**M E M O R A N D U M**

October 16, 2008

To: James Illig, President and Members of the Health Commission

Through: Anne Kronenberg, Deputy Director of Health, Director of Planning and Administration

From: Frances Culp, Senior Health Program Planner

Re: Health Care Accountability Ordinance – Suggested Revisions to the Minimum Standards

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## Section A: Introduction

The Health Care Accountability Ordinance (HCAO) represents one of San Francisco's early, pioneering efforts to reduce the number of uninsured in San Francisco. HCAO went into effect on July 1, 2001. It requires that employers doing business with the City offer health insurance coverage which meets a set of Minimum Standards to their employees or pay a fee to the Department of Public Health (DPH) to offset costs of health care provided to the uninsured.

The Health Commission has the authority to set the Minimum Standards. The employer fee is reviewed by the Health Commission, but changes must be approved by the Board of Supervisors through a resolution. Some businesses are exempt from HCAO, including small businesses (non-profits are defined as 50 or fewer employees and for-profits as 20 or fewer employees), public entities (e.g., UCSF), and others. The Office of Labor Standards and Enforcement (OLSE) is the primary enforcement body for HCAO, and works closely with DPH to ensure proper compliance among contractors and lessees.

A third choice for employer compliance was written into HCAO and requires that the Health Director develop a health benefits program specifically to cover employees subject to the Ordinance. Section E of this report addresses this issue in more detail.

## Section B: HCAO Minimum Standards Work-Group

HCAO requires that DPH and the Health Commission review (and revise, if necessary) the Minimum Standards once every two years. The Health Commission last acted to revise the standards in 2004, with an effective date in September of that same year. In 2004, the Health Commission also approved a number of additional revisions to the Ordinance, including an increase in the employer fee. These changes were sent to the Board of Supervisors. While not



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all of the changes were accepted by the Board, those that were (including the employer fee increase) were made effective in April 2006.

As has been DPH's practice since 2001, DPH convened a group of stakeholders to review the Minimum Standards. The group agreed to the following objective and goals:

> The Health Care Accountability Ordinance (HCAO) requires that the Health Commission, as necessary, make updates to the Minimum Standards[1] for health coverage and the employer fee (paid by employers not in compliance with the Minimum Standards)[2]. The HCAO Minimum Standards Work-Group was convened to assist DPH and the Health Commission in this process. The Work-Group consists of DPH staff, contractors and their representatives, brokers, and other stakeholders. The Work-Group will work together to review and possibly recommend changes to the:
>
> 1) Minimum Standards; and
> 2) Employer fee (hourly/weekly amount).

The group's first meeting was in July and continued through September (6 meetings total). Anne Kronenberg, DPH's Deputy Director of Health, Director of Planning and Administration, chaired the Work-Group and Frances Culp, DPH's Office of Policy & Planning, provided staff support. The following organizations were represented by one or more individuals at the meetings:

- Community Housing Partnership
- Conard House
- Episcopal Community Services, San Francisco
- Levinson Benefits Group Insurance Services
- Office of Labor Standards & Enforcement (CCSF)
- Richmond Area Multi-Services (RAMS)
- Shargel & Co. Insurance Services
- San Francisco Airport
- San Francisco Church Women United
- San Francisco Health Authority
- San Francisco Human Services Network
- San Francisco Living Wage Coalition
- San Mateo Labor Council
- SEIU Local 1877

The Minimum Standards Work-Group meetings gave individuals from various organizations, perspectives and experience with HCAO an opportunity to review the current Minimum Standards, study the small business health insurance market, and develop consensus on

[1] Excerpt from Section 12.Q.3.(a)(1): "The Health Commission shall review such standards at least once every two years to ensure that the standards stay current with State and Federal regulations and existing health benefits practices."

[2] Excerpt from Section 12.Q.3.(a)(2): "The Health Commission may increase this hourly rate and Weekly maximum in accordance with either the Bureau of Labor Statistics Consumer Price Index for Medical Care in the SF Bay Area or the increase in average Health Maintenance Organization (HMO) premiums in California, depending on which the Health Commission determines better reflects the cost of providing health care in the Bay Area, provided, however, the Health Commission shall take this action no more than once a year and any adjustments in such hourly rate of Weekly maximum must be approved by the Board of Supervisors by resolution."

recommendations for change. The Work-Group agreed that changes to the Minimum Standards should increase options for employers, while retaining an affordable and comprehensive benefit package for the employees.

The group reviewed in detail health insurance plans offered to small businesses (50 or fewer employees) by Blue Cross, Blue Shield, Health Net, Kaiser and CalChoice. The small business market provided the group with detailed information on which to base decisions. Though many small businesses are exempt from HCAO, these "off-the-shelf" plans were used as a proxy to obtain information regarding common benefits (some of which are required by law), copayments, deductibles, and rates (particularly the relative difference in rates between plans). Larger businesses work with brokers and health insurance companies to design their own packages, and have more flexibility, but standards reflect reality for all business types.

## Section C: Minimum Standards – Revisions

In order to be compliant with HCAO, the employer must offer the employee a plan that meets or exceeds the Minimum Standards. Of 37 health plans offered on the small business market and studied by the Work-Group, only nine are compliant with the current Minimum Standards (24%). This is an indication of the difficulty that employers have in meeting the Minimum Standards in today's market.

These points describe the Minimum Standards and the recommendations for change:

- **HMO Plan Requirement:** A guiding principle when the Minimum Standards were first set was to ensure that plans are cost-effective. In keeping with this principle, the standards require that a compliant plan is a health maintenance organization (HMO). In 2007, nearly half (47%) of insured workers in California were enrolled in HMOs (as opposed to a Preferred Provider Organization, or PPO, Point-of-Service plan, etc.).[3] The popularity of HMOs is due to both affordability and ease of use.
    - ***No change recommended.*** The Work-Group strongly considered allowing PPOs in addition to HMOs, recognizing that some employers and employees find PPOs preferable. This is generally so that the subscriber can have a more unlimited choice of physician. However, it was decided that because PPOs require subscribers to pay up front the full cost for some services, low-income workers may not be able to get the health care services they need. The group agreed not to change this requirement, and instead identified the issue as a priority for reconsideration when the Minimum Standards are reviewed again in two years.

- **Premium Cost-Sharing:** The current Minimum Standards require employers to pay the full premium, not allowing any portion of the cost to be passed on to the employee. Premiums reflect the amount that it costs to provide health coverage to an employee. Premium costs are usually shared between the employer and the employee. In fact, in 2007, 75 percent of all California businesses required that employees pay some portion of the premium.[4]
    - ***No change recommended.*** It was agreed that this important protection for workers that should be retained. Because many of the employees subject to

[3] California HealthCare Foundation, *California Employer Health Benefits Survey*, Dec. 2007, p. 37.
[4] California HealthCare Foundation, *California Employer Health Benefits Survey*, Dec. 2007, p. 22.

HCAO are low wage workers, a requirement that employees pay a portion of the premium may cause some employees to decline the coverage. (Employers are required to offer adequate coverage, but employees are not required to accept.)

- **Copayment:** The current Minimum Standards set a maximum copayment for physician office visits at $15 for Closed Panel HMOs and $20 for other types of HMOs. A copayment is the out-of-pocket costs borne by the employee when accessing covered services. As required copayments increase for the employees, monthly premiums paid by employers decrease and vice-versa. The trend has been for employers to choose higher copayment plans to save on premium costs. Among HMOs in 2007, 69 percent of employees paid $20 or more for office visits, an increase from 50 percent in 2004.[5]
    - ***Increase copayment to $30***[6]**.** An increase from the $15/$20 copayment for office visits (including primary care, perinatal/maternity, preventive care, and family planning) is recommended to a maximum of $30. The two-tiered system was discontinued in order to simplify the Minimum Standards. The increase in the amount of the copayment was decided upon to allow employers more options. While employees are protected under the Minimum Standards from premium cost-sharing, if coverage becomes unaffordable there is a risk of pushing employers toward paying the fee instead of insuring the employee.

- **Deductible*:*** A deductible is the set amount an insured individual is required to pay for health care services before complete insurance coverage starts. After the full amount of the deductible has been paid, the subscriber is required to pay only the cost of the copayment for the remainder of the year. Deductibles are most common in PPOs. High deductible plans (HMO and PPO versions) are becoming more common in the health insurance marketplace, many in combination with health-related savings accounts. Deductibles specific to brand-name prescription drugs are relatively new and becoming very common. These deductibles require that the subscriber pay the full cost of their brand name prescription drugs, until the amount of the deductible is paid. (Generic drugs are not included, and require the subscriber to pay a copayment fee only.)
    - ***Allow a drug deductible***[7]**.** Given the trend toward brand name prescription drug deductibles, it was decided that the Minimum Standards would allow a prescription drug deductible for the first time. Nearly one-third of the 37 small business health insurance plans reviewed by the Work-Group required a brand-name prescription drug deductible. They range in cost from $100 to $250 and all of Blue Cross's small business plans include a brand-name prescription drug deductible. A specific amount was not set, but is combined with the maximum Out-of-Pocket amount for the year, as described below.

- **Out of Pocket Maximum:** Most health insurance plans set a specific Out-of-Pocket (OOP) maximum, which limits the insured's liability for the year. The amount a subscriber pays during the year in copayments cannot exceed this amount. The current annual OOP maximum in HCAO's Minimum Standards is $2,500.
    - ***Increase Out-of-Pocket (OOP) Maximum to $3,500 (including any prescription drug deductible***[8]***):*** DPH and the Work-Group recommend that the HMO's annual

[5] California HealthCare Foundation, *California Employer Health Benefits Survey*, Dec. 2007, p. 24.
[6] The Living Wage Coalition abstained from a vote on the decision to increase the copayment.
[7] The Living Wage Coalition abstained from a vote on the decision to allow a prescription drug deductible.
[8] The Living Wage Coalition abstained from a vote on the decision to increase the annual OOP maximum.

OOP maximum may be no higher than $3,500 when combined with any applicable prescription drug deductible.

- **Health Benefits:** The health benefits are services that the subscriber is entitled to receive. It is a priority to DPH to ensure that the health benefit coverage offered to employees subject to HCAO is not limited to catastrophic care and that these employees are not among the chronically under-insured. As noted by Consumer Reports in 2007, 29 percent of those with health insurance nationally are under-insured. [9] No change is recommended to this list of benefits. The current Minimum Standards requires the following health care benefits:
    - Office visits
    - Hospital inpatient
    - Prescription drugs
    - Outpatient services & procedures
    - Diagnostic services (x-ray, labs, etc.)
    - Perinatal & maternity care
    - Emergency room & ambulance
    - Mental health services, outpatient and inpatient
    - Alcohol and substance abuse care, outpatient and inpatient detox
    - Rehabilitative therapies, outpatient and inpatient
    - Home health services
    - Durable medical equipment
    - Hospice care
    - Skilled nursing services

It was the Work-Group's aim to ensure that at least half of the small business HMO plans available in the insurance market meet the revised Minimum Standards. With the changes suggested above, 23 of the 37 plans (62%) reviewed by the Work-Group would meet the Minimum Standards. This is a significant increase from the 24 percent of small business plans that currently comply. Attachment A provides a summary of the Minimum Standards as revised, including a side-by-side comparison of the current and revised Minimum Standards.

## Section D: Employer Fee

When employers subject to HCAO are unable or unwilling to provide health insurance that meets the Minimum Standards, they are required to pay a fee to DPH. The Minimum Standards Work-Group discussed the concern that, as health coverage costs rise, the $2 hourly fee ($80 maximum per week) paid to DPH no longer corresponds to the reality of premium costs. It is crucial that employers are not incentivized to pay the fee instead of offering health coverage, which may happen if the fee was set much lower than the cost of offering health insurance.

According to the Ordinance, the employer fee may be revised no more than once per year and must be set in accordance with the Bureau of Labor Statistics Consumer Price Index (BLS – CPI) for Medical Care in the San Francisco Bay Area or the HMO premium increases in California. The last time the employer fee was raised, it was increased from $1.50/hour to $2/hour and was made effective in 2006 by the Board of Supervisors. The $2 amount was a midpoint between the

[9] Consumer Reports, http://www.pnhp.org/news/2007/august/consumer_reports_on_.php

two standards, using data available at the time (2000 through 2002 for the BLS-CPI and 2000 through 2003 for the HMO premiums).

The table below shows increases in the BLS-CPI and HMO premium increases since 2003 and 2004 respectively.

Annual Percentage Increases

| **Year** | **CPI, Medical Care (SF Bay Area)** | **HMO Premium Increases** |
|---|---|---|
| 2003 | 2.9% | ------ |
| 2004 | 6.8% | 12% |
| 2005 | 2.9% | 8% |
| 2006 | 10.0% | 10% |
| 2007 | 6.8% | 10% |
| *Total* | *29.4%* | *40%* |

The cumulative increase in BLS – CPI cost per year since the last time these data were reported and compared to the employer fee is 29.4 percent. Applied to the $2 hourly fee, this would increase the fee from $2 to $2.59. Though there is a shorter time span at issue (because 2003 was available and used in the last review) the cumulative HMO premium increase is significantly higher than the BLS – CPI cost increase at 40 percent. Applied to the hourly fee, this would increase the amount from $2 to $2.80.

DPH and the Work-Group recommend that the fee should be increased to $2.80 with a weekly maximum of $112. This conclusion was reached for two main reasons. First, a careful reading of the Ordinance led Work-Group members to believe that splitting the difference was not the intent of the Ordinance. HCAO allows for calculating the increase either by the BLS-CPI or the HMO premium increase. Using just one indicator, the group believed that the HMO premium increases were a better proxy for the cost of health insurance. In addition, this new fee ($2.80/hour) compares favorably to the premiums associated with the small business HMO plans.

DPH is in discussion with the City Attorney's Office to develop a methodology to make the increase to the employer fee automatic. This way, the Health Commission and Board will not have to act in order to make a small change to the dollar amount employers are required to pay. In any case, the fee impacts a relatively small number of employers, with 33 employers who paid the fee in FY 2007-08. Some of these employers pay only one time due to audit findings or other issues, and others pay each month. Most employers who do business with CCSF comply with HCAO by insuring their employees.

## Section E: Other HCAO Issues

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

In 2004, DPH studied this issue at length and found that the program could not be economically viable. Demand must be high enough to bring a sufficient number of employers and employees to any health insurance purchasing pool or coverage program. Without sufficient demand, the size will be too small to achieve what is expected, increased bargaining power. Additionally, savings must be achieved to some degree in the three areas that contribute to the eventual cost of an insurance program's premium – administration costs, provider rates and service utilization. These points remain true and DPH has not changed its position on this matter.

Since the last time this issue was brought before the Health Commission, however, there have been dramatic improvements in access to health care in San Francisco. The Health Care Security Ordinance (HCSO) and the Healthy San Francisco program create an environment where, for the first time, employees who are uninsured, including those subject to HCAO but without coverage, can enroll in Healthy San Francisco. Healthy San Francisco provides universal, comprehensive, affordable health care to uninsured adults irrespective of the person's income level, employment status, immigration status or pre-existing medical conditions.

HCAO takes precedent over the HCSO, meaning that employers subject to both ordinances must follow the tenants of HCAO first. Because HCAO requires that employers offer comprehensive health insurance coverage (or pay a fee), it continues to play an important role in reducing the number of San Francisco's uninsured. While the intent of this is to ensure that employers provide actual health insurance for workers, this is not always possible. HCAO requires employers to provide coverage for employees working 15 or more hours per week. Yet, health insurance companies offer programs for individuals working 20 or more hours per week. Health plans, as a rule, do not offer health coverage to employees working less than 20 hours per week. These workers cannot be insured, regardless of HCAO's rules or the wishes of the employer. For these workers, HCAO requires that the employer pay the fee to DPH. The employee may enroll in Healthy San Francisco individually, but they are not given the benefit of the employers' payment to the program through HCSO's rules because HCAO has superseded HCSO.

Because of this, DPH and the Work-Group recommend that the Board of Supervisors delete from HCAO the requirement to insure 15 to 19 hour per week workers. If these workers could access Healthy San Francisco in a similar manner to other workers not bound by HCAO, then the issue of the creation of a new health coverage program just for HCAO workers is not an issue. This small change will significantly improve the symbiotic relationship between HCAO and HCSO. By removing very part time workers from the HCAO, they can fully benefit from Healthy San Francisco and the HCSO and employers will no longer be required to pay a fee to DPH when they have no option to insure their employee.

## Section F: Conclusion

In conclusion, DPH fully supports the HCAO and has a strong interest in seeing the Ordinance meet its objective of reducing the numbers of uninsured and thereby enhancing the quality, stability and productivity of the workforce on the City's contracts and leases. The attached resolution (Attachment B) requests approval to revise the Minimum Standards effective November 1, 2008. It also contains changes to the Ordinance for the Health Commission to recommend to the Board of Supervisors. With the Health Commission's support and approval, the next step will be to present the modifications to the Ordinance (employer fee increase and change definition of covered employee from 15 hours or more per week to 20 hours or more per week) to the Board of Supervisors.

**City and County of San Francisco** **Department of Public Health**

**Mitchell H. Katz, MD**
**Director of Health**

# HEALTH CARE ACCOUNTABILITY ORDINANCE

2008 MINIMUM STANDARDS - FOR HEALTH PLAN BENEFITS: EFFECTIVE NOV. 1, 2008

Employers that choose to comply with the HCAO by offering a health plan must offer at least one health plan that meets the Minimum Standards, as described below.

The plan must be a Health Maintenance Organization (HMO).

Employers may not require employees to pay a premium contribution for employee-only coverage.

The HMO may not include a deductible of any amount for non-pharmacy services, but may include a deductible for prescription drugs, subject to the deductible cap specified below.

The HMO's annual Out-of-Pocket (OOP) maximum may be no higher than $3,500 when combined with any applicable prescription drug deductible. For example, it is acceptable to have a plan with a $3,000 OOP maximum and a $500 drug deductible. A plan with a $3,500 OOP maximum and a $500 drug deductible is not acceptable.

Co-payments for office visits (including PCP, perinatal and maternity, preventive care, and family planning) shall not exceed $30 per visit.

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

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

Employers not offering a health plan that meets the Minimum Standards as described above must pay to the San Francisco Department of Public Health $2.80 per hour (for a maximum of $112 per week).