

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

**A Report of  
the Department of Public Health  
the Office of Labor Standards Enforcement and  
the City Controller's Office**

**Submitted to the  
San Francisco Board of Supervisors**

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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) and further amended it in April 2007 (Ordinance No. 69-07). The Ordinance created two City and County programs, the Employer Spending Requirement (ESR) and Healthy San Francisco (HSF). Both program components of the Ordinance work in tandem and are designed to address the health needs of San Francisco's uninsured residents and workers. The Office of Labor Standards Enforcement (OLSE) oversees enforcement of the ESR while the Department of Public Health (DPH) oversees HSF.

This report provides an update on the implementation and operation of the Ordinance since submission of the July 2008 status report. Specifically, the following activities have occurred:

- The Office of Labor Standards Enforcement (OLSE):
  - Mailed the 2009 HCSO Notice to Employers (advising them of the new "hours worked" threshold and 2009 expenditures rates).
  - Mailed the 2008 HCSO Annual Reporting Form (ARF) to all employers registered with the City and County Treasurer & Tax Collector who, based on their size, are likely to be covered by the law.
  - Began analysis of ARFs submitted by covered employers.
  - Provided compliance assistance to employers that resulted in contributions of over \$2 million in payments to Healthy San Francisco.
  - Assessed penalties of approximately \$4,000.
  
- The Department of Public Health:
  - Reached enrollment of over 43,000 uninsured San Francisco adult residents in Healthy San Francisco.
  - Expanded the program's income eligibility from 300% to 500% of the Federal Poverty Level.
  - Announced expansion of the provider network to include a national, non-profit health maintenance organization (Kaiser Permanente) effective July 1, 2009.
  - Implemented an electronic interface with the San Francisco Human Services Agency to facilitate eligibility determination and enrollment into Medi-Cal.
  - Delivered a preliminary report on health care utilization and costs under the program.
  - Selected a national researcher to conduct the Healthy San Francisco program evaluation.

DPH's and OLSE's work on their respective programs continued while the Golden Gate Restaurant Association's lawsuit challenging the Employer Spending Requirement remained under legal review in the federal courts.

## I. INTRODUCTION

An estimated 60,000 adult San Francisco residents are uninsured.<sup>1</sup> 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.

In July 2006, the San Francisco Board of Supervisors adopted the San Francisco Health Care Security Ordinance (Ordinance No. 218-06) which created two new City and County programs, the Employer Spending Requirement (ESR) and Healthy San Francisco (HSF). The programs work in tandem and are designed to address the health needs of San Francisco's uninsured residents and workers.

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 HSF. HSF 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. It integrates public and private providers into a single system to provide universal care without relying on health insurance.

HSF became operational on July 2, 2007. The ESR went into effect on January 9, 2008 for San Francisco employers with 50 or more employees and on April 1, 2008 for for-profit employers with 20-49 employees.

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 Enforcement (OLSE) – Enforces the ESR provisions.
- Department of Public Health (DPH) – Administers the HSF program.
- 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 HSF.
- Office of Treasurer and Tax Collector – Provides to OLSE all non-financial information necessary for OLSE to fulfill its responsibilities.

The Ordinance requires regular reporting to the Board of Supervisors on the status of both programs. Quarterly reports were required during the period from July 1, 2007 through June 30, 2008. From July 1, 2008 through June 30, 2010 reports are submitted on a bi-annual basis. This report meets the mandated reporting requirement to provide a report on July 1, 2009.

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<sup>1</sup> Estimate is based on the 2007 California Health Interview Survey (CHIS) which is the nation's largest state health survey. CHIS provides detailed data on the health and health care needs of California residents. It is conducted by the UCLA Center for Health Policy Research.

## II. GOLDEN GATE RESTAURANT ASSOCIATION LAWSUIT

In November 2006, the Golden Gate Restaurant Association filed a lawsuit against the City and County of San Francisco challenging the Employer Spending Requirement (“ESR”) of the Health Care Security Ordinance (“Ordinance”) on the grounds that it conflicted with the federal Employee Retirement Income Security Act (“ERISA”). The lawsuit did not challenge the legality of the Healthy San Francisco program.

On December 26, 2007, the United States District Court (“Court”) issued an order granting the motion for summary judgment filed by the Golden Gate Restaurant Association. The Court ruled that the City and County San Francisco could not implement the ESR provisions of the Ordinance because of federal ERISA preemption. On December 27, 2007, the San Francisco City Attorney filed a petition with the United States Court of Appeals for the Ninth Circuit (“Ninth Circuit”) asking for an emergency stay pending appeal of the lower court’s decision.

On January 9, 2008, the Ninth Circuit granted the City Attorney’s petition which allowed the Health Care Security Ordinance to go into effect on January 9, 2008, pending the City and County’s appeal of the Court’s decision. As a result of the Ninth Circuit ruling, the ESR became effective on January 9, 2008 for employers with 50 or more employees. The effective date for for-profit employers with 20-49 employees was April 1, 2008.

On February 7, 2008, the Golden Gate Restaurant Association (GGRA) filed an application to the U. S. Supreme Court, seeking to lift the Court of Appeals’ ruling. On February 21, 2008, United States Supreme Court denied the GGRA’s application.

On April 17, 2008, Ninth Circuit heard oral arguments on the appeal. On September 30, 2008, a three-judge panel of the Ninth Circuit issued a unanimous ruling that the ESR enacted under the Ordinance was not pre-empted by federal law. The decision overturned the December 26, 2007 United States District Court decision and allowed for continued operation of the ESR.

On October 21, 2008, the GGRA filed a petition with the Ninth Circuit for “Rehearing En Banc.” The petition asks the full panel of judges in the Ninth Circuit to review the decision of the three-judge panel. On March 9, 2009, the Ninth Circuit denied GGRA’s request for a rehearing of the three-judge panel decision that the ESR was not pre-empted by federal law.

On June 8, 2009, GGRA filed a petition with the U.S. Supreme Court requesting that the Supreme Court rule on the legality of the ESR of the Health Care Security Ordinance. While the U.S. Supreme Court considers whether to hear the case, the Ninth Circuit’s September 30, 2008 decision upholding the ESR continues to be in effect for all covered businesses.

### III. EMPLOYER SPENDING REQUIREMENT

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

In the first and second quarters of 2009, the Office of Labor Standards Enforcement (OLSE) continued to review employer compliance with the Employer Spending Requirement (ESR).

In March 2009, the OLSE mailed the 2009 HCSO Notice to Employers (advising them of the new “hours worked” threshold and 2009 expenditures rates) and a 2008 HCSO Annual Reporting Form to all employers registered with the Treasurer & Tax Collector who, based on their size, are likely to be covered by the law. Although the ESR covers only businesses with 20 or more employees, the OLSE sent the mailing to a broader group of employers in order to reach those whose businesses may have grown.

In response to the March mailing, the OLSE experienced a spike in call and electronic mail communications from employers, as shown in the chart below.

<b>2009</b>	<b>HCSO emails</b>	<b>HCSO calls</b>
January	157	240
February	132	255
March	349	874
April	856	941
May	185	345
As of June 15, 2009	66	89
<b>Total</b>	<b>1,745</b>	<b>2,744</b>

In order to respond to the call volume in a timely manner, the OLSE temporarily reassigned staff from other regular duties.

While the volume of calls and e-mails has dropped since the April 30, 2009 deadline for returning the 2008 Annual Reporting Forms (ARFs), the OLSE anticipates another increase in call volume in the latter half of June and the month of July as staff makes and returns calls aimed at verifying the accuracy of the data provided on the ARFs, as described in further detail below.

Since the mailing, the OLSE has also seen an increase in voluntary compliance cases, as employers made aware of the Ordinance through the annual mailing requested guidance from the OLSE on how to come into compliance with the ESR.

As of June 12, 2009, the OLSE had opened 230 cases. Seventy-six cases (41% of open cases) were initiated by worker complaints, and 13 cases (7% of open case) were audits initiated by the OLSE, after the agency received evidence that the business was either not in compliance or experiencing difficulties coming into compliance. The

remaining 98 cases (52% of open cases) were initiated by employers who voluntarily contacted the OLSE to seek assistance in coming into ESR compliance. Forty-three HCSO cases (19% of total cases) have been resolved/closed by the OLSE. The backlog of open cases has continued to grow, and there currently are 187 open cases.

	<b>12/19/08</b>	<b>1/22/09</b>	<b>6/12/09</b>
<b>Total Cases</b>	115	138	230
<b>Initiated by Worker</b>	58 cases (62% of open cases)	69 cases (61%)	76 cases (41%)
<b>OLSE Audit</b>	14 cases (15% of open cases)	14 cases (12%)	13 cases (7%)
<b>Voluntary Compliance</b>	22 cases (23% of open cases)	31 cases (27%)	98 cases (52%)
<b>Closed Cases</b>	21 cases (18% of total cases)	24 cases (17%)	43 cases (19%)
<b>Open Cases / Backlog</b>	94	114	187

As of June 12, 2009, employers who received compliance assistance from the OLSE have contributed over \$2 million in payments to Healthy San Francisco. In addition, the OLSE has assessed penalties of approximately \$4,000 against those who have not made efforts towards compliance.

In the third quarter of 2009, the OLSE will work with the Cashiering Section of the Treasurer and Tax Collector's Office to scan the ARFs to collect data and begin preparing a summary report regarding HCSO compliance, including information regarding the options employers have selected to comply with the law.

Our initial review of the ARFs indicates that a number of employers did not complete the form accurately; thus, the entire OLSE staff is currently working to verify the accuracy of the data reported of these forms. Through the end of July, the OLSE will benefit from the assistance of eleven City Hall Fellows from San Francisco's City Hall Fellows public policy program, who chose the HCSO Annual Reporting Form as the focus of their final group project. The fellows are helping to review the forms and analyze the data to prepare preliminary results from a subset of ARFs that were completed correctly.

With the current focus on the ARFs, the OLSE is not able to devote much time or attention to pending cases. Thus, unless staffing levels increase, the OLSE expects a continuing decrease in the percentage of closed cases.

## IV. HEALTHY SAN FRANCISCO

This section provides a summary of Healthy San Francisco and Medical Reimbursement Account components of the Health Care Security Ordinance. The Department of Public Health (DPH) is responsible for implementing and administering these components.

### A. Major Activities since Submission of January 2009 Status Report

Since the January 2009 status report to the Board of Supervisors, DPH has:

1. Reached enrollment of over 43,000 uninsured San Francisco adult residents into Healthy San Francisco. Based on an estimated 60,000 uninsured adults, to date, the program has enrolled 72% of the population.
2. Expanded the program's income eligibility from 300% to 500% of the Federal Poverty Level.
3. Announced expansion of the provider network to include a national, non-profit health maintenance organization (Kaiser Permanente) effective July 1, 2009.
4. Implemented an electronic interface with the San Francisco Human Services Agency to facilitate eligibility determination and enrollment into Medi-Cal.
5. Delivered a preliminary report on health care utilization and costs under the program.
6. Selected a national researcher to conduct the Healthy San Francisco program evaluation.

### B. Healthy San Francisco Enrollment

As of late June 2009, there were 43,050 participants residents enrolled in HSF. This represents 72% of the estimated HSF enrollment of 60,000 participants.<sup>2</sup> The following chart provides basic demographic information based on the participants:

Age	11% are 18 - 24; 40% are 25 - 44; 24% are 45 - 54; 25% are 55 - 64
Ethnicity	40% Asian/Pacific Islander; 24% Latino; 18% Caucasian; 9% African-American, 3% Other; less than 1% Native American; 6% Not Provided
Gender	52% male; 48% female
Income	70% at/below 100% FPL; 22% between 101 – 200% FPL; 7% between 201 – 300% FPL; less than 1% above 300% FPL
Language	49% English; 27% Cantonese/Mandarin; 19% Spanish; 1% Vietnamese; 1% Filipino (Tagalog and Ilocano); less than 3% Other

Twenty-five percent (26%) of Healthy San Francisco participants reside in the Excelsior or Mission districts. Homeless individuals comprise 14% of all HSF participants.

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<sup>2</sup> Estimated number of uninsured is derived from data in the 2007 California Health Interview Survey which estimated 60,000 uninsured adults residing in San Francisco. Because HSF is a voluntary program, it is not anticipated that all uninsured residents will elect to enroll. As a result, the number of estimated participants is less than the number of estimated uninsured adults.

Providing program participants with a primary care medical home is a principal feature of HSF. The program is premised on the notion that primary care settings provide a more efficient mechanism to deliver preventive and primary care services, conduct disease management, and coordinate care across providers and service settings. HSF has four primary care medical home delivery systems. The distribution of participants across these systems is as follows:

- Chinese Community Health Care Association (CCHCA) – 2.2% (903 participants)
- Department of Public Health (DPH) – 51.2% (22,050 participants)
- San Francisco Comm. Clinic Consortium (SFCCC) – 44.34 (19,148 participants)
- Sister Mary Philippa Health Center (Sr. Mary) – 2.2% (949 participants)

HSF collects information on whether participants are existing clients or are new to the health care delivery system. Obtaining this information has been helpful in ascertaining the extent to which HSF serves an uninsured population that previously did not seek or receive services.

The HSF program has expanded access to care. To date, 27% of all those enrolled were not previous users of the health care delivery system (i.e., “new” -- defined as an individual who indicates that they have not received clinical services from the primary care medical home they selected within the last two years). The remaining 73% of program participants are existing safety net patients.

In addition to enrolling uninsured individuals in HSF, the program’s web-based eligibility and enrollment system (One-e-App) enables efficient identification and enrollment of uninsured residents into public insurance programs. Data indicates that to date the program has identified approximately 4,600 HSF applicants who were eligible for, but not enrolled in public health insurance programs (e.g., Medi-Cal, Healthy Families, etc.).

The Department analyzes participant disenrollments from HSF. Disenrollments can occur because participants no longer meet program eligibility criteria, no longer choose to remain in the program/voluntarily disenroll, do not pay the required quarterly participation fee, etc. Since the program’s inception, there have been approximately 55,000 HSF participants and of those roughly 11,814 are currently disenrolled from the program. As of late June 2009, the current disenrollments were the result of the following reasons:

<b>Disenrollment Reason</b>	<b>Percentage</b>
Program Eligibility	26%
Participation Fee Related	15%
Incomplete Annual Program Renewal	58%
Other Reasons	1%

The data indicates that 26% of those who were disenrolled no longer met the HSF program eligibility. Specifically, these individuals obtained health insurance (public or private), were determined eligible for another program during renewal, moved out of San Francisco and no longer met the residency requirement, or aged-out of the

program when they turned aged 65. Another 15% were disenrolled because of insufficient payment of the quarterly participation fee.

An incomplete annual renewal was the most frequent reason for HSF program disenrollments – totaling 58% of all disenrollments. To date, 85% of the individuals disenrolled for not completing the reenrollment process have annual incomes at or below 100% of the Federal Poverty Level and, as a result, pay no participation fees or point-of-service fees (with the exception of fees for emergency care, when appropriate). As a result, there should be no financial barrier to program renewal. However, it is not uncommon for individuals at this income level to have many other factors going impacting their lives. As a result, renewing their HSF participation on a timely basis may not be their highest priority. Some individuals may simply wait until their next clinical appointment to renew their eligibility.

To address disenrollments due to incompleteness of the annual renewal application, HSF program staff formed an inter-agency committee composed of representatives from enrollment organizations to monitor retention rates and identify outreach opportunities. Participants currently receive mailed notices 90, 60, and 30 days prior to the end of their annual term reminding them to return for an in-person renewal. In conjunction with the renewal reminder notices, upcoming issues of Heart Beat, the HSF participant newsletter, will have articles on the importance of the renewal process. All application assistors have been trained to stress the importance of the program's one-year eligibility and required renewal to participants. In addition, in March 2009 the program instituted a process whereby HSF participants up for renewal receive an automated telephone call reminding them to renew on time.

Individuals who are disenrolled from the program can re-enroll at any time, if eligible. The Department tracks the enrollment history of participants to determine enrollment patterns. Re-enrollment into the program can be viewed as an indicator of continued interest in and value of the program to participants. As of late June 2009, almost 4,444 individuals who had been disenrolled from the program voluntarily elected to re-enroll and are current participants again. The data notes that the majority of the re-enrollments occur for those individuals who did not complete their annual renewal in a timely manner.

<b>Original Disenrollment</b>	<b>Number</b>	<b>Percent</b>
Program Eligibility	411	9%
Participation Fee Related	867	20%
Incomplete Annual Renewal	3,148	71%
Other	18	< 1%

## **B. Income Eligibility Expansion**

In keeping with the program's intent to make HSF available to uninsured residents over the Federal Poverty Level (FPL), on February 9, 2009 uninsured San Francisco residents with household incomes up to 500% FPL became eligible to enroll in Healthy

San Francisco (\$54,150 for a family of one and \$110,250 for a family of four). The expansion recognizes the fact that uninsured residents with modest incomes also have difficulty accessing comprehensive health care services. Prior to this expansion, the income eligibility threshold was 300% FPL.

There are currently fewer than 350 HSF participants with incomes between 301% and 500% FPL enrolled in the program. Based on the first two months of this program expansion (February to April 2009), the age distribution of new participants with incomes 301-500% was similar to the overall age distribution in the HSF program to date, with 51% between 18-44 years of age vs. 50% for the total HSF population. New participants at this income level are disproportionately more Caucasian than the total HSF population (35% vs. 17%), and represent a roughly similar segment of the Asian/Pacific Islander population (36% vs. 40%).

### **C. Provider Network Expansion**

On June 3, 2009, Mayor Newsom announced that on July 1, 2009, the HSF provider network would expand to include Kaiser Permanente as a provider of care to the uninsured.

As a provider, Kaiser will provide primary, emergency, specialty, diagnostic, pharmacy and inpatient services. It will serve as a medical home for HSF participants. This expansion continues the Department's efforts to ensure that HSF applicants have a choice in their medical home selection. As a result of this expansion, the program will have five medical home systems effective July 2008 (listed in alphabetical order):

- Chinese Community Health Care Association
- Department of Public Health
- Kaiser Permanente
- San Francisco Community Clinic Consortium
- Sister Mary Philippa Health Center

While Kaiser Permanente is a health insurance plan, it is not participating in HSF as a health insurer. HSF is not health insurance and any San Francisco resident who selects Kaiser as their medical home will not be provided health insurance even though their medical home is Kaiser. As with all HSF participants, their health services benefits under the program are confined to the City and County of San Francisco and cannot be used at Kaiser facilities in other counties.

### **D. Interface Implementation with Human Services Agency**

HSF uses a web-based system (One-e-App) to enroll applicants into the program with the assistance of trained staff who determines an applicant's eligibility for public health insurance before HSF enrollment. With the San Francisco Human Services Agency (HSA) as the lead agency, on March 4, 2009, One-e-App was modified to allow application assistants to electronic interface between Medi-Cal's enrollment database and the HSF applicant screening system. This allows application assistants to

electronically submit Medi-Cal applications to HSA. This linkage enables both DPH and HSA to redirect applicants to the most appropriate program. Prior to launch of the interface, assistors used One-e-App to create and manually submit 5 – 12 Medi-Cal applications per week. In the first few six weeks after this enhancement, application assistors electronically submitted 228 Medi-Cal applications (an average of 38 per week) to HSA using One-e-App.

### E. HSF Services Utilization

There is a clinical data warehouse used to examine utilization, access, quality and other HSF health data. In March 2009, an initial report on HSF services and cost data was provided to the San Francisco Health Commission. It is important to note the following when examining the data that follows:

- There is no comprehensive pre-HSF utilization database that can be used as a baseline.
- Most of the encounter data (90%) available at the time of this analysis is concentrated in two medical home systems (the Department and North East Medical Services) with 80% of HSF enrollees.
- The hospitalization, emergency and urgent care data is included, but admissions to hospitals other than San Francisco General Hospital are not yet captured.
- When examining the changes in services data from one year to the next, it is important to remember that initial HSF enrollment occurs at the point of service.
- It is not entirely reasonable to expect or witness system-wide affects of participant behavior in the first year of the program.
- Over 70% of HSF participants have incomes at or below 100% FPL reflecting the targeted phase-in approach to initially enroll the most vulnerable into the program.

The data indicate the following utilization of health care services among participants:

**HSF Health Care Utilization Data – Actual (July 2007 – December 2008)**

<b>Service Utilization</b>	<b>FY 2007-08 Actual</b>	<b>FY 2008-09 Annualized</b>
Average visits per participant per year	3.93	3.05
Outpatient laboratory services per participant per year	1.47	1.10
Outpatient radiology services per participant per year	0.55	0.41
Surgical procedures (inpatient & outpatient) per participant per year	0.19	0.15
Average number of prescriptions per participant per year	8.75	6.45
Hospital admissions per 1,000 participants <sup>3</sup>	28.2	18.4
Number of hospital days per 1,000 participants <sup>4</sup>	103	61
Average length of stay – hospitalization <sup>5</sup>	3.64	3.34
ED visits per 1,000 participants	175	128
Urgent care visits per 1,000 participants	134	131
Average mental health visits per participant (CBHS data only)	1.53	1.33
Average substance abuse visits per participant (CBHS data only)	0.60	0.56

<sup>3</sup> Fiscal year 2008-09 data is for July 2008 – September 2008 only.

<sup>4</sup> Fiscal year 2008-09 data is for July 2008 – September 2008 only.

<sup>5</sup> Fiscal year 2008-09 data is for July 2008 – September 2008 only.

One key goal of HSF is to provide participants with a usual source of care (i.e., primary care medical home) in the hope that this will reduce episodic care, reduce emergency department and urgent care visits and reduce avoidable emergency department visits. The data indicates that 7.3% of the ED visits to date were avoidable which is lower (14.8%) in comparison to San Francisco Health Plan data for adults Medi-Cal recipients.

HSF hospitalization and emergency department data was compared to data from other public health insurance programs within the San Francisco Health Plan (i.e., Medi-Cal [adults only] and Healthy Workers). Data reveals that hospital utilization among HSF participants is lower than that found within the Healthy Workers and Medi-Cal population. The data also indicated that emergency department visits were higher among HSF participants than for Healthy Workers members and similar to or lower than rates experienced in the Medi-Cal population. The emergency department utilization may be a reflection of the fact that 14% of HSF participants are homeless and may continue to seek services in the ER despite a medical home selection.

#### **HSF Utilization Data in Comparison to Public Health Insurance Utilization Data**

<b>Service Category</b>	<b>Healthy Workers</b>	<b>Medi-Cal (Adults Only)</b>
Hospital Admissions per 1,000	HSF is Lower Than HW	HSF is Lower Than M-Cal
No. of Hospital Days per 1,000	HSF is Lower Than HW	HSF is Lower Than M-Cal
Avg. Length of Stay-Hospitalization	HSF is Lower Than HW	HSF is Lower Than M-Cal
ED Visits per 1,000	HSF is Higher Than HW	HSF is Similar to or Lower Than M-Cal

HSF data also examines disease prevalence. Data for the time period July 2007 to December 2008 reveals that 24% of the HSF population has at least one of the following chronic diseases: asthma, diabetes, hyperlipidemia or hypertension.<sup>6</sup> HSF expands chronic care services via Family Health Center (back pain, diabetes, mental health within primary care) and General Medicine Clinic (asthma/COPD, heart failure, resident continuity) serving both HSF participants and non-HSF patients. When the data is examined to determine the primary reason for a clinical visit, the encounter data for the top 20 primary reasons indicates that:

- 14% were for preventive care
- 41% were for conditions that, if left untreated, would lead to heart disease
- 45% were for conditions that, if left untreated, would lead to ER overuse

#### **F. HSF Estimated Department of Public Health 2008-09 Expenditures**

In March 2009, financial data indicated that for 2008-09, estimated Department expenditures for HSF will be \$113.2 million with revenues of \$32.7 million and a General Fund subsidy of \$80.5 million (the difference between expenditures and revenues). Based on estimated participant months, the monthly estimated per participant cost is \$280. This cost represents on average the cost of utilized services by a participant on a monthly basis. This cost recognizes that some participants will not use services in any given month. On an annual basis this would equate to \$3,360.

<sup>6</sup> Figure is for HSF participants who were enrolled in the program on or before September 30, 2008.

The estimated City and County cost to provide HSF is less than the estimated cost of providing HSF program participants with health insurance. A cost comparison of HSF with two California health insurance plans found monthly estimated premium costs of \$388 and \$618 per month. These costs are 39% (at \$388/month) to 120% (at \$618/month) higher than HSF at estimated \$280/month.

It is important to note that the costs reflect the Department's costs of operating HSF. HSF participants may receive services through other providers (e.g., emergency care at a hospital [other than San Francisco General Hospital] under the hospital's charity care program). The cost figures do not include the cost of such care and as a result do not reflect the total costs of providing services to uninsured HSF participants. At present, the Department does not have access to the service utilization or costs of services provided to HSF participants that were rendered: (1) outside the HSF provider network or (2) by non-profit hospitals. The Department anticipates having data from non-profit hospitals for the second annual HSF report scheduled for release in late summer 2009.

## **G. Evaluation**

The Department will evaluate HSF to determine if it is achieving its goals to improve access to health services for uninsured adults in a non-health insurance model. Since the January 2009 update, the Department moved forward on the following evaluation components:

- In March 2009, DPH released the Healthy San Francisco Program Evaluation Request for Proposals. Based on the RFP process, the Department is in the process of contracting with Mathematica Policy Research, Inc. to conduct the evaluation. The evaluation is structured to provide formative findings, in addition to a summative analysis, that can be used to guide development of any program improvements or modifications. Specific evaluation activities include examining utilization, administrative and financial data. In addition to City and County funding for the evaluation, the following foundations have provided generous support for the evaluation: Blue Shield of California Foundation, The California Endowment, the Commonwealth Fund and the Metta Fund.
- DPH secured the generous in-kind support of the Kaiser Family Foundation to conduct a HSF Participant Satisfaction Survey. The survey is designed to ascertain the experience of early HSF enrollees (a representative survey of enrolled HSF participants as of October 31, 2008). Questions are in the areas of: enrollment process, knowledge and understanding of HSF, uninsured status, satisfaction with HSF, health status, access to care and health care utilization. The survey was administered during March/April 2009; it is anticipated that results will be available in the Summer of 2009.

## H. HSF Customer Service

HSF participants have access to customer service representatives who care assist them in using the program effectively (e.g., explaining how to access medical services, correcting an address, replacing materials, etc.). Key customer service statistics for July 2008 to March 2009:

- 2,650 calls per month (avg.) from participants, applicants, employers, providers,
- 92% of calls responded to in less than 30 seconds and
- 52 calls per 1,000 participants per month.

Customer service works to resolve participant complaints. From July 2008 – March 2009, the program received 269 participant complaints (approximately 2.7 complaints per 1,000 participants). Of those, 97% were resolved within 60 days.

**HSF Participant Complaints (July 2008 – March 2009)**

Category	Number	Percent
Access Issue	107	40%
Enrollment Issue (Medical Home Selection)	56	21%
Quality of Service	46	17%
Other <sup>7</sup>	21	8%
Quality of Care	20	7%
Pharmacy	9	3%
Point of Service Fees <sup>8</sup>	7	3%
Participation Fee Bill	2	1%
Coverage Interpretation	1	Less than 1%

## I. Employer Selection of City Option to Meet Employer Spending Requirement

San Francisco employers are selecting the City Option to meet the Employer Spending Requirement (ESR) of the Health Care Security Ordinance. When an employer chooses the City Option, their employees will receive either Healthy San Francisco or a Medical Reimbursement Account depending upon the employee's eligibility.

If the employee is eligible for HSF, the employee will be notified and must complete the HSF application process to get enrolled in the program. An employer does not enroll an employee into HSF. If the employee is ineligible for HSF, then they will be given a Medical Reimbursement Account (MRA). All funds contributed on the employee's behalf by the employer are deposited into this account and the employee can access these funds to reimburse for out-of-pocket health care expenses.

Since implementation of the ESR (January 2008) to May 2009, roughly 960 employers have elected to use the City Option. These employers have committed \$45.541 million on behalf of 42,247 employees (eligible for either HSF or MRA). Of that amount,

<sup>7</sup> Complaints identified as "other" pertain to individual isolated circumstances that cannot be classified universally.

<sup>8</sup> The majority of the complaints regarding Point of Service fees are from one HSF primary care medical home associated with a non-DPH clinic.

roughly half is for employees are potentially eligible for HSF (\$22.643 million) and the other half are potentially eligible for MRA (\$22.898 million). Of the total funds committed by employers, \$44.330 million in health care expenditures (97%) have been collected to date.

Employer payments are submitted to the HSF Third-Party Administrator (the San Francisco Health Plan) for processing. The Third-Party Administrator transfers the Healthy San Francisco component of the employer payments to DPH on a periodic basis. DPH then submits these funds to the City Controller's Office for processing and deposit. In accordance with the Health Care Security Ordinance, those funds are used for the HSF program. To date, \$21.152 million in funds have been transferred from the Third-Party Administrator to the City and County of San Francisco. The amount transferred includes any employer contributions and HSF program participation fees paid by enrollees on a quarterly basis.

Employer health care expenditures designated for a Medical Reimbursement Account are not transferred to the City and County of San Francisco. Participant eligibility and contribution information is forwarded to the Medical Reimbursement Account vendor and accounts are created for each employee to use for reimbursable health care expenses. Funds are transferred weekly to the MRA vendor for claims and monthly for administrative fees.