despite the increase in insurance take up. One potential cause cited is the financial burden of out-of-pocket spending.[51] Affordability of health care remains a significant barrier to care, especially in cities like San Francisco with a high cost of living.

[50] Covered California 2014 Data book, available at http://hbex.coveredca.com/data-research/

[51] Danny McCormick, Amresh D. Hanchate, Karen E. Lasser, Meredith G. Manze, Mengyun Lin, Chieh Chu, and Nancy R. Kressin. "Effect of Massachusetts healthcare reform on racial and ethnic disparities in admissions to hospital for ambulatory care sensitive conditions: retrospective analysis of hospital episode statistics." BMJ, April 2015.

Additional Information

1. Median Out-of-Pocket Cost Methodology:

Median out-of-pocket costs for Silver and Enhanced Silver plans are taken from the report "Choosing the 'Best' Plan in a Health Insurance Exchange: Actuarial Value Tells Only Part of the Story," by Ryan Lore, Jon Gabel, Roland McDevitt, and Michael Slover. Data points not given in the report were obtained via email communication with the authors. The authors use sample national health plans and actual claims data to simulate out-of-pocket spending. We inflate median 2010 costs by 4% per year to estimate 2015 costs. These median costs reflect the costs for one person; for families we assume that only one member of the family incurs medical costs, resulting in a conservative estimate of family costs. The following table summarizes these median costs.

Figure 8. Estimated Annual Out-of-Pocket Spending for Plans by ACA Actuarial Value

Actuarial Value of Plan in ACA	Median 2010—single individual	Adjusted to 2015
70%	$765	$931
73%	$765	$931
87%	$438	$533
94%	$270	$328

2. San Francisco Basic Budget Methodology:

The calculations of a San Francisco monthly budget are based on county-by-county budget calculations from the California Budget Project in 2013,[52] updated with housing costs from HUD Fair Market Rent FY2015, and using our own calculations of taxes, earned income tax credit, and health care expenses. The budgets do not include CalFresh benefits or child care subsidies. The budget does not include such items as vacations or entertainment. Methodological summaries by category follow Figure 9 and draw on California Budget Project documentation for childcare, transportation, food, and miscellaneous.

[52] California Budget Project. "Making Ends Meet: How Much Does it Cost to Raise a Family in California?" December 2013. http://calbudgetcenter.org/MakingEndsMeet/index.php

Figure 9. San Francisco "Making Ends Meet" Monthly Budget, by Family Type

Area	San Francisco			CA statewide average	Modoc (lowest)
Family type	Single Adult	Single Parent, Two Children	Two Working Parents, Two Children	Single Adult	Single Adult
Housing and utilities	$1,256	$2,062	$2,062	$903	$456
Child Care	$ -	$1,507	$1,507	$ -	$ -
Transportation	$297	$297	$517	$325	$334
Food	$293	$627	$866	$293	$293
Miscellaneous	$212	$439	$509	$212	$212
Taxes & EITC	Calculated by UCB based on income level				
Health care	Calculated by UCB based on income level and medical use				
Monthly total before taxes and health care	$2,058	$4,932	$5,461	$1,733	$1,295

The cost of **housing and utilities** is based on 2015 fair market rents (FMRs), published annually by HUD to estimate the cost of shelter and utilities, excluding telephone and internet service, in given areas. FMRs generally represent the 40th percentile of rents paid by recent movers in an area, meaning that the cost of 40% of rental housing is lower than the FMR and the cost of 60% is higher. HUD sets FMR values at the 50th percentile in some metropolitan areas where affordable housing can be difficult to obtain. Individuals and families seeking housing may not be able to locate units at the rents shown in this report, particularly in parts of the state where housing markets are tight. We assume a studio for singles, and a two bedroom for families.

For **child care**, the budget assumes that single-working-parent families and two-working-parent families each have two children, one requiring full-time care and another requiring afterschool care. Child care costs are based on monthly estimates for full-time infant care and part-time care for school-age children in each county in 2009, adjusted for inflation using the CPI for child care, assumes that care is provided in licensed family child care homes.

Transportation costs utilized the US Department of Transportation's 2009 National Household Travel Survey (NHTS). A county's weekly mileage estimate for one person is the county's average weekday vehicle miles traveled per household adult plus an estimate of miles driven on weekends based on the driving habits of California households. Transportation cost estimates also assume that families with two working parents require two vehicles on weekdays, but that only one car is needed on the weekend.

Food costs include food consumed both at home and away from home, using the June 2013 US Department of Agriculture (USDA) Low-Cost Food Plan and the 2012 Consumer Expenditure Survey (CES). Food estimates for families with children assume that one child is age 1 and one child is between the ages of 6 and 8. Conservatively, the basic family budget estimate for food away from home is half of the amount reported for families in the second-lowest 5th (quintile) of the income distribution in the CES. Food away from home includes lunches purchased out or the occasional family meal eaten in a restaurant. Food costs are assumed to be the same throughout the state.

The **miscellaneous** budget item includes items such as clothing and diapers, school supplies, toiletries, cleaning supplies, and household products. Estimates are made using the CES.

Taxes and the **Earned Income Tax Credit (EITC)** are calculated using the latest rates for federal income tax, state income tax, Federal Insurance Contributions Act (FICA)/Medicare payroll taxes, State Disability Insurance, and the federal EITC.

Health care premiums are calculated using Covered California's age-rated premiums for San Francisco's second most affordable silver plan (from Kaiser) in 2015.

Appendix VI: UC Berkeley Labor Center Analysis

Modeling Enrollment in a San Francisco Public Benefit Program

UC Berkeley Center for Labor Research and Education

April 14, 2015

Introduction and Objectives

The Center for Labor Research and Education has been contracted by the California Healthcare Foundation to provide research analysis for the San Francisco Department of Public Health (SFDPH) to assist Health Management Associates (HMA) with the development of a public benefit program to provide premium assistance for eligible San Francisco residents who receive employer contributions to the City Option under San Francisco's Health Care Security Ordinance (HCSO) and are eligible to purchase coverage through Covered California. Our task has been to characterize the population of city residents eligible for the program and to estimate the associated enrollment and costs.

We begin in Part I with a profile of the population covered by the HCSO City Option including key demographics relevant to those eligible for the program. In this section we restrict ourselves strictly to data provided by SFDPH on City Option contributions made by employers for employees covered by the HCSO. In Part II, we extend this analysis by using the California Simulation of Insurance Model (CalSIM) to show anticipated trends (1, 3 and 5 years) in health care costs in San Francisco and estimated number of people eligible in addition to program take-up under various policies of premium assistance. A more detailed description of the methods used can be found later in this document.

Part I: Characterizing eligible employees via analysis of SFDPH data on employer expenditures to HCSO for City Option employees.

In this section we present a series of tables to characterize the current population of employees who would be eligible for the program using administrative data from SFDPH. The initial source of information is a listing of all health care expenditures made by HCSO covered employers to the City Option on behalf of HCSO covered employees for the calendar years 2013 and 2014.

We begin with Table 1, which provides an initial indication of the fraction of City Option employees who could be eligible for the program. Of the 35,109 employees with contributions made to the City Option, we see that 41% reside outside of San Francisco and would not be eligible for the program designed for only city residents. In addition, both city administrative data, and knowledge of practices of large employers in San Francisco, indicate that a significant number of employers provide job-based coverage with premium amounts that fall below the employer spending requirement. Employers then make small contributions to the City Option to meet their overall HCSO obligations. We refer to this practice as "topping off" employer sponsored insurance (ESI) and assume these employees would not enroll in Covered California benefits as they would not be eligible for premium subsidies due to already having an offer of an affordable job-based health plan. We identify "topped off ESI" employees as those indicated to have ESI but with employer contributions that total less than 8 hours of work per week—an amount that would make them exempt from the spending requirement—and estimate 9% of the employees fall in this category. The remaining 50% or 17,657 employees would possibly be eligible for program benefits.

Table 1 - City Option employees by residency and "topped off" ESI

Source: Expenditures for City Option employees, from SFDPH for Q3, 2014

	Number of individuals	%
Live outside San of Francisco	14,349	41%
In SF, with small contribution to "top off" ESI plan	3,103	9%
Possibly eligible for program benefits	17,657	50%
Total	**35,109**	**100%**

The next four tables focus on the 17,657 City Option employees who would possibly be eligible for program benefits. Table 2a shows the distribution of employees by firm size. We see that the majority work in large firms. 69% of the employees reside in firms with more than 500 employees and 83% in firms with more than 100 employees. Only 17% work in firms with fewer than 100 employees. A small fraction work in firms with fewer than 20 employees, even though these firms are not subject to the HCSO requirements.

Table 2a - City Option employees likely eligible for public benefit program by firm size; excluding those residing outside of San Francisco and employees with small contributions to "top off" ESI.

Source: Expenditures for City Option employees, from SFDPH for Q3, 2014

Number of employees	Number of individuals	%
Less than 20	125	1%
20-49	1,516	9%
50-99	1,258	7%
100-499	2,485	14%
500 or more	12,256	69%
Not reported	17	0.1%
Total	**17,657**	**100%**

Tables 2b and 2c show the typical quarterly hours worked, and the total employer contributions made on behalf of the employees. We see that only 12% work 500 or more hours, the equivalent of a 40 hour-a-week job. As most firms make contributions on a quarterly basis, there is no way to separate smaller contributions for employees working a partial quarter. The turnover rate of the work force is considerable (see Table 4) and this is likely the reason a fairly large percentage, 39%, work less than 200 hours in the quarter.

Table 2b - City Option employees likely eligible for premium assistance by number of hours worked in a quarter; excluding those residing outside of San Francisco and employees with small contributions to "top off" ESI.

Source: Expenditures for City Option employees, from SFDPH for Q3, 2014

Hours worked in quarter	Number of individuals	%
Less than 100	2,578	15%
100-199	4,213	24%
200-299	3,430	19%
300-399	2,631	15%
400-499	2,756	16%
500 or more	2,061	12%
Total	**17,657**	**100%**

Table 2c - City Option employees likely eligible for premium assistance by contributions made in a quarter; excluding those residing outside of San Francisco and employees with small contributions to "top off" ESI.

Source: Expenditures for City Option employees, from SFDPH for Q3, 2014

Quarterly contributions made	Number of individuals	%
Less than $250	2,981	17%
$250-499	4,587	26%
$500-749	3,381	19%
$750-999	2,737	16%
$1000-1,249	2,569	15%
$1,250 or more	1,414	8%
Total	**17,657**	**100%**

The distribution of ages can be found in Table 2d, below. The employees are younger, on average than the overall workforce in the city as 45% are younger than 30. A small fraction (2%) are 65 or older and an even smaller fraction (1%) are younger than age 19.

Table 2d - City Option employees likely eligible for premium assistance by age; excluding those residing outside of San Francisco and workers with small contributions to "top off" ESI.

Source: Expenditures for City Option employees, from SFDPH for Q3, 2014

Age	Number of individuals	%
younger than 19 years	165	1%
19-29	7,681	44%
30-39	4,094	23%
40-49	2,673	15%
50 -64	2,702	15%
65 or older	342	2%
Total	**17,657**	**100%**

Table 3 takes a closer look at whether City Option employees reside in San Francisco, and the average quarterly employer contribution made on their behalf, at different levels of firm size. We see that those working in smaller businesses are more likely to be city residents. For employers of 500 or more workers, the % of city residents to non-city residents comes close to being equal at 53% to 47%. Overall, non-residents have higher average employer contributions, $669 to $609, though this varies considerably when examined at a particular firm size grouping.

Table 3 - Employer expenditures and residency of City Option employees by firm size.

Source: Expenditures for City Option employees, from SFDPH for Q3, 2014

Number of employees	Number of individuals	Average employer contribution	% SF residents	% non-SF residents	Average quarterly contribution for SF residents	Average quarterly contribution for non-SF residents
Less than 20	181	$ 495	70%	30%	$ 549	$ 369
20-49	2,329	$ 456	70%	30%	$ 448	$ 474
50-99	2,005	$ 421	66%	34%	$ 420	$ 423
100-499	4,911	$ 583	56%	44%	$ 590	$ 574
500 or more	25,649	$ 681	53%	47%	$ 652	$ 713
Not reported	34	$ 347	53%	47%	$ 363	$ 329
Total	**35,109**	**$ 636**	**59%**	**41%**	**$ 609**	**$ 669**

Next we examine the employee turnover among the population, again focusing on just the population most likely eligible for the program. In Table 4 we look at individuals who had payments in their names to the City Option in the first quarter of 2013 and calculate when the last payment was made on the same individual. This includes payments made by any employer, as an employee

may have contributions from multiple employers. We find that nearly two-thirds (64%) of those with payments in quarter 1 of 2013 had payments in the last quarter of that same year. One third of the individuals (35%) had payments made on their behalf in the last quarter of 2014. Stated another way, two thirds of the population that began in the cohort were no longer receiving contributions in their name by end of the second year.

Table 4 - Likelihood of continued contribution to City Option from 2013-2014, for cohort with contributions in first quarter of 2013; excluding those residing outside of San Francisco and employees with small contributions to "top off" ESI.

Source: Expenditures for City Option employees, from SFDPH for 2013-2014

Year Quarter	Share remaining
2013, Q1	100%
2013, Q2	83%
2013, Q3	74%
2013, Q4	64%
2014, Q1	57%
2014, Q2	49%
2014, Q3	43%
2014, Q4	35%

The number of employees receiving City Option contributions jumped from 20,000 during the last quarter of 2013 to over 35,000 at the end of 2014. This large increase was likely due to firms phasing out their employees standalone Health Reimbursement Accounts (HRAs) to comply with local and federal HRA rules. Table 5 shows the distribution of firm size for employees appearing with their first contribution in 2014. Similar to Table 2a, we see that most of these are employees in large firms-- 84% work for employers with 100 or more employees. (The total number of employees is over 40,000 as it represents all individuals receiving with their first contribution over all four quarters of 2014. This amount is larger than the 35,000 employees receiving contributions in just the final quarter of 2014).

Table 5 - City Option employees with first contribution made in 2014, by firm size

Source: Expenditures for City Option employees, from SFDPH for Q3, 2014

Number of employees	Number of individuals	%
Less than 20	219	**1%**
20-49	2,991	**7%**
50-99	2,368	**6%**
100-499	7,364	**18%**
500 or more	27,308	**68%**
Not reported	66	**0.2%**
Total	**40,316**	**100%**

Tables 6a and 6b show the firm characteristics of individuals identified as covered through ESI that has been "topped off" with small contributions to meet the minimum spending requirement of the ordinance. In Table 6a we see that this group is even more highly concentrated in larger employers as 91% work in firms with more than 100 employees. Table 6b shows the most prevalent industries for workers with Retail Trade topping the list at 14.1%.

Table 6a - City Option employees with small contributions to "top off" ESI, by firm size

Source: Expenditures for City Option employees, from SFDPH for Q3, 2014

Number of employees	Number of individuals	%
Less than 20	4	**0.1%**
20-49	165	**5%**
50-99	106	**3%**
100-499	541	**17%**
500 or more	2,285	**74%**
Not reported	2	**0.1%**
Total	**3,103**	**100%**

Table 6b - City Option employees with small contributions to "top off" ESI, by industry

Source: Expenditures for City Option employees, from SFDPH for Q3, 2014

Number of employees	Number of individuals	%
Retail Trade	438	**14.1%**
Health Care and Social Assistance	402	**13.0%**
Educational Services	310	**10.0%**
Accommodation and Food Services	297	**9.6%**
Professional, Scientific, and Technical Services	260	**8.4%**
Finance and Insurance	240	**7.7%**
Other Services (except Public Administration)	934	**30.1%**
All other Industries	222	**7.2%**
Total	**3,103**	**100.0%**

Part II: Further information and predicted behavior under policies to increase affordability of health care benefits.

In this section we extend our analysis of the 17,657 City Option employees deemed possibly eligible for benefits as they reside in San Francisco and are not identified as having "topped off" ESI. Using the California Simulation of Insurance Markets (CalSIM) version 1.91, we can discern key features of this group such as income, immigration status and eligibility for other health benefit such as Medi-Cal or subsidized coverage through Covered California. The model also allows us to predict the resulting health coverage choices of employees and how these might change under a program of premium assistance for San Francisco residents. More information on the methods used can be found in Appendix B.

Table 7, on the next page, shows an overview of these employees by factors influencing eligibility for Covered California premium subsidies, including important figures needed in designing a program to increase affordability of benefits. The first column begins with the number of undocumented immigrants, those eligible for Medi-Cal and those enrolled in ESI through the health plan of another member their family. None of these 13,440 individuals would be eligible for premium subsidies in Covered California. [53]

The remaining 4,240 employees would be eligible to enroll in Covered California and constitute the employees potentially eligible for the San Francisco public benefit program. This benefit eligible population is further divided in the table by income and eligibility for Covered California subsidies. We estimate that 1,640 individuals would be eligible for subsidies and 450 have family incomes below 400% of the Federal Poverty Level but who are ineligible for subsidies because a family member has an offer of affordable job based coverage or because silver plan premiums for the individual are low enough that they do not exceed the thresholds where they would be subsidized. The last two rows indicate that 430 have incomes between 400-500% of FPL, 650 between 501-635% of FPL and 1,050 have incomes above 635% of FPL.

The next four columns show the expected health coverage for each of the rows through ESI, Medi-Cal, non-group coverage (including Covered California), or without insurance. From this we see that the model predicts 960 of the 1,640 eligible for subsidies would enroll in Covered California coverage, a take up rate of 58.5%.

The last 4 columns compare the costs of the premium paid by individuals who enroll in Covered California and their expected out-of-pocket (OOP) expenses to the total amount of contributions made by employers. The contributions have been divided into those made by employers with more than, or less than, 100 employees.

[53] The average monthly employer contribution for this group is $200 a month, 46 % of the average employee share of premium for family coverage in the state. NORC at the University of Chicago, California Employer Health Benefit Survey 2104, California Health Care Foundation. http://www.chcf.org/publications/2014/01/employer-health-benefits

Table 7 - Estimated coverage and eligibility for employees with City Option contributions from employers under current policy in 2014; excluding those residing outside of San Francisco and employees with small contributions to "top off" ESI.

Sources: SFDPH Data, ACS, CHIS and the CalSIM version 1.92, under "standard take up assumptions" recalibrated to City Option employees.

Eligibility and Coverage	Total	ESI	Medi-Cal	Remaining Uninsured	Purchasing Cov. CA / Non-group	Total Premium Costs after Covered CA Subsidies for Non-group	Expected Out-of-Pocket Expenses for Non-group	Employer Contributions to City Option, Firms <100 Employees	Employer Contributions to City Option, Firms 100+ Employees
2014									
Undocumented Immigrants	1,010	90	-	810	110	400,000	120,000	770,000	2,460,000
Enrolled or Eligible for Medicaid*	3,830	-	3,380	230	220	790,000	80,000	1,140,000	9,900,000
ESI Coverage Via Another Family Member	8,600	8,600	-	-	-	*Not Shown*	*Not Shown*	2,140,000	18,540,000
Eligible for Cov CA subsidies, up to 250% FPL	960	-	-	400	560	740,000	570,000	260,000	2,230,000
Eligible for Cov CA subsidies, up to 251-400% FPL	680	-	-	280	400	1,420,000	710,000	350,000	880,000
Not eligible for Cov CA subsidies, up to 250% FPL	130	-	-	50	80	340,000	80,000	30,000	320,000
Not eligible for Cov CA subsidies, 251-400% FPL	320	-	-	70	250	840,000	290,000	110,000	610,000
401-500% FPL	430	-	-	80	350	1,350,000	470,000	200,000	960,000
501-635% FPL	650	-	-	70	580	2,030,000	700,000	140,000	1,230,000
Above 635% FPL	1050	-	-	210	840	4,700,000	1,630,000	240,000	1,940,000
Subtotal for Covered CA Eligible Population	**4,220**	**-**	**-**	**1,160**	**3,060**	**$11,420,000**	**$4,450,000**	**$1,330,000**	**$8,170,000**

Table 8 (next page) displays the expected enrollment in Covered California health plans under a program of premium assistance where 100% of the premiums are covered for eligible City Option employees with incomes below 400% of FPL and 40% of the premiums are covered for those between 401-500% of FPL. The modeling is done without regard for the source of the premium assistance, so the first column shows the expected enrollment each year if second-lowest cost silver plan premiums were free for those below 400% and partially subsidized for those over between 401-500%. In this exercise we have assumed that even those who are ineligible for subsidies due to an affordable offer of ESI by a family member are also covered. The table restricts itself to the population that would be potentially eligible for the public benefit program.

The second column shows the total premium contributions required to cover the costs of the second-lowest cost silver plan while the third and fourth columns show how these premium contributions would be split between the benefit program and individuals. These premium contributions, when compared to the last two columns indicate the degree which the employer contributions to the City Option could cover the costs of such a premium assistance program, both overall, and by the income and eligibility categories.

The out-of-pocket costs represent the aggregate payments for co-pays, co-insurance, deductibles, etc. that are not covered by health the plans.

The final two columns provide projected employer payments on these individuals into the City Option. As indicated, the Employer contribution column also includes the contributions of the employees who would not enroll in Covered California and would remain uninsured. The first one assumes that additional employers moving into the City Option mirror those who have migrated in the last year in terms of firm size—about 80% of the employee hours are from employers with 100 or more employees and 20% from smaller firms. The last column makes a more conservative assumption that 80% of the new firms paying into the City Option have fewer than 100 employees while 20% are from larger firms, which results in approximately $1 million less in employer payments.

Table 8 – Estimated enrollment and costs in Covered California under a benefit program of 100% premium assistance up to 400% of FPL, 40% assistance between 400-500% of FPL. Assuming all take up the 2nd-lowest cost silver plan.

Population: City Option employees eligible for premium assistance

Sources: SFDPH, ACS, CHIS and CalSIM 1.92 with "standard take up assumptions" recalibrated to City Option employees

Eligibility and Income	Cov. CA / Non-group	Total Premium Costs after Covered CA Subsidies	Premium Costs Paid by SF Benefit Program	Premium Costs Paid by Individuals	Expected Out-of-Pocket Expenses	Employer Contri-butions High Estimate	Employer Contri-butions Low Estimate
2016							
Eligible for Cov CA subsidies, up to 250% FPL	1,000	1,340,000	1,340,000	-	890,000	3,550,000	3,350,000
Eligible for Cov CA subsidies, up to 251-400% FPL	610	2,250,000	2,250,000	-	1,020,000	1,870,000	1,790,000
Not eligible for Cov CA subsidies, up to 250% FPL	140	600,000	600,000	-	120,000	470,000	440,000
Not eligible for Cov CA subsidies, 250-400% FPL	470	1,870,000	1,870,000	-	640,000	1,400,000	1,330,000
401-500% FPL	610	3,530,000	1,412,000	2,118,000	1,280,000	1,590,000	1,500,000
501-635% FPL	850	3,450,000	-	3,450,000	1,200,000	2,230,000	2,110,000
Total	**3,680**	**13,040,000**	**7,472,000**	**5,568,000**	**3,950,000**	**11,110,000**	**10,520,000**
2018							
Eligible for Cov CA subsidies, up to 250% FPL	1,700	2,480,000	2,480,000	-	1,470,000	5,960,000	5,600,000
Eligible for Cov CA subsidies, up to 251-400% FPL	870	3,560,000	3,560,000	-	1,690,000	2,610,000	2,460,000
Not eligible for Cov CA subsidies, up to 250% FPL	140	690,000	690,000	-	120,000	380,000	360,000
Not eligible for Cov CA subsidies, 250-400% FPL	550	2,460,000	2,460,000	-	850,000	1,660,000	1,550,000
401-500% FPL	700	4,870,000	1,948,000	2,922,000	1,760,000	1,820,000	1,690,000
501-635% FPL	1,090	4,890,000	-	4,890,000	1,720,000	3,060,000	2,870,000
Total	**5,050**	**18,950,000**	**11,138,000**	**7,812,000**	**7,610,000**	**15,490,000**	**14,530,000**
2020							
Eligible for Cov CA subsidies, up to 250% FPL	1,780	2,940,000	2,940,000	-	1,750,000	6,730,000	6,330,000
Eligible for Cov CA subsidies, up to 251-400% FPL	910	4,230,000	4,230,000	-	2,010,000	2,950,000	2,790,000
Not eligible for Cov CA subsidies, up to 250% FPL	140	810,000	810,000	-	150,000	430,000	400,000
Not eligible for Cov CA subsidies, 250-400% FPL	570	2,920,000	2,920,000	-	1,020,000	1,870,000	1,750,000
401-500% FPL	730	5,770,000	2,308,000	3,462,000	2,100,000	2,050,000	1,910,000
501-635% FPL	1,140	5,800,000	-	5,800,000	2,050,000	3,220,000	3,220,000
Total	**5,270**	**22,470,000**	**13,208,000**	**9,262,000**	**9,080,000**	**17,470,000**	**16,400,000**

Tables 9 and 10 present enrollment in Covered CA, subsidy costs and employer contributions under two potential scenarios for the public benefit program that SFDPH requested be modeled.

In the first scenario (Table 9), the public benefit program provides a subsidy covering 80% of the premiums after any available Covered CA subsidies for eligible City Option participants with incomes below 635% of FPL.

In the second scenario (Table 10), the public benefit program covers 60% of the premium costs after available Covered CA subsidies, along with cost sharing subsidies for individuals with incomes below 400% of FPL. The cost sharing subsidies are as follows:

- <200% of FPL = $550 per year
- 200-250% = $673 per year
- 250-300% = $779 per year
- 300-350% = $485 per year
- 350-400% = $190 per year

The calculations in Table 10 assume full payout of the cost sharing subsidies. If the City chooses to provide subsidies *up to those* amounts each year (without a roll over from year to year) the actual cost would be lower than indicated in the tables.

Table 9 – Estimated enrollment and costs in Covered California under a benefit program with 80% premium assistance up to 635% of FPL.

Sources: SF DPH Data, ACS, CHIS and the CalSIM version 1.92 under "standard take-up assumptions", recalibrated to City Option employees.

Eligibility and Coverage	Cov. CA / Non-group	Total Premium Costs after Covered CA Subsidies for Non-group	Premium Costs Paid by SF Benefit Program	Premium Costs Paid by Individuals	Expected Out-of-Pocket Expenses for Non-group	Employer Contributions High Estimate	Employer Contributions Low Estimate
2016							
Eligible for Cov CA subsidies, up to 250% FPL	990	1,300,000	1,040,000	260,000	900,000	3,550,000	3,350,000
Eligible for Cov CA subsidies, up to 251-400% FPL	610	2,200,000	1,760,000	440,000	1,010,000	1,870,000	1,790,000
Not eligible for Cov CA subsidies, up to 250% FPL	140	600,000	480,000	120,000	120,000	470,000	440,000
Not eligible for Cov CA subsidies, 251-400% FPL	470	1,840,000	1,472,000	368,000	640,000	1,400,000	1,330,000
401-500% FPL	660	4,030,000	3,224,000	806,000	1,430,000	1,590,000	1,500,000
501-635% FPL	900	3,730,000	2,984,000	746,000	1,290,000	2,230,000	2,110,000
Total	**3,770**	**13,700,000**	**10,960,000**	**2,740,000**	**5,390,000**	**11,110,000**	**10,520,000**
2018							
Eligible for Cov CA subsidies, up to 250% FPL	1,680	2,420,000	1,936,000	484,000	1,490,000	5,960,000	5,600,000
Eligible for Cov CA subsidies, up to 251-400% FPL	860	3,470,000	2,776,000	694,000	1,670,000	2,610,000	2,460,000
Not eligible for Cov CA subsidies, up to 250% FPL	140	690,000	552,000	138,000	120,000	380,000	360,000
Not eligible for Cov CA subsidies, 251-400% FPL	550	2,430,000	1,944,000	486,000	850,000	1,660,000	1,550,000
401-500% FPL	710	5,150,000	4,120,000	1,030,000	1,770,000	1,820,000	1,690,000
501-635% FPL	1,140	5,250,000	4,200,000	1,050,000	1,820,000	3,060,000	2,870,000
Total	**5,080**	**19,410,000**	**15,528,000**	**3,882,000**	**7,720,000**	**15,490,000**	**14,530,000**
2020							
Eligible for Cov CA subsidies, up to 250% FPL	1,760	2,880,000	2,304,000	576,000	1,780,000	6,730,000	6,330,000
Eligible for Cov CA subsidies, up to 251-400% FPL	900	4,140,000	3,312,000	828,000	1,990,000	2,950,000	2,790,000
Not eligible for Cov CA subsidies, up to 250% FPL	140	820,000	656,000	164,000	150,000	430,000	400,000
Not eligible for Cov CA subsidies, 251-400% FPL	570	2,890,000	2,312,000	578,000	1,020,000	1,870,000	1,750,000
401-500% FPL	740	6,140,000	4,912,000	1,228,000	2,120,000	2,050,000	1,910,000
501-635% FPL	1,200	6,260,000	5,008,000	1,252,000	2,180,000	3,440,000	3,220,000
Total	**5,310**	**23,130,000**	**18,504,000**	**4,626,000**	**9,240,000**	**17,470,000**	**16,400,000**

Table 10 - Estimated enrollment and costs in Covered California under a benefit program with 60% premium assistance up to 635% of FPL; out-of pocket subsidies.

Sources: SFDPH Data, ACS, CHIS and the CalSIM version 1.92 under "standard take-up assumptions", recalibrated to City Option employees.

Eligibility and Coverage	Cov. CA / Non-group	Total Premium Costs after Covered CA Subsidies for Non-group	Premium Costs Paid by SF Benefit Program	Premium Costs Paid by Individuals	Out –of-Pocket Subsidies*	Expected Out-of-Pocket Expenses Paid by Individuals	Employer Contributions High Estimate	Employer contributions Low Estimate
2016								
Eligible for Cov CA subsidies, up to 250% FPL	990	1,260,000	756,000	504,000	580,000	340,000	3,550,000	3,350,000
Eligible for Cov CA subsidies, up to 251-400% FPL	610	2,160,000	1,296,000	864,000	300,000	710,000	1,870,000	1,790,000
Not eligible for Cov CA subsidies, up to 250% FPL	140	600,000	360,000	240,000	80,000	40,000	470,000	440,000
Not eligible for Cov CA subsidies, 251-400% FPL	470	1,810,000	1,086,000	724,000	190,000	450,000	1,400,000	1,330,000
401-500% FPL	650	3,870,000	2,322,000	1,548,000	-	1,400,000	1,590,000	1,500,000
501-635% FPL	890	3,690,000	2,214,000	1,476,000	-	1,290,000	2,230,000	2,110,000
Total	**3,750**	**13,390,000**	**8,034,000**	**5,356,000**	**1,150,000**	**4,230,000**	**11,110,000**	**10,520,000**
2018								
Eligible for Cov CA subsidies, up to 250% FPL	1,680	2,360,000	1,416,000	944,000	970,000	560,000	5,960,000	5,600,000
Eligible for Cov CA subsidies, up to 251-400% FPL	860	3,410,000	2,046,000	1,364,000	440,000	1,230,000	2,610,000	2,460,000
Not eligible for Cov CA subsidies, up to 250% FPL	140	690,000	414,000	276,000	80,000	40,000	380,000	360,000
Not eligible for Cov CA subsidies, 251-400% FPL	540	2,380,000	1,428,000	952,000	230,000	620,000	1,660,000	1,550,000
401-500% FPL	710	5,070,000	3,042,000	2,028,000	-	1,770,000	1,820,000	1,690,000
501-635% FPL	1,140	5,220,000	3,132,000	2,088,000	-	1,820,000	3,060,000	2,870,000
Total	**5,070**	**19,130,000**	**11,478,000**	**7,652,000**	**1,720,000**	**6,040,000**	**15,490,000**	**14,530,000**
2020								
Eligible for Cov CA subsidies, up to 250% FPL	1,760	2,810,000	1,686,000	1,124,000	1,150,000	670,000	6,730,000	6,330,000
Eligible for Cov CA subsidies, up to 251-400% FPL	900	4,060,000	2,436,000	1,624,000	530,000	1,460,000	2,950,000	2,790,000
Not eligible for Cov CA subsidies, up to 250% FPL	140	810,000	486,000	324,000	90,000	60,000	430,000	400,000
Not eligible for Cov CA subsidies, 251-400% FPL	570	2,830,000	1,698,000	1,132,000	280,000	730,000	1,870,000	1,750,000
401-500% FPL	740	6,030,000	3,618,000	2,412,000	-	2,120,000	2,050,000	1,910,000
501-635% FPL	1,200	6,200,000	3,720,000	2,480,000	-	2,180,000	3,440,000	3,220,000
Total	**5,310**	**22,740,000**	**13,644,000**	**9,096,000**	**2,050,000**	**7,220,000**	**17,470,000**	**16,400,000**

*This assumes the cost-sharing benefit is fully utilized. The amount of the benefit by of FPL is
<200% of FPL = 550/yr; 200-250% = 673/yr; 250-300% = 779/yr; 300-350% = 485/yr; 350-400% = 190/yr

Projected Enrollment without a Policy Change

Table 11 - Estimated enrollment and costs in Covered California under current policy.

Population: City Option employees eligible for premium assistance

Sources: SFDPH Data, ACS, CHIS and the CalSIM version 1.92, under "standard take up assumptions" recalibrated to City Option employees.

Eligibility and Income	Cov. CA / Non-group Enrollment	Total Premium Costs after Covered CA Subsidies	Expected Out-of-Pocket Expenses	Total Health Cost	Employer Contributions to City Option High Estimate	Employer Contributions to City Option Low Estimate
2016						
Eligible for Cov CA subsidies, up to 250% FPL	970	1,140,000	960,000	2,100,000	3,550,000	3,350,000
Eligible for Cov CA subsidies, up to 251-400% FPL	560	1,960,000	920,000	2,880,000	1,870,000	1,790,000
Not eligible for Cov CA subsidies, up to 250% FPL	140	600,000	120,000	720,000	470,000	440,000
Not eligible for Cov CA subsidies, 250-400% FPL	430	1,640,000	580,000	2,220,000	1,400,000	1,330,000
401-500% FPL	530	2,790,000	1,030,000	3,820,000	1,590,000	1,500,000
501-635% FPL	850	3,450,000	1,200,000	4,650,000	2,230,000	2,110,000
Total	**3,480**	**11,580,000**	**4,810,000**	**16,390,000**	**11,110,000**	**10,520,000**
2018						
Eligible for Cov CA subsidies, up to 250% FPL	1,640	2,130,000	1,610,000	3,740,000	5,960,000	5,600,000
Eligible for Cov CA subsidies, up to 251-400% FPL	780	3,030,000	1,500,000	4,530,000	2,610,000	2,460,000
Not eligible for Cov CA subsidies, up to 250% FPL	140	690,000	120,000	810,000	380,000	360,000
Not eligible for Cov CA subsidies, 250-400% FPL	490	2,150,000	770,000	2,920,000	1,660,000	1,550,000
401-500% FPL	600	3,800,000	1,410,000	5,210,000	1,820,000	1,690,000
501-635% FPL	1,090	4,890,000	1,720,000	6,610,000	3,060,000	2,870,000
Total	**4,740**	**16,690,000**	**7,130,000**	**23,820,000**	**15,490,000**	**14,530,000**
2020						
Eligible for Cov CA subsidies, up to 250% FPL	1,710	2,520,000	1,920,000	4,440,000	6,730,000	6,330,000
Eligible for Cov CA subsidies, up to 251-400% FPL	810	3,590,000	1,780,000	5,370,000	2,950,000	2,790,000
Not eligible for Cov CA subsidies, up to 250% FPL	140	810,000	150,000	960,000	430,000	400,000
Not eligible for Cov CA subsidies, 250-400% FPL	510	2,540,000	910,000	3,450,000	1,870,000	1,750,000
401-500% FPL	620	4,500,000	1,670,000	6,170,000	2,050,000	1,910,000
501-635% FPL	1,140	5,780,000	2,040,000	7,820,000	3,440,000	3,220,000
Total	**4,930**	**19,740,000**	**8,470,000**	**28,210,000**	**17,470,000**	**16,400,000**

Data and Methodology

This section describes the data sources and the methodology used in the analysis of the City Option employees and the predicted behavior of those who would be eligible for a public benefit program to increase the affordability of Covered California health insurance.

Data Sources

The initial source of information is a listing of all health care expenditures made by HCSO covered employers on behalf of City Option employees to the City Option. We used the expenditure information during the calendar years of 2013 and 2014. The listing contains unique employee and employer IDs (for anonymity) and the date and amount of each expenditure, along with information about the employee and the employer such as the age, firm size and industry. The size of the employer indicated the hourly rate for the spending requirement and this, with the amount of each expenditure, was used to calculate the quarterly hours worked. This data source provided an overview of the current population of employees.

We assume that the surge in employees receiving contributions during 2013-2014, after accounting for employment growth, was due to employers phasing out standalone HRAs. We estimate that 40% of such transitions had occurred at the end of 2014 and the process will continue until 2017 when HRA contributions will be 100% irrevocable. We use an employment growth rate of 2% per year, consistent with recent trends. To highlight the employees targeted for the public benefit program we exclude employees living outside of San Francisco. We also exclude and those employees with ESI who have small expenditures made by employers to meet the spending requirement. We refer to these employees as those with "topped off" ESI, and assume that they would not enroll in Covered California benefits as they would not be eligible for premium subsidies due to their employers already offering them an affordable job-based health plan. We assume that all employees indicated to have ESI, with employer contributions that would total less than 8 hours of work per week—an amount that would make them exempt from the spending requirement—are "topped off".

The resulting policy "target population" is modeled with the California Simulation of Insurance Markets (CalSIM) version 1.91. This is done by taking information on the target population (industry, firm size, hours worked, age) from the City Option data and from other sources on San Francisco workers such as the ACS and California Health Interview Survey (on income, race and ethnicity, actual health coverage, gender) and using the information to recalibrate CalSIM to match the demographics of the target population. The recalibrated model allows us to discern key features such as income and take-up of Covered California benefits and to model behavioral changes under a program of premium assistance.

Predicting Eligibility and Take Up of Benefits with the California Simulation of Insurance Markets

CalSIM is a "micro-simulation" model of the California health care system. The foundation of the model is a representative sample of individuals and their respective employers. As described in the previous section, the model has been calibrated to match the population of City Option employees targeted by the benefit program. For each individual in the sample, the model provides information on coverage, health expenses, income, and demographic characteristics. For each employer the model provides information on health plans offered and the premium costs of the benefits. CalSIM uses this data, along with behavioral research findings, to allow individuals and firms to "interact" and predict how they will fare under new health care policies such as the Affordable Care Act (ACA) or a premium assistance program to decrease the cost of Covered California plans. By summing up the impacts on the individuals, the model predicts the impact of new policies at the level of the entire target population and also at the level of particular demographic groups (e.g. those eligible for Covered California subsidies).

At the state-wide level, a variety of data sources are employed by CalSIM to ensure the model is representative of California residents. These include the California Health Interview Survey (CHIS), the Current Population Survey, the California Employer Health Benefit Survey and employer payroll information from the California Employment Development Department. With the new policies of the ACA, considerable shifts in coverage and costs have already been observed and CalSIM uses the most up-to-date statistics available to inform the model. As described in the previous section, demographic and employment characteristics from the City Option listing and other sources are used to further calibrate the model to the target population of the benefit program.

The city of San Francisco holds unique elements which are important to incorporate into our model. The most prominent is the recent increase in the minimum wage which will bring the rate to $15 per hour by 2018 with an index to inflation. This results in higher incomes and fewer eligible for Medi-Cal benefits. We also have included the Covered California premium levels, and subsequent subsidies used in 2015 for the San Francisco rating region. In future years, premiums are increased with an annual medical inflation of 6.5%.

The City Option information only includes employees with expenditures, which does not represent the entire work force of the firm, particularly for the many firms with additional employees working outside of San Francisco. This leads to a key modeling limitation: we cannot properly simulate employer responses to a new benefit program of premium assistance. In particular, the model does not account for "crowd-out" from small employers and part-time employers in large employers who may choose to drop coverage if the employers can access a greater benefit through the program than the employer can provide directly through their HCSO obligation.

In our modeling of the coverage shifts expected under a program of premium assistance (Tables 8, 9 and 10) one important feature is we include program eligibility for individuals who turn down an "affordable" offer of coverage from their employer, which bars them from receiving subsidies in the exchange. Full premium assistance for such employees, could lead some employees to turn down job-based coverage for a better option in the new program. Employers are currently required to make contributions on employees who turn down job based coverage if the employee has a share of cost, which is designed to eliminate incentives to offer coverage at a high cost to employees as a way to reduce HCSO expenditures.

Further information about CalSIM can be found in the Methodology Document, found at http://healthpolicy.ucla.edu/publications/Documents/PDF/2015/calsim1.91methods.pdf.

Limitations and Additional Assumptions

1. Microsimulations are intended to model large populations of individuals. The behavioral rules and tendencies are meant to apply to hundreds of thousands or millions of people. While this modeling exercise may be the best prediction available, with the best data sources available, the conclusions drawn from estimates of populations of this size, approximately 20,000 individuals, come with a higher degree of error than when modeling state-wide impacts.

2. A large increase in employees receiving contributions during 2013-2014, due to employers phasing out standalone HRAs, occurred at the end of 2013 and the beginning of 2014. Because of this, we gather the information on the target population from the City Option listing (industry, firm size, hours worked, age) from the third quarter of 2014. We assume that the firm, hours and age characteristics of the City Option population is relatively unchanged when the additional migration of standalone HRAs occurs in 2015, 2016 and 2017. If larger firms migrated first, then the average contribution for those with new payments in future years could be lower than projected.

3. Simulations assume the average quarterly employer health care expenditures for each employee will match average quarterly amount of $655 in the third quarter of 2014 for San Francisco residents without "topped off" ESI.

4. The employer spending requirement of the HCSO is assumed to increase annually by 4.1% --the average yearly increase during 2012-2015--for 2016 and subsequent years.

5. Some undocumented City Option employees may be eligible for Medi-Cal benefits under the Deferred Action for Childhood Arrivals, and perhaps under President Obama's 2014 Deferred Action for U.S. Citizens and Lawful Permanent Residents executive action (currently blocked due to a court appeal). These programs have not been included in the

model and they would not lead to any changes in Covered California enrollment. However, in Tables 8, 9, 10 and 11, some portion of the employees under the "Undocumented" category would the fall under the category of "Enrolled or eligible for Medi-Cal".

6. The expected out-of-pocket (OOP) expenses presented in Tables 8, 9, 10 and 11 sum the aggregate cost of all co-pays, co-insurance, deductibles, etc. for the individuals represented in each line. These are calculated by removing the administrative cost of the non-group plan—assumed to be 20%-- and using the remaining premium along with the actuarial value of the plan to estimate the OOP expenses paid by individual enrollees. Actuarial values provide expected spending by the insurer of total health costs for a standard population; so for a 70% AV plan, 30% of the costs would be borne by individuals across a standard population. Given the small sample sizes in each of these categories, actual spending may vary. This calculation includes the additional cost-sharing benefits for those below 250% of FPL who receive subsidies through Covered California.

Appendix VII: Public Benefit Program Planning; Stakeholder Engagement

San Francisco Department of Public Health

Overview

To inform the development of a public benefit program to increase affordability of health insurance with a stakeholder perspective, the San Francisco Department of Public Health (SFDPH) conducted focus groups with:

- employees who are San Francisco residents and receiving employer contributions to the City Option; and
- employers subject to the Health Care Security Ordinance (HCSO).

From the robust discussions touching on the affordability, value, and availability of health insurance, the following key themes emerged as relevant to SFDPH planning.

Key Findings: Employees

- **Cost is the most common reason for declining health insurance.** Among the uninsured, the most common reason cited for declining an offer of insurance from an employer was high cost.
- **Cost remains an issue for the insured.** Health care costs, whether in the form of unaffordable premiums or high deductibles, were reported as a top concern by 86% of participants. 20% of the insured respondents reported that they would not purchase insurance if it were not offered by their employers.
- **Most considered health care spending at 5% of income to be affordable.** 29% consider spending 2% of their annual income on health expenses (premiums + out-of-pocket costs) as affordable, 57% consider 5% affordable, and 14% consider 8% affordable. No participants considered more than 8% to be affordable.
- **Premium assistance would be preferred over cost-sharing assistance.** 79% responded that a combination of premium assistance and cost-sharing assistance would help to increase the affordability of health insurance. However, if they had to choose, the majority preferred lower premiums, in the interest of reducing ongoing fixed costs rather than the occasional out-of-pocket costs.
- **Reimbursement accounts do not present barriers to accessing care.** Reimbursement through the City Option Medical Reimbursement Account (City MRA) for expenses already incurred was described as inconvenient but not necessarily a barrier to getting care. However, the majority noted that a debit card would make it easier to use the benefit.

Key Findings: Employers

- **Offering health insurance is valuable for employers.** All participants agreed that offering health insurance is important for their businesses, citing employee recruitment and retention and the perceived value of health insurance as reasons. Balancing employee needs (i.e. whether they have insurance through another means), cost versus benefit, and the group's claims experience were reported as considerations in offering health insurance.
- **Cost is main reason for not offering insurance.** 29% reported that offering health insurance to all of their employees is feasible, with the remaining 71% citing cost as the most prohibitive factor.
- **Insuring part-time employees presents a challenge.** 14% reported not hiring employees working less than 20 hours/week because these employees wouldn't qualify for the group health insurance plan, due to insurance underwriting practices.
- **HCSO expenditures on behalf of employees with other sources of coverage may be redundant.** 60% reported that the HCSO benefit should go to those who need it, noting that HCSO expenditures on behalf of employees with other sources of coverage, such as insurance through a spouse, contribute to increased costs and administrative burden for employers.
- **HCSO expenditure per employee does not always equate to cost of insurance.** 71% reported that on average, the cost to insure an employee is higher than the spending requirement for that employee under the HCSO. Employers for whom the cost of insurance is lower than the spending requirement expressed that the additional expenditure above the cost of health insurance could be better used to reinvest in their business, redirected to offer insurance to uninsured employees, or to offset costs for employees who are more expensive to insure.
- **Administrative burden should be minimal**. Ease of administration was cited as the chief concern with HCSO compliance among all participants.
- **Some Affordable Care Act (ACA) provisions have affected HCSO compliance**. 93% of the participants reported having had to change their HCSO compliance methods because of the ACA; largely, because of the rules governing health reimbursement accounts (HRAs).

Focus Group Recruitment & Methods

For the employee perspective, SFDPH worked with the San Francisco Health Plan (SFHP, the third-party administrator of the City Option), and Healthy San Francisco (HSF) to recruit participants. Through HSF and SFHP, the outreach targeted San Francisco residents receiving employer contributions to the City Option. Of the 1,097 employees contacted, 30 expressed interest, and 14 ultimately participated in one of two 90-minute employee focus groups. These groups were convened on January 21st and January 23rd, 2015.

Based on a preliminary online survey completed by 23 of the 30 individuals who expressed interest, the two employee sessions were each balanced for diversity in insurance status, age, gender, and race/ethnicity. All participants had a City Option Medical Reimbursement Account (MRA) or were at some time enrolled in HSF, and each received a $25 gift card. Each group was asked the same set of questions addressing how employees use their HCSO health benefit, what they like or dislike about the benefit, what they consider to be "affordable" health insurance, exploring potential ways to address affordability, and the driving factors underlying employee decisions to enroll or not enroll in health insurance.

For the employer perspective, SFDPH worked with the San Francisco Chamber of Commerce, the Golden Gate Restaurant Association, the Small Business Commission, the Office of Labor Standards Enforcement, and the San Francisco Health Plan to recruit participants. Of the 1,638 employers contacted, 26 expressed interest in participation, and 14 ultimately participated in one of two 90-minute employer focus groups. These groups were convened on January 28th and January 29th, 2015.

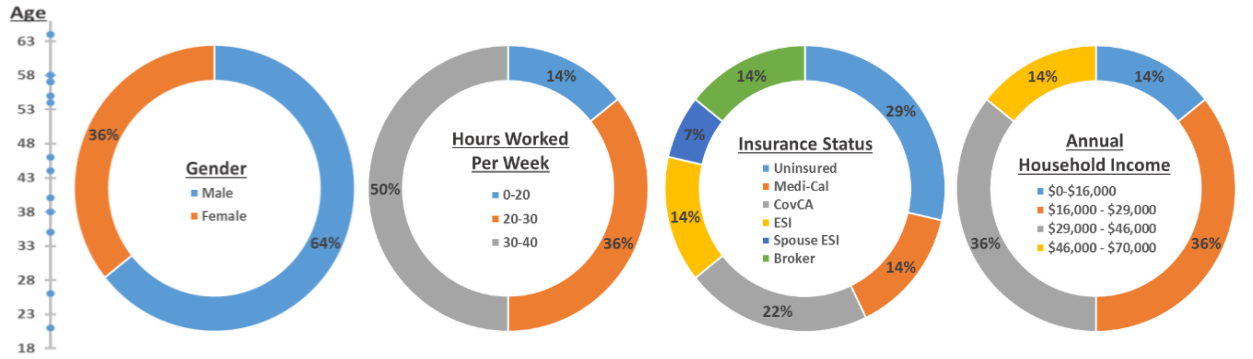
Based on employer availability and a preliminary online survey completed by 11 of the 26 employers who initially expressed interest, the two employer sessions were each balanced for diversity in employer size, industry, and non-profit status. Each group was asked the same set of questions addressing how employers makes HCSO compliance decisions, the factors driving employer decisions to offer or not offer health insurance, exploring potential solutions to increasing access to health insurance, and the employers' understanding of options and obligations under the Affordable Care Act.

All four sessions were facilitated by an experienced focus group moderator from the SFDPH Population Health Division, which is unaffiliated with the HCSO. Questions and facilitation guides were developed and finalized prior to the start of the first session in each group to ensure consistency across both sessions. The following pages summarize key points of discussion for each set of focus groups, with responses aggregated across each set.

Focus Group Summary: HCSO Employees

Total participants: 14

Participant Profile



Among the final 14 employee focus group participants, ages ranged from 20-64; 64% were male; 50% reported working part-time; 71% were insured (through Medi-Cal, Covered CA, employer-sponsored insurance (ESI), a spouse, or purchasing through a broker); and 86% reported household income below $46,000 (~400%of FPL) per year. 61% of the participants had a City Option MRA and 39% were presently or had previously participated in Healthy San Francisco.

Use of the HCSO Health Benefit

Employee participants were asked how they had used their HCSO health benefit (insurance or contribution to reimbursement account or City Option) over the past year. Seven percent reported using it to buy health insurance, 64% used it to see the doctor, and 79% used it for reimbursement for other health costs.

When asked how often they had used their HCSO health benefit over the past year, 7% of participants reported never using it, 7% used it fewer than five times, 43% used it five to ten times, and 43% used it more than ten times.

Participants were asked what they like about their HCSO benefit. Those with insurance appreciate lower premiums through a group rate and the availability of a full range of benefits (dental, vision, therapy, etc.). Those with a City Option MRA reported liking the regularity of their HCSO contribution and knowing that the benefit is available when needed. Reimbursement through the City Option MRA was described as inconvenient but not necessarily a barrier to getting care; however, the majority noted that a debit card would make it easier to use the benefit.

When asked what they dislike about their HCSO benefits, the most commonly cited problem was affordability. Health care costs, whether in the form of unaffordable premiums or high deductibles, were reported as a top concern by 86% of participants. The other 14% were enrolled in Medi-Cal or Healthy San Francisco. Several participants expressed disappointment that benefits such as chiropractic care or alternative therapies are not covered by their insurance.

Value of and Options to Increase Affordability of Health Insurance

There was general consensus and understanding among the participants that the value and utility of health insurance increases with age or high health needs. When asked what they think health insurance is worth, meaning what it costs regardless of the participants' ability to afford it, 36% of the participants found it difficult to estimate the value of health insurance without taking affordability into consideration. Fifty percent responded that health insurance is worth $150-$200 per month, while 14% valued health insurance at more than $300-$500 per month.

When asked what they think is a reasonable amount to pay for health insurance, 29% considered spending 2% of their annual income on health expenses (premiums + out-of-pocket costs) as affordable, 57% considered 5% affordable, and 14% considered 8% affordable. No participants considered spending more than 8% of their annual household income health expenses to be affordable.

Forty-three percent of participants reported that their employer health benefits do not cover all of their health costs. Dental services, acupuncture, and out-of-pocket costs for family members were all cited as costing more than the participants' available benefit. When asked whether lower premiums or lower out-of-pocket costs would do more to increase the affordability of health insurance, 79% of participants responded that a combination of both would be most helpful. However, if they had to choose, majority preferred lower premiums, reasoning that a reduction in ongoing costs would be more beneficial than reducing the occasional out-of-pocket cost.

Motivations for Enrolling in Insurance

To gauge attitudes toward insurance, participants were asked if and why they had ever denied an employer's offer of insurance. Among the uninsured the most common reason cited for declining an offer of insurance was the employee's share of the cost. Others reported that they had declined insurance if they were already covered by a spouse or parents' insurance. Eighty-six percent of participants reported that they would be willing to switch providers if it meant reduced health care costs.

Nearly all participants were aware of the ACA penalty for remaining uninsured, and 71% had researched their eligibility for federal subsidies on Covered California. However, only 29% reported that the availability of subsidies or the potential for penalties affected their decision to enroll in health insurance. The factor cited as most affecting this decision was cost. Further, 20% of the insured participants reported that they would not purchase insurance if their employer did not offer it.

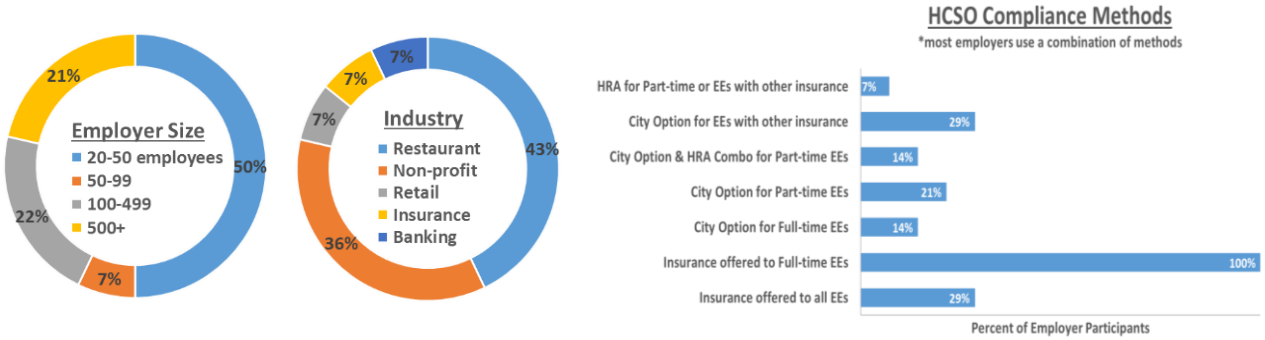
Other Comments

Focus group participants had an opportunity to provide additional comments. Several participants reported confusion regarding the role of Healthy San Francisco in a post-ACA world. One participant thought that HSF qualifies as insurance, and 50% of those on HSF stated that they would stay on the program as long as possible. Several participants also reported that communications around the City Option, whether from the City Option or from the employers, could be clearer and easier to understand.

Focus Group Summary: HCSO Employers

Total participants: 14

Participant Profile



Among the 14 employer focus group participants, half were representing businesses with fewer than 50 employees and 36% represented the non-profit sector. All participants offer insurance to full-time employees, and 71% use a combination of methods, including the City Option and HRAs, to make expenditures for part-time employees.

Compliance with HCSO

All participating employers reported offering insurance to full-time employees, defined either as working more than 20 hours/week or more than 30 hours/week. Fourteen percent reported not hiring employees working less than 20 hours/week because these employees wouldn't qualify for the group health insurance plan. National employers and non-profit employers reported additional stratification in employee insurance status by labor union agreements.

All large employers with more than 500 employees reported using the City Option for part-time employees, generally defined as working fewer than 20 hours/week. Thirty percent of medium-sized employers (20-99 employees) reported using a combination of health reimbursement accounts (HRAs) and the City Option for part-time employees.

All participating employers reported ease of administration as the chief concern with HCSO compliance. Twenty-one percent reported that offering health insurance to all employees is costly but worth the administrative simplicity of complying via one mode. Similarly, 21% reported that paying into the City Option has increased their administrative simplicity, compared to health reimbursement accounts.

Ninety-three percent of the participants reported having had to change their HCSO compliance methods over the past year because of the Affordable Care Act (ACA), generally as a result of changes to rules governing excepted-benefit HRAs. Forty percent of participating employers reported paying into the City Option for some or all of their HCSO spending requirement to comply with local and federal HRA rules.

Motivation to Offer Insurance

All participating employers agreed that offering health insurance is important for their businesses, citing employee recruitment and retention and the value of health insurance as reasons. However, only 29% reported that providing health insurance to all of their employees is feasible, with the others citing cost as the main prohibition to offering insurance to all employees. Balancing employee needs (i.e. whether they have insurance through another means), cost versus benefit, and the group's claims experience were reported as biggest considerations in offering health insurance.

As insurance take-up rates among employees are known to affect the cost of insurance for employers, focus group participants were asked about their experience with employee take-up. Among those who offer insurance, 29% reported a 100% employee participation rate, partially attributed to required participation in the group's plan as a condition for employment. Thirty-six percent reported 75-99% employee participation, 21% reported 50-75% participation, and 14% reported less than 50% participation. The most common reason reported for employees declining an offer of insurance was coverage through another source (spouse, parent, Medi-Cal). Other reported reasons were high employee costs, not deeming insurance a necessity, and unwillingness to fill out the required paperwork.

Seventy-one percent of participating employers reported that on average, the cost to insure an employee is higher than the amount the employer is required to spend for that employee under the HCSO. Among the factors that affect insurance costs, employers reported that employee age and work status are the most important in determining plan costs. Twenty percent considered the HCSO spending requirement not being tied to age as increasing compliance costs.

Except for actively growing businesses, most employer participants reported that their decision to offer insurance is not influenced by ACA requirements or penalties. Twenty-five percent reported partaking in the two-year ACA tax credits available to small businesses offering insurance. Several employers reported confusion regarding differences between HCSO and ACA rules and regulations, or expressed sentiments that the ACA makes the HCSO unnecessary.

Identifying Potential Solutions for Expanding Insurance to Uninsured HCSO Employees

Participants were asked which of their employees are most likely to be uninsured; responses included part-time, low-wage, young, or undocumented. Nearly all employer participants agreed that an affordable insurance product for part-time or low-wage employees would increase their ability to offer insurance overall.

When asked what the City could do to increase affordability of and participation in health insurance, 70% responded that the most helpful thing would be to connect low-wage and part-time employees to ACA coverage. 21% of employers stated that they would prefer their HCSO contribution to remain tethered to their employees, expressing wariness of a City-administered program. Some employers stated they would prefer to retain control over the administration of the employee's benefit because they know and understand their employees' needs.

Participants were asked what features would be important in a City-administered benefit that increases affordability of health insurance for hard-to-insure employees. Ease of administration topped the list. Employers expressed an interest in a system with clear and consistent

guidelines, and minimal processing. Fourteen percent indicated that making quarterly expenditures is administratively cumbersome.

Sixty percent of employers reported that the HCSO benefit should go to those who need it. These employers reported that making expenditures on behalf of employees who receive HCSO contributions alongside another source of coverage, such as insurance through a spouse, contributes to increased costs and administrative burden.

Other Comments

Participants were given an opportunity to share additional thoughts and comments. Non-profit employers reported an increased administrative burden related to requirements to comply with the City's Health Care Accountability Ordinance (HCAO) as well as the HCSO, and suggested that the City recognize the rising costs of healthcare in their contracts.

Several employers expressed dislike for the HCSO's requirement for a minimum expenditure per employee. Employers, particularly those with a younger workforce, viewed the requirement to make minimum expenditures for employees who may be less expensive to insure than their corresponding full HCSO expenditure as an inefficient use of resources. These employers stated that the additional expenditure above the cost of health insurance could be better used to reinvest in their business, redirected to offer insurance to uninsured employees, or to offset costs for employees who are more expensive to insure.

Several employers suggested that there may be a role for the City to conduct outreach to HCSO covered employees to educate about the benefits of health insurance.