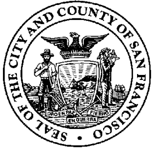

MEMORANDUM

July 13, 2004

To: Honorable Edward A. Chow, MD, President and Members of the Health Commission

Through: Anne Kronenberg, Deputy Director of Health

From: Frances Culp, Office of Policy and Planning

Re: Recommended Updates to the Health Care Accountability Ordinance's Minimum Standards and Fee

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The Health Commission last received an update regarding the City's Health Care Accountability Ordinance (HCAO) on November 18, 2003. At that time, the Department of Public Health (DPH) recommended that the Commission make two significant modifications to the HCAO. The first recommendation was to modify the Minimum Standards, raising acceptable copayments to put them more in line with small business health insurance options on the market in 2003. The second recommendation was to increase the amount employers pay from $1.50 to $2 per hour when they do not provide health insurance that meets the HCAO's Minimum Standards.

The Health Commission deferred acceptance of either modification, asking that DPH conduct further research and collaborate with stakeholders before returning to the Commission. This report documents the work done by DPH over the past several months and makes recommendations regarding HCAO. DPH and the stakeholders agree that these modifications will help HCAO meet its objective of reducing the numbers of uninsured working adults in San Francisco.

Employers, labor representatives, living wage advocates, DPH and others came to consensus on the recommendations made in today's report. These recommendations are:

- Modifications to the Ordinance: Modify the Ordinance with respect to part-time workers, relief workers, wait times and student interns, making the Ordinance easier to enforce and more realistic in light of the current health insurance market.
- Revise the Minimum Standards: The revisions recommended are based on a $15 or $20 office visit copayments and will put the Minimum Standards more in line with what is offered by health insurance companies.
- Increase the Employer Fee: This 50-cent increase will more closely reflect the average premium cost of health insurance.
- Local Health Coverage Program: A group will work to further study ideas and make recommendations for a local health coverage program for workers.

Updating the Health Care Accountability Ordinance

Stakeholders' Process

DPH convened a group of stakeholders from various perspectives interested in the Health Care Accountability Ordinance (HCAO). The individuals that spoke at the Health Commission's meeting on November 18 formed the core of this group, and others were added by recommendation of the group. Anne Kronenberg of DPH's Office of Policy and Planning chaired the group and Frances Culp provided staff support. DPH's Office of Policy and Planning convened the first HCAO stakeholders' group on March 5, with subsequent meetings on March 19 and May 21. In addition, DPH met with a stakeholder subcommittee three times to do additional work between the last two meetings in March and May.

The following individuals and groups participated in these meetings:

- Dale Butler, SEIU 790
- Jean Fraser, San Francisco Health Plan
- John Grgurina, PacAdvantage
- Mark Gruberg, Living Wage Coalition
- Richard Heasley, Conard House
- Dale Hess, SF Convention and Visitors Bureau
- Ken Jacobs, UC Berkeley Labor Center
- Paula Jesson, City Attorney
- Jose R. Juarez, Office of Contract Administration, Living Wage/Living Health
- Karl Kramer, Living Wage Coalition
- Debbi Lerman, SF Human Services Network
- Donna Levitt, Office Labor Standards Enforcement
- Alice Rogoff, Living Wage Coalition
- Aleeta Van Runkle, City Attorney
- Rich Waller, Office of Contract Administration, Living Wage/Living Health
- Kelly Wilkinson, Episcopal Community Services

Modifications to the Ordinance

The stakeholders' meetings gave individuals from various backgrounds, perspectives and experience with the HCAO an opportunity to discuss the proposed changes first given to the Health Commission in November. It became clear that one of the major reasons the original recommendations made by DPH were unacceptable related to the fact that there were still significant unresolved issues within the Ordinance itself. The stakeholders agreed that the Ordinance contained language that, directly or indirectly, created unnecessary burdens on employers and/or employees.

The Office of Contract Administration, which administers and enforces the Ordinance, reported at the first stakeholders meeting that they would be presenting on both HCAO and the Minimum Compensation Ordinance to the Board of Supervisors in August. With this in mind, the stakeholders felt that the August presentation would offer an opportunity to propose changes to the Ordinance. The group worked with the City Attorney's Office to come up with five suggested modifications, discussed below that would improve the Ordinance. Although the Health Commission only has authority to make changes in the benefit structure of the HCAO, DPH is proposing that the Health Commission recommend these changes to the Board of Supervisors. (Please see Attachment A for a revised copy of the Ordinance with these changes included.)

- **15 to 19 Hour/Week Employees**: HCAO requires employers to provide coverage for employees working 15 or more hours per week. Health insurance companies offer insurance through employers for individuals working 20 or more hours per week. DPH discussed this issue with representatives from Blue Shield, Health Net and Kaiser and DPH was consistently told that this standard is not likely to change. In fact, they explained that the current rule is based on State statute that defines a part-time employee as working more then 20 hours per week. The stakeholders group agreed that it was not desirable to have a mandate that employers could never fulfill, but were also hopeful that at some point in the future there might be a way to cover these part-time workers. Therefore, the group agreed to recommend a change to the Ordinance that requires employers to insure individuals working 15 to 19 hours per week effective on July 1, 2006, by which time DPH and the stakeholders can revisit this issue.

- **Student Interns**: Student interns are not considered covered employees through the HCAO. However, the stakeholders agreed that the current language in the Ordinance was not broad enough to include the range of possible student interns. The group agreed to suggest an expansion to this exemption.

- **Non-Profit Relief Workers**: Though it is a relatively small number of all HCAO employers, some non-profit contractors rely on relief workers to cover for regular employees. Employers are unable to insure these workers due to the sporadic nature of their employment. Therefore, the group agreed to recommend an exemption for these workers.

- **30-Day Wait for Insurance:** HCAO requires employers to provide coverage for employees within 30 days of their hire date. Because health coverage becomes effective on the first day of a month, a 30-day wait which will fall on any day of the month is impractical. The most common effective date is the first day of the first month after the employee is hired. The group agreed to recommend changing the

Ordinance to require the effective date of coverage be no later than the first day following the first complete calendar month worked by the employee. (This was previously recommended by DPH in May 2001, but was not written into the Ordinance at that time.)

- **Contracts Pass-Through for Health Insurance Costs**: Though never officially written into HCAO, the agreement from the beginning was that City departments would pay part or all of the cost of providing health insurance that meets HCAO's standards through the contract. (There has been an assumption among some City departments, including DPH, that non-profits could pass through 100% of their costs and for-profits could pass through 65% of their costs of complying with HCAO.) Not all City Departments have worked effectively with contractors to make this happen. The group agreed to recommend a new clause that would require City departments to consider the costs of HCAO (as well as the Minimum Compensation Ordinance and the Minimum Wage Ordinance) when developing a budget.

Imagining an HCAO with the changes above helped to frame the discussions regarding the Minimum Standards and the employer fee, and to make the agreements outlined below. These changes will be included in a package of changes, which, put together, will greatly improve HCAO.

Minimum Standards

The Minimum Standards guide employers in choosing a health plan that meets basic requirements determined by DPH and the Health Commission. In order to be in compliance, the employer must offer the covered employee a plan that is as good or better than what is outlined in the Minimum Standards. The standards include the following components:

- **Premium Cost-Sharing**: Premiums reflect the amount that it costs to provide health coverage to an employee. It is usually shown as a monthly figure. Premium costs are generally shared between employer and employee. In 2003 the average worker in California paid 14 percent of his or her monthly premium, up from 10 percent in 2000.[1] In contrast, HCAO covered employees are not required to pay anything toward the monthly premium. The Minimum Standards currently require the employer to offer at least one plan in which the premium is paid fully by the employer. DPH has not recommended any change in this requirement, and the stakeholders agreed that this was an important protection for workers that should be retained.

[1] Health Research and Educational Trust and Kaiser Family Foundation, March 2004, *California Employer Health Benefits Survey, 2003*.

- **Health Benefits**: The health benefits are essentially the services that the employee will be entitled to receive. Because DPH wants to ensure that the health benefit coverage offered to employees is not limited to catastrophic care, it recommends comprehensive health coverage (i.e., medical coverage) listing the specific services to be covered. Because of the increased costs in health coverage, 30 percent of employees in California have had their benefits reduced in the past three years.[2] DPH and the stakeholders agreed that this was another area that offered important protections to workers and that the comprehensive nature of the benefits should be maintained.

- **Deductibles**: A deductible is the set amount an insured individual is required to pay for health care services before insurance coverage starts. High deductible plans are increasing in frequency. Just this year, Kaiser began offering deductible plans for the first time, marking a major change in that insurer's practices. The Minimum Standards require zero deductible, and this is another area where no change is recommended.

- **Copayments**: The copayment represents the out-of-pocket costs borne by the employee when accessing covered services. The copayment is made to the provider. As required copayments increase for employees, monthly premiums paid by employers decrease and vice versa. Over the past few years, insurers have been increasing copayment amounts seeking relief from premium increases. There have also been shifts in the plans that insurers offer to employers, with copayment amounts increasing across the board. (Kaiser no longer offers a plan with a $10 copayment for office visits on the small business market, though they did have such a plan in 2001.) The group worked hard to develop a copayment structure that would be affordable to employees as they access health care services, affordable to employers paying the monthly premium, and flexible enough to remain workable over time.

Although it is possible to distinguish the different features (e.g., premiums, copayments) of a health insurance package, employers must choose among available packages. Unfortunately, not one health insurance package in the small business market reviewed by DPH in 2004 meets the current Minimum Standards in 2001. The pace of change in the area of health insurance benefits has been great.

In the area of copayments, according to California employers, 25 percent of small firms and 42 percent of large firms reported that they increased the amount employees pay for office visit copayments in 2003. In November, DPH recommended a change to the office visit copayment from $10 to $20. Many of the stakeholders and the Commissioners were uncomfortable with this increased amount, fearing that insured employees would avoid

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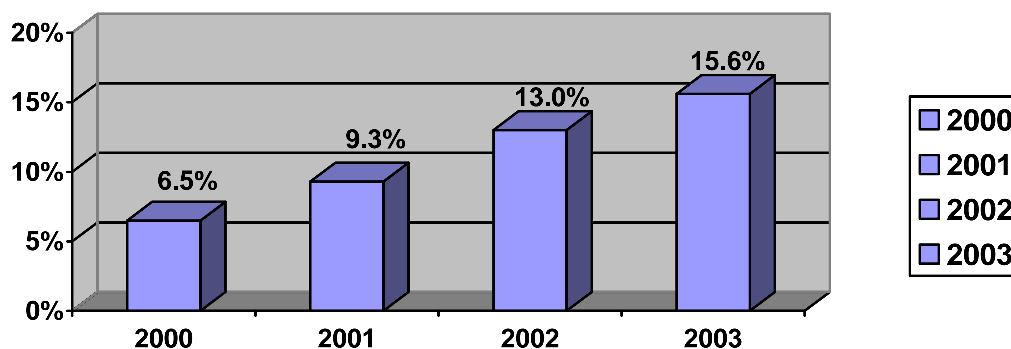
[2] Ibid.

important preventive care offered at physician office visits because of the cost. Yet there was also the competing fear that the high costs of premiums, especially premiums associated with low-copayment plans, would cause employers to drop insurance coverage for all employees.

Premiums have to be taken into account when discussing copayments because one always affects the other. One of the employers in the stakeholders' group reported a 39 percent increase in his health insurance premiums this year. This increase is far above the average, but the average employer has seen double digit increases in premiums for the past several years. Chart #1 shows that since 2000, California's HMO health insurance premiums have increased 44.4 percent.

Chart #1: Percentage Increases in HMO Health Insurance Premiums From Previous Year, 2000-2003



The group discussed and eventually dismissed a number of possible changes to the Minimum Standards. One of the options discussed at the Health Commission meeting in November 2003 was to initiate a bifurcated system where small businesses would be held to one standard with more flexibility in copayment amounts, while larger businesses would be required to keep to the current Minimum Standards. This was dismissed by the group for a number of reasons, specifically because of the concerns of larger non-profit employers who were struggling along with small businesses (and in some cases failing) to meet the Minimum Standards. For these larger businesses it was not because the plan design did not exist, but because premium increases had put the old plans out of reach. Non-profit representatives recommended basing the tiered scenario on whether the contractor was for-profit or non-profit. The group agreed that a tiered approach, especially with the various tiers (profit/non-profit, large/small business) would be too complex to design and enforce.

The group also considered making only minimal changes to the Minimum Standards. The changes would be based on the lowest possible copayment for the employee allowing only a few plans offered on the small business market to meet the Minimum Standards. There were a number of problems with this approach. Of greatest concern was the fact that the Minimum Standards would likely be outdated soon after they were approved. Insurers modify their plans at least once a year (usually in January) and often twice a year (again in July). In addition, it was disconcerting to some stakeholders that minor changes would make available

only the plans that have the highest premium costs. (This could again lead some employers to forgo offering health insurance altogether.) For these reasons, the group decided that this was not the best option to pursue.

DPH researched a separate idea even before the first meeting of the stakeholders. At the Health Commission's suggestion, DPH also researched the possibility of working with the insurance carriers that provide health coverage to City workers. There was hope that these health plans might be willing to create a product that would meet the current Minimum Standards and be available to small businesses. This meeting was held at the City Attorney's office and included representatives from Kaiser, Blue Shield and Health Net. The health plans explained that they would be unable to create a program for San Francisco only. Insurance plans cannot change their small business plans for one location only. By law, any small business plan that is offered must be made available throughout the state. They felt it was essentially impossible to create a new statewide package modeled on the current Minimum Standards.

The stakeholders' group eventually agreed that the best approach would be to create Minimum Standards that would be much more flexible, assigning fewer copayment amounts to required benefits. The minimum standards as they are now require specific dollar limits for each benefit, meaning that when insurers make even relatively minimal changes the employer is at a high risk of being out of compliance. For example, the current Minimum Standards require no copayment for diagnostic services. Beginning in 2004, all of Kaiser's small business plans require a $10 copayment for lab tests and a $50 copayment for MRIs, PET, and CAT scans. Whether an individual pays a $5 copayment for a physician office visit or $30, the same copayment for diagnostic services applies. Keeping up with these constant changes has proven to be a significant challenge for employers trying to comply with HCAO.

The group also decided that employers who purchase the lowest cost plans (i.e., closed panel HMOs, including Kaiser) should be required to extend at least part of this cost savings to the employee in the form of lower copayments. Therefore, the group agreed that the office visit maximum copayment for physician office visits should be less for Closed Panel HMOs ($15) and more for other insurers ($20). Other covered services are not assigned a particular dollar amount for copayments. However, it is important that the plans that require a $15 or $20 copayment for office visits are mid-range plans for each insurer. This means that copayments for other services will correspond and also be mid-range. (See Attachment B for health insurance plans currently on the market.)

DPH recommends that the Health Commission adopt the following Minimum Standards proposal agreed upon by the stakeholders' group.

Stakeholders' Proposal:
HCAO's Minimum Standards require employers to offer at least one health plan that is a Health Maintenance Organization (HMO). Employers may not require employees to pay a monthly premium contribution toward the HMO plan. This HMO must not charge employees a deductible of any amount for any services or benefits covered in the package.

Copayments for office visits (including PCP, perinatal and maternity, preventive care, and family planning) shall not exceed $15 per visit for a Closed Panel HMO; and $20 per visit for all other HMO models. The employee's annual out-of-pocket maximum shall not exceed $2,500.

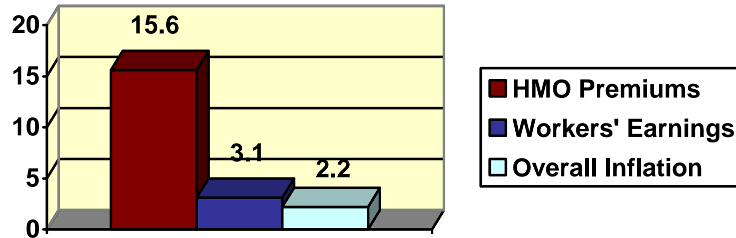
Each plan must be comprehensive and provide coverage for the following services:

- Office visits (including PCP, perinatal and maternity, preventive care, and family planning)
- Hospital inpatient
- Prescription drugs
- Outpatient services and procedures
- Diagnostic services (x-ray, labs, etc.)
- Perinatal and maternity care
- Emergency room and ambulance
- Mental health services, outpatient and inpatient
- Alcohol and substance abuse care, outpatient and inpatient detox
- Rehabilitative therapies
- Home health
- Durable medical equipment
- Hospice care
- Skilled nursing services

Review of Current Fee

The stakeholders' group also discussed the concern that, as health coverage costs rise, the $1.50 ($240 monthly fee for a full-time worker) paid to DPH no longer corresponds to the reality of premium costs. As discussed earlier, health insurance premiums have risen considerably over the past few years. In fact they are rising at a much higher rate than other indicators of cost increases for employers, including employee wages and inflation. The graph on the following page illustrates the 2003 increase in HMO premiums nationwide (15.6%) as compared to inflation (2.2%) and the increase in workers' earnings (3.1%). Premiums exceeded the overall inflation rate by more than 13 percentage points and exceeded increases in workers earnings by more than 12 percentage points.

Chart #2: National Average Increase in HMO Premiums Relative to Other Indicators - 2003



Premiums vary greatly based on the health plan and the age of the employee. For example, the lowest premiums offered through PacAdvantage are offered through Chinese Community Health Plan, with the lowest charge being $143 per month for an individual subscriber under 30 years old paying a $30 copayment for an office visit. The most expensive premiums are offered through Blue Shield, with the highest charge being $1,442 per month for an individual over 65 paying a $10 copayment for an office visit.

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. (It does not factor in the costs of health insurance.) Medical care services, the dominant component of medical care, is organized into two expenditure categories, professional medical services and hospital and related services. The percentage increases for the San Francisco Bay Area over the past four years has been:

Table #1: Consumer Price Index for Medical Care

Year	Percentage Increase
2000	4.4%
2001	5.1%
2002	4.2%
2003	2.9%

Applying each year's percentage increase in the Consumer Price Index for Medical Care since 2000, when the Ordinance drafted, would increase the $1.50 fee by 16.6 percent to $1.75, also increasing the maximum weekly amount to $70. Using the percentage increases since 2000 in the average HMO health insurance premiums in California would increase the $1.50 by 44.4 percent to $2.17, with a maximum weekly amount of $87. Paying the maximum would mean a monthly fee of $280 in the first scenario or $348 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 ($222/month). It also compares favorably to the premiums for Kaiser, Blue Shield and the PacAdvantage plans. Raising the fee to this level would ensure that both providing insurance and paying the fee remain viable alternatives for employers.

Local Health Coverage Program

The stakeholders group discussed in detail the provision in the HCAO that DPH develop a local health coverage program for workers: *"In developing the program, the Health Director shall (i) attempt to make health coverage available for uninsured Covered Employees and, if feasible, other uninsured City residents; (ii) use public health facilities to the maximum extent practicable; (iii) make the program economically viable; and (iv) provide a mechanism for funding which relies, as much as possible, on contributions by participating employers and employees."*

As was presented to the Health Commission on January 8, 2003, DPH studied this issue at length and found that the program, as imagined, could not be made economically viable. As reported at that time, demand must be high enough to bring a sufficient number of employers and employees to any health insurance purchasing pool. Without sufficient demand, the pool's size will be too small to achieve what is expected, increased bargaining power. Additionally, savings must be achieved to some degree in the three areas that contribute to the eventual cost of an insurance program's premium – administration costs, provider rates and service utilization.

Given the strong interest on the part of the stakeholders, however, a subcommittee has been formed to revisit this issue. Jean Fraser, of the San Francisco Health Plan, has convened the group, with staff support through DPH. The first meeting of this group is scheduled for July 21. These meetings will provide a forum for interested individuals to share ideas about how a health coverage program, pool, or insurance plan might work under HCAO.

Next Steps

DPH presents this report and the attached resolutions and requests approval of these recommendations. With the Health Commission's support, the next step will be to present the modifications to the Ordinance to the Board of Supervisors. At the same time DPH will continue to work with stakeholders to develop ideas for health insurance coverage programs.

In conclusion, 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.