San Francisco
Universal Healthcare Council 2013

FINAL REPORT

San Francisco Universal Healthcare Council 2013
FINAL REPORT - EXECUTIVE SUMMARY

On July 25, 2013, Mayor Lee asked Director of Health Barbara Garcia to reconstitute the Universal Healthcare Council (UHC) to engage stakeholders in a data-driven process to examine San Francisco's implementation of the federal Affordable Care Act (ACA) and its integration with the City's Health Care Security Ordinance (HCSO or Ordinance). The work of the original UHC, convened in February 2006, ultimately resulted in the enactment of the HCSO. The Ordinance imposes an Employer Spending Requirement, which requires some employers to make health care expenditures on behalf of their San Francisco employees, and establishes a public health benefit program that includes Healthy San Francisco, a health care access program for the uninsured. The reconstituted 41-member UHC reviewed in-depth analyses of the ACA, the HCSO, and the impact of these laws on individuals and employers in San Francisco. Council members held an open dialogue to share views and concerns, and collected suggestions for final submission to the Mayor in this report.

Two key findings emerged during the UHC's deliberations:

- **The HCSO remains intact alongside the ACA**. While the ACA's insurance market reforms remove one option for compliance with the HCSO (the medical stand-alone health reimbursement account), the Ordinance itself remains intact. This means that for the large majority of San Francisco employers covered by the HCSO, the ACA does not present hurdles to compliance with either law.
- **Potential affordability concerns remain for some.** Due to the high cost of living and doing business in San Francisco compared to other places in the state and the nation, the UHC identified a number of categories of people or entities (particular populations of individuals, certain types of employers, and the City public health system) that may face affordability concerns beginning in 2014.

The UHC did not seek consensus and, as such, a diversity of opinion is expressed in the 30 suggestions offered by UHC members, which fall generally into the following categories:

- Maintain the Current Status
- Modify the HCSO to Mirror the ACA
- Modify the HCSO Employer Spending Requirement
- Modify the City Option
- Address Carryover HRA Balances
- Conduct Outreach & Research
- Other

On July 25, 2013, Mayor Lee asked Director of Health Barbara Garcia to reconstitute the Universal Healthcare Council (UHC) to engage stakeholders in a data-driven process to examine San Francisco's implementation of the federal Affordable Care Act (ACA) and its integration with the Health Care Security Ordinance (HCSO). The work of the original UHC, convened in February 2006 by then-Mayor Newsom, ultimately resulted in the enactment of the HCSO, which requires employers to make health care expenditures on behalf of their employees and established a public health benefit program that includes Healthy San Francisco, a health care access program for the uninsured. This report details the work and recommendations of the 2013 UHC.

THE 2013 UNIVERSAL HEALTHCARE COUNCIL

The 2013 Universal Healthcare Council (UHC) was an inclusive group of stakeholders brought together to analyze, identify, and assess key issues underlying the intersection of the HCSO and ACA. The reconstituted 41-member UHC was co-chaired by Director Garcia and Dr. Sandra Hernandez, CEO of The San Francisco Foundation. The membership largely mirrored that of the 2006 UHC and included representation from the city's labor, business, health care, and government sectors. A list of 2013 UHC members is included as **Attachment 1**.

The UHC met five times from September to December 2013. Research support was provided by the City's Department of Public Health, Office of the Controller, and the Office of Labor Standards Enforcement. All meetings were open to the public and time was allotted for public comment. Complete meeting materials, including issue briefs, presentations, and minutes, can be accessed through the Department of Public Health website, at http://www.sfdph.org/dph/comupg/knowlcol/uhc/default.asp.

UHC members reviewed in-depth analyses of the ACA, the HCSO, and their impact on individuals and employers. A summary of the key data examined by the UHC is included in **Attachment 2**. They held an open dialogue to share views and concerns and to collect suggestions. The group did not seek consensus and, as such, the array of suggestions offered in this report reflects a diversity of opinion. The various suggestions have not been tested for their legality or practicality, nor have they been evaluated for the extent to which they reflect the UHC's guiding principles (set out below). Rather, this document presents the complete list of individual UHC members' suggestions in order to provide the Mayor with a full accounting of the many possibilities and considerations generated by the UHC to inform the City's policy deliberations going forward.

UHC Guiding Principles

The UHC unanimously adopted the following guiding principles, adapted from the 2006 UHC and updated to reflect the charge of the 2013 UHC in the post-ACA environment.

1. **Support the Affordable Care Act –** The UHC supports the ACA and is committed to full implementation of the ACA in San Francisco. The ACA builds on what San Francisco began and presents an opportunity for San Francisco to continue to lead the way in health care access.

2. **Maximize Enrollment into Health Insurance** – Health insurance is better than uninsurance and the UHC is committed to maximizing enrollment of San Franciscans into the new insurance opportunities created by the ACA.

3. **Leverage State and Federal Funding** – All available state and federal funds that support enrollment of San Franciscans into health insurance should be utilized and encouraged.

4. **Maintain Healthy San Francisco –** Though Healthy San Francisco is not health insurance, it provides access to health care services for San Francisco's most vulnerable uninsured. At a minimum, Healthy San Francisco should be preserved for individuals who do not qualify for publicly-funded health insurance, but also should not be an impediment to full implementation of the ACA.

5. **Maximize Affordability –** Health insurance options must be affordable for San Franciscans to maximize enrollment.

6. **Shared Responsibility** – Fundamental to the UHC's vision and goal is the notion of collective responsibility. All sectors of society – individuals as well as public, private, and non-profit entities – must take a role in reducing the number of uninsured residents and ensuring access to care. Shared responsibility increases affordability and should continue to form the basis of creative local solutions to provide access to health insurance and care.

BACKGROUND

Health Care Security Ordinance

The Health Care Security Ordinance (HCSO) requires employers with 20 or more total employees (50+ for non-profit) to make health care expenditures on behalf of covered employees working a minimum of 8 hours per week in San Francisco. Employers comply by providing health insurance, allocating funds to health reimbursement accounts (HRAs), or paying into the City Option. Under the City Option, the City subsidizes eligible employees' membership fees for Healthy San Francisco or sets up a medical reimbursement account, known as the City MRA. Healthy San Francisco is operated by

the City's Department of Public Health and provides program participants access to a medical home, which is a health care facility (in most cases, a clinic) through which participants access their medical care. To be eligible, one must be: a San Francisco resident, uninsured, earning less than 500% of FPL ($57,450/year), and not eligible for state or federally subsidized coverage. The City MRA reimburses employee account holders for eligible health care expenditures.

The HCSO requires health care expenditures in an hourly dollar amount, but the employer controls how it makes its expenditures. Employers may use a single compliance strategy for all of its employees, multiple compliance strategies to cover different employees, or use multiple strategies to cover one employee. Each year, HCSO-covered employers report their compliance strategies and expenditures to the City's Office of Labor Standards Enforcement (OLSE). Through the HCSO's Employer Spending Requirement (ESR), employers have contributed an average of $1.2 billion for health expenditures to cover on average 235,000 employees each year.[1]

Since its enactment in 2007, the HCSO has served an important role in increasing access to health care and is a contributing factor to the declining rate of uninsurance in San Francisco, which dropped from 15.2% in 2009 to 13.6% in 2012.[2] Healthy San Francisco has won national acclaim and has provided medical homes to over 116,000 uninsured San Franciscans during the past five years. The program currently serves an estimated 70% of the City's uninsured population.

The HCSO has also helped to put San Francisco ahead of the curve in implementing the ACA. Healthy San Francisco has provided uninsured San Franciscans regular access to health care services since 2007. In addition, Healthy San Francisco currently serves more than 70 percent of San Francisco's uninsured, who can now easily be contacted to tell them of the changes that are coming with Health Reform and help them enroll into insurance.

Affordable Care Act

The Affordable Care Act (ACA) was enacted in March 2010. Over the past three years, local health systems and City Departments have developed implementation strategies to comply with the phase-in process of the federal law. Over the next two years, several more important reforms and provisions directly affecting San Franciscans will take effect. The individual mandate, which requires most individual taxpayers to carry health insurance for themselves and their dependents, and health insurance market reforms go into effect January 1st, 2014. The employer mandate, which requires employers with 50+ full-time employees to offer affordable health insurance to full-time

[1] San Francisco Office of Labor Standards, Analysis of Annual Reporting Forms, 2010-2012.
[2] United States Census Bureau, American Community Survey, 2009-2012.

employees, is effective January 1st, 2015. To assist with these mandates, the ACA makes new health insurance options available through Covered California and expands eligibility for Medi-Cal, beginning January 1st, 2014. It also creates a health insurance exchange and limited subsidies for small businesses that wish to offer health insurance.

UHC FINDINGS ON THE INTERSECTION OF THE HCSO AND ACA

At the intersection of the HCSO and the ACA, the UHC identified two key issues that have implications for individuals, employers, and the City: the compatibility of the HCSO with the ACA, and the affordability of health care coverage.

HCSO Remains Intact Alongside the ACA

Insurance market reforms under the ACA affect one market-based option for compliance with the HCSO but leave the Ordinance itself intact. This means that for the large majority of San Francisco employers covered by the HCSO, the ACA does not present hurdles to compliance with either law. Eighty-eight percent of the City's employers meet their HCSO Employer Spending Requirement by offering insurance to some or all of their employees, a trend that is particularly evident among large employers and further incentivized under the ACA. Employers who currently pay into the City Option can also continue to do so unaffected, and their covered employees will continue to have access to Healthy San Francisco or the City MRA, which the employees can use to purchase individual insurance on Covered California.

However, the ACA does make changes to the third commonly used method of HCSO compliance, the health reimbursement arrangement (HRA). HRAs are accounts created by employers on behalf of employees to reimburse employees for their health care expenditures. Typically, HRAs are structured such that employer contributions expire and the unused funds revert to the employer. Under the HCSO, contributions are treated as employer health care expenditures only if the contribution remains available for at least 24 months from the date of the contribution or 90 days from separation. The HCSO also requires HRA contributions to be "reasonably calculated to benefit the employee" to ensure that eligible expenses are not subject to restrictions that make it unreasonable to believe that the employee will be able to benefit fully from the employer's contributions.

HRAs have been a cost-effective way for some businesses to comply with the HCSO because the average employee expenditure rate is 24.6%, meaning that roughly 75 cents of every dollar contributed to an HRA reverts to the employer. In comparison, dollars paid for insurance premiums and to the City Option do not revert to the employer. The use of HRAs to make health care expenditures (HCE) is highest among small businesses and those with many part-time employees. OLSE estimates that a minimum of 658 employers (16%) subject to the HCSO allocated funds to at least one

stand-alone HRA in 2012. Per the HCSO 2012 annual reporting forms, 190 employers (5%) used stand-alone HRAs exclusively.

The ACA market reforms affect HRAs such that they will no longer be available as a complete HCSO compliance strategy for employees who work more than 20 hours per week. As of January 1st, 2014, the ACA requires most HRAs to be integrated with comprehensive, employer-sponsored health insurance plans.[3] HRAs that are not coupled with an insurance plan, known as stand-alone HRAs, are disallowed unless they reimburse only for "excepted benefits."[4] "Excepted benefits" is a term used in the Affordable Care Act to describe a limited number of health benefits that are "excepted" from some of the market reform requirements, so employers can still provide excepted benefits whether or not they also provide health insurance. But the scope of such benefits is extremely limited in comparison to the full range of health care benefits that stand-alone HRAs could provide prior to January 1st, 2014. Because the excepted benefits will be so limited, OLSE has correspondingly limited the HCSO credit an employer receives for contributing to an excepted benefits HRA to the amount of the employer's spending requirement for an employee who works an average of 20 hours per week. Contributions to stand-alone HRAs that were not limited to excepted benefits did not have this limit.

This change will affect how some employers comply with the HCSO and will likely have financial impacts for both employers and employees. Employers who relied exclusively on HRAs to make health care expenditures for employees working more than 20 hours per week can no longer do so and will have to choose a different type of expenditure for any additional hours. Because providing insurance and paying into the City Option are more expensive than HRAs, this will create additional costs for affected businesses in 2014. Employees will also have additional burdens, because their non-excepted medical expenses, including health insurance premiums, will not be eligible for reimbursement.

In addition, the City has confirmed with federal officials that beginning January 1st, 2014, individuals who have carryover balances in stand-alone HRAs that provide

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[3] U.S. Departments of Treasury and Labor. IRS Notice 2013-54: Application of Market Reform and other Provisions of the Affordable Care Act to HRAs, Health FSAs, and Certain other Employer Healthcare Arrangements. September 13, 2013.

[4] Section 9832(c) of the Internal Revenue Code and its accompanying regulations contain the full list of excepted benefits and place some limits on how they can be offered. But only some of those excepted benefits also qualify as "health care services" under the HCSO. Those benefits are:

- dental benefits limited to treatment of the mouth;
- vision benefits limited to treatment of the eye;
- medical indemnity insurance;
- long-term, nursing home, home health, or community-based care; and
- coverage limited to a specific disease or illness.

reimbursements for health care expenditures other than excepted benefits will not be eligible for federal subsidies on Covered California for any month they carry an HRA balance. Employees may still spend down their accounts, including by using it toward unsubsidized purchase of plans on Covered California (if the terms of the HRA allow), or they may permanently opt out and waive the balance in the account in order to qualify for a subsidy sooner. This rule affects HCSO covered employees, who are guaranteed access to their HRA funds for 24 months from the date of the allocation. OLSE estimates that a minimum of 35,469 employees (13%) had stand-alone HRAs in 2012, many of which will have rollover balances in 2014. These employees are likely to be part-time and/or low-wage employees. The carryover rule also affects employers who have employees with HRA balances. Under the ACA, these employers must allow employees to opt out of their HRAs at least once per year; and under the HCSO, these employers will need to use another strategy to make the required expenditures on behalf of employees who opt out.

It is important to note that the non-excepted benefit stand-alone HRA issue is a temporary one. Employers can continue to comply with the HCSO in other ways, and employees become eligible for premium subsidies as soon as they spend down their accounts or permanently opt out. Any remaining carryover accounts will expire by their own terms by the end of 2015.

Potential Affordability Concerns Remain for Some

The cost of living and doing business in San Francisco is high compared to other places in the state and the nation. Health insurance can also be expensive, with small businesses and part-time employees at high risk for not being able to afford coverage. While the ACA provides new coverage options through Medi-Cal and Covered California's individual and small business insurance exchanges, and offers federal subsidies in some cases, the high cost of living in San Francisco may keep health insurance out of reach for low- and middle-income individuals and families. Meanwhile, ACA changes to HRAs potentially increase the cost of complying with the HCSO for small businesses. Such affordability concerns could translate to a lack of coverage, which ultimately becomes a financial concern for the City.

The UHC identified the following populations and entities as potentially facing affordability concerns beginning in 2014.

	Potential Affordability Concern
Individuals	• Undocumented immigrants • Part-time employees • Employees of small business • Families • Individuals with Carryover Balances in Existing Stand-alone HRAs • Individuals choosing to pay penalties
Employers	• Small businesses (20-49 employees) • Businesses relying on stand-alone HRAs • Businesses choosing to pay penalties
City	• Public health care system

Undocumented immigrants are ineligible to purchase insurance through Covered California and eligible only for limited Medi-Cal benefits. While low-income undocumented persons below age 65 will continue to have health care access through Healthy San Francisco or Healthy Kids, those whose income or age does not qualify them for these programs may not have access to affordable health care.

Part-time employees are less likely to have offers of employer-sponsored insurance, and are also more likely to be low- and middle-wage earners. ACA employer provisions do not extend employer-sponsored coverage to part-time workers. Employees working 8-29 hours per week are covered by the HCSO, but those benefits may not cover the full cost of insurance. The ACA provides financial assistance for individuals with incomes between 138-400% of FPL ($15,856-$45,960 per year) when purchasing insurance on Covered California. The amount of the subsidy declines sharply between 250-400% of FPL, meaning that a person earning $45,000 pays nearly the full price of premiums, which may be a deterrent to buying insurance.

Employees of small business are less likely than employees of large business to have insurance and are likely to pay more for premiums and deductibles than employees working for large businesses. Small business employees currently comprise a large number of enrollees in stand-alone HRAs.

Families may face financial and coverage concerns depending on an employer-sponsored offer of coverage. The ACA considers employer–sponsored coverage as affordable if an employee's contribution for self-only coverage is less than 9.5% of household income. However, family coverage can cost three to four times more than individual coverage, which could in practice be unaffordable for the family. Should a

family decide to decline employer coverage and purchase on Covered California, all family members covered under the employer's plan are barred from accessing federal subsidies on Covered California.

Employees with carryover stand-alone HRA balances will be considered to have satisfied the individual mandate during the months they retain a balance. If otherwise eligible for federal tax subsidies on Covered California, these employees will lose access to those subsidies during the months they carry a balance.

Individuals choosing to pay ACA penalties rather than purchase health insurance would remain uninsured and liable for all health related costs.

Small businesses with 20-49 employees have difficulty financing insurance for their employees for various reasons, including high cost and low employee participation in insurance, especially if the employees are low-wage earners. A small business also may not have the requisite number of full-time employees or a large enough workforce to negotiate affordable health insurance rates. Small employers generally operate on low profit margins and it is unclear whether Covered California's small business exchange will put health insurance within their reach.

Businesses relying on stand-alone HRAs as a mode of compliance with the HCSO anticipate the reversion of allocations that go unused for 24 months. These may be small businesses relying solely on HRAs, or larger businesses that offer HRAs to part-time or low-wage employees.

Having built the HRAs into their business strategy, these businesses face an increase in costs to the extent that they will have to move a portion of their HCSO spending to insurance or the City Option.

Businesses choosing to pay ACA penalties rather than provide health insurance would do so to save health insurance costs, but this may not be a cost-effective option for businesses that would still be required to comply with the HCSO.

The **City's public health care system,** operated by the Department of Public Health (DPH), absorbs the cost of care for those who are uninsured and/or indigent through its hospitals and clinics and the Healthy San Francisco program. To recover revenue losses related to caring for the uninsured, DPH draws from the City's General Fund. In the last three years, DPH has required $248.7–336.5 million per year in General Fund support; these numbers reflect revenue shortfalls related to patient care only and do not include General Fund support for DPH's other programs and services. Currently, DPH projects that 49,000-53,000 San Franciscans will remain residually uninsured in 2014. A higher rate of insurance among San Franciscans may help to reduce DPH's revenue shortfall.

SUGGESTIONS OFFERED BY MEMBERS OF THE 2013 UHC

The UHC's suggestions for the City, collected throughout the process, are listed below. Like ideas were combined and grouped for ease of understanding and numbered for ease of reference. The order in which they are presented is not a reflection of priority. Each suggestion stands on its own and, as the UHC process did not require members to reach consensus, some suggestions may directly or indirectly conflict with others.

Maintain the Current Status

1. **Maintain the HCSO** in its current form with robust monitoring and enforcement.
2. **Maintain Healthy San Francisco and Healthy Kids** for those left out of the ACA.

Modify the HCSO to Mirror the ACA

3. **Align HCSO employer obligations with ACA employer provisions**, and eliminate the Employer Spending Requirement for businesses with fewer than 50 employees.[5]
4. **Deem** large and small **employers that offer full- or part-time employees ACA-compliant health insurance as compliant with the HCSO** and provide a "safe harbor" from any financial obligations that may remain under the HCSO.
5. For large employers that choose to pay the ACA penalty, **credit the amount of the ACA penalty toward compliance with HCSO**.

Modify the HCSO Employer Spending Requirement

6. **Lower the health care expenditure rate** (e.g., to reflect the current average health reimbursement account reimbursement rate of 24.6%.)[6]
7. **Tether** health care expenditure **rates to costs on Covered California**, rather than to the 10-County Survey rate.
8. **Remove requirement** for employers to make health care expenditures **for employees who decline insurance**.[7]

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[5] The HCSO requires employers with 20+ employees to make health care expenditures on behalf of employees working a minimum of 8 hours per week in San Francisco. The ACA requires employers with 50+ full-time equivalent employees to offer affordable health insurance to employees working at least 30 hours per week.

[6] The health care expenditure (HCE) rate is currently set to 75% (for large employers) and 50% (for small and medium employers) of the average contributions made by the 10 most populous California counties to their employees' health insurance. The 2014 rates are $1.63/hour worked per employee for businesses with 20-99 employees, and $2.44/hour worked per employee for businesses with more than 100 employees.

9. **Credit** as valid health care expenditures **only those funds that are irrevocably spent by employer**.
10. **Approve a method of HCSO compliance that allows for direct reimbursement of employee health expenses** that does not require fully irrevocable, upfront expenditures for small businesses and does not jeopardize employee eligibility for ACA subsidies, **such as excepted benefit health reimbursement accounts**.
11. **Restrict** the amount of funds that can be allocated to **excepted benefits health reimbursement accounts to a level that can reasonably be spent by an average employee in a year**, and require employers to make remaining expenditures through another option.

Modify the City Option

Medical Reimbursement Accounts

12. **Allow unused City medical reimbursement account funds to revert to employers** after a certain time.
13. **Petition Covered California to accept direct payments from City medical reimbursement accounts**, saving employees the need to pay for premiums up-front.
14. Enforce the HCSO policy that **allows unclaimed City medical reimbursement account funds to be transferred to the Department of Public Health** to help defray the costs of indigent care.

Healthy San Francisco

15. **Expand Healthy San Francisco eligibility to cover San Francisco residents not eligible for ACA coverage**, including seniors without coverage, people exempt from the individual mandate, immigrants not eligible for publicly-subsidized coverage, individuals barred from subsidies due to the "family glitch," and those for whom insurance would cost more than eight percent of family income.
16. **Delay the disenrollment of current Healthy San Francisco participants** until after confirming that they have enrolled through Covered California.

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[7] The HCSO allows employees to waive HCEs made on their behalf only if they have employer-sponsored coverage, either from another employer or through a spouse's employer. Individual coverage, whether purchased through Covered California or through the individual market, does not qualify for a waiver.

Create a New City Option

17. **Create a wrap-around program** funded by health care expenditures **to pay for services not covered by Medi-Cal or Covered California plans** (e.g., dental, vision).
18. **Create a public benefit program** that pools health care expenditures **to support Healthy San Francisco** for those ineligible for ACA coverage **and to assist with premiums and out-of-pocket costs** to assure the affordability of health insurance for those eligible for ACA coverage.

Address Carryover HRA Balances

19. Work with employers to **convert carryover health reimbursement accounts to City medical reimbursement accounts**.
20. Work with employers to **modify policies to keep carryover health reimbursement accounts from interfering with employee eligibility for health insurance subsidies** on Covered California.
21. Work with employers to **amend restricted carryover health reimbursement accounts to allow employees to spend down the balance to purchase insurance** on Covered California.
22. **Do not require** employers to make **additional health care expenditures for employees who opt out of carryover health reimbursement accounts**.[8]

Conduct Outreach & Research

23. **Conduct** an **extensive outreach** campaign **to educate employees about** the consequences of and options for use of **carryover health reimbursement account balances**.
24. **Disseminate educational materials highlighting the** difference that City **medical reimbursement accounts** could make to the affordability of health insurance on Covered California.
25. **Promote the City Option to employers** as a means of complying with the HCSO for employees for whom they do not provide health insurance.
26. **Aggressively market availability of unused City medical reimbursement accounts funds to account holders**, in conjunction **with a campaign to help enroll account holders into insurance** on Covered California.

[8] Under HCSO regulations, if an employee opts out of the HRA and waives his/her carryover funds, the employer is not considered to have met its HCSO obligations and is required to make valid health care expenditures in the amount of the waived funds.

27. **Conduct further research and data analysis on affordability concerns** for San Franciscans under the ACA.
28. **Educate the community at large about** continued access to health care services through **existing charity care and sliding fee scale programs** at health care providers throughout the City.

Other

29. **Continue the UHC into 2014**.
30. **Indemnify employers if they face federal penalties** for following City's guidance on HCSO.

PUBLIC INPUT

The following were suggestions offered by members of the public.

1. Small businesses that purchase insurance through the Small Business Health Options Program (SHOP) on Covered California should not be required to make the full amount of HCE for insured employees. The cost of SHOP plans is likely to be less than the annual HCE for a full-time employee, while providing comprehensive ACA-approved coverage.
2. Create a non-MRA HCSO compliance option specifically for small businesses.
3. Because California law extends insurance to employees regularly working 20 hours per week, the focus should be on solutions that provide insurance to employees working 20-30 hours/week.

Attachment 1

2013 UNIVERSAL HEALTHCARE COUNCIL MEMBERS		
Last Name	**First Name**	**Organization**
Adams	Steve	President, San Francisco Small Business Commission
Black	Rob	Executive Director, Golden Gate Restaurant Association
Browner, MD	Warren	Chief Executive Officer, California Pacific Medical Center
Chan, PharmD	Eddie	President/Chief Executive Officer, Northeast Medical Services
Chung	Anni	President/Chief Executive Officer, Self Help for the Elderly
Fields	Steve	Co-Chair, Human Services Network
Fung, MD, PhD	Gordon	Member, San Francisco Medical Society Board of Directors
Garcia	Estela	Chicano Latino Indigena Health Equity Coalition; Executive Director Instituto Familiar de la Raza
Garcia, Co-Chair	**Barbara**	**Director of Health, San Francisco Department of Public Health**
Gressman	John	President/Executive Director, San Francisco Community Clinic Consortium
Grumbach, MD	Kevin	Professor & Chair of Family Practice, UCSF/SFGH; Co-Director, UCSF Clinical Translational Science Community Engagement and Health Policy Program; Co-Director, UCSF Center for Excellence in Primary Care
Hauge	Scott	President, CAL Insurance & Associates; Founder, Small Business California
Heilig	Steve	Policy Director, SF Medical Society
Hernandez, MD, Co-Chair	**Sandra**	**Chief Executive Officer, The San Francisco Foundation**
Jacobs	Ken	Chair, UC Berkeley Center for Labor Research and Education
Lang	Perry	African-American Community Health Equity Council; Executive Director, Black Coalition on AIDS
Laret	Mark	Chief Executive Officer, UCSF Medical Center
Lewis	Ian	Research Analyst, Unite Here Local 2
Lazarus	Jim	Senior Vice President, SF Chamber of Commerce
Melara	Sonia	President, San Francisco Health Commission
Miller	Rebecca	Director, Workforce Development, United Healthcare Workers - West
Muscat	Bob	Chair, Public Employees Committee, San Francisco Labor Council
Naranjo	Fred	Principal, Scarborough Insurance Agency

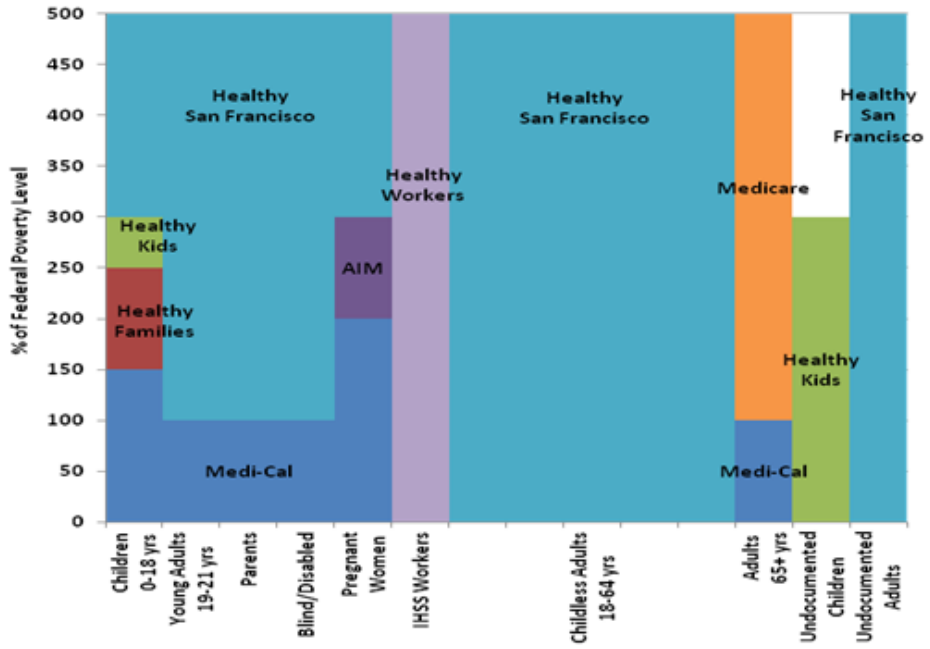
2013 UNIVERSAL HEALTHCARE COUNCIL MEMBERS		
Last Name	**First Name**	**Organization**
Pappas	Michael	Executive Director, Interfaith Council
Paulson	Tim	Executive Director, Labor Council
Rhorer	Trent	Executive Director, San Francisco Human Services Agency
Robisch	Christine	Senior Vice President & Area Manager, Kaiser Foundation Hospitals and Health Plan
Rose	L. Wade	Vice President, External & Government Relations, Dignity Health
Rosenfield	Ben	Controller, City and County of San Francisco
Santiago, DPM	Amor	Asian & Pacific Islander Health Parity Coalition; Executive Director, APA Family Support Services
Smith	Ron	Regional Vice President, Hospital Council of Northern and Central California
Snay	Abby	Executive Director, Jewish Vocational Services
Stead-Mendez	John	Deputy Executive Director, Field & Programs, SEIU Local 1021
Storey	Brenda	Executive Director, Mission Neighborhood Health Center
Thomas	Laurie	Rose Pistola & Rose's Café
Thomason	Richard	Director, Health Care and Coverage, Blue Shield of California Foundation
Valdes, MD	Ana	Medical Director, St. Anthony's Clinic
Wright	Chris	Executive Director, Committee on Jobs
Wulsin, Jr	Lucien	Executive Director and Founder, Insure the Uninsured Project
Wunderman	Jim	President/Chief Executive Officer, Bay Area Council
Yee	Brenda	Chief Executive Officer, Chinese Hospital

Attachment 2

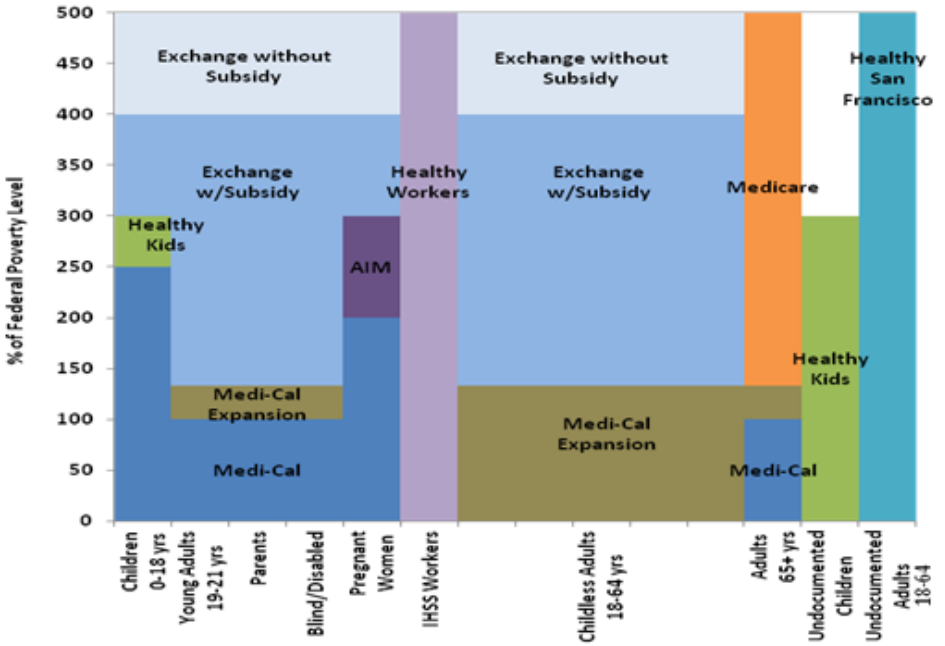
The following is a compilation of key data examined by the 2013 Universal Healthcare Council. Some of the content has been updated to reflect information that became available during the course of the UHC deliberations. More context and detail can be found in the full issue briefs and follow-up materials presented at UHC meetings. The information contained herein represents the City's best understanding to date of a dynamic situation, and some graphs and charts have been updated to reflect changes since the data's original presentation. This information is not intended to serve as legal advice regarding the ACA or the HCSO.

Attachment 2A. State and Federal Programs Available in San Francisco
With full implementation of the Affordable Care Act, new state and federal health coverage options will be created for many San Franciscans.

Current



2014



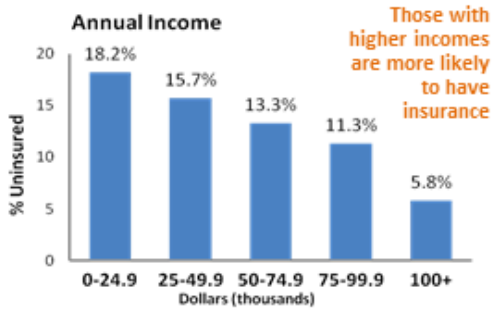
Attachment 2B. Insurance Status in San Francisco

The graphs below detail the characteristics of San Franciscans with and without health insurance. Data reported are from the 2011 American Community Survey for the City and County of San Francisco.

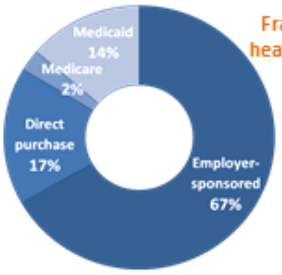
Insured

Most San Franciscans have private insurance

Type of insurance	Age % of San Franciscans			
	Under 18	18-34	35-64	65+
Private	65.2%	72.4%	71.4%	2.9%
Public	26.4%	8.4%	14.1%	51.9%
Public & Private	4.3%	1.1%	2.7%	44.3%
None	4.1%	18.1%	11.8%	0.9%

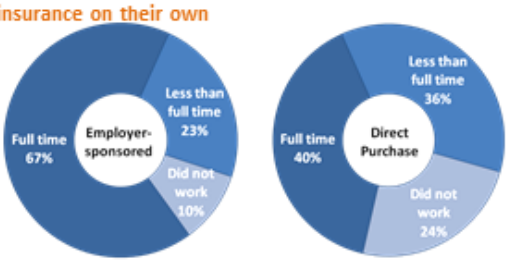


Those with higher incomes are more likely to have insurance



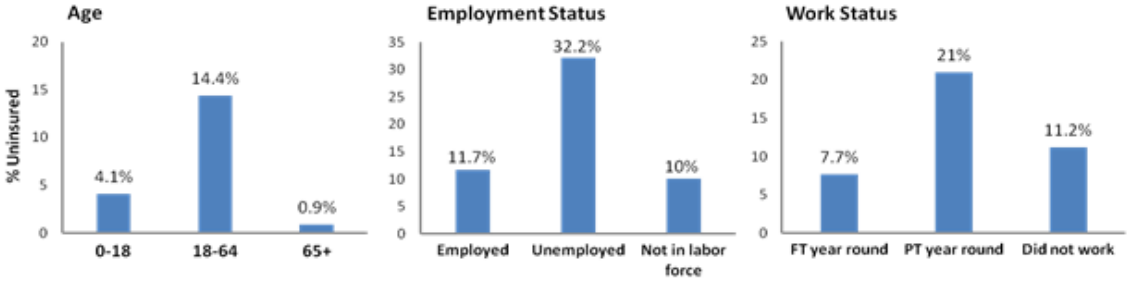
Most San Franciscans get health insurance through employment

Those working less than full time are more likely to buy insurance on their own



Uninsured

Among all San Franciscans, 18-64 year olds, those who are unemployed, and those who work part time have the highest rates of uninsurance



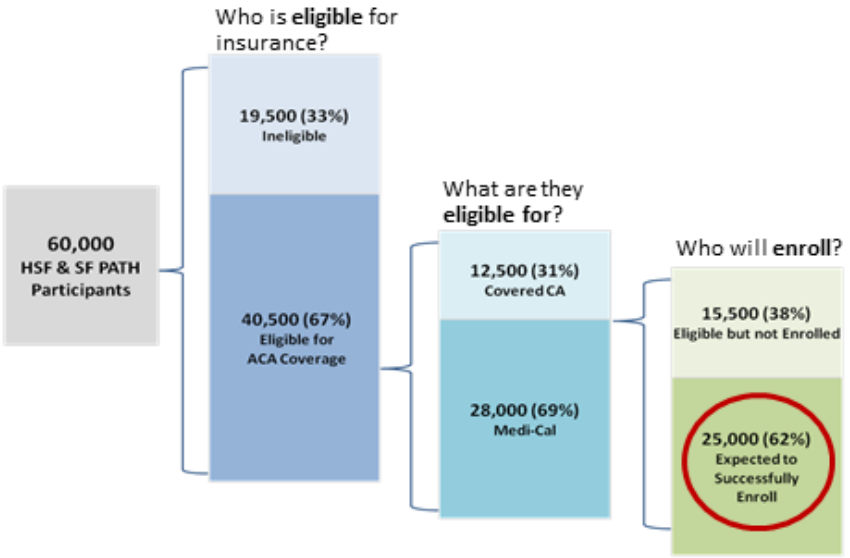
Among those without insurance, the majority are employed, work part-time, and earn less than $50,000 per year

Attachment 2C. Residually Uninsured

a) Of the ~84,700 uninsured San Franciscans, ~60,000 are served by Healthy San Francisco (HSF) and SF PATH, which is a program that will automatically transition enrollees into Medi-Cal in 2014. Given historical uptake rates and experience with the HSF population, approximately 25,000 of current HSF/SF PATH participants are expected to successfully enroll in ACA coverage.

b) Using UC Berkeley's CalSIM model to estimate insurance uptake rates among ~24,700 uninsured persons non enrolled in HSF/SF PATH, DPH estimates that a total of ~49,000 – 53,000 San Franciscans are likely to remain residually uninsured in 2014. The total residually uninsured number reflects persons ineligible for ACA coverage, as well as those who may be eligible but are unlikely to enroll for a variety reasons.

a. Expected Transitions Among Healthy San Francisco (HSF)/SF PATH Participants:

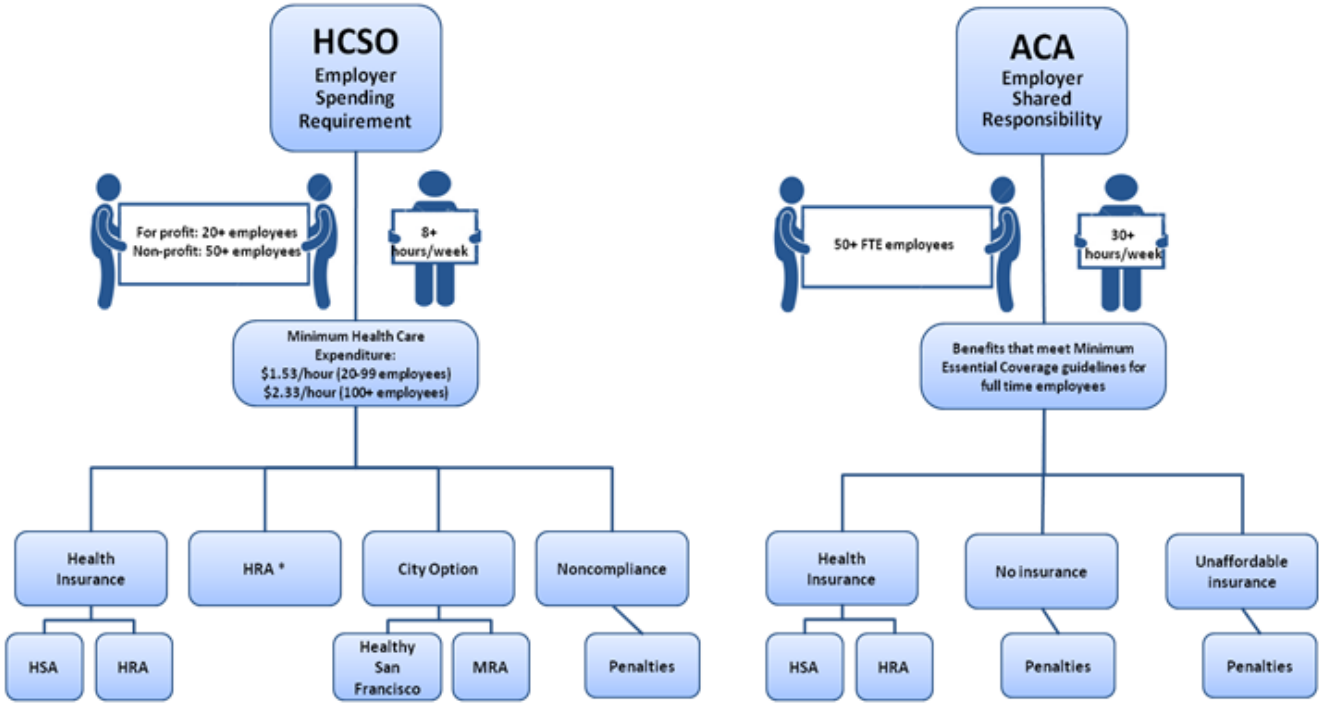


b. Total Residually Uninsured Estimates

	Insurance Uptake Scenario Among Non-HSF Uninsured Population		
Healthy San Francisco Uninsured + non-Healthy San Francisco Uninsured	**Low**	**Mid**	**High**
Total Eligible for ACA	58,722	58,722	58,722
Eligible--Expected to Enroll	31,395	33,607	35,362
Eligible--Likely not to Enroll	27,327	25,115	23,360
Total Ineligible	25,975	25,975	25,975
# of all San Franciscans Residually Uninsured (Ineligible + Eligible Likely not to Enroll)	**53,302**	**51,090**	**49,335**
Residually Uninsured as % of Total Uninsured	**63%**	**60%**	**58%**
Residually Uninsured as % of San Francisco Population aged 18-64	**9.1%**	**8.7%**	**8.4%**

Attachment 2D. Key Employer Provisions under the Health Care Security Ordinance (HCSO) and the Affordable Care Act (ACA)

The HCSO covers a broader range of employers and employees than the ACA, and does not require health insurance as the only mode of compliance.



= Covered Employer

= Covered Employee

HRA = Health Reimbursement Account
HSA = Health Savings Account
MRA = Medical Reimbursement Account

*Effective January 2014, the ACA disallows HRAs that are not integrated with group health insurance.
*Effective January 2014, excepted benefit HRAs will be allowed under the HCSO.

Attachment 2E. Comparison of ACA Employer Provisions and HCSO Employer Spending Requirement

	Large Employer Shared Responsibility under the ACA	Employer Spending Requirement under the HCSO
Effective Date	January 1, 2015	January 9, 2008
Covered Employer	Businesses with 50+ full-time equivalent (FTE) employees	Employers with: one employee working at least 8 hours in SF and: • 20+ employees (medium, for-profit) • 50+ employees (medium, non-profit) • 100+ employees (large, regardless of profit status)
Covered Employee	Working an annual average of 30 hours/week	• Employed for 90+ days; and • Working at least 8 hours/week in SF
Employer Responsibility	• Offer affordable self-only health insurance (defined as covering at least 60% of health costs with employee contribution <9.5% of household income) to all covered employees (defined as at least 95% of FTEs) • Employers with 200+ employees must automatically enroll employees in health coverage. Employee may refuse.	Make minimum Health Care Expenditures (HCE) for all covered employees via: • Health insurance • Health reimbursement accounts • Payments to the City Option • Any combination of the above, or • By any other means that provides health care or reimburses health care costs for covered employees
Minimum Contribution	• Cost of affordable health coverage to 95% of full-time employees; or • Possible penalties	For 2014: • $1.63/hour paid (20-99 employees); $2.44/hour paid (100+ employees) • Capped at 172 hours/month per covered employee • Expenditures must be made w/in 30 days of end of each quarter
Penalties	• For no coverage: $2,000 annually/FTE beyond the first 30 • For unaffordable coverage, lesser of: • $2,000 annually/FTE beyond the first 30; or • $3,000 annually/employee purchasing subsidized coverage on Covered CA	• Failure to make HCE: full compensatory payment to employee and $100/ employee/quarter • Failure to submit annual reporting form: $500/quarter • Retaliation against employees: $100/ targeted employee/day • Not allowing City access to records: $25/employee with missing records/day • Failure to maintain accurate or complete records: $500/quarter
Reporting Requirement	Annual	Annual
Enforcement Agency	United States Internal Revenue Service (IRS)	San Francisco Office of Labor Standards Enforcement (OLSE)

Attachment 2F. HCSO Compliance: The Numbers
The charts below are taken from the Analysis of the 2012 Healthy Care Security Ordinance Annual Reporting Forms, conducted by the Office of Labor Standards Enforcement.

Chart 1: Submissions by Employer Size
(4,204 Total)

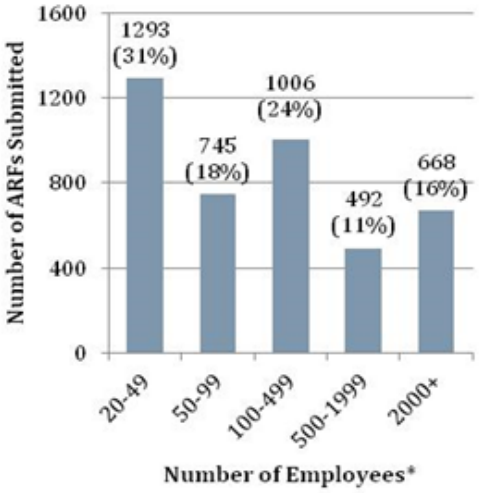


Chart 2: Covered Employees
(263,674 Total Employees)

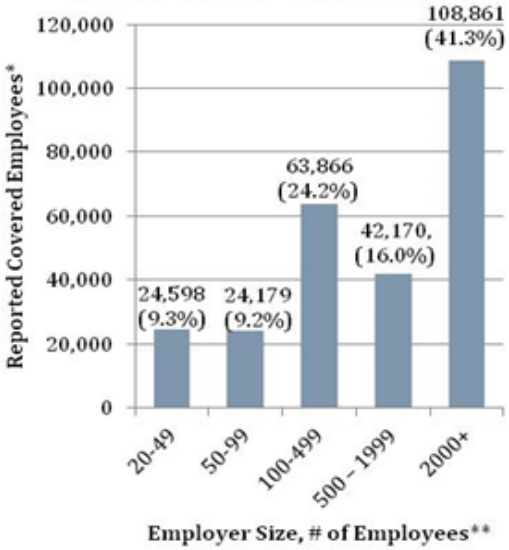
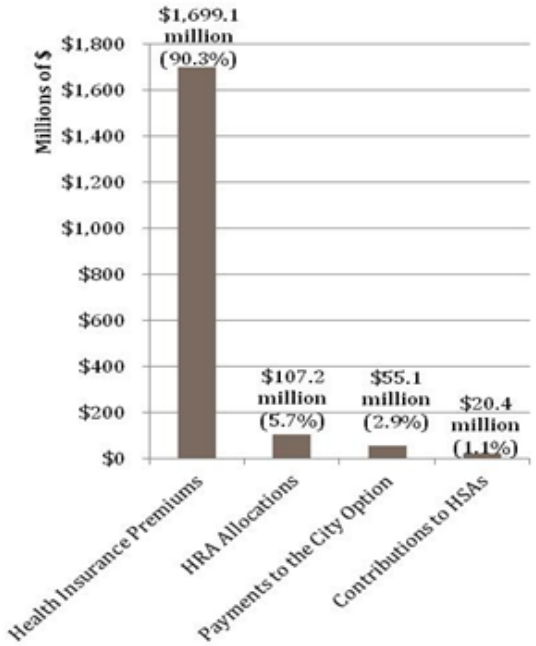


Chart 3: Reported Health Care Expenditures
($1,881.7 Million Total)



In 2012, 4,204 employers made $1.88 billion in health care expenditures to cover 264,674 employees. While 49% of covered employers are small/medium businesses (20-99 employees), 82% of covered employees work for large businesses with more than 100 employees. 90% of all health care expenditures made by employers are for health insurance premiums.

Attachment 2G. HCSO Compliance: The Numbers

The charts below are taken from the Analysis of the 2012 Healthy Care Security Ordinance Annual Reporting Forms, conducted by the Office of Labor Standards Enforcement.

88% of HCSO covered employers offer health insurance to some or all of their employees (a), and use of HRAs is highest among businesses with 20-99 employees (b).

a. COMPLIANCE STRATEGIES

COMPLIANCE STRATEGY	NUMBER OF EMPLOYERS	% OF TOTAL
Health Insurance Only*	2407	57.3%
Health Insurance* + City Option	590	14.0%
Health Insurance* + HRA	720	17.1%
City Option Only	143	3.4%
HRA Only	190	4.5%
Other Strategy	154	3.7%
Total Employers	4204	100.0%

b. EMPLOYERS UTILIZING HEALTH REIMBURSEMENT ACCOUNTS (HRA)

Number of Employees (EEs)	20-49 EEs	50-99 EEs	100-499 EEs	500+ EEs	Total
Employers with HRAs in 2012 (#)	336	212	223	225	996
Employers with HRA in 2012 (%)	26.0%	28.5%	22.2%	19.4%	23.7%
Employers with HRA in 2011 (%)	22.0%	24.9%	17.6%	17.7%	20.3%

By cross referencing the number of Covered Employees receiving Health Insurance with the number participating in HRAs, OLSE estimates that a minimum of 658 employers subject to the HCSO (16% of all) allocated funds to at least one stand-alone HRA in 2012.

c. EMPLOYEES WITH HEALTH REIMBURSEMENT ACCOUNTS (HRA) BY EMPLOYER SIZE

Number of Employees (EEs)	20-49 EEs	50-99 EEs	100-499 EEs	500+ EEs	Total
Employees with HRAs (includes both stand-alone and integrated)	6,112	6,589	11,723	21,627	46,051

By cross referencing the number of Covered Employees receiving Health Insurance with the number participating in HRAs, OLSE estimates a minimum of 35,469 HCSO covered employees (13% of all) had stand-alone HRAs in 2012.

d. EMPLOYEES RECEIVING CITY OPTION CONTRIBUTIONS BY EMPLOYER SIZE

Number of Employees (EEs)	20-49 EEs	50-99 EEs	100-499 EEs	500+EEs	Total
Employees Receiving City Option Contributions	1,401	1,092	2,874	14,335	19,701

Attachment 2H. Comparison of Health Reimbursement Account (HRA) and City Option Medical Reimbursement Account (City MRA)
This chart represents the City's best understanding and interpretation of available federal guidance. It does not constitute legal advice or opinion.

	Health Reimbursement Account (HRA)	SF City Option Medical Reimbursement Account (MRA)
Contribution	Employer	Employer
End of year funds	May roll over. (HCSO requires HRA funds to be available for 24 months from the date of distribution. Employee may opt out of rollover HRA.)	Roll over. (City MRA funds technically revert to the City after 18 consecutive months of non-use. However, in practice, the funds roll over in perpetuity and administratively closed accounts are reactivated at employee's request.)
Considered by ACA to be a group health plan	Yes	No
Funds at termination of employment	Revert to employer. (HCSO requires HRA funds to be available to employees for 90 days after separation from employment.)	Remain available to employee
Restrictions	Employer may restrict benefits	Unrestricted; qualifying expenses defined more broadly than tax-exempt expenses
Types	• Carryover Health Care HRAs • Excepted Benefit HRAs	N/A

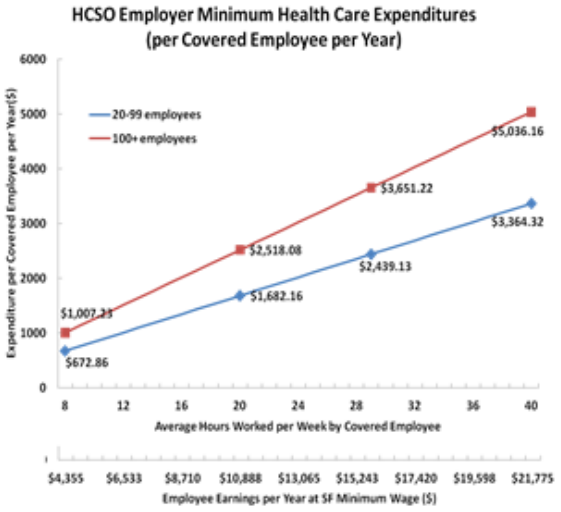
After ACA Market Reforms	• Carryover Health Care HRAs:
	  • qualify as minimum essential coverage
	  • disqualifies individual for premium subsidies on Covered CA
	  • Some disallow insurance premium reimbursements
	• Excepted Benefits HRAs:
	  • Allowable as stand-alone HRA only for excepted benefits (e.g., vision, dental)
	  • Does not qualify as minimum essential coverage
	  • Does not disqualify from individual for premium subsidies on Covered CA
		• Does not qualify as minimum essential coverage
		• May be used toward premiums for individual coverage on Covered CA
		• Does not disqualify employee from accessing income-based subsidies on Covered CA

Attachment 2I. Impact of ACA Insurance Market Reforms on HCSO Compliance Choices

	Employer Impact	Employee Impact
Group health insurance	• Large employer may meet shared responsibility requirement through HCSO if insurance is "affordable" for FT employees • Small employer may be able to leverage tax credit and ESR to provide insurance • May not be available option for some part-time employees • May not be sufficient to meet ESR • Tax favored • Premium payments may be irrevocable	• Employer-sponsored health insurance will be more widely available to employees • Will satisfy individual mandate • May meet ACA definition of affordability without being affordable in practice
HRA	• Employer must also offer health insurance unless employee is covered by spouse's insurance or HRA only covers excepted benefits • Excepted benefits HRA may stand alone • Must be "reasonably calculated to benefit employee" • Tax favored • Unused funds may be returned to employer after 24 months.	• 2013 carryover balances are considered minimum essential coverage • Unrestricted carryover HRA funds may be used to buy unsubsidized insurance on Covered CA • Eligible for subsidies month after spend down or permanent opt out • Excepted Benefits HRA provides only limited benefits to employee
City Option	• No change to employer • Doesn't satisfy shared responsibility provisions under ACA for employers required to offer group health insurance	• Neither HSF nor MRA is minimum essential coverage • Does not satisfy individual mandate • Does not disqualify from premium subsidies • MRA can be used to purchase insurance on Covered CA

Attachment 2J. Financial Considerations-Individuals and Families

The total cost of health care includes insurance premiums and out-of-pocket costs, which include deductibles, co-pays, and co-insurance. For individuals and families, age, income, household size, and employment status are key determinants of the availability and affordability of health care coverage. The ACA imposes limits on annual out-of-pocket costs for individuals and families; however, these costs vary greatly depending on a person's rate of utilization and health status.



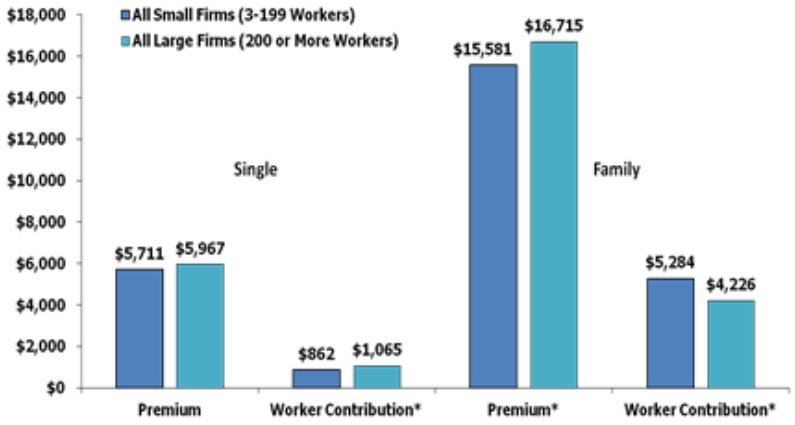
Using 2014 expenditure rates, a person employed full-time in San Francisco can expect between $3,300 and $5,000 in annual health care expenditures from his/her employer, depending on employer size.

Individual Eligibility for Publicly-Subsidized Insurance

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

Depending on wages and work schedule, low- and middle-income persons are eligible for no cost Medi-Cal or for federally subsidized coverage on Covered CA.

Average Annual Worker Premium Contributions and Total Premiums for Covered Workers, Single and Family Coverage, by Firm Size, 2013



* Estimates are statistically different between All Small Firms and All Large Firms (p<.05).
SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2013.

Family coverage can cost two to three times more than single coverage. For out-of-pocket costs, participants in employer-sponsored insurance face average annual deductibles of $1,107/year for individuals and $1700-$4,000/year for families. Other out-of-pocket costs, such as co-pays and co-insurance vary widely by the type of plan.

Attachment 2J. Financial Considerations-Individuals and Families

Costs of health insurance on Covered CA can be greatly mitigated for persons who are eligible for subsidized coverage (earning between 138-400% of FPL). Subsidies are tethered to the cost of the second-lowest cost silver plan, but may be used to purchase any plan. However, persons earning less than 250% of FPL are eligible for additional cost-sharing subsidies if they purchase the silver plan.

Cost of Plan Premiums on Covered CA by Household Size and Income

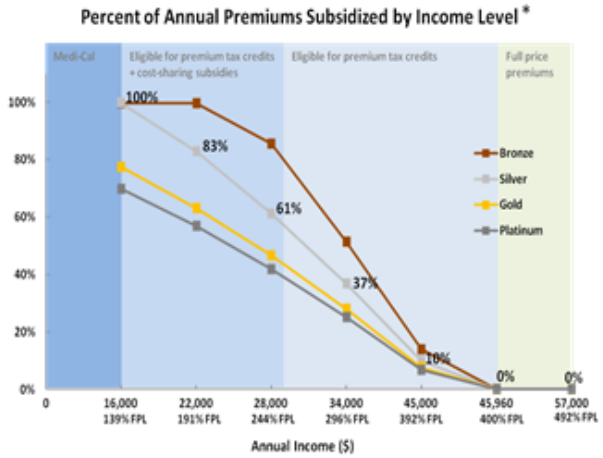
Household Size: 1 Age: 42 Annual Income	Premium Tax Credit ($/month)	Final Cost ($/month)			
		Bronze	Silver	Gold	Platinum
$16,000 (139% FPL)	$243-346	$1	$1-93	$101-179	$150-283
$22,000 (191% FPL)	243-282	1-42	58-157	165-242	213-347
$28,000 (244% FPL)	208	35-116	132-231	239-317	288-421
$34,000 (296% 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

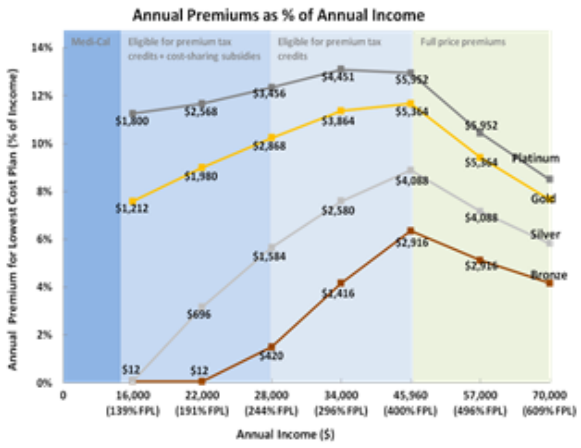
*Child may be eligible for Medi-Cal for incomes up to 250% of FPL.

**The subsidy in this case is higher at the higher income because it now includes the subsidy for the child, who was eligible for Medi-Cal at lower incomes.

At incomes below 250% of FPL, the combination of premium assistance tax credits and cost-sharing subsidies significantly reduces enrollee costs.



*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.



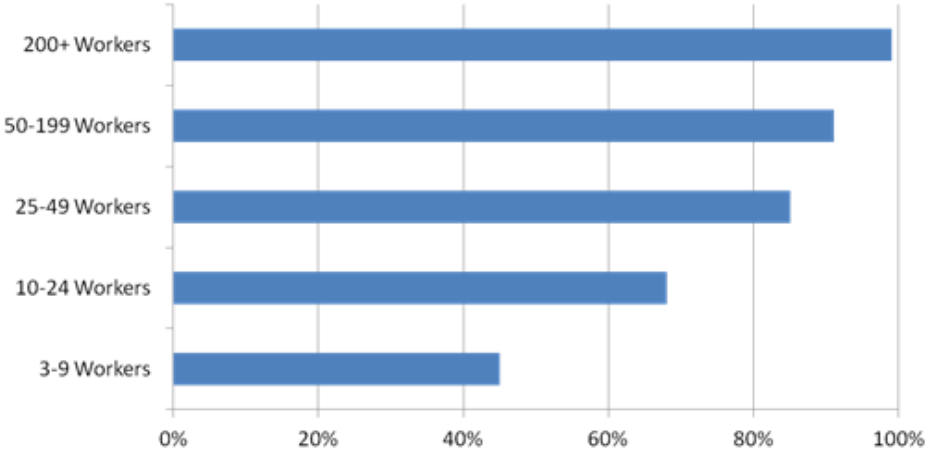
*Curves based on maximum allowable annual tax credit and price of lowest cost plan in each tier for a 42-year old San Francisco resident. Dollar values reflect annual price of premiums only; out-of-pocket costs are not included.

As household income surpasses 250% of FPL, the amount of the subsidy declines sharply and cost-sharing assistance is no longer available (left graph). Effectively, this means that persons earning near 400% of FPL are likely to pay a higher percent of their annual income toward premiums than persons earning more or less than 400% of FPL (right graph). Below 400% of FPL, subsidies reduce cost, and above 400% of FPL, the cost is mitigated by higher incomes.

Attachment 2K. Financial Considerations-Employers

For employers, the ability to offer health insurance depends largely on business size and employee demographics. Larger businesses often have more full-time employees and the strength of numbers to negotiate lower rates than small businesses.

Percentage of Firms Offering Health Benefits, by Firm Size, 2013



SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits 2013

The larger an employer is, the more likely it is to offer health insurance to its employees.

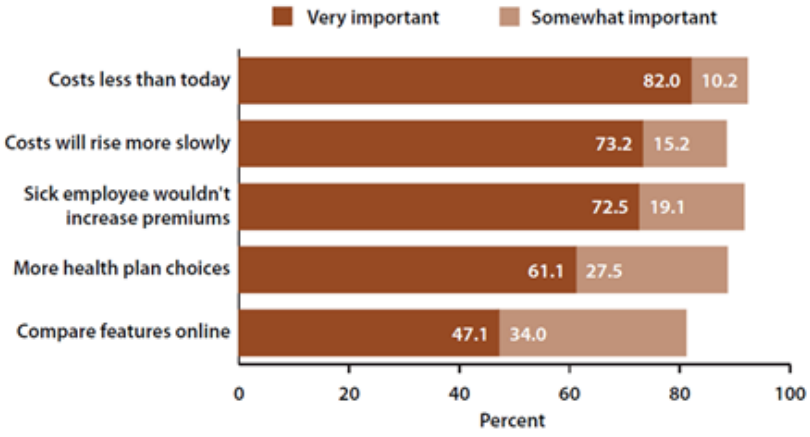
Health insurance for small business has:

Higher admin costs

More volatile pricing

Lower value products

Importance to Nonoffering Firms When Considering Whether to Offer Insurance



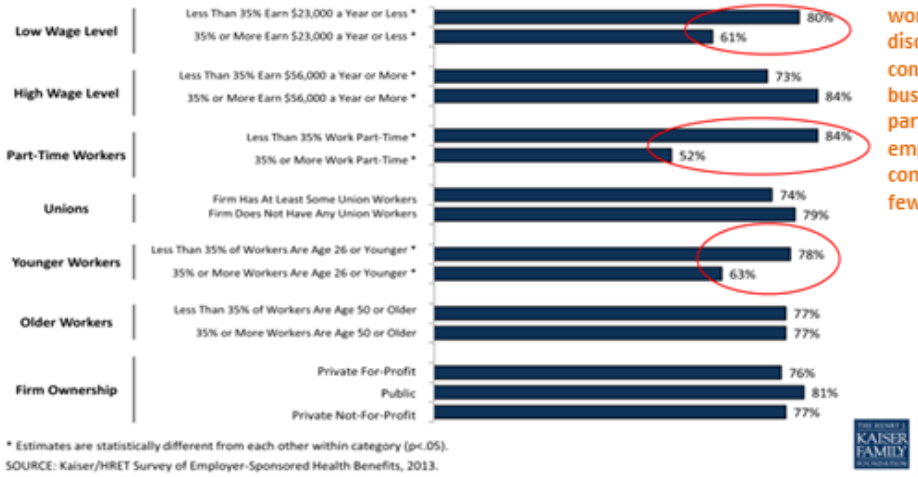
Data: Commonwealth Fund/NORC 2013 Survey of Small Employers.
Source: Adapted from J. R. Gabel, J. Pickreign, H. Whitmore et al., "Small Employer Perspectives on the Affordable Care Act's Premiums, SHOP Exchanges, and Self-Insurance," *Health Affairs* Web First, published online Oct. 16, 2013.

Small businesses cite cost as the most important consideration in offering insurance.

Attachment 2K. Financial Considerations-Employers

Employee demographics strongly affect whether employees are eligible for insurance (as deemed by the insurance plan) and whether employees participate in an employer-sponsored plan.

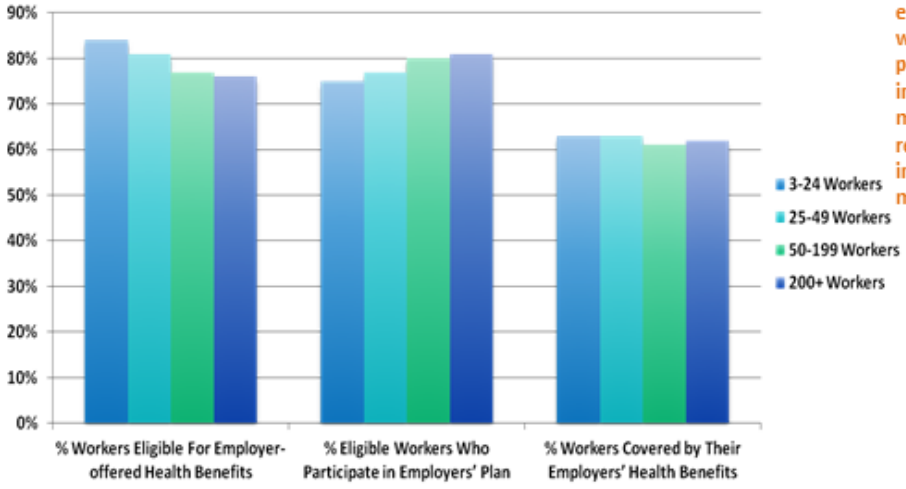
Exhibit 3.3
Among Workers in Firms Offering Health Benefits, Percentage of Workers Eligible for Health Benefits Offered by Their Firm, by Firm Characteristics, 2013



* Estimates are statistically different from each other within category (p<.05).
SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2013.

Fewer employees are eligible for health benefits at firms that have high proportions (35% or more) of low-wage workers, part-time workers, and younger workers. The discrepancy is most evident when considering part-time employees: at businesses that have more than 35% part-time workers, only 52% of employees are eligible for insurance, compared to 84% at businesses with fewer part-time workers.

Eligibility, Take-Up Rate, and Coverage in Firms Offering Health Benefits by Firm Size, 2013



SOURCE: Kaiser Family Foundation, Employer Health Benefits Survey 2013, Exhibit 3.2

Although more employees are eligible for insurance at businesses with fewer than 49 employees, the percent of employees participating in the plan is higher at firms with more than 49 employees. This is a reflection of higher costs for insurance in the small business market.

Attachment 2L. Financial Considerations-Public Health Care System

The cost of providing care to uninsured persons is passed on to the local public health system. The San Francisco Department of Public Health (DPH) 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**