UNIVERSAL HEALTHCARE COUNCIL 2013
NOVEMBER 7, 2013 MEETING AGENDA

November 7, 2013 | 10AM – 12PM | 25 Van Ness Avenue, Room 610

Meeting Objectives

- Examine financial considerations at the intersection of the ACA and HCSO from the perspectives of employees employers, & the San Francisco health system
- Offer recommendations

1. Meeting overview — 10 min
   - Reminders
   - Agenda review
2. Presentation — 40 min
   Financial Considerations for Individuals, Employers, and the Local Public Health System
   Colleen Chawla, Deputy Director of Health, Director of Policy & Planning, San Francisco Department of Public Health
3. Discussion — 40 min
4. Public Comment — 15 min
5. Closing Comments and Next Steps — 5 min
   - November 14: Recommendations

Upcoming Council Meetings:

DATE	TIME	LOCATION
November 14, 2013	10AM-12PM	25 Van Ness, Room 610

Meeting Materials

- Agenda
- October 24, 2013 Meeting Minutes
- Financial Considerations Issue Brief

Meeting Accessibility

Wheelchair Accessibility

Meetings of the Universal Healthcare Council will be held at 25 Van Ness Avenue, Room 610. The building is accessible by wheelchair on Van Ness Avenue. The 6th floor is accessible by elevator and room 610 is accessible by a chair lift.

The nearest accessible BART station is Civic Center (Market/Grove/Hyde Streets). Accessible MUNI Metro lines are the J, K, L, M, and N (Civic Center or Van Ness Stations). MUNI bus lines serving the area are the 47 Van Ness, 9 San Bruno, and the 6, 7, 71 Haight/Noriega. For more information about MUNI accessible services, please call (415) 923-6142. For information about MUNI services, please call (415) 673-6864. There is accessible parking on Oak Street.

Other

To assist the City's efforts to accommodate persons with severe allergies, environmental illnesses, multiple chemical sensitivity or related disabilities, attendees at public meetings are reminded that other attendees may be sensitive to various chemical based products. Please help the City to accommodate these individuals.

Interpretation Services

American Sign Language interpreters and readers and/or language interpreters are available *with advance notice of three business days*. The Department of Public Health will make every effort to accommodate requests for sound enhancement systems and alternative formats for meeting minutes and agendas. Please make these requests as far in advance as possible. For all requests, please contact Aneeka Chaudhry at (415) 554-2925.

UNIVERSAL HEALTHCARE COUNCIL 2013
OCTOBER 24, 2013 MEETING MINUTES

October 24, 2013 | 10 -12 PM | 25 Van Ness Avenue, Room 610

1. Co-Chair Remarks and Agenda Review

The Co-Chairs briefly reviewed the finalized UHC principles.

Ms. Garcia noted that the presentation materials do not constitute legal opinion or advice, but rather, the City's current understanding of the impact of the ACA on City laws and programs. She acknowledged that members of the Council may have differing views or interpretations; however, the goal of the meeting is not to resolve all issues, but to relay as much helpful information as possible.

Dr. Hernandez invited UHC members to offer recommendations, which would take into account potential scenarios and keep in mind that the federal government is continuing to issue guidance. She reminded members that the recommendations need not all align or show consensus.

2. Presentation on ACA Shared Responsibility Provision in Depth

Ms. Chawla presented on the HCSO in-depth, ACA market reforms relevant to HCSO compliance, and the intersection of the HCSO and ACA.

Major discussion themes during the presentation are highlighted below and centered on the uncertainty of health reimbursement account (HRA) arrangements moving forward into 2014. Answers to requests for follow-up are included at the end of this document.

- Status of stand-alone HRAs
- Status of HRAs with carryover balances in to 2014
- Whether HRA funds qualify as minimum essential coverage (MEC)
- City MRA as viable option for continued HCSO payments
- HRA reimbursement rates
- Value of HRA balances to employees and employers
- Impact of employee insurance take-up rates on businesses ability to offer coverage
- Recommendations and potential solutions moving forward

3. Public Comment

Samantha Ehlen, an insurance broker noted that California law only allows insurers to contract with businesses to provide coverage for employees working 20-30 hours per week or more, and insurers generally have participation requirements in terms on how many employees must sign-up. She recommended that the council should work toward finding solutions for insuring those who are eligible (working 20+ hours/week).

4. Closing Comments and Next Steps

Upcoming Council Meeting Dates:

DATE	TIME	LOCATION
November 7, 2013	10AM-12PM	25 Van Ness Ave, Room 610
November 14, 2013	10AM-12PM	25 Van Ness Ave, Room 610

Members Present:

- Rob Black
- Eddie Chan
- Steve Fields
- Gordon Fung
- Estela Garcia
- Barbara Garcia
- John Gressman
- Keven Grumbach
- Scott Hauge
- Steve Heilig
- Sandra Hernandez
- Ken Jacobs
- Perry Lang
- Jim Lazarus
- Ian Lewis
- Sonia Melara
- Rebecca Miller
- Wade Rose
- Amor Santiago
- Ron Smith
- Abby Snay
- John Stead-Mendez
- Laurie Thomas
- Richard Thomason
- Ana Valdes
- Chris Wright
- Lucien Wulsin, Jr
- Jim Wunderman
- Brenda Yee

- Emily Webb (Observing for Warren Browner)
- Jim Illig (Observing for Christine Robisch)
- Noelle Simmons (Observing for Trent Rhorer)
- Barbara Hendricks (Observing for Fred Naranjo)
- Ana Guzina (Observing for Bob Muscat)
- Michael Wylie (Observing for Ben Rosenfield)

Materials Distributed:

- Meeting Agenda
- October 23, 2013 Meeting Minutes
- Finalized "Mission, Goals, Principles, and Structure"
- "HCSO in Depth, ACA Market Reforms, and the Intersection of HCSO and ACA"
- FAQs from the Office of Labor Standards Enforcement

Follow-up information requested at 10.24.13 Universal Healthcare Council meeting

Sent via email:

1. **How many individuals and employers have penalties under OLSE for HCSO noncompliance?**
   - Individuals do not have any obligations under the HCSO
   - After conducting investigations and audits, OLSE has found 95 employers in violation of the HCSO Employer Spending Requirement. To date, OLSE investigations have resulted in recovery of over $9.5 million in health care expenditures (cash payments to workers, contributions to the "City Option", and allocations to reimbursement accounts) from 95 employers on behalf of 7,739 San Francisco workers. OLSE has issued official Determinations or reached settlement agreements in 21 additional cases – which are on appeal, in default, or subject to payment plans – representing an additional $4.7 million in health care expenditures owed to 2,168 workers. OLSE has also recovered over $436,000 in penalties from employers who failed to make required health care expenditures.

2. **How much does DPH have on the books in MRAs?**
   - In 2011, San Francisco General Hospital received the $3.387 million that were aggregated from the closing of 5,244 inactive MRAs
   - As of the end of September 2013, approximately $73.1 million in unused MRA funds are in an non-interest bearing account managed by the San Francisco Health Plan

3. **What are the total numbers of employers and employees taking the MRA option?**
   - Employers and employees do not have an option to choose an MRA. The employer chooses to pay into the City Option, and from there, the City allocates funds depending on the employee's eligibility for Healthy San Francisco or an MRA. As of September 2013, there are approximately 41,000 open MRAs; this estimate includes duplicate accounts (i.e. an employee may have accounts from multiple employers).

4. **Link to 9th Circuit 2008 ruling on GGRA vs. CCSF:**
   http://cdn.ca9.uscourts.gov/datastore/opinions/2008/09/29/0717370.pdf

5. **A description of preventive services covered under the ACA can be found here:**
   https://www.healthcare.gov/what-are-my-preventive-care-benefits/#part=1

6. **Request that City's correspondence with federal government regarding HRA and MRA guidance be made available**
   - As relayed at the meeting, all contact with the federal government has been verbal. There is no correspondence to be made public.

7. **To what extent are individuals between 400%-500% FPL enrolled in Healthy San Francisco?**
   - Currently, 429 Healthy San Francisco enrollees (<1% of all enrollees) have incomes between 400-500% FPL
   - Thirty-six (.08%) enrollees have incomes above 500% FPL.

8. Request for additional information on HRAs and City Option/MRA, and Employer Payment Plan/Other Options

- **HRAs:** In what instances are stand alone HRAs allowed under ACA? Are carryover balances considered MEC and therefore prohibit employees from subsidy eligibility under Covered California?
  - Stand-alone HRAs are allowed if integrated with group health coverage that the beneficiary is enrolled in. Details can be found in the September 2013 Department of Labor technical release.
  - The City is seeking federal guidance on the issue of carryover balances.

- **Employer Payment Plan/Other Options:** Is this permissible under ACA pre/post tax or both/neither?
  - The September 2013 Department of Labor technical release addresses this issue.

- **City Option/MRA**: Is this considered a group health plan and therefore satisfy employer shared responsibility and employee MEC?

  The following information is the City's best current understanding of outstanding questions related to the City Option/MRA. However, please be reminded that the federal government continues to issue new guidance about the Affordable Care Act that could affect the City's understanding of these issues.

  A City MRA is a benefit provided by a public benefits program.

  The Health Care Security Ordinance (HCSO), San Francisco Administrative Code Chapter 14, has two prongs. Section 14.3 imposes an hourly minimum health care expenditure requirement on some employers, and section 14.2 establishes a related but separate government benefits program comprised of Healthy San Francisco (HSF) and Medical Reimbursement Accounts (MRAs). The HCSO allows covered employers to meet their employer spending requirements in a number of ways, including "payments by a covered employer to the City to be used on behalf of covered employees." §14.1(7)(a).

  Once an employer pays the City, the funds belong to and are unilaterally controlled by the City, not the employer or the employee. § 14.2(h). The City currently uses them to provide certain benefits to covered employees, either as a discount on HSF participation fees or as a fund available to reimburse health care expenses, and to support Healthy San Francisco generally. See §§ 14.1(7)(a), 14.2(h). But the City is free to change the eligibility criteria and extent of these benefits by amending its HCSO regulations, and the Board of Supervisors could amend the HCSO to provide entirely different types of benefits instead of, or in addition to, HSF discounts and MRAs. In contrast, the employer has no control over the levels and kinds of benefits the City chooses to provide; it cannot choose which of its employees will receive which benefits; and it can make no assurances to its employees in regard to any benefits they may receive.

  As the Ninth Circuit Court of Appeals has explained, these are all hallmarks of a public benefits program, not an employee benefit plan, even when the City uses an

employer's payment to help support the program and the employer's covered employees are among the benefit recipients. *See Golden Gate Restaurant Assoc. v. City and County of San Francisco*, 546 F.3d 639, 653-54 (9th Cir. 2008) (available at *https://www.casetext.com/case/golden-gate-restaurant-v-san-francisco/*.)

City MRAs are not a "group health plan" subject to the ACA requirements for group health plans.

The ACA regulates "group health plans" and requires them to comply with the market reforms described in the meeting materials. Some council members have raised the question whether MRAs qualify as a regulated "group health plan" under the ACA. The meeting materials took the position that they do not.

Section 5000A of the Internal Revenue Code defines "group health plan" as "a plan (including a self-insured plan) of, or contributed to by, an employer" to provide health care to its employees. 26 U.S.C. § 5000A(b)(1). The regulations to that section further specify that this definition of "group health plan" has the same meaning as in section 2791(a) of the Public Health Service Act. See 26 C.F.R. § 1.5000A-1(d)(7), released August 30, 2013 at 78 Fed. Reg. 53646, 53650. Section 2791(a), in turn, adopts the ERISA definition of "employee welfare benefit plan," which is limited to "any plan, fund, or program which . . . was established or is maintained by an employer or by an employee organization, or by both." 29 U.S.C. § 1002(1).

MRAs do not appear to fit that definition for two reasons. First, as discussed above, MRAs are a component of a public benefits program established and maintained by the City, a public entity, not a group health plan established and maintained by employees or employees. Second, employers that pay the City instead of providing health care benefits do not "contribute to" MRAs. The City uses employer payments to help support its benefits program, but the City decides how to allocate the funds, which may not go to an MRA at all. And even though an employer may be able to predict how the City will use the funds to the benefit of its employee (if it knows the laws and regulations that govern the program and has sufficient information about its employee), knowing how the City spends its public funds is different than making a "contribution" to that use.

A City MRA is not "minimum essential coverage," so it does not affect an employee's entitlement to federal premium assistance.

Some council members have asked for additional information explaining why the City believes that having a City MRA will not affect the recipient's eligibility for federal premium assistance.

Internal Revenue Code section 36B provides that individual taxpayers whose household incomes are at or below 400% of the federal poverty line are eligible for premium assistance tax credits for insurance purchased on Covered California unless they are eligible for or enrolled in "minimum essential coverage." 26 U.S.C. § 36B(c)(2)(B). One definition of "minimum essential coverage" is "[g]overnment sponsored programs." 26 U.S.C. § 5000A(f)(1)(A). That term is also defined and means coverage under any one of seven federal programs listed in section 5000A(f)(1)(A)(i)-(vii). No local government-sponsored programs are on the list, including the City's program, so City MRAs are not considered minimum essential coverage as a "government sponsored program."

The definition of minimum essential coverage also includes "employer-sponsored plans." 26 U.S.C. §§ 5000A(f)(1)(B). That term is further defined to include a "governmental plan (within the meaning of section 2791(d)(8) of the Public Health Service Act)." 26 U.S.C. § 5000A(f)(2)(A). Section 2791(d)(8), in turn, references a section of ERISA that defines "governmental plan" as an employee benefit plan established by a federal, state or local government entity for its employees. 29 U.S.C. § 1002(32). Because MRAs are not an employee benefit plan for City employees, they do not qualify as an employer-sponsored plan.

MRAs do not fit under any definition of minimum essential coverage, so they do not disqualify an employee who has a City MRA from receiving federal premium assistance if they otherwise qualify.

A City MRA can be used to reimburse insurance premium payments, including on Covered California.

Insurance premiums are health care expenses that are eligible for reimbursement under the terms of the City's MRA. Some council members have expressed concern that this may be impermissible if the benefits recipient is buying insurance on Covered California, particularly if he or she receives a premium assistance tax credit. They point out that the IRS has prohibited this sort of "double-dipping" in regard to employer plans and does not permit employees to use pre-tax dollars to purchase coverage on an Exchange.

Here, too, the City's position reflects the fact that public benefits and employee benefits are subject to different legal rules. Unlike for employee benefit programs, the City is not aware of restrictions on using government benefits – whether in the form of a general assistance check or a disaster relief subsidy or something else – to buy insurance on an Exchange. In the absence of guidance to the contrary, the City believes the same is true of MRA benefits.

To be discussed at next meeting, 11.7.2013

- Employees between 20-30 hours/week
- Employers w/ 20-49 employees
- "cost" of HRAs not reverting to employer
- Employer Considerations: Small businesses have to take into consideration the eligibility requirement and uptake rate requirement of insurers prior to choosing a plan
- Employer Affordability/Costs: Impact on small business sustainability
- Scenarios outlining implications of not having HRAs and/or City Option in place

UNIVERSAL HEALTHCARE COUNCIL 2013

FINANCIAL CONSIDERATIONS FOR INDIVIDUALS, EMPLOYERS, AND THE LOCAL PUBLIC HEALTH SYSTEM

As San Francisco moves forward with Health Reform, cost considerations will play a key role for all parties who bear a shared responsibility for ensuring access to health care for all San Franciscans – individuals, employers, and local government. This brief begins with an overview of health care costs, followed by relevant financial considerations from individual and employer perspectives and identifies potential coverage or affordability concerns for affected populations. Financial considerations for San Francisco's health care system follow next and the brief concludes with points for consideration and discussion using various scenarios.

HEALTH CARE COSTS

Total health care costs include insurance premiums and out-of-pocket costs. These costs may be shared between employers and employees.

PREMIUMS

Insurance premiums are determined, among other factors, by benefits covered, provider networks, enrollee's age, health status, geographic location, smoking status, household size, and whether insurance is purchased directly or through one's employer. Most people receive health insurance through their employers and premiums have been most expensive for small businesses and those purchasing on the individual market.

According to the Kaiser Family Foundation's 2013 Employer Health Benefit Survey, the average premium price of employer-sponsored insurance is $6,140/year for an individual and $16,670/year for family coverage.[1] On average, employees contribute 18% ($999 annually) toward premiums for an individual and 29% ($4,565 annually) toward family employer-sponsored coverage.

On the individual market in Covered CA, a 42 year old San Franciscan earning $50,000/year can expect to pay $2,916/year in premiums for the least expensive plan to $7,548/year for the most expensive plan.

[1] Kaiser Family Foundation, Employer Health Benefits Survey 2013. Exhibit 1.3; data reported for the West region (CA, AZ, CO, ID, MT, NV, NM, UT, WY, AL, HI, OR, WA).

OUT-OF-POCKET COSTS

Out-of-pocket costs include deductibles (a flat amount an enrollee must pay before the insurer will make benefit payments), co-pays (a flat amount paid by an enrollee for a covered service), co-insurance (a percentage of cost paid by an enrollee for a covered service), over-the-counter medications, and any other health-related expenses not covered by the insurer. Out-of-pocket costs are highly dependent upon an individual's health status. An individual in poor health is likely to require more visits to the doctor, have higher prescription costs, and/or need medical procedures more often than someone in good health.

Out-of-pocket costs are also driven by plan type and cost-sharing scheme. For example, the average annual deductible in an individual health maintenance organization (HMO) is $729, compared to $2,003 in a high-deductible health plan with a savings option.[2] Likewise, some plans may aggregate a family's deductible, or require a separate deductible for each member. Enrollees in employer-sponsored plans paid an average of $1,107/year for annual deductibles in individual plans and $1,700 - $4,000/year in family plans in 2013.[3]

Like deductibles, co-pays and co-insurance also vary by type of plan. For in-network physician care, the average employer-sponsored plan co-pay is $23 per primary care visit and $35 per specialty care visit; the average co-insurance is 18% for primary care and 19% for specialty care.[4] For hospital services, the average enrollee in an employer-sponsored plan can expect to pay 18% in co-insurance, $278 per admission, and $436 in a separate hospital deductible.[5]

Plans available on Covered CA limit out-of-pocket costs to $6,350/year for individuals and $ 12,700/year for families. These limits apply only to essential health benefits covered in network, and include all cost-sharing (deductibles, co-pays, and co-insurance). Out-of-network costs or costs related to benefits not covered by the plan are not subject to annual limits.

EFFECT OF ACA FEES AND MARKET REFORMS

The ACA introduces a variety of reforms to the individual, small group, and large group health insurance markets, and levies new fees and taxes on health insurance companies. Some examples include the Patient-Centered Outcomes Research Institute fee (advances clinic effectiveness research), the annual fee on health

[2] Kaiser Family Foundation, Employer Health Benefits Survey 2013. Exhibit 7.14.
[3] Kaiser Family Foundation, Employer Health Benefits Survey 2013. Exhibit 7.6; data reported for the West region (CA, AZ, CO, ID, MT, NV, NM, UT, WY, AL, HI, OR, WA).
[4] Kaiser Family Foundation, Employer Health Benefits Survey 2013. Exhibit 7.26.
[5] Kaiser Family Foundation, Employer Health Benefits Survey 2013. Exhibit 7.24.

insurance providers (funds certain provisions of the ACA such as premium subsidies and cost-sharing reductions), and the transitional reinsurance program (supports plans that cover high-cost individuals). Each of these fees is assessed on a per "covered life" basis, and insurers are likely to pass these fees onto businesses and consumers.

Reforms such as guaranteed issue, the requirement to cover essential health benefits, and the requirement to cover 60% of a beneficiary's costs have increased the cost of individual and small group policies. To put this in context, prior to the passage of the ACA, the average California individual plan's average actuarial value was 55%.[6] While enrollees in these markets receive more comprehensive coverage, some individuals may pay higher premiums compared to their plans in the pre-ACA small group and individual markets.

INDIVIDUALS AND FAMILIES

FINANCIAL DRIVERS

There are four key drivers that impact the cost of the shared responsibility considerations for an individual or a family:

Age

The ages of the individual and covered dependents factor into the rates offered on Covered CA and in employer-sponsored health coverage. Assuming good health, premiums for a 15 year-old child will be less than for a 50 year-old adult. However, because the ACA limits how much premiums can vary by age, premiums for adults younger than 35 are expected to increase from current rates while decreasing for adults older than 55.

Income

Household income, measured as a percent of the federal poverty level (FPL), is a key factor in determining eligibility for Medi-Cal, which is a no-cost insurance option, and for premium assistance and cost-sharing subsidies for insurance purchased on Covered CA. Cost-sharing assistance is discussed in greater detail below. If the lowest cost plan available on Covered CA or through an individual's employer is more than 8% of income, the individual may apply for an exemption to the individual mandate.

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6 California Healthcare Foundation, "Health Reform in Translation: What is Actuarial Value?" August 2013. Retrieved 11/5/13 from http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/H/PDF%20HealthReformTranslationActuarialValue.pdf.

Household Size

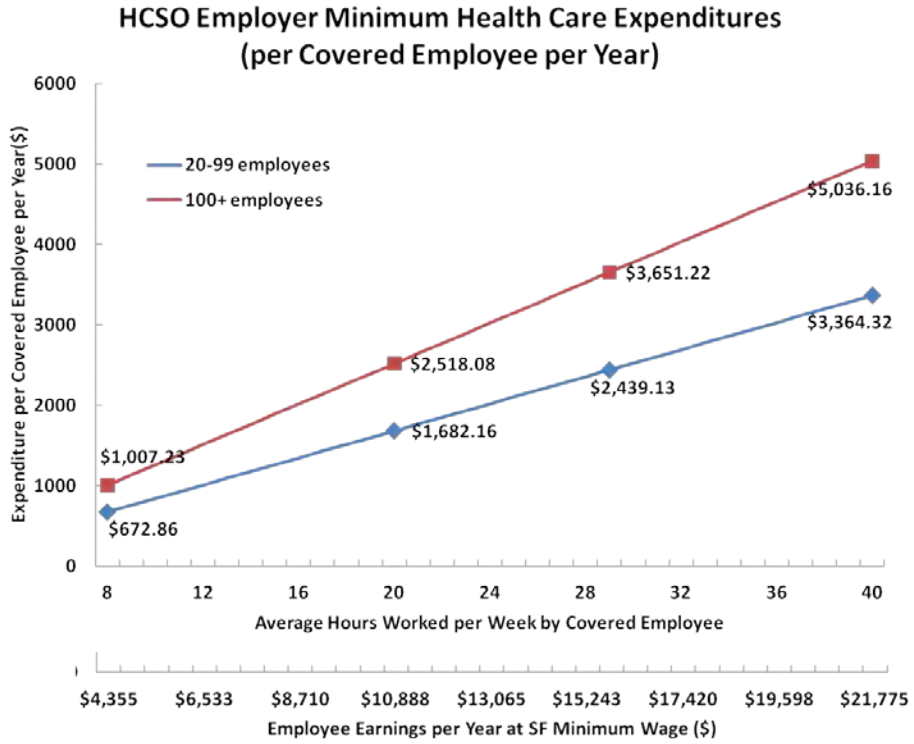
Combined with income, household size also determines how much families will pay for coverage and whether they are eligible for Medi-Cal. The average size of a family in San Francisco is three.

Employment Status

Employers in San Francisco may have obligations under either or both the ACA and the HCSO that affect the affordability of insurance for an employee. The HCSO requires covered employers to make health care expenditures for any employees working at least 8 hours per week. A full-time covered employee is eligible for $3,300 to $5,000 per year in health care expenditures under the HCSO.

The ACA requires covered employers to provide affordable insurance to employees working more than 30 hours per week (full-time). The cost of ACA employer compliance (as described in more detail in the Employer section below) will vary depending upon the number of employees and average income of employees, as well as the final SHOP rates and small business eligibility for tax credits.

The following chart depicts how much an employee earning the San Francisco minimum wage can expect in annual health care expenditures from covered employers in 2014, by hours worked.



INDIVIDUAL CONSIDERATIONS

Depending on an individual's age, income, household size, and employment status, as described above, there are different coverage opportunities available under the ACA and HCSO. Each of the opportunities discussed below has affordability implications as measured by the price of premiums, out-of-pocket costs, and availability of federal subsidies. In situations where premium or out of pocket costs are prohibitive, individuals may decide to forgo coverage. Without coverage, an individual (1) faces additional costs including but not limited to a federal tax penalty and (2) is at high risk for incurring 100% of health care costs if an adverse event occurs. These costs associated with forgoing coverage are not only borne by the individual but also the greater community.

Medi-Cal

An individual earning less than $15,856 or family of three earning less than $ 26,951 annually is eligible for Medi-Cal, a public insurance program that pays for a variety of medical services for children and adults with limited incomes for low-to-no cost. The following chart shows Medi-Cal and Covered CA eligibility by hourly income for individuals earning below 400% of FPL.

Individual Eligibility for Publicly-Subsidized Insurance

	40 hrs/wk	36 hrs/wk	30 hrs/wk	25 hrs/wk	20 hrs/wk
Min Wage	$16,640	$14,976	$12,480	$10,400	$8,320
$9/hr	$18,720	$16,848	$14,040	$11,700	$9,360
$10/hr	$20,800	$18,720	$15,600	$13,000	$10,400
$11/hr	$22,880	$20,592	$17,160	$14,300	$11,440
$12/hr	$24,960	$22,464	$18,720	$15,600	$12,480
$13/hr	$27,040	$24,336	$20,280	$16,900	$13,520
$14/hr	$29,120	$26,208	$21,840	$18,200	$14,560
$15/hr	$31,200	$28,080	$23,400	$15,600	$15,600
$16/hr	$33,280	$29,952	$24,960	$20,800	$16,640
$17/hr	$35,360	$31,824	$26,520	$22,100	$17,680
$18/hr	$37,440	$33,696	$28,080	$23,400	$18,720
$19/hr	$39,520	$35,568	$29,640	$24,700	$19,760
$20/hr	$41,600	$37,440	$31,200	$26,000	$20,800
Premium assistance through Covered California					
Medi-Cal					

Employer-sponsored Insurance

Nationwide, approximately 60% of Americans receive health insurance through their employer.[7] Under the ACA, an employee may be offered a traditional employer-sponsored group health plan, or may be offered coverage through the Small Business Health Options Program (SHOP) on Covered CA.

An individual's options for employer-sponsored health insurance are dependent upon their employer's offerings. Nationally, 99% of employers with more than 200 employees offer health insurance and approximately 57% of employers with 3-199 employees offer health insurance.[8] Small business employees face higher costs than their counterparts in large businesses. For example, the average annual deductible for an individual in a small business health plan is $1,715, compared to $884 in a large business health plan.[9] There are several reasons for this, which are discussed in the Employer section of this brief, below.

Large employers will be required to offer individual coverage at a cost to the employee that is less than 9.5% of the employee's income or face penalties. However, while employers are required to offer dependent coverage, the ACA does not require employers to offer spousal coverage. Additionally, the cost of employer-sponsored family coverage will necessarily be higher than the cost of individual coverage, but is not subject to the affordability calculation and, thus, may be more than 9.5% of a family's income.

Covered CA Individual Market

Plan Tiers

The ACA requires Covered CA to offer plans in four tiers based on actuarial value. All plans offer the same essential benefits and the only difference between them is the percentage of health care costs covered by the plan. The available tiers are: Bronze (covering 60% of costs), Silver (70%), Gold (80%), and Platinum (90%). As the actuarial value of a plan increases, so do premiums, though out-of-pocket costs decrease. The following chart shows the standardized cost-sharing schemes in each plan tier for 2014. Bronze plans have the lowest premiums and highest out-of-pocket costs, while Platinum plans have the highest premiums and lowest out-of-pocket costs. For San Francisco, five insurers each offer one plan per tier. The following table shows the cost parameters for each of the metal tier plans offered on Covered CA.

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7 Sonier J, Fried B, Au-Yeung C, And Auringer B, State-Level Trends In Employer-Sponsored Health Insurance: A State-By-State Analysis, Robert Wood Johnson Foundation, April 2013.
8 Kaiser Family Foundation, Employer Health Benefits Survey 2013. Exhibit 2.2.
9 Kaiser Family Foundation, Employer Health Benefits Survey 2013. Exhibit 7.5.

KEY BENEFITS	Platinum	Gold	Silver (Lower Cost Sharing Available on Sliding Scale)	Bronze
Copays In the Yellow Sections are Not Subject to any Deductible and Count Toward the Annual Out-of-Pocket Maximum			Benefits In Blue are Subject to Deductibles	
Deductible (if any)	No Deductible	No Deductible	$2,000 Medical Deductible	$5,000 Deductible for Medical and Drugs
Preventative Care Copay	No Cost – at least 1 yearly visit	No Cost – at least 1 yearly visit	No Cost – at least 1 yearly visit	No Cost – at least 1 yearly visit
Primary Care Visit Copay	$20	$30	$45	$60 – 3 visits per year
Specialty Care Visit Copay	$40	$50	$65	$70
Urgent Care Visit Copay	$40	$90	$60	$120
Generic Medication Copay	$5	$20	$25	$25
Lab Testing Copay	$20	$30	$45	30%
X-Ray Copay	$40	$50	$65	30%
Emergency Room Copay	$150	$250	$250	$300
High cost and infrequent services like Hospital Care and Outpatient Surgery	HMO Outpatient Surgery – $250 Hospital – $250/day up to 5 days PPO – 10%	HMO Outpatient Surgery – $600 Hospital – $600/day up to 5 days PPO – 20%	$250	30% of your plan's negotiated rate
Imaging (MRI, CT, PET Scans)	$150	$250	$250	40%
Brand medications may be subject to Annual Drug Deductible before you pay the copay	No Deductible	No Deductible	$250 deductible then pay the copay amount	$50-$75 after meeting deductible
Preferred brand copay after Drug Deductible (if any)	$15	$50	$50	$50
MAXIMUM OUT-OF-POCKET FOR ONE	$4,000	$6,350	$6,350	$6,350
MAXIMUM OUT-OF-POCKET FOR FAMILY	$8,000	$12,700	$12,700	$12,700

Premiums

Individuals earning more than $46,960 per year (400% FPL) do not qualify for financial assistance on Covered CA and must pay the full price of premiums. The following table reflects the range of premiums for plans available to individual San Franciscans earning above 400% of FPL for the 2014 plan year.[10]

Household Size: 1		Covered CA Plan Premium ($/month)			
Annual Income	Age	Bronze	Silver	Gold	Platinum
$46,960+ (400% FPL and above)	22	$183-244	$257-331	$337-396	$374-475
	27	192-256	269-347	353-415	392-497
	42	243-324	340-439	447-524	496-629
	57	447-596	625-807	882-964	911-1157

[10] Source: Covered California, Shop and Compare tool, 10.5.2013

Financial Assistance

Persons earning between 138-400% of FPL ($15,856 - $45,960/year individual, $25,951 - $78,120/year for family of three) are eligible for premium assistance in the form of federal tax subsidies. Available on a sliding scale, these subsidies may be used to purchase any plan offered on Covered CA.

In addition to premium assistance, people earning up to 250% of FPL ($28,725/year individual, $48,825/year for family of three) will qualify for cost-sharing assistance. Available only through the Silver plan, this assistance is also applied on a sliding scale, and decreases cost-sharing by offering enrollees reduced co-pays, smaller deductibles, and lower annual out-of-pocket caps.

For individuals eligible for both premium and cost-sharing assistance, Covered CA automatically offers eligible individuals a customized plan, known as the Enhanced Silver plan.

Penalties

Individuals may determine for financial reasons to pay the penalty instead of purchasing health insurance.

POTENTIAL COVERAGE AND AFFORDABILITY CONCERNS

There are several populations for whom there are potential coverage and/or affordability concerns that arise from the drivers and considerations for individuals and families under the ACA and HCSO.

- **Undocumented Immigrants:** potential coverage and affordability concerns. Undocumented immigrants are not eligible for the full range of Medi-Cal benefits. Medi-Cal allows eligible undocumented immigrants access to limited services, such as emergency care, pregnancy-related services, and skilled nursing care. Healthy San Francisco will continue to be available for individuals who do not qualify for health insurance options under the ACA (including undocumented immigrants) who meet the programs other eligibility requirements. However, undocumented persons who are not eligible for limited scope Medi-Cal or Healthy San Francisco are at risk for high out-of-pocket costs or forgoing needed care.
- **Part-time Employees:** potential coverage and affordability concerns. Neither the ACA nor the HCSO requires an employer to offer health insurance to part-time employees. Further, many insurers do not offer employers the option to cover their part-time employees. If an individual is not eligible for Medi-Cal, individual coverage on Covered CA is the only other ACA insurance option for this group which may or may not be affordable to the individual or family.

- **Small Business Employees:** potential coverage and affordability concerns. Small employers are less likely to offer health insurance than large employers and, when they do, their employees face higher costs than their counterparts in large businesses.
- **Families:** Potential affordability or coverage concerns. The ACA defines employer-sponsored coverage as affordable if the employee's share of premium costs for his/her individual policy – not including spousal or dependent coverage – falls below 9.5% of annual household income.[11] Affordability is calculated on the employee's share of coverage only and does not take into account the additional premiums an employee would pay to cover a spouse or a dependent. This could result not only in a family actually paying more than 9.5% of household income on employer-sponsored insurance, but also a determination that the family has been offered affordable coverage, making them ineligible for subsidies on Covered CA.
- **Individuals with Carryover Balances In Existing Stand-alone HRAs:** Potential affordability concern. In 2012, covered employers under the HCSO reported 46,051 employees with approximately $107 million available in HRAs, some portion of which are in stand-alone HRAs that are not integrated with employer health insurance coverage.[12] If the federal government treats carryover balances in stand-alone HRAs as "minimum essential coverage," employees who hold such accounts and earn between 138% and 400% of the FPL would not be eligible for federal premium tax credits. The City is seeking guidance on this question.
- **Individuals Using Premium Assistance for a Bronze Plan:** Potential affordability concern. While the premiums on the Bronze plan are the least expensive of all of the plans, and someone with financial assistance could pay as little as $1/month for the least expensive Bronze, that plan includes a $5,000 deductible. This may subject individuals to high unanticipated health care costs.
- **Individuals Choosing to Pay Penalties:** Potential coverage and affordability concerns. Individuals choosing the penalty would be uninsured and liable for 100% of their health care costs.

[11] U.S. Dept of the Treasury, Internal Revenue Service, Notice of Proposed Rule Making: Shared Responsibility for Employers Regarding Health Coverage, REG-138006-12.

[12] San Francisco Office of Labor Standards Enforcement. Analysis of the HCSO 2012 Annual Reporting Forms.

EMPLOYERS

FINANCIAL DRIVERS

There are three key drivers that impact an employer's shared responsibility considerations under the ACA and the HCSO:

Employer Size

Employer size determines whether and how an employer must comply with the ACA or HCSO.

- Under the ACA, large employers (>50 FTE) must offer affordable health insurance to at least 95% of full-time employees or face penalties. Small businesses (<50 FTE) are not required to provide insurance to their employees, but may do so through Covered CA's Small Business Health Options Program (SHOP).
- The HCSO's Employer Spending Requirement is determined by employer size depending upon business type. Large employers (>100 employees) pay a higher expenditure rate ($2.44/hour worked) than do small and medium sized employers (20-99 employees, $1.63/hour worked).
- The ACA provides tax credits for certain small businesses (<25 or <10 FTEs, depending on business type) that purchase insurance through Covered CA. These tax credits may cover up to 50% of an employer's insurance costs, if the employer pays for at least 50% of the employee's premiums.

Employee Work Status

The ACA requires large employers to provide affordable health insurance to employees working full-time, defined as more than 30 hours per week, while the HCSO requires medium and large employers to make hourly health care expenditures for employees working more than 8 hours per week. Employee work status also affects employer health care spending options. Depending on an employer's mix of full-time and part-time workers, it may not be feasible to provide insurance. Insurance companies often do not allow for coverage of part-time employees working fewer than 20 hours, and smaller businesses generally lack the strength in numbers required to negotiate affordable premium rates.

Uptake

There are certain factors that impact an employer's ability to provide health insurance for their employees. Just as employer demographics and actions affect employee options for coverage, employee demographics and actions also affect employer options for coverage. A business's ability to offer insurance or to negotiate affordable rates is affected by the extent to which their employees are eligible for insurance and choose to enroll (referred to as the take-up rate). For example, according to national

survey data, in businesses with 35% or more low-wage workers, only 61% of the workforce is eligible for insurance, compared to 80% at firms with fewer low-wage workers. Similarly, at businesses with 35% or more part-time workers, only 52% of employees are eligible for insurance, compared to 84% at firms with fewer part-time workers.[13] Furthermore, on average, 76% of employees eligible for insurance at businesses with 3-49 employees participate in their employer's plan, compared to 82% at businesses with more than 50 employees.[14] Insurers often require the participation of a minimum percentage of a business's employees, which puts small businesses and businesses that rely more heavily on part-time or low-wage employees at a disadvantage in the insurance marketplace.

EMPLOYER CONSIDERATIONS

Depending on an employer's size and employee work status, as described above, there are several coverage options, as outlined below.[15] Each of these options has affordability implications measured by the price of insurance, health care expenditures under the HCSO, amount of tax credit, and any potential penalties.

Employer-sponsored Insurance

To Meet HCSO and ACA Requirements

Covered employers may offer health insurance benefits to fulfill their requirements under both the ACA and HCSO. In fact, in 2012, 90% of expenditures under the HCSO were for health insurance.[16] Of the 4,204 employers reporting their compliance with HCSO in 2012, 88% provided health insurance to their employees (either alone or in combination with another health care expenditure option). Thus, few, if any, changes may be necessary for the majority of employers already providing health insurance to comply with the ACA.

Small Employer Options

Soon, small employers will be able to offer SHOP plans. While the actual SHOP rates have not yet been released, the following Covered CA's August 2013 analysis shows how 2014 projected SHOP rates compare to the current average rate for San Francisco employees in the small group health insurance market. As shown below, the premiums for small businesses plans could be more expensive than an individual plan purchased on Covered CA.

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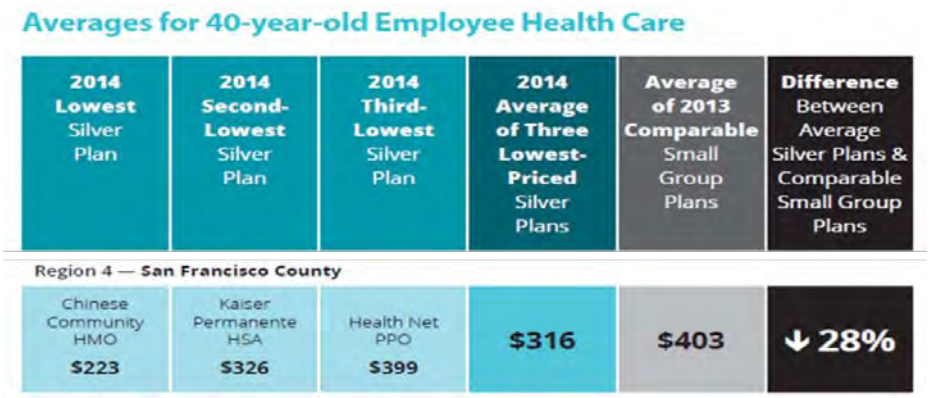
[13] Kaiser Family Foundation, Employer Health Benefits Survey 2013. Exhibit 3.3.
[14] Kaiser Family Foundation, Employer Health Benefits Survey 2013. Exhibit 3.2.; averages recalculated to reflect businesses sized 3-49, and 50+.
[15] This presentation of information acknowledges the uncertainty regarding HRA carryover balances.
[16] San Francisco Office of Labor Standards Enforcement. Analysis of the HCSO 2012 Annual Reporting Forms.



The following two examples, taken from Covered CA's August 2013 SHOP booklet, illustrate two potential scenarios for employers purchasing SHOP coverage. The company on the left, Kaput Auto Repair, illustrates the total monthly cost to an employer who qualifies for the small business tax credits. The company on the right, Fluor+Whal Architects, illustrates the total monthly cost to an employer who does not qualify for tax credits. Both employers cover 50% of their employees' premium costs.

	Kaput Auto Repair Tax Credit Eligible	**Fluor + Wahl Architects** Not Eligible for Tax Credit
Location	San Bernardino, CA	San Jose, CA
# Employees	9	15
Average Wage	$24k	$90k
SHOP Silver Plan Choice	Health Net Standard Coinsurance PPO	Kaiser HSA
Percent Enrolling	100%	100%
Employer's Share of Premium	50%	50%
Total Premium	$2,614	$5,894
Total Employer Responsibility (50%)	$1,307	$2,947
Total Less Tax Credit (50%)	$654	$2,947

Health Care Expenditures

Employers currently comply with the HCSO by using multiple strategies to make health care expenditures. As of 2014, the ACA disallows one such strategy, the stand-alone health reimbursement account (HRA). The City is seeking federal guidance on this issue. In 2012, 996 of the 4,204 reporting employers used HRAs to comply with the HCSO

– 199 used stand- alone HRAs and 806 used some combination of stand-alone and integrated HRAs. [17]

Penalties

Just as individuals may determine for financial reasons to pay the penalty instead of purchasing health insurance, employers may also choose to pay penalties rather than comply with the ACA or the HCSO if doing so is less expensive.

POTENTIAL COVERAGE AND AFFORDABILITY CONCERNS

There are several business populations for whom there are potential coverage and/or affordability concerns that arise from the drivers and considerations for businesses under the ACA and HCSO.

- **Businesses with a High Proportion of Low-wage or Part-time Employees:** Potential affordability concern. National survey data shows that businesses that are more reliant on a part-time or low-wage workforce are more likely to have low health insurance uptake rates. This affects an employer's ability to find affordable health care coverage.
- **Small Businesses:** Potential affordability concern. For businesses with 20-49 employees it may be cost-prohibitive to offer insurance; or the employer may not have enough full-time employees to satisfy insurance plan uptake requirements. Additionally:
    - Small businesses with <25 employees. To qualify for tax credits for participating in SHOP, these employers must pay at least 50% of employee premiums. Depending on the rates available on SHOP, this may be cost-prohibitive for some employers.
    - Small businesses with 25-49 employees. While these businesses may purchase coverage through Covered CA, they are ineligible for the small business SHOP tax credits available to employers with fewer than 25 employees.
- **Businesses Relying on Stand-Alone HRAs:** Potential affordability concern. Because HRA utilization by employees has historically been below 25% and because the HCSO allows unused HRA funds to revert to the employer after 24 months, businesses have budgeted for HRA expenditures at the anticipated utilization rates. In 2012, roughly $80.1 million HRA dollars were unused.[18] If employers are required to contribute the full amount, it could create a

[17] San Francisco Office of Labor Standards Enforcement. Analysis of the HCSO 2012 Annual Reporting Forms.

[18] San Francisco Office of Labor Standards Enforcement. Analysis of the HCSO 2012 Annual Reporting Forms.

sustainability concern particularly for small businesses. In 2012, 94 of the 190 employers relying solely on HRAs to meet their HCSO spending requirements were employers with 20-49 employees.[19]

- **Businesses Choosing to Pay Penalties:** Potential coverage concern. By not providing insurance or making health care expenditures, businesses run the risk of having a workforce that does not access health care. Such a workforce is more likely to require sick days and to delay getting needed care, which reduces productivity.

CITY AND COUNTY OF SAN FRANCISCO

CITY CONSIDERATIONS

There are three key factors that impact the cost of the shared responsibility considerations for the City.

Section 17000

Section 17000 of the California Welfare & Institutions Code requires that "[e]very county and every city and county shall relieve and support all incompetent, poor, indigent persons, and those incapacitated by age, disease, or accident, lawfully resident therein, when such persons are not supported and relieved by their relatives or friends, by their own means, or by state hospitals or other state or private institutions." This statutory obligation has been interpreted to apply to essential health services, which in San Francisco have been provided by the San Francisco Department of Public Health (SFDPH) in several ways, including charity care, sliding fee scale for health care services, and Healthy San Francisco.

Reimbursement

SFDPH provides comprehensive health care services and will see an increase in insurance revenues as patients transition from uninsurance to insurance. These revenues will be largely in the form of capitated payments under managed care, which provide a flat dollar amount per patient per month regardless of how frequently or infrequently patients use services. Given the Department's relative inexperience with managing capitation and the complex nature of the patient population, the Department of Public Health will be challenged in this new payment environment.

At the same time, revenue sources intended to support care for the uninsured are declining. In order to help counties fulfill their Section 17000 responsibilities, the State

[19] San Francisco Office of Labor Standards Enforcement. Analysis of the HCSO 2012 Annual Reporting Forms.

provided funding to county health departments to offset the cost of indigent care. In addition, recognizing that certain facilities provided a disproportionate amount of care to low-income and uninsured individuals, the federal government also provided funding to public hospitals for indigent care. As a result of Health Reform, both of these funding sources are decreasing substantially, resulting in an estimated loss of more than $70 million to San Francisco's public health care system over the next 5 years.

Residually Uninsured

Currently, 60,000 uninsured individuals are enrolled in Healthy San Francisco, the City's health access program for the uninsured. This represents approximately 71% of San Francisco's estimated 84,600 uninsured adults. SFDPH estimates that 20,000 current Healthy San Francisco enrollees individuals will be ineligible for insurance options under the ACA. An estimated 15,000 will be eligible but will not enroll. This could leave as many as 49,000 residually uninsured San Franciscans after Health Reform – approximately 35,000 Healthy San Francisco enrollees plus approximately 14,000 uninsured individuals who are not currently enrolled in Healthy San Francisco.

The estimated 49,000 residually uninsured San Franciscans comprise both those ineligible for health benefits and those that are eligible but not enrolled. For those low-income individuals that are ineligible for health insurance options under the ACA, Healthy San Francisco will remain an option for health care access. For those individuals that have health insurance options but do not enroll, they will be able to access health care services at SFDPH and at other health care providers throughout the City on a sliding fee scale based upon their income. Further, low-income individuals may also be eligible for charity care provided by hospitals in the City.

POTENTIAL COVERAGE AND AFFORDABILITY CONCERNS

There potential coverage and/or affordability concerns that arise from the drivers and considerations for the City under the ACA and HCSO.

- **San Francisco's Public Health Care System:** potential affordability concern. While the City has a strong health care safety net, the ultimate cost of providing care for the uninsured falls on taxpayers. In FY2012, 42% of the patients served at San Francisco General Hospital were uninsured. In the current fiscal year, the City is contributing $500 million in local general funds to the Department of Public Health. It is not the best use of local general fund dollars to provide care to people with health insurance and subsidy options that would otherwise pay for that care.

FOR CONSIDERATION/DISCUSSION

POTENTIAL CONCERNS AT THE INTERSECTION OF THE HCSO AND ACA

The table below summarizes the areas of concern discussed earlier. Each member of the shared responsibility triangle is likely to experience gaps in coverage or affordability. These may serve as a useful backdrop for offering recommendations.

	Potential Coverage Concerns	Potential Affordability Concerns
Individuals	• Undocumented immigrants • Part-time employees • Small Business employees • Families • Individuals choosing to pay penalties	• Undocumented immigrants • Part-time employees • Employees of small business • Families • Individuals with Carryover Balances in Existing Stand-alone HRAs • Individuals Using Premium Assistance for a Bronze Plan
Employers	• Businesses choosing to pay penalties	• Businesses with a High Proportion of Low-wage or Part-time Employees • Small businesses (20-49 employees) • Businesses relying on stand-alone HRAs
City	N/A	• Public health care system

BAY AREA COST OF LIVING

Most of the data presented on health care costs is national. However, such costs must be examined in light of the very high cost of living in the Bay area.[20] Among 325 national metropolitan areas assessed for cost-of-living, the San Francisco area (San Francisco, Marin, and San Mateo counties) ranks 4th overall, while San Jose (Santa Clara county) ranks 6th, and the Oakland area (Alameda and Contra Costa counties) ranks 12th. The top 15 areas with the highest cost-of-living are:

1. New, York, (Manhattan), NY
2. New, York, (Brooklyn), NY
3. Honolulu, HI
4. **San, Francisco, CA (SF, Marin, and San Mateo Counties)**
5. New, York, (Queens), NY
6. **San, Jose, CA (Santa Clara County only)**
7. Stamford, CT

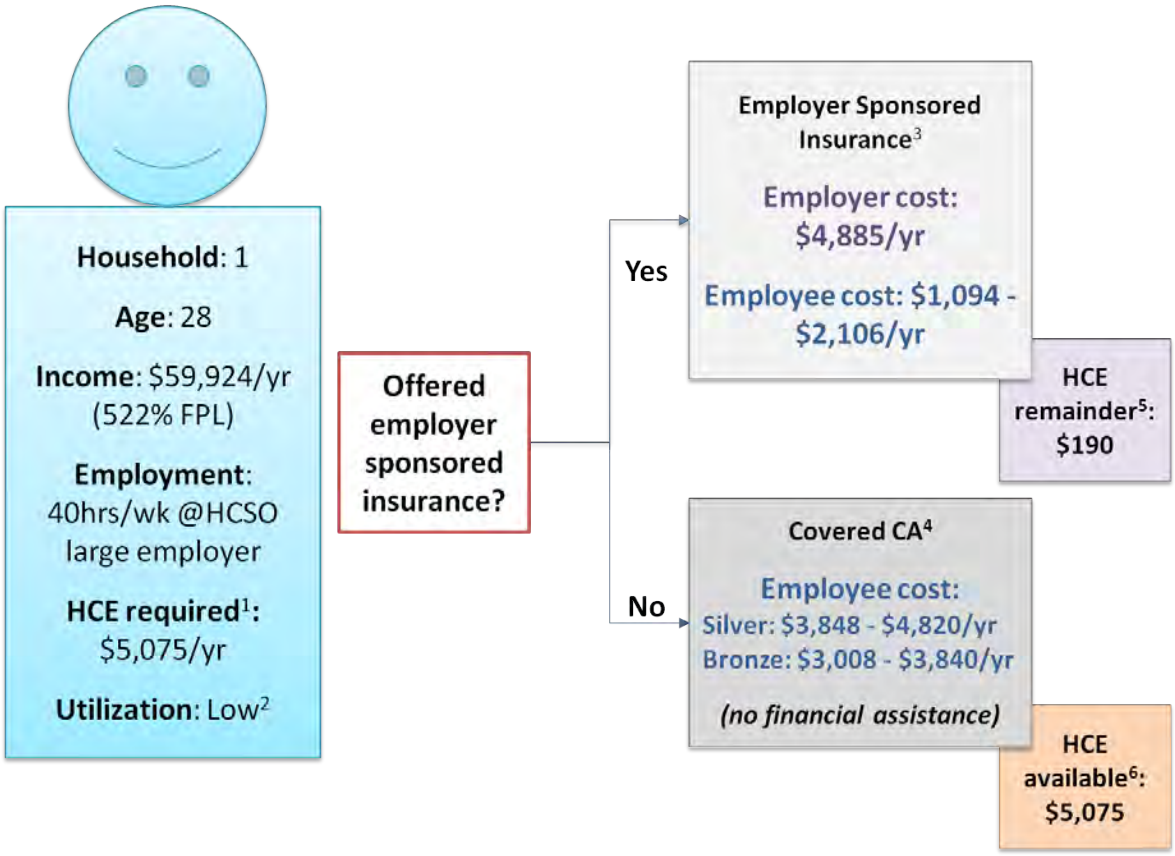
[20] U.S. Census Bureau, Statistical Abstract of the United States: 2012, Table 728. Cost of Living Index—Selected Urban Areas, Annual Average: 2010, Retrieved 10/28/13 at http://www.census.gov/compendia/statab/2012/tables/12s0728.pdf

8. Truckee-Nevada, County, CA
9. Orange, County, CA
10. Nassau, County, NY
11. Washington-Arlington-Alexandria, DC-VA
12. **Oakland, CA (Alameda and Contra Costa County)**
13. Fairbanks, AK
14. Juneau, AK
15. Los Angeles-Long Beach, CA

SAMPLE SCENARIOS

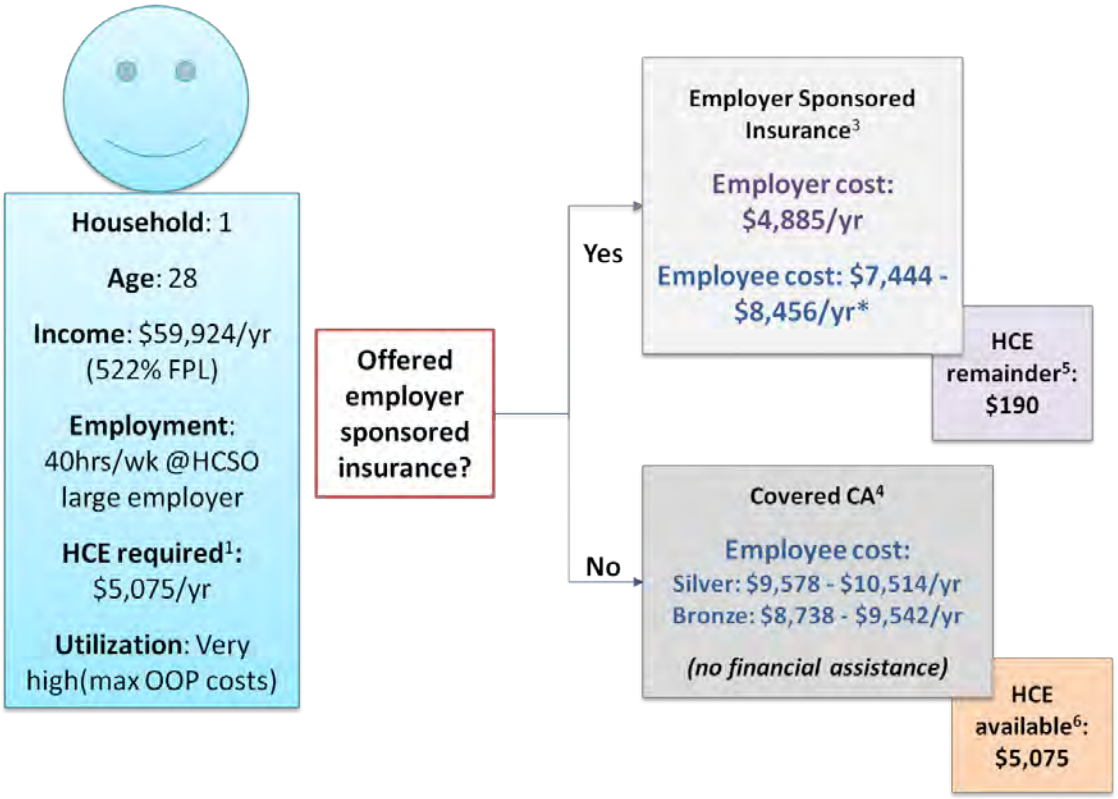
The following pages contain just a few sample scenarios to illustrate the financial considerations associated with the various drivers and options.

Scenario 1: A healthy young individual earning San Francisco's median income at a large employer is likely to spend more for individual coverage on Covered CA than through an employer-sponsored plan. HCE funds would be available to help cover this or other health-related costs. If this large employer offered coverage, the employer's contribution the plan would be slightly less than the HCE requirement.



1. HCE required = annual health care expenditures made on behalf of employee by covered employer ; calculated at 2014 expenditure rates
2. Low utilization = 1-2 doctor visits/year; 1 Rx; 1 specialist visit; no hospitalization
3. Employer sponsored insurance: costs estimated using 2013 KFF Employer Health Benefit Survey ; employer cost = average employee contribution to annual premiums; employee total cost = average employee contribution to premiums + out-of-pocket costs
4. Covered CA costs calculated for range of silver and bronze plans, and include total costs of premiums + out-of-pocket costs
5. HCE remainder = employer's remaining HCSO expenditure requirement after subtracting contribution to insurance
6. HCE available = health care expenditures remaining available to employee under HCSO

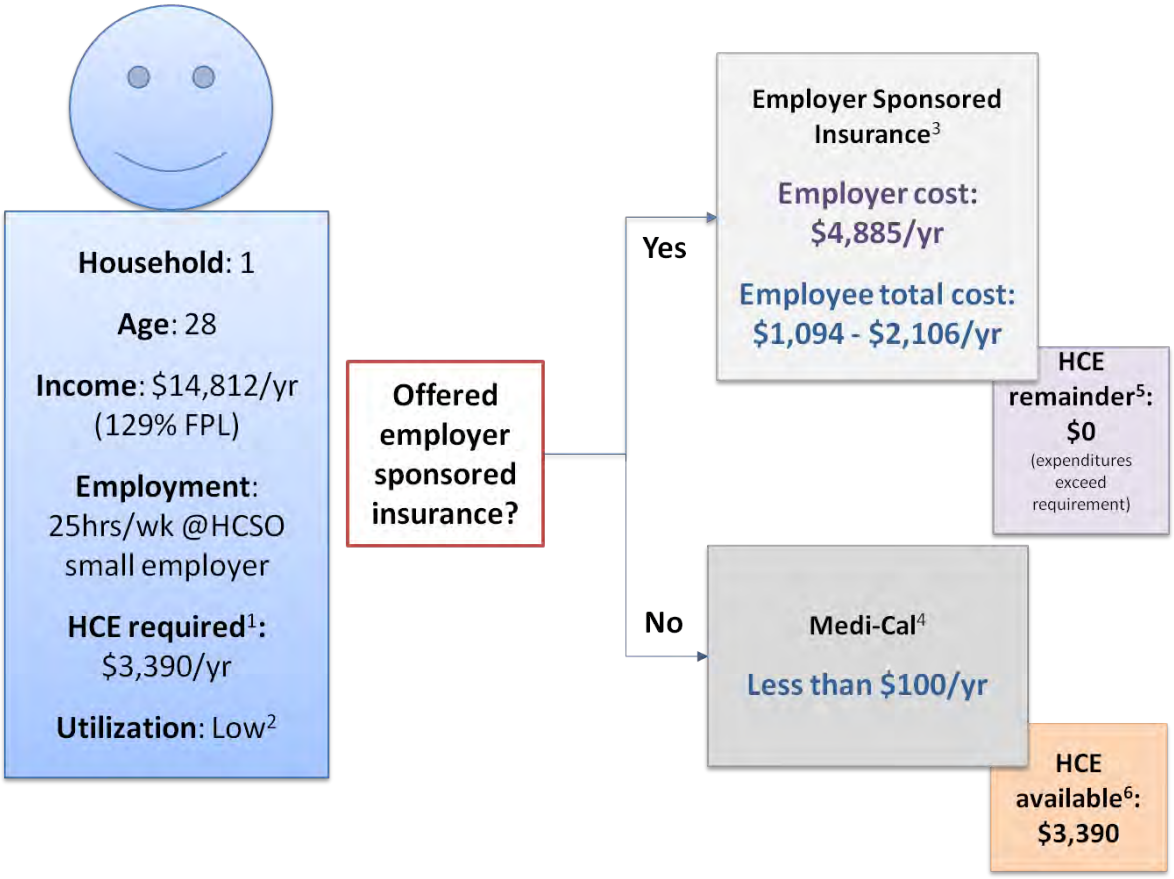
Scenario 2: If that same young median-income-earner is in poor health, his/her out-of-pocket costs will be very high in proportion to income. On Covered CA, such costs would be capped at $6,350 per year for individuals, but may or may not be capped in employer-sponsored plans. HCE funds would be available to help cover these or other health-related costs. The individual would still experience high costs under employer-sponsored health insurance and this large employer's contribution to an employer-sponsored plan would be slightly less than the HCE requirement.



1. HCE required = annual health care expenditures made on behalf of employee by covered employer ; calculated at 2014 expenditure rates
2. Low utilization = 1-2 doctor visits/year; 1 Rx; 1 specialist visit; no hospitalization
3. Employer sponsored insurance: costs estimated using 2013 KFF Employer Health Benefit Survey ; employer cost = average employee contribution to annual premiums; employee total cost = average employee contribution to premiums + out-of-pocket costs
4. Covered CA costs calculated for range of silver and bronze plans, and include total costs of premiums + maximum out-of-pocket costs
5. HCE remainder = employer's remaining HCSO expenditure requirement after subtracting contribution to insurance
6. HCE available = health care expenditures remaining available to employee under HCSO

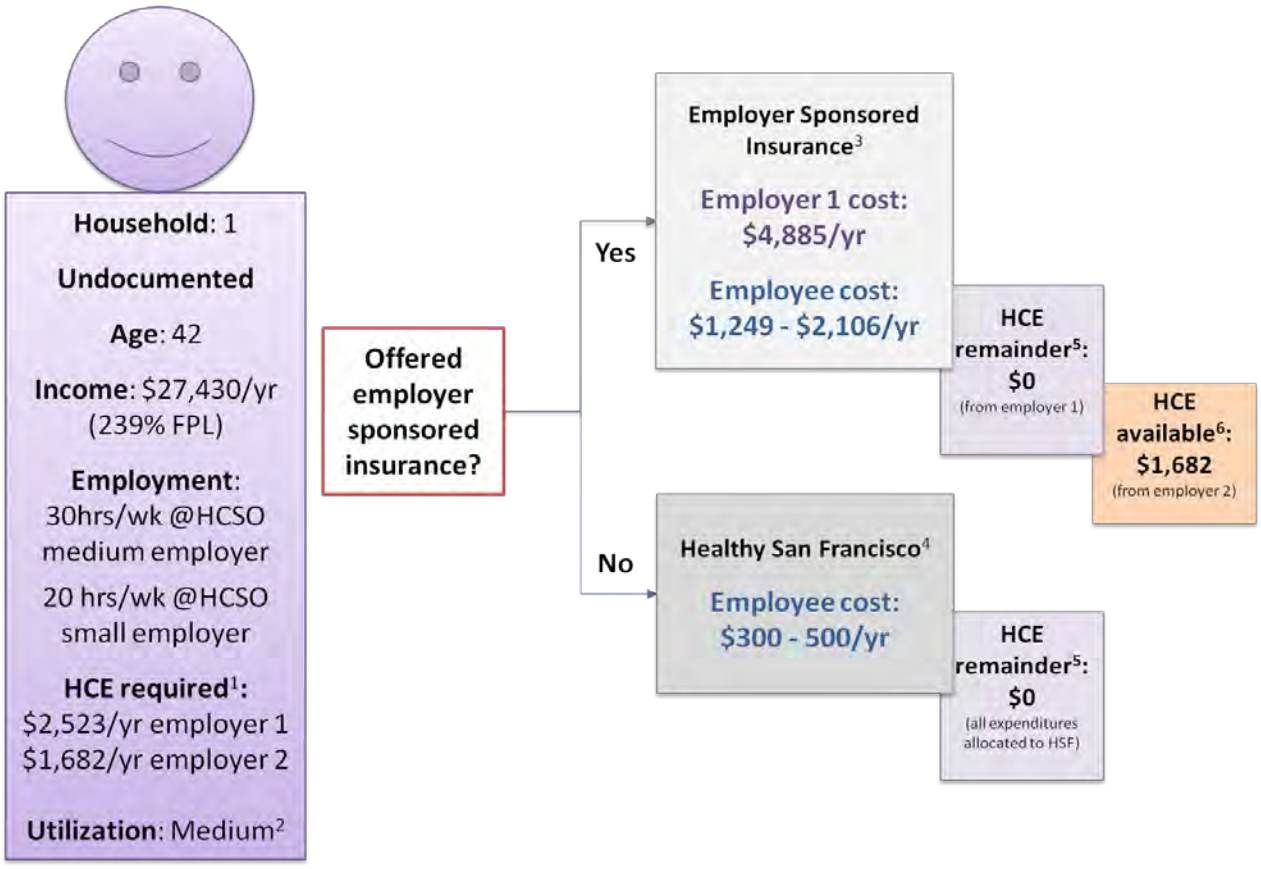
* Plan may not be subject to ACA maximum out-of-pocket limits (i.e. if self-insured or grandfathered)

Scenario 3: A part-time, low-income worker eligible for Medi-Cal would have no premiums and minimal out-of-pocket health care costs. The HCE contributions of this small employer would be available to help cover these or other health-related costs.



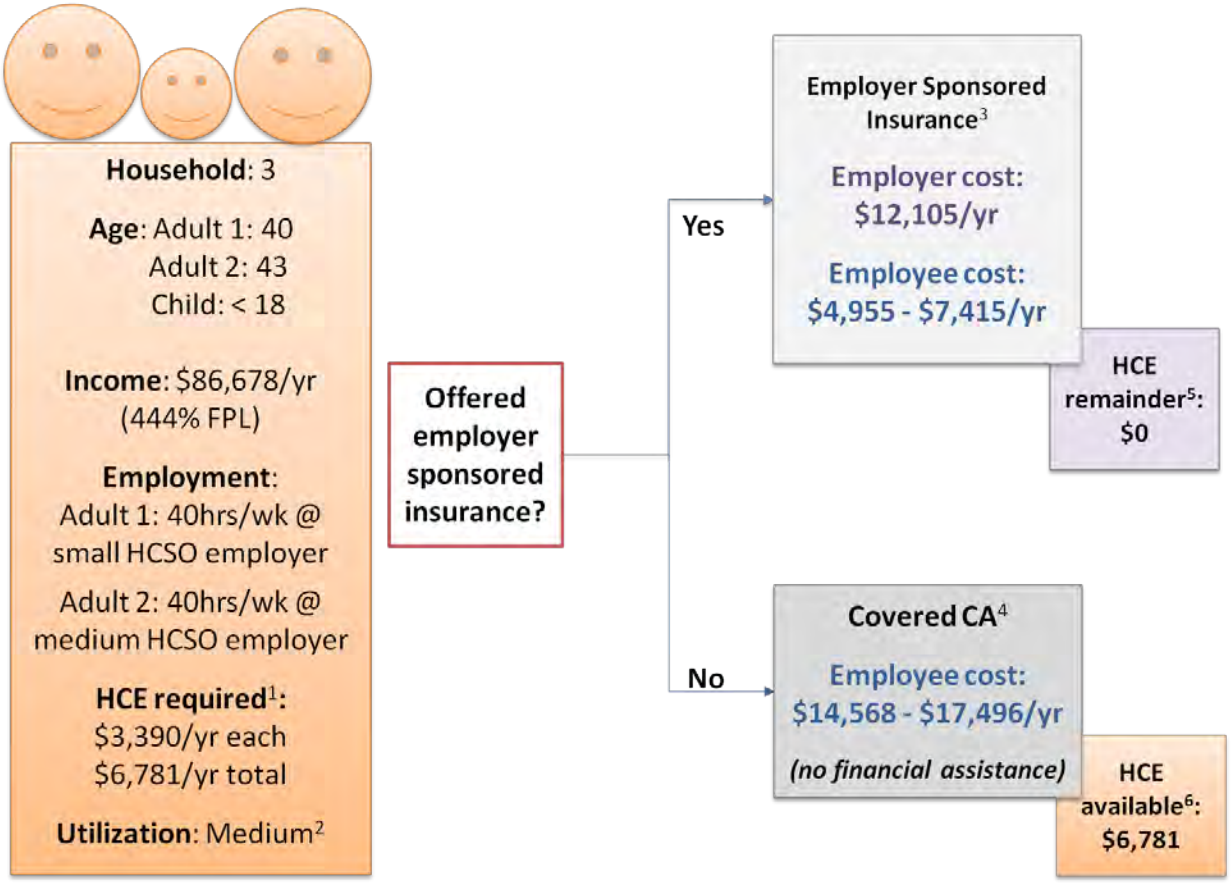
1. HCE required = annual health care expenditures made on behalf of employee by covered employer ; calculated at 2014 expenditure rates
2. Low utilization = 1-2 doctor visits/year; 1 Rx; 1 specialist visit; no hospitalization
3. Employer sponsored insurance: costs estimated using 2013 KFF Employer Health Benefit Survey ; employer cost = average employee contribution to annual premiums; employee total cost = average employee contribution to premiums + out-of-pocket costs
4. Medi-Cal costs are estimated by applying the utilization rate to allowable cost-sharing under Medi-Cal
5. HCE remainder = employer's remaining HCSO expenditure requirement after subtracting contribution to insurance
6. HCE available = health care expenditures remaining available to employee under HCSO

Scenario 4: An undocumented individual working two jobs would receive health care expenditures from each employer. If one employer offered health insurance, the cost to the medium employer offering health insurance would be nearly double the HCE requirement and the HCE of the small employer would be available to assist with out-of-pocket costs. If neither employer offered health insurance, s/he would be enrolled in Healthy San Francisco.



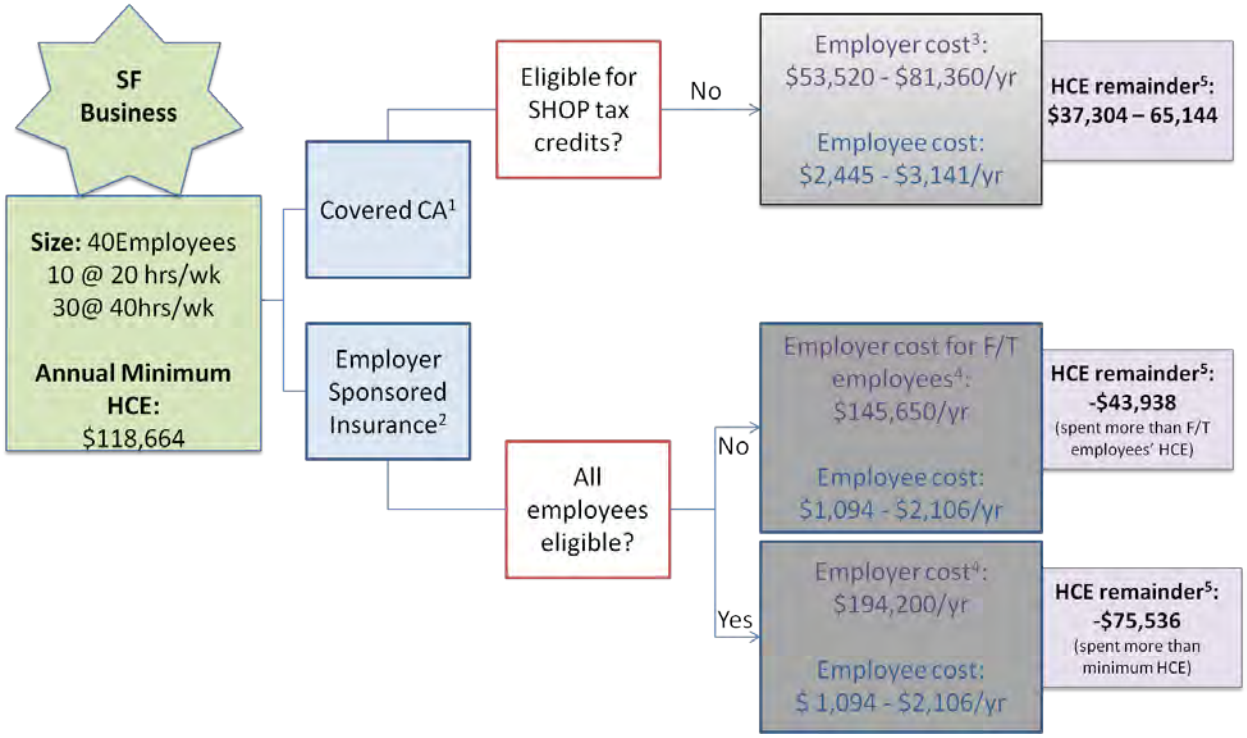
1. HCE required = annual health care expenditures made on behalf of employee by covered employer ; calculated at 2014 expenditure rates
2. Low utilization = 1-2 doctor visits/year; 1 Rx; 1 specialist visit; no hospitalization
3. Employer sponsored insurance: costs estimated using 2013 KFF Employer Health Benefit Survey ; employer cost = average employee contribution to annual premiums; employee total cost = average employee contribution to premiums + out-of-pocket costs
4. Healthy San Francisco costs include annual participation fee + POS service costs
5. HCE remainder = employer's remaining HCSO expenditure requirement after subtracting contribution to insurance
6. HCE available = health care expenditures remaining available to employee under HCSO

Scenario 5: For a family earning the median family income in San Francisco, an offer of employer insurance is more cost-effective for the employee than purchasing coverage on Covered CA, even if the HCE were available to help offset that cost. The cost of employer-sponsored insurance is nearly double the HCE requirement for these small and medium-sized employers.



1. HCE required = annual health care expenditures made on behalf of employee by covered employer ; calculated at 2014 expenditure rates
2. Medium utilization = 5-6 doctor visits/year; 1-2 Rx; 3 specialty visits; no hospitalization
3. Employer sponsored insurance: estimated using 2013 KFF Employer Health Benefit Survey ; employer cost = average employee contribution to annual premiums; employee cost = average employee contribution to premiums + out-of-pocket costs
4. Covered CA costs calculated for range of silver plans, and include total costs of premiums + out-of-pocket costs
5. HCE remainder = employer's remaining HCSO expenditure requirement after contribution to insurance
6. HCE available = health care expenditures remaining available to employee under HCSO

Scenario 6: Small businesses with a mix of full- and part-time workers may find purchasing insurance on the SHOP exchange to be less expensive than current market rates and to fall below the HCE requirements. Remaining HCE funds would be available to help employees cover out-of-pocket or other health-related costs.



1. Covered CA costs estimated using preliminary rates released in Covered CA's August 2013 SHOP booklet.
2. Employer sponsored insurance costs estimated using 2013 KFF Employer Health Benefit Survey, average costs
3. Employer cost on Covered CA assumes employer pays 50% of employee premiums
4. Employer costs estimated using 2013 KFF Employer Health Benefit Survey, average employer contribution to employee premiums is 71%
5. HCE remainder = employer's remaining HCSO expenditure requirement after contribution to insurance