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MEMORANDUM

DATE: April 16, 2010

TO: Jim Illig, Health Commission President, and Members of the Health Commission

FROM: Tangerine Brigham, Deputy Director of Health, Director of Healthy San Francisco
Colleen Chawla, Director of Grants and Special Projects

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

RE: **April 20, 2010 Health Commission Meeting - Health Reform**

This memo summarizes the recently-enacted federal Health Reform and will be presented to you at your April 20, 2010 meeting.

I. Introduction

In March 2010, the President signed H.R. 3590, the Patient Protection and Affordable Care Act, and H.R. 4872, the Health Care and Education Reconciliation Act of 2010. These bills make historic changes to the U.S. health care system and are referred to herein together as Health Reform.

Health Reform is projected to insure 32 million people who are uninsured today. (See Appendix A.) Ultimately, 92 percent of U.S. residents will have health insurance by 2016. This estimate includes approximately 9 million non-elderly undocumented persons.

In California, Health Reform is anticipated to provide health insurance for 7.3 million individuals who are currently uninsured. U.S. citizens and legal residents will be required to have health insurance. To help individuals meet that requirement, Health Reform expands eligibility for Medicaid, creates health insurance exchanges to allow individuals and small businesses to purchase coverage, and creates new requirements for private health insurance providers to make health insurance more accessible and affordable. Health Reform makes a number of tax changes and includes cost containment measures as well as provisions to improve quality and performance. In addition, Health Reform makes investments in public health, including prevention and wellness programs, and the healthcare workforce. These reforms will be implemented incrementally over the next 10 years. (See Appendix B.)

Within the framework for Health Reform, there lies ahead a significant amount of work on interpretation and implementation that must be accomplished at the federal and state levels. For that reason, it is too early to say with any certainty or specificity what impact these reforms will have on San Francisco. However, this memo provides a summary of the major components of

Health Reform and addresses the potential impacts on San Francisco and the Department of Public Health.

II. Major Components of Health Reform

At more than 2,500 pages, the Health Reform law contains numerous and complex changes to federal law across numerous issue areas. Following is a brief overview of Health Reform's major provisions.

A. Individual Mandate

Beginning January 1, 2014, most U.S. citizens and legal residents will be required to have baseline health insurance. There are exemptions to this requirement for undocumented immigrants, financial hardship, religious objections, American Indians, people who have been uninsured for less than three months, incarcerated individuals, those for whom the lowest cost plan option exceeds 8 percent of their income, and those with incomes below the tax filing threshold. Individuals will be able to access health insurance through expanded public programs, employer-based insurance, or individual coverage purchased through a health benefit exchange. Individuals who do not obtain coverage will be required to pay an annual financial penalty of \$695 per person (up to a maximum of \$2,085 per family) or 2.5 percent of household income, whichever is greater. The penalties will be phased-in between 2014 and 2016.

B. Medicaid Eligibility Expansion

Also effective January 1, 2014, Health Reform will expand Medicaid (Medi-Cal in California) to all individuals under age 65 (including children, pregnant women, parents and adults without dependent children) with incomes up to 133 percent of the federal poverty level (FPL). Under the current law, FPL limits for Medicaid eligibility vary by state and adults under age 65 without dependent children are not currently eligible for the program. States are required to maintain current eligibility limits levels for children in Medicaid and the Children's Health Insurance Program through September 30, 2019. Health Reform will eliminate the asset test for most Medicaid populations (excluding seniors in long term care).

States will receive 100 percent federal funding for the expanded patient population from 2014 through 2016, with federal rates of 95 percent in 2017, 94 percent in 2018, 93 percent in 2019 and 90 percent thereafter. States have the option to expand eligibility as early as 2011; however, they would not receive the enhanced federal matching rate until January 1, 2014.

Undocumented individuals will continue to be ineligible for non-emergency Medicaid. "New" legal immigrants (here less than five years – the population California currently serves under a state-only Medi-Cal program) will also continue to be ineligible.

C. Health Benefit Exchanges

States will be required to create health benefit exchanges, operated by either a governmental agency or a non-profit organization, through which individuals or small businesses may purchase health insurance. States may create one exchange for individuals and one exchange for small businesses or combine the two. States may also form regional exchanges or allow more than one exchange to operate in the state if it serves a distinct geographic region. Citizens and legal

immigrants and employers with up to 100 employees may purchase coverage through an exchange.

Plans in the exchanges will be required to offer benefits that meet a minimum set of standards. Insurers will offer four levels of coverage that vary by premiums, out-of-pocket costs, and benefits beyond the minimum requirements plus a catastrophic coverage plan.

D. Premium and Cost-Sharing Subsidies

Premium credits will be provided to individuals and families with incomes between 133 percent and 400 percent of FPL to help them purchase insurance through exchanges. These subsidies will be offered on a sliding scale basis and will limit the cost of the insurance premiums to between 2 percent of income for people with incomes up to 133 percent of FPL and 9 percent of income for people with incomes between 300 and 400 percent of FPL.

Cost-sharing subsidies will also be available to people with incomes between 133 and 400 percent of FPL to limit out-of-pocket spending.

E. Basic Health Plan

Health Reform provides states the option to create a Basic Health Plan for uninsured individuals with incomes between 133-200 percent of FPL who would otherwise be eligible to receive premium subsidies in the exchange. States opting to provide this coverage will contract with one or more standard plans to provide at least the essential health benefits and must ensure that eligible individuals do not pay more in premiums than they would have paid in the Exchange and meet certain cost-sharing requirements. Individuals with incomes between 133 and 200 percent of FPL in states creating Basic Health Plans will not be eligible for subsidies in the Exchanges and states will receive 95 percent of the funds that would have been paid as federal premium and cost-sharing subsidies to establish the Basic Health Plan.

F. Temporary High-Risk Pool

The U.S. Department of Health and Human Services (HHS) will establish a new national temporary high-risk pool that will subsidize the cost of health insurance for individuals with pre-existing conditions who have been uninsured for at least six months. The new federal risk pool must be established by mid-June 2010 and will be in place until 2014, when health insurers will be barred from denying coverage to people with health problems. The Government Accountability Office estimates that 4 million people who are uninsured and have health problems would be eligible for the temporary risk pool. HHS plans to work with existing state high-risk pools, such as California's Major Risk Medical Insurance Program, wherever possible.

G. Medicare "Doughnut Hole"

Each year, the Medicare Part D drug benefit provides coverage for medications up to a certain level (\$2,830 in 2010). Once a beneficiary's total drug cost reaches that level, Medicare coverage ceases until beneficiaries have spent a certain amount of their own money (\$3,610 in 2010). Once that happens, catastrophic coverage steps in and pays 95 percent of the remaining costs for the rest of the year. That gap is called the "Doughnut Hole." Health Reform will

incrementally close the Medicare Part D “Doughnut Hole” by reducing beneficiary responsibility for the gap from 100 percent to 25 percent by 2020.

Beginning this year, Medicare beneficiaries who reach the Part D coverage gap will receive a \$250 rebate. In 2011, pharmaceutical manufacturers will provide 50 percent discounts on brand name drugs in the gap. Federal subsidies will incrementally bring the patient share down to 25 percent by 2020. Federal subsidies will also incrementally reduce the patient cost of generic drugs in the gap from 100 to 25 percent.

H. Insurance Reforms

Among the first of the health insurance reforms to be implemented is the expansion of health insurance coverage for dependents up to age 26 and the elimination of pre-existing condition exclusions for dependent children up to age 18. Beginning in 2014, health insurers will be prevented from denying coverage to people for any reason, including their health status, and from charging people more based on their health status and gender. Health plans will also be required to provide comprehensive coverage that includes at least a minimum set of services that covers behavioral health at parity with physical health, caps annual out-of-pocket spending, provides preventive services without cost-sharing, and prohibits annual or lifetime limits on coverage.

I. Employer Requirements

Though there is no employer mandate, beginning in 2014, employers with more than 50 employees will be assessed a fee of \$2,000 per full-time employee if they do not offer coverage and if they have at least one employee who receives a premium credit through an exchange. Employers that do offer coverage but have at least one employee who receives a premium credit through an exchange will also be assessed a fee. Employers that offer health insurance may avoid this penalty by providing employees with incomes below 400 percent of FPL whose share of employer-sponsored insurance premiums would be between 8 percent and 9.8 percent of their income with a free choice voucher. The voucher amount is to be equal to the employer contribution to health insurance and will offset the premium costs for plan the employee purchase through the exchange.

III. Important Considerations

A. Federal Implementation

It is important to emphasize that the Department cannot assess with any level of precision how each of the various components in Health Reform will be implemented and their exact impact. The federal Health Reform legislation signed by the President established the policy directive, broad guidelines and program parameters. It did not provide the specific regulatory and operational components that are necessary to implement the various legislative components. This will be the responsibility of the federal Department of Health and Human Services. The legislation is comprehensive and complex with various components going into effect at different times over the next four years. As a result, it is very likely that the various federal regulations needed to implement Health Reform will be done in a step-wise manner as opposed to at once.

B. State Role

While health care delivery is at the local market level, implementation of key components of this Health Reform effort rests with states, not localities. Much of the heavy lifting will be at the state level, but states cannot proceed until additional federal guidance and regulations are finalized. Once this has taken place, then states can begin adopting their own applicable legislation, regulations and/or new programs consistent with the federal provisions. It is important to note that they will be doing this in the context of a \$20 billion deficit. Absent these two necessary conditions, it is difficult to fully ascertain at the local level how the provisions will be implemented and their impact.

C. 1115 Waiver

For California, implementation of Health Reform has another dimension related to the State's Section 1115 Waiver. A Section 1115 waiver provides authority to waive many of the federal requirements that normally apply to a state that accepts federal funding for Medicaid (with required federal budget neutrality). The State of California has a five-year Medi-Cal Hospital/Uninsured Care Section 1115 Demonstration Waiver that provides funding to the safety-net hospitals, implements Medicaid reforms and creates the Health Care Coverage Initiative (HCCI). The Department participates in both the safety net care pool and HCCI. This waiver is scheduled to expire on August 31, 2010.

The State's goal is to have a new waiver in place before the current waiver expires. In December 2009, the State submitted a concept paper to the federal government seeking another five-year waiver (from September 1, 2010 – August 31, 2015). The waiver concept paper includes several targeted initiatives including safety net hospital financing, managed Medi-Cal for seniors and persons with disabilities, redesign of the California Children's Services Program, integration of behavioral health and physical health, partnering with Medicare on care for the dual eligibles, and expansion of the HCCI, which the State believes helps "prepare for federal Health Reform and enhance the delivery system for the uninsured."

While additional federal funding may be available to the state through the renewed waiver, a corresponding state government match is required to access those funds. Given California's current budget situation, there is concern that the required match may be sought from counties. Still, a new State 1115 waiver presents a potential opportunity to serve as a bridge to Health Reform enabling the State to implement aspects of health care reform sooner and/or in a manner appropriate to the diversity of the State.

D. State Attorneys General Lawsuit

As Health Reform was being signed by the President, Florida State Attorney General Bill McCollum filed a lawsuit alleging that Health Reform was unconstitutional. Fourteen states are currently a party to the lawsuit, which claims that Health Reform is an illegal expansion of Congress' regulation of interstate commerce and unfairly penalizes uninsured people who refuse to buy into the program. Legal scholars believe the suit is likely to end up in the hands of the Supreme Court, but many agree that the supremacy clause of the Constitution, which puts the powers of the U.S. government above those of the states, will prevail.

IV. Potential Impact on San Francisco and the Department of Public Health

A. Medicaid Eligibility

Impact Assessment: Health Reform will increase eligibility for Medicaid, increasing Medicaid reimbursement and decreasing the number of uninsured patients cared for at DPH facilities. For every one percent shift from uninsured to Medicaid among the Department's patient population, DPH's hospitals and clinics would receive an estimated \$800,000 in additional reimbursement.

The federal Medicaid eligibility expansion is expected to increase enrollment by 16 million nationwide and by as much as two million in California. (See Appendix C.) Using San Francisco's percentage of the Medi-Cal population as a guide, Health Reform could add as many as 36,000 new Medi-Cal beneficiaries to San Francisco's existing enrollment of approximately 125,000. This represents an increase of nearly 29 percent, which is consistent with national projections.

To provide some estimate of the impact of how a shift in patient population from uninsured to Medi-Cal would impact DPH, using current Medi-Cal reimbursement rates, it is estimated that DPH would receive an additional \$800,000 for every one percent increase in Medi-Cal volume. (This estimate does not include reimbursement for Community Behavioral Health Services, which is discussed in Section IV.D., below.) Were all persons eligible for Medicaid to enroll in DPH, revenue would be \$23 million. However, undoubtedly a substantial proportion would choose other providers.

B. Disproportionate Share Hospital Funding

Impact Assessment: While it is impossible at this time to calculate with any accuracy the amount of Disproportionate Share Hospital funding reductions DPH will experience, DPH estimates show annual reductions ranging from \$2.9 million to \$32.4 million beginning in 2014 for a total aggregate reduction of \$104.7 million over seven years.

The Disproportionate Share Hospital (DSH) program provides special funding to hospitals in recognition of the higher operating costs they incur in treating a large share of low-income patients. Health Reform makes annual reductions to both the Medicaid and Medicare DSH programs beginning in 2014, when significant enhancements to Medicaid eligibility and private insurance requirements become effective. The reductions in DSH payments coincide with the increase in Medi-Cal reimbursement from newly insured patients described in the previous section.

Health Reform directs the Secretary of Health and Human Services to develop a methodology for imposing the DSH reductions based upon a number of factors and provides no guidance on how states are to allocate DSH funds to individual hospitals. Additionally, California's Medicaid DSH funding is currently provided through the state's 1115 Medicaid waiver, which, as discussed above, will be renewed with significant modifications later this year. While these factors make it impossible to predict precisely how the DSH reductions will affect San Francisco General Hospital, the table below provides a preliminary estimate.

**San Francisco General Hospital
Preliminary Estimates of DSH Reductions in Health Reform**

	Baseline	Estimated Reduction
FY 08-09 Medicare DSH Baseline:	9,232,103	
TOTAL MEDICARE DSH REDUCTION (beginning no later than 2014; may be phased-in over time)		6,924,077
FY 09-10 Medicaid DSH Baseline:	65,586,000	
Annual Medicaid DSH Reductions:		
2014	4.4%	2,892,497
2015	5.3%	3,470,997
2016	5.3%	3,470,997
2017	15.9%	10,412,990
2018	44.1%	28,924,972
2019	49.4%	32,395,968
2020	35.3%	23,139,977
TOTAL MEDICAID DSH REDUCTIONS		104,708,398

Comparison of the amount of revenue potentially gained through a Medicaid expansion but potentially lost through DSH. This provides a sobering glimpse of the potential impact of Health Reform on counties.

C. Primary Care

Impact Assessment: The Medicaid primary care rate enhancements provided in Health Reform are not expected to impact DPH revenue as primary care services at DPH are reimbursed as federally qualified health centers. However, Health Reform includes several other potential competitive grant funding opportunities to expand access to primary care.

The critical role of primary care is recognized and supported in several ways under Health Reform. In addition to the numerous workforce development opportunities described below, health reform makes investments in services and construction for community health centers and federally qualified health centers. Health Reform increases Medicaid rates for primary care physicians to 100 percent of the Medicare rates for 2013 and 2014 and Medicare provides incentive payments for primary care providers. The cost of the enhanced Medicaid rate will be borne by the federal government. These provisions are not expected to increase reimbursement for DPH, because DPH provides primary care services through federally qualified health clinics rather than through individual primary care physicians.

Health Reform also establishes a Primary Care Extension program that will support and assist primary care providers with the dissemination and implementation of innovations and best practices to improve community health. State/Multi-state Hubs and local extension programs will be created to administer the program. If they accomplish their goals, these improvements will attract new primary care providers into the health care system to help share the responsibility for providing care to newly insured populations.

D. Behavioral Health

Impact Assessment: Health Reform will increase eligibility for Medicaid, increasing Medicaid reimbursement and decreasing the number of uninsured patients cared for in DPH's Community Behavioral Health Services. This shift from uninsured to Medi-Cal is estimated to result in additional revenue of \$19.8 million. Additional grant funding opportunities may also be available.

Much like the benefit to DPH's hospitals and clinics described in Section IV.A.1. above, increased enrollment in Medi-Cal will result in new revenues for currently uninsured Community Behavioral Health Services (CBHS) clients. Applying CBHS's Medi-Cal penetration rate of approximately 17.5 percent to the estimated 36,000 individuals that are anticipated to become eligible for Medi-Cal in 2014, it is estimated that approximately 6,300 newly-eligible Medi-Cal beneficiaries may be served by CBHS. Using current data on approved claim per beneficiary, CBHS estimates that the shift from uninsured to Medi-Cal for those 6,300 clients would result in approximately \$19.8 million in additional revenue annually. Approximately 3,000 CBHS clients will continue to be uninsured. It is also possible that the new parity requirement for private insurance will decrease the number of insured patients who seek behavioral health services with DPH because the needed services are now covered by their current insurance. Additionally, the closure of the doughnut hole is expected to decrease DPH expenditures for CBHS patients in the mental health system, though we do not yet have an estimate of that amount.

Also in the area of behavioral health, Health Reform will make available competitive grant funds for demonstration projects to provide coordinated and integrated services to adults with mental illnesses who have co-occurring primary care conditions and chronic diseases. Eligible projects will provide services through the co-location of primary and specialty care services in community-based mental and behavioral health settings. Health Reform authorizes up to \$50 million in 2010 and additional sums as necessary through 2014. However, it is important to note that these funds are subject to federal appropriation.

E. Long-Term Care

Impact Assessment: Health Reform provides a number of incentives and opportunities for states to enhance home- and community-based long-term care services for Medicaid beneficiaries. Though access to funding will be largely dependent upon federal and state implementation, these investments could be used to support DPH's Direct Access to Housing program and compliance with the Chambers Settlement Agreement.

Health Reform provides states with new options for offering home and community-based services for Medicaid beneficiaries. Beginning October 1, 2010, Health Reform establishes a new Medicaid state plan option called the Community First Choice Option to cover community-based attendant services and supports to help Medicaid beneficiaries with daily activities and health-related tasks. States that adopt this option will receive a 6 percent increase in the federal match for costs associated with this program. The new State Balancing Incentive Payment Program, effective October 1, 2011 through September 30, 2015, further incentivizes states to make structural and administrative changes designed to increase the proportion of non-institutionally-based long-term care services. Health Reform also requires the HHS to improve coordination of care for patients who are eligible for both Medicaid and Medicare. These enhanced opportunities for community-based care could help DPH meet its goal of placing

individuals referred to and discharged from Laguna Honda Hospital in the most integrated setting appropriate to their needs and preferences. These settings may include options available under DPH's Direct Access to Housing program. However, at the current time we do not know whether California will adopt this option.

F. Public Health and Prevention

Impact Assessment: Over the next several years, Health Reform could provide several potential public health funding opportunities for DPH. Grants for a number of prevention and wellness activities will be awarded on a competitive basis.

In addition to requiring health plans to cover preventive care, Health Reform provides a number of potential public health, prevention, and wellness funding opportunities. A new Prevention and Public Health Fund was created to incrementally increase funding of programs authorized by the Public Health Service Act for prevention, wellness, and public health activities above the FY 2008 levels. Which programs would be subject to the increase and how the additional funding would be allocated remains unclear.

Additionally, funding will be made available to states for early childhood home visitation beginning this year and increasing incrementally through 2014. The specific qualifications and guidelines for implementation are yet to be finalized, but DPH's Maternal, Child, and Adolescent Health division is working closely with the State to ensure that DPH will be poised to take whatever action is needed to become eligible for funding.

Health Reform also establishes a number of new public health program opportunities, subject to federal appropriation and awarded through competitive bid processes. Potential areas of interest include:

- Community- and school-based health centers
- Prevention and reduction of chronic disease and health disparities
- Healthy aging programs
- Childhood nutrition and physical exercise
- Epidemiology and laboratory capacity

G. Workforce Development

Impact Assessment: Health Reform provides a number of provisions intended to expand and develop the health care and public health workforces. These enhancements could broaden the provider base serving San Francisco's safety net population and may also provide DPH with opportunities to become directly involved in provider training.

Health Reform includes numerous potential opportunities for expanding and developing the health care workforce as well as the public health workforce. On the health care side, many of the development opportunities focus on the provision of primary care. These provisions include:

- Training programs that focus on primary care models, such as medical homes, team management of chronic disease, and those that integrate physical and mental health services;

- Grants to teaching health centers, defined as community-based, ambulatory care patient centers that may include federally qualified health centers, to establish or expand primary care programs;
- Grants to employ and provide training to family nurse practitioners who provide primary care in federally qualified health centers and nurse-managed health clinics;
- A multi-pronged approach to addressing the projected shortage of nurses and retention of nurses;
- Enhancements to recruitment and training programs, scholarships, loan repayment programs for a variety of health care professionals, including primary care practitioners, physician assistants, nurses, pediatric specialists, and dentists; and
- Redistributing unused Graduate Medical Education slots with priority given to primary care and general surgery.

On the public health side, Health Reform's workforce developments include:

- Training in preventive medicine and public health for medical residents;
- Targeted activities to address documented workforce shortages in state and local health departments in the areas of applied public health epidemiology and public health laboratory science and informatics;
- Grants for the operation of nurse-managed health clinics;
- Scholarships for mid-career professionals in the public health and allied health workforce to receive additional training in these fields;
- Establishment of the U.S. Public Health Sciences Track, to award advanced degrees in public health, epidemiology, and emergency preparedness and response; and
- A public health workforce loan repayment program.

H. Local Health Care Programs

Over the past several years, the City and County of San Francisco has undertaken efforts to improve access to care ranging from the creation of local health insurance programs to employer and contractor mandates to a local health access program. The City and County created these programs in the absence of national Health Reform.

The passage of Health Reform requires a re-examination of the following local health care policies and programs:

1. Health Care Security Ordinance (Employer Spending Requirement and Healthy San Francisco)
2. Local health insurance programs (Healthy Workers and Healthy Kids)
3. Health Care Accountability Ordinance

This is principally because Health Reform creates an individual mandate for health insurance, expands health insurance opportunities for the uninsured and imposes employer requirements. Health Reform requires the Department to evaluate the continuation, program eligibility, target population, etc. for each local health care initiative that has been created.

As much as possible, given the individual health insurance mandate and available health insurance options, the Department's approach must be to ensure that its local health programs do

not create a disincentive for individuals to enroll in the federal/state subsidized health insurance options. As the Department undertakes efforts to help expand health insurance under Health Reform, a few guiding principles for consideration are, to the fullest extent possible:

- San Francisco should actively encourage and provide assistance to eligible uninsured residents so that they are enrolled in one of the subsidized health insurance options available to them.
- San Francisco should seamlessly transition those San Francisco residents enrolled in a locally developed health insurance program into a federal/state subsidized health insurance option to efficiently use local City and County General Fund for uninsured residents without these options.
- San Francisco should ensure that the eligibility determination process for its health access program is modified as appropriate to assess eligibility for any new federal/state health insurance programs.

The key Health Reform components impacting health care programs created in San Francisco are:

- Access to high-risk health insurance pools for individuals with no insurance due to pre-existing conditions (beginning 7/2010)
- Expansion of dependent coverage for young adults up to age 26 (beginning 10/2010)
- Requirement of an individual health insurance mandate (beginning 2014)
- Expansion of public health insurance programs (beginning 2014)
- Creation of subsidized health insurance exchanges for the uninsured to purchase insurance (beginning 2014)
- Elimination of provisions that allow health insurers to deny coverage based on pre-existing conditions, etc. (beginning 2014)
- Employer requirements related to provision of health care coverage or payment of a penalty (beginning 2014)

At this time, the Department is not recommending any changes to the local health programs and initiatives developed in San Francisco. However, over the course of the next 12 – 36 months, before Health Reform is fully implemented, the Department will work with other key stakeholders to fully assess each program and develop a comprehensive strategy and plan for continuing, modifying or ending any particular health care initiative.

1. Summary of Health Insurance Options for the Uninsured

Under Health Reform, all eligible citizens and legal immigrants are mandated to have health insurance (with exemptions noted individuals above in Section II.A.). Individuals taking up health insurance offered through an employer will be deemed as meeting this provision. Those who do not take up employer-based coverage would be required to obtain coverage through one of the options sited below. Eligible uninsured San Francisco residents will be eligible to participate in one of the following:

Health Insurance Program	State Option to Implement	Federal Poverty Level	Enrollee Subsidies	Effective Date
Medicaid Expansion	No	0% - 132% FPL	Not Applicable	1/1/2014 (or sooner)
Basic Health Plan	Yes	133% - 200% FPL	Yes	1/1/2014 (or sooner)
Health Exchange	No (states can work with non-profits)	133% and above	Yes, up to 400% FPL	1/1/2014 (or sooner)
High Risk Pool	National Level	All Income Levels	Yes	6/2010 - 1/1/2014

While Medicaid is being expanded to those with incomes up to 133 percent of FPL, at this time, it is not clear what the scope of benefits will be, how care will be delivered to this population (i.e., managed care system or fee-for-service system) or how eligibility and enrollment will occur in California under the Medi-Cal program.

It is important to note that Health Reform recognizes that to require individuals to have health insurance and to require guarantee issue from health insurers without sufficient provider capacity would be disastrous. In an effort to promote improved access to primary care and to attract providers to serve what will be a newly insured population, Health Reform increases Medicaid payments (fee-for-service and managed care) for primary care services provided by primary care doctors to 100% of the Medicare payment rates for 2013 and 2014. States receive 100% federal financing for the increased payment rates. It is unclear what happens to these rates post-2014.

The Department supports any and all efforts that result in expanding the pool of private providers serving low-income populations. This is critical to ensuring sufficient access to care and clinical capacity across all health care delivery systems -- safety net, community-based and private sector. In the past, federal and state financing mechanisms have not created the appropriate financial incentives to entice providers to serve this population. Health Reform begins to tackle this issue directly through enhanced provider reimbursement.

2. San Francisco Health Care Security Ordinance

In 2006, the City and County implemented its own local health care reform effort with passage of the San Francisco Health Care Security Ordinance. The principal goal of the Ordinance was to expand access to health care benefits for uninsured workers and residents by creating two new provisions: (1) the mandated Employer Spending Requirement (ESR) and (2) the Healthy San Francisco (HSF) program.

Federal Health Reform will have a potential impact on aspects of the Ordinance. However, the impact would likely not occur until 2014 when the major components of Health Reform become effective.

a) Employer Spending Requirement (ESR)

Impact Assessment: The ESR remains in effect. The Department is aware of no language in Health Reform which suggests an intent by the federal government to interfere with San Francisco's ESR. Although the City Attorney's Office is analyzing Health Reform in more detail, the City and County will operate under the assumption that it remains fully authorized to operate the ESR. As noted above, the federal employer requirement does not take effect until 2014. To

the extent any inconsistency may arise in the implementation of Health Reform and ESR, these can presumably be addressed with either federal or local regulation between now and 2014.

The ESR and Health Reform share a similar objective; namely, to ensure that employers provide health benefits to their employees. However, each provision approaches this common goal differently with respect to employer obligation, business size, covered employee and employer expenditure. (See Appendix D.)

Health Reform is narrower in its intent and impact than ESR. The significant differences between Health Reform and ESR are:

1. Health Reform does not create an employer mandate, while ESR is an employer mandate.
2. Health Reform applies to a smaller number of employers (i.e., size of business based on number of employees) and employees (i.e., eligible employees based on hours worked) than ESR.

Data on employer compliance with the ESR is not yet available. The Office of Labor Standards Enforcement, which oversees the ESR, is currently analyzing annual employer reporting data to determine rate of compliance, health care options offered by employers and expenditures made by employer. With respect to employer selection of the City Option (which includes Healthy San Francisco), since implementation of the ESR, roughly 1,070 employers have chosen this option on behalf of 52,000 employees.

As the Health Commission is aware, in June 2009, the Golden Gate Restaurant Association filed a petition with the United States Supreme Court requesting that the Court rule on the legality of the ESR. On October 2009, the Supreme Court invited the United States Solicitor General to file a brief expressing the federal government's views on the case. The Court will decide whether to hear the case after reviewing the Solicitor General's brief. While the Court considers whether to hear the case, the Ninth Circuit's September 2008 decision upholding the ESR continues to be in effect for all covered businesses.

b) Healthy San Francisco (HSF)

Impact Assessment: Full implementation of the Health Reform (after 2014) will decrease the number of adults San Francisco residents eligible for and enrolled in HSF. However, because the major health insurance expansion components of the Health Reform do not take effect until January 2014, DPH does not anticipate an immediate or significant reduction in HSF enrollment or HSF General Fund expenditures at this time. In addition, the HSF program will still be needed after Health Reform is fully implemented.

Health Reform is beneficial to San Francisco on two fronts:

1. Health Reform provides health insurance opportunities for uninsured some HSF participants. Health insurance is preferable to HSF.
2. Some health care services costs now incurred by the City and County's General Fund for the HSF program will be funded by federal/state funds post 2014.

At the same time, full implementation of Health Reform (post 2014) will not dismantle HSF. The City and County will still need to maintain and operate the HSF program, albeit serving fewer people. The HSF program will continue because:

1. Health Reform does not cover all uninsured individuals (e.g., those with exemptions).
2. While Health Reform creates an individual mandate for health insurance, it is unlikely that all uninsured individuals will comply with this mandate. Some uninsured individuals may elect not to enroll in the subsidized health insurance exchanges or purchase private insurance for various reasons (e.g., financial, inability to complete paperwork, etc.). Financially, some may decide that the cost of getting health insurance through the exchange is more than the combined cost of participating in HSF and paying the penalty for not having health insurance.
3. Some individuals may be unable to provide sufficient documentation of public health insurance eligibility, etc.

Because HSF is not health insurance, it could not be a health insurance product in any health exchange established by the State nor does enrollment in HSF meet the individual health insurance mandate. The Department is not recommending that HSF be converted to a health insurance plan or product; this is consistent with the legislative intent of the Health Care Security Ordinance. Over the course of next three years, the Department will re-examine key features of the HSF program (eligibility, fee/subsidy structure, network, etc.) to determine if changes are needed as components of the Health Reform legislation are implemented.

In many respects, implementation of Healthy San Francisco and the Department's participation in the Health Care Coverage Initiative will help prepare uninsured residents and providers for Health Reform. For example through HSF, the Department has:

- Created a single, streamlined eligibility determination and enrollment for multiple health programs – a stated goal in the Health Reform legislation
- Expanded the network of providers serving uninsured residents – this has been critical to ensuring access and combating preconceived notions related to serving uninsured persons
- Promoted the use of primary care medical homes – critical to reducing episodic care
- Data identifying uninsured adults that are potentially eligible for Medi-Cal – this will enable the City and County to work effectively and efficiently to assist individuals in the Medi-Cal application process.

Enrollment Assessment: DPH's current assessment of the impact of Health Reform on HSF enrollment is that of the current HSF participants (51,200), if all were still enrolled in the program in 2014, 60 percent (30,700) could disenroll from HSF and enroll in health insurance options created under Health Reform. This estimate was developed by examining the HSF population by income level. (See Appendix E.)

The estimate above is a very preliminary approximation, and will be subject to significant and constant revisions over time by DPH as more data becomes available. It is a point-in-time analysis with the following caveats:

1. It does not take into account any HSF enrollment gains that might occur between now and full implementation of Health Reform in 2014.
2. The HSF application was specifically designed not to require applicants to provide information on citizenship or provide information on employment status, pre-existing medical conditions, dependent coverage options (for young adults), etc. However, this is

the type of data that is needed to develop more precise estimates given Health Reform's approach to health insurance expansion and reform.

3. Updated data on the number of insured Californians at the county level is tentatively scheduled to be released by researchers at the UCLA Center for Health Policy Studies. This will revise the estimated number of uninsured adults in San Francisco.

3. Healthy Kids (HK) and Healthy Workers (HW)

Impact Assessment: Full implementation of Health Reform (after 2014) will decrease the number of children eligible for and enrolled in Healthy Kids. The City and County will need to assess the impact of Health Reform on Healthy Workers from a programmatic, eligibility and fiscal perspective. However, because the major health insurance expansion components of Health Reform do not take effect until January 2014, DPH does not anticipate an immediate or significant reduction in either program.

Healthy Kids (HK) and Healthy Workers (HW) are two health insurance programs created by the City and County in the early 2000s. HK covers children and youth (aged 0 – 18) in households with annual income up to 300 percent of FPL who are ineligible for either Medi-Cal or Healthy Families. HW covers In-Home Supportive Services workers registered with the San Francisco Public IHSS Authority.

HK covers two distinct children and youth populations: (1) undocumented who are ineligible for Medi-Cal or Healthy Families at any family income level and (2) citizens and legal immigrants ineligible for Medi-Cal or Healthy Families because their family income is above 250 percent of FPL. It is funded by City and County General Fund, Proposition J (via the Department of Children, Youth and Families), State Proposition 10 funding and the federal Children's Health Insurance Program; it is administered by the San Francisco Health Plan. It will be appropriate for the Department to reassess the continued need for and scope of a local health insurance program for children and youth. For example, children and youth in the second group noted above will be eligible for the health exchanges and should be appropriately transitioned to this health insurance exchange option.

Under Health Reform, IHSS workers will have expanded opportunities for health insurance. The City and County will need to know how Healthy Workers (HW) might work given Health Reform. HW, which is also administered by the San Francisco Health Plan, is funded partially with City and County General Fund and federal/state funding via a reimbursement mechanism overseen by the Human Services Agency. The San Francisco Public IHSS Authority acts as the employer of record for IHSS workers and contracts with the San Francisco Health Plan to provide health insurance to these individuals.

4. Health Care Accountability Ordinance

Impact Assessment: Full implementation of Health Reform (after 2014) does not appear to preempt the Health Care Accountability Ordinance which essentially functions as a City and County contracting requirement and not an employer health insurance mandate. However, under the Ordinance, the Health Commission sets the minimum standards met by employers (i.e., City and County contractors) and reviews the employer fee. This will need to be examined in light of the employer provisions of Health Reform.

The Health Care Accountability Ordinance (HCAO) requires that employers doing business with the City and County offer health insurance coverage which meets a set of minimum standards to their employees or pay a fee to the Department of Public Health to offset costs of health care provided to the uninsured.

V. Health Reform Task Force

Mayor Newsom announced the creation of a Health Reform Task Force to analyze the impact of health reform on San Francisco, and to make recommendations to the Health Commission, the Board of Supervisors, and the Mayor on: 1) any changes that San Francisco should make to existing programs to be better positioned for health reform and 2) any changes in State or Federal legislation or regulations that would benefit the health care received by San Franciscans. The task force will involve representatives from:

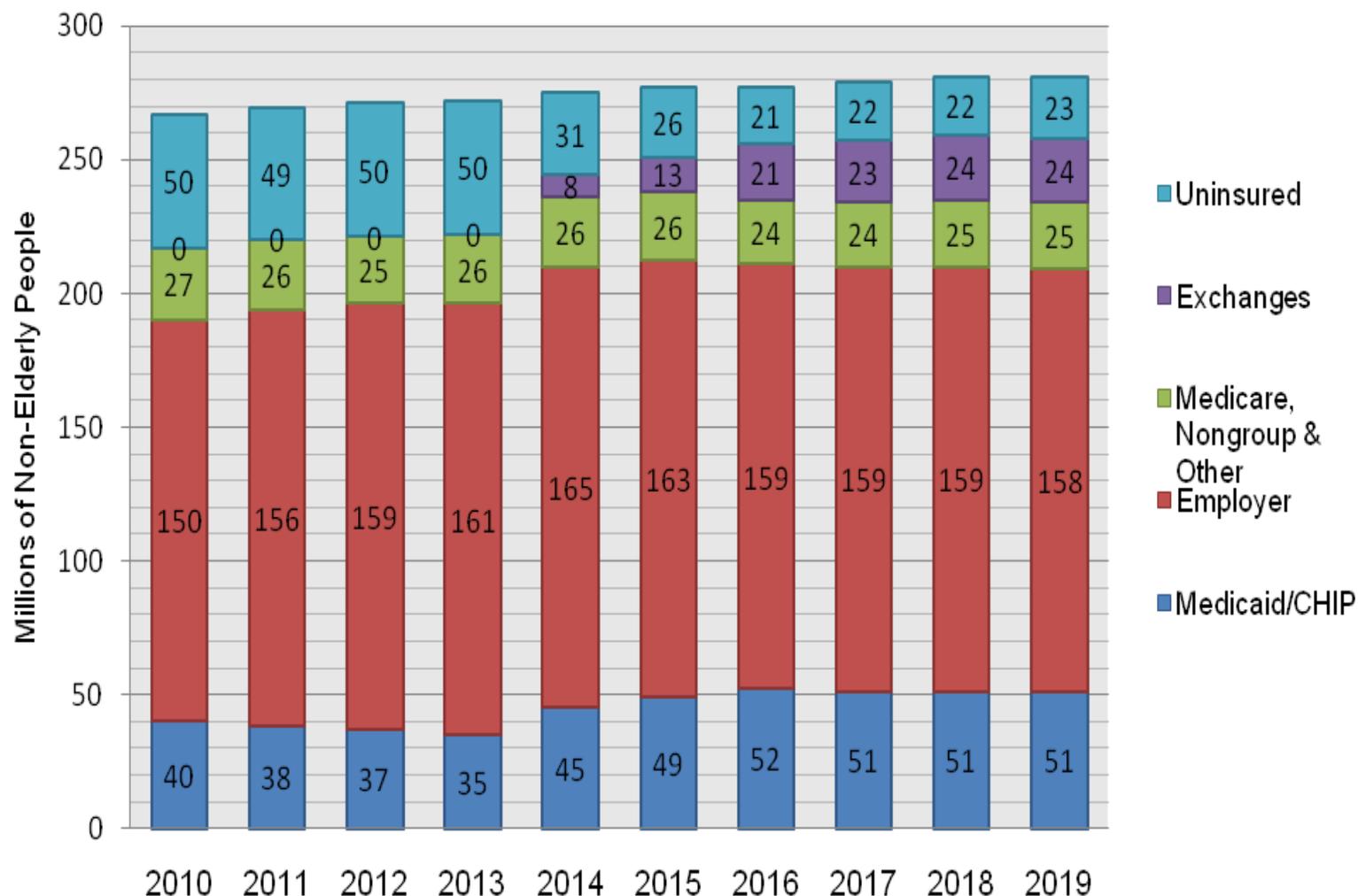
- Healthy San Francisco
- San Francisco City Attorney
- Department of Human Services
- Hospital Council of Northern and Central California
- San Francisco Community Clinic Consortium
- San Francisco Medical Society
- San Francisco Health Plan
- Organized labor
- Business community
- Patient's advocates

The Mayor asked Dr. Katz to lead the task force. We have not yet sent out invitations or scheduled a first meeting because to make the experience as efficient as possible for representatives, we are working now on gathering the necessary information and performing analyses so we can articulate to the members the likely impacts of the legislation for them to review as a starting point. In this respect, this Commission presentation, which includes separate presentations from several of our partners, is really the first step in gathering the necessary information for the task force.

VI. Summary

Health Reform brings tremendous opportunities to re-envision health care in San Francisco. The components of Health Reform that will impact DPH most directly will not take effect until 2014. Between then and now, federal and state implementation will become clearer and we will have the benefit of the insights of the Health Reform Task Force to help guide us to a new era of health care in San Francisco. We will continue to closely monitor Health Reform implementation and provide the Health Commission with regular updates on significant developments and seek policy guidance.

Appendix A
Year-by-Year Impact of Health Reform on Insurance Coverage Nationwide*



Source: Congressional Budget Office, letter to the Honorable Nancy Pelosi about a preliminary analysis by CBO and JCT of the direct pending and revenue effects of the reconciliation proposal (March 18, 2010).

Appendix B

Health Reform Implementation Timeline

90 days after enactment

- Provides immediate access to high-risk pools for people who have no insurance because of preexisting conditions.

Six months after enactment

- Bars insurers from denying people coverage when they get sick.
- Bars insurers from denying coverage to children who have preexisting conditions.
- Bars insurers from imposing lifetime caps on coverage and regulates annual limits.
- Requires insurers to allow young adults to stay on their parents' policies until their 26th birthday.

Within a year

- Provides a \$250 rebate to Medicare prescription drug plan beneficiaries in the Part D “Doughnut Hole.”
- Subsidies begin for small businesses to provide coverage to employees.

2011

- Provides a 50% discount on brand-name drugs for Medicare prescription drug plan beneficiaries in the Part D “Doughnut Hole.”
- Provides funding to build new and expand existing community health centers.
- Establishes a national, voluntary long-term care insurance program for community living assistance services and support.

2014

- Requirement begins for most people to have health insurance.
- Expands Medicaid eligibility to 133 percent of FPL.
- Creates exchanges where people without employer coverage, as well as small businesses, can shop for health coverage.
- Provides subsidies for families earning up to 400 percent of FPL to purchase health insurance.
- Requires most employers to provide coverage or face penalties.
- Subsidies for small businesses to provide coverage increase.
- Tax credits phase out for larger businesses.
- Insurance companies barred from denying coverage to anyone with pre-existing illness.

2016

- Penalty for those who don't carry coverage increases.

2017

- Businesses with more than 100 employees may be able to buy coverage on insurance exchanges.

2018

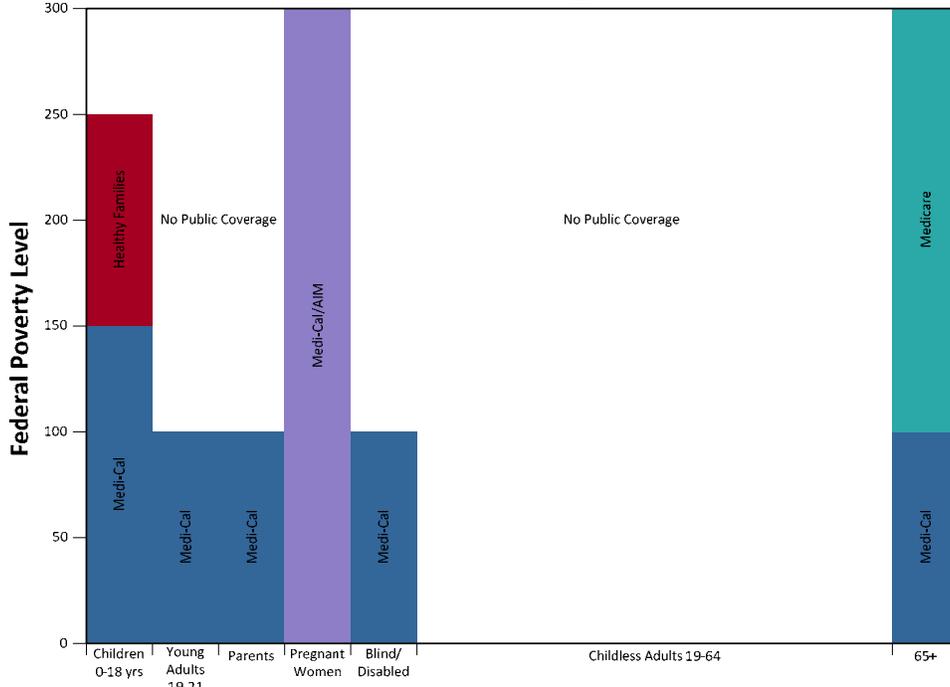
- Imposes a 40 percent excise tax on high-end insurance policies.

By 2019

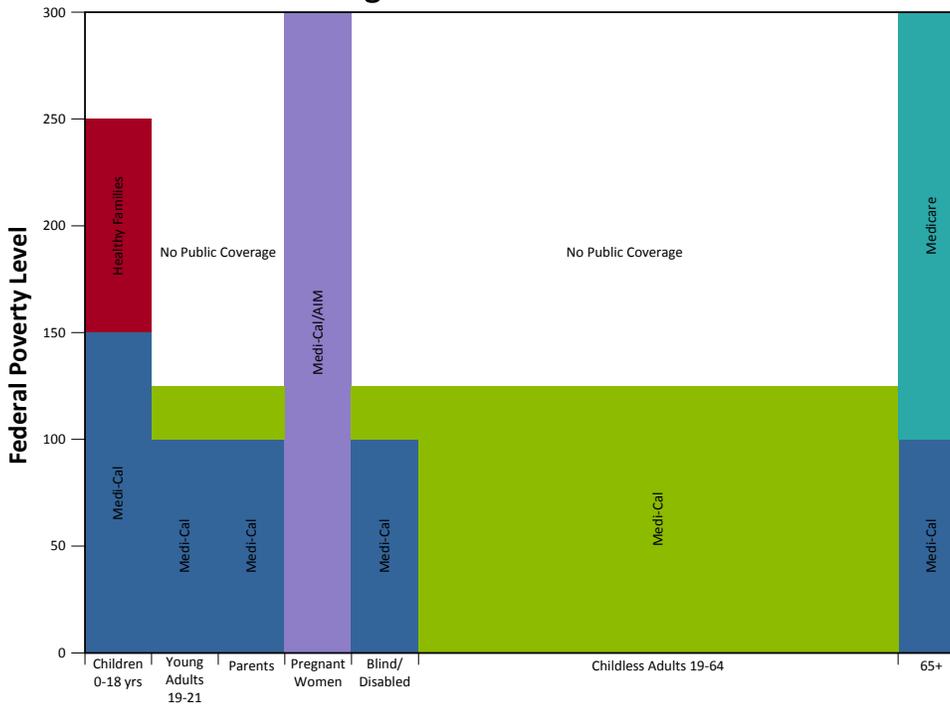
- Expands health insurance coverage to 32 million people.

Appendix C Effect of Medi-Cal Expansion

Current Public Coverage in California



Public Coverage Post-Health Reform in California



Appendix D
Health Reform and ESR Side-By-Side Comparison of Major Provisions

	Employer Mandate	Business Size	Eligible Employees	Employer Expenditure/Penalty
CCSF Employer Spending Requirement	Yes. Mandated provision to make health care expenditures.	<ul style="list-style-type: none"> • All for-profit businesses with 20+ employees • All non-profit businesses with 50+ employees 	At least 8 hours per week (after 90 days of work); includes seasonal workers	<ul style="list-style-type: none"> • Amount based on formula (size of employer and annual expenditure rate). • For 2010, \$1.31 for medium sized (20 -99) and \$1.96 for large sized (100+). • Adjusted annually.
Federal Health Care and Education Reconciliation of 2010	<p>No. Provision of health coverage or payment of assessed fee.</p> <p>Note: Employers with 200 or more employees must automatically enroll employee into insurance plan.</p>	All businesses with 50+ employees	Full-time employees (30 hours a week; excludes seasonal workers)	<ul style="list-style-type: none"> • If employer does not offer health insurance and at least one employee is in Exchange, annual penalty is \$2,000 per full-time employee (excluding first 30 employees). • If employer does offer health insurance and at least one employee is in Exchange, pay lesser of \$3,000 per employee in Exchange or \$2,000 per full-time employee. • Employees with 50 or fewer employees are exempt from penalties. • Penalty limit • Penalty amounts indexed after 2014.

Appendix E
Health Reform Impact of HSF Enrollment

	# of HSF Participants	Immediate Enrollment Impact (based on current enrollment)	Future Enrollment Impact (based on current enrollment)
High-risk health insurance pools for individuals with pre-existing conditions (PEC)	Unavailable – no data on HSF participants w/ pre-existing conditions	<ul style="list-style-type: none"> • Provision goes into effect 7/2010 • Unable to estimate. • Potential decrease in residents with PEC applying for HSF, if financially able to purchase in high-risk pool 	<ul style="list-style-type: none"> • Unable to develop estimate at this time • Note: Less than 1,000 HSF participants have incomes over 300% FPL
Expansion of coverage for young adults up to age 26	5,484 HSF participants aged 18 – 25 (with 4,719 of them having incomes up to 133%)	<ul style="list-style-type: none"> • Provision goes into effect 10/2010 • 70 – 80 HSF participants may disenroll (10% of those with w/ incomes above 133%) w/i next year 	Potential 5%-10% reduction in HSF enrollment by individuals in this age group starting in 2011
Expansion of Medicaid to those with incomes up to 133% FPL	<ul style="list-style-type: none"> • 39,234 HSF participants w/ incomes up to 133% FPL • No undocumented or employment status data for this income group 	None – provision does not go into effect until 1/2014	Potential 63% (24,700) reduction in HSF participants at this income level: <ul style="list-style-type: none"> • Estimated 70% of HSF participants may be legally eligible for Medicaid • Of those estimate 90% enroll in Medicaid
Health insurance exchanges for those with incomes 133% - 400% FPL	<ul style="list-style-type: none"> • 11,782 HSF participants have with incomes 133% - 400% FPL • No undocumented or employment status data for this income group 	None – provision does not go into effect until 1/2014	Potential 49% (5,800) reduction in HSF participants at this income level: <ul style="list-style-type: none"> • Estimated 70% of HSF participants may be eligible for health exchange • Of those estimate 70% enroll in health exchange
Individual health insurance mandate for US citizens and legal residents	<ul style="list-style-type: none"> • 51,200 HSF participants • Those w/ incomes above 400% FPL no Medicaid or subsidy in exchange • 200 HSF participants w/ incomes over 400% FPL • No undocumented or employment status data for this income group 	None – provision does not go into effect until 1/2014	Potential 50% reduction (200) in HSF participants at this income level: <ul style="list-style-type: none"> • Estimated 50% of HSF participants at income level may fulfill mandate either through employer based coverage or privately purchased
Elimination of exclusion for PEC	Unavailable – no data on HSF participants w/ PEC	None – provision does not go into effect until 1/2014	Unable to develop estimate at this time
Employer requirement	Unavailable – no data on employment status of HSF participants	None – provision does not go into effect until 1/2014	Unable to develop estimate at this time