Health Care Accountability Ordinance (HCAO)

Section I: Overview

On July 1, 2001 San Francisco's Health Care Accountability Ordinance (HCAO) went into effect. This Ordinance is the first of its kind nationwide, requiring that employers doing business with the City provide health care coverage for their employees or pay a fee to offset health costs for care provided by the City to the uninsured. This historic legislation grew out of the Living Wage movement and the Minimum Compensation Ordinance (MCO). The MCO mandates a specific hourly wage that businesses contracting with the City and County of San Francisco must pay their employees.

The HCAO requires that contractors providing services to the City and County or leasing property from the City and County (including certain subcontractors and subtenants) do one of the following:

1. Offer health plan benefits at no cost to the covered employees that meets the minimum standards;
2. Make payments to the Department of Public Health (DPH) to help partially offset the costs of services for uninsured workers; or
3. Participate in a health benefits program that was to be developed by DPH.[1]

The standards apply to all contractors and lessees subject to the HCAO. One of the required options (as cited in Chapter 12Q of the administrative code) must be offered to all employees funded through the affected contract. If a contract is funded through general fund and grant funding, any employee specifically funded through the grant is exempt. The HCAO requires that employers offer these benefits to employees working 15 hours or more per week.

There are a number of reasons for which a business may be exempt from HCAO's requirements. The primary reasons for exemption includes the following:

- The organization is a public entity;
- The business employs too few employees (for-profits with 20 or fewer employees and non-profits with 50 or fewer employees);
- The contract amount is less than the required amount (for-profits with a contract of $25,000 or less and non-profits with a contract of $50,000 or less);
- The contract duration is for less than one year; and
- The contract concerns the purchase or lease of goods, or for guarantees, warranties, shipping, delivery, or installation or maintenance of such goods.

The purpose of this report is twofold, to provide the Health Commission with an annual update and to review and amend the minimum standards that were decided upon by the Health Commission and became effective two years ago. According to the HCAO, it is the Health

[1] Option #3 was determined by the Health Commission not to be an economically feasible option based on data presented to the Health Commission in January 2003.

Commission's responsibility to review the minimum standards every two years and to make changes that will ensure that they are in line with current realities. As this report will illustrate, the health insurance market is volatile and has changed significantly in the past two years. Therefore modifications to both the minimum standards and the fee paid by employers who do not offer health insurance to their employees are recommended in this report. These changes will allow the HCAO to be current and help ensure that it meets its ultimate goal of helping more workers in San Francisco gain health insurance through their employer thereby providing a better qualified and stable workforce on City contracts and leases. This is also compatible with DPH's Strategic Plan, as one strategy is to "Expand health care coverage to San Francisco's uninsured to improve health status and access to care."

Section II: HCAO Enforcement & Related Activities

Passing the Minimum Standards

On June 19, 2001, the Health Commission adopted Resolution 13-01*, "Approving and Adopting Minimum Standards for Health Plan Benefits Required in the Healthcare Accountability Ordinance*." (See Attachment A.) Before the final standards were established, DPH reviewed current health plan benefits and discussed its approach in open forums (e.g., San Francisco Board of Supervisors, Small Business Commission). The adopted minimum standards reflect input from the open forums and meetings. To the greatest extent possible, the minimum standards addressed the various and sometimes conflicting perspectives of the interested parties.

Guidelines for Developing Minimum Standards

The original minimum standards passed by the Health Commission were developed using the following guiding principles:

1. Minimize disruption for employers and lessees who currently provide a comprehensive scope of medical benefits.
2. Out-of-pocket costs (both premiums and copayments) should not be so high that they decrease employee "take-up" rate (i.e., the percentage of employees who are offered health insurance and who decide to accept the coverage).
3. A comprehensive scope of medical benefits is included.
4. Standards are cost-effective and therefore based on a health maintenance organization (HMO) model.
5. Any health benefit package that is mandated must reflect those currently offered to small businesses – that is, what an employer can currently purchase in the health care market. For example, DPH looked at packages offered by PacAdvantage (formerly HIPC), Kaiser, Blue Cross, Blue Shield, and Aetna because these were the most commonly purchased plans by business.
6. Employers and lessees must offer at least one health benefits package. If an employer or lessee offers more than one health insurance package to its employees, then at least one of the products must meet the minimum standards.

These guidelines also served as a useful tool for the current review of the minimum standards and the subsequent recommendations presented in this report.

Final Standards

It is essential that the minimum standards are obtainable and reflect current realities. The ordinance requires the Health Commission to review the minimum standards every two years and to make changes if necessary. The current components of the minimum standards for health plan benefits include the following:

1. Effective Date of Coverage:

Effective date of coverage refers to the time at which an employee receives health insurance coverage from their employer after starting employment. The effective date of coverage varies across employers – from 30, 60 to 90 days. Employers have discretion over setting the effective date of coverage, but the date must take into account time needed to process health insurance paperwork. *According to the HCAO, the effective date of coverage must be no later than 30 days following the start of employment by the employee on a covered contract, subcontract, lease, or sublease.*

2. Percentage of Premium Paid by Employer and Employee:

Premiums reflect the amount that it costs to provide coverage to an employee. It is usually shown as a monthly figure. In most cases, employers and employees share premium costs. Many of HCAO's impacted employees are low-income workers. For these workers it is particularly important to keep premiums affordable so that beneficiaries avoid needed care. If the employee's share of the premium is too high, employees will not "take up" the coverage offered to them. It was feared that small employers might require their employees to pay a larger percentage of the monthly health care premium (than larger employers) in order to comply with HCAO's requirements. *HCAO requires employers to pay 100 percent of the employee's health coverage premium costs for a plan to meet the minimum standards.*

3. Benefits Offered under Coverage:

Health benefits are essentially the list of services that the employee will be entitled to receive through their health insurance plan. DPH's priority is to ensure that the health benefit coverage offered to employees is not limited to catastrophic care, but is instead comprehensive health coverage (i.e., medical coverage). All employers must ensure that their health plan offers, at a minimum, the benefits dictated by the Health Commission. *The benefits offered under HCAO's minimum standards are comprehensive, including routine care, hospitalization, mental health and substance abuse among other services. Dental and vision care and dependent coverage are not required*.

4. Employee Copayments for accessing services:

The copayment represents the out-of-pocket costs borne by the employee when accessing services. The copayment is made directly to the provider. Copayments are often structured to create incentives for appropriately utilizing services. Yet, this must be balanced with making copayments affordable. In developing the copayments DPH examined the benefit packages and copayments offered to small businesses by other health plans. *The minimum standards reflect a*

copayment structure based on a $10 fee for routine services, with some higher copayments for other services like pharmacy, emergency department visits, etc.

Feasibility of Option #3

In January 2003, the Health Commission made a decision to postpone, for the foreseeable future, the creation of a local health benefits program. The third option offered to employers through the HCAO required DPH to consider the feasibility of a locally created pool. A local pool was found to not be economically feasible and, due to changes in legislation (AB 2178), essentially unnecessary.

Adopting HCAO Rules and Regulations

The Office of Contract Administration (OCA), Living Wage/Living Health Division administers, monitors and enforces the HCAO and the Minimum Compensation Ordinance (MCO). DPH and OCA collaborate closely and have worked together to implement several components of the HCAO. For example, OCA had the responsibility under the HCAO to create Rules and Regulations that would provide clear interpretation of the ordinance. Toward this end, OCA, in consultation with DPH, facilitated and implemented the HCAO Rules and Regulations that were adopted in May 2002.

Prior to implementation, an HCAO introductory Town Hall Meeting was held in August 2001 with over two hundred participants. In the months following, multiple meetings were held with the Living Wage Task Force members, small business communities, non-profit communities, advocate groups and the San Francisco Living Wage Coalition to bring about a full consensus of the final rules and regulations. OCA sent 140 Notices of Public Hearing and the draft HCAO Rules and Regulations to concerned organizations and individuals. There were six draft interim Rules and Regulations and the final regulations adopted on May 10, 2002 represent a careful balancing of diverse concerns.

Outreach to Contractors

In April 2002 OCA sent a letter to all Contractors regarding the payment option (Option #2) under the HCAO. (See Attachment B.) This letter instructed employers about the particulars of paying the hourly fee in place of providing health coverage. If employers are unable or unwilling to offer a health insurance option that meets the minimum standards to their employees, they are required to pay $1.50 for each hour worked by employees, not to exceed $60 per employee in any workweek. If the employee is a resident of the City and County of San Francisco, the fee is paid directly to DPH. If the employee resides outside of San Francisco, the employer shall pay the fee directly to the employee.

In addition, OCA prepared and sent out 1,000 posters in August 2002 to all City contractors informing them of the requirements of the HCAO. The posters also address employee rights under the ordinance and how to contact OCA if their employer is not in compliance.

Outreach to Uninsured Employees

When an employer selects Option #2, the employee is very likely to be uninsured (unless they are covered through a spouse or have a plan which does not meet the minimum standards). There was a concern that these employees may need assistance in finding adequate health care. Therefore, in July 2003 DPH, in consultation with OCA, sent information to the thirteen employers now paying the monthly fee instructing individuals where and how to access free or low-cost health care services in San Francisco.

This document, entitled "Free or Low Cost Health Care Services in San Francisco," was mailed to all employers with instructions to distribute among their staff. (See Attachment C.) This reference document is intended to help uninsured workers access health care services since their employers are assumedly not offering any health insurance, and certainly not insurance that meets HCAO's minimum standards. This mailing will also be sent to all new employers paying the fee each month, and will be re-mailed to all employers annually. This information is also available on the DPH website.

Outreach to Insurance Brokers

In this time of rising health costs, employers face mounting difficulties securing affordable health coverage for their employees. AB 2178 became effective January 1, 2003 and was created to alleviate the difficulty in securing health insurance for businesses faced with living wage requirements, like San Francisco's MCO.

AB 2178 modified the California Health Reform Act (CHRA), allowing larger businesses (with over 50 employees) that are subject to local living wage laws to participate in small business pools and plans, like PacAdvantage. The CHRA guarantees small businesses access to health plans and limits the cost increases they face. With AB 2178, California became the first state in the country to explicitly link local living wage ordinances to other State efforts to expand health care coverage.[2] AB 2178 covers both part-time and full-time employees, defining part-time as working at least 20 hours per week.

In order to help educate brokers about the situation in San Francisco, DPH worked with OCA to send a letter in July 2003 to 58 local brokers describing HCAO requirements (see Attachment D), AB 2178, and the opportunities to market health insurance plans to businesses subject to HCAO and MCO (most employers subject to HCAO are also subject to MCO). Employers need the assistance of a well-informed insurance broker to find affordable health coverage. DPH assumed that the more brokers who understood this new State law and the unique requirements in San Francisco the better off businesses would be in finding health plans for their employees.

[2] Mark D. Brenner, "Expanding Health Care Coverage Using Living Wage Ordinances: New California Law Paves the Way for Expansion," Political Economy and Research Institute, University of Massachusetts Amherst, October 2002.

Granting Exemptions and Waivers

The Living Wage/Living Health Division of the City's OCA has oversight over implementation and enforcement of the HCAO. All the statutory exemptions and waivers are listed directly in the ordinance. To obtain an exemption or waiver from the HCAO, the "HCAO Exemption and Waiver Request" is submitted to OCA directly from the contracting City Department. If the OCA approves the request, then the Department's contracting office may omit the MCO/HCAO language from the agreement documents.

In FY 2002-2003 OCA granted 364 exemptions and approved only two waivers for individual businesses throughout the City. Of these exemptions, 250 were for DPH contracts. DPH has more contracts than many other City agencies, with approximately 540 contracts representing 200 vendors. Of DPH's contracts, 290 are subject to HCAO. Approximately 150 vendors hold these 290 contracts, representing $110 million. The vast majority of these are non-profit organizations, with only 20 for-profit agencies. The remaining 250 contracts were exempted for various reasons.

- 110 contracts are funded through private grant funds (as opposed to City funds), representing nearly $61 million.
- 80 contracts are with businesses that have too few employees, representing approximately $6 million.
- 33 contracts are with public entities, representing approximately $19.8 million dollars.
- 25 contracts are for less than the required amount, representing $200,000.
- 2 contracts were entered into before July 1, 2001, representing $3 million dollars.

Audits

The OCA, Living Wage/Living Health Division began its monitoring/audit efforts in early January 2002. OCA conducts audits to monitor both MCO and HCAO activity. According to the Rules and Regulations, OCA will monitor the operations of employers to ensure compliance by conducting site visits and payroll audits. The OCA will also perform an investigation when there is a specific concern or complaint about an employer. In FY 2002-2003 OCA initiated 73 compliance investigations. As a result of these compliance activities nearly 600 employees gained health coverage and over $40,000 was restored to employees who had made premium payments. (The minimum standards require that employers pay 100% of the premium costs.)

SECTION III: MINIMUM STANDARDS/OPTION #1

Review of Current Standards

After a review of currently existing health care coverage options, DPH concludes that small employers would find it nearly impossible to find a plan that would meet HCAO's minimum standards. In fact, this difficulty impacts not only small businesses, but also larger businesses that stand to gain from AB 2178. This is mainly due to the rising copayment structure required by most small business health insurance offerings.

In the marketplace in general, employer and employee contributions toward health care costs have been increasing while benefits have been shrinking. In the last three years, monthly premiums for health insurance have increased by 42 percent, primarily due to "a combination of rapid inflation in the costs for health care services and insurers' efforts to emphasize profitability in their pricing."[3] As an alternative to higher cost health insurance premiums and in an effort to maintain the availability of some health insurance products at a cost close to that which employers have been paying, insurers have instead either scaled back benefits or increased copayments.

Large employers tailor their health insurance plans to meet a variety of needs and requirements, while smaller employers must choose from ready-made plans, in which benefit packages are dictated and monthly premiums set by the insurer. Common insurers in this market include PacAdvantage (California's purchasing pool for small employers), Kaiser, and Blue Shield. DPH's review focuses on the plans offered to small businesses through these carriers as well as a review of what may be offered to employees if new legislation on the State level expanding health coverage passes.

Copayment Comparisons to Other Small Business Plans

The minimum standards that are currently in place were approved in May 2001 using information from 2000 and 2001 and they reflect the reality of that time. However, much has changed in the health insurance market in the past few years, especially for small businesses. A review of the small business insurance carriers' plans (Kaiser, Blue Shield and PacAdvantage) shows that current copayments are generally much higher than those set by the Health Commission in 2001. The following table compares PacAdvantage's small business health plan offerings with HCAO's minimum standards. As this table illustrates (shaded boxes denote an area in which the minimum standard is not met), there is not one PacAdvantage plan that would satisfy the minimum standards in all regards. (See Attachment E for similar comparisons using Blue Shield and Kaiser's HMO plans for small businesses.)

HCAO Minimum Benefits –

Comparison to 2003 PacAdvantage HMO Plans

Services Required by HCAO Min. Standards	HCAO Minimum Benefits	PacAdvantage HMO $10	PacAdvantage HMO $20	PacAdvantage HMO $30
Professional Services	$10/Visit	$10/Visit	**$20/Visit**	**$30/Visit**
Outpt. Surgery & Procedures	$100/Procedure	$100/Visit	**$150/Visit**	**$300/Visit**

[3] Claxton, Gary, et. al, "Employer Health Benefits, 2003 Summary of Findings," The Henry J. Kaiser Family Foundation & Health Research and Educational Trust, September 9, 2003.

Services Required by HCAO Min. Standards	HCAO Minimum Benefits	PacAdvantage HMO $10	PacAdvantage HMO $20	PacAdvantage HMO $30
Diagnostic, X-Ray, & Lab Services	No Charge	No Charge	No Charge	No Charge
Perinatal & Maternity				
Office Visits	$10/visit	$5/Visit	$5/Visit	$5/Visit
Inpatient	$100/admission	$100/admission	**$150/admission**	**$300/admission**
Preventive Services	$10/visit	$10/Visit	**$20/Visit**	**$30/Visit**
Family Planning Services	$10/visit	$10/Visit	**$20/Visit**	**$30/Visit**
Prescription Drug Coverage	Brand: $25/30 days Generic: $15/30 days	Brand: $20/30 days Generic: $10/30 days	Brand: $25/30 days Generic: $15/30 days	**Brand: $30/30 days** **Generic: $15/30 days**
Hospital Services				
Outpatient	$75/visit	**$100/Visit**	**$150/Visit**	**$300/Visit**
Inpatient	$100/admission	$100/admission	**$500/admission**	**$1,000/admission**
Emergency Services	$50/visit (waived if admitted)	**$100/visit (waived if admitted)**	**$100/visit (waived if admitted)**	**$100/visit (waived if admitted)**
Ambulance Services (medically necessary)	$50/trip	$50/trip	$50/trip	$50/trip
Mental Health Services				
Outpt. (min. 20 visits/year)	$20/visit	**$30/visit**	**$30/visit**	**$30/visit**
Inpt. (min. 10 days)	$100/admission	$100/admission	**$500/admission**	**$1,000/admission**
Alcohol and Substance Abuse Care				
Outpt. (min. 20 visits/year)	$20/visit	**$30/visit**	**$30/visit**	**$30/visit**
Inpt. (detox)	$100/day	$100/admission	**$500/admission**	**$1,000/admission**
Rehabilitative Therapies				

Services Required by HCAO Min. Standards	HCAO Minimum Benefits	PacAdvantage HMO $10	PacAdvantage HMO $20	PacAdvantage HMO $30
Office/Outpt.	$20/visit	$10/Visit	**$20/visit**	**$30/visit**
Inpatient	$100/day	$100/admission	**$500/admission**	**$1,000/admission**
Home Health Services (min. 100 days/year)	$15/visit	$10/visit	**$20/visit**	**$30/visit**
Durable Medical Equipment	50% of allowable charges	20% of allowable charges	20% of allowable charges	50% of allowable charges
Hospice Care	$15 per visit	$10/visit	**$20/visit**	**$30/visit**
Skilled Nursing Services (min. 100 days/year)	$100/admission	$100/admission	**$500/admission**	**$500/admission**
Yearly out of pocket (total yearly costs paid by person accessing services)	Co-Payment max $2,000 per year	$2,000	**$2,500**	**$2,500**

State Insurance Expansion Initiatives – SB 2

On October 4, 2003, Governor Davis signed SB 2 into law. SB 2 facilitates health insurance expansion in the State similar to HCAO. Sponsored by Senate President pro Tem John Burton and Senator Jackie Speier, the Health Insurance Act of 2003, or SB 2, is considered "play or pay" legislation. SB 2 requires that employers doing business in the state of California provide health insurance for employees and in some cases their dependents, or pay into a state health purchasing pool. It is estimated that SB 2 would provide coverage for approximately one million of California's uninsured.

SB 2 and HCAO use similar standards to identify employers and employees affected by their provisions. Both pieces of legislation establish a minimum number of employees to determine when employers must provide coverage or pay a fee. SB 2 affects companies that employ at least 20 people (or at least 50 people if a tax credit of 20% of the net coverage cost for small employers (20-49 people) fails to pass). HCAO affects for-profit companies with at least 21 employees and non-profit firms with at least 51 employees.

SB 2 uses the same model as HCAO to establish employee eligibility for coverage, specifically, the minimum number of hours worked. According to SB 2, employers must provide coverage or pay into the pool for all employees who work at least 100 hours per month. At firms with 200 or more employees, employers must also provide coverage or pay into the pool for eligible

employees' otherwise uninsured dependents. HCAO sets a lower bar for employees at 15 hours per week (approximately 60 hours per month), but makes no provision for dependents.

HCAO and SB 2 differ in one critical way. When employers pay the fee under HCAO this money goes to DPH to support San Francisco's safety net, which provides care to the uninsured. Employees do not receive health insurance coverage and remain uninsured (or underinsured). SB 2 would use the fee to create the State Health Purchasing Program, which would be administered by the Managed Risk Medical Insurance Board (MRMIB). This program would provide health coverage to employees when the employer chooses to pay a fee rather than offer health insurance.

With regard to the health coverage provided by SB 2 and its cost to the employee, the details of SB 2 are yet to be established. At this point it is known that coverage under SB 2 must comply with Knox-Keene HMO standards and provide prescription drugs. The Knox-Keene Health Care Service Plan Act of 1975 is the set of laws passed by the State Legislature to regulate HMOs within the State. Knox-Keene regulates a number of areas related to HMOs, including consumer protections, access to care, emergency coverage, continuity of care, grievances and dispute resolution, utilization review and claims processing, marketing and advertising, and specific benefit coverage areas. The benefits in HCAO's minimum standards are fairly close to the Knox-Keene requirements but go beyond in some ways, specifically by requiring coverage for substance abuse and mental health treatment services. Specific benefits under Knox-Keene include:

- Physician services, including consultation and referral;
- Hospital inpatient services and ambulatory care services;
- Home health services;
- Preventive health services, including preventive care for children which includes lead screening;
- Emergency care, including ambulance and ambulance transport services and out-of-area coverage;
- Hospice care;
- Newborn coverage, coverage for spouse or dependents includes immediate accident and sickness coverage for an infant born to a subscriber or spouse;
- Maternity, labor and delivery, inpatient hospital care for at least 48 hours following delivery, 96 hours after a C-section;
- OB/GYN services, right to select OB/GYN as a primary care provider and to seek OB/GYN services without prior approval;
- Cancer screening tests, those that are "generally medically accepted";
- Reconstructive surgery, under certain circumstances like to improve function;
- Orthotic and prosthetic devices; and
- Severe mental illness and serious emotional disturbance, Mental Health Parity (basic mental health coverage is not a required benefit).

HCAO and SB 2 while not identical are similar in many significant ways. Labor leaders have enthusiastically embraced SB 2, just as they backed and helped to shape HCAO. It is logical at this stage that HCAO's revised minimum standard requirements are consistent with what

MRMIB requires in other programs, since fee and coverage specifications will be determined by MRMIB.

SB 2 currently provides more specifics about employee premium contributions, capping them at 20 percent of the premium, or for low-wage workers at 5 percent of wages. HCAO disallows any employee contribution toward the cost of the premium for HMO coverage. However, employers may charge an employee 25 percent of the premium cost of a PPO or POS plan, but only if an HMO option is offered to the employee at no charge.

Questions remain as to whether SB 2 preempts HCAO. If HCAO is challenged on this basis, the answer will turn on whether a court finds that the measure was intended to preempt related local legislation. In addition, it also remains to be seen how SB 2 may be challenged in the courts. Press reports after passage of SB 2 noted that the California Chamber of Commerce is considering a lawsuit alleging that the law constitutes a new tax on businesses, which would require a two-thirds legislative majority to pass, rather than a simple majority which passed SB 2. The chamber also is looking toward court challenges based on federal ERISA laws covering employer-sponsored health plans. Since SB 2 would not be effective until January 1, 2006 at the earliest, HCAO continues to be relevant for businesses in San Francisco.

Copayment Comparisons to MRMIB Plans

The California Managed Risk Medical Insurance Board (MRMIB) was created in 1990 with a broad mandate to advise the Governor and the Legislature on strategies for reducing the number of uninsured persons in the state. MRMIB is the entity that, according to SB 2, would create and manage the State Health Purchasing Program. Currently, MRMIB manages three health care programs.

- Access for Infants and Mothers (AIM): The AIM program provides low cost health insurance coverage to uninsured, low-income pregnant women and their infants. The average subscriber is a married woman, living in a household with a family income between 200-300% of the federal poverty level. A pregnant woman and her infant(s) enrolled in AIM receive their care from one of nine health plans participating in the program. The pregnant woman participates in the cost of her health care services through a low cost subscriber contribution. The State of California supplements the subscriber contribution to cover the full cost of care. AIM is funded from tobacco tax funds.

- Healthy Families: Healthy Families provides low cost health, dental and vision coverage to uninsured children in low wage families. Families participating in the program choose their health, dental and vision plan. Families pay premiums of $4-$9 per child per month (maximum of $27 per family) to participate in the program. Healthy Families is California's version of the national State Children's Health Insurance Program (SCHIP) and the federal government matches state funds used to pay for this program.

- Major Risk Medical Insurance Program (MRMIP): MRMIP provides health insurance for Californians who are unable to obtain coverage in the individual health insurance market. The majority of subscribers are women between the ages of 40-59 who are

enrolled in the program because they have been rejected for coverage by an insurance carrier or health plan due to a pre-existing condition. MRMIP has served over 72,000 persons since it opened in 1991. Services in the program are delivered through contracts with 6 health insurance plans. Californians qualifying for the program participate in the payment for the cost of their coverage by paying premiums. The State of California supplements those premiums to cover the full cost of care. Like AIM, MRMIP is funded from tobacco tax funds.

At one time MRMIB also managed the Health Insurance Plan of California (HIPC), now known as PacAdvantage, California's small employer purchasing pool. In July 1999, MRMIB transferred the management of HIPC/PacAdvantage to a non-profit agency, the Pacific Business Group on Health.

AIM and Healthy Families were designed specifically to be affordable for lower income individuals and families; premiums and copayments are subsidized and therefore kept low. MRMIP and HIPC/PacAdvantage were not designed for accessibility for low-income individuals. MRMIP is subsidized to make health insurance more affordable for individuals with one or more pre-existing conditions. The premium rates are similar to what individuals without a pre-existing condition would find on the individual insurance market. At this time, there is no way to know what benefits and copayment limits MRMIB would require of California's businesses or of its own newly created health plan if SB 2 were to become law. However, the MRMIP program may be one indication of what can be expected.

MRMIP offers subscribers in San Francisco two HMO options that are illustrated in the following chart:

Benefit	Current Minimum Standards	Kaiser's MRMIP Plan	Blue Shield's MRMIP Plan
Professional Services, including routine office visits	$10 copayment	$20 copayment	$15 copayment
Emergency Room Visit	$50 copayment	$100 copayment	$25 copayment
Hospitalization	$100 per admission	$200 per day	$200 per day
Copayment Maximum	$2,000 per year	$2,500 per year	$2,500 per year

Recommended New Standards

In all of the HMO options reviewed above, including MRMIP, PacAdvantage, Kaiser, and Blue Shield, none of the plans meet the minimum standards and only the most expensive plans even come close. It is the Department's belief that the minimum standards should reflect market reality and balance the needs of the employer and the employee. On one hand, the minimum standards should reflect what employers are actually able to purchase in the

marketplace. On the other hand, businesses should not be given incentive to reduce the level of health care coverage that they are currently providing nor shift health care costs to their employees.

With these issues in mind, DPH recommends that the Health Commission adopt changes in the minimum standards that would allow employers to purchase mid-range HMO plans offered to small employers. DPH does not recommend any changes in the benefits offered; the type of benefits offered to employees (e.g., mental health services, emergency services, etc.) would remain the same. However, we recommend increases in the allowable copayments for these benefits. These recommendations were developed following the guidelines listed previously and used two years ago to develop the first version of the minimum standards. The recommended copayment structure is based on PacAdvantage's mid-range HMO plan. *This would allow employers to meet the minimum standards through two out of three PacAdvantage plans, three out of four Kaiser plans and one of three Blue Shield plans for small businesses.*

According to the HCAO the "Health Commission shall review [minimum] standards every two years to ensure that the standards stay current with State and Federal regulations and existing benefits practice." Benefits offered through health plans have remained fairly consistent over the last few years. However, the costs associated with these benefits have changed significantly. Therefore DPH recommends that the Health Commission adopt the following changes to the minimum standards to be effective January 1, 2004 to be more in line with the plans offered to businesses today:

Services Required by HCAO Min. Standards	HCAO Minimum Benefits - Current	HCAO Minimum Benefits - Proposed
Professional Services	$10/Visit	**$20/Visit**
Outpt. Surgery & Procedures	$100/Procedure	**$150/Visit**
Diagnostic, X-Ray, & Lab Services	No Charge	*No Change*
Perinatal & Maternity		
Office Visits	$10/visit	*No Change*
Inpatient	$100/admission	**$500/admission**
Preventive Services	$10/visit	**$20/Visit**
Family Planning Services	$10/visit	**$20/Visit**
Prescription Drug Coverage	Brand: $25/30 days Generic: $15/30 days	*No Change*
Hospital Services		
Outpatient	$75/visit	**$150/Visit**
Inpatient	$100/admission	**$500/admission**
Emergency Services	$50/visit (waived if admitted)	**$100/visit (waived if admitted)**
Ambulance Services (medically necessary)	$50/trip	**$75/trip**
Mental Health Services		
Outpt. (min. 20 visits/year)	$20/visit	**$30/visit**
Inpt. (min. 10 days)	$100/admission	**$500/admission**

Services Required by HCAO Min. Standards	HCAO Minimum Benefits - Current	HCAO Minimum Benefits - Proposed
Alcohol and Substance Abuse Care		
Outpt. (min. 20 visits/year)	$20/visit	**$30/visit**
Inpt. (detox)	$100/day	**$500/admission**
Rehabilitative Therapies		
Office/Outpt.	$20/visit	*No Change*
Inpatient	$100/day	**$500/admission**
Home Health Services (min. 100 days/year)	$15/visit	**$20/visit**
Durable Medical Equipment	50% of allowable charges	*No Change*
Hospice Care	$15/visit	**$20/visit**
Skilled Nursing Services (min. 100 days/year)	$100/admission	**$500/admission**
Yearly out of pocket (total yearly costs paid by person accessing services)	Copayment max $2,000 per year	**Copayment max $2,500 per year**

It is the unfortunate reality that health coverage has become much more expensive in just a few short years, for both employers and employees. Yet it is important to note that even in an analysis this year employers across the nation are continuing to offer health insurance to their employees and bearing the higher costs. Employers continue to display the desire to offer comprehensive health coverage to their employees. By setting attainable minimum standards, employers have reasonable options in meeting HCAO's requirements.

SECTION IV – PAYING THE DEPARTMENT/OPTION #2

If employers are unable or unwilling to offer a health insurance option to their employees, they are required to pay DPH $1.50 for each hour worked by employees who have not been offered health care coverage, not to exceed $60 per employee in any workweek. When this amount was originally written into the ordinance, $240 per month was higher than the average monthly premium cost paid by employers. Therefore, it was significant enough to serve as an incentive to employers to provide coverage as opposed to payment of the fee.

What is being Paid to the Department

OCA created a HCAO Payment Form that employers are required to complete and remit to DPH's Accounting Department at San Francisco General Hospital (SFGH) along with the payment. The HCAO Payment Form is sent to the Accounting Department by the 15th of each month for the previous month's payment. The HCAO requires DPH to use this funding for staffing and other resources to provide medical care for the uninsured. The Health Commission may increase the hourly fee and/or monthly maximum according to applicable standards no more than once per year. The Board of Supervisors must approve these adjustments by resolution.

There are 13 businesses paying the fee to DPH at this time. The following is a list of the employers and the number of employees, provided by SFGH's Accounting Department. Some employers, due to the changing nature of their workforce, may pay for a different number of employees from month to month.

- Aampco System Airport Parking – *6 to 10 employees*
- Bernal Heights Neighborhood Center – *1 employee*
- CDM – *1 employee*
- Compass Community Services – *1 to 3 employees*
- Episcopal Community Services of San Francisco – *34 employees*
- Family Service Agency – *3 employees*
- Glide Memorial Church – *3 employees*
- Golden Gate Disposal – *2 employees*
- San Francisco Conventions and Visitors Bureau – *3 to 6 employees*
- See's Candies – *16 to 17 employees*
- U.R.S. – *6 to 9 employees*
- Westside Community Mental Health Center – *2 to 4 employees*
- Weiss Associates – *1 employee*

In FY 2002-2003, the payments made by employers to DPH equaled $153,755.37. This payment covered 102,210.71 hours worked by various employees of these businesses. In FY 2001-2002, there were only a few payments made to DPH as HCAO was just beginning to be understood by employers and enforced by OCA. During this time, only four employers made payments, amounting to $5,940.41 (for 3,960.35 hours). The numbers of employers that pay the fee will likely increase in the current fiscal year, as OCA continues auditing and as more contracts come up for renewal and employers are educated about HCAO.

Review of Current Fee

There is concern, as health coverage costs rise, that the $240 monthly fee paid to DPH will become a more attractive option than actually maintaining health coverage for employers. In fact, it has been reported to DPH through OCA that some employers have called to confirm the maximum fee under Option #2, noting that this is less than what they are currently paying for health coverage. Though nationally the majority of employers appear to want to continue to offer their employees health care coverage despite the rising cost of care, even if only a few employers choose to pay the fee rather than offer insurance, it is contrary to the goal of HCAO, the interests of DPH, and the will of the voters (Proposition J).

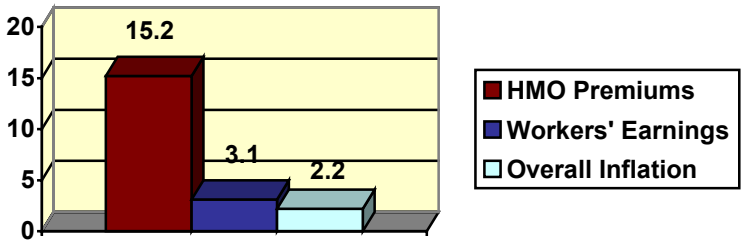
Average HMO Premiums

In 2002, the average HMO premium for a single employee in an HMO plan in California was $197 per month ($2,364 annually), and in 2003 is reported to be approximately $234 per month ($2,808 annually). California's average HMO premiums are less than the national average. HMO premiums are traditionally lower in the western United States, where HMO penetration is highest. Nationally, the average premium in 2003 is $263 per month ($3,156 annually). Yet it

appears that this trend may be changing, edging California closer to the national average. California's actual increase in premium costs for HMOs in 2003 was higher than the national average. While the national average was a 15.2 percent increase in 2003 HMO premiums, California employers (within an average of six western states) experienced a 19 percent increase.[4]

Health insurance premiums are rising at a much higher rate than other indicators of cost increases for employers, including employee wages and inflation. The graph below illustrates the 2003 increase in HMO premiums nationwide (15.2%) as compared to inflation (2.2%) and the increase in workers' earnings (3.1%). Premiums exceeded the overall inflation rate by 13 percentage points and exceeded increases in workers earnings by 12 percentage points.

National Average Increase in HMO Premiums Relative to Other Indicators - 2003



The costs of health insurance premiums for all types of plans (HMO, PPO, etc.) continue to increase in the double digits after a significant jump in 2002. In 2003, California's employers are paying 52.3 percent more in premiums than they were paying in 1998. Businesses with 3 to 199 employees are the hardest hit by these increases, experiencing higher than average increases in many cases. Premiums in California have been increasing every year and are expected to increase in 2004 at the following average rates:

- In 1999 premiums increased 4.8%;
- In 2000 premiums increased 6%;
- In 2001, premiums increased 9.5%
- In 2002, premiums increased 13%[5];
- In 2003, premiums increased 19%[6]; and
- preliminary data shows that premiums will increase 12.6% in 2004[7].

[4] Hewitt, Press Release: "HMO Rates Continue Double-Digit Trend but are Lower than Last Year," June 2003, http://was4.hewitt.com/hewitt/resource/newsroom/pressrel/2003/06-23-03.htm, Internet, Accessed September 2003.

[5] Health Research and Educational Trust and Kaiser Family Foundation, February 2003, *Calfornia Employer Health Benefits Survey, 2002*.

[6] Hewitt, Press Release: "Health Care Costs Continue Double-Digit Pace, but May Start Moderating in 2004," October 13, 2003, http://was4.hewitt.com/hewitt/resource/newsroom/pressrel/2003/10-13-03_hc.htm, Internet, Accessed October 16, 2003.

[7] Ibid.

Small Business Plan HMO Premiums

The following table represents Kaiser's monthly premium cost for the 15-N plan and Blue Shield's for the HMO Plan 10 Premier. These plans are small business plans offered directly through the insurance carrier and not through PacAdvantage. Both of these plans are examples of ones that would meet the minimum standards if the recommended copayment increases are adopted. In these examples, depending on the age of the employee, Kaiser charges between $173 and $450 per month and Blue Shield charges between $245 and $663 per month. The $240 fee paid for uninsured workers per month is more expensive relative to employees under 50 years old in Kaiser and less expensive for all ages of employees for the Blue Shield plan.

Kaiser 15-N Employee Age Range	Kaiser 15-N Monthly Premium	Blue Shield HMO Plan 10 Premier Employee Age Range	Blue Shield HMO Plan 10 Premier Monthly Premium
Under 30	$173	Under 30	$245
Age 30-39	$191	Age 30-39	$267
Age 40-49	$222	Age 40-49	$343
Age 50-54	$288	Age 50-54	$394
Age 55-59	$365	Age 55-59	$546
Age 60-64	$450	Age 60-64	$663

PacAdvantage was created to help small businesses secure affordable health, dental, and vision coverage by buying insurance together as one big group. The 2003 premiums for PacAdvantage's HMOs offered in San Francisco are illustrated in the following tables. PacAdvantage's Standard plan is based on a $30 copayment; its Plus plan is based on a $20 copayment while its Preferred plan is based on a $10 copayment, both Plus and Preferred would be available to employers if the recommended changes to the minimum standards are adopted.

As these tables illustrate there is great variation in premiums based on health plan selected and the age of the employee. The lowest premiums are offered through Chinese Community Health Plan, with the lowest charge being $129.90 per month for an individual subscriber under 30 years old who would pay a $30 copayment for an office visit. The most expensive premiums are offered through Blue Shield, with the most expensive charge being $1,200.86 per month for an individual over 65 who would pay a $10 copayment for an office visit.

PACADVANTAGE BLUE SHIELD PREMIUMS

PacAdvantage Standard Employee Age Range	PacAdvantage Standard Monthly Premium	PacAdvantage Plus Employee Age Range	PacAdvantage Plus Monthly Premium	PacAdvantage Preferred Employee Age Range	PacAdvantage Preferred Monthly Premium
Under 30	$257.59	Under 30	$294.01	Under 30	$335.05
Age 30-39	$280.77	Age 30-39	$320.49	Age 30-39	$365.22
Age 40-49	$361.13	Age 40-49	$412.21	Age 40-49	$469.76
Age 50-54	$415.23	Age 50-54	$473.95	Age 50-54	$540.11
Age 55-59	$574.91	Age 55-59	$656.24	Age 55-59	$747.85
Age 60-64	$697.81	Age 60-64	$796.49	Age 60-64	$907.68
Age 65+	$923.19	Age 65+	$1,053.75	Age 65+	$1,200.86

PACADVANTAGE HEALTH NET PREMIUMS

PacAdvantage Standard Employee Age Range	PacAdvantage Standard Monthly Premium	PacAdvantage Plus Employee Age Range	PacAdvantage Plus Monthly Premium	PacAdvantage Preferred Employee Age Range	PacAdvantage Preferred Monthly Premium
Under 30	$225.17	Under 30	$246.05	Under 30	$281.21
Age 30-39	$240.26	Age 30-39	$262.53	Age 30-39	$300.05
Age 40-49	$289.31	Age 40-49	$316.11	Age 40-49	$361.29
Age 50-54	$402.22	Age 50-54	$439.50	Age 50-54	$502.31
Age 55-59	$507.39	Age 55-59	$554.41	Age 55-59	$633.66
Age 60-64	$636.69	Age 60-64	$695.69	Age 60-64	$795.12
Age 65+	$777.45	Age 65+	$849.51	Age 65+	$970.93

PACADVANTAGE CHINESE COMMUNITY HEALTH PLAN PREMIUMS

PacAdvantage Standard Employee Age Range	PacAdvantage Standard Monthly Premium	PacAdvantage Plus Employee Age Range	PacAdvantage Plus Monthly Premium	PacAdvantage Preferred Employee Age Range	PacAdvantage Preferred Monthly Premium
Under 30	$129.90	Under 30	$142.31	Under 30	$152.71
Age 30-39	$139.22	Age 30-39	$151.76	Age 30-39	$162.53
Age 40-49	$186.18	Age 40-49	$199.68	Age 40-49	$211.33
Age 50-54	$234.63	Age 50-54	$249.14	Age 50-54	$261.68
Age 55-59	$287.25	Age 55-59	$302.87	Age 55-59	$316.49
Age 60-64	$326.42	Age 60-64	$342.77	Age 60-64	$357.20
Age 65+	$373.37	Age 65+	$390.62	Age 65+	$406.08

PACADVANTAGE KAISER PREMIUMS

PacAdvantage Standard Employee Age Range	PacAdvantage Standard Monthly Premium	PacAdvantage Plus Employee Age Range	PacAdvantage Plus Monthly Premium	PacAdvantage Preferred Employee Age Range	PacAdvantage Preferred Monthly Premium
Under 30	$180.57	Under 30	$190.86	Under 30	$217.14
Age 30-39	$198.86	Age 30-39	$210.29	Age 30-39	$240.00
Age 40-49	$230.86	Age 40-49	$244.57	Age 40-49	$277.71
Age 50-54	$300.57	Age 50-54	$318.86	Age 50-54	$361.14
Age 55-59	$380.57	Age 55-59	$402.29	Age 55-59	$458.29
Age 60-64	$469.71	Age 60-64	$496.00	Age 60-64	$564.57
Age 65+	$557.71	Age 65+	$589.71	Age 65+	$670.86

Although it is not known what the average premiums will be in California for 2004 the projected rate increase is approximately 13 percent, which would increase the 2003 HMO premium average rate from $234 per month to $264 per month. As can be seen in the tables above, small businesses often pay more than the average.

Recommended New Fee

DPH recommends that the Health Commission consider a 50-cent increase in the fee to ensure that, consistent with the HCAO's original intent, it creates an incentive to have employers offer health care coverage to its employees. According to the Ordinance: "*The Health Commission may increase this hourly rate and Weekly maximum in accordance with the Bureau of Labor Statistics Consumer Price Index for Medical Care in the SF Bay Area or other such factors as the Health Commission finds appropriate; provided, however, the Health Commission shall take this action no more than once a year and any adjustments in such hourly rate or Weekly maximum must be approved by the Board of Supervisors by resolution*."

The Consumer Price Index for Medical Care consists of medical care commodities and medical care services. Medical care services, the dominant component of medical care, is organized into two expenditure categories (EC's), professional medical services and hospital and related services. The percentage increases for the San Francisco Bay Area over the past three years has been:

Year	Percentage Increase
2000	4.4
2001	5.1
2002	4.2

The Consumer Price Index for Medical Care does not factor in the costs of employer paid health insurance. This is better reflected by examining increases in the costs of premiums as noted previously, especially since employers under HCAO are required to pay the full cost of premiums.

The $1.50 fee was determined by using information from 2000 and 2001; therefore the proposed increases begin with data from one of these years. Applying each year's percentage increase in the Consumer Price Index for Medical Care since 2000 would increase the $1.50 fee by 13.7 percent to $1.71, also increasing the maximum weekly amount to $68. (There is not yet a figure for the increase in the Consumer Price Index for 2003; premiums are set at the beginning of each year, so a figure for 2003 does exist.) Using the percentage increases since 2001 in the average health insurance premiums would increase the $1.50 by 41.5 percent to $2.12, with a maximum weekly amount of $85. Paying the maximum would mean a monthly fee of $272 in the first scenario or $340 in the second.

DPH suggests that the Health Commission recommend to the Board a moderate increase of 50 cents in the fee to $2.00 per employee/per hour, with a weekly maximum of $80 or $320 per month. This makes the fee higher than the current HMO average premium for 2003 ($234/month) and also higher than the projected increase for 2004 ($264/month). It also compares favorably to the premiums shown in the tables above for Kaiser, Blue Shield and the PacAdvantage plans. Raising the fee to this level would insure that there is an incentive for an employer to provide insurance rather than pay the fee.

SECTION V – CONCLUSION

The HCAO has put San Francisco on the cutting edge of innovative health coverage expansions. DPH fully supports the HCAO and has a strong interest in seeing the Ordinance meet its objective of reducing the numbers of uninsured and thereby enhancing the quality, stability and productivity of the workforce on the City's contracts and leases. Failure to adequately insure challenges the community as a whole as public health resources are diverted to fund basic health care services. The goals of the HCAO are in line with DPH's priorities as outlined in its Strategic Plan and the will of the voters as demonstrated by Proposition J.

The HCAO acknowledged the changing health care marketplace by requiring that its provisions would be updated and refined periodically to ensure that its overall policy directive would be met. Toward this end, DPH has made two major recommendations in this report. A draft resolution (see Attachment F) is attached for Health Commission approval. These recommendations are:

- To modify the copayment structure to match what is offered in the small business health insurance market (based on a $20 copayment structure); and
- To increase the fee paid by employers who do not offer health insurance that meets the minimum standards to better reflect premium costs (from $1.50 to $2.00).

HCAO will remain in effect for businesses in San Francisco for several more years. Therefore, DPH must continue to do its part in updating the HCAO to be workable until new legislation is enacted that would modify or make the HCAO obsolete. Making the appropriate changes to the HCAO now will encourage employers to find a health plan that meets the minimum standards. The modifications recommended in this report help to achieve these objectives.

The health insurance market has been, and continues to be in flux and this is not expected to change in the next year. Double digit increases in premiums are expected again for 2004.

Health insurers report changes to their benefit packages each January. DPH will watch next year's changes carefully and report to the Health Commission in one year. DPH will assist OCA in educating employers impacted by HCAO and will also continue efforts to educate brokers so that they can be of assistance to employers seeking health coverage that meets the minimum standards.

Next Steps

As noted in Section IV, any increases in the fee (Option #2), as recommended by the Health Commission, must be approved by the Board of Supervisors. If the Health Commission approves a fee increase, DPH will forward the recommendation to the Board for their concurrence.