UNIVERSAL HEALTHCARE COUNCIL 2013
December 5, 2013 MEETING AGENDA

December 5, 2013 | 10AM – 12PM | 25 Van Ness Avenue, Room 610

Meeting Objectives

- Review OLSE FAQs on rollover HRAs
- Review and Discuss Draft Final Report

1. Meeting overview — 5 min
   - Reminders
   - Agenda review
2. Review of OLSE FAQ on HRAs — 10 min
3. Presentation — 30 min
   Draft Final Report
   Colleen Chawla, Deputy Director of Health, Director of Policy & Planning, San Francisco Department of Public Health
4. Discussion — 55 min
5. Public Comment — 15 min
6. Closing Comments and Next Steps — 5 min

Meeting Materials

- Agenda
- November 7, 2013 Meeting Minutes
- OLSE FAQ on rollover HRAs
- Draft Final Report

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
November 7, 2013 MEETING MINUTES

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

1. Co-Chair Remarks and Agenda Review

Ms. Garcia noted that the topic of this meeting was financial considerations for all those who bear a shared responsibility to access to health care. She reiterated that the meeting materials and presentation are the Department's current best understanding of a fluid and dynamic situation, and are not legal advice or opinion.

Dr. Hernandez reminded members that the UHC will be making recommendations for consideration by policy makers. The recommendations need not reach a consensus, and in the absence of final federal guidance, may take the form of if-then scenarios. Please submit recommendations to Colleen Chawla by November 27th.

The Co-Chairs postponed the final UHC meeting, from November 14th to December 5th, in the interest of allowing members more time to submit recommendations.

2. Presentation on Financial Considerations

Ms. Chawla presented on health-care costs faced by individuals and families, employers, and the local public health system. The presentation used scenarios to highlight cost considerations from each perspective and identified groups of San Franciscans with potential health care affordability or coverage concerns.

Major discussion themes during the presentation are highlighted below, and answers follow-up requests are included at the end of this document.

- Out-of-pocket costs contribute greatly to health care costs
- Federal tax subsidies may not be enough to make health insurance truly affordable for those earning between 300-400% of FPL
- Families and some spouses face barriers to affordable health insurance
- Small businesses face barriers to offering affordable health insurance
- Small businesses rely heavily on HRAs to comply with the HCSO
- Part-time employees, particularly those who are low-wage earners, are at high risk for not having coverage or being unable to afford coverage
- The costs of caring for the uninsured and indigent are very high for the City
- Bay area has very high costs of living and doing business
- Uncertainty around HRA balances may have negative consequences for employers and employees

3. Public Comment

Nate Pollak, owner of two SF restaurants, noted that movement away from HRAs reduces a small business's access to usable, flexible cash flow and increases the cost of doing business in SF. He also commented that young workforces, like his, might value wage raises more than health care expenditures. He recommended

aligning the HCSO with the ACA, by either eliminating the employer spending requirement for businesses with fewer than 50 employees, or by allowing a flexible spending compliance option for small businesses.

4. Closing Comments and Next Steps

Upcoming Council Meeting Dates:

DATE	TIME	LOCATION
December 5, 2013	10AM-12PM	25 Van Ness Ave, Room 610

Please submit recommendations to Colleen Chawla by November 27th.

Members Present:

- Rob Black
- Eddie Chan
- Steve Fields
- Gordon Fung
- Estela Garcia
- Barbara Garcia
- John Gressman
- Scott Hauge
- Steve Heilig
- Sandra Hernandez
- Ken Jacobs
- Perry Lang
- Ian Lewis
- Sonia Melara
- Bob Muscat
- Fred Naranjo
- Michael Pappas
- Tim Paulson
- Trent Rhorer
- Wade Rose
- Ben Rosenfield
- Amor Santiago
- Ron Smith
- Abby Snay
- John Stead-Mendez
- Brenda Storey
- Laurie Thomas
- Chris Wright
- Lucien Wulsin, Jr
- Brenda Yee
- Emily Webb (Observing for Warren Browner)

Materials Distributed:

- Meeting Agenda
- October 24, 2013 Meeting Minutes
- "Financial Considerations for Individuals, Employers, and the Local Public Health System"

Follow-up information requested at 11.7.13 Universal Healthcare Council meeting
Sent via email on 11.18.13:

Covered CA subsidies and affordability:
Federal tax credits to reduce the cost of premiums for plans purchased on Covered CA are available for individuals and families earning between 138-400% of FPL. Applied on a sliding scale, these subsidies are designed to cap the cost of the second least expensive Silver plan at a percent of income defined by the ACA. For example, an individual earning 200% of FPL ($22,980/yr) will receive a subsidy in the amount needed to ensure that annual premiums for the second-lowest cost Silver plan do not exceed $1,488 (6.3% of household income). The following table shows premium contribution caps by income and household size.

Annual Household Income			Maximum Annual Contribution to Premiums		
% of FPL	Individual ($)	Family of Three ($)	% of Household Income	Individual ($)	Family of Three ($)
138 – 150%	$15,836-17,235	$26,951-29,295	3–4%	$476-689	$809-1,172
150 – 200%	17,235-22,980	29,295-39,060	4–6.3%	689-1,448	1,172-2,461
200 – 250%	22,980-28,725	39,060-48,825	6.3–8.1%	1,448-2,327	2,461-3,955
250 – 300%	28,725-34,470	48,825-58,590	8.1–9.5%	2,327-3,275	3,955-5,566
300 – 400%	34,470-45,960	58,590-78,120	9.5%	3,275 -4,366	5,566-7,421
400% +	45,960+	78,120+	9.5% if employer-sponsored N/A on Exchange, but if lowest cost Bronze plan exceeds 8% of income, a hardship exemption may be available		

Premium tax credits can be used on any plan, but people earning less than 250% of FPL are eligible for additional subsidies for out-of-pocket costs if they purchase the Silver tier plan (known as the Enhanced Silver plan on Covered CA). Because plan premiums generally increase with age, older persons usually receive a higher subsidy than younger persons with the same income.

The following tables show examples of final Covered CA premium costs (after subsidies are applied) for an individual and family of three living in San Francisco, by income level.

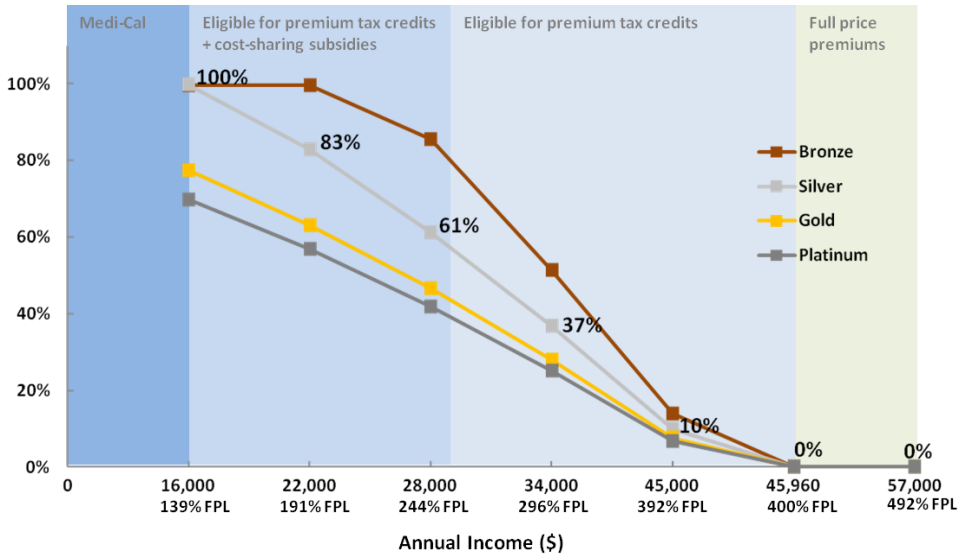
Household Size: 1 Age: 42 Annual Income	Premium Tax Credit ($/month)	Final Cost ($/month)			
		Bronze	Silver	Gold	Platinum
$16,000 (139% FPL)	$243-346	$1	$1-93	$101-179	$150-283
$22,000 (191% FPL)	243-282	1-42	58-157	165-242	213-347
$28,000 (244% FPL)	208	35-116	132-231	239-317	288-421
$34,000 (296% FPL)	125	118-199	215-314	322-400	371-504
$45,000 (392% FPL)	34	209-290	306-405	412-490	461-595
$57,000 (496% FPL)	0	243-324	340-439	447-524	496-629

Household Size: 3 Ages: 36, 36, 5* Annual Income	Premium Tax Credit ($/month)	Final Cost ($/month)			
		Bronze	Silver	Gold	Platinum
$28,000 (143% FPL)	$451-651	$2	$2-$174	$189-$333	$279-$527
$37,000 (189% FPL)	451-546	2-56	86-269	284-428	374-622
$46,000 (235% FPL)	436**	15-166	195-309	394-538	484-732
$57,000 (292% FPL)	472**	96-285	322-553	571-753	685-997
$76,000 (389% FPL)	310	257-446	484-715	733-914	847-1159
$94,000 (481% FPL)	0	568-757	794-1025	1043-1227	1157-1471

*Child may be eligible for Medi-Cal up to $51,900/yr (250% of FPL). ** Covered CA calculates a larger subsidy for the higher income, because the child is no longer eligible for Medi-Cal.

The following graph depicts how subsidies on Covered CA reduce premium costs by income level for a 42-year old San Franciscan. From 250-400% of FPL, there is a sharp decline in the amount of assistance available, and an individual earning near 400% of FPL is responsible for 90% of the plan cost.

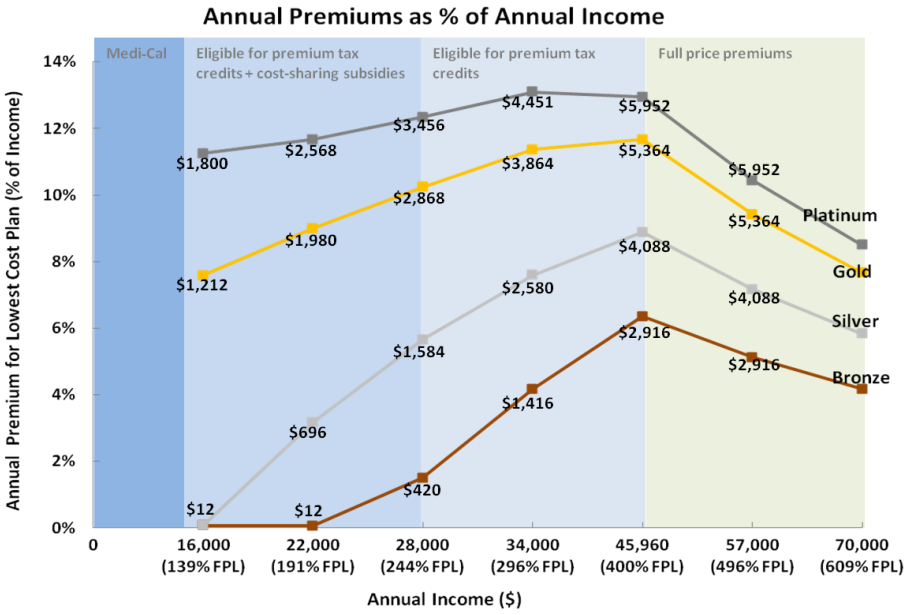
Percent of Annual Premiums Subsidized by Income Level *



*Curves based on maximum allowable annual tax credit and price of lowest cost plan in each tier, for a 42 year-old San Francisco resident. Out-of-pocket costs are not accounted for. Values are shown for the Silver plan, to which the subsidies are tethered.

Those earning between 300-500% of FPL are likely to pay a higher proportion of their incomes toward premiums than those earning below or above these thresholds. This is due to the declining subsidy rate from 250-400% of FPL, and the fact that higher incomes can compensate for the cost of premiums. The following graph illustrates this affordability concern by depicting the annual premiums that a 42 year-old San Franciscan would pay for the least expensive plan

in each tier. The dollar figures show annual plan price, and the curve points reflect the cost of that plan as percent of income.



*Curves based on maximum allowable annual tax credit and price of lowest cost plan in each tier for a 42-year old San Francisco resident. Dollar values reflect annual price of premiums only; out-of-pocket costs are not included.

Employer sponsored health insurance for part-time workers:

- *To what extent are group plans offered to employees who work 20/hours a week or less?*

  The Current Population Survey (CPS), administered by the U.S. Census Bureau, estimates that in California, 9.6% of employees working less than 20 hours per week have employer-sponsored insurance, compared to 15.3% of employees working 20-29 hours per week, and 54.3% of employees working more than 30 hours per week.[1] County level data are unavailable.

  Note: Division 2, Part 2, Chapter 8, Section 10705(f) of the California Insurance Code stipulates that insurers may not encourage small employers to exclude eligible employees from a health benefit plan, and Section 10705(g) states that insurers may not reject applications for insurance from eligible small employers who offer insurance to 100% of their employees.

  For these purposes, Section 10700(f)(1) defines "eligible employees" to include permanent employees working 20-29 hours per week if all of the following conditions are met: the employee is otherwise eligible except for the number of

[1] U.S. Census Bureau, CPS March Supplement, 2011-2013.

hours worked (i.e. has met any required waiting periods), the employer offers insurance to that employee, all similarly situated employees are offered coverage under the plan, and the employee has worked a minimum of 20 hours per week for at least 50% of the weeks in the previous quarter.

- *How many small firms provide coverage to families?*

  The California Employer Health Benefits Survey (CEHBS) finds that among California firms with fewer than 50 employees, 65.9% offer some form of coverage to their employees, and 60.6% offer family benefits.[2] However, employees of smaller firms are likely to pay more for family coverage than employees of larger firms: 33% of employees at smaller firms (3-199 employees) pay more than half of the cost of premiums for family coverage, compared to only 4% of employees at large firms (200+ employees).

Healthy SF:

- *How does an individual qualify for Healthy San Francisco if offered unaffordable insurance (i.e. per family glitch scenario)?*

  Under current Healthy San Francisco (HSF) eligibility rules, persons who are eligible for subsidized coverage (earning up to 400% of FPL) are not eligible for HSF. Individuals earning between 400-500% of FPL are eligible to participate in HSF. Those earning above 500% FPL are not eligible, unless they are uninsured San Francisco residents whose employer contributes to the City Option on their behalf.

HRAs:

- *HRA spending by industry:*

  Cross-referencing the HCSO 2012 Annual Reporting Forms to data from the Office of the Treasurer and Tax Collector, found that among the 996 employers using HRAs as a form of compliance with the HCSO, the top six industries represented are:

  - Business Services (except advertising) -- 229 (23%)
  - Eating and Drinking Places (restaurants) -- 202 (20%)
  - Eating Places (restaurants) -- 92 (9.2%)
  - Other Retail stores -- 44 (4.4%)
  - Business Services -- 36 (3.6%)
  - Retail Stores -- 32 (3.2%)
  - all other industries represent 0.1% -3.3% of the 996 employers

- *Use of stand-alone HRAs:*

  Analysis of the 2012 Annual Reporting Forms, conducted by OLSE, found that a minimum of 658 employers contributed to at least one stand-alone HRA, and a minimum of 35,947 employees had funds in a stand-alone HRA. Due to how the data are reported, only minimum estimates are possible.

[2] California Health Care Foundation & NORC at University of Chicago, CEHBS, 2012.

- *Accrual vs. Cash business accounting methods:*
  - The cash method of accounting does not count sales as income until a check or cash is actually received. Similarly, expenses are not deducted until actually paid.
  - Under the accrual method, business transactions are recorded as they happen, whether or not actual money has been received or paid.

Cost to the local health system:

- *General Fund draw down*

  The San Francisco Department of Public Health is the largest department in the City and draws heavily from the General Fund (GF). The largest proportion of DPH expenditures is allocated to delivering care to patients, including those who are seen through Healthy San Francisco and DPH hospitals and clinics. In the last three years, DPH has required $248.7-$336.5 million per year from the General Fund to cover shortfalls resulting from the cost of delivering health care services.

DPH Direct Patient Costs FY 2010-11 to FY 2012-13			
	FY 2010-11 ($)	**FY 2011-12 ($)**	**FY 2012-13 ($)**
Expenses	1,382,649,481	1,482,827,765	1,596,688,969
Revenues	1,096,922,204	1,234,116,532	1,260,184,512
GF Support	**285,727,277**	**248,711,233**	**336,504,457**

- *History of DPH financing indigent care and new revenue shortages*

  DPH has a history of heavily financing indigent care, as evidenced by the numbers above. Under the ACA, the Department will see new revenue shortages, as "lump sum" payments to support the uninsured and safety net services will be reduced. To maintain current service levels, these payments will need to be replaced with earned managed care revenues. Examples of revenue loss include $31.4 million in federal payment reductions for hospitals that take on a disproportionately high share of indigent patients, and a loss of $40 million to the state's realignment strategy for indigent care funds.

- *What proportion of DPH reimbursement is from Medi-Cal?*

  Based on the projected FY14 baseline budget, Medi-Cal and Short-Doyle Medi-Cal comprise 46% of Net Patient Service Revenue ($318million of $686million).

The cost of doing business in San Francisco:

Correlating to its ranking 4th highest for overall cost of living, San Francisco also has a high cost of doing business:

- A 2005 Moody's Analytics analysis of 361 Metropolitan Statistical Areas (MSAs) indicated that San Francisco's MSA ranked 7th in the overall cost of doing business. This ranking takes into consideration labor costs, state and local taxes, energy costs, and office space costs. Aggregation of data by region indicated the West had the second-highest costs overall, and, by state, California had the second highest overall business costs.

1. Boston MA
2. San Diego CA
3. Los Angeles CA
4. Sacramento CA
5. New York NY
6. Riverside CA
7. **San Francisco CA**
8. Oxnard CA
9. Fresno CA
10. Madera CA

Note: This analysis does not account for employer costs related to various city ordinances or the SF minimum wage.

Office of Labor Standards Enforcement (OLSE)

FAQs on Remaining Balances in Stand-Alone Health Reimbursement Accounts (accessed from http://sfgsa.org/index.aspx?page=6306#HRAFAQ)

11. Q: Under the Health Care Security Ordinance (HCSO), what are an employer's obligations with respect to unused funds credited to stand-alone HRA accounts before January 1, 2014?

A: To constitute a Health Care Expenditure on behalf of a Covered Employee, the HCSO requires that a contribution designated or paid to a reimbursement program, which is not irrevocably paid to a third party, remain available to the Covered Employee for a minimum of 24 months from the date of contribution.

12. Q: Given that most stand-alone HRAs will not comply with the requirements of the Affordable Care Act (ACA) that go into effect on January 1, 2014, will an employer face a federal tax penalty for continuing to administer its HRA (ie: without making new deposits) until the 24-month availability requirement is satisfied?

A: Probably not. Unused HRA funds credited before January 1, 2014, may still be used after December 31, 2013, in accordance with the terms of the HRA as they existed on January 1, 2013, without subjecting the employer to a penalty. However, the employer may not make any new contributions to non-ACA-compliant HRAs on or after January, 1, 2014, and some contributions made in 2013 may be subject to a ceiling.

13. Q: Can employees use remaining HRA funds to purchase health insurance through Covered California?

A: Possibly. If an employer's HRA plan permits employees to seek reimbursement for health insurance premiums, employees may use HRA funds to reimburse the cost of health insurance premiums purchased through health care exchanges such as Covered California the same as any other health insurance coverage.

Please note, however, that employees with health reimbursement accounts will be ineligible for federal premium assistance tax credits (subsidies) when purchasing insurance through Covered California for any month in which HRA funds remain available to the employee. This is true regardless of whether the employee uses the HRA funds to buy insurance through the exchange, uses them for other reimbursable expenses, or does not use the funds at all.

14. Q: Are there any federal tax consequences for employees who have access to funds remaining in an employer's Health Reimbursement Arrangement (HRA) after December 31, 2013?

A: Yes. The Internal Revenue Service considers an employee with a HRA to be enrolled in an employer-sponsored group health plan that constitutes "Minimum

Essential Coverage." Beginning January 1, 2014, the Affordable Care Act requires each individual taxpayer to have Minimum Essential Coverage or pay a tax penalty. Employees with HRAs will not be subject to this penalty. However, as noted in question 3, employees with HRAs will also be ineligible for federal premium assistance tax credits for any month in which the HRA funds remain available to the employee.

15. Q: Can employees opt out of HRAs and become eligible for federal premium assistance tax credits to assist with purchasing health insurance through Covered California?

A: Yes. Employees may forfeit the available funds. If they do so, those employees who meet certain residency, citizenship and income requirements and who do not have another source of Minimum Essential Coverage become eligible for federal premium assistance tax credits in the following month.

16. Q: If an employee opts out of an HRA and forfeits funds before the funds have been available for 24 months from the date of contribution, what are the employer's responsibilities under the HCSO?

A: If an employee opts out of an HRA and forfeits available funds before those funds have been available for a minimum of 24 months from the date of contribution, the forfeited funds do not constitute Health Care Expenditures and do not satisfy the employer's obligations under the Employer Spending Requirement of the HCSO. A contribution designated or paid to a reimbursement program, which is not irrevocably paid to a third party, constitutes a health care expenditure only if that contribution remains available to the employee for a minimum of 24 months from the date of contribution and meets other conditions described in Section 14.1(b)(7)(B) of the Ordinance. If the forfeited funds were not available for a minimum of 24 months, the employer will be required to make a valid Health Care Expenditure of an equivalent amount through another HCSO compliance strategy. See FAQ #3 for examples of Health Care Expenditures.