STATUS REPORT ON THE IMPLEMENTATION OF THE SAN FRANCISCO HEALTH CARE SECURITY ORDINANCE

A Joint Report of
The Department of Public Health and
The Office of Labor Standards and Enforcement

Submitted to the
San Francisco Board of Supervisors

January 31, 2007

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EXECUTIVE SUMMARY

In July 2006, the San Francisco Board of Supervisors adopted the San Francisco Health Care Security Ordinance (Ordinance No. 218-06) which creates two new City and County programs, the Employer Spending Requirement (ESR) and the Health Access Program (HAP). The Office of Labor Standards and Enforcement (OLSE) oversees the implementation of the ESR while the Department of Public Health (DPH) oversees the implementation of the HAP.

Significant progress has been made toward the implementation of the Health Care Security Ordinance. Specifically: draft ESR regulations, and draft HAP design rules and program recommendations have been developed. Both DPH and OLSE are working towards a July 1, 2007 launch for HAP and ESR, respectively. The HAP will be phased-in incrementally. An incremental process is necessary given the complexity of the implementation and to provide an opportunity to make appropriate adjustments and modifications in the program as necessary.

Since the signing of the Ordinance, both DPH and OLSE have worked to ensure that the public is keep abreast on the implementation of the ESR and HAP, websites have been created to provide the public with information and updates (www.sfgov.org/site/olse_index.asp?id=45168 and www.sfhap.org). Both organizations have obtained feedback from interested parties including employers, providers, advocates and others.

Information obtained from employer focus groups and broker interviews suggest a need to modify the Health Access Program component of the Ordinance to ensure that it does not create a barrier to employer participation. As designed, HAP participation is limited to residents and contains a San Francisco-based network of providers. Various focus group participants felt that the residency requirements, a limited network, lack of coverage outside of San Francisco and/or the additional burden of administering a small number of employees were disadvantages to contributing to the HAP. Employers indicated that they would be much more willing to contribute to the HAP if it would benefit all their employees instead of only their San Francisco resident employees

To address this finding, DPH recommends that the Health Care Security Ordinance be amended to create a Flexible Spending Account option under the Health Access Program for non-resident workers of employers subject to the Employer Spending Requirement. With this feature, San Francisco employers with both resident and non-resident workers who elect to participate in the HAP would send their health care expenditures to one single place. Once the expenditures are received, the employer's resident workers would become HAP participants and their non-resident workers would receive a FSA.

In addition to DPH, OLSE, the San Francisco Health Plan and the Health Access Program Advisory Committee are in favor of modifying HAP in this manner to strengthen the Program and address the issues raised in the employer focus groups and broker interviews.

I. INTRODUCTION

An estimated 82,000 adult residents are uninsured. These residents have limited access to routine preventative care, delay seeking treatment when ill, suffer from poorer health outcomes and ultimately rely on more costly episodic or emergency care for health conditions that could have been treated in primary care settings. Whenever care is needed, uninsured residents must navigate a cumbersome and fragmented delivery system comprised of public and non-profit providers.

In July 2006, the San Francisco Board of Supervisors adopted the San Francisco Health Care Security Ordinance (Ordinance No. 218-06) which creates two new City and County programs, the Employer Spending Requirement (ESR) and the Health Access Program (HAP). The programs work in tandem and are designed to address the health needs of San Francisco's uninsured residents and workers. The law goes into effect on July 1, 2007 for San Francisco employers with 50 or more employees and on March 31, 2008 for employers with 20-49 employees. Non-profit employers with 20 – 49 employees are exempt from coverage under the law.

The ESR requires medium and large businesses to spend a minimum amount on health care for their employees. Employers have flexibility in how they make their required expenditure, as long as it used for health care for their employees. In order to provide affordable health care options, the Ordinance also created the HAP. HAP is a health care program that, though not health insurance, will provide participants with access to comprehensive health care services, their own doctor, and protection from large medical bills. Participating in HAP will be a way for employers to fulfill their ESR obligation and provide a benefit to their employees.

The Health Care Security Ordinance (Ordinance) requires the City and County to develop and promulgate regulations governing both aspects of the programs – the ESR and HAP. The Ordinance specifies the roles and responsibilities of various City and County agencies in the development and maintenance of this Ordinance. They are:

- Office of Labor Standards and Enforcement (OLSE) – Enforces the ESR provisions.
- Department of Public Health (DPH) – Administers the HAP.
- Controller's Office – Ensures that any required health care expenditures made by an employer to the City are kept separate and apart from general funds and limits use of these funds to the HAP. Coordinates with DPH and OLSE to prepare periodic reports.
- Office of Treasurer and Tax Collector – Provides to OLSE any and all non-financial information necessary for OLSE to fulfill its responsibilities as the enforcing agency.

The Ordinance specifies regular reporting to the Board of Supervisors on the status of both programs. Quarterly reports are required during the period from July 1, 2007 through June 30, 2008. From July 2008 through June 2010, reports are then submitted on a bi-annual basis. The reports are a joint submission of the OLSE, DPH and

Controller's Office. The Ordinance states that OLSE and DPH will report to the Board of Supervisors by January 31, 2007 on the development of rules for the Health Access Program and for the enforcement and administration of the employer obligations.

This joint report of OLSE and DPH meets the January 31, 2007 mandated reporting requirement. It provides the proposed rules for the ESR and the proposed rules for the HAP. Both OLSE and DPH stress that the rules are at a drafting stage and may be subject to modification based on feedback from policy officials and bodies, key staff designing and implementing both programs, and the general public.

II. EMPLOYER SPENDING REQUIREMENT

Pursuant to Section 14.4(h) of the Ordinance, this section provides an update on the development of rules for the enforcement and administration of the employer obligations under the HCSO.

Since the passage of the Health Care Security Ordinance, the Office of Labor Standards Enforcement (OLSE) has taken the steps necessary for successful administration and enforcement of the Ordinance.

The OLSE has hired Joannie C. Chang as lead staff for implementation of the Ordinance. Ms. Chang was most recently the Director of Employment & Labor Projects at the Asian Law Caucus (ALC), where she represented numerous immigrant and low-wage workers in wage and hour cases, including minimum wage and overtime claims with the Division of Labor Standards Enforcement and in both state and federal courts. Before joining the ALC, she was the Ruth Chance Law Fellow at Equal Rights Advocates and a Staff Attorney at The Legal Aid Society - Employment Law Center. In addition to litigating Title VII and FMLA/CFRA cases, Ms. Chang has drafted, testified, and lobbied for the passage of the first comprehensive paid family leave law in the nation.

The OLSE has also established a number of tools to assist the public with understanding its rights and obligations under the Ordinance, including a multi-lingual dedicated phone line (554-7892) and an e-mail address (HCSO@sfgov.org) to answer questions about the Ordinance. The Office has also created a page on its website with useful information to assist the public in understanding the law (http://www.sfgov.org/site/olse_index.asp?id=45168).

In addition to responding to telephone and e-mail inquiries, the OLSE has held several meetings, with representatives of several temporary staffing agencies and an employer human resources consultant, to discuss their questions and concerns regarding the Ordinance. The OLSE is also exploring a partnership with Mayor's Office of Economic and Workforce Development to develop the education and advice program to assist employers with meeting the requirements of the law, as required by Section 14.4(b) of the Ordinance.

The OLSE has developed and distributed a one-page Notice to Employers informing employers of their obligations under the Ordinance (Attachment A of this Report). This Notice was included in the Treasurer& Tax Collector's annual business registration mailing, sent to approximately 100,000 employers conducting business in San Francisco this January. The Notice is also available for download from the OLSE's website.

Working closely with the Deputy City Attorneys, the OLSE has completed the first draft of the Rules and Regulations for the Health Care Security Ordinance (Attachment B of this Report). On January 31, 2007, this first draft will be posted on the OLSE website.

By mid-February, the OLSE aims to have completed a mailing of a notice of the availability of the draft Rules to stakeholders, which will also invite public input in the form of written comments and/or public testimony at any of a series of public hearings. Following the mailing, the OLSE will hold a series of public hearings on selected topics for which the Office believes targeted input will be helpful, with an open period at the end of each hearing for comments on any segment of the Rules and Regulations.

Finally, the OLSE continues to partner with the Department of Public Health on implementation of the San Francisco Health Access Program. The Office has a seat on the HAP Advisory Committee and regularly attends the meetings of the Committee.

III. HEALTH ACCESS PROGRAM

This section provides an update on the development of rules for the Health Access Program (HAP). The Department of Public Health (DPH) is responsible for implementing and administering HAP.

An estimated 82,000 San Francisco adult residents are uninsured. Under State law (California Welfare and Institutions Code Section 17000) California counties are required to relieve and support poor and indigent residents and provide medically necessary services. In the area of health services, San Francisco has met this obligation through the Sliding Scale Program administered by DPH. As a public health care safety net system, DPH provides primary, urgent, specialty and inpatient services through the City and County's community clinics and public hospital (San Francisco General Hospital).

DPH data indicates that approximately 50,000 adult uninsured San Francisco residents participated in the Sliding Scale Program and were seen at DPH facilities during the 2005-06 Fiscal Year. Thus, 61% of all uninsured adult residents rely on the public safety net system for routine or episodic care. The remaining uninsured (39%) may seek services from other safety net providers (i.e., community clinics or disproportionate share hospitals), traditional providers, hospitals offering charity care, private physician's offices (self-pay) or simply do not obtain care at all.

While DPH and other community providers have strong reputations in the community for providing quality care, improvement is needed in the overall safety-net delivery system, eligibility and enrollment processes, and service levels. The City and County recognizes that San Francisco's public and non-profit providers cannot continue to deliver services in the same manner to uninsured residents. The current system is not readily accessible -- it is not transparent with regards to where care is available, how to access it and how much it will cost. It does not promote care coordination through a medical home and more often provides episodic care. The HAP is designed to transform the public and non-profit health care safety-net system.

A. What is the Health Access Program (HAP)?

The HAP is the catalyst for changing the current system of care for uninsured residents. It is an innovative medical care program designed to expand access to health services and deliver appropriate care to San Francisco's uninsured adult residents. HAP provides a package of services, promotes choice of providers, recognizes the importance of affordability, and maintains a focus on accountability. HAP addresses both access to and management of care. Under the HAP, the safety-net system is restructured from a crisis delivery approach into one that:

- emphasizes prevention and primary care,
- ensures the availability of a medical home (i.e., a designated primary care clinic or provider that will function as the usual source of care for an uninsured person),
- decreases the challenges in navigating the care system,
- targets management of care,
- increases access to appropriate care and
- reorganizes the client registration systems and eligibility processes to be more customer-friendly, administratively efficient, and fiscally productive.

HAP will also improve patient tracking which provides the basis for improving the quality and coordination of care, and thus improved health outcomes.

HAP is designed to provide an affordable alternative to health insurance. While HAP provides a comprehensive scope of services, emphasizes primary care and prevention, promotes choice of providers and offers health plan participation, it is not health insurance because:

- it is fundamentally a restructuring of the county indigent health system to encourage preventive care and primary care, and coordination of ongoing care,
- although individuals in HAP participate in the SFHP, the health plan will bear no financial risk for the payment of services (the City and County of San Francisco [CCSF] will be the payor of last resort given that HAP is a restructuring of the indigent care program),
- services rendered outside the CCSF will not be provided or paid and those rendered by non-HAP providers will not be paid for,
- it uses an income-based fee structure to determine the financial contribution of HAP participants (this structure does not exist for private health insurance products) and

- HAP participants must be ineligible for coverage under Medi-Cal and other publicly-funded health insurance programs.

B. HAP Design Rules and Program Recommendations

In developing the design rules and program recommendations, DPH collaborated with and received input from a number of other entities to ensure that HAP is implemented appropriately. Its planning activities have included staff from the San Francisco Health Plan (SFHP), the Human Services Agency (HSA) and the Office of Labor Standards and Enforcement (OLSE). In addition, the Health Access Program Advisory Committee, which is mandated by the Ordinance, provides DPH with expert consultation and direction on HAP matters. Finally, as part of a more comprehensive consulting engagement for DPH coordinated by the City Controller's Office, the City and County entered into a contract with The Lewin Group to do specific analyses for HAP development. Policy, program and financial issues regarding the HAP are reviewed by the San Francisco Health Commission as DPH's governing body.

The recommended HAP design components that follow were developed through an interagency planning committee process comprised of staff from DPH, SFHP, OLSE and HSA. These design recommendations outline the rules and program recommendations for HAP. To provide context with respect to the recommendations, the summaries below indicate whether the recommendation changes current practice, policy or programs.

1. Eligibility

Eligibility rules and regulations are important because they define the scope of the program and provide potential HAP participants with critical information regarding their eligibility. In the area of eligibility, the following HAP rules are recommended:

HAP Eligibility Rules Recommendations

Category	**Proposed HAP Program Rule and Regulation**	**Change from Current Safety Net System (Public and Non-Profit)**
Age	Adults aged 19 – 64	None; adults 65 and over are generally eligible for Medicare and will be assisted in application process
Eligibility Period	12 months with re-determinations: • Every 12 months for those with incomes at or above 101% FPL • Every 6 months for those with incomes at or below 100% FPL	Yes; more frequent re-determinations for those with incomes at or below 100% FPL to ensure person not eligible for public health insurance programs
Income Limit	Up to 500% of the Federal Poverty Level before no longer eligible for subsidization	No change for current DPH Sliding Scale program which goes up to 500% FPL. Some community clinics limit sliding scale to those at and below 200% FPL.
Insurance Status	Uninsured	None
Public Coverage	Willingness to apply for public coverage and determined ineligible	None
Residency	San Francisco resident irrespective of immigration status	None

2. Program Provisions

The following grid summarizes key program provisions. These are less regulatory in nature and more programmatic to set the parameters of the program and define the available benefits. Consistent with the recommendations of the Universal Healthcare Council, a comprehensive set of health benefits is recommended. In keeping with the Ordinance, HAP will not offer cosmetic, dental, infertility or vision services.

HAP offers participants many health plan services through a partnership with the San Francisco Health Plan (SFHP), a long-standing partner of the CCSF. SFHP is a governmental not-for-profit health maintenance organization that was created by the CCSF in 1994 to increase access to health care by providing affordable health insurance to low and moderate income San Franciscans. Under the HAP, all uninsured adult residents will become participants in SFHP and have access to a more organized service delivery system. The HAP benefits from this arrangement because the SFHP is well-equipped to help DPH ensure that all individuals have a medical home, track and monitor quality of care, promote primary and preventive care, increase individual understanding of health, and promote the availability of services. Without a link to a health plan, there are limited opportunities for utilization management, member services or population-based monitoring and planning that can drive improvements to care and access. Without such a link, the uninsured population is not assured case management, health education and promotion, or quality monitoring and improvement in a systematic way.

In the area of program provisions, the following components are recommended:

HAP Program Provision Recommendations

Category	**Proposed HAP Program Rule and Regulation**	**Change from Current Safety Net System (Public and Non-Profit)**
Health Services	HAP participants will receive preventive care, primary care, specialty care, urgent care, emergency care, behavioral health, home health, laboratory, inpatient, x-ray, care/case management and prescription drugs	None
Administration of Behavioral Health Services	DPH's Community Behavioral Health Services will administer behavioral health services (mental health and substance abuse), develop the network of providers, ensure payment of providers and oversee utilization management	None
Care/Case Management	All participants will have access to improved care and case management offered via the SFHP	Yes; not uniformly available from safety net and traditional providers
Health Plan Participation	All uninsured adult residents will participate in the SFHP	Yes; currently no health plan participation
Health Plan Membership Card	All uninsured adult residents will receive identification card from SFHP with participation	Yes; no identification cards are currently provided

Category	Proposed HAP Program Rule and Regulation	Change from Current Safety Net System (Public and Non-Profit)
Health Promotion and Education	All participants will have access to improved health promotion and education offered via the SFHP	Yes; not uniformly available from safety net and traditional providers
Medical Homes	100% of HAP participants will have medical homes (i.e., have a designated primary care clinic or provider to deliver services)	Yes; uninsured residents lack a usual source of care; 60% of DPH patients have medical homes
Member Services Call Center and Member Materials	All HAP participants will receive access to the SFHP Member Call Center for inquiries, to change providers and to resolve problems. Participants will also receive member materials that include a list of covered services, a list of available providers with location, operating hours, language ability, etc; a list of participant fees and/or point of service charges	Yes; not provided
Utilization Management and Quality Improvement	SFHP's Utilization Management and Quality Improvement Programs will monitor, and evaluate quality of care and work with DPH to improve access and health delivery, focusing on primary and preventive care	Yes; capacity to undertake quality improvement activities limited within safety net and traditional providers

3. Participant Fees

Consistent with current provisions, HAP participants will pay contributions in the form monthly participation fees and/or co-payments when accessing health services. Participant fees are tiered to family income and are designed not to discourage participation or accessing services. With respect to point of service/co-payment fees for pharmacy and primary care visits, this issue is still under discussion and review and therefore a final recommendation has not yet been developed. In the area of behavioral health the point of service fee structure will be consistent with the Uniform Methods of Determining Ability to Pay (UMDAP) outlined by the State of California.

HAP Participant Fee Recommendations

Category	Proposed HAP Program Feature	Change from Current Safety Net System (Public and Non-Profit)
Participant Fee	*Income Level* — *Monthly Fee* 0 – 99% FPL — $0 100 – 199% FPL — $20 200 – 299% FPL — $50 300 – 399% FPL — $100 400 – 499% FPL — $150	• Difficult to ascertain since providers may or may not have monthly fees • For DPH – fee structure is similar to existing Sliding Scale program taking into account current fees and service utilization
Point of Service Fees	*Service* — *<100% FPL* — *>100% FPL* Primary Care — TBD — TBD Urgent Care — $10 — $10 Specialty — $15 — $15 Drugs — TBD — TBD ER (waived w/ admit) — $25 — $50 Hospitalization — $0 — $200	Difficult to ascertain since there is no uniform point of service fee schedule used by all safety net and traditional providers serving uninsured residents

C. Remaining Program Issues Still Under Consideration

At this time, DPH is still considering recommendations on the following program components:

- Program Phase-In: The HAP will be phased-in. An incremental process is necessary given the complexity of tasks needed to implement the program. Significant systems change cannot be accomplished in "one giant leap;" moreover, the phase-in process provides an opportunity to make appropriate adjustments and modifications in the program, as necessary. Phase-in is needed for: (1) those uninsured who are currently within the DPH system as participants in the Sliding Scale program, (2) those who currently receive services from health centers affiliated with the San Francisco Community Clinic Consortium, (3) those who may use other providers or not seek care at all and (4) those who participate via their employer's selection of HAP to meet the Employer Spending Requirement. At this time, DPH is exploring three phase-in approaches for the uninsured residents transitioning from the Sliding Scale program into HAP:
    1. by annual re-certification: to phase in the estimated 2,000 – 2,500 Sliding Scale clients who complete the re-certification on a monthly basis,
    2. by clinic: to phase in all clients receiving services from a clinic and phasing in one clinic at a time or
    3. by beginning with the transition of all those under 100% of the Federal Poverty Level into HAP given that no monthly participant fee is recommended for this population.

- Provider Network: The HAP is a city-wide effort and therefore its provider network should be broader than DPH. It should include other community clinics, private providers and non-profit hospitals. Non-DPH provider interest in participating in HAP will be based on reimbursement rates, method of reimbursement and risk (i.e., expected utilization compared with adequacy of reimbursement). DPH currently services approximately 50,000 of the estimated 82,000 uninsured adult residents. DPH has the capacity to serve another 12,000 individuals in the primary care setting and provide roughly 4,200 – 4,500 specialty care visits in medical and surgical sub-specialties with additional resources (i.e., staff and/or extended hours). Additional providers will be needed for the delivery of services to the HAP population. The provider network will be developed and monitored by the San Francisco Health Plan. SFHP and DPH are meeting with providers to ascertain their interest in participating and at what levels. Many are supportive of HAP and its goals. While the provider network is still under development, two principles have been agreed upon:
    1. HAP will be launched with a provider network which is broader than DPH.
    2. Timing of the incorporation of consortium clinics and other private networks will be aligned to meet health needs and the number of HAP participants.

D. Other Planning Activities

In addition to the programmatic issues described above, the following has occurred:

- The first phase of an external communications plan has been implemented. The San Francisco Health Plan (SFHP) has taken a lead role in this effort. In addition, both SFHP and DPH have their own internal communications plan to keep staff apprised of HAP's development. The San Francisco Health Access Program website was launched in August 2006 (www.sfhap.org).

- Under the HAP, CCSF will enter into a vendor arrangement with SFHP, via DPH, to administer the HAP. The agreement will outline the scope of activities to be performed by SFHP, reporting requirements and reimbursement mechanism. DPH and SFHP have agreed on the functional responsibilities that will be under the purview of SFHP and will constitute the outline of a scope of services.

E. Finance and Budget Issues

DPH notes that implementation of HAP will require increased expenditures, but will also provide increased revenue to cover the cost increases. Expenditures increase with HAP implementation because it entails serving more uninsured individuals, revamping eligibility and registration processes, enhancing information technology systems, expanding access (clinical hours, services and staff), increasing the number of providers serving the population and contracting with a vendor to administer the program. All of these components have additional associated costs. To assist in the planning of the Ordinance, the City and County appropriated $1 million to DPH – with $724,000 allocated to the San Francisco Health Plan, $228,000 to DPH and $48,000 to the Office of Labor Standards and Enforcement.

DPH has developed initial estimates with respect to start-up and ongoing costs of the HAP for a three-year period. At this time, DPH anticipates HAP will be budget neutral once implemented – that is, expected cost increases will be covered by anticipated revenue increases. The incremental cost estimates along with the revenue projections are as follows:

Estimated HAP Cost and Revenue Projections

Year	Increased Cost	Increased Revenue	Less Planning Appropriation	Net Impact
Planning	$4.6 mil	$900K	$1 mil	($2.7 mil)
Year 1 (7/07 – 6/08)	$8.70 mil	$9.55 mil	$0	$850K
Year 2 (7/08 – 6/09)	$26.41 mil	$27.16 mil	$0	$750K
Year 3 (7/09 – 6/10)	$31.41 mil	$32.08 mil	$0	$670K

A significant cost component in the planning period is information technology development. Significant changes in the information technology enterprises of both the Department and the San Francisco Health Plan are needed. Changes include, but are not limited to, developing and/or enhancing billing systems, eligibility and enrollment

systems, provider payment systems and centralized patient registration. Appropriate assessment, development and installation of selected IT products will require staging, pre-production and production to ensure that the systems work properly. Without appropriate time and resources to operationalize the IT changes, successful implementation of HAP may be severely jeopardized.

The source of those funds has been defined in broad terms (e.g., employer contributions, participant fees, additional State funds). Note that the revenue estimates above do not include estimates from employer contributions. DPH believes that without more definitive information on how employers will fulfill the ESR, it is prudent to exclude this funding from the initial revenue estimates until there is at least one year of ESR experience to inform any expectation of new revenue from employers. The financing estimates assume no reduction in General Fund support to DPH for services to uninsured persons.

With respect to additional State revenue, earlier this month DPH submitted a competitive application for federal funding under the State Health Care Coverage Initiative. The purpose the Initiative is to extend health care coverage to individuals who are currently uninsured. Funding decisions will be made in March 2007. DPH is hopeful that its application will be selected for funding. DPH was conservative with respect to the allocation of funds from this funding source in additional revenue. DPH notes that receipt of these funds will require the City and County to adhere to federal Medicaid rules and regulations regarding citizenship verification, similar to those that exist for the Medi-Cal program administered by the Human Services Agency. As a result, while undocumented persons would still be able to participate in the HAP, San Francisco, if successful in its application, could not use any funding that it received under the Initiative to provide services to this population.

IV. LINKING THE EMPLOYER SPENDING REQUIREMENT AND THE HEALTH ACCESS PROGRAM

It is unlikely that all employers subject to the Employer Spending Requirement (ESR) will choose to purchase health insurance on behalf of their employees to meet the mandate of the Ordinance, due to employer preference and affordability issues (particularly among medium sized employers with 20 – 49 employees). The HAP was designed to provide a viable health care option for employers needing to ensure access to health services for their employees; thus DPH and OLSE anticipate that some employers will choose to satisfy their ESR by paying for their covered employees to participate in HAP. Although there are no solid estimates with respect to the number of employers that may select the HAP to meet the ESR obligation, systems must be put in place to link the ESR to the HAP and ensure that such employees are able to participate in the HAP.

All parties spent significant and valuable time exploring linkage options that would: (1) enable employer payments into HAP, (2) provide employees with services, (3) be

administratively simple, (4) support a non-insurance model and (5) discourage crowd out. The recommended approach is that employees (of employers who elect to pay their spending requirement to the HAP) will be enrolled as individuals and offered discounted participant fees.

The Health Care Security Ordinance (Ordinance) addresses two distinct populations, namely:

Program	Population
Employer Spending Requirement	All uninsured San Francisco workers irrespective of their county of residence (i.e., includes non-residents)
Health Access Program	Limited to uninsured San Francisco residents (working and non-working)

The populations in both programs do not overlap entirely, but are more accurately depicted by two partially overlapping Venn diagrams such that some portion of the population is comprised of: (1) non-resident workers, (2) uninsured working residents and (3) uninsured residents (some may be working for employers not subject to the ESR or not working). As a result, the available options to full the ESR are not the same for the two populations, namely:

Available Options for Employers to Fulfill ESR	Uninsured San Francisco non-resident workers	Uninsured San Francisco resident workers
Payments to a third party to provide health care services for covered employees	Available	Available
Contributions on behalf of a covered employee to a health savings account	Available	Available
Reimbursement to a covered employee for expenses incurred in the purchase of health care services	Available	Available
Costs incurred in the direct delivery of health care services for covered employees	Available	Available
Payments of behalf of covered employees to the Health Access Program	Not Available	Available

Recent findings from employer focus groups and broker interviews held in November 2006 suggest that improvements in HAP could facilitate employer participation. The findings also compromised DPH's ability to develop estimates of employer participation in HAP. The purpose of the focus group research was to learn what would influence an employer's choice to comply with the ESR. In addition, the research sought to gauge: (1) the overall reaction to HAP and ESR and (2) which option(s) would be likely chosen to comply with ESR and what motivators are behind the selection. This research was supported with the generous financial support of Blue Shield of California Foundation.

Key findings from the research were:

- Employers found the Ordinance very complicated and although some were appreciative that the City and County was addressing health care for the uninsured, others, viewed it as a tax.

- Initial reaction from a majority of the employers on how to meet the ESR was to establish a Health Savings Account. It was perceived to be the easiest option and a benefit that all employees, regardless of where they lived, could utilize.

- Overall, employers felt that HAP was a cost-effective way of providing healthcare benefits to temporary and part-time employees who currently have no benefits.

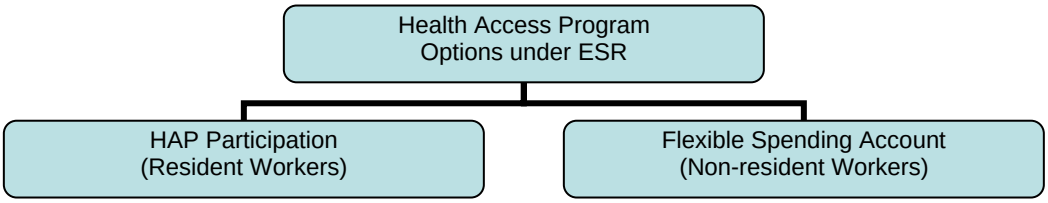
- Various participants felt that the residency requirements, the limited network of providers, the lack of coverage outside of San Francisco and/or the additional burden of administering a small number of employees were disadvantages to contributing to the HAP. Employers indicated that they would be much more willing to contribute to the HAP if it would benefit all their employees instead of only their San Francisco resident employees.

The findings suggest a need to restructure HAP so that it does not create a barrier to participation; specifically, HAP must offer an option for non-resident, uninsured workers. DPH, SFHP, OLSE and the HAP Advisory Committee have explored options to address this issue.

As the Board of Supervisors is aware, HAP is a subsidized program (i.e., City and County General Fund is used to cover that portion of the health care costs that cannot be paid for by the HAP participant). The subsidy is for the individual, not the employer. Because the subsidy supports San Francisco residents and not support non-residents, irrespective of their employment status, non-residents cannot participate in the HAP, obtain a subsidy and receive services.

However, DPH believes that there is a method that would allow non-residents employees of employers subject to the ESR to participate in HAP on a non-subsidized basis. This could be achieved if the HAP were modified to include a Flexible Spending Account option. Flexible Spending Accounts (FSAs) are mechanisms that allow individuals to set aside pre-tax earnings to pay for eligible out-of-pocket health and dependent care costs. The FSA pays for uncovered or un-reimbursed medical costs. With an FSA, an individual submits a reimbursement request to the FSA administrator which includes a claim form and any supporting documentation of the health care cost incurred. The FSA administrator processes the claim and issues a payment to the individual.

DPH is recommending the creation of a Health Care FSA. As a result, San Francisco employers with both resident and non-resident workers would have the following option:



For an employer who selects the HAP, their San Francisco employees would receive health services via HAP while their non-San Francisco resident employees would receive a FSA that can be used to cover health related expenses. Under this system, San Francisco employers with both resident and non-resident workers who elect to participate in the HAP would send their health care expenditures to one single place. Employer contributions to HAP would still be based on the size of the employer and the number of hours worked by the employee. Contributions for those employees with HAP participation would be separated from contributions for those employees who will receive a FSA. Data with respect to the name of the employee, hours worked, county of residence, etc. would be collected. Once the expenditures and data are received, the employer's resident workers would become HAP participants and their non-resident workers would receive a FSA.

In order to implement this new provision, DPH recommends that the City and County retain a FSA administrator. DPH believes that this would be both effective and efficient in light of the fact that the City and County does not have experience or expertise in administering spending accounts. There are, however, well-qualified firms that specialize in this field.

In order to implement a Flexible Spending Account option within HAP, DPH believes that the Health Care Security Ordinance should be amended because there is no specific authority in the legislation to allow for the creation of this mechanism in HAP. The amendment would create a FSA option under HAP for non-resident workers. The expansion of HAP to include a FSA option was discussed by the Health Access Program Advisory Committee and committee members were in favor of this approach as a way to strengthen the HAP and address the issues raised in the employer focus groups and broker interviews.

V. CONCLUSION AND NEXT STEPS

Significant progress has been made toward the implementation of the Health Care Security Ordinance. Specifically:

- draft regulations have been promulgated for the Employer Spending Requirement and
- draft design rules and program recommendations have been developed for the Health Access Program

To ensure that the public is keep abreast on the implementation of the ESR and HAP, websites have been created to provide the public with information and updates Both DPH and OLSE are working towards a July 1, 2007 launch for HAP and ESR, respectively. HAP will be phased-in to ensure that it is implemented appropriately.

With respect to the HAP, the DPH recommends that the Health Care Security Ordinance be amended to create a Flexible Spending Account option under HAP for non-resident workers of employers subject to the Employer Spending Requirement.